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POLICY BRIEFING

HOSPITAL PHYSICIAN REMUNERATION IN AN INTEGRATED CARE SYSTEM

Part 2: Integrated Care in Ontario and Comparative Perspectives on Remuneration

This Backgrounder is part of a series of research work prepared by the OHA to examine the issue of physician remuneration in the context of an integrated care environment.

Part 1 of the series presents an overview of the current landscape in Ontario with respect to physician employment and compensation mechanisms, and outlines the specifics of local remuneration models. Part 1 can be accessed here.

Part 2 of the series examines physician remuneration in the context of integrated care in Ontario, and presents lessons learned from comparative perspectives.

Part 2: Integrated Care in Ontario and Comparative Perspectives on Remuneration

A. Background and Context

On June 6, 2019, the provisions of the *Connecting Care Act, 2019* (CCA)[1] came into effect. This new health statute was introduced as a Schedule under Bill 74, *The People's Health Care Act, 2019* (PHCA).[2]

The Ontario government's intention in passing the PHCA was to take "a comprehensive approach to modernizing Ontario's public health care system by focusing on improving the patient experience and on better connected care, which will help reduce wait times and end hallway health care."[3]

The introduction of Ontario Health Teams (OHTs) is central to the government's mandate of system transformation under this new legislation. OHTs are described as "a new model to integrate care and funding that will connect health care providers and services around patients and families in the community. These coordinated teams will be responsible for delivering care, understanding patients' health care history, connecting patients to the different types of care they need and navigating the health care system."[4]

[1] *Connecting Care Act, 2019*, S.O. 2019, c. 5, Sched. 1 [CCA].
[2] *The People's Health Care Act, 2019*, S.O. 2019, c. 5.
[3] Government of Ontario, News Release. "Ontario Passes Legislation That Puts Patients at the Centre of an Integrated Health Care System." April 18, 2019 (available online).
[4] *Ibid.*

OHTs are established under the authority of the CCA, which authorizes the creation of "integrated care delivery systems" (ICDS). [5] ICDSs are groups or entities, designated by the Minister of Health and Long-Term Care, to deliver integrated and coordinated care in at least three areas.[6] The OHT model will require groups of local health care providers to deliver comprehensive patient care, while sharing clinical and fiscal resources and accountability. They will also be required to establish common standards and target outcomes, and securely share the information necessary to advance coordinated care. OHTs will be free to determine the governance model that works best for them, their patients and their communities.[7]

B. The Role of Physicians in the Integrated Care Environment

Physician engagement and inclusion in leadership and governance is a foundational element of the OHT model.[8]

The government has noted that "because OHTs are responsible for providing a full continuum of coordinated care and improving health outcomes for an entire population, strong physician participation and leadership (both primary care and specialist) are essential cornerstones of the model."[9] It is envisioned that physicians will play an integral role as core members of OHTs, both at a governance and service-delivery level.

The role of physicians in OHTs is different from other efforts to achieve an integrated health system (such as through Local Health Integration Networks). In the OHT model, physicians are strategically engaged as part of the integrated care delivery approach, across the care continuum (i.e. both primary and specialty care).[10]

At maturity, physician engagement in the OHT would be comprised of several functions, among them:[11]

- Offering a full and coordinated continuum of services, which includes primary and specialty care as core functions, as well as other health services and supports such as: coordination of specialist appointments and referrals to a range of medical and community-based care, facilitation of medication management

[5] CCA, *supra* note 23, section 29.
[6] CCA, *supra* note 23, Section 29(2). These areas are: hospital services, primary care services, mental health or addictions services, home care or community services, long-term care services, palliative services or any other prescribed health care service or non-health service that supports the provision of health care services.
[7] Government of Ontario. "Ontario Health Teams: Guidance for Health Care Providers." April 2019 (available online) [Ministry Guidance Document].
[8] *Ibid,* page 15.
[9] Ministry Guidance Document, *supra* note 7, at page 23.
[10] It should be noted that in contrast, primary care is excluded from the ambit of the *Local Health Systems Integration Act, 2006*, S.O. 2006, c. 4.
[11] Ministry Guidance Document, *supra* note 7, at pages 23–24.

through partnerships with community pharmacies, and broader supports to address issues affecting a patient's health outcomes;
- Championing an inclusive approach to care and a relentless focus on quality improvement and rapid learning at all levels of operations;
- Advancing virtual care options for patients (for example, digital self-care supports for chronic disease management), and furthering patients' digital access to their own health records (for example, a patient health information portal);
- Participating in leadership and accountability structures to support achievement of shared performance targets, and enable the achievement of accountability objectives; and
- Using data and analytics to create a culture of learning, performance measurement, and continuous quality improvement, at a local and system level.

The demands on physicians working in an integrated care environment (such as within an OHT) will extend far beyond clinical care – by also requiring that physicians participate in collaborative decision-making over shared accountabilities. This model of care will also formally require physicians to orient their thinking beyond individual patient care to system-level impacts and will highlight their key role as leaders in local and provincial health system transformation. As such, physician remuneration models in this environment must be considered in light of these additional responsibilities.

C. Conceptual Foundation – Physician Remuneration in the Integrated Care Environment

Below, we suggest that there are three elements that are essential to the conceptual foundation of physician remuneration in the context of integrated care; and we examine each of them with a local lens.

