ONTARIO PHYSIOTHERAPY ASSOCIATION

BUNDLED CARE (INTEGRATED FUNDING MODELS) – NEGOTIATIONS AND AGREEMENTS

Member Resource for Clinics in the Community Engaging in the Funding Model

November 20th, 2019

BACKGROUND

OPA has prepared this resource to help our members participate in the Ministry of Health's (MOH) Bundled Care funding model for integrated acute and post-acute (including rehabilitation) pathways for patients who have had unilateral total hip or knee replacements, bilateral total hip or knee replacement surgeries, shoulder arthroplasty and for future programs including coronary artery bypass graft (CABG), and stroke.

This document has been developed based on the Association's work with the Ministry and other stakeholders and our members' experiences in the implementation of the Bundled Care program for unilateral total hip or knee replacement patients. It is subject to ongoing review and updates as needed as the program continues to evolve.

There may be additional considerations for populations with more complex conditions such as CABG and stroke that the OPA will continue to monitor and address as implementation of those bundled pathways begin in order to support our members.

Launched on April 1, 2018 as a pilot, the Bundled Care funding model was initially piloted for unilateral hip and knee replacement patients at 33 hospitals across Ontario and has since moved to full scale implementation with all 56 hospitals across Ontario that perform these surgeries participating for fiscal year 2019/20. This funding model has gone through some adjustments as the Ministry, bundle holders, and their networks worked through the implementation process. Some of those adjustments have been prompted by the OPA, based on feedback from our members. The OPA is continuing to work with the Ministry hopefully to resolve those issues that persist to

ensure that patients can have timely access to physiotherapy in their community that is sufficiently resourced to meet best practices.

The Bundled Care model will continue to expand to additional procedures. Implementation of bundled pathways for bilateral hip or knee replacement surgery and shoulder surgery (reverse arthroplasties, total and hemi arthroplasties) across hospitals that have volunteered to participate in the expansion began on April 1, 2019.

The Ministry is in consultation with key stakeholders to develop an approach for phased implementation of bundled pathways for coronary artery bypass graft surgery (CABG) and stroke (hemorrhagic, ischemic and unspecified). It is suspected that participation in all these models will be mandatory by 2020-2021.

This resource is intended to assist members who are considering entering into, or who have already entered into formal agreements with bundle holders and those who do not have formal agreements, but are accepting patients who are eligible for treatment under the Bundled Care funding model on an ad-hoc/invoicing basis.

This resource does not constitute legal advice. Members are encouraged to seek legal assistance as appropriate.

Members are encouraged to share their experiences with respect to agreement content, negotiations and bundle holder conduct with the OPA. Your experience will help us continue to offer the best support we can to members in this area and will inform our conversations and strategies with the Ministry moving forward. Please contact the OPA via email with the subject line "Experience with Bundled Care".

ADDITIONAL RESOURCES

The Ministry is also providing resources to help interested parties who are considering participating and currently participating in the model. Members who are interested in these resources and learning more about Bundled Care are encouraged to join Health Quality Ontario's (HQO) Bundled Care Community of Practice group on their web-based platform Quorum to access further information. Sign-up is required but registration is free. You can also access HQO webinars on Bundled Care here.

The information that follows in this resource is offered for members who own or manage physiotherapy clinics to do their due diligence on agreements and to protect their interests in making decisions as to whether and how to participate.

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TYPES OF AGREEMENTS

A bundle holder and physiotherapy clinic can enter into two types of agreements:

- A formal agreement; where a signed agreement exists between a bundle holder and a clinic and referrals are made to the clinic based on this agreement. The agreement is based on pre-established terms and conditions between the bundle holder and physiotherapy clinic and may include elements such as payment, types of services, specified volume of patients; and

- An ad-hoc arrangement; no formal agreement exists. The patient presents with a referral for physiotherapy from the bundle holder. The clinic contacts the bundle holder to establish payment and services on a one-off basis. This was formerly known as invoicing.

Formal agreements enable integrated care delivery through a team-based approach to program implementation. If negotiated to include these things, formal agreements can establish certainty with respect to:

- Anticipated patient volumes;
- Prices;
- Billing mechanisms;
- Quality and reporting expectations; and
- Allow for risk and gain sharing elements to be linked to payments, which creates incentives for providers to maximize the quality of services provided.

A bundle holder may seek to form an ad-hoc arrangement for individual patients with physiotherapy clinics that are considered an "out-of-network" provider and are not in the bundle holder's usual catchment area. Ad-hoc arrangements should include prices, payment procedures, and reporting and performance expectations. Invoicing the bundle holder for services rendered based on an ad-hoc arrangement, instead of establishing a formal agreement, can provide some flexibility for physiotherapy clinics.

