INCOME EQUITY INITIATIVE

Implementation Plan

Submitted to: AMA Representative Forum

Submitted by: AMA Compensation Committee

August 31, 2017

Contents

1. Executive Summary 3
2. Income Equity Initiative Introductory Highlights 4
    I. IEI Goals and Objectives 5
    II. AMA CC Mandate 5
    III. Summer 2017 Engagement and Consultation Process 5
    IV. Expectations of RF; Components of the IEI Implementation Plan for Approval at the Fall 2017 RF 10
3. Governance and Organizational Roles 11
4. Guiding Principles 12
5. Income Equity Definition 13
6. Proposed ANDI Model 14
    I. Introduction 14
    II. ANDI Factors to be used for Calculation 14
        A. Physician Compensation for Insured Clinical Services 16
        B. Overhead 18
        C. Daily Working Hours 19
        D. Training/Career Length 20
    III. ANDI Formula 21
    IV. Equity Target 22
    V. Equity Band 24
    VI. ANDI Reallocation and Allocation 25
7. Market Considerations 25
8. Income Equity Timelines and Milestones 26
    I. Major deliverables and timelines 26
    II. Critical path activities 27
    III. Time Frame for Adjustment 27
    IV. On-going Reporting and Tracking 27
9. Linkages and Interdependencies 27
10. Validation, Verification and Testing of the ANDI Model 28
11. Legal Compliance Review 30
12. Dispute Resolution Process 31
13. Income Equity Initiative Incremental Resources and Budget 32
14. AMA Member Ratification 33

15. Recommendations Summarized 33
16. Unresolved Items and Unanswered Questions: 34
17. Appendices 36
Appendix 1 36
Appendix 2 42
Appendix 3 44
Appendix 4 46

Alberta Medical Association
Income Equity Initiative Implementation Plan

1. Executive Summary

This Income Equity Initiative (IEI) Implementation Plan, prepared by the AMA CC under direction of the AMA Board, is being presented for approval of the AMA Representative Forum (RF) at its Fall 2017 meeting.

This document provides the plan to achieve the objectives of the Spring 2017 RF as directed by the resolutions:

- THAT to aid in allocation decisions, the AMA adopt the concept of an adjusted net daily income model as an additional tool,
- THAT reallocation be a mechanism to achieve intersectional income equity,
- THAT intersectional income equity, as will be defined by the implementation plan, be achieved within five years or less, and
- THAT an implementation plan to achieve intersectional income equity be presented for approval to the Fall 2017 RF.

The document outlines the work that has either started or is planned over the next year to design, build and implement the Average Net Daily Income (ANDI) model, as well as the subsequent steps required in the following years for the reallocation process. It explains the organization structure and the authorities and responsibilities for the decision making, project management and individual work tasks. The AMA Compensation Committee (AMA CC) has been delegated the responsibility of project oversight by the AMA Board, so much of the document provides the thoughts and considerations put forward by the AMA CC for review, feedback and approval over the timeline of the initiative.

Included in the work that has been started and is highlighted in the document is:

- Design and development of the ANDI model, including the milestones and timelines that need to be met in order for each of the reallocations within the five year timeframe
- Identifying and assessing possible factors of adjustment, those that are strong factors and others that may not be considered as useful in the model, with the explanations of the AMA CC's rationale
- Identifying and describing the steps/activities required in the implementation plan, and
- Planning and implementing the engagement, consultation and communications requirements with sections, members and stakeholders for each element of the plan.

The plan also provides information on required activities that would be initiated following the approval of the RF, such as the validation and verification process.

The last section of the document lists some of the issues that have been identified during the initial stages of the project that are currently unresolved and unanswered. It is expected that these issues will be resolved using the same process currently used by the AMA Board and AMA CC to engage section representatives, members, stakeholders and partners throughout the design, development and ongoing work associated with the equity initiative.

The recommendations in Section 15 summarize the work completed to date as well as work that is planned as part of the IEI Implementation Plan. These require the approval of the RF at its September 2017 meeting.

2. Income Equity Initiative Introductory Highlights

The AMA Agreement commits government and physicians to have direct involvement of the profession in stewardship of health care dollars, including responsible and appropriate management and distribution of the physician services budget. Alberta's physicians are uniquely positioned to lead positive change in managing policy and funding and particularly in improving the delivery of care when resources are limited.

Over the past 20 or more years, fees and changing practice patterns have affected the income earning capacity among sections. Recent increased awareness of these differences amongst physicians has exacerbated income equity concerns. Income inequity or the perception of inequity has a negative impact on the social cohesion and collegiality of the profession. Inequitable payments are also undesirable because they can skew the delivery of services; over-valued services are more likely to be provided, while under-valued services may be neglected.

The profession has not had a clear and common definition of what fee and income relativity mean amongst physicians and sections. Furthermore, up until recently there has been a reluctance to take on these issues on a large scale, likely in part due to difficult past experiences with developing complex relative value guides, fear of creating rifts in the profession, and concerns over the potential impact on patient care.

The topic of income equity and the ANDI model appeared on the 2017 Spring RF agenda arising from direction from its September 2016 meeting, whereby a resolution directed the AMA Board to consider the ANDI model as an additional tool in the context of seeking long-term intersectional income equity. Following the June special meeting of the RF, the AMA Board and staff have proceeded to develop the IEI implementation plan for presentation and approval at the Fall 2017 RF meeting. The board of directors has delegated the day-to-day project oversight to the AMA CC.

To capture the needs and expectations of the AMA's RF and Board, section executives and stakeholders within the implementation plan, the AMA CC has sought feedback from and consulted with physicians at various levels in the organization on the key components of the income equity initiative and the ANDI model. The various methodologies and frequency of consultation and engagement will continue throughout the design, development and implementation of the IEI.

I. IEI Goals and Objectives

The Spring 2017 RF provided direction to the AMA Board of Directors:

- THAT to aid in allocation decisions, the AMA adopt the concept of an adjusted net daily income model as an additional tool,
- THAT reallocation be a mechanism to achieve intersectional income equity,
- THAT intersectional income equity, as will be defined by the implementation plan, be achieved within five years or less, and
- THAT an implementation plan to achieve intersectional income equity be presented for approval to the Fall 2017 RF.
- These and the additional resolutions arising from the Spring 2017 and Special meeting held in June are included as Appendix 1.

II. AMA CC Mandate

The board of directors has delegated the day-to-day project oversight to the AMA CC. More specifically, the Board has mandated the AMA CC to provide the implementation plan to the Fall 2017 RF that includes AMA CC's assessment of:

- A definition of equity,
- Proposed factors for consideration in the ANDI model,
- Proposed equity target,
- Proposed equity band,
- Timelines and milestones for the proposed implementation of ANDI, and
- A plan to achieve intersectional income equity within the proposed five year timeline.

