

Alberta Health

Clinical ARP Framework Explained

A companion document

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This companion document is not a legal document, nor does it have legally binding effect. This document is intended to help you understand the Clinical ARP framework, but the language in the Clinical ARP Program Parameters and the Conditions of Payment Ministerial Orders (MOs) ultimately speaks for itself. In the event there is a discrepancy between this document and the provisions in the signed MOs, the signed MOs shall be paramount.

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Introduction

Purpose

The offering of Physician Compensation models that are complementary to the traditional fee-for-service model, such as the approach used in Clinical Alternative Relationship Plans, is intended to help to achieve a sustainable, integrated, and flexible health care system. Clinical ARPs support flexibility in the way Physicians provide care. They support a specific service delivery model and often enable Physicians and AHS to more effectively deliver services to targeted patient populations. Clinical ARPs have been established to enhance Physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction, and value for money.

This document is intended to be a companion to the Ministerial Orders (MOs) that make up the Clinical ARP framework. As will be explained in more detail below, MOs are legal instruments with the format and language associated with a legal document. As such, this document will explain and clarify the concepts of Clinical ARPs under the framework into plainer language, and it will explain the rationale for or elaborate on clauses in the MOs. In addition, this document will help you through the process of establishing a Clinical ARP, and provide guidance for you while operating within a Clinical ARP framework.

*Please note, however that this companion document is **not** a legal document, nor does it have legally binding effect. This document is intended to help you understand the Clinical ARP framework, but the language in the Clinical ARP Program Parameters and the Conditions of Payment MOs ultimately speaks for itself.*

We expect this document to be a living document, the content of which will be adjusted over time as the Clinical ARP framework itself and as Physicians' need to better understand various framework topics evolve. If you have suggestions for changes or new topics, please contact the Alternative Compensation Delivery Unit at Alberta Health.

Overview of the Clinical ARP framework

The Clinical ARP framework consists of two parts. These are the Clinical ARP Program Parameters that set out the general rules for all Clinical ARPs, and the Clinical ARPs Conditions of Payment (CoP) which set out the particular details of each Clinical ARP.

The Clinical ARP Program Parameters include the roles and responsibilities of Participating Physicians and Authorized Representatives, rules for claiming and receiving Compensation, as well as templates and rules for Physicians who want to join a Clinical ARP or want to terminate their participation in a Clinical ARP.

Included in the CoP are the funding details, the goals of the Clinical ARP, the Program Services its Participating Physicians will provide, a description of the Patients to whom those Program Services will be provided, the service delivery model, and details on the reporting requirements.

These two pieces are enabled and established by MO. The Clinical ARP Program Parameters were established under MO 53/2011 effective October 1, 2011. Over time, as changes to the Program Parameters are required, MO 53/2011 will be updated. Each Clinical ARP's Conditions of Payment will be established by its own MO. Similarly to the Program Parameters, the CoP for a Clinical ARP will change over time, and the MO that established that particular Clinical ARP's CoP will be updated accordingly.

Types of Clinical ARPs

There are three models of Clinical ARPs currently in existence in Alberta: Annualized Sessional, and Blended Capitation.

Annualized Model

In the first model, Compensation is based on the number of Physician Full Time Equivalents (FTEs) required to deliver the direct and indirect clinical services within the Clinical ARP. An FTE is a time-based unit of measure (e.g., hours per year). This annualized model compensates Physicians for the delivery of Program Services based on a pre-determined payment rate to targeted Patient groups per FTE per year. Annualized Clinical ARPs are the most common within Alberta.

Sessional Model

In the second model, Compensation is based on an hourly rate for the delivery of direct and indirect clinical services (i.e. Program Services) within an organized Program to a defined Patient group by a Physician. The sessional model is intended for part-time participation by a Physician up to an equivalent of two days per week on average over the fiscal year. This model primarily applies to small specialized Programs.

Blended Capitation Model

In the third model, Compensation is based on an annual amount per rostered patient to provide a defined set of Insured Medical Services plus 15% of the fee-for-service payment for program services that is shadow billed. The annual amount is determined using clinical risk groups and determining a rate based on a basket of health services. The Physicians are paid 85% of this rate and the total paid per patient does not exceed 100% of this capitation rate.

The blended capitation model encourages the establishment of a long-term relationship between a Patient and a Physician or between a population and a group of Physicians. It encourages Physicians to provide continuity of high quality primary health care

Definitions

The capitalized words used in this document are defined terms under the Clinical ARP framework. See Appendix 1.0, Section 1, of the Clinical ARP Program Parameters for most defined terms; Clinical ARP-specific defined terms are located at the beginning of Schedule A of the CoPs.

The legislative process

Alberta's laws exist in the form of statutes or "acts" (e.g., the *Health Information Act*, and the *Alberta Health Care Insurance Act*). Acts are passed by Members of the Legislative Assembly (MLAs) and receive royal assent from the Lieutenant Governor. Generally, a bill comes into force upon royal assent, but in some cases the act states that it or portions of it will come into force on a specified date.

However, the Legislature has the ability to delegate its law-making functions to other bodies or persons. Any person or body to whom the Legislature has delegated the authority to make a regulation may make a regulation. Regulations are subordinate to acts. They receive their authority from the acts but unless specifically authorized by an act, they cannot be inconsistent with the act. Regulations can further delegate law-making powers in authorizing the creation of Ministerial Orders (MOs), which are instruments by which a Minister makes a formal order.

In the case of the Clinical ARP framework, the *Alberta Health Care Insurance Act* authorizes the Minister to create the *Medical Benefits Regulation*, which then authorizes the creation of the MOs that establish legislation for Clinical ARPs. These MOs allow the Minister to create Clinical ARP legislation without having to go through the same extensive process that creating an "act" would require.

For a detailed summary regarding Alberta's legislation process, please see *A Guide to the Legislative Process – Acts and Regulations*, available on the Government of Alberta's website at: http://justice.alberta.ca/programs_services/law/Documents/Leg_Process_manual_Nov%202008.pdf.

