Longitudinal Family Medicine (LFM)

Frequently Asked Questions – Sept. 25, 2023

	Question	Answer
Questions about how certain services are handled within the LFM		
1.	What happens when an LFM physician is providing other community services outside the office, such as ED shifts, hospitalist or other inpatient work, etc.?	**LTC, ED, Inpatient, etc. work –** If an LFM physician is providing other community services outside the office (and outside their LFM practice) such as ED, hospitalist, PMC, CHIP, hospice sessional, etc. they will generally be paid for that work under the remuneration model for those other services. Here is the approach for each service: **Long-Term Care –** Physician can choose to claim LFM hours and 30% FFS, OR claim 100% FFS and no LFM hours for their LTC work. This means, if a physician chooses to include their LTC services within their LFM, they will only ever bill 30% for their LTC work. Physicians cannot choose to do some LTC within the LFM and some outside the LFM. Please note that the New Patient Intake Visit (NPIV) fee code can be billed for LTC services delivered to new LTC patients effective October 28 (LTC patients not already attached to your practice thru the ME=CARE code), but only by physicians who have opted to include LTC within their LFM. Note also that the option to include LTC work within the LFM model is only available to an LFM physician with an office-based comprehensive family medicine practice. **Level 4 Emergency Department (ED)** – For Level 4 EDs and CECs, where the ED volumes are sometimes light, a physician that returns to their office to deliver LFM services during an ED shift, will bill 30% FFS for LFM patients booked in the office but no LFM hours (since you are still receiving the ED hourly rate), and must remain available to the ED as needed and on short notice. Expectation is that patients will not be redirected from an ED to the physician's office

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		to earn the 30% FFS (mindful that patients will still be directed to the most appropriate forum for their medical needs). This is for Level 4s and CECs – not applicable to Level 3 or other EDs. **Inpatient –** Inpatient work should be included within LFM hours and billed at 30% FFS (similar to home visits), unless the inpatient work is covered by the CHIP or Regional Hospitalist model, in which case it is outside LFM (not included in LFM hours) and covered by the CHIP/Hospitalist payments. **UTCs –** For physicians in the LFM model who do shifts at a local community UTC, these UTC shifts are outside the LFM and paid separately (sessional). **FP consults / Unattached patients –** Physician can choose between two approaches: (1) If seeing unattached patients in your practice (such as well women's referrals, paps, etc.), spread throughout your day or week, those will simply be counted within your LFM hours and billed at 30%. **OR** (2) If seeing unattached patients for an entire day or half-day (such as a clinic), you can choose to keep those services outside the LFM. In that case, you would not bill LFM hours and you would instead bill 100% FFS for services delivered to those patients. **Primary Maternity Care (PMC) –** A physician on PMC shift may at times be able to deliver LFM services (depending on volume of PMC needs). In that case, the physician would bill the 30% FFS plus the LFM hours while delivering LFM hours in their LFM practice (while collecting the PMC daily stipend). Once the physician returns to PMC work, that time cannot be claimed as LFM hours and PMC work is 100% FFS. **Community Hospital Inpatient Model (CHIP)** – Same as PMC above. A physician on CHIP may at times be able to deliver LFM services (depending on volume of CHIP needs). In that case, the physician would bill the 30% FFS plus the LFM hours while delivering LFM services (while collecting the CHIP daily stipend). Once the physician returns to CHIP work, that time cannot be claimed as LFM hours and CHIP work is 100% FFS. **Surgical Assist** – All outside LFM, so billed at 100% FFS.

Question		Answer
		Primary Care Centre (PCC) shifts – All outside LFM (sessional). **Specialty services** paid sessionally (chronic pain, palliative) – All outside LFM. **Walk-in clinics** – All outside LFM. Note: Duty clinics that support evening access for an LFM practice are part of the LFM practice. These types of clinics (even if called a walk-in clinic) are part of the LFM practice. **Home visits** – All inside LFM, so LFM hours are payable along with 30% FFS.
2.	What happens when an LFM physician is providing WCB services?	**WCB work –** LFM physicians may enter contractual arrangements with other parties or otherwise derive revenue from the delivery of professional services, including Workers Compensation Board (WCB). When submitting a claim for these services, use the non-LFM FFS BA and ensure the payment responsibility is entered as "WCB." These services are adjudicated and paid as fee-for-service and will be submitted through your existing FFS BA. These must be provided outside of your LFM hours to be claimed as FFS. If providing WCB services during your LFM day, this time spent cannot be claimed towards your LFM hours. For example, if you had two patients who currently qualify for WCB – each having a 20-minute visit – you would subtract 40 minutes from your daily tally of hours because you will be claiming 100% of the fee codes for those patients.
3.	What about home visits - how are they dealt with in the LFM?	**Home visits –** Home visits are part of LFM and these patients are considered part of the panel. So, you would count home visits as part of your LFM hours and receive 30% FFS for all home visits.
4.	What about non-insured services?	**Non insured services -** Non insured services (as defined in the Physician Manual) are outside of LFM. These must be provided outside of your LFM hours.
5.	What about virtual services – are they part of the LFM? If I deliver virtual services in the evenings, is	**Virtual services –** Virtual services delivered to your patients are part of the LFM. When you are delivering services virtually you would still claim LFM hours, and you would bill 30% FFS for each service