III. Summer 2017 Engagement and Consultation Process

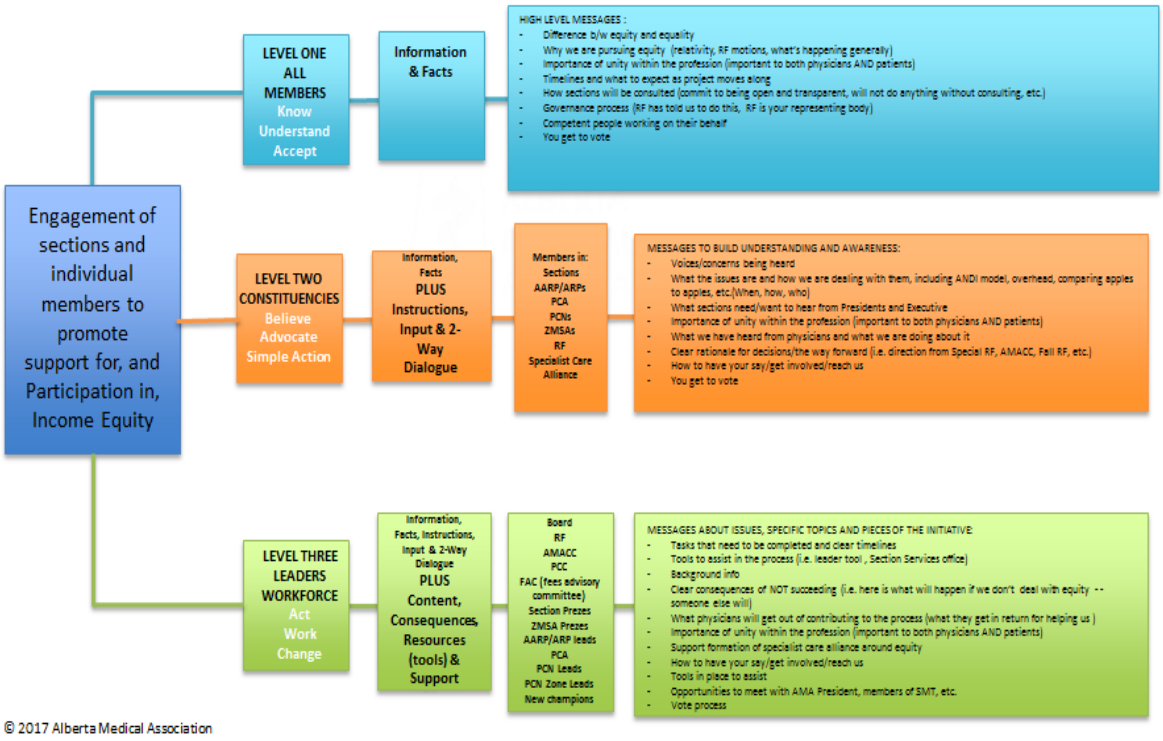
From a communication, consultation and engagement perspective, the AMA must respond to a variety of challenges and opportunities related to income equity. Communication, consultation and engagement are direct components of

the overarching income equity project plan.

Consistent and professional communications with members and stakeholders is key to emphasizing the importance of the project and highlighting messages about the initiative. The AMA has taken measures to heighten the visibility of the initiative, build awareness of the consultation and engagement activities, and highlight regular progress updates. A portion of the AMA website has been dedicated to the income equity initiative regularly providing information and updates.

The Income Equity Engagement Level diagram below illustrates the strategies that the AMA has undertaken in its engagement, consultation and communications with members:

Income Equity Engagement Levels



The engagement and consultation process includes a feedback loop that captures the comments, suggestions and issues raised and will share that information and any decisions arising with members. The follow-up may be shared with the section raising the issue, as well as through the Updates and Leader Information posted on the AMA web-site. Summaries will also be provided to the AMA CC at its meetings as a regular report and more specifically, on issues that have required consultation. The AMA's Board and RF will also receive reports on the activities and results of the consultation and engagement of the income equity initiative.

Between the Spring 2017 RF and leading up to the Fall 2017 RF, there have been a number of engagement and consultation processes undertaken. The most significant activities are noted:

IEI Activity	**Date**
President's Letter - Preparing for Representative Forum Circulation of Fee and Income Relativity 101 document to all members via President's Letter on March 1, 2017	March 1
Spring 2017 RF held and extended to include an in-depth discussion on income equity	March 10 & 11

IEI Activity	Date
President's Letter - RF's direction to Board and work with sections ahead	March 22
President's Letter - More from the Spring 2017 RF - and plans for a Special RF	March 29
Consultation paper circulated to Section Presidents *Income Equity - Possible Inputs to ANDI Model*	April 6
President's Letter - About the Special RF	June 8
Special RF	June 10
Income Equity Initiative Update sent to all members, posted on AMA website's Income Equity page	July 18
Consultation paper circulated to Section Presidents, Fees Reps and RF Delegates via Leader Information email *AMA Compensation Committee Assessment of ANDI Factors - July 26 - Compilation of Feedback from Sections*	July 29
Consultation paper circulated to Section Presidents, Fees Reps and RF Delegates via Leader Information email *Key Components of an Income Equity Strategy - DRAFT*	August 4

In addition, the Income Equity working group, AMA CC Co-Chairs, AMA Executive Director, Health Economics staff and AMA President have met with or have scheduled meetings with sections and physician groups to present information, answer questions and gather feedback.

The income equity page on the AMA website features a 'Request a Meeting' form where sections and groups can request representatives of the AMA to attend an already occurring or stand-alone meeting to discuss income equity.

A list of completed and scheduled meetings at the time of writing includes:

Date	Activity
Jun 16	Meeting (Section of Vascular Surgery)
Jul 26	Meeting (Central Zone Medical Staff Association)
Jul 31	External Stakeholder Meeting (Alberta Health)
Aug 2	Meeting (Section of Diagnostic Imaging)
Aug 3	Meeting (SGP Executive teleconference)
Aug 3	Meeting (Section of Dermatology representatives)
Aug 17	Meeting (Section of Ophthalmology)
Aug 22	Meeting (Specialty Care Alliance Ad-hoc executive)

Date	Activity
Aug 30	Town Hall Meeting (Section Presidents, Fees Reps and RF Delegates)
Aug 31	Meeting (SGP Executive)
Sept 7	Meeting (Section of Dermatology)
Sep 14	Meeting (GP Forum)
Sep 14	Meeting (Specialty Care Forum)
Sep 15	Meeting (Physical Medicine and Rehabilitation AGM)
Sep 30	Meeting (Section of Orthopedics AGM)

The AMA CC has used the engagement and consultation process to inform sections and members on its proposed plan, as well as various analyses and research, including but not limited to:

- First hand review of every e-mail sent to equity@albertadoctors.org, as well as involvement with most e-mails sent to the AMA president on the topic of income equity
- Visits to other provincial medical associations including the Doctors of British Columbia and the Ontario Medical Association as well as discussions with health economic colleagues from nearly every other provincial medical association.
- Discussions with Alberta Health and Alberta Health Services through the Physician Compensation Committee and the Management Committee.
- Discussions with the Institute of Health Economics.
- Various meetings and phone-calls with physicians.
- Consultant advice.

The AMA CC will continue consulting with sections throughout the income equity initiative process and will continue considering and incorporating feedback. This plan includes feedback received up until August 28, at which point the final changes were incorporated so that the final version could be submitted to the delegates in advance of the Fall 2017 RF. The AMA CC anticipates more discussion and review to go beyond the RF and will incorporate improvements along the way, according to the iterative process that has been established. Further feedback and thoughts will be captured prior to and during the RF and the AMA CC will clarify any final changes to the plan at the RF.

