



OVERVIEW: AMENDMENTS TO THE 2011–2018 AMA AGREEMENT

“The parties undertook extensive discussions concerning priority issues including immediate financial viability of the health care system; shared stewardship of limited health care resources; enhanced opportunities for physician participation in health care system decision making; and governance.”

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INTRODUCTION AND HOW TO USE THE OVERVIEW

This Overview document explains the structure of the legal document containing the proposed amendments. It explains only the elements of the tentative Amending Agreement.

The overview does not, however, explain how the elements work together or why they have been created as they have. For that information, we have prepared the companion document *Backgrounder: Proposed Amendments to the AMA Agreement*.

To better interpret what you are seeing, we recommend that you read the *Backgrounder* first, before proceeding with this Overview.

READY TO READ THE OVERVIEW? Here's how it works

Each section of the Overview describes an element of the 2011-18 AMA Agreement with the proposed amendments. You will see three sections:

- **What/How** explanation about the tentative amendments.
- **References** to where you can find the relevant content in both the Consolidation and the Amending Agreement.
 - The “Consolidation” refers to the consolidated version (with yellow highlighting) of the AMA Agreement and proposed amendments.
 - The “Amending Agreement” is the same set of amendments, but in a stand-alone document.
 - You will also see references to Consultation Agreements and a Strategic Agreement. All these have been provided with your voting package.
- **You Might Ask:** Questions and answers on the elements.

If you have questions, please let us know: email president@albertadoctors.org.

Element 1. Two-Party Agreement

? What/How

The 2011-18 AMA Agreement is between the Alberta Medical Association (AMA) and Alberta Health (AH).

The tentative Amending Agreement remains bilateral, but there are several areas that have been amended to acquire critical involvement of Alberta Health Services (AHS). For example, AHS will appoint representatives on the Management Committee, the Physician Compensation Committee, Physician Resource Planning Committee, Schedule of Medical Benefits (SOMB) Working Group, and others. These items are further discussed below.

A new Strategic Agreement among AH, AHS and the AMA has also been tentatively agreed upon. This Strategic Agreement involves a set of initiatives that will foster collaboration and partnership between the three parties, and leverage core capabilities within each organization. It includes a framework that identifies a fair process to resolve AHS negotiations with independent contractor physicians.

> Consolidation Reference

Section 23 Pages 16-17.

> Amending Agreement Reference

Section 6 Page 10.

Element 2. Term

? What/How

The 2011-18 AMA Agreement has a term of April 1, 2011 to March 31, 2018.

The tentative Amending Agreement does not change this term. The amendments to this agreement will be carried out for the remainder of the term. Because of Evergreen Terms (see Element 7), not all portions of the agreement expire March 31, 2018 (see also Q2.2 below).

If the tentative Amending Agreement is ratified, the parties agree to commence negotiations as of the effective date to address financial and non-financial matters for the end of the term of the 2011-18 agreement. This recognizes that while the tentative Amending Agreement contains a number of short-term measures toward sustainability from both fiscal and quality perspectives, the high-value system initiatives in the interests of patients will require time and early commitment from the parties to advance.

> Consolidation Reference

Section 6 Pages 11-12.

> Amending Agreement Reference

Section 1(g) Page 7.

+ You Might Ask

Q2.1 *Do all provisions of the AMA Agreement expire in 2018?*

- No. There are certain elements of the agreement that are “evergreen” in nature; they will continue to survive the initial term of the AMA Agreement (see Element 7 Evergreen Term).

Q2.2 *Why begin Negotiations 2018 early when we have an agreement until then?*

- As noted above, the high-value initiatives that will result in the biggest change will take time and early commitment. We need a stable environment to work through these things and commencing formal discussions will contribute to that.

Element 3. Scope and Purpose

? What/How

The 2011-18 AMA Agreement defines a long-term financial working relationship between AMA and AH. The scope includes: physician compensation paid by AH; payment rates for the SOMB and alternative relationship plans (ARPs), specifically the clinical insured medical services component of academic ARPs (AARPs).

The tentative Amending Agreement expands the scope to include a closer, direct involvement with several initiatives.