1) *A strong approach to integrated funding*

As OHTs are premised on a model of shared responsibility, integrated funding is a necessary feature of remuneration. Bundled care payments[12] will be an important tool for advancing integrated care in OHTs. The government anticipates that, "At mature state, [OHT] budgets will be set according to a blended funding model, which will feature risk-adjusted population-based funding, as well as elements of activity-based funding (i.e., bundled care) for specific episodic conditions."[13] The government also aims to put into place a shared savings incentive structure that will reward OHTs that realize efficiencies and exceed established (standardized) performance targets. OHTs

[12] Bundled care refers to a payment model where a group of health care providers receives a single payment to cover all the care needs of an individual patient's full spectrum of care for a specific health issue. See Government of Ontario, "Bundled Care (Integrated Funding Models)" April 2018 (available online).
[13] Ministry Guidance Document, *supra* note 7, at page 28. Risk adjusted population-based funding refers to the fact that payment is adjusted to differences in health or clinical characteristics of patient populations (for example, to account for patients with complex medical problems) to ensure that funding is distributed more fairly.

will be required to use these savings for improvements in direct patient care. Finally, the government anticipates that as OHTs mature, they will be able to engage in risk and gain sharing amongst participating partners.[14]

Specific mechanisms for physician remuneration within OHTs are not yet identified in available literature. The government has, however, indicated that "successful Ontario Health Teams can be built on existing physician remuneration models"[15] (for example, as outlined above in Part 1 of this Research Series). This suggests that physician services within an OHT may be funded in many ways, as the legislation and/or government policy does not prescribe a specific physician funding or remuneration approach (even though the broader parameters of integrated funding are established).

2) *Clear alignment and strong collaboration with primary care delivery*

As highlighted in the recent Price-Baker Report, primary health care "is considered the cornerstone of any health care system and as such must be an area of focus when addressing broader health system challenges."[16] The Report proposed a vision for an integrated primary health care system, designed around Patient Care Groups (PCGs) that deliver coordinated care.[17] The Report also addressed the need for PGPs to establish collaborative relationships with other parts of the health system, including local hospitals, in order to improve patient outcomes and overall health system performance.[18]

Clear alignment and strong collaboration between primary and specialty care delivery is critical to successful integrated care delivery. Current physician remuneration models mostly work in functional silos (for example FHGs, FHTs and FHOs as alternatives to FFS in primary care; and AFAs or specialty-specific models as alternatives to FFS for hospital-based physicians).[19] Physician remuneration models in the context of integrated care need to capture the clinical and non-clinical work involved in alignment and collaboration between primary and specialty care. Breaking down the functional silos between various remuneration models may be a helpful starting point for enhanced alignment and collaboration.

[14] Ministry Guidance Document, *supra* note 7, at page 28. Risk and gain sharing is an approach that aligns incentives across different providers and sectors, see page 12 of this Backgrounder for further explanation. Each partner in a risk and gain sharing arrangement shares financial gains from efficiencies. For Ontario Health Teams, all savings must be redirected into front line care.
[15] Ministry Guidance Document, *supra* note 7, at page 23.
[16] Price et al. "Patient Care Groups: A New Model of Population-Based Primary Health Care in Ontario." Government of Ontario, May 2015, at page 7 (available online).
[17] *Ibid.*
[18] *Ibid* at page 5.
[19] See Part 1 of this Research Series for further explanation.

The literature highlights several success factors for closer alignment and collaboration between primary and specialty care.[20] Notably, it is important to "take advantage of existing networks, informal linkages among practitioners and a strong patient focus to facilitate physician integration."[21] The organizational structure itself should support this collaboration, whether it is through joint ownership or contracts, or joint executive/planning committees.[22] A key concern that should be addressed is the possibility of relativity related to remuneration, and perceived/actual inequities that may arise. As noted above, careful consideration must also be given to technical aspects of remuneration arrangements to ensure that all physician members of the group feel adequately supported through compensation changes.

3) *Robust physician engagement in governance*

Robust physician engagement in local and system governance is foundational to integrated care delivery. The literature notes that in the context of health system reform, physician engagement in leadership roles is critical to success. This requires that physicians be involved in the design, implementation and evaluation of integrated health care delivery systems. [23] Another foundational element of this engagement is recognizing the importance of physician autonomy. Providing physicians with the opportunity to determine their own organizational and financial arrangements, within a consistent set of parameters, facilitates independence and ownership; and such autonomy also has key implications for quality of care.[24]

One approach to physician governance that warrants further exploration is that of Accountable Care Organizations (ACOs) in the United States. ACOs are a "financial model through which shared savings incentives are created. In this model, incentive payments are predicated on aspects of performance that require physician and hospital management contributions and the attainment of specific quality of care targets." The governing legislation, the *Affordable Care Act*, allows ACOs to include several types of practice arrangements:[25]

- ACO professionals (i.e., physicians and hospitals) in group practices;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals; and
- Hospitals employing ACO professionals.

[20] Marriott J and Mable AL. "Integrated Health Organizations in Canada: Developing the Ideal Model." Healthcare Papers. 2000; 1:76–87 at pages 78–79 (available online).
[21] Suter E. et al, "Ten Key Principles for Successful Health System Integration." Healthcare Quarterly 2009, 13 (Spec No): 16–23 at page 6.
[22] *Ibid.*
[23] *Ibid* at page 12.
[24] Marriott, *supra* note 19 at pages 82–83.
[25] Baker et al. "Exploring Accountable Care in Canada: Integrating Financial and Quality Incentives for Physicians and Hospitals." Canadian Foundation for Healthcare Improvement, March 2014 at page 8 (available online).

ACO models therefore vary in their relationship to individual physicians, with some directly employing providers; while others have a contractual relationship through a joint venture or other arrangement. The opportunity for shared savings also presents an opportunity for increased market share, and therefore, increased income for both the organization and the physician. These models may therefore have a corollary benefit of stability of income/revenue.

The ACO model requires that provider-led organizations be accountable for the entire continuum of care for a defined population of patients; and that they establish a mechanism for shared governance that provides appropriate proportionate control over the ACO's decision-making process. As noted above, the rules allow flexibility in the ACO's governing structure (for example, a network of health care professionals, or a partnership between hospitals and health care professionals); however, the governing body must always be representative of constituent interests.[26] For this reason, the ACO model might offer valuable insights into the potential structure of physician governance in an integrated care environment.

The detailed mechanisms of physician participation in integrated care governance structures are beyond the scope of this Backgrounder. An initial jurisdiction review of various models has been included as **Appendix A**.

