

Clinical ARPs 101 Webinar

May 29, 2020

Frequently Asked Questions (FAQ)

These questions were gathered as a result of the Clinical ARP 101 Webinar on May 29.

This document is intended to help you understand Clinical Alternative Relationship Plans (cARPs), but the language in the cARP Program Parameters and Conditions of Payment Ministerial Orders (MOs) speak for themselves and the provisions within the MOs supersede all other agreements. The information contained in this document does not constitute legal advice and is not legally binding.

If there are discrepancies in the information contained in this document please contact:

webinar@albertadoctors.org so it can be addressed and corrected.

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Tools and Resources

- **For AMA assistance with clinical ARPs:**
 - For assistance with the annualized, sessional and full capitation models contact the AMA's ARP Physician Support Services at arpinquiries@albertadoctors.org or 1 (866) 953-3130
 - For assistance with the primary care Blended Capitation Model (BCM) contact: christine.deMontigny@albertadoctors.org or (780) 970-6204
 - For AMA negotiations and advocacy support for cARPs please contact: Didi.Wimmer-Frank@albertadoctors.org or (780) 482-0698
- **AMA ARP Physician Support Services (ARP PSS) Website:**
 - [Main Page](#)
 - [Guiding Principles for cARPs](#)
 - [Funding Models](#)
 - [Stakeholder Roles](#)
 - [Governance and Ministerial Orders](#)
 - [Rates](#)
 - [Listings and Map of Current cARPs](#)
 - [Application Process](#)
 - [Support and Resources](#)
 - [Forms](#)
 - [Frequently Asked Questions](#)
 - [Success Stories](#)
 - [Contact Information](#)
- **Alberta Health Website: Information on cARPs**
 - [Overview of ARPs](#)
 - [Models, Establishing a cARP, Operations, Contact Info](#)
 - [Annualized Model](#)
 - [Sessional Model](#)
 - [Blended Capitation Model](#)
 - [ARP Service Codes \(Non-SOMB Codes Eligible for Payment\) - Bulletin ARP3](#)
- [AMA Billing Advice](#)
- [AMA Fee Navigator](#)
- [AMA Virtual Code Information](#)
- [AMA Physician Benefit Programs](#)
- [HQCA Case Study Evaluation of Crowfoot and Taber Capitation Models](#)
- [CME Credits](#)
- **Academic Medicine and Health Services Program (AMHSP) Resources:**
 - [AMA Website AMHSP Information](#)
 - AMA AMHSP Email: AMHSP@albertadoctors.org
 - [Alberta Health Website AMHSP Information](#)

Live Webinar Questions & Answers

The following questions were directed to and addressed by panelists during the live webinar session on May 29, 2020. Panelist responses can be found in the [webinar's recording](#) as per the time stamps provided in the table below:

Question	Respondent	Answer Recording Time
You mentioned that Crowfoot model has demonstrated significant health system savings. What is your perspective on why Alberta Health has not made your model available to other applicants?	Dr. Ward	1:02:18
If your clinic was operating under fee-for-service right now and you were considering an ARP, what would be your biggest concerns?	Dr. Hanelt	1:04:06
The PICU is very tied into AHS operations. What is your perspective on physician autonomy in clinical ARPs and has Alberta Health or AHS ever directed changes to your program's practice or model of care, against the wishes of physicians?	Dr. Ross	1:06:45
You mentioned that you work in your program under a sessional ARP and in a primary care clinic under fee-for-service. From your perspective, which payment model do you prefer?	Dr. Carter	1:10:38
What is your perspective on physician flexibility in a clinical ARP with regard to working hours and vacation time off?	All panelists	1:12:15
From your perspective, what sort of characteristics would make a practice suitable to explore a clinical ARP?	Dr. Ward	1:15:23
What is the flexibility in the design of an ARP? Can some services be included and others excluded? How many physicians need to participate and what specialties can be included?	Dr. Carter, Dr. Hanelt, Dr. Ross	1:17:43
Can you comment on continuity - how challenging was it to achieve excellent continuity for your practice, how did you help patients understand the importance, and what impact did it have on your work hours/work conditions to maintain excellent continuity? Also, what is the average panel size each FTE carries? How have any part-time physicians managed within your model - have they been able to manage their continuity measures successfully?	Dr. Ward	1:20:18
Is there a minimum time that an ARP physician must work?	Dr. Ross, Carter, Hanelt	1:23:26
Do you think the average family doc makes more money with an ARP or FFS?	Dr. Ward	1:25:22

Post-Webinar Questions & Answers

The following questions were presented during and immediately following the webinar by attendees. These questions have been reviewed and consolidated into this FAQ document. If you have additional specific questions, or require further information, please contact webinar@albertadoctors.org.

General / Policy

How can a physician be comfortable entering an ARP given Ministerial Orders, Bill 21, and the government's focus on cutting physician payments?

Please refer to the [AMA President's Letter on May 15, 2020](#) for the AMA President's thoughts on this topic. One of the key points in this letter was, "The best way for us to move forward in the development of ARPs in Alberta is through a collaborative approach with government."

In order to increase physician trust and confidence in ARPs, and to assist the government with its goal of expanding physician uptake of ARPs, the AMA proposed the following changes to the clinical ARP framework during the course of recent negotiations with Alberta Health:

1. Implement contractual agreements, with fair dispute resolution mechanisms (instead of Ministerial Orders).
2. Utilize "Quadruple Aim" as the overall objectives for clinical ARPs.
3. Implement a multi-stakeholder governance structure for clinical ARPs.
4. Honour the original clinical ARP program principles.
5. Update clinical ARP rates and FTE definitions with current data.
6. Expedite the clinical ARP application and approval processes.

An ARP Working Group composed of ARP representatives from across Alberta has just been appointed. The AMA will continue to advocate for these and other improvements to ARPs as well as some of the bigger issues that exist in relation to the provinces approach with contracts in general.

It is clear that physician choices to enter into an ARP are best made voluntarily, without duress, coercion or undue influence. It is also undeniable that moving into new remuneration models requires a trusting relationship with government and with fair representation so that current information and a full exploration of options are considered. The AMA understands this sentiment.

Our goal would be, with fair representation, to have compensation mechanisms available to physicians that improve one's ability to care for patients by better aligning payments with patients' needs.

What is “Quadruple Aim”?

The [Triple Aim](#), developed by the Institute for Healthcare Improvement in 2007, describes an approach for optimizing health care performance focused on the following three dimensions:

1. *Improve the patient experience of care (including quality and satisfaction).*
2. *Improve the health of populations.*
3. *Reduce the per capita cost of health care.*

In 2014, Dr. Thomas Bodenheimer and Dr. Christine Sinsky recommended that Triple Aim be expanded to a [Quadruple Aim](#), adding the following dimension:

4. *Improve the experience of providing care.*

Many healthcare organizations, including Alberta Health Services (AHS), have adopted quadruple aim in their organizational goals and strategic planning.

What would be the benefits of setting up an ARP for my practice?