- **Physician resource planning:** Alberta's physician supply has been growing at a rate far above population. The tentative Amending Agreement creates a Physician Resource Planning Committee to develop a needs-based physician resource plan and advise the Minister on appropriate physician supply and distribution. The committee will be comprised of multiple stakeholders including the AMA, College and Physicians & Surgeons of Alberta (CPSA), the Professional Association of Resident Physicians of Alberta and medical students.
- **Audit/peer review process:** With a goal of achieving cost savings of \$20 million for 2016-17 and \$35 million for 2017-18, the peer review is an opportunity to educate physicians about best billing practices and prevent audits. AMA billing services and the Fee Navigator app will be important tools. Government will continue to undertake audits where necessary and any recoveries will be counted toward savings targets (See Element 6 SOMB Savings Initiatives).
- **Blended capitation model option:** A model that primary care physician leaders have been developing for several years will now be supported by the tentative Amending Agreement. The parties will continue to work on the details of the blended capitation model, with five pilot projects projected to test the model beginning in February 2017 and 10 more by spring 2018. The blended capitation model is voluntary and will be modified based on the learnings of the pilot projects. The model aligns incentives at the practice level with what the system needs.
- **Centralized patient attachment registry:** A Centralized Patient Attachment Registry will be developed and implemented by December 2017. This can be used for implementation of the voluntary blended capitation model for primary care and will be tied into the AH billing payment system. A physician provider registry system will also be enhanced.
- **ARPs and AARPs:** The AMA will be directly involved in the development and maintenance of academic and clinical ARPs. We will have representation and voting status on the Provincial AARP Strategy Committee and the Provincial AARP Operations Committee.
- **Data sharing:** AH commits to provide AMA with data necessary for many activities under the tentative Amending Agreement, e.g., peer review and education and physician resource planning. A data-sharing agreement will be signed within 30 days of ratification of the Amending Agreement.
- **Appropriateness and evidence-based improvements:** Based on the Health Quality Council of Alberta (HQCA) Quality of Care Matrix, the parties will seek opportunities and activities to bridge the gap between current evidence and improving health outcomes, focusing on appropriateness and quality of care.
- **Integrated care:** The parties shall work towards an integrated care delivery strategy, working within existing committees and structures, or creating new committees and structures where necessary.

In addition, the new Strategic Agreement broadens the scope beyond the AMA Agreement to include physicians paid as independent contractors of AHS.

With exception to the Strategic Agreement and amendments noted above, the 2011-18 AMA Agreement Scope and Purpose remains as it was before the amending agreement.

> Consolidation Reference

Section 3 Pages 6-7, Schedules 7-11 Pages 36-46, Strategic Agreement, Primary Medical Care/Primary Care Networks (PCNs) Consultation Agreement.

➤ Amending Agreement Reference

Appendix B-F Pages 13-23, Strategic Agreement, Agreement to Amend the Primary Medical Care/PCNs Consultation Agreement.

⊕ You Might Ask

Q3.1 *Does this agreement cover compensation for insured medical services paid through AHS?*

- Yes. Even though the 2011-18 AMA Agreement covers only payments for clinical services paid directly by AH, the Strategic Agreement will cover compensation for insured medical services paid through AHS to independent contractor physicians.

The Strategic Agreement, however, will not cover physicians who are employees of AHS (e.g., clinical assistant employees or administrators). As always, the AMA will support physicians in negotiating these separate contractual arrangements when requested. We believe the right of these employee physicians to associate and choose the AMA as their representative has not changed.

Q3.2 *Does the main AMA Agreement cover PCNs and their funding?*

- Yes. These matters are directly addressed in the Primary Medical Care/PCNs Consultation Agreement which has been amended to include a broader set of discussions and involvement (see Element 13A).

Q3.3 *How are clinical ARPs and AARPs affected by this agreement?*

- Clinical ARP service rates are covered under the 2011-18 AMA Agreement.
- New provisions in the tentative Amending Agreement allow for AMA representation on the provincial AARP Strategy Committee and the Provincial AARP Operations Committee.

Q3.4 *What do you mean by “audit/peer review processes?”*

- The process is intended to inform and educate physicians about billing rules and norms; it works with, but is distinct from, the audit activity that is carried out exclusively by AH. While the AH audit focuses on transgressions and individuals, the Peer Review initiative is intended to prevent audits. While the mechanisms remain to be developed, it will build on efforts and knowledge already delivered by the AMA to support accurate billing practices such as billing seminars from AMA staff, “Billing Corner” articles in *MD Scope* and the AMA Fee Navigator billing tool.

Element 4. AMA Recognition

⊕ What/How

The 2011-18 AMA Agreement recognizes the AMA as the sole and exclusive representative of Alberta physicians with regard to the term, scope and purposes. It also requires that AH will consult with and seek advice from the AMA on matters that touch and concern physicians but are not within the stated scope and purposes of the AMA Agreement.

The tentative Amending Agreement provides for broader representation – via the new Strategic Agreement – to opted-in AHS independent contractor physicians.