D. Insights from Comparative Perspectives

Given the relatively unchartered terrain of physician compensation in the context of integrated care delivery systems in Ontario, it is worthwhile to draw on comparative perspectives to understand the conceptual and operational implications for the local context. Although there are a number of instances of regional (Canadian) innovations in physician remuneration,[27] the three examples below were selected for the important principles that they demonstrate around the role of physicians in remuneration reform.

Quebec Example: The Balance of Accountability

In 2015, the Quebec government introduced legislation to abolish regional health authorities and create integrated health care and social services networks.[28] These new networks were tasked with managing population health within a defined territory, integrating hospital services and coordinating care provided by family medicine groups. The government's aim was to establish a coherent continuum of care, incorporating

[26] *Ibid*.

[27] See jurisdictional summaries of policy innovations in primary care in Peckham A, Ho J, and Marchildon GP. "Policy Innovations in Primary Care across Canada." Toronto: North American Observatory on Health Systems and Policies. Rapid Review (No. 1), 2018 (available online).

[28] Rosenberg, L. "Healthcare Delivery and Physician Accountability in Quebec: A System Ready for Change." IHPME Healthcare Papers, Vol. 17 No. 4, 2018 at page 33 (available online)

community care, home care, specialty hospital care, primary care, mental health, rehabilitative care and mental health services.[29]

While the system-level transformation has already begun to provide clear measurable benefits for users and providers, the issue of physician remuneration in Quebec has been far more challenging. The government proposed to align physician working conditions and performance standards with population needs through changes to remuneration models (by moving away from pure FFS models to one where at-risk pay was involved). However, the changes were not well-received among physician associations and the parties were mired in legal conflict. Physicians perceived the changes as clawing back their income without proper incentives, and as an imposition on their professional autonomy to bill for clinical services. The government, in turn, positioned the matter as one of containing the tide of rising health care delivery costs.[30]

Policy commentators have noted that physicians' backlash against the changes is "indicative of deeper structural incongruities within the Canadian health care system", and in particular, the need to more closely examine the ways in which governance and accountability are tied to physician payment and reimbursement models.[31] Quebec's experience with health system transformation shows that the matter cannot merely be positioned as " health system fiscal sustainability" on one end; and "unfettered professional autonomy" on the other. Rather, a proper balance must be struck between physician remuneration approaches and the accountability of physicians as stewards of the system. For example, this may involve finding ways to properly engage physicians and health system managers as partners in strategic (system-wide) and operational (and more local) planning.[32] Drawing from Quebec's experience, physician remuneration reform, in an integrated care context, must focus on the balance of accountability between physicians and health system payers/administrators.

Alberta Example: The Role of Physicians as Health System Stewards

In 2016, the Government of Alberta, the Alberta Medical Association (AMA) and Alberta Health Services (AHS) agreed to a series of contractual amendments that "would draw physicians into a greater governance role in the system and thus put some of the accountability for the system's management and outcomes on the profession."[33]

There were several key provisions of Master Service Agreements as part of this process, the most notable of which are:

[29] *Ibid* at page 33.
[30] *Ibid* at page 34.
[31] *Ibid.*
[32] On this issue generally, see Marchildon, G. and Sherar, M. "Doctors and Canadian Medicare: Improving Accountability and Performance" IHPME Healthcare Papers, Vol. 17 No. 4, 2018 at pages 20–24 (available online).
[33] McIntosh, T. "From Autonomous Gatekeepers to System Stewards: Can the Alberta Agreement Change the Role of Physicians in Canadian Medicare?" IHPME Healthcare Papers, Vol. 17 No. 4, 2018 at page 58 (available online).

- New compensation models for some primary care physicians, as well as academic physicians, to reward time and quality of care given to patients rather than the number of services provided;
- New physician peer review and accountability mechanisms; and
- A Memorandum of Understanding between the AMA and AHS which outlines the parties' shared interests in promoting continuity of care, cooperating on initiatives to improve physician workplace leadership, and participating in projects to improve integration of care, among other issues. [34]

Policy commentators have noted that "this agreement marks the first attempt by a Canadian government to incorporate physicians into a stewardship role in a provincial health system, one that would provide them with both benefits and responsibilities linked to the fiscal health of the system and to improving the health outcomes of the population."[35] Although it is yet unclear whether these changes have had a significant impact on health system cost savings in Alberta, the focus on physicians as "stewards" of the health system provides important lessons for the Ontario context.

The Alberta reforms provide physicians with an opportunity to move beyond a "gatekeeper" function to one focused on the overall health of the system. As gatekeepers, physicians can regulate the patient's access and journey through the system based on medical judgment – for example, by limiting unnecessary diagnostic tests. In a stewardship role, as contemplated by the Alberta reforms, physicians account for other system actors – for example, by engaging in peer review of billing practices, or by collectively enforcing new billing rules.[36] As such, one might propose that within an integrated care context, physicians acting as stewards would take greater ownership by engaging in more "systems-level" thinking about medical decisions. This is in line with the expectations of physicians within OHTs to engage in the evolution of the health care system.

Additionally, the stewardship role of physicians also orients their thinking towards health system quality improvement. In their role as stewards in Alberta's reforms, physicians were expected to identify how costs in medical decision-making might ultimately be tied to quality of care. For example, redundant diagnostic tests or the over-prescription of antibiotics could be framed as barriers to quality patient care. Thus, in negotiations around the Master Service Agreements, discussions around quality of care and patient centeredness were linked to resource allocation issues and the overall financial health of the system.[37] In Ontario, for physicians working in an integrated care context, the orientation towards health system quality improvement will also be a core function. In

[34] Details of the Master Agreements are available through the Alberta Medical Association (available online).
[35] McIntosh, *supra* note 32 at page 59.
[36] McIntosh, *supra* note 32 at page 60.
[37] McIntosh, *supra* note 32 at page 61.

this regard, the Alberta experience provides important lessons around the role of physicians as system stewards.