Prior to the Fall RF, consultation has largely consisted of written feedback, for example in response to the three consultation papers the committee has sent out, and meetings upon request. Moving forward post Fall RF, a more structured approach will be implemented to ensure that all sections are aware of any request or questions from the other sections as well as any information that is generated in response. Consideration will also be given to how this information

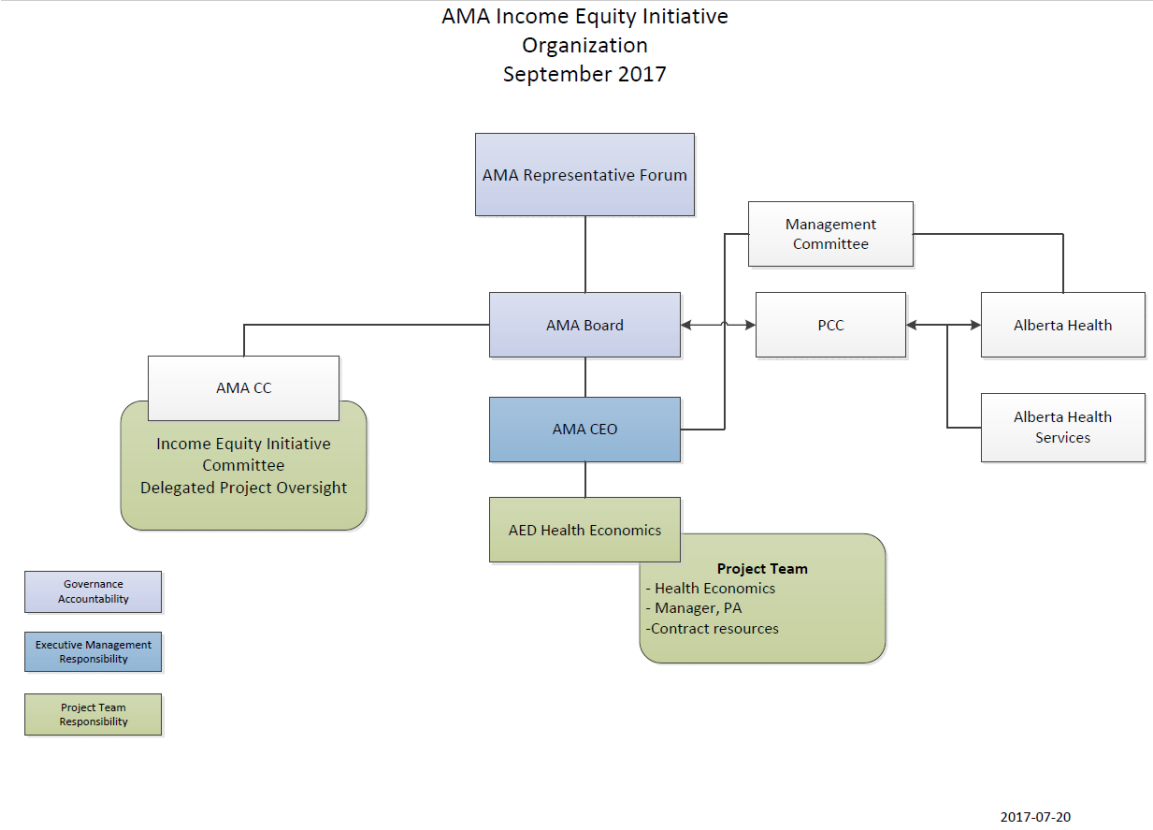
can be shared with members.

IV. Expectations of RF; Components of the IEI Implementation Plan for Approval at the Fall 2017 RF

- The AMA CC is recommending the IEI Implementation Plan and its submission to the Fall 2017 RF for approval.
- The IEI Implementation Plan includes the following components that follow this section of the report with greater detail and explanation:
  - IEI governance and organizational roles
  - Guiding principles to support good decision-making related to AMA's IEI Implementation Plan
  - Definition of income equity
  - The IEI ANDI model including:
    - A list of factors for inclusion in the ANDI model
    - An ANDI formula
    - An equity target
    - An equity band
    - ANDI reallocation and allocation
  - Market considerations
  - Timelines and milestones for the implementation of ANDI
    - Major deliverables and timelines
    - Critical path and activities
    - Timeframe for adjustment
  - Linkages and Interdependencies
  - Validation, verification and testing of the ANDI Model
  - Legal compliance review
  - Dispute resolution process
  - IEI budget
  - Member ratification
  - Summary of recommendations
  - Unresolved items and unanswered questions
  - The following outlines in greater detail the components of the IEI Implementation Plan.

3. Governance and Organizational Roles

- Following motions carried at the Spring 2017 RF and subsequent Special RF in support of the income equity concept, the mandate to the AMA CC has led to the development of an implementation plan, which could lead to the implementation and operationalization of the ANDI model, depending on the approval of the plan at the Fall 2017 RF.
- The income equity initiative is being organized as a project within the AMA's governance and management framework (see income equity organization diagram below). The Board of Directors is responsible and accountable for governance oversight of the project; providing strategic direction, monitoring progress and performance and assessing organizational risks and opportunities. The Board will refer recommendations to the RF for policy direction.



- The AMA CC is a board appointed standing committee that has been delegated the responsibility of overseeing the IEI as well as monitoring progress. This responsibility is consistent with AMA CC's role to develop, maintain and implement the AMA's Physician Compensation Strategy (PCS) including the priorities, outcomes and roles and responsibilities arising from it and to oversee key strategic activity related to physician compensation. The AMA CC will provide regular reports to the board on IEI's progress, priorities, risks and linkages that may have potential

impacts to the AMA's operations and strategy. It will identify issues, develop options for possible actions if required and provide recommendations for the board's consideration and resolution. Administrative/staff support for the AMA CC is provided by the Health Economics (HE) branch.

- The AMA's Executive Director is accountable and responsible to the board for the executive management oversight of the IEI project.
- The organization and project management of the IEI, including financial management, the ANDI design, implementation and transition to the AMA's operations is the responsibility of the HE branch. HE has established a project team of internal staff from HE and Public Affairs with external contractors and advisors supporting the work as required.
- Alberta Health and Alberta Health Services are also involved with the initiative. This critical involvement is important for several reasons, e.g.: To secure access to data necessary for the ANDI model and other components of the Income Equity Strategy; To gain assurances (beyond those mentioned in the agreement) that all ANDI-based monies be reallocated within the schedule of medical benefits; and To approve reallocations. Discussions are being held at the Physician Compensation Committee (PCC) and the Management Committee to define this critical involvement.

4. Guiding Principles

Principles that will guide and support good decision-making related to the AMA's Income Equity Strategy are:

Principle	**Definition**
Goal Driven:	The Income Equity Strategy aligns with the AMA's Mission and Vision in its leadership role in a high performing health system, including the strategic priorities of physician leadership and wellness.
Inclusive:	All parties with a significant interest in the income equity strategy will be engaged, consulted and communicated with during the process.
Transparent:	The process and outcomes will be open and accountable with full disclosure within confidentiality and legal guidelines. Access to relevant information with the opportunity to provide information and feedback will be available to section leaders, RF delegates and other AMA stakeholders holding an interest in the process and outcomes.

Principle	Definition
Respectful:	Acceptance and understanding of the diverse values, interests and knowledge of the parties engaged in the process is essential.
Fair and Equitable:	Physicians will treat each other fairly and equitably.
Accountable:	The AMA and its stakeholders are accountable to their members for the processes, decisions and actions agreed to within the scope of the income equity strategy.
Measurable:	There will be clear and specific outcomes that will be defined as specific, measurable, attainable, realistic and time bound over the period of the initiative, as well as through ongoing assessments.
Flexible:	Flexibility will be designed into the process to accommodate changing conditions, data needs, political environment impacts and contractual obligations, and as well, to possibly correct any unintended consequences (such as patient access to care) that arise and require adjustments.
Stewardship:	The outcomes will support quality care for Albertans, where possible reflecting best practice and supporting an appropriate level of medical service to patients with health system improvement as an overall intent. Furthermore, decisions should consider any potential of adversely impacting patient care or health system outcomes.