Ministerial Order Revisions

The Clinical ARP framework was established by MO 53/2011. From time to time, sections of this MO may be revised by new MOs, but MO 53/2011 will continue to be in force with the exception of the revision.

For example, an appendix in MO 53/2011 was repealed and replaced by a new appendix in MO 101/2012. This means that MO 53/2011 is still in force, but now includes the revised appendix that is attached to MO 101/2012. Therefore, the appendix to MO 101/2012 has this as a header:

MO 101/2012
Amends MO 53/2011

This process allows revisions to be made to sections within MO 53/2011, rather than repealing the entire MO and replacing with a new one.

Establishing a Clinical ARP

Establishing a Clinical ARP consists of a number of steps including: developing an expression of interest (EOI), developing an application, developing the CoP, and implementing the Clinical ARP. There are a number of decision points along the way. This section describes the process of establishing a Clinical ARP.

Initial development

Generally, the development of a Clinical ARP begins when AHS or a Physician group identifies Physician services that could benefit from being structured under a Clinical ARP. This could include a service gap or already existing services that struggle under the Compensation structure in use.

At this stage, Physicians and AHS seek out the ARP Physician Support Services (ARP PSS), an organization that will assist Physicians and AHS in exploring whether a Clinical ARP may be a good fit to address the service gap or service inadequacy. The ARP PSS can help link Physician groups and AHS to begin exploratory work.

If the Physician group and AHS determine, with the assistance of the ARP PSS, that they would like to pursue a Clinical ARP, ARP PSS staff will help them create an EOI.

Expression of Interest

An EOI is a short document that informs Alberta Health, AHS, and the AMA that a Physician group is interested in pursuing a Clinical ARP application, or expanding their current Clinical ARP. It includes basic information about the proposed Clinical ARP, including intended location, Patients to be served, and Program Services to be provided. The EOI is intended to act as a “head’s up” and is not intended to be an exhaustive review of the proposed Program.

The EOI is sent to AHS and the ARP PSS Director for their review. If AHS and the ARP PSS Director accept the EOI, they will send it to Alberta Health for their review and to schedule a meeting with AHS, the Physician group and the ARP PSS. The purpose of this meeting is to gain a common understanding of the request and to clarify data and documentation requirements for the application.

Consent Forms

Often in the development of a Clinical ARP proposal, Physician groups, AHS, and the ARP PSS need access to data, including data about the services already being provided by Physicians who would become part of the Clinical ARP. They request this data from Alberta Health and AHS.

The *Freedom of Information and Protection of Privacy (FOIP) Act* governs the disclosure of Physicians’ personal information, including their billing information. In order to adhere to

ARP Expansions

If your Clinical ARP needs an expansion — i.e., an increase to the maximum number of FTEs or Program Service Hours — you can contact the ARP PSS to begin the process for drafting an expression of interest and for applying for an expansion. This involves developing an expansion request in concert with AHS, which Alberta Health, AHS, and the AMA will review. Once supported, Alberta Health will work with you to modify your CoP to reflect the expansion. The CoP will then be reviewed by AHS and the AMA for recommendation to the Minister. If supported by the Minister, your expanded Clinical ARP will be established upon your CoP MO's Effective Date.

ARP Term and Rate Adjustments

Clinical ARPs are, in essence, contracts with Physicians; therefore all Clinical ARPs will have terms applied to them. These terms do not indicate that the Clinical ARP will expire on this date and the Physician group will need to apply again. Alberta Health will work to extend these timelines with the Program when the term end date is close. Clinical ARPs that have term adjustments will happen on April 1 of each year.

Clinical ARP rates will change on April 1 each fiscal year, dependant on the AMA Agreement. The rate changes will be based on the macro allocation done by Alberta Health and AMA, and are then approved by the Physician Compensation Committee. Alberta Health will provide a new MO every April 1 when there is a rate change.

Clinical ARP Program Parameters explained

This section is organized numerically by the sections and sub-sections in the Clinical ARP Program Parameters.

Section 1: Definitions

This section sets out most of the defined terms used under the Clinical ARP framework. These terms are common to all Clinical ARPs. There are, however, some terms that are specific to a particular Clinical ARP payment arrangement, or terms whose definition varies from one Clinical ARP to the next. These more specific defined terms are found in each Clinical ARP's CoP.

Section 2: Program Services

This section links the Clinical ARP Program Parameters to the CoP, outlines rules regarding Participating Physician's service commitment, sets the standards for Program Services, indicates precedence between the Clinical ARP Program Parameters and the CoP, and describes linkages between the Clinical ARP framework and relevant Services Agreements with AHS.

Section 3: Participating Physicians & the Centre

Under the Clinical ARP framework, the Minister is responsible for creating Clinical ARPs. As such, the Minister is accountable to the Legislature for those Clinical ARPs and must also be able to manage them. This means having discretion over who is allowed to participate in the Program. See Appendix 1.0 for an example of the Letter of Participation (LOP).

The LOP approval process detailed in Section 3.1 of the Clinical ARP Program Parameters ensures Physicians who want to join a Clinical ARP have the appropriate credentialing to do so (i.e., credentials match the Specialties funded under the Clinical ARP), and also provides an opportunity for the Minister, AHS, and the Authorized Representative to evaluate whether a Clinical ARP's CoP accurately identifies all the Specialties required for the functioning of the Program.

This is important as, in the past, there have been cases in which a Clinical ARP brought on a new Participating Physician whose credentialing did not match the Specialties funded under the Clinical ARP. When this happens, there has been a requirement to retro-fit the Clinical ARP to match this new Specialty. Requiring the Minister to approve LOPs before a Physician can become a Participating Physician in the Clinical ARP will avoid this retro-fitting.

This process also enables all stakeholders to have full knowledge of the change in Physicians and allows Alberta Health to perform due diligence to ensure this change is in the best interests of the health system.

Physicians will be notified of their approval to join the ARP once Alberta Health receives, approves, and enters the new Physician in to the Ministry's Claims Assessment System (CLASS). The Physician will be notified via letter informing them of the Clinical ARPs business arrangement (BA) number so the Participating Physician can submit Service Event Reports. This provision of the BA number will constitute the Minister's approval for the LOP.