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	that billable at the premium LFM hourly rate, or must premium services be in-person?	delivered. If virtual services are delivered in the evenings or on weekends, those are billable at the premium LFM hourly rate. Remember that LFM physicians are expected to provide a majority of services in-person (see Q9 below).
Questions about eligibility for the LFM		
6.	Am I eligible for the LFM if I do not want to work 46 weeks per year?	**Work less than 46 weeks per year? –** Generally, no. While the LFM model does allow for physicians to work part time, physicians are still expected to provide service for a minimum of 46 weeks in the year. You can work 20, 40, or 60 hours per week, but will still need to be accessible to your practice and your patients (both virtually and in-person) over a 46-week period. The LFM provides you with an annual panel payment per patient and the expectation is you will be accessible to those patients. As a result, the LFM is not an appropriate model for physicians who intend to take extended holidays or time away from their office-based family practice. Exceptions will be made for physicians who are unable to be in-office for 46 weeks because of other health/community services they are providing, such as hospitalists, long term care/Care by Design, Primary Maternity Care (PMC), or emergency room coverage. These services are heavily dependent on family physicians, and they sometimes require physicians to be on-call for a week at a time, will not be prohibited by the LFM. These specific arrangements will be discussed on a case-by-case basis as part of your contract discussion.
7.	Can I work different hours each week? Each day?	**Work different hours? –** You can work different hours each week and each day. You commit to a minimum number of hours annually over 46 weeks. These hours will be smoothed over 52 weeks and form the hours component of your bi-weekly pay. If you work and bill more hours than committed to in your contract, you will be paid for them at the point of annual reconciliation. The hours are smoothed over 52 weeks. You commit to a general practice profile as part of your contracted activities as a guide to your practice intentions. For significant and prolonged changes in scheduled hours, a midyear adjustment can be made to increase/reduce hours paid. For example, if a colleague in a collaborative practice suddenly departs and there is no locum, a physician may wish to increase hours to cover some of the load for a prolonged period. Alternately, a physician who commits to full-time hours might

Question		Answer
		experience a life event where they must reduce access to part-time hours for a prolonged period. Another example is when a physician is scaling back their access (hours) as they are nearing retirement. **In those circumstances a physician should advise that they wish to have their hours adjusted, up or down (contact alternate.funding@novascotia.ca).** For all nominal and/or irregular changes (peaks/valleys throughout the year), the reconciliation will be completed on an annual basis.
8.	Am I eligible for the LFM if I do not have an EMR?	**No EMR? –** Generally, no. The LFM experience will be enhanced and more efficient with an EMR. Just as EMRs have been a pre-condition for conversion to APPs for several years now, the expectation for the LFM is that physicians will be on an EMR or will commit to move to an EMR within a reasonable time period. If a later-in-career physician is interested in converting to the LFM and feels unable to move to an EMR, DHW will consider grandfathering exceptions on a case-by-case basis.
9.	To participate in the LFM, a majority of my services must be delivered in-person. But a lot of my patients prefer virtual services. How will the "majority" requirement be monitored and calculated?	**Virtual services in the LFM –** The LFM is a model best suited to family physicians with robust in-office comprehensive family medicine practices. Virtual services are an important element of providing effective access to patients, but they must be a complement to an in-person practice. The intent with the LFM is that services delivered virtually will be monitored. We are currently working collaboratively to finalize details and we will provide those details in the coming few months. In the meantime, please just continue to ensure you are offering reasonable access to in-person services. When we are ready to monitor the "majority" requirement, your stats will be included in your quarterly LFM performance reports. If this is a significant concern for you, it is possible that the LFM is not your best payment model.
10.	I'm a FFS physician. Am I eligible to convert to the LFM? How and when can I apply?	**FFS physicians converting to LFM –** FFS physicians are eligible to convert to the LFM. Right now, we are solely focused on converting our existing APP physicians to the LFM. Beginning October 1st, expressions of interest from FFS family physicians can be submitted. To do so: 1. Send your request to psaccountability@novascotia.ca

Question		Answer
		2. Within 2 weeks, PSAccountability will respond with a contract/contracted activities template and the ME=CARE panel size for subject physician(s) 3. Once the physician has asked any questions (DNS is also available to assist) and they indicate they are ready to sign, they propose a start date that is no less than 4 weeks from the date of physician signature 4. Contract is completed with the start date and completed contracted activities schedule, signed by the physician and returned to psaccountability@novascotia.ca 5. Once contract activities are received, Medavie will establish new LFM BAs, smooth hours/panel payment, and confirm banking arrangements 6. Physician commences LFM on the start date noted in their contract
Questions about audit under the LFM		
11.	Clause 6 of the LFM Agreement talks about "Inspection by the Minister". What kind of audit and/or inspection will LFM physicians be subject to?	**LFM Audits –** LFM physicians, just like physicians in all other payment models, will be subject to potential billing audits by MSI for all billing claims submitted. This will fall under the standard auditing process. For hours submitted under the LFM, physicians will submit daily hours using two new billing codes that will be available starting October 28, 2023. Once those codes are activated, physicians will self-report how many hours they work (broken down by daytime or evening) each day under the LFM. The Minister will monitor those hours to ensure there has been contemporaneous reporting to support the clinical services provided by the physician each day (direct and indirect clinical services). Physicians do not have to report/claim clinical support services as this is an automatic adjustment and these activities will not be audited.
Questions about payment under the LFM		
12.	What will my bi-weekly payments look like under the LFM?	**LFM Payments –** There are three components to your bi-weekly payments: hours, panel attachment and billing. Each component will have a separate Business Arrangement which will allow you to see how your bi-weekly pay is comprised of these components.

Question		Answer
		Biweekly payments will include: 1. Intended hours + 10% Clinical Support Services - smoothed annually based on the hours noted in your contract. 2. Panel payments - calculated each quarter based on your panel size at that time and smoothed over that quarter. 3. 30% of FFS billings - this amount will be variable based on actual FFS billings. You'll get paid as you bill. Most physician's clinic schedules look fairly similar day to day, week to week, but there will be some slight variability. The reason why the panel numbers are being reconciled quarterly is to ensure panel remuneration is responsive to panel size changes throughout the year. You will bill the initial "new patient" encounter and the patient will then get added to your panel when the quarter rolls over. While this means there will be some quarterly variability in bi-weekly payments, it will allow for responsiveness to panel size changes. If you are entitled to a community complexity modifier, this will be included in your smoothed payments for panel and hours worked. It will be paid quarterly against any FFS billings in that quarter. FFS billing accounts for the least amount of total remuneration under the new model so we anticipate it should be feasible to budget from a business perspective. For example: if you're a fulltime physician who intends to work 37.5 daytime hours per week with a panel of 1000, your biweekly pay will be: ● Base hours: 75 x $92.70 weekday (does not address any evening/weekend for comparison purposes) = $6,952.50 ● 10% Clinical Support Services = $6952.5 x 0.1 = $695.25 ● Quarterly panel payment: 1000 x $103.00 divided by 26 pay periods = $3962 ● Total predictable biweekly income (before any FFS earnings) = **$11,609.75 every two weeks**.