5. Income Equity Definition

Alberta's publicly funded healthcare system is designed to meet the medically necessary healthcare needs from a publicly managed fund. One of the concepts of publicly insured medical services places the majority of physician income in Alberta within a regulated price structure. Recognizing the regulated price structure exists, the Representative Forum has indicated that:

- Equity is an issue;
- The AMA needs to take responsibility;
- Use Reallocation to address inequity; and
- Reach intersectional income equity in five years or less.

This direction from RF and corresponding input from Alberta physicians has led AMA CC to recommend a definition of income equity as:

> "A fair and justifiable distribution of daily income earning capacity among sections"

The RF supports the belief that physicians should have a similar earning capacity for the delivery of publicly insured clinical services after accounting for intersectional differences in such things as overhead costs, working hours, after-hours work, medical training and career length. There are other considerations that items such as complexity of work, value of services or intensity should be used to assess the relative value of an individual fee, such as through the sectional INRV process but that differences arising between fees for these items are less likely to be measurable between sections.

6. Proposed ANDI Model

I. Introduction

The ANDI model provides a method to compare daily income earning capacity among sections, and then allocate funding to correct disparities among sections. This type of model was first developed in British Columbia in the 1990s and subsequently went through various adaptations. The Ontario Medical Association adopted a similar model in the mid 2000s.

Models of this type begin with a look at daily gross payments earned by various sections. The composition of payments can vary by province, but typically includes payments for publically funded medical services, such as fee-for-service earnings and ARP earnings. Adjustments are then made for various "factors" such as overhead costs (ON and BC), years of post-graduate training (ON and BC) and hours of work (ON), among others. A discussion of ANDI factors (including income components) that are under consideration and undergoing consultation is contained in Section II.

Once the comparison is made, parameters are then established to use the model for allocation or reallocation. This involves setting an equity target to compare incomes among sections. The AMA CC has also reviewed the concept of an equity "band" or zone to recognize that the data gathered will never be perfect, and will never capture 100% of the acceptable variation between sections. Before applying adjustments, it will be necessary to review market considerations to avoid unintended consequences. Finally, the RF has provided clear direction that adjustments should account for differences in section contributions from initiatives such as the recent Schedule of Medical Benefits (SOMB) savings initiative and peer review.

II. ANDI Factors to be used for Calculation

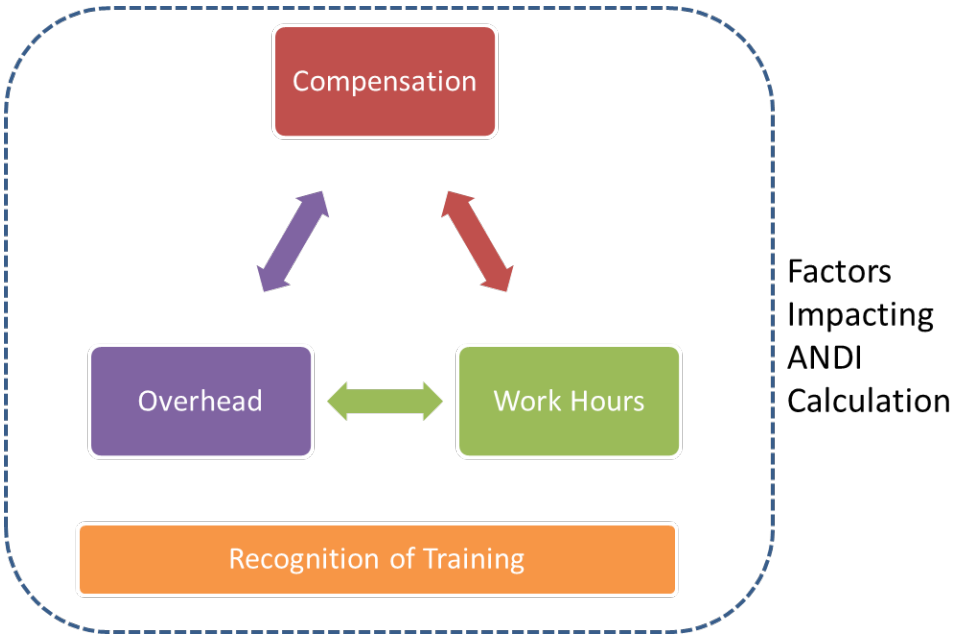
A preliminary model was presented to the AMA RF in March 2017 and some initial feedback was received on the model factors at that meeting.

In April 2017, an email was sent to sections that provided a draft inventory of suggested factors (i.e., datasets, parameters, considerations) to be built into

ANDI to allow for income equity comparisons. Sections were invited to provide comments, as well as recommend further factors that should be taken into account. Feedback was also gathered at the Special June 2017 RF, where delegates passed a number of resolutions pertaining to the ANDI model. The AMA Compensation Committee provided an assessment of the factors based on this feedback, and sought further input from sections at the end of July. Feedback was also gathered through email correspondence and/or direct phone calls with physicians.

The AMA CC was struck by the number of comments it received to "keep things as simple as possible" and to focus on a smaller number of "core" items, gathering as high quality data as possible, given the AMA's resource abilities. It is recognized that as the model matures over time, additional factors could be considered and incorporated into the model.

Based on the feedback, the AMA CC has identified a core group of three highly inter-related factors (see diagram below), including: Compensation data; overhead estimates; and estimates of working hours, as a common 'thread' in the feedback it received from sections and the RF. A number of sections highlighted the importance of aligning the parameters around these three factors, which has important implications for how the studies are designed and implemented.



In addition to these three factors, some sections identified that differences in post-graduate medical training is equally as important and should be considered as part of the core group. Other factors, such as market considerations and section utilization were also considered to be important, but in the AMA CC's view, may be more appropriately handled as part of the equity adjustments covered in Section III.

A second paper 'AMA Compensation Committee Assessment of ANDI Factors'

was sent to section presidents, fees reps, and RF delegates on July 29 and the AMA CC has considered the feedback it has received thru that consultation process as well.

The following list of factors includes an assessment and recommendation based upon AMA CC's review up to the date of the writing of this plan:

A. Physician Compensation for Insured Clinical Services

Accurate compensation data is seen as the most central and vital component of the ANDI formula. The AMA CC is proposing the model include compensation components that either represent provincially funded clinical services, or are linked in some way to the SOMB. These include:

i. Daily Gross Fee-For-Service Payments
ii. Alternative Relationship Plan (ARP) Compensation
iii. Alberta Health Services (AHS) Compensation
iv. Primary Care Network (PCN) Compensation

i. Daily Gross Fee-for-Service (FFS) Payments

Anonymized claims-level fee-for-service data are readily available to the AMA for the purposes of allocation and SOMB management. Fee-for-service payments represent approximately 90% of total payments to physicians for insured clinical services.

There are unique characteristics of physician practice among sections that affect the ability to use this raw dataset to reliably compare the distribution of daily income earning capacity among sections. The AMA CC has consulted with sections on this matter but is still studying the effects of various trimming proposals, examples include:

1. Trimming of low-earning days.
2. Trimming high earning days or high earning physicians within a section.
3. Removing after-hours services/days.
4. Removing technical and tray fees.
5. Adding reciprocal claims.
6. Adjusting for weekly management fees.
7. Adjusting for shifts over midnight.