The BA number is important for billing purposes. The Physician is responsible for adding their submitter to their BA in order to enable the submission of claims and Service Event Reports or other party that needs to know the number for billing or other purposes agreed to by the Physician

Section 4: Authorized Representative

An Authorized Representative is a Participating Physician who has been authorized by the other Participating Physicians of that Clinical ARP to act as their agent with respect to the Clinical ARP. There must always be at least one Authorized Representative (and preferably one back-up Authorized Representative) for each Clinical ARP. Having an Authorized Representative in place is extremely important as it enables Alberta Health to liaise with one person or a small group of people instead of having to communicate regularly with the entire group of Participating Physicians, which would create significant administrative and practical roadblocks.

If a Clinical ARP ever ceases to have an Authorized Representative, for any reason, Section 4.1(d) requires the Participating Physicians to appoint a new Authorized Representative within ten days. If they do not, AHS must appoint a "temporary Physician administrator" within a further five days. This ensures that there will not be a significant gap in a Clinical ARP having an Authorized Representative. A temporary Physician administrator may function as the Authorized Representative for up to three months, which will allow the Participating Physicians more time to determine which Participating Physician they will appoint as an Authorized Representative. If the Participating Physicians do not appoint an Authorized Representative within this time frame, the Minister may (but is not required to) cancel the Clinical ARP. (See Section 9.1 of the Clinical ARP Program Parameters for more details.)

Section 5: Compensation Adjustments

Although the Clinical ARP framework does not link adjustments to the Compensation to any Other Funding mechanism, including the Schedule of Medical Benefits (SOMB), Alberta Health will review Clinical ARP rates regularly and adjust them as required. And as Section 5.4 indicates, any Compensation adjustments will take into consideration any relevant factors, including any updates to the SOMB.

Section 6: Program Funding

This section acknowledges that a Clinical ARP may have sources of funding other than the Compensation paid by the Minister, and directs the reader to Schedule A, Appendix 1.0, of the CoP for more information.

Section 7: Claims for Benefits

Under a Clinical ARP, a Claim for Benefits is documentation that proves Participating Physicians have provided Program Services to Patients, and Compensation is contingent on the submission of this documentation. Claims for Benefits take the form of two types of documents. The first documents are Service Event Reports, which all Participating Physicians are required to submit. (See Appendix 3.0: Claims for Benefits in the CoP Section for more information on Service Event Reports.) The second type of document depends on how the Clinical ARP is paid.

- For Clinical ARPs that are paid according to the number of FTEs worked, the document is an FTE report.
- For Clinical ARPs that are paid according to the number of Program Service Hours worked, the document is a Program Service Hours report (or an invoice).
- For Clinical ARPs that are paid according to the number of Rostered Members enrolled in the Clinical ARP, the document is either an update to the list of Rostered Members, or is that information the Minister may require to update the list of Rostered Members from time to time.

The name “Claim for Benefits” is used in order to maintain consistency with the terminology used in the *Alberta Health Care Insurance Act* and related regulations.

The Claims for Benefits documentation required for your Clinical ARP is described in Schedule A, Appendix 3.0, of your CoP.

The Minister has the authority to reassess Claims for Benefits according to Section 18 of the *Alberta Health Act*. If the Minister authorizes a reassessment and finds that the amount paid to Physicians exceeds the amount that a reassessment indicates should have been paid, the Minister may, among other remedies set out in this Act, withhold future payments until the excess amount is recovered. If an underpayment is identified, Alberta Health will communicate with the Authorized Representative to confirm payment amounts and to make arrangements to issue the amount that was underpaid to the Clinical ARP.

Compensation for Program Services to people who are not Patients

Only Residents and Out of Province Patients may be Patients of a Clinical ARP and receive Program Services from Participating Physicians. If Participating Physicians provide services to a non-Canadian Resident, a Non-Insured Patient (e.g., people from out of the country who have not met the *Alberta Health Care Insurance Act's* residency requirements or Workers' Compensation Board Patients), or to a resident of Quebec (including any types of services that would be Program Services if the individual were actually a Patient of the Clinical ARP), they must bill the individual or WCB directly for this service. Physicians are not allowed to bill Alberta Health for this service.

Payments for services provided to individuals who are not Patients of the Clinical ARP are not factored into the Compensation rates for the Clinical ARP.

If Participating Physicians provide services that are not Program Services to Canadian Residents who are not Patients of the Clinical ARP, payment for these services falls outside the scope of the Clinical ARP framework and the Physicians should bill for these services in the ordinary, non-Clinical ARP course (i.e., likely as fee-for-service or medical reciprocal claims).

For more information on the provision of Program Services to Out of Province Patients, see the section on medical reciprocal claims below.

Compensation for On Call Availability

Participating Physicians will only be paid for time spent actually delivering Program Services, or for time incurred due to short-notice appointment cancellations or no-shows. On call availability is not compensated through Clinical ARPs. There are a number of Physician on call programs operated by AHS that Participating Physicians can access that compensate for on call availability.

Medical Reciprocal Claims

Within the Clinical ARP framework, the provision of Program Services to Out of Province Patients counts as Program Services and is counted in FTE reports. As such, payment for services provided to Out of Province Patients is included in the Clinical ARP Compensation.

Participating Physicians are required to bill medical reciprocal claims for Program Services provided to Out of Province Patients, and the amount will be immediately recovered by Alberta Health's Claims Assessment System so as to avoid a double payment for the same work. This allows Participating Physicians to know exactly how much medical reciprocal billing they have done and ensures Alberta Health can correctly invoice other provinces for Out of Province Patient claims.

Alberta Health will take into account Program Service hours spent providing Physician Services to Out of Province Patients when determining the FTE's for a Clinical ARP.

For Clinical ARPs that are paid according to their list of Rostered Members, Out of Province Patients are not included as Rostered Members. Participating Physicians in these

Clinical ARPs will bill medical reciprocal claims and receive medical reciprocal payments for services to Out of Province Patients.