ARPs can provide a payment plan that effectively supports the relationship between physicians and their patients where, in some circumstances, fee-for-service does not suffice. Some of the potential benefits of clinical ARPs:

- Better predictability and stability of physician revenue.
- Potential to use the model to help support innovation and improvements in service delivery:
 - Improved continuity of care
 - Enhanced preventive care
 - More time for management of patients with chronic diseases and complex conditions
 - Expanded team-based care
 - Enhanced patient access
 - More comprehensive care
 - Enhanced implementation of Patient’s Medical Home
 - Enhanced integration of care in the Health Neighborhood
 - Practice efficiencies
- May enable better work-life balance in some practice types.
- Potential for greater physician and patient satisfaction.
- May facilitate physician recruitment and retention.
- Providing value to the health system (e.g., reducing unnecessary emergency department and acute care utilization).

Can a physician group withdraw from a clinical ARP and return to fee-for-service?

The terms in the [Clinical ARP Program Parameters Ministerial Orders](#) (Sections 8 and 9) allow for the Ministry or the physician group to cancel an ARP at any time, with at least 30 days’ notice. This has been a very rare occurrence in either case. In addition, any individual physician can terminate his/her participation in the ARP at any time, with at least 30 days’ notice, and return to fee-for-service.

What level of individual physician autonomy exists in designing a new clinical ARP and with respect to work scheduling, payment distributions and other internal governance matters?

With the annualized and sessional models, there is significant flexibility in designing a new proposed clinical ARP in terms of the goals, target patients, locations, services, service delivery model, internal governance and work schedule. Physicians can work part-time or full-time. There is no minimum required. With available capitation models, the basket of services and location types (e.g., office-based) are defined, but there is significant flexibility with the other aspects. If the services are provided in AHS or third party facilities, the physician group must work in partnership with those parties to develop the details. In order to get the proposed ARP approved by Alberta Health, the applicants must clearly demonstrate that the ARP meets the overall ARP goals and dimensions, including value-for-money.

With respect to internal governance, the [Clinical ARP Application Overview](#) (page 6) states that “Physicians are responsible to manage, individually or as a group, their work scheduling, workload, shifts, and holiday schedules.” The level of individual physician flexibility in internal governance matters varies among clinical ARPs, depending on the size of the physician group, whether the ARP is new or established, and/or how much the ARP is tied into AHS or other third party operations.

For example, in a new ARP, the prospective participating physicians can design the service delivery model and the internal governance rules. Ideally, it is best if these internal rules are outlined in a formal physician practice agreement, with clear decision-making and dispute resolution procedures. For more established ARPs, the internal governance rules may already be established so any new physician joining the ARP would need to abide by those rules.

In cases where a clinical ARP is heavily tied into AHS operations, the physician group will need to work in partnership with AHS to determine how things like work scheduling will be managed. The physician group may voluntarily decide to give AHS more control over internal governance, in order to simplify and reduce their own administrative burden.

Can a solo physician have a clinical ARP?

Very few of the existing cARPs are solo physician practices. Alberta Health has historically preferred larger programs and programs where all physicians within a practice participate in the ARP. However, Alberta Health has recently been considering solo physician Expressions of Interest and applications on a case-by-case basis where the rationale for creating an ARP meets the ARP dimensions (Patient Satisfaction, Access, Value for Money, Team-based Approach, and Recruitment and Retention). If you are interested in exploring this further, please contact [ARP PSS](#) for assistance.

I am a specialist and my practice is unique - how will any future ARP models address this?

Clinical ARPs were initially created to ensure physician services could provide services in situations where fee-for-service (FFS) did not provide appropriate remuneration. Whether FFS

or a clinical ARP is the best option depends on your own specific situation and factors such as your patient population and the services you provide. For example, a clinical ARP can work well for time-intensive services and patient populations not adequately compensated by FFS such as complex patients, marginalized populations and seniors. A clinical ARP is customized for your practice and can accommodate many special considerations. The current approved clinical ARP Provincial Based Payment [Rates](#) are listed by specialty. [ARP PSS](#) can help programs to investigate the feasibility of a clinical ARP for their work.

If the physician works at more than one location, can they do ARP payment at their primary clinic and bill through FFS at the other?

This is possible in most circumstances, but depends on the target patients, types of services, and the geographic scope of the ARP (e.g., some ARPs cover a whole zone for specialized services). These details are outlined in Schedule A, Appendix 2.0 of the program's clinical ARP Ministerial Order. If the services are outside of the ARP target patients, types of services, and geographic scope outlined in Schedule A, a physician is able to bill fee for service. If in doubt, it is best to check with Alberta Health first.

How do you initiate an ARP when new in practice, without an existing patient panel?

Physicians are not required to have an existing patient panel to apply for a clinical ARP. They can join an existing program or create a new program that defines certain parameters (location(s), time, services, target patient population, etc.). With that said, without any FFS claims history, it is difficult for Alberta Health to complete analyses and financial modeling to determine annual funding amounts. For this reason, Alberta Health may recommend that the physician(s) operate under FFS for a period of time prior to applying for a clinical ARP.

Why is the government not expanding the Academic Medicine and Health Services Program (AMHSP) at this time?

The overall budgets in the AMHSP Master Agreements (North and Sectors) were held flat for 2020-21 versus the previous fiscal year. Alberta Health (AH) recently conducted an independent external review of the AMHSP to inform decisions about the program's future strategic framework, governance structure, and accountability. AH is now starting the process of consulting with stakeholders, including the AMA, to develop a new AMHSP Master Agreement to take effect April 1, 2021. While many physicians have expressed a desire to join the AMHSP, it is uncertain at this time if the overall budget for the 2021-22 fiscal year will allow for any new AMHSP arrangements or expansion of existing ones.

Compensation

Are compensation rates and total funding negotiable in clinical ARPs?

[Clinical ARP rates](#) are predetermined and cannot be negotiated for individual ARPs. The rates are intended to reflect average annual Alberta fee-for-service (FFS) payments for a full-time physician for each specialty. Prior to the termination of the AMA agreement, the AMA had input into clinical ARP rates through the [Physician Compensation Committee \(PCC\)](#), which had an equal number of AMA and Alberta Health representatives, along with an independent chair.

The PCC was in the process of reviewing options for rate methodologies and updating the rates and FTE definitions with more current FFS data. With the dissolution of the PCC, the AMA is uncertain where this work stands now and what input, if any, the AMA will have into rate and FTE definition changes in the absence of an agreement.

For new clinical ARP applications, there is limited ability to negotiate the total compensation. For capitation models, the total ARP funding calculation is relatively simple. It is based on the capitation rates for each patient cohort (i.e., the provincial average FFS payments per patient for the ARP basket of services) multiplied by the number of affiliated patients in each cohort in the clinic panel. The clinic can expand the total clinic funding by affiliating more patients.

For annualized and sessional models, total ARP funding is based on the provincial rates multiplied by the number of full-time equivalents (FTEs) or sessional hours required to deliver program services. With AMA assistance, extensive evidence-based analysis is completed during the [application process](#) to help physicians determine the number of FTE/hours required. In cases where the physicians and AH do not agree on the total FTE/hours required, AMA Health Economics can help facilitate discussions, but either party can say 'no' at any time, as it is a voluntary payment option. The same application process is used if a physician group wants an expansion to their maximum approved ARP funding due to volume growth, addition of new services, etc.