The AMA CC is recommending that trimming occur, however, the results of these studies are not yet completed and AMA CC's recommendation will be provided to the Spring 2018 RF. It is also important to note that the AMA CC is recommending the use of the latest FFS data prior to all reallocations to ensure the effect of most recent initiatives and other realities are accounted for (such as

rule changes, individual fee review, utilization swings, retention benefit, etc.).

ii. Alternative Relationship Plan (ARP) Compensation

The AMA CC recommends that clinical ARP compensation and the clinical portion of academic ARP compensation be included in the ANDI comparison. This is especially relevant for small, ARP-dominated sections whose fee-for-service earnings are not reflective of full-time practice.

There are a number of issues with this component:

- Shadow claims data (readily available) are not always a good indicator of activity or payment.
- ARP contracts are typically with a group and not an individual physician. Occasionally, groups are comprised of members of more than one section.
- Data on hours, days or FTEs worked by ARP physicians are not always available.
- It's currently not possible to match FFS and ARP earnings for physicians on blended payment.
- Measurable time for clinical insured services of physicians involved with AARPs can be blurred with other activity and may not easily be distinguishable.

Notwithstanding these issues, the AMA is committed to working with Alberta Health to get as clear a picture as possible of ARP earnings. The AMA should work with Alberta Health to improve reporting and data quality over time.

The AMA CC recommends the inclusion of ARP compensation however, the data has not yet been collected and therefore, inclusion of ARP compensation will be reported to the Spring 2018 RF.

iii. Alberta Health Services Compensation

The AMA CC recommends the inclusion of AHS compensation be included in the ANDI comparison. Incorporation of AHS Compensation will require attention to a number of issues:

- There are typically no shadow claims to match with FFS days worked for those on blended payment.
- AHS compensation can take a number of forms including contracts for services, stipends to augment FFS, guaranteed incomes. In some cases, AHS will pay a physician a contracted amount, and then recoup some of the costs by billing FFS to Alberta Health for the physician's services.
- Contracts can be with physician groups (e.g. Diagnostic Imaging groups) and compensation is subsequently not reported on a physician-level basis,

making it difficult to reliably link with fee-for-service claims to calculate blended payments.

Notwithstanding these issues, the AMA is working with Alberta Health Services to calculate and incorporate AHS earnings as accurately as possible. The inclusion of AHS compensation will be reported to the Spring 2018 RF.

iv. Primary Care Network Physician Compensation

The AMA CC recommends inclusion of PCN compensation to physicians related to insured clinical services.

The AMA CC identified three separate categories of PCN funding:

1. Funding paid out as physician compensation. This is mostly to family physicians, but also to some specialists working under PCNs, such as pediatricians. Recent Alberta Health policy has severely restricted these payments.
2. Funding that offsets clinic overhead costs.
3. Funding to support the health care team.

PCN funding for the most part reflects infrastructure support for primary health care, analogous to the infrastructure support in acute care through hospitals and other means. However, to the extent that there is some overlap with primary medical care practices (e.g. subsidization of physicians or clinic operations), funding should be assessed and where appropriate, included in ANDI data.

The AMA CC is recommending that, if it can be identified, the portion of PCN funding that is paid out as physician compensation for insured clinical services be included in the ANDI model. Funding that flows to the health care team (i.e. not paid to physicians or their clinics) should be excluded from analysis.

B. Overhead

The development of an up-to-date, broadly accepted, and reasonably accurate overhead study is vital to the success of the ANDI allocation model and overall AMA equity strategy. Under the guidance of the PCC, the AMA is partnering with Alberta Health and Alberta Health Services in the design and implementation of a new study (note that this study is proceeding along a separate, yet parallel track). The AMA is cost sharing this approximate $1M study on a 50%/50% basis with government.

The request for proposal, launched in May through government procurement, establishes certain objectives for the study:

- To determine actual physician expenditures by section within different facility types and compensation models. The intention is to estimate gross

overhead costs, with an ability to match costs to the compensation components in the ANDI model.

- To provide a breakdown of organizational supports/subsidies that provides overhead funding, in order to calculate net overhead costs. This could include AHS subsidies such as non-hospital surgical facility payments, PCN funding for regular overhead costs, Business Costs Program Payments (BCP), Canadian Medical Protective Association (CMPA) reimbursement, technical and tray fees.
- To provide a detailed breakdown of fixed and variable costs.
- To develop a simulation model.
- To propose methods to also develop fee-based overheads.

The RFP also calls for section engagement in the development of the study parameters, such as the overhead cost categories, as well as section validation of overhead estimates. Discussions have occurred between Alberta Health, the AMA and the consultants regarding the need to align this study with work underway to gather requirements for the assessment of hours of work and other ANDI factors related to compensation. It is acknowledged that methodologies need to be consistent in order to maximize the quality of data and to best use the time of section representatives in the consultative process. As such, consultation sessions will be scheduled starting the week before the Fall RF meeting. It is anticipated that sections will be asked for their feedback into study methodology and design for both the overhead and hours of work assessments during these sessions.

The study is expected to be completed by June 2018.

The AMA CC recommends that the PCC's overhead study be coordinated with the Income Equity Strategy and that the results be applied toward the ANDI model.

C. Daily Working Hours

The RF provided clear direction that an adjustment to account for intersectional differences in clinical working hours is an important component of the ANDI model. As with the overhead study, it will be necessary to carefully match the hours of work study to the compensation components listed above.

Hours of work are generally very difficult to measure in a FFS system, for a number of reasons:

- Physician fees are generally service-based and not time-based.
- There is a great deal of unremunerated work, especially with indirect patient care.

- Most studies rely on self-reported working hours. Self-reported working hours are hard to verify and suffer from low response rates (due to the complexity of information gathered).
- Validated, time-motion type of studies are usually narrow-focused and resource intensive (i.e. very expensive).

In July 2017, the AMA hired a consultant to develop a high-level plan that includes section engagement in the development and implementation of the study. The study is expected to begin this fall with the above described section consultation sessions to gather requirements to inform the study design. A final report, informed by the above study and with section validation is expected in late 2017 or early 2018.

High level objectives of this study are to:

1. Clearly define what types of work should be considered for inclusion.
2. Quantify per section, average hours spent per day on direct clinical, indirect clinical and other activities. Consider incorporating an ideal hourly assessment to suit the model office.
3. Align hours of work estimates with other ANDI factors, particularly compensation and overhead.
4. Develop a methodology that is clear, feasible, credible and reproducible.

The AMA CC recommends proceeding with the Hours of Work study, and that the results be applied toward the ANDI model. If possible, the hours of work study will be linked in with the overhead review.

The AMA CC is still analyzing and looking at options regarding after hours and recommends consideration for the after-hours work in the ANDI model. A further update and recommendation on how best to apply the data from the hours of work study and after-hours work will be presented to the Spring 2018 RF.

D. Training/Career Length

Many sections have indicated that ANDI should account for intersectional differences in post-graduate training, though there is fair amount of variation in their recommended adjustments.

The AMA CC favors the development of a composite modifier to recognize the returns from specialty training which would encompass opportunity cost of medical training, potential shortened career length, as well as the formal acquisition of specialist skills.