It should be noted that in February 2020, the Government of Alberta announced that it would end the current Master Agreement, and that a new agreement would be put in place effective April 1. The parties to the agreement had been engaged in extensive discussions around several contentious issues, including changes to remuneration involving complex modifiers, and had not been able to reach an agreement prior to the expiry of the agreement.[38] The Government's decision to terminate the Master Agreement is based on Alberta's recent omnibus Budget bill, which expanded the Government's unilateral authority with respect to the Agreement.[39]

British Columbia Example: The Importance of Targeted, Incremental Change

The General Practice Services Committee (GPSC) was established in British Columbia in 2002 as part of efforts at primary care reform.[40] Since then, it has been responsible for a number of initiatives, including clinical incentive payments, maternity care bonuses, training modules to enhance clinical and administrative skills and the creation of Divisions of Family Practice to coordinate and support family doctors at the regional level. The GPSC includes representatives from Doctors of BC, the government of BC and regional health authorities.[41]

Rather than forcing structural change, the GPSC has encouraged improvements in primary care through targeted financial incentives for primary care physicians.[42] These financial incentives cover a number of areas, for example, chronic disease management to include hypertension and chronic obstructive pulmonary disease; managing patients with mental health issues, comorbidities or palliative care needs; creating prevention plans for cardiac disease; telephone and e-mail consultations for complex or high-needs patients; and embarking on shared care arrangements with specialists and other healthcare providers for patients with complex health problems. These incentives payments work alongside physicians' existing remuneration structure (primarily FFS) – however, they reward physicians for accepting the responsibility of providing comprehensive, continuous care, rather than favouring episodic care. The incentive system is voluntary; and allows physicians working on an FFS basis to justify spending more time with their chronic and complex care patients.[43]

[38] CBC News, "Alberta ends master agreement with doctors, new rules to be in place April 1", February 2020 (available online).
[39] Government of Alberta, "Enabling the *Budget Act*, 2019", November 2019 (available online)
[40] Tregillus, V. and Cavers, W. "General Practice Services Committee: Improving Primary Care for BC Physicians and Patients. Healthcare Quarterly, 14 (2011) at page 1 (available online).
[41] Government of British Columbia. "General Practices Services Committee: Who We Are." Accessed October 2019, online.
[42] Tregillus, *supra* note 37 at page 3.
[43] Tregillus, *supra* note 37 at page 3.

This BC example of remuneration reform is important in that it demonstrates the success of targeted, incremental change. Rather than wholesale reform of physician remuneration, the GPSC model has sustained meaningful change through its flexible and evolving nature. The incentive structure has consistently focused on establishing collaborative decision-making and iterative measurement and feedback loops.[44] Physicians have been fully engaged through these processes, which has also ultimately enhanced physician job satisfaction.

In the Ontario context, this example may be informative for the guidance that it provides on the effects of specific, evidence-based modifications to physician remuneration. Such an approach suggests that incremental change, rather than a complete overhaul of physician remuneration, may be a valuable path to consider. One way that such incremental change could be implemented is through enhancements (modifiers) to existing FFS remuneration structures. Such mechanisms are already in place in certain contexts – for example, modifiers for certain complex or high-needs patients enrolled in primary care practices.[45] Use of these complexity modifiers may be a starting point for further evidence-based modifications to physician remuneration.

E. Operational Considerations – Physician Compensation in the Context of Integrated Care

Having explored the legal/policy basis of integrated care delivery in Ontario; and having considered the conceptual lessons learned from other jurisdictions, the practical realities of operationalizing OHTs still remain.

This section of the Backgrounder will outline some of the relevant issues, from a physician remuneration perspective, for the operationalization of OHTs, and will draw on relevant examples to provide additional context. Several key questions are considered below as a starting point for discussion:

> ***What are the key parameters around disbursement of physician funding for OHTs? What kinds of legal and/or other accountabilities might one expect from the payer and the payee(s)?***

As noted above, the Ministry of Health anticipates that existing physician remuneration models may be used within the context of OHTs.[46] Resultingly, one might expect that existing legal accountabilities and frameworks (for example, the role of the OMA in negotiating physician remuneration) would continue to be in place.

[44] Tregillus, *supra* note 37 at pages 4 to 5.
[45] Ontario Ministry of Health and Long-Term Care, Fact Sheet, "Primary Care Physician Compensation and Complex Patients", May 2014, available online
[46] See Part B of this Backgrounder, above.

However, the nature of OHTs also requires that physician funding be integrated (i.e. part of a broader or blended funding package); and responsive (i.e. tied to the OHT's established performance targets or outcomes). As such, a hybrid or blended model of compensation can be considered. A few examples from other jurisdictions are described below:

- The ACO model relies on a shared savings program for both public and private payer models. Under this risk-and-gain sharing program, ACOs are reimbursed through an FFS-equivalent approach, with the added layer of an incentive structure – at the end of the year, savings from the budget are split with the payer (as measured against predetermined benchmarks).[47]
    - In public ACO models,[48] providers may receive a budget based on a population case-mix, and if costs at the end of the year are below the global budget, the ACO providers retain the savings.
    - In private ACO structures,[49] providers may be paid in advance and are responsible for any costs they incur above their payment.
- The Manitoba Physician Integrated Network compensates physicians through an FFS model, but also provides quality-based incentive funding (QBIF), and capital funding for IT systems implementation to primary care providers working in group clinics.[50] The QBIF is provided to clinics who meet quality targets on certain primary care indicators (established through a working committee).
- The General Services Contract (GSC) in the United Kingdom compensates physicians through a blend of capitation and FFS payments.[51] The GSC is coupled with a national Quality and Outcomes Framework – an extensive pay-for-performance program offering bonus payments to clinics (rather than individual providers) for achieving targets in a clinical and administrative areas.
- The Experiment with New Remuneration Models (ENRM) in France blends FFS remuneration for physicians with funding for multi-professional practice groups. Group practices must meet several requirements (for example, taking care of patients with chronic conditions, providing health promotion and disease prevention activities, and enhancing continuity of care).[52] The ENRM started as an initial pilot project in 2010, and as of 2015, was scaled up to a national level, with over 300 health structures participating.