To the extent that the Amending Agreement expands the scope and purpose as referenced above, recognition has been expanded. Beyond these areas, the AMA continues to be recognized (at a minimum) as the sole and exclusive representative of Alberta physicians with regard to the term, scope and purposes (see Element 2 Term and Element 3 Scope and Purpose).

➤ Consolidation Reference

Section 2 Page 5, Section 4 Page 7, AMA Strategic Agreement.

➤ AMA Agreement Reference

Section 1(e) Page 5, AMA Strategic Agreement.

⊕ You Might Ask

Q4.1 *What happened to the provision in the AMA Agreement for AH to entrench recognition in legislation?*

- While not specifically recognized, as noted, AH is required to consult with AMA on all health matters which “touch and concern physicians.” The AMA will also assist upon request with specific negotiations with other entities, e.g., AHS physicians always have the right to request that the AMA act as their representative.

Q4.2 *Why does the agreement include a provision for AH to entrench recognition in legislation?*

- Entrenching recognition in legislation could give added comfort to physicians that the AMA will be recognized by government in an ongoing fashion as the representative of Alberta physicians. There are other provinces which have taken the legislative route with respect to medical association recognition. The language remains in the 2011-18 AMA Agreement, however, for various reasons, the parties were unable to reach agreement on legislated recognition at this time. Commitments made in the tentative Amending Agreement, including the intention to immediately begin Negotiations 2018, strengthen the AMA’s role. (See Element 2.)

Element 5. Financial and Reconciliation

? What/How

The 2011-18 AMA Agreement provides specific financial provisions for the remaining financial term of the arrangement as follows:

- 2016-17: Cost-of-living adjustment (COLA), already implemented.
- 2017-18: COLA.

The tentative Amending Agreement introduces elements of a budget co-management model. This model identifies an available amount or target spending amount. A Reconciliation Committee will be created to determine if there is a Reconciliation Gap, based upon comparison of the target (Available Amount) vs. Actual Expenditures.

The Available Amount for year one 2016-17 is determined as follows:

$$\begin{array}{rcccccc}
 \text{2015-16} & & \text{General Inflater} & & \text{Impact of New Physicians} & & \text{2016-17} & & \text{2016-17 Available} \\
 \text{Actual Expenditure} & + & \text{(1.1\% COLA already} & + & \text{(\$200K per net new} & + & \text{Contingencies} & = & \text{Amount} \\
 \text{(includes all benefits)} & & \text{distributed April 1,} & & \text{doctor in first year of} & & & & \\
 & & \text{2016)} & & \text{practice)} & & & &
 \end{array}$$

The Available Amount increases with Contingencies and physician growth. This way, physicians will not be held responsible for items over which they have little or no control. This includes the Impact of New Physicians and other Contingencies that result in an increase in actual expenditure such as:

- Unilateral new programs from AH or AHS.
- Extraordinary public health measures (e.g., SARS).
- AH actions such as addition of new insured services.
- AHS off-loading of physician services to the Physician Services Budget.
- Any other items to which the Master Committee may agree.

Regarding Impact of New Physicians in the formula, each net new physician to Alberta in 2016-17 will add \$200,000 to the available amount. This is the average amount that a newly entered physician bills in the first year. In the second year, the average amount increases by an additional \$164,000.

For year one, the maximum amount that physicians put at risk is equivalent to the 2016-17 Retention Benefit (RB). This RB for 2016-17 year one will be held in abeyance (i.e., is the Withhold) until June 30, 2017 at which point the Reconciliation Committee will determine whether a Reconciliation Gap exists as follows:

2016-17 Actual Expenditures (includes all benefits)	-	2016-17 Available Amount	=	Reconciliation Gap	If > 0 then	AH keeps the amount of the gap up to value of the Retention Benefit
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If the Reconciliation Gap (Actual Expenditures minus Available Amount) is greater than zero, then more was spent than was available. In that case, AH keeps an amount corresponding to the size of the gap.

- If that gap is greater than the amount of year-one RB, then AH keeps the total RB and no RB payment is made to physicians for that year.
- If the gap is greater than zero, but also less than the amount of year-one RB, then the remainder is paid in the form of a pro-rated RB by AMA to the physicians.

If the Reconciliation Gap is less than or equal to zero, that means that expenditures matched or came in under what was available. In that case, physicians will receive the full RB for year one.

RB for year one will range from \$5,184 to \$12,852 per physician depending upon the number of years of service for a total projected amount of \$73 million.