Locum Physicians

Under Schedule A, Section 7.5 of the Clinical ARP Program Parameters, Participating Physicians may arrange for Locum Physicians to provide Program Services to Patients. However, Locum Physicians may not bill Alberta Health for those Program Services. Participating Physicians are responsible for making payment arrangements with the Locum Physician. This could include using Compensation to pay the Locum Physician.

Section 8: Termination and withdrawal of Participating Physicians

Under the Clinical ARP framework, Section 8.1 applies to the termination of Participating Physicians. This section enables Participating Physicians to withdraw from a Clinical ARP at any time by providing the Minister with a Letter of Termination (LOT) with 30 days' prior notice of the effective withdrawal date (see Appendix 2.0). Copies of LOTs must also be provided to AHS and the AMA. Physicians who submit LOTs may require written authorization from the Minister to return to fee-for-service billing in accordance with Section 8.6; however, the Minister is not permitted to unreasonably withhold such written authorization. As well, the Minister is required to consult with AHS, the Authorized Representative, and the AMA prior to making his decision.

Under the Clinical ARP framework, the Minister is accountable to the Legislature for Clinical ARPs, including the funds required to operate them, therefore the Minister has the authority to terminate, while acting reasonably, a Participating Physician if they see fit. Section 8.3 acknowledges the Minister's ability to terminate a LOP and the participation of a Participating Physician in a Clinical ARP, and requires the Minister to act reasonably in making such a decision. As well, the Minister is required to consult with AHS, the Authorized Representative, and the AMA prior to making his decision.

In addition, the Authorized Representative of a Clinical ARP has the right to terminate a Participating Physician by signing an LOT on his or her behalf. This is required in such instances as when a Participating Physician leaves the Clinical ARP without signing an LOT. In order to ensure the Clinical ARP Physician List is accurate and kept up to date, the Authorized Representative will sign an LOT for that Participating Physician, and the Physician will be removed from the list.

From a practical perspective, there are some cases when the Minister needs to be able to terminate a Participating Physician for this same reason. In the case of a Clinical ARP that only has one Participating Physician, that Participating Physician is also the Authorized Representative. If that Participating Physician leaves without signing an LOT, there is no one available to sign it on his or her behalf. In that case, the Minister would terminate his or her participation.

Further, Section 8.5 enables the Minister to initiate a dialogue with the Participating Physician and AHS about any perceived shortcomings of the Participating Physician's

fulfillment of their obligations under the Clinical ARP, including providing time for the Participating Physician to respond to the Minister and rectify any problems. Within this process, under Section 8.5, the Minister will consider any responses received from the Participating Physician or AHS in determining whether or not to terminate the Participating Physician.

Authorization to Return to Fee-For-Service

Many Clinical ARPs are built to provide an entire Program to a region or group of Patients. When a Physician leaves a Clinical ARP with the intent of returning to fee-for-service payment for the provision of those same Program Services they provided under the Clinical ARP, there may be an impact on the Program. By requiring the Physician to obtain authorization from the Minister, AHS has an opportunity to review the impact the Participating Physician's returning to fee-for-service billing may have on the Program and the Patients.

This review might reveal that the Clinical ARP as a whole should be reconsidered or reframed. The goal is to ensure the Clinical ARP still meets the needs of its Patients.

Section 8.6 requires the Minister to consult with AHS, the Authorized Representative, and the AMA when considering authorization to return to fee-for-service.

Section 9: Cancellation of a Clinical ARP

Legally, under the Clinical ARP framework, the Minister creates Clinical ARPs pursuant to his authority under the *Medical Benefits Regulation*. As such, the Minister is accountable to the Legislature for those Clinical ARPs, including the funds required to operate them. On this basis, the Minister must retain ultimate discretion over whether the Clinical ARP should be cancelled. Section 9.1 acknowledges the Minister's discretion in this regard, but it also requires the Minister to act reasonably in making such a decision. As well, the Minister is required to consult with AHS, the Authorized Representative, and the AMA when determining whether to cancel a Clinical ARP.

Practically, there are a few circumstances that require that this provision be in place. If all the Participating Physicians were to decide to terminate their participation in the Clinical ARP, a shell would be left still in place. Over time, if no Physicians choose to participate in that Clinical ARP, cancelling it would be an administrative exercise to clean up the Clinical ARP Program. Alternatively, AHS may indicate that the Program the Clinical ARP shell was to provide is no longer required or is being framed differently and no longer fits best with the Clinical ARP funding model.

In the case of perceived shortcomings with respect to the Participating Physicians' fulfillment of their obligations under the Clinical ARP, there is a process of rectification built into the framework. See Section 9.2.

Rectification of a Clinical ARP

This section enables the Minister to enter into a dialogue with the Participating Physicians and AHS about any perceived shortcomings of the Participating Physicians' fulfillment of their obligations under the Clinical ARP. This process includes providing time for the Authorized Representative to respond to the Minister's concerns and to rectify any problems. Within this process, the Minister will consider any responses received from the Participating Physicians or AHS in determining whether or not to cancel the Clinical ARP.

Section 10: Notices

This section describes the process by which legal notice may be given to Alberta Health, AHS, and the Participating Physicians. It's included in the framework so that all three groups will know who to contact and how to ensure legal notice is given when necessary.

Section 11: Relationship

This section clarifies that by entering into a Clinical ARP by submitting an LOP, the intent is not to create an agency relationship between the Clinical ARP participants. The intention is that each participant to a Clinical ARP maintains their independent legal status.

Section 12: Information management

For accountability purposes, the Minister needs to be able to access information regarding a Clinical ARP to monitor performance, payment, and to calculate the Compensation. This section describes what kind of records the Participating Physicians and AHS will provide the Minister upon request. Note that these records are limited to what is reasonable and permitted under Applicable Laws. The section also describes records retention and disposition requirements.

Section 13: Evaluation of Clinical ARPs

The evaluation of a Clinical ARP is intended to be a collaborative venture between Alberta Health, AHS, and the Participating Physicians. In this way the effectiveness of the Program can be measured and improvements can be considered to enhance the delivery of Program Services to Patients.