[47] Peckham A et al. "Accountable Care Organizations and the Canadian Context." Toronto: North American Observatory on Health Systems and Policies. Rapid Review (No. 9) (2018) at page 6 (available online).
[48] There are three primary types of public Medicare ACO structures, with Medicare Shared Savings Program being the largest federal program. See Peckham et al, *ibid.*
[49] There are two models for private ACOs: insurance-led and provider-driven (usually hospitals and physician organizations). See Peckham et al, *supra* note 43.
[50] University of Manitoba, Community Health Sciences, "Models of Primary Health Care Delivery" October 2016 (available online)
[51] National Health Service, England, "General Medical Services Contract" August 2019 (available online)
[52] Pomey M-P et al. "Innovation in Physician Remuneration in France: What Lessons for Canada?" (2019) Health Reform Observer - Observatoire des Réformes de Santé 7 (2): Article 1 at pages 7–9

As these examples show, innovative blended physician remuneration models have been explored in numerous contexts. The available literature is mostly limited, however, to reforms in primary care remuneration, rather than cross-sectional (primary/specialist) funding integration.

> ***What is the potential for remuneration to be tied to particular outcomes (pay for performance models or at-risk pay)? Could physician compensation be tied to performance-based metrics (through a standard set of clinical indicators) or through a preventative model, where compensation is tied to health promotion outcomes?***

There are numerous examples of models of remuneration with linkages to performance-based metrics or incentivization for health promotion and disease prevention. The examples are outlined extensively in the literature; given the complexity of these models, they are not explored in detail in this Backgrounder.[53]

The literature generally demonstrates that there is no clear evidence that pay-for-performance or similar models will lead to improvements in quality of care. One important limitation is that the research in this area is generally focused on primary (rather than specialty) care. However, the research suggests that pay-for-performance models should be approached with some degree of caution. As evidenced in the UK example, pay-for-performance models with an extensive number of clinical targets may become overly cumbersome for providers; or may not be suitable for patients with more complex problems (for example, patients with multimorbidity) because important aspects of care might not be easily measurable.[54]

Although there are no immediate legislative barriers to implementing pay-for-performance models in OHTs, the literature suggests that policy-makers should proceed with caution, keeping several key design principles in mind:[55]

- Pay-for-performance should be part of wider quality improvement efforts.
- Alternative strategies should be used to improve quality for aspects of care not easily measured to avoid them being neglected.
- Single disease indicators may not be appropriate for important patient groups such as complex patients with multimorbidity.
- Clinicians should be strongly represented among those selecting indicators and designing the program.

[53] For detailed explanations, see Mattison CA and Wilson MG. "Rapid synthesis: Examining the effects of value-based physician payment models" (2017) McMaster Health Forum Paper (available online).
[54] Martin, R and Frede, O. "Can pay for performance improve the quality of primary care?" British Medical Journal (2016) 354: i4058 at page 1 (available online).
[55] *Ibid.*

- Technical expertise in developing and implementing indicators is needed so that they measure what they are intended to measure and reduce unintended consequences.
- Payments should be large enough to change behavior, but not so large as to divert excessive effort onto incentivized aspects of care.
- Unexpected consequences should be anticipated and continuously monitored.
- The effect on inequalities in delivery of care should also be monitored.

As demonstrated in the US experience with ACOs, with respect to pay-for-performance models, "it is likely that meaningful improvements in quality and reductions in costs require complex and multi-faceted interventions that include a combination of performance measurement, appropriate incentives, integrated care and quality improvement efforts. In addition, essential system level changes may be necessary to promote better performance."[56]

The design and implementation of a pay-for-performance remuneration model would be multifaceted task, requiring extensive technical expertise and health care stakeholder engagement. As such, it should be approached with due consideration for the complexities involved.

> ***How would accountability over patient care outcomes be shared within an OHT? If the overall funding model/agreement specifies targets/outcomes/specific patient measures, how might individual physicians and other providers be individually accountable for shared outcomes?***

The concept of provider risk bearing (or risk pooling) emerges in the literature as one means of sharing accountability in the context of integrated care. Risk pooling refers to an arrangement whereby a larger medical group retains or withholds a portion of the payments that are contractually due to physicians and other participants. These withheld amounts are then placed in one or more risk pool funds held by the medical group. The medical group may also contribute funds to the risk pool.[57]

This concept presupposes that two tiers of financial incentives bear on physician behaviour: the method of payment by the payer and the method used by the medical group to compensate individual physicians. Given that individual physicians are sometimes paid on a different basis than the group, a risk adjustment can be made at the individual practitioner level.[58] The following example may be informative:

[56] Baker et al, *supra* note 24 at page 14.
[57] American Medical Association, "New Payment Methods – Withholds", January 2018 (available online)
[58] Trybou, J et al. "Provider Accountability as a Driving Force Towards Physician-Hospital Integration: A Systematic Review." International Journal of Integrated Care, Jan–Mar 2015, pages 2–3 (available online)

- The reimbursement system of the group physicians could rely on capitation (with a fixed fee per capita). Capitation is a low-risk mechanism as it is inelastic;[59]
- The financial means (and risk) are pooled at the physician group level (pooling the fees of all the physicians belonging to that physician group);
- An alternative remuneration system for the individual physicians can be applied (e.g. a fee per patient visit – cased based visits, or an FFS model). The higher risk (more elastic) compensation mechanism is assumed at an individual level.