Question		Answer
		● 30% of FFS billings will be additional, over and above this amount. For comparison purposes: current APP family physicians receive roughly **$10,696 every two weeks** with no option to bill FFS on top. The above projections will depend on how many actual days are in a pay period but it's a decent representation of what you could expect for a "typical" pay period.
13.	How do I get the Business Arrangements numbers for the LFM? Do I have to do anything?	**Process for Business Arrangement (BA) Numbers –** Medavie will be sending out BA's to LFM physicians; LFM physicians do not have to take any steps to initiate this. There will be 3 BAs for each LFM Agreement: 1. 30% FFS BA# 2. Hours BA# 3. Panel BA# LFM physicians will receive their BAs the week of October 30th.
14.	What do physicians lose in terms of bonuses and grants within the LFM? For example, do we lose the EMR grant, and the CDM, if the code still exists? Are they only worth 30%?	**What's in and what's out of LFM compensation –** Compensation under the LFM model includes some new money and some that was previously provided as grants or bonuses on top of the APP rate. Now, it is all included in the LFM funding: ● Overhead support ● EMR envelopes B, C ● Collaborative Practice Incentive Program ● Chronic disease management (physicians in the LFM model will receive 30% of the value as part of their fee-for-service billings) ● 5.6% bonus for physicians who shadow billed more than 80% of APP contract value Physicians paid via the LFM model <u>can continue to bill</u> for the following work provided *outside* the LFM: ● Work under the regional hospitalist model or Community Hospital Inpatient Program (CHIP)

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		● Work under the regional Primary Care Maternity (PMC) program ● Emergency department work ● Work in other sessional arrangements (such as sexual health clinics, primary care centres, urgent care centres, MAID, etc.) ● EMR envelope A (one-time grant) ● Surgical Assist Incentive Program ● Preceptor funding (annual payment, premium on billings and daily stipends)
15.	As a transition physician, how much will be received if I have less than 1.0 FTE?	**Transition physicians less than 1.0 FTE –** 1.0 FTE = $324,450 plus 30% billing for one year commencing Oct 1, 2023. If you are less than 1.0 FTE, this amount will be adjusted accordingly. Example: 0.5 FTE = $162,225 plus 30% billing for one year.
16.	Is there a cap on the number of hours that can be claimed?	**Cap on hours? –** There is no cap on the number of hours that can be claimed, however a minimum of 2.8 service encounters per hour must be maintained (averaged quarterly).
17.	Are the CME stipend and CMPA rebate in or out of the LFM base pay?	**CME and CMPA –** The CME stipend is paid outside of the LFM payment model, so the annual $2,000 payment is paid on top of the LFM model. The CMPA is paid outside of the LFM model as well.
18.	How does the community complexity modifier increase our income? Is the modifier multiplied by our entire income and when is it paid?	**Community Complexity Modifier –** Yes, the modifier will be applied to all LFM income as follows: - Hours and Panel Attachment – The community complexity modifier will be applied (automatically) to the hours and panel payments, smoothed and paid biweekly. - 30% FFS – For FFS claims, because the community complexity modifier cannot be added at the source when the claims are entered, it will be applied and paid quarterly based on what was claimed in the quarter. So, if the claims for Q3 totaled $10,000, the community complexity modifier would be calculated on that amount and paid out lump sum each quarter.

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		The communities eligible and their associated modification are found in Schedule B to the LFM contract.
19.	What if I work more time/hours than I have included in my Contracted Activities. How and when will I be paid for those additional hours?	**Additional hours worked –** For all nominal and/or irregular changes (peaks/valleys throughout the year), the reconciliation will be completed on an annual basis. For significant and prolonged changes in scheduled hours, a midyear adjustment can be made to increase/reduce hours paid. For example, if a colleague in a collaborative practice suddenly departs and there is no locum, a physician may wish to increase hours to cover some of the load for a prolonged period. Alternately, a physician who commits to full-time hours might experience a life event where they must reduce access to part-time hours for a prolonged period. Another example is when a physician is scaling back their access (hours) as they are nearing retirement. **In those circumstances a physician should advise that they wish to have their hours adjusted, up or down (contact alternate.funding@novascotia.ca).**
Questions about uncontracted time, "vacation" time, statutory holidays, etc.		
20.	What are "uncontracted hours"?	**"Uncontracted hours" –** Physicians are independent contractors, regardless of which remuneration model they are paid under (APP, FFS, LFM). As such you don't get paid vacation, statutory holidays, sick time, or education leave. This is "uncontracted" time. The current APP model is based on 46 weeks per year of contracted time, and 6 weeks of work for uncontracted time. Annual hours based on 46 weeks of work per year are smoothed over 52 weeks. This is why it "appears" as though APP physicians get paid vacation when in fact they don't. The LFM model is set up very similarly based on your self identified intended hours of work. The target LFM income outlined in the ratification material is based on 46 weeks of contracted time and 6 weeks of uncontracted time.
21.	Family physicians currently paid via an APP are paid for 46 weeks, spread over 52 weeks of pay - will	**Minimum 46 weeks per year –** The LFM model is built on 46 weeks of clinical work/year. As you are signing your LFM Agreement and Contracted Activities (previously known as Deliverables), you will be asked to identify your intended annual hours of work. Your total intended hours of work for the year