Evaluations of Clinical ARPs depend on Participating Physicians and AHS providing the Minister with the records, documentation, and reports (including performance reports) the Ministry requires. However, the Minister may only require that which is reasonable and in line with Applicable Laws. Likewise, although the Minister may direct that Participating Physicians and AHS participate in conducting evaluations, they must take reasonableness into account.

Section 14: Dispute resolution

This section details a dispute resolution mechanism for when Alberta Health, AHS, and the Participating Physicians have a difference of opinion respecting the contents and particulars of a Clinical ARP. When they cannot achieve consensus on an issue, each will submit their concern in writing to Alberta Health, AHS, and the Participating Physicians. Each group will then designate a person to represent them to review the issues and attempt to resolve them. If the issues cannot be resolved, they will be referred to a resolution committee that will attempt to resolve the issue. If the resolution committee (which includes the AMA as a representative for the Participating Physicians) cannot resolve the issue either, the committee will submit a report including recommendations and options from each member of the committee to the Minister for his decision.

Purpose of Dispute Resolution Process

The process of dispute resolution is intended to be used when there is disagreement between Alberta Health, AHS, and the Participating Physician on how to interpret or apply the Clinical ARP framework. It is not intended to be a venue where these parties dispute the content of, or wording, in either the Clinical ARP Program Parameters or the CoP.

Since a Clinical ARP is established by the Minister, and Participating Physicians exercise their option to participate in a given Clinical ARP by submitting an LOP for the Program, the Minister must maintain control and accountability for that Clinical ARP, including an ability to terminate a Clinical ARP if termination is warranted. The Minister is accountable to the Legislature for the Clinical ARP.

As such, disputing the termination of a Participating Physician and the cancellation of a Clinical ARP is not included under Section 14 in order to avoid fettering the discretion of the Minister. Instead, in order to continue to hear the voices and input of AHS, the Authorized Representative, and the AMA, provisions have been added that allow the Minister to receive guidance and recommendations from these other stakeholders and Clinical ARP participants. Sections 8 and 9 of the Clinical ARP Program Parameters require that the Minister not terminate a Participating Physician nor cancel a Clinical ARP without having consulted AHS, the Authorized Representative, and the AMA. As well, the framework includes provisions for the Minister to enter into a dialogue with the Authorized Representatives and AHS regarding perceived shortcomings, and time for the Authorized Representatives to respond and address the concerns.

Appendix 1.0: Letter of Participation

The Authorized Representatives will send the original LOP to Alberta Health and will send copies to AHS and the AMA.

LETTER OF PARTICIPATION

{NAME} CLINICAL ARP

To: Her Majesty the Queen in Right of Alberta, as represented by the Minister of Health and Wellness (the "Minister")

And to: {NAME}, Authorized Representative

The undersigned Participating Physician wishes to participate in this Clinical ARP on the following basis and in accordance with the Clinical ARP Program Parameters and the corresponding Clinical ARP Ministerial Order for this Clinical ARP, which together define the program rules, conditions and framework for this Clinical ARP:

1. Terms with initial capitals used herein and defined in the Clinical ARP Program Parameters or the Clinical ARP Ministerial Order which established the Clinical ARP referenced above, shall have the meanings set out therein.
2. By signing this Letter of Participation, I, and _____ ("my PC") which I control, acknowledge I am bound by the Clinical ARP Program Parameters, the corresponding Clinical ARP Ministerial Order for this Clinical ARP, and any Services Agreement with respect to the Clinical ARP, all of which I have read and fully understand. My PC and I have obtained professional and legal advice, if desired.
3. I acknowledge that the Clinical ARP Program Parameters and the corresponding Clinical ARP Ministerial Order for this Clinical ARP govern the Program, my obligations, and my right to Compensation notwithstanding any different or conflicting terms of any Services Agreement.
4. I acknowledge that disclosure of information to the Minister and AHS is required in order to allow proper monitoring, information sharing, accountability and evaluation of my participation in the Clinical ARP as provided for in the Clinical ARP Program Parameters and the corresponding Clinical ARP Ministerial Order in accordance with Applicable Laws.
5. I hereby authorize the Authorized Representative:
 - (i) to receive funds paid or payable to me as a Participating Physician under the Clinical ARP;
 - (ii) to give and receive notices on my behalf pertaining to the Clinical ARP, including a Letter of Termination;
 - (iii) to enter into a Services Agreement on my behalf (and acknowledge the Authorized Representative had proper authority to have done so if the Services Agreement pre-dates this Letter of Participation);
 - (iv) to disclose any personal information, including my practitioner identification and licence numbers, to the Minister and AHS as is reasonably required by Applicable Laws and pursuant to Ministerial Orders pertaining to the Clinical ARP or Services Agreement; and
 - (v) generally to act on my behalf as a Participating Physician as contemplated by the Clinical ARP and as I direct from time to time.
6. I hereby authorize the Authorized Representative to disclose the contents of this Letter of Participation and any subsequent Letter of Termination to The Alberta Medical Association (C.M.A. Alberta Division).
7. I hereby acknowledge that my PC and I are bound by any actions taken by the Authorized Representative as described in Ministerial Orders pertaining to the Clinical ARP or the Services Agreement.
8. I am aware of Section 7.2 of the Clinical ARP Program Parameters which states as follows: "A Claim for Benefits submitted by the Participating Physicians in a Clinical ARP constitutes and is deemed to be a claim for Benefits submitted by each Participating Physician under the *Alberta Health Care Insurance Act* and all regulations made under this Act. For clarity, Compensation paid or payable hereunder is subject to the Minister's rights under the *Alberta Health Care Insurance Act* and regulations to assess, approve, and re-assess said claims, including the right to reduce future Compensation payments and withhold Compensation and/or any other Benefits payable by the Minister for Program Services and/or other Insured Medical Services rendered prior to, during, and after the Physician became a Participating Physician."