In this way, the "risk assumption" operates at different levels in the organization – firstly, via a group effect, and secondly, at the individual physician level.[60] The technical components behind risk-sharing arrangements are complex, and as such, their implementation should be approached in an evidence-based manner. It may be worthwhile to review the experiences of other jurisdictions, particularly the US, where risk-sharing arrangements are more well-developed through the ACO model.[61]

In the Ontario context, it is clear from legislation that there is flexibility to consider a wide variety of financial arrangements to structure risk and accountability among physicians. As there is no prescribed governance structure for the OHT model, there is significant room to explore how physicians might be held accountable to each other and to the payer, and ultimately, to the public.

Conclusion

Physician remuneration in an integrated health care delivery environment presents numerous challenges and opportunities. Considering the experiences of other jurisdictions provides important insights that are valuable to Ontario as it approaches the momentous task of system reform. In particular, the Quebec and Alberta examples draw our attention to the importance of engaging physicians as leaders and collaborative partners in this task. Two clear principles emerge: the importance of meaningful engagement of physicians in the design of remuneration mechanisms; and clear accountability mechanisms through the overall structure of remuneration. The research also confirms the need to invest in physician leadership, to further engage physicians in systems-thinking and their role as system stewards Numerous operational complexities still remain; however, there is legislative and policy flexibility to address these issues through a true "made-in-Ontario" approach to physician remuneration in integrated care.

[59] Inelasticity in this context refers to the fact that physicians would be compensated regardless of how many services are performed. Capitation is inelastic to income risk – income does not depend on the risk of performing more or fewer services.
[60] Trybou, *supra* note 53 at page 2
[61] See generally Friedberg, M et al. "Effects of Health Care Payment Models on Physician Practice in the United States" Rand Corporation and the American Medical Association, 2014 (available online).

Discussion Questions

To prompt further engagement on the issues considered in this Backgrounder, a series of guiding discussion questions are outlined below:

What are some of the current barriers to greater alignment and collaboration between primary and specialty care? In the context of integrated care delivery, how might these barriers be addressed?

What are the key enablers to facilitate physician engagement in local and system governance? What are some of the core criteria for an effective integrated care governance model?

The Alberta, Quebec and BC examples of remuneration reform each present unique insights for the Ontario context. Which key learnings are most valuable for understanding physicians' role in health system transformation?

When considering the specific mechanisms of integrated funding for physicians, which elements are key to successful implementation? Among the US, UK, French and Manitoba examples, are there any commonalities that might be useful for the Ontario context?

What are some of the benefits and drawbacks to a pay-for-performance remuneration model? What might be some of the key implications for physician engagement, clinical outcomes and patient satisfaction?

In Ontario, the concept of "risk-bearing" with respect to physician remuneration is relatively novel. Learning from comparative experiences, how might this concept inform future discussions about physician accountability through remuneration?

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Appendix A: Jurisdictional Scan

Physician Involvement in Integrated Care Governance

Prepared by Georgina Archbold, Research Advisor

Summary of Main Findings

- In all models reviewed, physicians are involved to some degree in the governing body.
- Integrated care models that encompass a greater number of providers across a broader continuum of care (e.g., UK Integrated Care Systems, Canterbury Clinical Network) have fewer or no stipulations on the involvement of physicians in governing and leadership bodies. Governance arrangements and leadership involve partner representation.
- Integrated networks of physicians (predominantly primary care), as observed in physician-led ACOs and Clinical Commissioning Groups, have boards with a physician-held majority.
- Mayo Clinic and Kaiser Permanente, two models with a long history delivering multidisciplinary collaborative care, are predominately physician-led, but physicians holding board and executive have a breadth of experience across the organizations.

Key Talking/Advocacy Points

- It is important to recognize the limitations of using physician-led ACOs as evidence to push for physician-led governance.
    - While physician-led ACOs continue to demonstrate the greatest savings, all ACO types are now averaging some level of savings.[i]
    - There is significant heterogeneity within physician-led ACOs and there is some evidence that variations within this ACO type are more responsible for increased savings (e.g., number of attributed beneficiaries).
    - ACOs do not currently take on full financial responsibility for the overall health of a geographic population – they are only responsible for the care costs for an attributed population, which in some cases is small.
    - Although the number of physician-led ACOs continues to grow, this ACO type has the highest dropout rates.

- Within the current OHT context, a more representative or interdisciplinary governance model, similar to the models adopted in New Zealand and the UK, is likely to foster greater collaboration between healthcare partners.

Model / Country	Overview of Model	Governance / Leadership Structure
Clinical Commissioning Groups (CCG)[ii,iii] – UK	• Replaced primary care trusts • Required to support quality improvement in general practice and deliver more integrated care • GPs are legally obliged to join CCG • Commissions health services for entire resident population within geographical boundaries • CCGs work collaboratively with other providers to deliver better health outcomes for patients • Range of care includes elective hospital care, rehabilitation care, urgent/emergency care, community health services, mental health, learning disability services • Population size and patient profiles vary across CCGs	• Statutory bodies, and as such must fulfil a considerable number of legal responsibilities and structural requirements designed to ensure good governance and accountability to the public • Local GP practices are represented at various levels in a CCG's governance structure[iv] • Governing body chair is elected GP and governing body includes combination of member representatives (most commonly GPs) • Practice and procedures for each CCG differ • Elected GPs on the governing body are remunerated for participation[v] • Lay members on the governing body are also remunerated for participation, but calculated at different rate[vi] • Governing body must include other clinicians besides GPs, although the legal requirements for this are minimal (one nurse and one secondary care clinician in each CCG) • Most CCGs also have a member council that comprises all provider representatives or locality representatives (for larger CCGs) • All CCGs set out agreed governance arrangements in publicly available constitution
Integrated Care Systems (ICS)[vii] – UK	• Bring together NHS providers, local authority, and third sector bodies to take on collective responsibility for the resources and health of the population of a	• No single national framework for governance[ix] • Not a statutory body – doesn't replace individual accountability of organizations within it that are statutory bodies (i.e., NHS trusts, CCGs) • Governance arrangements built using existing