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	this be the same with our baseline pay in the LFM?	will be smoothed over 26 bi-weekly payments so you continue to be paid even though you're taking some uncontracted time. This really isn't all that different from the current APP that pays a total of 1,725 annual hours over 46 weeks of the year (with payments smoothed over 52 weeks). Except in the new LFM, if you don't take 6 weeks off, you'll get paid what you actually worked. You are required to commit to 46 weeks of service per year if you are moving to the LFM. This is because one of the key principles of this model was to ensure timely access for your patients with the panel payments. LFM physicians can take a total of 6 weeks uncontracted time without panel payments being adjusted but any extended leave beyond that will be unpaid and can only be granted with permission from the Minister.
22.	Do the six weeks of uncontracted time include mandatory public holidays (i.e., when we have to close as we don't have staff working on those days)?	**Statutory Holidays –** Yes, statutory holidays are included in the six weeks of uncontracted time, just as they were included in the APP.
23.	When the clinic is closed due to the statutory holidays but a lot of us still review labs, etc. on those days - how does the LFM deal with that?	**Indirect clinical time –** You are able to bill clinical hours for indirect patient time when you are not in your office, during statutory holidays or anytime, providing that you're actually doing patient specific indirect care. Note that evening and weekend indirect patient care cannot be claimed as premium evening/weekend hours, unless patient services (visits) have been delivered in the evening/weekend as well. So, if you are doing only indirect clinical time on an evening, weekend or holiday (without any direct services), you can only claim the daytime hourly code. Note: hours tracking will be easily done with the use of new codes currently under development. More information will be provided by Medavie once they are ready for use.
24.	What about uncontracted time during this year of transition?	**Uncontracted time during this year of transition** (proration for Oct 1 start of the LFM) – - Effective Oct 1st, physicians get 3 weeks of uncontracted time between Oct. 1, 2023 and March 31, 2024. So, the expectation for the next 6 months is 23 minimum weeks of service (as opposed to 46 weeks for a full year).

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		- Effective April 1st, the clock resets and 6 weeks are available each fiscal year (meaning, the expectation is then for minimum 46 weeks of service each year). - For the current year of transition, if a physician was saving their uncontracted weeks under the APP to the last half of the year, the physician should reach out and we will discuss solutions, which would include verifying time taken in the first half of the year. Must be minimum one week unused (not a single day or two).
Questions about claiming "time" or "hours" in LFM		
25.	Can you define "time" as it relates to the LFM model?	**How is "time" defined in the LFM –** The LFM model pays you for your "time". *Clinical Time*: Refers to any time a physician spends providing patient specific care. This can be both direct and indirect care and can be spent at the office or at home, during the day, in the evening, or over the weekend. As long as your focus and efforts are being spent on patient specific care, it's considered clinical time. ● Direct Care: refers to care provided directly to a patient in a one-on-one setting, this can be in-person or virtually. ● Indirect Care: refers to services that support the care of a specific patient or discussion with a designated decision maker when they are not present (either in person or virtually) – i.e., charting, reviewing diagnostic reports, reading consult letters, etc. *10% Clinical Support Service Time:* refers to services which are not patient specific but provide benefit to the patient population and the health system. It could also include any time you spend collaborating with team members, etc. You will not have to calculate or submit this time yourself; it is already applied to your smoothed hours and any additional hours billed over the year will have 10% added when reconciled.
26.	How will I claim my LFM hours? How do I determine my daily baseline numbers, i.e., number of hours of direct patient care,	**Payment for LFM hours –** At the time of the conversion to LFM, physicians will identify their annual intended clinical hours broken down by day and evening/weekend. You will also outline a practice plan for a generic week – this gives DHW an understanding of how you generally anticipate distributing

Question		Answer
	indirect patient care, paperwork, etc. while meeting the 2.8 encounters per hour expectation?	your hours, similar to what has historically been done in the APP template. The smoothed hours that you will be paid every two weeks will be based on the number of intended hours you stated you would work. When communicating your intended hours, you can include all anticipated clinical time (both direct and indirect). As defined above, clinical time is defined as any time you are doing patient specific work and includes both direct and indirect patient care. Direct clinical time will be appointment time (office visits both in person and virtual) and indirect clinical time is patient specific "paperwork" time like reviewing labs, charting, etc. There is no need to distinguish between direct and indirect clinical time when identifying your intended hours of work to be smoothed. If you typically do an hour of paperwork at the office before you go home, you can include that as an hour of intended work. If you typically do an hour of work at home in the evening and are confident you will continue to do this work, then claim that upfront as well but note that evening/weekend rates can only be claimed if direct patient services are also provided during that time. You will need to monitor your own direct:indirect patient time ratio to make sure you don't slip below the 2.8 service encounter expectation in terms of average patients per hour but that's up to you to manage. DHW will be monitoring your average service encounters on a quarterly basis, and it will be included in your quarterly practice report. Remember that the 2.8 service encounters per hour is a <u>minimum</u> required average per hour. Even if you greatly exceed that minimum requirement, you can only bill an LFM hour if you actually do patient specific work in that hour. We've been asked, for example, if a physician that sees 5 patients per hour would be able to bill additional hours under the LFM since they are so far above the minimum 2.8 service encounters per hour. The answer is <u>no</u>. You can only bill for the hours in which you are in fact providing clinical care (direct or indirect), regardless of how many patients per hour you are seeing. It is important to remember that the 2.8 is an average expectation and some clinic hours may be more, some may be less.