For year two, the Available Amount is determined as follows:

2016-17 Available Amount	+	General Inflatior (2017-18 COLA)	+	Impact of New Physicians (\$200K per net new doctor in first year of practice; \$164K in second year)	+	2017-18 Contingencies	=	2017-18 Available Amount
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COLA is used to establish the allowable growth for 2017-18 and the value is only relevant if the Consumer Price Index (CPI) is positive (greater than 0%). In the unlikely event that CPI is negative, 2017-18 COLA will be considered as zero. Each net new physician to Alberta in 2016-17 will add \$164,000 to the 2017-18 Available Amount and each net new physician to Alberta in 2017-18 will add \$200,000 to the 2017-18 Available Amount.

For year two, the maximum amount that physicians put at risk is equivalent to the 2017-18 RB plus the 2017-18 COLA increase. The year-two RB plus year-two COLA will be held in abeyance (i.e., are the Withholds) until June 30, 2018, at which point the Reconciliation Committee will determine whether a Reconciliation Gap exists as follows:

2017-18 Actual Expenditure (includes all benefits)	-	2017-18 Available Amount	=	Reconciliation Gap	If > 0 then	AH keeps the amount of the gap up to value of the COLA + RB
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Because 2016-17 is already underway with less time available to achieve savings in year one, any over-expenditure in year one 2016-17 will not be transferred to year two 2017-18.

Note also that the ordering of any payments to physicians in year two is COLA first (adding to base) and RB second.

Similar to what happens in year one, if the 2017-18 Reconciliation Gap (Actual Expenditures minus Available Amount) is greater than zero, then more was spent than was available. In that case, AH keeps an amount corresponding to the size of the gap.

- If the year-two gap is greater than the amount of COLA plus year-two RB, then AH keeps the total COLA, plus year-two RB and no corresponding payment is made to physicians for 2017-18.
- If the gap is greater than zero, but also less than COLA plus year-two RB (i.e., more was spent than available, but the overage was less than COLA plus RB), then the corresponding remainder is paid to physicians in that order.

If the Reconciliation Gap is less than or equal to zero (i.e., expenditures matched or came in under the Available Amount), then physicians will receive the full COLA and full year-two RB.

RB amount for year two is projected at \$75 million.

COLA will be determined in accordance with the Alberta All Items Consumer Price Index as determined by Statistics Canada and published in the December 2016 Consumer Price Index Report.

➤ Consolidation Reference

Section 1 (l-u) Pages 3-5.

➤ Amending Agreement Reference

Section 1(d) Page 2-5.

+ You Might Ask

Q5.1 *What happens if Actual Expenditures still exceed the Available Amount for year two (beyond the value of COLA and year two RB)? Will my fees be clawed back?*

- No. Maximum risk in year two is COLA plus year-two RB. There will be no claw back of fees arising from utilization increases that are above these two figures.

Q5.2 *Is the budget co-management model the same thing as a hard cap?*

- No. In a hard cap model, the Physician Services Budget would be reduced by the amount of over-expenditure of the Available Amount and typically there would be no allowances for physician growth or other contingencies. The maximum amount at risk for physicians is the 2017-18 COLA and the two RB payments and there are allowances for physician growth as well as contingencies discussed in this Element 5.

Element 6. SOMB Savings Initiatives

? What/How

The 2011-18 AMA Agreement does not reference the SOMB Savings Initiatives, which are new.

The tentative Amending Agreement introduces an SOMB Working Group. This Working Group will create a list of SOMB savings initiatives, amounting to \$100 million in annualized savings. A first set of initiatives is due from the working group on November 15, 2016 and a final list is due February 3, 2017. Note that \$15 million in savings will be applied toward the target from the individual fee review conducted by the Physician Compensation Committee in 2015-16. This reduces the target to \$85 million. Any savings from the Peer Review/Audit process (See Element 3 Scope and Purpose) will reduce Actual Expenditures, thereby reducing the potential of a positive gap where spending exceeded the amount available.

This effort to achieve cost savings is not through fee review or reduction of fees nor is it through any Physician Compensation Committee process. The focus will be on evaluating the SOMB billing rules to better align them with best clinical practice. This creates an opportunity to identify things done in practice that drive costs to the system but are low-value in terms of patient care.

The approach to each savings initiative should be guided by the following principles:

- Where applicable, be informed by Choosing Wisely Canada.
- Be driven by best available evidence and national guidelines for high quality care.
- Reduce inappropriate variation in physician practices.
- Be objective, transparent, driven by peer-reviewed literature, reliable data, expert opinion.
- Improve alignment of quality care incentives across different modes of payment.
- Simplify existing complexity and modernize the SOMB.