Model / Country	Overview of Model	Governance / Leadership Structure
	defined area, with the aim of delivering better, more integrated health and social care for patients[viii] • Also expected to focus on managing population health, delivering care through redesigned community and home-based services • Introduced in 2017 as evolution of Sustainability and Transformation Partnerships (STPs) • 44 local 'footprints' • Funded by 'capitated payment' arrangement	legislative flexibilities such as joint committees, MOUs • Alliance agreement between member organizations sets out governance arrangements • Common features: o Partnership board made up of representatives from organizations within the system (commissioners, providers, primary care networks, local authorities, and third sector organizations within the ICS) o Senior leadership team made up of chief executives, accountable offices, senior clinical leaders o Sub-committees and workstreams to drive delivery on key priorities o Joint committees of providers to make collective decisions
Canterbury Clinical Network[x] – New Zealand	• Collective alliance of health care leaders, professionals and providers • Initiated by Canterbury District Health Board Second (CDHB) – largest health board serving population of over 500,000, responsible for 18 health facilities including 7 central hospitals, 8 rural hospitals, outreach clinics • Network includes 12 partner organizations (e.g., primary care, acute care, home care, pharmacy, radiology, nursing, midwives) • Includes Pegasus Health (a	• Comprises the Alliance Leadership Team, Alliance Support Team, workstreams and service level alliances and workgroups[xii] • Alliance Leadership Team is led by an independent chair and includes representation from primary health organizations, secondary/tertiary care, CDHB, allied health, nursing • Also includes a patient and Maori representative • Responsible for overall guidance, direction and leadership framework for the network • Alliance Support Team is the senior level working core of the network and is primarily made up of senior executives from alliance member organizations (includes CEOs from the 3 PHOs) • Separate Programme Office coordinates network activities, and provides day-to-day operational support to the various partners

Model / Country	Overview of Model	Governance / Leadership Structure
	large Primary Healthcare Organization and primary care network) that supports general practices and community-based health providers deliver care to over 445,000 enrolled patients o Most GPs are part of Primary Health Organizations (PHOs) • CDHB is funder and contractor with partners • Payments partially made under capitated formula • In 2013, government required alliance between each district health board and corresponding PHOs[xi]	
Accountable Care Organizations (ACOs)[xiii,xiv] – US	• Legal entity composed of a group of providers accountable for the total cost and quality of care for a defined patient population • Typically include primary care providers through which patients are attributed to the ACO • Include group practices, networks of individual practices, partnerships or joint venture arrangements between hospitals and other providers, regional collaboration of health providers o Often classified as	• Has the legal ability and administrative organization to receive and distribute payments for shared savings to participating providers • ACA requires ACOs establish a governing body representing ACO providers of services, supplies, and Medicare beneficiaries[xvii] • At least 75% control of the governing body should be held by ACO participating providers • Rules do not set any specific standards or requirements for representation by particular provider or stakeholder categories – ACA requires ACOs "provide for meaningful participation in the composition and control of the ACO's governing board" • If an ACO is comprised of a self-contained financially and clinically integrated entity that has a pre-existing

Model / Country	Overview of Model	Governance / Leadership Structure
	physician-led, hospital-led, integrated o More variation within types than between[xv] • Not all ACOs are integrated delivery systems – ACOs may have to work with providers outside of their ACO to provide care across a continuum • Different models: Medicare Shared Savings Program (MSSP), Advanced payment ACO Model (mostly rural), Pioneer ACO Model (experienced in delivering coordinated care) • MSSP is most common and pays provider groups under a FFS shared savings arrangement – does not incentivize or require that patients seek care from providers within the ACO • Diverse in terms of population size and profile – on average, physician-led ACOs have smaller attributed populations • Physician-led ACOs are likely to be an arrangement where the ACO contracts with hospitals and skilled nursing providers for required services • CMS now classifies ACOs as	board or other governing body, no separate ACO governing body is required • Involvement of physicians in governance varies from one ACO to another (i.e., physician-led ACOs primarily composed of physician/PHC groups will have more physician representation on the governing body) • Has been reported that physicians constitute majority of governing board in 78% of ACOs[xviii] • Some ACOs may require one or more physicians on the ACO board • Physicians may be in independent practice or non-active practice with administrative focus • Clinical management and oversight, required under ACA must also be managed by a medical director

Model / Country	Overview of Model	Governance / Leadership Structure
	"low revenue" (generally physician-led) and "high revenue" (typically include hospitals)[xvi] • Low revenue – control less than 35% of the Medicare costs for their attributed beneficiaries	
Kaiser Permanente[xix] – US	• Self-contained delivery system that coordinates primary, secondary and tertiary care • Strong emphasis on prevention and primary care • Consists of 3 entities: o Kaiser Foundation Health Plans o Kaiser Foundation Hospitals (non-profit) o Permanente Medical Groups (PMG) – for-profit partnerships or professional corporations of multispecialty physicians who provide care exclusively for Kaiser health plan members in Kaiser facilities • Medical Groups receives capitation and other payments from Health Plan • Medical Group pays physicians a market-based salary, supplemented by small incentives	• Each entity has its own management and governance structure • Kaiser Foundation Health Plan and Hospitals board includes physician representation, but is not physician-led • PMGs operate on principle of self-governance at a local level – physicians from primary, secondary and tertiary care determine policies of own group through direct participation and through elected, representative physician leadership • Each PMG has its own Board of Directors • Permanente Federation LLC is the organizing entity that represents the shared interests of the 8 PMGs – primarily consists of physicians
Mayo Clinic[xx] – US	• Integrated multi-specialty group	• Board of Governors (executive committee of