Question		Answer
		Once you've identified your intended clinical time, DHW will add 10% and those are the hours your bi-weekly smoothed payments will be based on. The additional 10% is for the Clinical Support Services which is the work that is not patient specific but provides benefit to the health system. This can also include collaborative practice support such as team meetings. This work includes the old CSS time like team meetings, QI, etc. but it also could include time spent hiring collaborative or administrative staff, etc.
27.	How will I actually claim the LFM hours - what's the mechanism? And how will the hours be reconciled with the hours I actually worked?	**How to claim LFM hours –** You don't actually have to claim the hours for your smoothed biweekly payment. This is calculated from what you have entered in your Contracted Services document. For tracking, you will submit hours you actually worked using new LFM fee codes (no direct value) for the number of clinical hours worked per day – broken out by daytime and evening/weekend. When claiming actual hours worked, you should include both direct and indirect clinical time. **Please note that these new codes will not be available until October 28, 2023. Details on how to bill for October are being provided under separate communication.** Remember that this will not affect your smoothed biweekly payment for hours. But it is important that you submit your daily hours worked to ensure government has accurate information for purposes of reconciling hours paid with hours worked later in the year. This is also how government will be monitoring the expectation of average 2.8 service encounters per hour. At the half year mark, we (DHW/DNS) will assess how you are progressing towards your intended target. There are many reasons why there will be variation across the months, included the use of uncontracted time. However, if you have fulfilled less than 90% of half of your yearly target, DNS will reach out to understand your plan. The intent is to limit the potential for any recouping of payment due to fewer hours worked and allow proactive identification if a contract adjustment is required. At the end of the year, financial reconciliation against actual versus intended hours will be undertaken. Any additional hours worked will be paid as a lump sum, and if fewer hours are worked than paid, payment will be recovered.

Question		Answer
		Note for monitoring purposes, the calculation of whether you met the 2.8 service encounters per hour will not include the 10% clinical support services time. It will only be calculated based on the 90 percent direct/indirect clinical time.
28.	What about the 10% for Clinical Support Services - how do we claim for that?	**10% CSS time –** The 10% will be added automatically. You do not have to calculate or submit for those hours. 10% will be added to the hours you committed to at the beginning of the year, but any additional hours billed over the year will have 10% added when reconciled.
29.	If we do paperwork for a colleague on vacation, can we bill for this?	**Paperwork for a colleague on vacation –** This work can be included within your billed LFM hours if you complete indirect patient specific care.
30.	What about virtual services – are they part of the LFM? If I deliver virtual services in the evenings, is that billable at the premium LFM hourly rate, or must premium services be in-person?	**Virtual services –** Virtual services delivered to your patients are part of the LFM. When you are delivering services virtually you would still claim LFM hours, and you would bill 30% FFS for each service delivered. If virtual services are delivered in the evenings or on weekends, those are billable at the premium LFM hourly rate. Remember that LFM physicians are expected to provide a majority of services in-person.
Panel related questions		
31.	What is my expected panel size?	**Panel size expectations –** We know panel size will vary from physician to physician and is influenced by a number of factors, including your years in practice, the demographics of your community, the nature of your practice and commitments outside of the office. Under the LFM, you will be paid for the panel you have attached via the ME=CARE algorithm – therefore there is no threshold on panel size. However, lower panel size will affect income.
32.	What is meant by "healthy unseen"?	**"Healthy unseen" –** "Healthy unseen" refers to those on your patient panel who are seemingly attached; however, have not presented for service since the establishment of ME=CARE in 2018/2019. Patients that have not been seen in the last five years will visit their physician over time and new patients will automatically be captured with NPIV on the initial visit. This will cause the

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		'healthy unseen' number of patients on your panel to move towards zero but 10% is added to your panel size to account for this population and other panel nuances. This might mean that you are remunerated for more or less patients than are attached via your EMR.
33.	How can I see what is on my patient panel list?	**Panel validation –** Your ME=CARE panel is about aggregate panel size for ME=CARE attached patients. The panel validation service offered by DHW (reach out to psaccountability@novascotia.ca if interested) will show you the alignment between your EMR data and the ME=CARE remunerated panel. This will provide you some patient level information not normally available to physicians related to patients that have moved, are deceased or are otherwise no longer in your care.
34.	How is the panel size calculated?	**Calculating panel size –** The ME=CARE algorithm outlined in the Physician Agreement is the means of determining panel size for the purposes of remuneration. The Physician Agreement says: "ME=CARE algorithm" means the method used by DHW to determine patient attachment to an individual Physician to derive the Physician's panel of attached patients, including the following features which are subject to change only by agreement of the Parties: (i) the ME=CARE algorithm assigns a point value to every physician encounter with a patient, calculating a score using the points, and crediting the physician with the highest score with attachment to that patient; (ii) a patient can only be credited to one physician's panel; (iii) the points awarded for each encounter are determined by the formula 10/(m+5), where m is the number of months between the panel evaluation date and the encounter date, such that recent appointments count for higher points; (iv) in the event of a tie, the physician with the most recent ME=CARE encounter with the patient is credited with the attachment; (v) once a physician's panel of attached patients has been determined according to the algorithm outlined in articles 1(k)(i)-(iv), the physician's panel size will be increased by 10% to reflect patients who have not sought care from the physician in recent years but who would nonetheless consider the physician to be their most responsible provider;