A list of initiatives that the parties believe can achieve \$100 million is required. The AMA, however, is not responsible for making up the difference should the actual reduction of expenditures not be equivalent to \$100 million. Working toward the target as a profession and as stewards of the system gives an opportunity to shed some low-value activities that do not deliver value for patients. If we succeed in reducing total expenditures by \$100 million, it will help to reduce Actual Expenditures down to or below the Available Amount (See Element 5 Financial and Reconciliation) and trigger the payment of the RB payments and COLA.

A preliminary “Ideas List” has been developed through various efforts. These include proposals that came from AMA sections in 2012 for consideration in the System-Wide Efficiencies and Savings initiative. Other ideas have been developed through the Choosing Wisely Canada initiative and there is a proposal from AH. The Ideas List needs to be tested for applicability to achieve savings within the SOMB. It will be verified through a physician-engagement process prior to submitting to the SOMB Working Group. The current version of the Ideas List will be available among the other information resources about the tentative Amending Agreement for physicians on the AMA website.

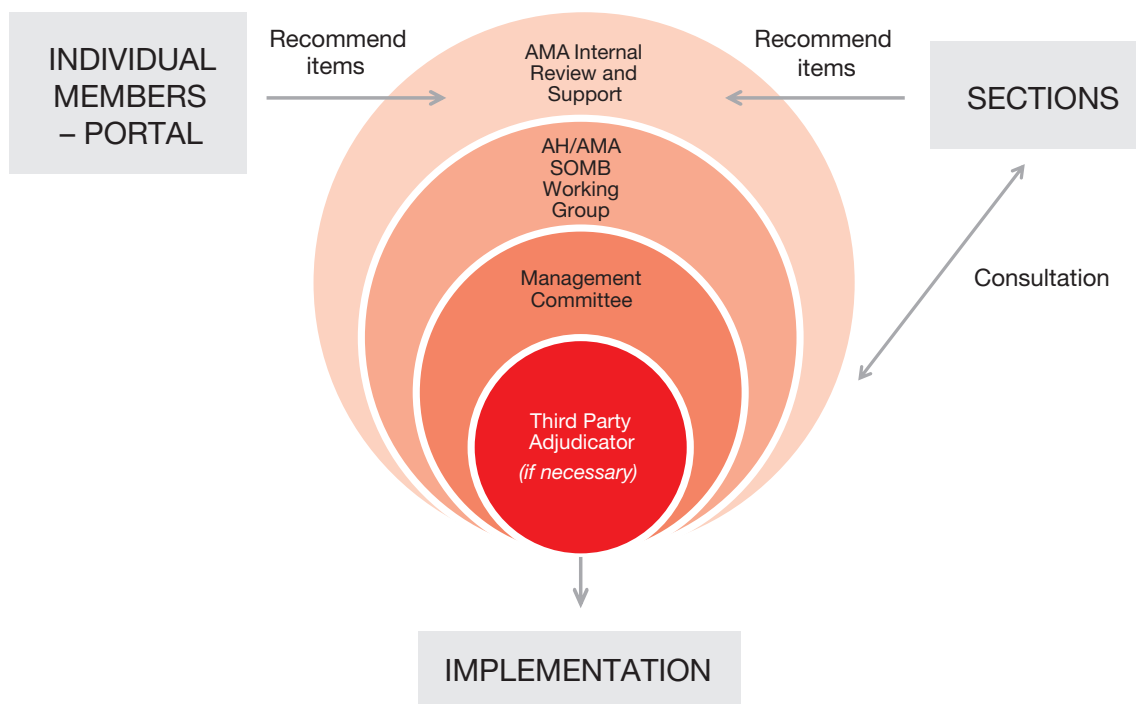
The physician engagement process (see conceptual diagram below) is currently under development as far as feasible while still tentative. The process will seek input from all members. This could be done anonymously, through a web-based portal or through consultation with sections. Various communications are also being planned, through President’s Letters and directly with sections.

Section feedback is critical to determine:

- Potential impact on patients and patient care.
- Evidence in support of a rule change.
- New items that have not been captured in the Ideas List as well as highlighting those already there that would constitute a preferred list.
- Expert opinion.

Staff support will be available to estimate the cost impact of any item preferred by physicians, provide data (e.g., on previous utilization of any relevant code), or to help determine applicability of any initiative to the SOMB.

The SOMB Working Group will make the final decision on the list prior to implementation. If agreement on the list cannot be reached, or if the parties are not in agreement on the potential savings amount from an item on the list, each party will submit their preferred list to a third party for a decision based upon a final-offer selection.