9. Should my PC or I submit Claims for Benefits under Section 3 of the *Medical Benefits Regulation* for any Patients for Program Services while I am a Participating Physician within the meaning of the Clinical ARP Program Parameters and the corresponding Clinical ARP Ministerial Order, except as permitted by the Clinical ARP, the Minister is hereby expressly authorized and empowered to withhold such amounts from any payment owing to my PC or me, whether under the provisions of the Clinical ARP or the provisions of the *Alberta Health Care Insurance Act*.
10. As and when requested, I shall, or I shall cause my PC to, provide the Minister and the Auditor General of Alberta any books of account and financial records respecting the delivery of Program Services under the Clinical ARP and the Letter of Participation.
11. Upon payment of Compensation to the Authorized Representative or to my PC or me pursuant to the Clinical ARP or Services Agreement, the Minister and/or AHS, as the case may be, are discharged from their respective obligations to me and my PC.
12. I am registered with the College as a _____ or as a Specialist in _____.
13. Subject to prior approval of the Minister, I intend this Letter of Participation to be effective on the later of _____ [commencement of services date] or the Effective Date of the Clinical ARP.

Participating Physician

By: _____
 Signature

 Print Name

Date: _____

Authorized Representative

Per: _____
 Signature

 Print Name

Date: _____

Professional Corporation

Per: _____
 Signature

 Print Name

Date: _____

Participating Physician's mailing address: _____	Email address: _____
_____	Practitioner identifier: _____
_____	College licence number: _____
Facsimile number: _____	_____

cc: Alberta Health Services
 The Alberta Medical Association (C.M.A. Alberta Division)

Appendix 2.0: Letter of Termination

The Authorized Representatives will send the original LOP to Alberta Health and will send copies to AHS and the AMA.

LETTER OF TERMINATION

{NAME} CLINICAL ARP

To: Her Majesty the Queen in Right of Alberta, as represented by the Minister of Health and Wellness (the "Minister")

And to: {NAME}, Authorized Representative

Terms with initial capitals used herein and defined in the Clinical ARP Program Parameters or the Clinical ARP Ministerial Order which established the Program referenced above, shall have the meanings set out therein.

This is notice of withdrawal of my Letter of Participation and the termination of my, and of my Professional Corporation's, if any, participation under the Clinical ARP.

Termination is effective on _____ (insert date).

I understand that I must provide this Letter of Termination to the Minister and AHS at least 30 days prior to the above date.

I understand that after the effective date of termination indicated above neither I nor my Professional Corporation, if any, is eligible to claim or receive Compensation for Program Services under the Program.

I am aware of Section 8.6 of the Clinical ARP Program Parameters which restricts my ability to claim Benefits under Section 3 of the *Medical Benefits Regulation* for Program Services.

If I am an Authorized Representative as described under the Clinical ARP, I understand that I can no longer act as the Authorized Representative and that I shall leave in the custody of the Clinical ARP any documentation related to the duties of the Authorized Representative.

Physician or Authorized Representative
on behalf of Physician

Professional Corporation or Authorized
Representative on behalf of
Professional Corporation

By: _____
SIGNATURE

Per: _____
SIGNATURE

PRINT NAME

PRINT NAME

Date: _____

Date: _____

Practitioner identifier: _____

College licence number: _____

cc: Alberta Health Services
The Alberta Medical Association (C.M.A. Alberta Division)

Conditions Of Payment Ministerial Orders Explained

General

Alberta Health will work with you and AHS to create or update your CoP. After the CoP is in effect, any additional changes, such as changing your program description, can be made efficiently and quickly. Your CoP sets out the specific term for your Clinical ARP, but Participating Physicians do have the opportunity to request changes throughout the term. Please see ARP Term and Rate Adjustments section above for more information.

Schedule A

Schedule A is the heart of your Clinical ARP's CoP. The first section of Schedule A includes some language that makes explicit the linkage between the CoP and the Clinical ARP Program Parameters as well as lists any defined terms that are unique to the Clinical ARP. This includes the definition of FTE for those Clinical ARPs paid by FTEs worked.

Compensation for no-show appointments

Many Clinical ARPs work with populations that may have difficulty attending scheduled appointments. The Clinical ARP Program provides incentive to Participating Physicians to provide Program Services to these Patients when they otherwise may not be appropriately compensated to do so under the fee-for-service model. Alberta Health recognizes Participating Physicians are often unable to reschedule appointments cancelled on short notice and, subject to the Participating Physicians making best efforts to limit the occurrence of no-shows, Alberta Health will credit Participating Physicians for this time with compensation generally limited to a 15 minute interval. See the Program Service Day or Program Service Hour definition in Schedule A of your CoP for the specific time period that will be compensated within your Clinical ARP.

Appendix 1.0: Compensation

Compensation to Clinical ARPs paid by FTEs worked will be limited to the lesser of the number of Participating Physicians multiplied by the payment rate and the maximum number of funded FTEs multiplied by the payment rate. For example, if there are five Participating Physicians in a Clinical ARP that is funded for eight FTEs, the Compensation will be five multiplied by the annual payment rate.

For those Clinical ARPs that are paid for FTEs worked, subject to receiving prior approval from the Minister, a Clinical ARP will not be paid for work a Participating Physician performs that is over 1.5 FTE per year. (See Appendix 1.0, Section 1(b) of your CoP.)

Appendix 2.0: Program Description

One of Alberta Health's goals in the Clinical ARP framework is to have consistency among Clinical ARPs in terms of overall format and also to have a transparent overarching framework (i.e. the Clinical ARP Program Parameters) that applies to all Clinical ARPs and clearly describes Participating Physicians' responsibilities and accountabilities under the Clinical ARP framework. Therefore, your Program description will be populated using information pertinent to your Clinical ARP, but will be done in a way that is standardized across the province.

The Centre

The Centre is comprised of the buildings, facilities, locations, or geographic areas in which Participating Physicians provide Program Service to Patients. Alberta Health maintains a list of these facilities for each Clinical ARP and works informally with Authorized Representatives to keep these lists up-to-date. Section 3.2 of the Clinical ARP Program Parameters describes and formalizes this process.

For government accountability reasons, we have to refer to the concept of "the Centre" in the CoP rather than include the actual list of buildings, facilities, etc., in the document. If the actual list were included, an amendment to the CoP MO would have to be done each time there was a change to that list of facilities. Instead, "the Centre" refers to a list of facilities that Alberta Health maintains and updates upon receiving changes from the Authorized Representatives.