For AMA representation, negotiation and advocacy support on clinical ARPs, contact Didi.Wimmer-Frank@albertadoctors.org.

Do ARP physicians earn more or less than FFS physicians?

One of the [guiding principles](#) of an ARP is a fair and equitable payment rate:

- Physicians will receive fair and equitable payment within provincial payment rates for their area of practice.
- Payment to physicians will continue to be made from the Provincial Physician Services Budget and will go directly to physicians.
- Physicians will continue to have access to benefits under the Physician Services Budget.

[Clinical ARP rates and FTE definitions](#) are predetermined and cannot be negotiated for individual ARPs. For the annualized model, the rates are intended to reflect average annual Alberta fee-for-service (FFS) payments for a full time physician for each specialty. Therefore,

assuming you are working the same amount of time as the average 1.0 FTE, then if your FFS billings for that same time are higher than average, you will generally make less on an ARP; if your FFS billings for that same time are lower than average, you will generally make more on an ARP. The sessional rate is a fixed rate for all specialties. In general, it is comparable to average hourly gross FFS payments for family physicians, but is significantly less than hourly gross FFS payments for higher billing specialties. For capitation models, see the capitation section at the end of this document for further insights on comparing FFS and ARP payments.

Was the clinical ARP physicians' compensation as significantly affected as fee-for-service physicians were compensated during COVID-19?

It depends on the type of model. Full capitation ARPs were generally not affected financially as they receive an annual capitation amount per patient. Blended capitation clinics were somewhat affected by the 15% FFS portion of their blend if their patient visit volumes went down. For annualized and sessional models, payments are based on days/hours of services provided. The impacts for those models have been variable depending on the type of practice. ARPs providing critical services like the Calgary and Edmonton NICUs and PICUs experienced minimal impacts as they need to maintain physician staffing levels. ARPs that provide primary care, consults or elective surgery services were affected as they provided less hours of services due to reduced patient volumes.

Can you provide more information about the FTE definition?

For the annualized model, a [full-time equivalent \(FTE\) definition](#) is a time-based unit of measure (e.g., days per year or hours per year), which is typically derived from the average days worked (ADW) per year for 1.0 FTE in each specialty. The GP FTE definition is 1,928 annual hours (241 ADW X 8 hours per day) of program service per 1.0 FTE.

What are the hourly rates for physicians in the sessional models - is there a range and what is it?

The compensation for sessional clinical ARPs is based on an hourly rate for the delivery of clinical services. This model applies to small, specialized programs and is intended for part-time participation up to an average of two days (16 hours) per week per physician. The current clinical ARP sessional rates are \$221.73 per hour for both general practice and specialists. In general, the sessional rate is comparable to average hourly gross FFS payments for family physicians, but is significantly less than hourly gross FFS payments for higher billing specialties.

What are the overhead expenses in a clinical ARP?

As with fee-for-service, overhead is built into the rate for clinical ARP funding. As such, the amount of remuneration received by a physician is variable and depends on the overhead expenses of the practice and how the physicians chooses to distribute the funding. The participating physicians could choose to pay a higher rate internally for less desirable shifts or they could choose to apply some overhead to cover things that are not funded by AH in a clinical ARP (e.g., if one of the physicians has to travel to see patients, they could internally compensate that physician for their time).

How does the clinical ARP support on-call?

If an ARP physician is on-call, the ARP only funds the time spent providing direct and indirect clinical services, not for time being available while on call. As with FFS, clinical ARP physicians are eligible for all physician benefit program payments including Specialist On-Call or Rural On-Call (if eligible and approved), in addition to earning ARP income.

Do all physicians earn the same per hour or is there a degree of variability depending on practice style?

Both general practitioners and specialists earn the same per hour in a sessional model (\$221.73). However, the average payments per 1.0 FTE vary across the specialties and factor in the average days worked per year in an annualized model.

In terms of practice style (e.g., if one physician sees 30 patients in an eight-hour day, and another sees 20 patients in an eight-hour day because they want to spend more time with each patient), it depends on how the physician group wants to arrange their internal compensation. Most existing clinics pay the same amount per hour internally in those cases, but they could decide to vary the internal pay in that situation. These arrangements should be specified in an internal physician practice agreement. The physician group as a whole must ensure they meet the ARPs quarterly and annual objectives, some of which may include volume measures.

As a general pediatrician paid as a family physician due to my licensing, in a clinical ARP would I be paid as a general pediatrician or a family physician?

Clinical ARP compensation can only be paid at the [clinical ARP specialty rate](#) that matches your official specialty as determined by the College of Physicians and Surgeons of Alberta (CPSA). Alberta Health can develop a new rate or apply a rate from a similar specialty in cases where there is no available approved rate. Currently, there is no rate for pediatricians and the GP rate is used.

Governance, Operations and Reporting

How important is a physician agreement inside the clinical ARP?

An internal physician agreement is extremely important for a common understanding and agreement of how the physician group will manage their practice and make decisions within the ARP (e.g., payment distribution, overhead, workload distribution and scheduling, productivity/accountability expectations, and the group will make decisions and resolve disputes). [ARP PSS](#) has expertise in ARP implementation and change management to provide you with the right tools and advice when needed.

Administration in clinical ARPs sounds very challenging, any comments on this?

On average, the management/administrative burden is greater in a clinical ARP when compared with FFS because there are additional reporting requirements. The degree of additional burden can vary depending on internal policies and procedures developed by a clinical ARP (i.e., internal pay scale, funding locum positions at a premium, allocation of program service days, etc.). In addition, a clinical ARP needs to have an authorized representative for the group that is responsible for communication with AH, coordinating the ongoing operation of the ARP, and signing up or terminating physicians who decide to leave the ARP. For clinical ARPs that are in AHS facilities, a services agreement between the AHS and physicians is required and the terms are the same as specified in the MO. The AMA is able to assist in contract review, advocacy and negotiation and ARP PSS is able to assist in the change management from FFS to the ARP.

Systems with ability to collect the performance measure data for reporting quarterly and annually to AH, and administration for reporting FTEs or invoicing (depending on the type of ARP) are required. System and administrative needs are explored with the program during application development and in cases where the program is within an AHS facility there may be other administrative supports.

How are the outpatient specialized clinics covered from a clinical ARP perspective and how does it work for operating cost?

If the clinic operates within an AHS (or Covenant Health) facility, then the organization(s) provide approval for the clinical ARP application, and agree to provide facility/space and non-physician staff resources (e.g., allied health staff) where appropriate. The participating physicians may be required to pay an agreed upon portion of overhead for these provisions out of the ARP funds.

Expansion sounds like it is very difficult to achieve?

Development of the clinical ARP application includes provisions for projected growth in both patient services and volumes. An application for expansion may be required if these projections are exceeded at which point evidence would be provided to rationalize an expansion to the program's funding. The criteria for expansion is not always explicit and the process can be lengthy.

Is shadow billing required in clinical ARPs?