➤ Consolidation Reference

Schedule 8 Pages 42-43.

➤ Amending Agreement Reference

Appendix C, Pages 19-20.

+ You Might Ask

Q6.1 *How will the SOMB Working Group determine which rule-change initiatives should be prioritized over others?*

- It is ultimately up to the Working Group to use their best judgment based upon the principles identified and after hearing from physicians.
- The Working Group will refer to the list of principles when deciding on these initiatives.

Q6.2 *What happens if the list of \$100 million agreed upon savings initiatives do not achieve the full \$100 million after implementation?*

- The agreement requires the joint committee to develop a list that would reasonably result in \$100M savings. There is no agreement to guarantee \$100 million in savings from this initiative.
- While there is no post implementation reconciliation on the \$100 million rule changes, the realization of \$100 million (or more) will help reduce the likelihood of a Reconciliation Gap and therefore improve the likelihood that physicians will receive full RB payments and COLA at the end of years one and two.

Element 7. Evergreen Term

? What/How

The 2011-18 AMA Agreement identifies matters that survive the initial financial term (April 1, 2011 – March 31, 2018) and these include the following:

- AMA recognition.
- The agreement governance structure (see Element 8 Governance).
- Dispute resolution processes, including binding interest-based arbitration (see Element 11 Dispute Resolution).
- Rates and prices for the SOMB, ARPs and programs (identified in the agreement as Physician Support Programs):
 - Continuing Medical Education.
 - Medical Liability Reimbursement.
 - Parental Leave.
 - Physician and Family Support.
 - Compassionate Expense.
 - Physician Locums (Regular and Specialist).
 - Practice Management.

The tentative Amending Agreement does not change the fact that the AMA Agreement guarantees these items to exist beyond March 31, 2018, or the continuation of a binding arbitration process for resolution in the event that the parties cannot agree.

Programs that are not subject to the Evergreen Term (identified in the AMA Agreement as Physician Assistance Programs) are guaranteed to exist until at least March 31, 2018. Processes have been established to negotiate their future after March 2018, including a non-binding dispute resolution process. These are:

- Physician On-Call.
- Physician Learning.
- Program Management Offices.
- Towards Optimized Practice.
- Business Costs.
- Retention Benefit.
- Rural Remote Northern.

➤ Consolidation Reference

Section 3 Pages 5-6, Section 6 (a-c) pages 11-12.

➤ Amending Agreement Reference

N/A.

+ You Might Ask

Q7.1 *Will this evergreen provision put an end to long periods of time without a negotiated agreement?*

- It is expected that this AMA Agreement will allow for a smoother transition period between one agreement term and the next. Evergreen elements of the AMA Agreement continue, that is, they will always be in place.

Q7.2 *Can government end these evergreen provisions unilaterally?*

- Notwithstanding that government always retains certain legislative powers, these evergreen matters are to remain in place until ended by mutual written agreement of the parties.

Element 8. Governance

? What/How

The 2011-18 AMA Agreement has a more streamlined governance process than the previous agreement, with only two formalized committees: The Management Committee and the Physician Compensation Committee.

The tentative AMA Amending Agreement adds to the governance structure. New sub-committees that will report to the Management Committee include: SOMB Working Group, the Advisory Committee, the Reconciliation Committee, the Blended Capitation Model Committee and the Appropriateness and Evidence-Based Improvements Committee. In addition, the Physician Resource Planning Committee will consult with the Management Committee and report to the Deputy Minister of Health.

➤ Consolidation Reference

Sections 8.1,8.2,8.3 Page 13, Schedule 3 Pages 21-22, Schedule 7-11 Pages 36-46, Schedule 8 Pages 42-43.

➤ Amending Agreement Reference

Section 1(k) Page 8, Appendix B-F Pages 13-23.

+ You Might Ask

Q8.1 *Why have you added all these committees to what was supposed to be a streamlined structure?*

- All of the stakeholders in the health care system need to work more closely together for system improvement. These sub-committees bring voices, input and authorities owned by numerous important players together for the first time to accelerate change and progress.

Element 9. Management Committee

? What/How

The 2011-18 AMA Agreement creates the Management Committee with overall authority to manage the agreement. The committee is comprised of the Deputy Minister of Health and the AMA Executive Director or their designates. The specific roles, responsibilities and duties of the Management Committee are laid out in Schedule 3 of the AMA Agreement. Generally, these include:

- Ensuring the scope and purposes of the AMA Agreement are followed and implemented.
- Providing general direction to the committees noted in Element 8 above.