Question		Answer
35.	How will they account for rostered patients who see the doctor once every five years because they are young and healthy?	**Are my "healthy unseen" patients counted –** If a patient has been seen only once in the last five years, they will already be attached to you if you billed ME=CARE. For those that have not yet been seen, they are part of the 'healthy unseen' accounted for in the additional 10% added to your calculated panel. Also, remember that once a patient is on your panel they will only be removed from your panel if another physician bills ME=CARE for that patient more often than you or if a physician claims the new NPIV code (ex. if patient moved, or voluntarily changed providers). So, if a patient is simply "well" and not in need of care, they will remain on your panel as one of your patients.
36.	How are you going to account for rostered patients who get prenatal care with another family physician (FP) who works in the same model? What about when rostered patients see other FPs in duty clinics?	**Prenatal care –** Prenatal care codes are not accounted for in the ME=CARE attachment algorithm. Primary care physicians who do their own prenatal work already have attachment to these patients due to other ME=CARE billings and this keeps patients from transferring to maternity care providers when they are just seen for pregnancy and delivery. The ME=CARE algorithm outlined in the Physician Agreement denotes how rostered patients that see other collaborative providers are calculated.
37.	How often are the panel fees paid out and the roster size determined?	**Panel payments –** The panel payment will be paid out bi-weekly but will be smoothed quarterly. This means your bi-weekly panel payment will be adjusted each quarter based on panel size at the beginning of the quarter.
38.	I'm worried about losing patients on my roster due to working in a collaborative practice where my colleague can bill a ME=CARE code for a patient. This may de-incentivize same day access and cross coverage as those who do more same day access coverage	**Collaborative practices –** The ME=CARE algorithm is evolving and we've already done some work to address the shared-care model in the algorithm. DHW has done many panel validation exercises over the last year and have found them to be within a few percentage points of accuracy in collaborative practices. The new billing codes will ensure any previously 'invisible work' is reflected in panel attachment, as well. We will continue to monitor as the panel algorithm is operationalized and evolve our understanding of attachment in collaborative practice.

	Question	Answer
	or have learners whose schedules sometimes allow for more same day access appts will be "stealing" roster patients from others.	If this is remains a concern in your collaborative practice, use the panel validation service offered by DHW (reach out to psaccountability@novascotia.ca if interested) to see the alignment between your EMR data and the ME=CARE remunerated panel.
39.	For new-to-practice doctors with a smaller panel size or with new physicians taking over an existing panel, what is the plan for fair compensation in the first 1-2 years with ME=CARE codes?	**New to practice physicians –** Physicians who are new to family practice will be entitled to a guaranteed minimum income under the LFM for their first year of active family practice. The minimum guarantee will be based on intended hours plus a panel of 1317 (pro-rated for part time physician), plus 30% of fee-for-service billings. See details on page 37 of the Physician Agreement. To ensure a retired physician is no longer getting "credit" for patients assumed by a new-to-practice physician, we've taken several steps: a. The new NPIV code will enable faster attachment for new providers with the first visit to allow for rapid panel establishment. b. Retired providers will have their ME=CARE history erased or "zeroed out", to ensure their patients are not "sticking" to the retired provider's panel and can instead be picked up by the new physician. c. Where there are still patients (more than 100) who are showing on a retired provider's panel after the above steps have been taken, physicians should reach out to DHW (psaccountability@novascotia.ca) to have patients manually transferred (using an NPIV-0 code that DHW can access). Note: any extended leave of absence within the first year of practice such as parental leave, will lead to a "pause" in your time accrual toward your first year of active family practice deadline, which will result in a date extension.
40.	How is DHW calculating panel/roster sizes	**Calculating panel size –** We refer to the formula used to calculate panel size as the ME:CARE Algorithm. Here are the details:

<table>
<tr><th colspan="2">Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>For all encounters using the ME=CARE Health Service Modifier since the inception of the code in 2018/19, DHW determines:

● Number of encounters with each provider
● Last encounter date with each provider, with more recent visits weighted more highly

The patient is counted in the provider panel with the most encounters. If tied, the patient is counted in the provider panel with the most recent encounter.

<table>
<tr><td></td><td colspan="3">Physician X</td><td colspan="3">Physician Y</td></tr>
<tr><td rowspan="5">Patient A</td><td>Date</td><td>m</td><td>Score</td><td>Date</td><td>m</td><td>Score</td></tr>
<tr><td>21-May-23</td><td>1</td><td>1.67</td><td>21-Mar-23</td><td>3</td><td>1.25</td></tr>
<tr><td>21-Aug-22</td><td>10</td><td>0.67</td><td>21-Feb-23</td><td>4</td><td>1.11</td></tr>
<tr><td>21-Oct-21</td><td>20</td><td>0.4</td><td>21-Sep-22</td><td>9</td><td>0.71</td></tr>
<tr><td></td><td></td><td>2.74</td><td></td><td></td><td>3.07</td></tr>
</table>

Patient A is attached to Physician Y</td></tr>
<tr><td>41.</td><td>I don’t agree with the calculation of my panel size. I believe my panel is larger. How can I address that?</td><td>Panel validation –
If you feel that the calculation of your panel is not accurate you can request a panel validation. To take part:

- Email: psaccountability@novascotia.ca. Let them know you have some concerns that your calculated panel may not be accurate and express your desire to participate in a validation exercise.</td></tr>
</table>

Question		Answer
		- You can expect to hear back initially from DHW within 1-3 business days. - You will be asked to export a list from your EMR including patient name, DOB and HCN. DHW will send you a secure link by which you can securely email your list confidentiality. - Your individual panel report will be calculated and sent back to you within 7-10 business days. - Once you've received your report, DHW will sit down with you to review and discuss any discrepancies if requested. The review may or may not result in an adjustment to the panel. The feedback we have received from physicians who have participated in panel validation is very positive.
42.	I'm taking on new patients (or have been in the last few months) but I'm also holding my New Patient Intake Visit (NPIV) claims until Sept 15th because the MSI system cannot accept them yet. Will my panel roster number be reassessed before the transition to the LFM? If so, when?	**Taking new patients in Aug/Sept –** Your first quarter smoothing will be calculated based on your panel effective 6 Sept, in advance of the new code rollout in order to allow the smoothing to be applied to all providers for the first time. However, your panel size will be rerun for Sept 30 to reflect the held claims and LFM bridging payments will be based on this panel size. Be sure to submit your billings – including your New Patient Intake Visit (NPIV) claims – before the end of September so any new patients you've attached will be captured in the updated panel. Any difference between the 6 Sep and 30 Sep panel will be paid out as a lump sum in January/February 2024.
43.	If I am taking over the practice of another physician, do I bill the New Patient Intake Visit (NPIV) fee when I see the patients for the first time, even if they are already patients of the practice?	**NPIV when taking over a colleague's practice –** You cannot normally bill NPIV for patients for whom you have already billed ME=CARE. But if you are taking over the practice of another physician, you can bill NPIV for patients you are attaching even if they are already part of the practice and even if you had billed ME=CARE for that patient sporadically (as one of the providers within the same collaborative practice). This is a change to what was noted in the NPIV code description in the Physician Agreement, and you can expect to see an MSI Bulletin on this shortly.