Although physicians are paid differently from fee for service in a clinical ARP, they are still required to submit billing claims to Alberta Health for accountability for services provided. The actual claims do not have a dollar value attached in the Albert Health system, hence the term shadow billing (or service event reporting). SOMB Health Service Code modifiers are utilized in shadow billing as much as possible to account for time spent with patients (CMGP, after-hours time premium, complexity modifiers). Clinical ARPs also use ARP Service Codes to account for clinical activity that cannot be captured using the SOMB (e.g., indirect patient care). More information and a list the ARP Service Codes can be found [here](#).

Can you provide information on a billing information session, common and not so common codes, codes that are under-utilized and billing errors and tips?

The AMA has billing experts who regularly provide billing help and billing sessions. You can reference some of their tips here or book an individualized/group session:

[AMA billing help](#)

[AMA Fee Navigator](#)

ARP PSS works with clinical ARP programs to develop customized billing sheets for applicable SOMB Health Service Codes and ARP Service Codes. It is important to ensure that you submit billings on a regular basis, keep a record of submissions for reference, and review Alberta Health statements of assessments for rejections and errors.

Can locums work in clinical ARPs?

Physicians in clinical ARPs can still obtain locums. A locum participating in a clinical ARP is remunerated by the program using the funds that are not used when a participating physician is away. The AMA Physician Locum Services and AHS usually have additional incentives for locums but ultimately the ARP would pay for the portion of time that is covered by the locum as a base income. Further information about locums can be found on the AMA website:

<https://www.albertadoctors.org/services/physicians/pls>

Hospital Based Services:

Can an ARP be designed or limited to cover a portion of my work within multiple settings/roles?

Clinical ARPs can be designed to fit the needs of both patients and physicians. There are three criteria that need to be considered when designing the scope of the ARP:

1. The defined patient population,
2. The defined services that will be provided to this population, and
3. The defined time period and location for delivery of these services.

The scope of the ARP would be limited to these three defined criteria. Physicians would be able to work elsewhere in other funding models (e.g., fee-for-service, another ARP) and provide services that are outside of the scope of the defined clinical ARP. An [ARP PSS](#) consultant can assist you in exploring options and provide more detail on the rules and feasibility.

Can a clinical ARP work for surgeons?

Clinical ARPs attract many types of specialists and non-specialist physicians. There are several trauma and surgical-based programs that are currently in development in addition to several [existing clinical ARP](#) surgical programs.

How would an ARP work with a labile patient load and multiple sites of practice (i.e., clinic and hospital triage/ inpatient) as in low risk obstetrics.

The annualized and sessional clinical ARP models are time-based, so physicians are paid for the time required to provide service. Physicians can determine which sites and which services they wish to include in the ARP, providing it meets with approval of AHS and Alberta Health and can successfully demonstrate the achievement of the clinical ARP goals and dimensions, including value-for-money.

If I read correctly, PICU Calgary has 13 physicians rostered for 8 FTEs. Does this mean that "x" amount of physicians are working a full time 1.0 FTE with several working at a very "part-time" role, or are all physicians working collectively the same around a 0.6 FTE each? I am not sure either scenario above would work in many other specialty areas, can you elaborate?

In most clinical ARPs, there is significant flexibility with distributing workload / FTE amongst the participating physicians. Physicians can work part-time or full-time in a clinical ARP; there is no minimum required. If certain conditions are met, an individual physician can work up to 1.5 FTEs. Clinical ARP funding rates for the annualized model are based on a 1.0 full-time equivalent (FTE). If a physician works less than 1.0 FTE, then the ARP gets funding for that proportion of FTE provided (e.g., 0.2 FTE, 0.5 FTE, etc.). One important caveat with the PICU (open 24/7/365) is that there is no flexibility on the total workload for the ARP. The total workload needs to be fully distributed amongst the participating physicians, the PICU can't shut down for a day. If a physician leaves the group, then the rest of the group needs to adjust and pick up that workload until other physicians can be recruited. The group works very collaboratively and makes adjustments as required (e.g., if someone is sick or has an unexpected leave). This is why the flexibility works well for the program – it's not a clinic where patients can be reshuffled, rescheduled or wait times increased. In other clinical ARPs, delivering the total workload is not an absolute necessity as there are other options for patients outside of the ARP to receive that care. The way we have set up the remuneration is not a salary but a set dollar amount for specific work times and types. Thus if you work more - i.e., pick up - you get paid for this, but if you have to give up shifts you do not receive the pay associated with this. Your group has the flexibility to set up a payment scheme that is most reflective of your type of work. Within the PICU, due the extreme intensity, and excessive volume of consecutive on service hours, most physicians work between a 0.5 and 1.0 FTE to prevent physician burnout, promote patient safety and quality of care (with a minimum internal requirement of a 0.5 FTE to maintain practice standards).

Rural Services

How would a clinical ARP work for rural physicians with multiple roles (inpatient hospitalist, ER, anesthesia, community clinic, etc.)?

There are several existing rural clinical ARPs in the province. Clinical ARPs can be designed and tailored to the site, time and physician/patient population. The scope of the ARP would define the funded services. For example, select services could be funded through fee-for-service while

all others are captured in the ARP or vice versa. This involves extensive analysis of the community and current state along with input from Alberta Health and Alberta Health Services.

Do you consider a clinical ARP for primary care physicians, as it currently stands, adequately flexible and adapted to rural practice? If no, what is Alberta Health (AH) doing to creating appropriate models for rural physicians?

There are several [rural primary care clinics successfully utilizing the annualized model](#), with varying service scopes/location types (including some with comprehensive scope in office, ED, acute care and LTC). The Taber Clinic has had tremendous success and results utilizing a capitation model with geographic patient affiliation and a comprehensive scope (as described above). The Blended Capitation Model is currently limited to office-based primary care services. Alberta Health is currently examining other potential models to make available, but it is unknown what applicability these new models will have for rural practice.

Capitation Models

What actions does CVFP take to maximize patient continuity and minimize negation?

(Response from Dr. Ward)

At CVFP, the keys to maximizing patient continuity and minimizing negation are patient education and access. Before we formally affiliate patients (where both physician and patient sign an affiliation form), we educate patients on our model of care and ensure that patient circumstances and desires for receiving care are aligned with CVFP's Patient's Medical Home (PMH) framework and ARP business model.

We stress to patients the [benefits of continuity of care](#) and the [benefits of a PMH](#) as it relates to their health outcomes. We advise patients that their medical record will be here at CVFP and we have a wide range of skilled providers who collaborate with each other to provide comprehensive and proactive patient care, and have access to important information like recent visits, lab results, allergies, immunizations and medication history. Our message to patients is "call us first."

In line with our ARP business model, we gain conceptual agreement from the patient to maximize continuity with our clinic and minimize this outside care. If a patient is not willing to embrace that from the start, we encourage them to get care somewhere else.

Following affiliation, we take steps to try to minimize negation that is avoidable. We continue to educate patients about continuity, PMH, and our ARP model through many different communication channels (e.g., in-person 'elevator speech' by team members, [website](#), pamphlets, videos, newsletters, etc.). When we are negated we often follow-up with that patient to try to understand the reasons why that occurred and how we can work with that patient to improve continuity with our clinic.