The tentative Amending Agreement continues this provision. It adds the President and CEO of AHS to the Management Committee. A number of committees would be formed to broaden input into decision making and increase the level of information. These are:

- Advisory Committee: HQCA; Institute of Health Economics; Alberta Innovates Health Solutions; Deans of Medicine; CPSA.
- Reconciliation Committee: (See Element 5 Finance and Reconciliation). Members to be determined by the Management Committee.
- Appropriateness and Evidence-Based Improvements Committee: Members to be determined by the Management Committee. The group will advise the Management Committee on issues and opportunities relating to improvement of health care delivery, including appropriateness and quality of care, etc.

➤ Consolidation Reference

Section 7 page 12, Schedule 3 Pages 21-22, Schedule 9-11 Pages 44-46.

➤ Amending Agreement Reference

Appendix A Pages 11-12.

+ You Might Ask

Q9.1 *Are there any decisions the Management Committee cannot make?*

- The MC does not have the authority to overrule or set aside a properly made decision/ recommendation of the PCC.

Element 10. Physician Compensation Committee

? What/How

The 2011-18 AMA Agreement creates the Physician Compensation Committee (PCC) with authority regarding physician compensation matters. The specific roles, responsibilities and duties of the PCC are laid out in Schedule 4 of the AMA Agreement. Generally, these include:

- Managing the compensation aspects of the AMA Agreement, including:
 - Allocation of negotiated increases.
 - Reviewing and adjusting fees.
 - Reviewing and managing the distribution of funding among insured medical services, plans and programs.

The tentative Amending Agreement continues these provisions and expedites PCC's efforts to set relative values, including the implementation of a new business costs model and improving administrative processes for SOMB changes.

➤ Consolidation Reference

Section 8 Pages 12-13, Schedule 4 Pages 23-25.

➤ AMA Agreement Reference

Appendix B Page 14.

+ You Might Ask

Q10.1 *Given the tentative Amending Agreement, how will the PCC determine its priorities?*

- The PCC mandate will be determined by the provincial strategic requirements for physician compensation, programs and plans. Under the tentative Amending Agreement, these requirements will be established by AH in consultation with the AMA. The Management Committee will consult with AH and AMA on these strategic requirements and give broad general direction to PCC on priorities.

Q10.2 *Element 2 noted that AHS is now included in the PCC. Does the addition of AHS change the current voting structure for making decisions?*

- No. AHS will now provide up to two representatives while AH and AMA each continue to provide up to three. The independent chair continues. Voting is unchanged: AH will still only have one vote, as will the AMA.

Element 11. Dispute Resolution

? What/How

The 2011-18 AMA Agreement establishes ways to resolve future disputes about financial terms. Some of these processes are binding on the parties and some are not.

The tentative Amending Agreement does not change the mechanisms to resolve future disputes, including binding interest-based arbitration.

> Consolidation Reference

Schedule 5 Pages 26-30.

> AMA Agreement Reference

N/A.

+ You Might Ask

Q11.1 *Other provinces have experienced difficulties arising from lack of dispute resolution and/or binding arbitration. Will the dispute resolution mechanisms prevent similar situations?*

- It's expected that the dispute resolution processes incorporated in the AMA Agreement will promote timely and evidence-based resolution of disputes in a fair manner for both parties.

Element 12. Grant Agreements

? What/How

The 2011-18 AMA Agreement acknowledges the AMA's history in managing a number of programs on behalf of physicians. This has occurred under the terms of grant agreements between AH and AMA. The following programs are included:

- Compassionate Expense.
- Parental Leave.
- Physician and Family Support.
- Continuing Medical Education.
- Medical Liability Reimbursement.
- Locum Programs (Regular and Specialist).
- Physician Learning.
- Practice Management.
- Toward Optimized Practice.
- Retention Benefit.
- ARP Program Management Office.
- PCN Program Management Office.

The tentative Amending Agreement continues to manage grant agreements under the same terms. The only exception is the Continuing Medical Education grant. The AMA will retain accumulated allotments that otherwise expire during fiscal years 2015-16, 2016-17 and 2017-18 for the purpose of funding the Towards Optimized Practice Program.

➤ Consolidation Reference

Schedule 6 Pages 31-34.

➤ Amending Agreement Reference

Section 1(o) Pages 8-9.

⊕ You Might Ask

Q12.1 *Will I continue to receive my Retention Benefit directly from the AMA?*

- Yes. The RB (and funding for the other programs listed above) will be paid through the AMA. It is noted, however, that the RB will be held in abeyance (i.e., part of the Withhold) until June 30 of each year, pending determination of the Reconciliation Gap (see Element 5).