Model / Country	Overview of Model	Governance / Leadership Structure
	medical practice at 3 main sites (Arizona, Florida, Minnesota) • Serves over 500,000 patients annually • Includes physicians and researchers representing most medical disciplines • Provides inpatient (full integration of hospitals) and outpatient care • Strong emphasis on research and education • Patients are attended by a multi-specialty group of clinicians who collectively address the "whole patient", managed by a coordinating physician • Physicians are salaried • Physicians are expected to not only participate in clinical practice but also in education, research and administration • Teams of physicians, scientists, administrators, and allied health professionals are responsible for the strategy and execution of virtually all major initiatives • Consistently win awards for quality of care: o Rochester, Minnesota site ranked number 1 in 2018-2019 and 2019-20 'Best Hospitals Honor	governing body) is physician-led and has clear physician majority[xxii] • Physicians also chair and are part of other committees of the governing body • President/CEO and site CEOs are physicians with leadership experience across organization • Rotating leadership – generally 2 terms of 4 years each

Model / Country	Overview of Model	Governance / Leadership Structure
	Roll' compiled by the *U.S. News & World Report* o 3 sites recipients of 2019 Bernard A. Birnbaum, MD, Quality Leadership Award • Leader in addressing physician burnout and ensuring patient satisfaction – burnout rates approximately two thirds the national average[xxi]	

References

[i] Gonzalez-Smith, J., Blser, W.K., Muhlestein, D., Richards, R., McClellan, M.B. & Saunders, R.S. (2019). Medicare ACO Results for 2018: More downside risk adoption, more savings, and all ACO types now averaging savings. *Health Affairs Blog*. Available at: https://www.healthaffairs.org/do/10.1377/hblog20191024.65681/full/

[ii] Naylor, C., Curry, N., Holder, H., Ross, S., Marshall, L. & Tait, E. (2013). Clinical commissioning groups: Supporting improvement in general practice? The King's Fund & Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/files/2017-01/clinical-commissioning-groups-web-final.pdf

[iii] Sheaff, R., Charles, N., Mahon, A., et al. (2015) NHS commissioning practice and health system governance: a mixed-methods realistic evaluation. *Health Services and Delivery Research*, 3(10). Available at: https://www.ncbi.nlm.nih.gov/books/NBK284568/ doi: 10.3310/hsdr03100

[iv] NHS Commissioning Board (2012). *Clinical commissioning group governing body members: Role outlines, attributes and skills*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/09/ccg-members-roles.pdf

[v] NHS West Cheshire Clinical Commissioning Group (2018) Clinical Leadership and Governing Body Remuneration Framework. Available at: https://www.westcheshireccg.nhs.uk/media/1883/remuneration-framework-final-for-gov-body.pdf

[vi] NHS West Cheshire Clinical Commissioning Group (2018) Clinical Leadership and Governing Body Remuneration Framework. Available at: https://www.westcheshireccg.nhs.uk/media/1883/remuneration-framework-final-for-gov-body.pdf

[vii] British Medical Association (2019). *Integrated Care Systems: What are they, and what do they mean for doctors?* Available at: https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/nhs%20structure%20and%20delivery/integrated%20care%20systems%20briefing.pdf?la=en

[viii] Checkland, K., Allen, P., Coleman, A., et al. (2013). Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS. *BMJ Open*, 3(12). doi: 10.1136/bmjopen-2013-003769

[ix] Charles, A., Wenzel, L., Kershaw, M., Ham, C., & Walsh, N. (2018). A year of integrated care systems: Reviewing the journey so far. The King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/2018-09/Year-of-integrated-care-systems-reviewing-journey-so-far-full-report.pdf

[x] Timmins, N. & Ham, C. (2013). The quest for integrated health and social care: A case study in Canterbury, New Zealand. The King's Fund. Available at: https://www.cdhb.health.nz/wp-content/uploads/c476aa13-canterbury-kings-fund-report.pdf

[xi] Gauld, R (2014). What should governance for integrated care look like? New Zealand's alliances provide some pointers. *The Medical Journal of* Australia 201(3). doi: 10.5694/mja14.00658. Available at: www.mja.com.au/system/files/issues/201_03/gau00658.pdf

[xii] Canterbury Clinical Network. Who we are: our structure. Available at: http://ccn.health.nz/WhoWeAre/OurStructure.aspx

[xiii] Centers for Medicare & Medicaid Services. (2013). Accountable care organizations (ACOs): General information. Available at: http://innovation.cms.gov/initiatives/aco/

[xiv] Barnes, A., Unruh, L., Chukmaitov, A., & van Ginneken, E. (2014). Accountable care organizations in the USA: Types, developments and challenges. *Health Policy*, 118(1), 1-7. doi: 10.1016/j.healthpol .2014.07.019

[xv] Comfort, L. N., Shortell, S.M., Rodriguez, H.P. & Colla, C.H. (2018). Medicare Accountable Care Organizations of Diverse Structures Achieve Comparable Quality and Cost Performance. *Health Services Research*, 53(4), 2303-2323. doi: 10.1111/1475-6773.12829

[xvi] National Association of ACOs. NAACOS Assessment of high-Low Revenue Designations. Available at: https://www.naacos.com/naacos-assessment-of-high-low-revenue-designations

[xvii] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010) Available at: http://housedocs.house.gov/energycommerce/ppacacon.pdf

[xviii] Colla, C.H., Lewis, V.A., Shortell, S.M. & Fisher, E.S. (2014). First national survey of ACOs finds that physicians are playing strong leadership and ownership roles. *Health Affairs*, 33(6). https://doi.org/10.1377/hlthaff.2013.1463

[xix] McCarthy, D., Mueller, K. & Wrenn, J. (2009). Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology. *The Commonwealth Fund*. Available at: https://www.sma.sk.ca/kaizen/content/files/2009%20Commonwealth%20Fund%20Kaiser%20Permanente.pdf

[xx] McCarthy, D., Mueller, K. & Wrenn, J. (2009). Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care. *The Commonwealth* Fund. Available at: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2009_aug_1306_mccarthy_mayo_case_study.pdf

[xxi] Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clinic Proceedings, 90(12), 1600–1613.

[xxii] Mayo Clinic (2019). Governance and Management Structure. Available at: https://www.mayoclinic.org/documents/governance-management-structure-pdf/doc-20079617