Using access improvement principles, we've structured our clinic schedule to ensure quick patient access. We have a low time to third next available appointment (TNA) and allocate slots every day to accommodate urgent patient concerns. Our registered nurses triage about 25 to 40 health issues daily, by telephone and for walk-in patients. If a patient goes to another FP clinic because they cannot access our clinic within a reasonable time, that's a signal to us to adjust our scheduling.

For after-hours coverage, we consider FP/staff work-life balance and the costs of keeping the clinic open versus the cost of potential negation. We've experimented with different clinic schedules. We've found that only 11% of our negations occur on evenings and weekends. The optimal balance for us is to be open during regular weekday business hours (8am to 5pm). If a patient has an urgent, non-emergency concern outside of these hours and cannot wait to get into our clinic, we encourage them to go to the Calgary Foothills PCN Access 365 Clinic (open evenings and weekends). Our patients who call Health Link after-hours may also be directed to the Foothills PCN Access 365 Clinic or to the most appropriate provider.

As a provider, it's important to put negations into perspective. On one hand it's a 'checkpoint' to see if you've been successful in educating your patients and providing good access. However, a certain level of negations (for us, approximately 7 - 10% of capitation payments) is inevitable and part of the 'cost of doing business'. While negations are potentially frustrating, the financial model is robust enough to sustain healthy finances within a certain range of negation.

In our clinic, most negations occur from patients seeking specialized FP services (e.g. FP extenders at Cancer Center, weight loss treatment, cannabis clinic physicians, Botox, etc.). We also get negated at 50% of FFS value if one of our patients receives FP care at an acute care facility. We minimize this by providing comprehensive and proactive care focused on optimizing health promotion, disease management and prevention. A recent [study by the Health Quality Council of Alberta \(HQCA\)](#) demonstrated that CVFP has much lower ED and acute care utilization than average, which results in significant health system savings.

While negation only occurs if one of our affiliated patients sees a FP outside out the 16 FPs at our clinic, we recognize the [evidence on relational continuity](#) which shows that patients who consistently see the same FP have better outcomes and lower costs. We strive to maintain individual FP-patient attachment. If a patient's regular FP is not available, they will generally be scheduled with another FP who works in the same smaller team or 'pod' that is knowledgeable about the patient's conditions and care plan.

Can physicians de-affiliate patients in the CVFP capitation model?

(Response from Dr. Ward)

The short answer is yes. We can de-affiliate a patient if they relocate outside of Calgary, they have at least six visits with a non-CVFP FP, or if circumstances determine it is not possible to maintain an appropriate FP-patient relationship. However, this is infrequent. Before we formally

affiliate patients, we ensure the patient is aligned with our model care. It is often changing patient circumstances that lead to de-affiliation. For example:

- patient moves further from the clinic and can no longer commit to clinic continuity;
- patient is attending an educational institution out of town/province
- patient gets fly-in/out job in Fort McMurray; or
- patient's primary health need for a period of time is a specialized FP service not provided by CVFP like weight loss treatment, cannabis, Botox, etc.

If a patient is de-affiliated, whether initiated by the patient or FP, then CVFP cannot bill FFS for that patient. CVFP is currently limited to one FFS visit for an unaffiliated patient, and this one FFS visit is typically the first visit with the patient, prior to affiliation.

De-affiliated patients cannot be re-affiliated for at least one year after de-affiliation, except in extenuating circumstances with written approval from the Minister.

How frequently does CVFP utilize virtual care, before and after the pandemic started?

(Response from Dr. Ward)

Prior to the pandemic, CVFP family physicians (FPs) and allied staff utilized virtual care (phone, secure email or video visits) for approximately 40% of patient encounters. CVFP initiates 250 to 300 patient contacts daily (telephone results, disease management follow-up, medication changes, patient recall).

After the pandemic began, it was relatively seamless for CVFP to shift to providing about 95% of our patient encounters virtually (April-May 2020). This also included wellness outreach to our at-risk patients (seniors, patients who live alone or with chronic conditions). In addition, we conducted three live webcast series to our patients regarding COVID-19 and advance care planning where we have had upwards of 1,500 patients participate at one time.

Since we get paid a fixed amount per patient, CVFP has managed to sustain staff levels and administration and we have ensured continuous, comprehensive, and quality care for our patients. We see increased future opportunities to utilize virtual care options to increase continuity and minimize negotiations, and may explore this as an option for providing after-hours service to patients at some point.

Please provide an overview of your staffing resources at CVFP.

(Response from Dr. Ward)

CVFP currently has the following staff:

Funded by CVFP	Funded by Foothills PCN
<ul style="list-style-type: none"> • 16 family physicians (mix of full/part time) • 8.0 FTE registered nurses (primary care) • 0.6 FTE nurse practitioner • 0.3 FTE registered nurses (respiratory education) • 25.0 FTE medical office assistants • 4.0 FTE administrative clerks • 1.0 FTE human resources manager • 1.0 FTE operations coordinator • 1.0 FTE executive director 	<ul style="list-style-type: none"> • 0.6 FTE registered nurse (CDM) • 3.5 FTE pharmacists (with 2.0 FTE dedicated to diabetes education) • 1.0 FTE behavioral health consultant • 0.1 FTE dietician

For efficiency, the wider clinic team is divided into five ‘pods’ or teams of staff. Each team has three FPs, one registered nurse, 2.5 MOAs, and one administrative clerk.

We are a Community Teaching Clinic for Family Practice residents from University of Calgary, Faculty of Medicine. We precept five second-year residents and five first-year residents each year and host several elective learnings. For undergraduates, we typically precept nine final-year medical students.

What is the average physician panel size, workload and hours at CVFP?

(Response from Dr. Ward)

There has obviously been some adjustments and changes during the pandemic, but the following describes the pre-pandemic scenario.

Our current clinic panel is approximately 22,700 affiliated patients. Full time FPs have approximately 1,700 patients on their panel. This is significantly higher the estimated average full-time FP panel of approximately 1,200 patients (for patients whom the FP is providing the majority of total FP care throughout the year). With CVFP’s service delivery model, FPs are able to handle this larger panel and still maintain high continuity and offer same day or next day appointments.

All CVFP FP’s work in the office 4.0 days per week or less. Panel sizes vary depending on number of days in the office. Most patients are booked in 15 minutes slots. Complex patients and ‘annual physicals’ are booked for longer appointments.

As outlined in the [HQCA study](#), CVFP’s average annual return visit rate (total visits by affiliated patients to any FP in all settings) was 3.39 in 2016-17, significantly lower than the Alberta metro average of 4.31. FP-patient visit frequency is driven by patient need. If a patient has an uncontrolled chronic disease, we see them often. If a patient is stable, we see them less often. We address multiple patient concerns in a single visit. We don’t book a FP-patient visit for

anything that can be done more efficiently virtually or by other staff members (e.g., dressing changes, ear syringes, simple injections etc.).

All team members work to full scope. Our non-FP clinical staff provide approximately 30% of all patient encounters, with half of those from our CVFP-funded registered nurses the other half from PCN-funded health professionals.

CVFP has a 'medical-legal' team who compile information and present first drafting of forms and letters required by third parties. That means that physicians spend very little time preparing insurance reports, medical-legal letters and sick/disability notes.