GENERAL POINTS ON AGREEMENTS

- Discussions on establishing agreements can be initiated by either party. Physiotherapy clinics can initiate conversations with bundle holders by reaching out to them with their proposed terms and conditions. It is important to note that bundle holders are not required to enter into formal agreements with providers for the provision of rehabilitation services, although the Ministry prefers that they do so in order for the program to reach a mature and stable state of implementation.

- There is no requirement that the bundle holder enter into agreements with *a single* provider. If bundle holders enter into agreements, they may do so with individual providers but may also do so with a network of providers in order to meet the needs of their patients by expanding geographic access to care.

- It is possible that a physiotherapy clinic could be located in an area with two or more Bundled Care networks and, thereby, the clinic may have agreements with multiple bundle holders or the clinic could have no agreement in one network and an agreement in another. In all cases, agreements could be materially different between bundle holders.

- It is important to note that regardless of the option provided by the Ministry to forgo formal agreements and enter into an ad-hoc arrangement, the bundle holder can insist on a partnership agreement as a precondition to participating in the network.

- A physiotherapy clinic should not enter into a Bundled Care agreement, or complete an Expression of Interest (EOI), Memorandum of Understanding (MOU), or Request for Proposal (RFP) without first carefully reading and understanding the provisions, particularly the obligations and liabilities that the agreement imposes on the clinic and the financial costs, risks and benefits of being a party to the agreement. It is recommended that any agreement that a physiotherapy clinic considers entering into should be reviewed by the clinic's legal counsel.

- Regardless of whether a physiotherapy clinic enters into a formal agreement or ad-hoc arrangement with a bundle holder, physiotherapy clinics are encouraged to have a conversation with their bundle holder on the terms and conditions. All agreements between bundle holders and physiotherapy clinics should be mutually beneficial. It is important that physiotherapy clinics understand and accept the terms and conditions prior to the care being delivered to a patient.

Please note that when the program was first piloted in 2018, the Ministry indicated that only Community Physiotherapy Clinics (CPCs) were eligible to enter into ad-hoc arrangements with bundle holders. This exclusivity was one of the issues raised by the OPA as limiting access to care and opportunities for those outside the CPC system to participate. The Ministry has broadened program criteria to allow bundle holders to establish ad-hoc arrangements with all physiotherapy clinics whether or not the clinic currently holds a contract to provide CPC services. All physiotherapy clinics may now provide outpatient/ambulatory care services for Bundled Care patients by establishing 1) a formal agreement with a bundle holder; or 2) an ad-hoc, patient-specific arrangement with a bundle holder.

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KEY ITEMS TO CONSIDER IN NEGOTIATIONS

All agreements between bundle holders and physiotherapy clinics, whether that be through a formal agreement or an ad-hoc arrangement, are meant to be mutually-beneficially agreements. OPA encourages members to have a conversation with their bundle holder on various terms and conditions prior to forming and accepting a formal agreement and/or ad-hoc arrangement with a bundle holder.

The following are things physiotherapy clinics should consider when seeking to form agreements with bundle holders:

Payment of Fees

A formal agreement or ad-hoc arrangement should specify what the fees are per patient and what these fees cover. In the case of the Bundled Care program for total hip or knee replacement patients, there is no provincially prescribed payment rate for post-acute rehabilitative care. The Ministry has stated in their Bundled Care FAQs that they are not setting or suggesting standard prices for agreements or arrangements between bundle holders and physiotherapy clinics, and that the fees used to calculate the costing model for the program was only a baseline and is not meant to be interpreted as a suggestive price for physiotherapy services. The baseline cost did not include things like overhead and administrative costs for services provided outside the hospital system in a clinic in the community. In addition, it is a requirement of physiotherapy clinics that have agreements and arrangements with bundle holders to use specific data reporting software including NACRS Clinic Lite.

All agreements and arrangements between bundle holders and physiotherapy clinics should be mutually beneficial. It is, therefore, important for physiotherapy clinics to consider their own business practices, including the cost of providing care and based on that, determine a payment fee that would be reasonable to meet the requirements set out in the agreement with the bundle holder.

There are various things to consider when determining a payment fee that is appropriate based on the individual patient and nature of services provided including overhead costs or the costs associated with required data reporting. Physiotherapy clinics should, therefore, aim for their usual and customary fees for physiotherapy services in their negotiations with bundle holders.

The Ministry points to the best practices as set out by the Rehabilitative Care Alliance (RCA) for unilateral hip or knee replacement and bilateral hip or knee replacement and shoulder arthroplasty, which have been provided to the bundle holders. The fees

should cover up to a predetermined maximum number of visits per patient based on these best practices. Members are encouraged to be familiar with these best practices before engaging in negotiations and/or participating in Bundled Care. Members are encouraged to have a conversation with their bundle holder on determining a payment fee that is reasonable to achieve best practices and the requirements in the agreement proposed by the bundle holder.