Question		Answer
44.	What is ME=CARE?	**ME=CARE definition –** ME=CARE is a fee code modifier established in 2018/2019 to incentivize patient attachment to a provider. ME=CARE allows physicians to be paid an increased value (or premium) on most office-based billing codes when seeing a rostered/attached patient. As a condition of billing ME=CARE, physicians commit to providing comprehensive primary health care to that attached patient. Physicians can claim ME=CARE for a patient of a provider for whom they share a collaborative practice. Allied health providers do not bill ME=CARE when shadow billing.
45.	What about pre-natal care – a lot of my patients seek pre-natal care from another family physician and that physician is able to bill ME=CARE for them. Am I losing them in my panel calculation?	**Pre-natal care –** Though pre-natal providers can bill ME=CARE, these codes are removed from the algorithm to ensure that patients remain with their primary care physician.
46.	I am a physician in Amherst and I have a lot of NB patients in my practice. How are NB patients treated within the LFM? Will I get the panel payment for those patients?	**New Brunswick patients –** Physicians in Amherst will have manual adjustments to their panel to account for NB patients (for smoothing and bridging) until a more permanent solution can be found.
Questions about service encounters		
47.	What are service encounters and why are they being monitored in the LFM?	**Service encounters –** Service encounters are defined in the Physician Manual as "a transaction which describes the health service performed by the provider to the service recipient". Because the LFM payment model pays physicians in part based on hours worked and submitted, service encounters are being monitored to ensure there is a reasonable amount of throughput or volume for each LFM hour claimed. The time that a service encounter will take can vary greatly depending on a number of factors including the nature of the service, the condition of the patient, and the physician delivering the service. 2.8 service encounters per hour represents the current average service encounters per hour for Nova Scotia's APP physicians.

Question		Answer
48.	How will the 2.8 service encounters be calculated and monitored by DHW/NSH?	**Calculating service encounters –** Service encounters are defined in the physician manual but there are some refinements we have committed to making under negotiations and with the introduction of the new fee codes: for example, the new office visit multiplier for complex visits being counted as additional service encounters to the original visit for LFM physician reporting. In addition, existing fee codes such lifestyle counselling, mental health and addictions codes, house calls etc., require consideration. Currently, the majority of these examples are noted as a single service encounter under the Physician Manual and we do not necessarily agree that this should remain true. We have opted to ensure that this review is thorough and considered as we understand the importance to physician remuneration. For this reason, we have committed to prioritizing this work in the first LFM quarter, communicating the resulting methodology to physicians, as opposed to a speedy and incomplete action. Given this, service encounter rate will be reported on the first quarterly report (Jan 2024) for learning/baselining purposes, <u>but the first quarter of LFM will not be considered for contract performance</u>. We will be providing greater detail in the coming weeks on the method/details of service encounter monitoring.
49.	What happens if we don't average 2.8 service encounters per hour?	**What if we're under 2.8 service encounters per hour –** A minimum of 2.8 service encounters per hour, averaged over the quarter, is the expectation and it will be shown on your quarterly report. 2.8 service encounters per hour represents the current average service encounters per hour for Nova Scotia's APP physicians. If a physician is unable to meet that minimum expectation for any quarter in a 12-month period, this will trigger a meeting with DHW/NSH/DNS to discuss your practice context. If there is no clear rationale or plan to remedy the issue, the DHW could choose to terminate the LFM contract and the physician would have to revert to fee-for-service. See the LFM contract for further details. Remember though, when you're spending time with more complex patients you will be billing multiples, which will count as separate service encounters. Remember also that the minimum requirement of 2.8 service encounters will be

Question		Answer
		averaged over the quarter and is based on what APP physicians have already been doing on average, even before the new fee codes in the 2023 Physician Agreement. Some physicians who provide valuable home visits to their patients (or other time-consuming services) on a fairly regular basis are concerned their daily encounter data will be negatively impacted. If this is in fact happening, it will be assessed and considered during the all-stakeholder meeting.
50.	How will prolonged services count as service encounters for purposes of ensuring a physician is meeting the required minimum of 2.8 service encounters per hour? For example, would a home visit count as only one service encounter? What about counselling and psychotherapy services or palliative visits?	**How are prolonged services counted –** When you bill multiples on a regular 03.03 office visit or a geriatric 03.03A office visit, the additional multiples will count as additional service encounters. That means a regular 03.03 plus one multiple will count as two service encounters. Prolonged services that entail only one billing, such as counselling, psychotherapy or palliative care support services, and where the base visit is based on 30 minutes with the patient, will also count as one service encounter *at this time*. Note that this is under review. We have committed to prioritizing this review in the first LFM quarter. Given this, service encounter rate will be reported on the first quarterly report (Jan 2024) for learning/baselining purposes, <u>but the first quarter of LFM will not be considered for contract performance</u>. We will be providing greater detail in the coming weeks on the method/details of service encounter monitoring.
51.	What about paps and immunizations – will they count as separate service encounters?	**Paps and immunizations –** If a pap or immunization is done by itself (without a visit), it will count as a service encounter. But if it's done with a visit, the visit + pap are still just 1 service encounter. Same for immunizations. The only time multiple services or procedures will count as multiple service encounters is with the prolonged visits (where each multiple is going to count as another service encounter). Remember that the minimum requirement of 2.8 service encounters is an *average*, and it will not be assessed on a daily or even weekly basis but averaged quarterly.
30% fee for service questions		

<table>
<tr><th colspan="2">Question</th><th>Answer</th></tr>
<tr><td>52.</td><td>How is the 30% FFS going to be paid?</td><td>How is the 30% FFS paid –
Services will be billed on a business arrangement specific for your 30% FFS billings. These services will be paid at 30% of FFS value on a biweekly basis. These will show as an adjustment on your statement.