Our nurse practitioner (NP) works in a pod and cares for a dedicate panel of approximately 350 patients who are primarily young, healthy women, aged 18 to 55. The NP has a focus on women's wellness and books appointments with patients on her own panel or patients referred by clinic physicians. On average, our NP sees approximately 15 patients per day (which translates to approximately 9 patients per day the clinic is open, as our NP is 0.6 FTE). The NP also does specialized care like IUD insertions and pessary fitting.

CVFP has been innovative in expanding the scope of our MOAs. For example, our pod-based MOAs ask patients detailed questions about their symptoms and history and use algorithms to guide decision-making about whether a physician or nurse is needed to address a patient's concern. Other MOAs have distinct clerical roles.

Further information on the specific responsibilities of CVFP non-FP clinical and admin staff can be found on pages 19-21 of [HQCA study](#).

Can you provide details on physician compensation at CVFP?

(Response from Dr. Ward)

Full-time CVFP family physicians (FPs) have similar net compensation for insured clinical services as the average FP in Alberta providing comprehensive office-based primary care. Our primary objective in implementing / continuing with this capitation model is to have the freedom to organize our service delivery in a way we think provides the best possible patient care and high provider satisfaction, while receiving fair compensation.

CVFP financials are not a big secret. Many of the figures from prior years are included in the [HQCA study](#). As of April 1, 2020 our average capitation rate is about \$355 per patient. We currently have about 22,700 patients so our expected gross capitation revenue is about \$8.06M. We expect negation to be about 10% this year, so our net capitation revenue will be about \$7.25M. Our FFS billings (for unaffiliated patients and out-of-basket services) are expected to be about \$100K, for a total insured-services clinical revenue of about \$7.35M. Our overhead expenses are approximately 45%, so the net payments for insured clinical services are expected to be about \$4.04M.

While average CVFP physician compensation is similar to what a comparable FFS physician would enjoy – there is variation based on panel size cared for by that physician, hours spent providing clinical care and the capital investment provided by founding physicians.

Over time, CVFP has fine-tuned its compensation model to reflect panel size, active management of patients and compensation for initial investment of clinic and ongoing business risk (example – holding lease and other business related contracts).

Another attractive feature of the funding model is that expenses are paid prior to compensating physicians for clinical activities. So, when physicians take time off – they don't have to pay overhead. There is a good availability for locum coverage given the stability of payment model extended to locums.

As with many FFS clinics, CVFP also generates additional revenue for [uninsured services](#), teaching, research, and physician benefit programs (e.g., Business Cost Program).

Prior to the Ministry increasing our capitation rates on April 1, 2020, CVFP net capitation payments were approximately 10% lower. Our previous capitation rates were based on 2015-16 FFS data and did not reflect the most current average FFS payments. This was a critical financial sustainability issue for CVFP, as most of our overhead is fixed and subject to inflation; therefore, net physician payments were falling. We continue to work with the Ministry to ensure our model is financially sustainable so we can continue to deliver the patient outcomes and health system savings as outlined in the [HQCA study](#).

Do you think the CVFP practice model selects out for a certain type of patient?

(Response from Dr. Ward)

The demographics of CVFP's patient panel are outlined in Table 2(a) of the [HQCA study](#). Our clinic panel has a slightly higher proportion of females and slightly lower material and social deprivation scores than Alberta Metro comparators. Our panel demographics have not changed significantly over time and generally reflect the demographics of the area in which our clinic is located.

Theoretically, capitation models incent physicians to avoid sicker patients (a.k.a., 'cream-skimming') to reduce costs. This has not been our experience or motivation. With all of the patient panel data available today, we believe it would be quite obvious if any clinic was systematically cream-skimming, which would likely jeopardize their long-term ARP funding sustainability from Alberta Health.

With a large patient panel such as ours, the health risks for individual patients tend to average out when looking at the total clinic panel. As such, capitation rates based on age and gender are reasonable predictors of, and provide reasonable compensation for, the average office-based services our patients require.

Stated another way – CVFP gets paid most for older patients of any gender and least for young adult males. A practice would thrive if comprised of healthy 90-year old's who had no health problems but be financially non-viable with a panel of complex, sick 25-year-old men! Of course, most practices have balanced patient ages and levels of clinical complexity.

Clinics with patient panels whose average health risk is significantly higher than the provincial average for each age and gender category would likely not be reasonably compensated under the CVFP model. These types of clinics may be better suited for the Blended Capitation Model (BCM), as the capitation rates in BCM are adjusted for age, gender and health risk.

With that said, most physicians tend to overestimate the average risk of their patient panel and clinic panel. Capitation rates are applied to the clinic panel; the larger the clinic panel size, the more this tends to average out. The [HQCA Primary Healthcare Panel Report](#) (Clinic Report – proxy or confirmed) provides some good indicators of the average risk of a clinic panel (e.g., percentage of patients with chronic conditions and/or mental health conditions; material and social deprivation scores, etc.). The return visit rate (average number of visits per panel patient to any FP during a fiscal year) can also provide clues, but this indicator is also influenced by physician practice patterns and FFS incentives (e.g., if an FP provides shorter appointments, recalls patients for follow-up visits more often than average, etc.).

What types of characteristics make a clinic well suited for a capitation model?

(Response from Dr. Ward)

For those considering a capitation model, it's important to understand the journey ahead before making the leap. It's not for everyone. Financial modeling will give you an initial sense of the financial viability. From there, it's not like flicking a switch. There are many important **change factors** and **general prerequisites** that must be considered in order to successfully implement. I've tried to capture these in the list below based on the CVFP experience. The list is long as I wanted to paint a picture of the full journey; not all items are essential and there are many different ways to do this depending on our clinic circumstances and the scale of change you desire. Also, don't fret too much about the potential change. Embrace and enjoy the journey if you feel it's right for you. If you try it and decide it's not right, the clinic has the option of going back to FFS at any time.

Capitation Model Change Factors for Success (based on the CVFP experience)

- A **physician leader** willing to initiate and champion the change process and culture shift. Dr. Peggy Aufricht was CVFP's leader/champion when we first moved to a capitation model in 1999.
- The physician group shares a **common vision** (i.e., North Star) for what they want to accomplish through the ARP. You'll need several meetings to discuss and come to consensus; if some don't want this, you may decide to nix the plan or those opposed may decide to part ways so the rest can proceed. With the scope of change involved, it's an 'all-in' venture.