Services In-Scope

The Ministry has stated that the bundle holder is responsible for funding in-scope (i.e. what is included in the bundle), post-acute rehabilitation services for a Bundled Care patient until the patient has 1) achieved functional outcomes as outlined by the RCA best practice guidelines or 2) plateaued in their recovery.

This responsibility of the bundle holder to fund in-scope services is applicable under various circumstances, such as:

- When a patient has accessed multiple pathways and has transitioned among different types of physiotherapy providers (i.e. home care, clinic-based, out-patient and/or in-patient); and

- When a patient receives physiotherapy services from one clinic but wants to continue their physiotherapy with another clinic.

Services are considered within scope as long as physiotherapy is required to achieve the functional outcomes outlined by best practice guidelines. If the patient is deemed to have met those functional outcomes, any physiotherapy services provided to the patient are out-of-scope services and will not be funded by the bundle holder.

Physiotherapy clinics and bundle holders should establish a clear discharge criteria and how any unanticipated circumstance or need for care outside the scope of the program or the parameters of their agreement or arrangement will be addressed, such as:

- Specifying what happens with patients who need more than the predetermined maximum number of visits, such as whether the bundle holder will continue to pay as per a specific fee per visit.

- The Ministry has made a program decision to allow patients to choose to access private-pay physiotherapy services instead of, or in addition to, services funded through Bundled Care.

- Whether a patient can access care through a CPC and a funded Episode of Care (EOC) for the next phase of their rehabilitation. Please see patient eligibility on page eight for more information.

Terms of Payment

This may be challenging to negotiate because it is in the best interest of the bundle holders to minimize the number of transactions to limit their overhead and, therefore, delay payables for the maximum time possible. Most agreements specify payment within 60 days. A bundle holder may choose to pay for services at one time (e.g. pay all Bundled Care invoices by a provider with a single payment), or extend the payment period. Providers will have to evaluate the impact of this on their cash flow, as delayed receivables will make it harder for small practices or sole providers. The best scenario is one where the physiotherapy clinic submits invoices for each patient at the conclusion of each course of treatment for payment by the bundle holder "on receipt".

There should also be a provision applying to the late payment of invoices. Under the *Interest Act (Canada)* the interest payable for late payment must be specified in the Agreement and specified as an annual rate, then prorated by day to the actual late payment. Late payment penalties in the range of 6-12% per annum are the current market norm.

Volume of Referrals

When establishing a formal partnership agreement, the agreement should project the number of patients anticipated to be referred by the hospital to the provider. Though such a projection will probably be difficult to get and, in any event is not likely to be legally binding, it is important to try to establish so the provider can better calculate the per-patient cost of treatment, have the appropriate human and other resources and plan accordingly. The estimated volume of referrals will help calculate whether the arrangement makes good business and clinical sense.

Practitioner Independence

An agreement should specify that the physiotherapist is expected to determine a treatment plan and the appropriate course and number of treatments for each patient based on the practitioner's own clinical knowledge, skills and judgment in keeping with best practices and reflecting the regulations, policies, standards of practice and guidelines of the College of Physiotherapists of Ontario.

Providers should be wary of any agreement that allows the bundle holder to dictate treatment, or to establish rigid protocols for treatment. It is important that each

physiotherapy clinic be able to determine, following best practices, how patients are to be treated and by whom (e.g. physiotherapists, physiotherapist assistants, etc.).

Patient Eligibility

The bundle holder will want physiotherapy clinics to accept every patient that the bundle holder refers. For the clinic's protection, the agreement should include provisions whereby the clinic may not accept (or may refer to another provider within the network) a patient for clinical reasons, conflict of interest reasons, to comply with the requirements of the College of Physiotherapists, or because treatment cannot be provided within a clinically reasonable timeframe. The agreement should also have allowances that protect the patient's right to choose their provider.

The Bundled Care program and Episode of Care (EOC) program are distinct programs and have separate eligibility conditions. The Ministry has stated that Bundled Care patients must be discharged from the Bundled Care program prior to receiving any physiotherapy under EOC funding. Patients are still required to meet the eligibility conditions of the EOC program delivered by Community Physiotherapy Clinics (CPC). It is therefore important for CPCs to determine whether a patient is eligible to receive physiotherapy under an EOC. Questions about EOC eligibility may be directed to moh.physiotherapyagreements@ontario.ca.

Performance Incentives

The Ministry has indicated to bundle holders that any financial benefits that accrue as a result of improved patient outcomes should be shared by all partners within the network. This has been articulated as a principle only, with no guidance as to how performance benefits should be shared. Therefore, there should be a discussion with the bundle holder about incentives for improved performance (based on patient outcomes) starting from the premise that monetary performance benefits should be shared equitably among providers within the network. For example, if improved performance renders a $100,000 "saving" for the bundle holder in a given year, that saving should be shared among the network providers, prorated to the number of patients each provider has treated, and the proportion of services provided by each provider.