Keeping this list up to date is important, as the facilities associated with a Clinical ARP affect payment. If a facility in which Participating Physicians provide Program Services to Patients is not on the list, Service Event Reports for those services could inadvertently trigger fee-for-service payments that Alberta Health would have to recover from the Clinical ARP.

Program Services

Program Services are all of the Insured Medical Services and other services related to the provision of Insured Medical Services that Participating Physicians provide to Patients. Program Services are specific to each Clinical ARP and include the services that are listed in Schedule A, Appendix 2.0, Section D of the CoP.

Alberta Health has standardized the format for describing Program Services; however, in collaboration with the Authorized Representative and AHS, the specifics can be updated for your Clinical ARP's Program Services description as required.

Service Delivery Model

The service delivery model is contained in Section F of Schedule A, Appendix 2.0 of the CoP that describes the context and manner in which Program Services are to be provided. It is a narrative description of how the Program operates, and may describe the various

components of the Program or the interrelation between Program Services and services provided by non-Physician staff.

The service delivery model can be updated as needed in collaboration with the Authorized Representative and AHS.

Appendix 3.0: Claims for Benefits

Submitting Claims for Benefits

The frequency with which Claims for Benefits need to be submitted are described in Schedule A, Appendix 3.0 of your CoP. All Clinical ARPs are required to submit Service Event Reports and Claims for Benefits within timelines that vary based on how the Clinical ARP is paid:

- For those Clinical ARPs paid for FTEs worked, Claims for Benefits reports (also known as FTE reports) are submitted monthly and Service Event Reports are to be submitted no later than 90 days after the service event
- For those Clinical ARPs paid for Program Service Hours worked, Claims for Benefits (also known as Program Service Hours reports) are submitted at any time depending when Program Services have been provided. Sessional Clinical ARPs submit their Claims for Benefits using the Service Event Reporting tool by adding a time modifier (TM) to the Health Service Code that records the amount of time spend on that service in 5 minute allotments.
- For those Clinical ARPs paid according to their list of Rostered Members, updates to the list of Rostered Members are made as required. Service Event reports are to be submitted no later than 90 days after the service event.

Service Event Reports

Service Event Reports are best described in comparison to claims submission in the fee-for-service world. In order to receive fee-for-service payments from Alberta Health for the provision of Insured Medical Services listed in the Schedule of Medical Benefits (SOMB), Physicians submit claims that identify elements:

- the services provided (based on the health service codes in the SOMB)
- the Patients to whom those services were provided
- when the services were provided
- which diagnostic codes are associated with the services
- if the fee for the identified service should be modified from the base amount.

Alberta Health does not pay Physicians for their services unless it receives such claims.

For Clinical ARPs, Service Event Reports are one half of a Claim for Benefits. Service Event Reports are documents submitted in the same way as fee-for-service claims, and they

contain all of the same information. The only difference is that Alberta Health does not pay Participating Physicians the fees associated with the reported health service codes. For Clinical ARPs, Service Event Reports show evidence that Participating Physicians have provided the Program Services. Other such evidence is provided in the remaining document required for the Claims for Benefits — i.e., the FTE report, the Program Service Hours report, or the list of Rostered Members.

Deadline to submit Service Event Reports

Alberta Health compensates Participating Physicians for the provision of Program Services upon receipt of either a FTE report, Program Service Hours report, or as per arrangements regarding Rostered Members. But this documentation does not include evidence that the work is actually being performed. The role of Service Event Reports is to show that evidence. This why Alberta Health requires they be submitted within 90 days of the service event. For accountability purposes, this evidence is required sooner than the traditional 180 days allowed for fee-for-service billing.

Non-Compliance with Service Event Reporting Submission

The Compensation Alberta Health pays to your Clinical ARP is contingent on receipt of Claims for Benefits, including Service Event Reports. If Alberta Health does not receive Service Event Reports within 90 days of the Program Services being provided, there is a process to rectify the problem. This includes communication between Alberta Health, AHS, and the Authorized Representative to identify the issue and an opportunity for the Authorized Representative to respond and address the issue. The Minister does have the right to withhold future Compensation if the problem is not rectified (see Section 7.6(e) of the Clinical ARP Program Parameters for more information.).

FTE Reconciliation Process

FTE Reconciliation Process without an Expansion

Alberta Health will reconcile payments against FTE reports annually for Annualized Clinical ARPs. This reconciliation will be done against the number of FTEs identified in your Conditions of Payment. As long as Alberta Health receives Claims for Benefits consistent with the requirements of the Clinical ARP framework, the Minister will make Compensation payments in equal monthly installments regardless of the number of FTEs reported in the monthly FTE reports. However, adjustments to the payment amount can be made during the fiscal year based on variations in the FTE reports and physician requests. Based on your FTE reporting, the reconciliation amount is derived by comparing the amount that should have been paid with the amount you were paid in order to ensure there is no over or under-payment to your ARP.

In the situation where your ARP worked more the maximum FTEs allocated in your Conditions of Payment, Alberta Health will only pay the contract maximum. **Under no circumstances** will Alberta Health pay for services that exceed the contracted FTEs in the Conditions of Payment. Reconciliation will be completed by Alberta Health no later than September 30th after the fiscal year.

FTE Reconciliation Process with an Expansion

If your Clinical ARP had an expansion during the fiscal year, your reconciliation will be done in two parts. Reconciliation will be done in this fashion for any change in MO throughout the year, even if your MO does not change the amount of FTEs but, rather, changes Program Services, for example.

The first part of your reconciliation will be from April 1 to the effective date of your Clinical ARP expansion, which can be found in your Conditions of Payment. This means that all work **before** the date of your expansion will **only** be reconciled against the **prorated** maximum compensation as stated in your Conditions of Payment. Under no circumstances will Alberta Health pay for services that exceed the prorated maximum compensation prior to date of the signed expansion.

The second part of your reconciliation will be from your expansion date on your Conditions of Payment until March 31. Your FTEs, **for this period only**, will be assessed at your expanded FTE rate. Your increased FTEs are **only** available to you **after** the date of your expansion in your new Conditions of Payment and cannot be retro-actively applied to work done before the expansion date.