From October 1-31, 2023, physicians should continue to submit claims for health service codes to their existing APP business arrangement number, for claims now associated with your LFM contract. You will be paid for the 30% billings under the LFM model via an adjustment on your payment statement for the existing APP BA. This BA will be terminated and a new LFM FFS BA will be provided the week of October 30 for continued submission for your health service code claims.</td></tr>
<tr><td>53.</td><td>When is a multiple on an 03.03 office visit (or a long-term care visit) billable – at minute 16 or minute 24 with the patient?</td><td>Claiming multiples / prolonged visits –
In order for a physician to claim multiples they need to spend 80% of the total time in direct patient care (so for a 30-minute visit this means 24 minutes is direct patient care). If 24 minutes was not reached with the patient, the physician would claim a regular visit (1 multiple).

The MSI billing system recognizes and labels the base fee as 1 multiple. The base fee for the prolonged visit is the regular 03.03 office visit. When the physician has spent 24 minutes (80% of the total time) in direct patient care, the physician can bill a second multiple – MU 2. If 24 minutes was not reached with the patient, the physician would claim a regular visit.
<table>
<tr><th>Multiples</th><th>Total Time</th><th>Direct physician to patient contact</th></tr>
<tr><td>MU 2</td><td>30 minutes</td><td>24 minutes</td></tr>
<tr><td>MU 3</td><td>45 minutes</td><td>36 minutes</td></tr>
<tr><td>MU 4</td><td>60 minutes</td><td>48 minutes</td></tr>
</table>
Multiples can be billed on the geriatric office visit (03.03A) (as per the same expectations as the above).</td></tr>
</table>

Question		Answer
54.	Will there be billing codes for collaborative meetings?	**Collaborative meetings –** The Fee Committee will be considering several additional codes to capture currently "invisible work" that better compensate physicians for the work they are doing or recognize work that is currently not compensated appropriately, including: ● Physician-to-physician capacity building, mentoring, maintenance of competency ● NSH/IWK Health–requested quality/safety work ● Collaboration time ● Team development ● Family physician consults ● Group medical visits ● Multiples on specialist telephone advice ● Triage ● Shared care/co-management of patients (for example, high-risk obstetrics rounds, organ transplant rounds) ● General internal medicine visit and consult codes (including complex discharge, follow-up office visit and subsequent hospital visit) ● Care of the elderly ● Long-term care (case management conferences, chart reviews) ● End-of-life care
55.	My billing clerk does not have a solid understanding of the new fee codes, how to bill ME=CARE, etc. Can they access billing education?	**Billing clerk education –** Billing education is under development and there will be further communication once this is finalized.
Parental leave questions		
56.	Parental leave while on the LFM – how will that work?	**Parental leave –** Under the LFM, an LFM physician going on leave puts their LFM on "hold". The incoming physician covering the leave essentially "sublets" the LFM – they will receive the LFM payments in their entirety (hours, panel payments and FFS billings). The incoming physician should also be required to cover overhead for the duration of the leave, since the LFM payments include overhead (but that's between the two physicians to sort out)

Question		Answer
57.	What if physician on leave wants to do some work during the parental leave?	**Working while on leave –** An LFM physician who is off on parental leave can get a separate parental leave Business Arrangement number from MSI and bill 100% FFS for any services they choose to deliver during the leave within their LFM practice. Physicians on parental leave may choose to provide services in other locations while on leave, in which case the prevailing compensation rate would apply. Physicians are reminded that while on parental leave they may receive payment to a maximum of $1200 in any given week.
58.	What about now until the LFM starts in October?	**Transition –** Temporary APPs or sessional arrangement will continue to be provided to cover parental leaves until the LFM takes effect on October 1st. If a physician is on parental leave when the LFM takes effect in October, they won't be required to sort out transition to the LFM while they're on leave. The temporary APP/sessional arrangement for their replacement physician will remain in place and won't be arbitrarily terminated on Oct 1st when the LFM is launched.
59.	How do I project my hours in my LFM Agreement if I know I'm going off on parental leave?	**Projecting hours in LFM –** You should project your intended hours for a "normal" year so that your bi-weekly pay until your leave is accurate. You should also note your intention to take parental leave and your intended start date. Please contact DHW (alternate.funding@novascotia.ca) to sort out those details in advance of your leave (when to suspend your LFM payments; who will be taking over your practice; when to make arrangements with your replacement physician(s); etc.).
60.	When I'm off on parental leave, will patients on my panel end up getting rostered to my replacement or another physician that bills ME=CARE for them while I'm away?	**Protecting panel calculation while on leave –** Your panel upon departure on leave is guaranteed for the same period of time as your leave when you return to practice. Any attachment billings by locum or subletting physicians will be removed from the attachment algorithm upon your return. If your replacement physician has accepted new patients into your practice, you will need to bill NPIV for those patients to have them rostered to you.
Miscellaneous payment questions		
61.	When will the rostering bonus (the one-time "LFM bridging payment" of $10 per patient for	**LFM Bridging Payment –**

Question		Answer
	APP family physicians) be paid out?	The LFM bridging payment will be paid in the coming months. We do not have a fixed date at this stage. The payment will reflect your panel size on Sept 30th, according to the ME=CARE algorithm.
62.	What about the Collaborative Practice Incentive Payment (CPIP) – will we receive any further CPIP payments?	**CPIP Payment –** APP physicians transitioning to the LFM will receive their final CPIP payment in the Fall. The CPIP will eventually be transitioned to fees which will benefit both LFM and FFS family physicians.