Should there be a contractual performance bonus plan, the agreement should specify how performance bonuses are calculated and that there be complete transparency with participating providers in the calculation and the data and any assumptions used.

If the bundle holder collects clinic-specific performance data, the agreement should specify that the data is to be held in confidence between the bundle holder and the

clinic. The performance data should also be accessible by the clinic. The data should notbe disclosed to other clinics in the network, or to third parties.

Provider clinic and patient experience, as well as clinic performance in terms of patient outcomes, may all be captured in the data collection and how this information will be used in the evaluation of the program should be a transparent part of the agreement.

Start-Up & Infrastructure Costs

Start-up and infrastructure costs relating to the launch of a Bundled Care network may occur. These can include the creation of an interconnected Electronic Medical Record (EMR) and participation in data entry through NACRS Clinic Lite. The clinic should approach the bundle holder to determine if and how this will be compensated for in the agreement.

The Ministry has announced that bundle holders are now required to work towards ensuring that all post-acute rehabilitative care providers, regardless of whether they have a formal agreement or ad-hoc arrangement report into NACRS Clinic Lite for Bundled Care patients who have had total hip or knee replacement surgery. The OPA will continue to update members on reporting requirements for other bundled pathways once implementation of those programs begin, as they may unfold through a phased or voluntary approach during the pilot phase.

Key resources on data reporting for post-acute rehabilitative care providers to support NACRS Clinic Lite implementation whether you are currently participating or planning to participate in Bundled Care are available through HQO's Bundled Care Community of Practice group on Quorum.

Sharing of Clinical Information

There should be a provision whereby all relevant health records, diagnostic test results, etc. are shared in real time with the physiotherapy clinic. Should the physiotherapy clinic reasonably require additional diagnostic tests, the bundle holder should make the appropriate arrangements on a timely basis. Equally, the physiotherapy clinic should provide the bundle holder and any other provider involved in a patient's care all relevant clinical information. An interconnected and secure EMR should be the objective. The agreement should include a requirement that all parties must comply with all applicable privacy legislation e.g. *Personal Health Information Protection Act (PHIPA).*

Termination of Agreement

Make sure there is:

- A specified termination date: The bundle holder will probably want the Termination date to correspond with the end of the fiscal year (i.e. March 31);
- A provision by which the termination date may be extended (usual custom is by another year), by mutual agreement between the parties, expressed in writing by both parties;
- A provision specifying that payment is due and payable in full by the bundle holder for all services rendered up to and including the date of termination.

Usually, there is a provision that an agreement can be rendered null and void if either party to the agreement does not comply with the provisions of the agreement.

A physiotherapy clinic may also want a provision for early termination written into the agreement, in the event that the agreement becomes too onerous for the clinic, or otherwise fails. This is particularly a consideration in new circumstances such as the Bundled Care framework where there are currently many unknowns. The most ideal situation is one in which either party is allowed to terminate at any time, for any reason, by the terminating party providing written notice to the other party. This kind of provision gives maximum protection to the physiotherapy clinic, but also allows the bundle holder to terminate the agreement, thereby providing the physiotherapy clinic with limited security. Each physiotherapy clinic will have to do its own risk/reward calculation to determine whether it is in their best interest to have an early termination clause.

Amendment of the Agreement

There needs to be a provision whereby the parties can amend the agreement in-year without terminating the agreement. This type of provision is usually along the lines of: "This Agreement may be amended at any time and in any way by the mutual consent of the parties, each in writing to the other."

Dispute Resolution

This should be a standard clause that any dispute between or among the parties will " attorn to the jurisdiction of " (i.e. be decided in) the Courts of Ontario but there should also be some mechanism whereby disputes among the providers in the network, particularly disputes between the bundle holder and one or more clinics, can be resolved without going to the Courts.

Additional Clinic Fees

The agreement should contain no fees or discounts of any kind that are payable by the clinic in order to participate in the network. Such fees could be viewed as constituting conflicts of interest and thereby be in contravention the Professional Misconduct regulation under the *Physiotherapy Act, 1991*.

Other Considerations

The agreement should also cover the following pathway-related information and how these would impact the program provided by the clinic and payment:

- What is the referral process?
- What is the expected time frame from referral/hospital discharge to a physiotherapy clinic?
- How are decisions made in hospital to refer to home care, and then from home care to the clinic?
- How are decisions made to refer patients directly to clinic care from hospital?
- How are patient experience and clinic outcomes measured in the clinic?
- What occurs if a patient doesn't show, self-discharges or changes clinics midway through treatment? Do you still receive payment? Is it pro rated?