The AMA CC recommends striking a broad-based physician panel, with representation from specialist sections and general practice. The panel could

consider evidence from other jurisdictions (e.g. opportunity cost studies, etc.) as well as studies that estimate the returns from education in other professions. Recommendations could be put forward to the AMA CC and Board for consideration (including any dissenting opinions). Further recommendations will be presented to the Spring 2018 RF.

III. ANDI Formula

Bringing all the above factors together, the AMA CC recommends calculating Adjusted Net Daily Income as follows:

Gross Daily Payments (including FFS with potential trimming and claims adjustments, ARP, AHS, PCN compensation)

x Overhead Adjustment

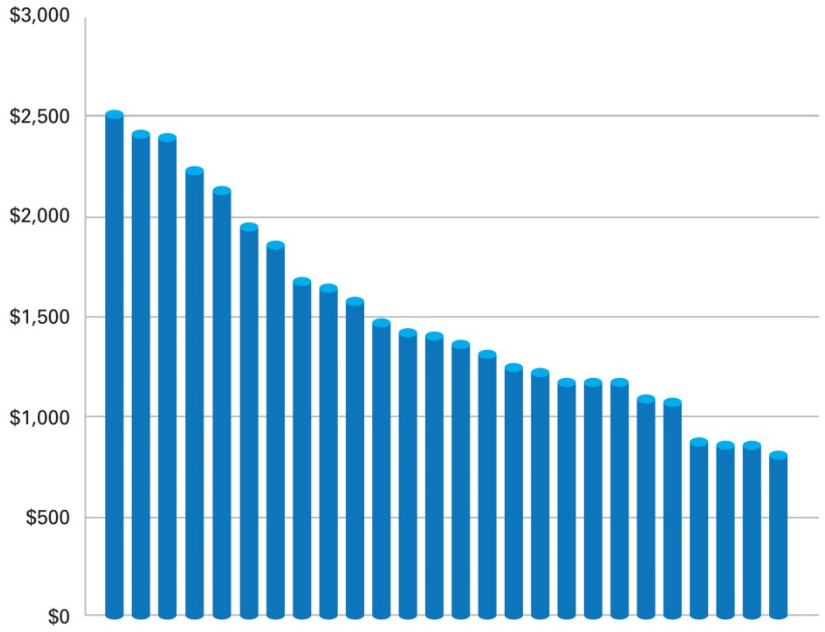
x Hours of Work Adjustment

x Adjustment for Differences in Training

= Adjusted Net Daily Income

ANDI is then compared among sections to show the difference in income earning capacity after accounting for the various factors. Rank ordering the results yields a chart similar to the one below:

Adjusted Net Daily Income Example

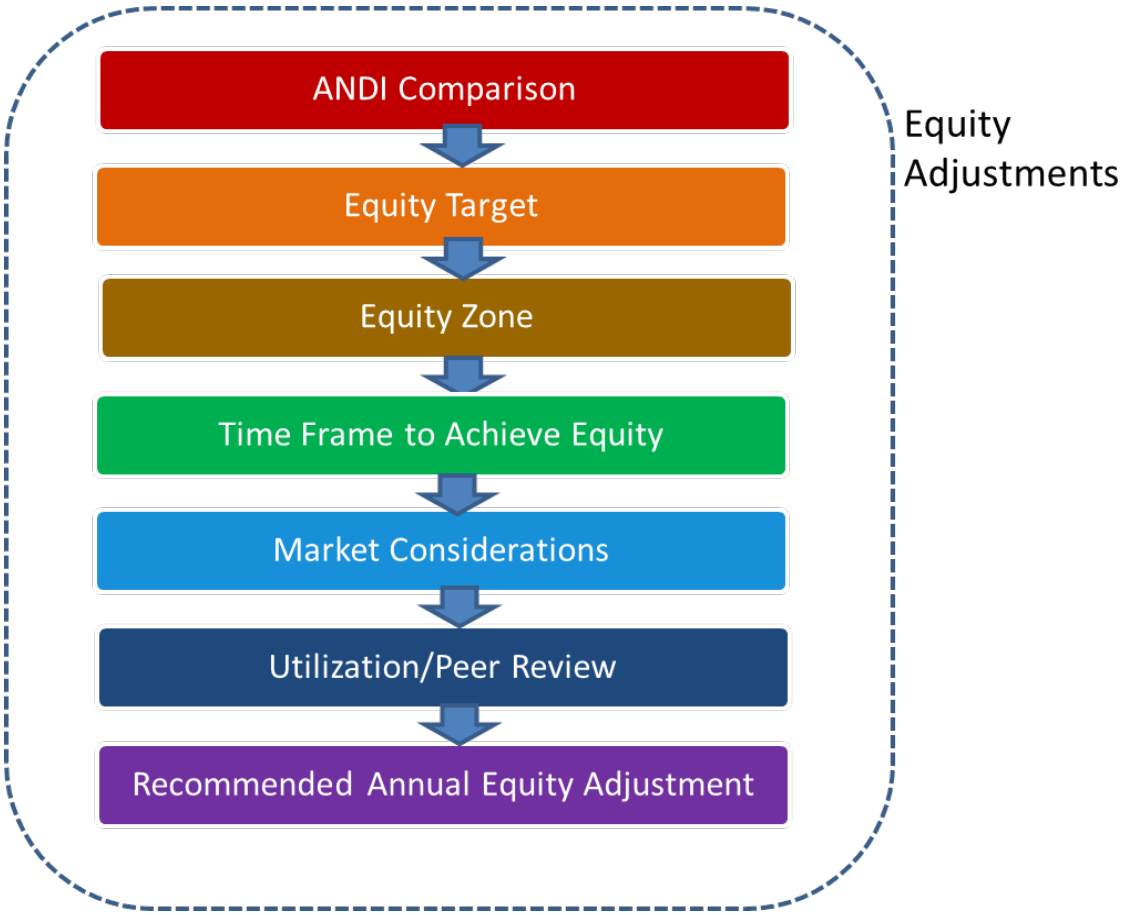


Note: Section names are removed as the AMA CC is in the process of collecting new data that will result in the recalculation of the ANDI distribution.

Once the ANDI comparison has been calculated, the model can be used for scaling allocation adjustments, including reallocation of fees among sections.

This includes considering:

- Establishment of an equity "target" to evaluate each section's adjusted net daily income. Various allocation adjustments/rules can be established, depending on whether or not a section is above, near or below this target.
- Establishment of an "equity band" to recognize that the model does not perfectly capture all, nor are data from any particular factor 100% accurate.
- A timeframe to achieve equity. The RF has indicated this should be achieved within five years.
- Market considerations that might impact the adjustments
- Factoring in section credit for initiatives such as SOMB savings, peer review and utilization improvements