- If the common vision includes implementing innovative changes to provide comprehensive, proactive, team-based, patient-centred care in **Patient's Medical Home (PMH)** model, while earning reasonable compensation, this model is a good fit. If it's more about the money or if there is low willingness to invest the time/effort to make changes, this model is not the right fit.
- A high-functioning internal **governance structure**: For smaller clinics, this could be done through a **physician practice agreement**. CVFP is a large clinic and we have implemented a **board structure**, with a well-designed board manual, committees with clear terms of reference, clear role descriptions, an annual board evaluation process, compensation strategy for board members (i.e., how we will distribute net funds), workload distribution and scheduling, productivity/accountability expectations, and how we will make decisions and resolve disputes. We implement board training for all members and new members joining. Note – time spent by CVFP physicians in planning, organizational and leadership activities is compensated. This is part of the 'cost of doing business' and part of clinic overhead.
- Once the governance structure is in place, then physicians need to further develop the **vision, mission, values and business strategy**. This will inform organizational structure (including leadership roles) and objectives (i.e. key **performance indicators** such as TNA, patient satisfaction, staff satisfaction, return visit rate, bounce-back rate, etc.). Developing a **systematic quality improvement process** to achieve these performance objectives is critical.
- In terms of exploring potential **organization structure**, the model provides opportunities to **expand patient panels** and **hire more staff**. For example, full-time CVFP FPs have an average of 1,700 paneled patients versus approximately 1,200 for the average FFS FP. For CVFP, that extra 500 patients per physician multiplied by \$320 (net average capitation rate after negotiation) generates approximately \$160,000 annually, most of which goes to our expanded staff.
- The larger the clinic, the more **options** you have in terms of **types of staff** you can hire (e.g., CVFP has 9 FP FTE multiplied by \$160,000 per FTE from the extra 500 patients on the expanded panels equals \$1.44 million to put towards additional staff. Beyond additional nurses and MOAs, we have an executive director, operations coordinator, and HR manager.
- If hiring more staff, the clinic requires the **physical space** to accommodate the expanded team (including PCN allied staff) and may need to **redesign the space** for optimal work flows; **co-location** of the broader health team is critical to effective teamwork and collaboration.
- At CVFP, each FP/NP works out of 3 exam rooms, a drop-down space for charting and share an office. There are 5 rooms for MDT use and two larger conference areas for group medical appointments and staff meeting space.
- There are opportunities to **expand the scope of work** for all staff (existing and new). This requires a big mental and behavioral shift. Physicians need to embrace a **team approach** to providing care, which includes being willing to 'let go' and **delegate work** to other providers so they can focus on more complex issues. A high level of **trust** in the skills and competencies of other team members is required.
- At CVFP, 30% of patient encounters are provided by non-physician staff. This requires **redefining roles, new work flows, care protocols**, and increased **virtual care**. The scope of work for our MOAs, for example, includes reviewing patient records to see if **screening** requirements are up-to-date, asking patients detailed questions about their symptoms and history, using **algorithms** to determine whether a physician or nurse is needed for a specific concern, and **coordinating** and communicating with patients to get their all their needs addressed on the same day.

- **Coaching and training** are essential for all roles and **skill assessments** should be completed regularly. Physician leaders and operational leaders often require additional leadership training. New physicians often require extensive coaching from our physician leaders to make this mental shift to our model (i.e., letting go of some tasks). Similarly our nurses and MOAs receive training and coaching from their operational leaders.
- The clinic also needs to orient, train and **optimally integrate PCN allied health professionals** into the clinic's model of care.
- Clinic leaders work with their staff and across functions to determine optimal **methods for staff communication**, connection (how often will we meet) and engagement.
- All clinic staff are focused on maximizing **patient education and engagement**. Before affiliation, we educate patients about the clinic's PMH and ARP model to ensure alignment with the clinic's vision, and we reinforce those messages after affiliation. We educate patients about **disease prevention and management**, and empower patients to proactively **self-manage** their care.
- Investing in formal **human resources expertise** can generate tremendous benefits in terms of positive culture, staff engagement, morale, productivity and minimizing turnover. CVFP has a full-time HR manager. We have an employee handbook with well-defined clinic policies and procedures, including privacy.
- CVFP conducts **regular performance reviews** for all staff, including for physician leaders and operational leaders, to boost performance.
- Capitation clinics need the **administrative capacity** to handle clinic **financial management** (e.g., ARP funding, negotiations, overhead, internal payments, budgeting/forecasting, **cash flow**, etc.), ensure **ARP reporting and accountability** requirements are met, **monitor key QI metrics**, and liaise with Alberta Health to **discuss/resolve issues** and implement ARP changes (e.g., basket of service updates). CVFP has an **executive director** who oversees all clinic operations and administration and additional administrative staff to support **patient affiliation and negotiation analysis** / patient follow-up.

Other general prerequisites we think are important (based on CVFP experience):

- A well-functioning **EMR** to support team collaboration and coordination, and patient care.
- High comfort with using virtual care technology (e.g., **secure emails** and **video visits**).
- Clinics that have already made a good start implementing the **Patient's Medical Home** model and have a strong **desire and readiness to take it to the next level**.
- Clinics with **reasonable patient continuity** and/or prospects for achieving it with the current or target patient panel; see your [HQCA Clinic Panel Report](#) for clues. If your clinic has a more transient patient base (e.g., episodic care; high walk-ins), this model will likely not work well.
- **Knowledge/training/experience** with access improvement principles and related measures (e.g., clinic is currently measuring third next available appointment (TNA) and understands the concept of optimal panel size), the Central Patient Attachment Registry (**CPAR**), and Alberta Screening and Prevention (**ASaP**) program.
- Willingness to accept a **closer relationship with Alberta Health** and accept the terms and conditions in the **Ministerial Orders** and all of the reporting and accountability requirements, including service event reporting (**shadow billing**).

- Clinics who provide **comprehensive primary care**; if you're referring often to special-interest FPs for services that in the ARP basket, negotiation will become an issue; examine ways to bring those services and expertise in-house, if possible.
- There should be **enough FPs in your clinic to generate operational economies of scale**. It's difficult (not impossible) for a clinic with less than four FPs to make this work. You need enough FPs to maintain reasonable patient access (managing vacations/leaves, spikes in demand, etc.) and to expand the clinic panel enough to generate reasonable funds to expand nursing and MOA staff. Larger clinics can also generate **administrative economies of scale** through adding management and specialized admin staff.
- Clinics willing to **accept assistance from available supports** (e.g., AMA programs like ARP PSS and ACTT, FPs with experience in implementing capitation, PCN change facilitators, etc.) to help expedite the changes.
- **Part-time FPs can make it work** by taking on a proportionate patient panel, providing there are enough other FPs in the clinic to deliver required FP visits for the part-time FP's panel on his/her days off, and if there is a high level of teamwork in the clinic to ensure continuity of care.
- **Rural FPs can make it work** if the basket of services is expanded to include all services they provide (e.g., office, emergency department, inpatient, LTC, etc.). The Taber Clinic is an excellent example of a highly successful rural-based capitation model. Unfortunately, the Taber model is not currently available to new applicants, and the BCM and Crowfoot models are for office-based services only.

What are the key differences between the Crowfoot model and the Blended Capitation Model?