For example, if your Clinical ARP is funded for two FTEs beginning April 1st and an expansion to three FTEs has been approved for October 1st, any services that exceed two FTEs provided before October 1st cannot be “carried over” once the expansion is in place. The reconciliation will be performed for April-September at 2 FTEs and October-March at 3 FTEs, and will not be prorated for the entire fiscal year.

For Clinical ARPs that have been issued an expansion, there is a possibility that Alberta Health may reconcile your payments and require a re-payment of funds, even if your Participating Physicians worked more than the allotted FTE amounts before your expansion. Authorized Representatives must be aware of the reconciliation process so that they can manage their program effectively.

Appendix 4.0: Performance reporting

Clinical ARPs will submit quarterly and annual performance reporting on the indicators listed in Appendix 4.0. The indicators identified for performance reporting are taken from previous funding agreements or other documentation from the Clinical ARP. They can easily be updated as the Clinical ARP evolves, and Alberta Health encourages Authorized Representatives to limit performance reporting to three to five indicators that are relatively easy to monitor and report on.

The CoP requires that you only report the variance between anticipated and actual results at the end of the year, rather than for each quarter. As well, the format of quarterly reporting and the data component of annual reporting is standardized.

Operating your ARP

How to submit Service Event Reports

Service Event Reports can be submitted to Alberta Health via H-link in the same fashion as fee-for-service reports are submitted. Participating Physicians will be required to use their ARP Business Arrangement (BA) when submitting, and can use codes from either the SOMB or the Service Event Reporting Schedule. Payment rules do not apply; therefore all services will be paid at zero dollars.

How to Calculate your FTEs

In order to calculate your monthly FTEs, you need to be aware of your Clinical ARP's FTE definition. Clinical ARPs will have an FTE definition in Program Service Weeks, Program Service Hours or Program Service Days. You will find your Clinical ARP's FTE definition on the first page of Schedule A in your CoP MO. Your definition may have two parts: the FTE definition itself, and a supplementary definition that provides further detail.

Program Service Days – 24-hour period

A *sample* FTE definition in Program Service Days (PSD), where a PSD is defined as a 24-hour period is as follows:

“Full-Time Equivalent” or “FTE” means 241 Program Service Days per year in accordance with the requirements of the Ministerial Orders applicable to this Clinical ARP.

“Program Service Day” or “PSD” means Program Services provided by a Participating Physician within a 24 hour period beginning at 12:00 am and ending at 11:59 pm in accordance with the requirements of the Ministerial Orders applicable to this Clinical ARP. A PSD shall not include a Participating Physician's on call availability, either during regularly scheduled weekdays or after-hours, as may be described further in Appendix 2.0 of this Schedule, but may include the Participating Physician's time spent at the Centre waiting for Patients who fail to attend scheduled appointments.

To calculate monthly FTEs, you first need to determine the number of PSDs a Participating Physician has worked. To do this, add up the number of 24-hour periods (beginning at 12:00 am and ending at 11:50 pm) in which the Participating Physician provided Program Services that month. Once you have determined this, use the following calculation to determine your monthly FTEs.

Monthly FTEs = Number of PSDs worked per month x 12 ÷ Number of PSDs in your FTE definition.

Program Service Days – specified number of hours

A *sample* definition of Program Service Days (PSD), where a PSD is defined as a specified number of hours is as follows:

“Full-Time Equivalent” or “FTE” means 241 Program Service Days per year in accordance with the requirements of the Ministerial Orders applicable to this Clinical ARP.

“Program Service Day” or “PSD” means eight hours of Program Services provided by Participating Physicians in accordance with the requirements of the Ministerial Orders applicable to this Clinical ARP. A PSD shall not include a Participating Physician’s on call availability, either during regularly scheduled week days or after-hours, as may be described further in Appendix 2.0 of this Schedule, but may include the Participating Physician’s time spent at the Centre waiting for Patients who fail to attend scheduled appointments, each unattended appointment being deemed equivalent to the Participating Physician having provided 15 minutes worth of Program Services hereunder.

To calculate monthly FTEs, you first need to determine the number of PSDs a Participating Physician has worked. To do this, add up the number of hours in which the Participating Physician provided Program Services that month. Then use the following formula to calculate the number of PSDs worked.

Monthly PSDs = Number of hours worked ÷ Number hours in the PSD definition

Once you know the number of PSDs worked, use the following calculation to determine monthly FTEs.

Monthly FTEs = Monthly PSDs x 12 ÷ Number of PSDs in the FTE definition

Program Service Hours

If you are using a Program Service Hour definition, you will not have a supplementary definition in your CoP. The FTE definition contains all information required to calculate monthly FTEs.

A *sample* FTE definition is as follows:

“Full-Time Equivalent” or “FTE” means 1928 hours of Program Services per year provided by the Participating Physicians in accordance with the requirements of the Ministerial Orders applicable to this Clinical ARP. Program Service shall not include a Participating Physician’s on call availability, either during regularly scheduled weekdays or after-hours as may be described further in Appendix 2.0 of this Schedule, but may include the Participating Physician’s time spent at the Centre waiting for Patients who fail to attend scheduled appointments, each

unattended appointment being deemed equivalent to the Participating Physician having provided 15 minutes worth of Program Services hereunder.

To calculate monthly FTEs, you first need to determine the number of hours a Participating Physician has worked. To do this, add up the number of hours in which the Participating Physician provided Program Services that month. Once you know the number of hours worked, use the following calculation to determine monthly FTEs.

Monthly FTEs = Number of hours worked per month x 12 ÷ Number of hours in FTE definition.

Adding ARP facilities

To add, change or end the existence of a facility attached to your Clinical ARP, you will be required to fill out the Facility Registration – Delivery Site Registry form that you can get from this website: <http://www.health.alberta.ca/documents/AHCIP-form-AHC0910A.pdf>

You can then mail the form to:

Professional and Facility Management Unit
PO Box 1360 Station Main
Edmonton, AB T5J 2N3

Or Fax at 780-422-3552