IV. Equity Target

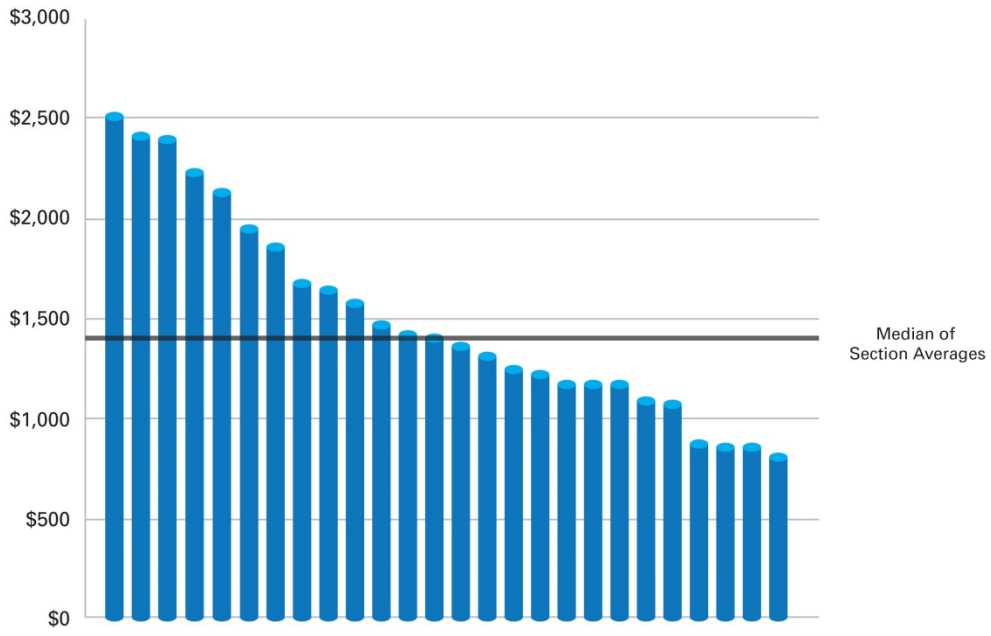
The "equity target" represents the standard against which sections' adjusted net daily incomes are compared. The AMA CC has considered that the equity target could be chosen arbitrarily, based upon a number of reference points that physicians think are important, e.g.:

- Scientific averages, mean/median/mode (of all physicians, specialists, etc.)
- 50th percentile
- 75th percentile
- Realistic (reachable) target
- Anticipating future revenues (government partnership)
- Political sensitivities

Initial draft versions of the ANDI model presented to the Board and RF used the specialty average (excluding GPs), as this was the target used in British Columbia and Ontario. The AMA CC has explored other options, and prefers a target that captures all sections and is less likely to change significantly throughout the five year equity plan.

The committee recommends the 'Median of Section Averages' (see graph below) which chooses the adjusted net daily income of the median section as the equity target. With the original draft data, this median was in fact very close in value to the specialty average.

ANDI Example: Target Shown as Median of Section Averages



Note: Section names are removed as the AMA CC is in the process of collecting new data that will result in the recalculation of the ANDI distribution.

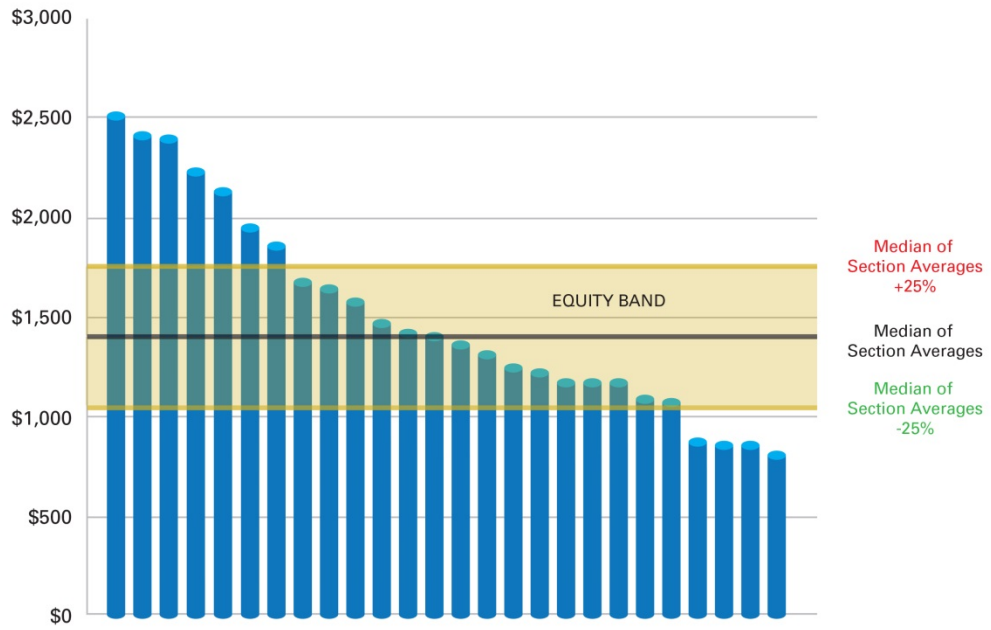
V. Equity Band

The AMA CC prefers to introduce upper and lower confidence thresholds to the equity target. These thresholds represent a level of confidence in the data and the model. The "Equity Band" accounts for the following:

- Did we measure our chosen factors accurately?
- Did we measure everything we could?

The figure below shows an example of what this equity band looks like:

ANDI Example – Equity Band Set at +/- 25%



Note: Section names are removed as the AMA CC is in the process of collecting new data that will result in the recalculation of the ANDI distribution.

According to the ANDI model, sections that arrive at or are within the equity band at any time are presumed to have reached an acceptable measurement of income equity and therefore, will not receive ANDI adjustments. Sections that fall outside the equity band at any time will receive ANDI adjustments via planned reallocations. It is foreseeable that sections will either be moved into or out of the equity band at any time, based upon new or updated information. Each year, a reallocation will be proposed, based upon the latest available data.

AMA CC has considered the following in relation to the equity band:

- A rough estimate in the confidence of data measurement.
- Variation in section payments, e.g., based on the standard variation or range.

- Amount of unexplained variation remaining after accounting for the ANDI factors.
- The setting of a realistic target that can be reached within five years.
- While it's not possible to know the level of confidence with full certainty, we expect our level of confidence will increase over time.

Given the limited data sets available at this time, the AMA CC is recommending that the band be initially set at +/- 25% of the equity target (see graph above). Based on the recommended parameters, physicians in the equity band would earn between 75% and 125% of the median of section averages. This allows a 167% (=1.25/0.75) difference in income earning capacity within the equity band.

While the AMA CC is hoping the equity band would remain relatively stable over the five year process, the committee recommends that a confidence level re-assessment should be reviewed each year prior to each reallocation, with recommendations made by AMA CC to the AMA Board of Directors.

VI. ANDI Reallocation and Allocation

It is quite conceivable that the reallocations resulting from the ANDI model will coincide with allocations resulting from negotiated revenues.

As allocations are likely to coincide with reallocations, a number of policy options could be employed to complement the AMA equity strategy. AMA CC recommends that new policy be developed by the AMA Board complimentary to the income equity strategy for anticipated allocation and reallocation cycles that can occur each year. This policy should be developed prior to the first reallocation and reconsidered at the time of each reallocation.

7. Market Considerations

It is important to carefully monitor any unintended consequences arising from the implementation of the equity strategy. This should include collecting and presenting data on the following:

1. Patient access – e.g., are waiting lists being impacted, or a patient's ability to access generalist and specialist care?
2. Physician supply – e.g., is Alberta maintaining its ability to attract physicians? Are there sections where physicians appear to be in oversupply?
3. Quality care – e.g., is there evidence that patient care being impacted through fee adjustments?
4. Income earned by the same specialty in other provinces – e.g., are Alberta physicians falling significantly behind their counterparts in other jurisdictions and does this represent a cause for concern?