Q12.2 *Are any other grant agreement programs affected by the reconciliation process?*

- No. Second year COLA and first- and second-year RB are the only amounts at risk under the tentative Amending Agreement.

Element 13. Consultation Agreements

? What/How

The 2011-18 Amending Agreement recognizes that physicians and the AMA play a broad role in the health care system, beyond determining physician compensation. The agreement recognizes this by stating: “For health matters which touch and concern physicians but which are not within the stated scope and purposes of this AMA Agreement ... AH will consult with and seek the advice of AMA, from time to time.”

As a step toward this commitment to consultation, the parties negotiated three independent Consultation Agreements that are referenced in the main AMA Agreement, each focused on a particular area of interest and importance to physicians.

- Electronic medical records.
- Primary medical care.
- Achieving efficiencies in the health care system.

The tentative Amending Agreement amends one Consultation Agreement (the Primary Medical Care/PCNs Consultation Agreement) and creates a fourth (Integrated Care Consultation Agreement).

➤ Consolidation Reference

Section 4 Page 7.

➤ Amending Agreement Reference

Section 1(e) Page 5.

Element 13A Agreement to Amend the Primary Medical Care/PCNs Consultation Agreement

? What/How

The tentative Amending Agreement provides an expansion to the Primary Medical Care/PCNs Consultation Agreement as follows:

- Mandates the PCN Committee to develop a provincial framework that will apply to all PCNs – and be ratified accordingly – by individual PCN physicians as well as each PCN itself.
- Creates a Blended Capitation Model Committee to oversee the development of a voluntary Blended Capitation Alternative Relationship Plan with the goal of having five implemented by February 2017 and 10 more by Spring 2018.

Consolidation Reference

Primary Medical Care/Primary Care Networks Consultation Agreement.

Amending Agreement Reference

Agreement to Amend the Primary Medical Care/PCNs Consultation Agreement.

You Might Ask

Q13A.1 *What roles do established primary care structures within the AMA play in this Consultation Agreement?*

- The Amendments to the Consultation Agreement recognize that there are many structures and existing committees within primary care. It commits to review these committees and structures and make changes as necessary to improve function and clarify roles and responsibilities.

Element 13B Integrated Care Consultation Agreement

? What/How

A new tentative Integrated Care Consultation Agreement has been developed to address the importance of integrated care throughout the health care system. Achieving such a goal requires the integration of delivery models and the support mechanisms that are being developed. Potential solutions include:

- The parties shall work towards an integrated care delivery strategy, working within existing committees and structures, or creating new committees and structures where necessary.
- Consideration for:
 - Community-based integration programs, bringing together community and AHS resources.
 - The role of funding and physician payment models in the integration of care.
 - The opportunities for stewardship and performance incentives which consider the impact of physician decisions on utilization of health system resources.
 - The opportunities presented by Strategic Clinical Networks for aligning care and promoting evidence-based decisions.
 - Access of physicians to change-management support programs offered by all the parties, with an emphasis on promoting integrated care.
- Enhanced accountability models such as those that address relativity utilization concerns.

> AMA Agreement Document Reference

Integrated Care Consultation Agreement.

Element 14 In Conclusion

The proposed package of amendments to the AMA Agreement are intended to be a proactive approach to some of the challenges facing Alberta, both in the general economy and within the health care system. It puts some short-term cost-saving measures in place and also launches key strategies for the long term. It positions the AMA and government for future negotiations, providing an 18-month window to implement and assess new approaches.

What is being proposed builds on an already strong AMA Agreement. It introduces a shared budget responsibility model with an allocation of responsibility and authority. Some important and specific new provisions and strategies build on the existing general model of consultation with the profession.

This additional consultation is significant and goes well beyond simple commitments to work together. The amendments provide for enhanced data sharing, a mechanism (and physician ratification process) for a PCN framework, a needs-based physician resource plan and direct involvement in the provincial academic ARP. There are other items we could list, but the point is that the amended AMA Agreement is much more than a statement of “we want to partner.” It is a detailed and pragmatic description of the partnership and how it will work.

There is risk. The amendments bring stability to current prices and most programs, but some future amounts may now need to be applied to cover utilization instead of the April 1, 2017 SOMB fee adjustment or the two remaining Retention Benefit payments.

There is also risk, however, in not taking action and not approving the amendments. The question for the profession is this: Which approach will do a better job of serving physicians and patients? The choice is yours.