Model	Crowfoot Village Family Practice	Blended Capitation
Availability & Incentives for New Applicants	<ul style="list-style-type: none"> • Not currently available to new applicants, but it is expected to be soon. • Incentives to be provided to new applicants (when the model becomes available) are unknown. 	<ul style="list-style-type: none"> • Available to 10 new physician group applicants as part of a demonstration project (currently 3 implemented). • As an incentive, no negotiation is applied in the first year of implementation to provide income stability to allow clinics to invest the time required to implement practice changes.
Affiliation	<ul style="list-style-type: none"> • Formal Affiliation: Both the patient and physician sign an affiliation agreement. • Affiliated patients can be de-affiliated at the request of the patient or the physician, or other circumstances (patient is admitted to LTC facility, patient affiliates with another ARP, Minister determines that patient is not eligible to be affiliated). • De-affiliated patients cannot be re-affiliated for at least one year after de-affiliation, except in extenuating circumstances with written approval from the Minister. 	<ul style="list-style-type: none"> • Formal Affiliation: Both the patient and physician signs an affiliation agreement. • Affiliated patients can be de-affiliated at the request of the patient or the physician, or other circumstances (patient is admitted to LTC facility, patient affiliates with another ARP, Minister determines that patient is not eligible to be affiliated). • De-affiliated patients cannot be re-affiliated for at least one year after de-affiliation, except in extenuating circumstances with written approval from the Minister.

Model	Crowfoot Village Family Practice	Blended Capitation
Basket of Service (BOS)	<ul style="list-style-type: none"> 91 health service codes. Reflects a very broad spectrum of comprehensive office-based primary care services provided by family physicians. Includes the new virtual care and 'Z' health service codes that correspond with the codes in BOS. 	<ul style="list-style-type: none"> 59 health service codes. Reflects a broad spectrum of comprehensive office-based primary care services provided by family physicians. Includes the new virtual care and 'Z' health service codes that correspond with the codes in BOS.
Compensation	<ul style="list-style-type: none"> For affiliated patients for in-basket services: 100% of the cap rate (minus negotiation). For non-affiliated patients for in-basket services: May bill FFS for one visit; after this, if patient is not affiliated then may only bill FFS in special circumstances, including emergency visits (by special permission). For affiliated or non-affiliated patients for out-of-basket services: 100% FFS. Compensation is inclusive of all overhead. 	<ul style="list-style-type: none"> For affiliated patients for in-basket services: 85% of the cap rate, plus 15% of the FFS rate for each in-basket service provided, up to a combined maximum of 100% of the patient's annual cap rate (minus negotiation). For non-affiliated patients for in-basket services: 100% FFS for up to two visits per consecutive two-year period; after this, if patient is not affiliated then may only bill FFS for emergency circumstances (by special permission). For de-affiliated patients for in-basket services: No FFS claims will be paid for one year following de-affiliation date unless for emergency circumstances (by special permission). Compensation is inclusive of all overhead.
Capitation (Cap) Rate Calculation	<ul style="list-style-type: none"> Cap rates are calculated for 40 age/gender cohorts. For each cohort, the cap rate equals the total annual Alberta GP FFS payments for in-basket services for that cohort from a base fiscal year, divided by the number of discrete patients who received in-basket services in that cohort during that base fiscal year, multiplied by the cumulative macro allocation sectional rate change for GPs in the year(s) following the base year up to and including the current year. 	<ul style="list-style-type: none"> Cap rates are calculated for 9,560 cohorts based on 40 age/gender categories and 239 health risk categories (CIHI Health Profile Groups). For each cohort, the cap rate equals the total annual Alberta FFS payments for in-basket services provided by a GP in an office setting for that cohort from a base fiscal year, divided by the number of residents in Alberta that were categorized as belonging in that cohort in the base fiscal year, multiplied by the cumulative macro allocation sectional rate change for GPs in the year(s) following the base year up to and including the current year.
Average 100% Cap Rate for Patient Panel	<ul style="list-style-type: none"> Approximately \$355 per year 	<ul style="list-style-type: none"> Approximately \$280-\$320 per year
Cap Rate Range	<ul style="list-style-type: none"> \$188 to \$720 per year 	<ul style="list-style-type: none"> Unknown (very wide range as there are 9,560 different cohorts)

Model	Crowfoot Village Family Practice	Blended Capitation
ARP Payment Frequency	<ul style="list-style-type: none"> Semi-monthly 	<ul style="list-style-type: none"> Semi-monthly
Negation	<ul style="list-style-type: none"> Negation is applied at full FFS claim value and will not exceed the individual patient's annual cap rate. Service provided at acute facilities outside the centre negated at 50%. No negation for special-interest family medicine physicians on the approved list. 	<ul style="list-style-type: none"> Negation is applied at 93% of FFS claim value up to a maximum of 85% of the individual patient's annual cap rate. (Note: the 93% reflects 7% negation forgiveness in recognition of referrals to special-interest family medicine physicians and foreign-trained specialists) No negation for the clinic in the first year of BCM implementation.
Review of BOS and Cap Rates	<ul style="list-style-type: none"> BOS will be reviewed and adjusted annually, as required, and cap rates adjusted accordingly. However the Minister may, at any time, adjust cap rates and BOS to ensure they accurately reflect services provided. 	<ul style="list-style-type: none"> BOS will be reviewed and adjusted annually, as required, and cap rates adjusted accordingly. However the Minister may, at any time, adjust cap rates and BOS to ensure they accurately reflect services provided.

Webinar CME Credits

I attended the webinar and watched it live, however I watched it jointly with another physician so did not log in under the registration link I was provided. I am concerned that I am no longer eligible for the CME credit?

Physicians who attend the webinar 'live' must login under the account they used to register for the webinar to ensure automatic receipt of certificate of attendance with study credits from AMA. The AMA may facilitate manual generation of a certificate in justified circumstances; however, physicians will need to contact the AMA to initiate this process.

The AMA is working to streamline the process for physicians to obtain their certificates of attendance with study credits and will communicate clear instructions in the future.

Will CME credits be available if I listen to the recorded webinar vs watching it live?

Attending the Webinar Live:

Physicians will receive a certificate of attendance from AMA with study credit information if they attend a webinar 'live' within the *Maintaining and Optimizing Your Practice During Times of Rapid Change*.

Mainpro+: attending a webinar 'live' in this series is a Mainpro+ one-credit-per-hour certified Group Learning Activity and physicians will receive a certificate from AMA.

MOC: attending a webinar 'live' in this series is a Maintenance of Certification (MOC) accredited Group Learning Activity (Section 1) and physicians will receive a certificate from AMA.

Watching the Webinar Recording:

Physicians who watch a recorded webinar within the *Maintaining and Optimizing Your Practice During Times of Rapid Change* webinar series may use this as a non-certified/non-accredited continuing professional development activity. AMA will not provide a certificate to physicians for this activity.

Mainpro+: watching a recording of the webinar is eligible for non-certified credits. More information available [here](#)

MOC: may claim 0.5 credits MOC: Section 2 (Scanning Activity) for watching or listening to the webinar. More information available [here](#)

Earning additional credits:

Attending 'live' or watching a recording of a webinar in the *Maintaining and Optimizing Your Practice During Times of Rapid Change* may prompt or identify a self-initiated learning activity that involves critical inquiry and practice reflection which may be used to earn additional study credits. AMA will not provide a certificate for this activity.

Mainpro+: physicians may also complete a [Linking Learning exercise](#) to earn five Mainpro+ certified credits

MOC: physicians may also complete a [Personal Learning project](#) to claim 2 credits per hour MOC: Section 2 (Planned Learning Activity)