The AMA CC recommends that the ANDI implementation be carefully monitored for unintended consequences impacting patient access, patient care, and physician supply. In addition, the AMA CC recommends that a risk assessment be made by AMA CC prior to any reallocation of the potential impact to patient access and provided to the AMA Board of Directors.

8. Income Equity Timelines and Milestones

The purpose of this project is to design, build and implement the ANDI model as the tool to compare income earning capacity among sections and then reallocate funding to correct for disparities among sections.

The AMA's IEI proposes to plan, build and implement the competencies, processes, methodologies and tools to achieve income equity within the five year time frame as directed by the RF.

I. Major deliverables and timelines

The IEI GANTT (Appendix 2) illustrates the project schedule for the major activities of the development of the ANDI and each of the expected completion dates within the overall timeline of the project. In keeping with the five year target to achieve income equity as defined, the AMA CC is recommending five annual reallocations.

The timing for the first reallocation will depend on a number of contingencies:

- Data collection – e.g., overhead review, hours of work study, section INRV – data requirements should be completed 6 months before any reallocation.
- Consultation with sections, including a process to resolve disputes if needed.
- Support for the initiative from Alberta Health – final approval for reallocations occurs at the Physician Compensation Committee. This approval process must occur 3 months prior to any reallocation.

The AMA CC is recommending a first reallocation commencing April 1, 2019. This timing provides opportunity for consultation with sections, data collection, due process and confirmation of stakeholder support.

Recognizing the importance of progress by April 1, 2019, the AMA CC will provide a proposed allocation / reallocation to the Board by August 15, 2018. This proposal will consider the degree to which the contingencies have been fully satisfied.

II. Critical path activities

Activities on the critical path are those project tasks that must start and finish on time to ensure that the IEI meets the expectations of the approved plan and delivers on time. Any delay of a critical path activity will most certainly impact the implementation schedule and subsequent timing of the allocation processes.

All aspects of the design, build and implementation of the ANDI are critical path activities, including its operational processes, as well as the supporting allocation process that will be redesigned to support the goal to achieve income equity.

The definition of income equity is important in that all the parties are clear about and in agreement with the policy direction and project goals.

III. Time Frame for Adjustment

The scale of annual adjustments is dependent on the overall time frame given to achieve ANDI equity in Alberta. The RF has indicated that equity be achieved within five years. The AMA CC recommends five annual adjustments, beginning April 1, 2019.

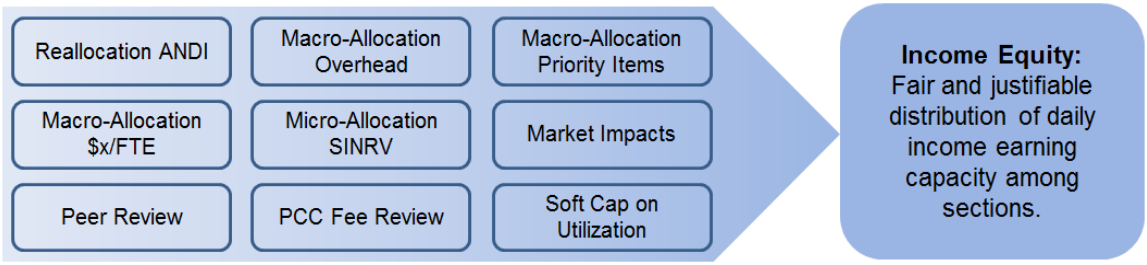
Exact timing of these adjustments will depend on regular allocation increases (such as the withheld 2017 COLA Allocation) and the timing of data collection. Any change to this timeframe will be presented to the Spring 2018 RF.

IV. On-going Reporting and Tracking

An on-going reporting mechanism should be developed in support of a progress report to membership. The AMA CC recommends this reporting take the form of the template attached in Appendix 4.

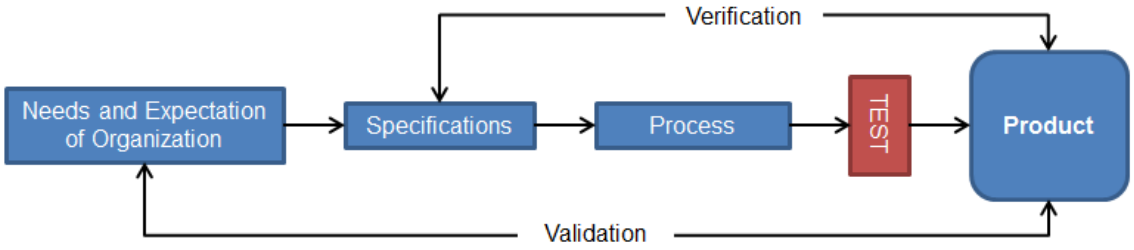
9. Linkages and Interdependencies

As illustrated in the diagram below, there are other initiatives and realities that affect physician income directly and indirectly. The AMA CC recommends that the income equity strategy consider all initiatives that impact physician income in relation to the annual reallocation adjustment. It is also recognized that the inclusion of the latest data in the ANDI formula will mitigate against unintended consequential impact (e.g. having the effect of doubling a reduction).



10. Validation, Verification and Testing of the ANDI Model

The AMA CC prefers multiple levels of assurance built into the design, development and implementation of the ANDI model to enhance and secure the confidence of the AMA's RF and Board, members, section representatives and stakeholders that ANDI will fulfill its intended purpose and meet the expected outcomes.



Terms commonly used for describing the procedures to provide assurance are:

1. Validation: "Are you building the right thing?"

   The process of checking whether the specifications of the system will meet the needs of the user.

2. Verification: "Are you building it right?"

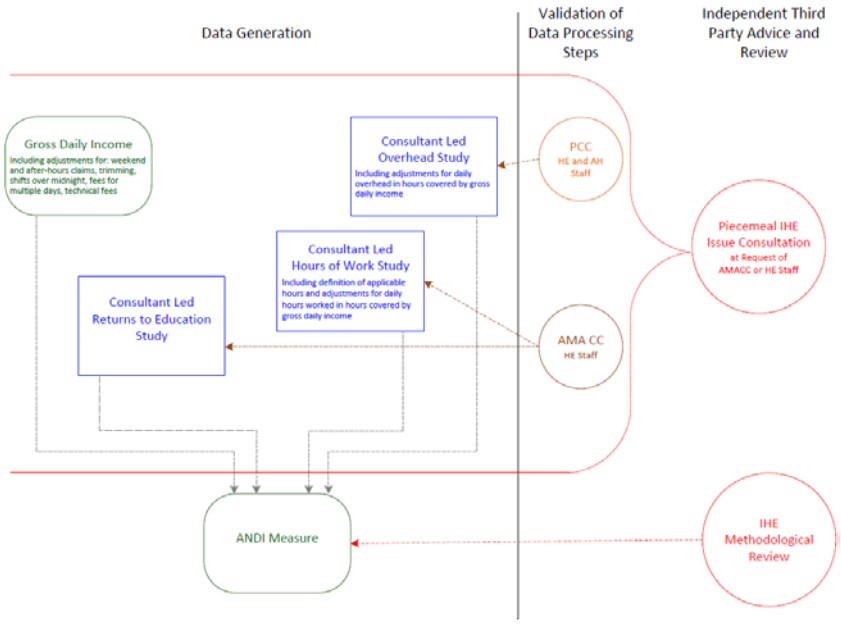
   Checks whether the system is in compliance with the design requirements, specifications, quality, accuracy and consistency of performance.

3. Testing: "Does it work correctly and accurately when it's supposed to?"

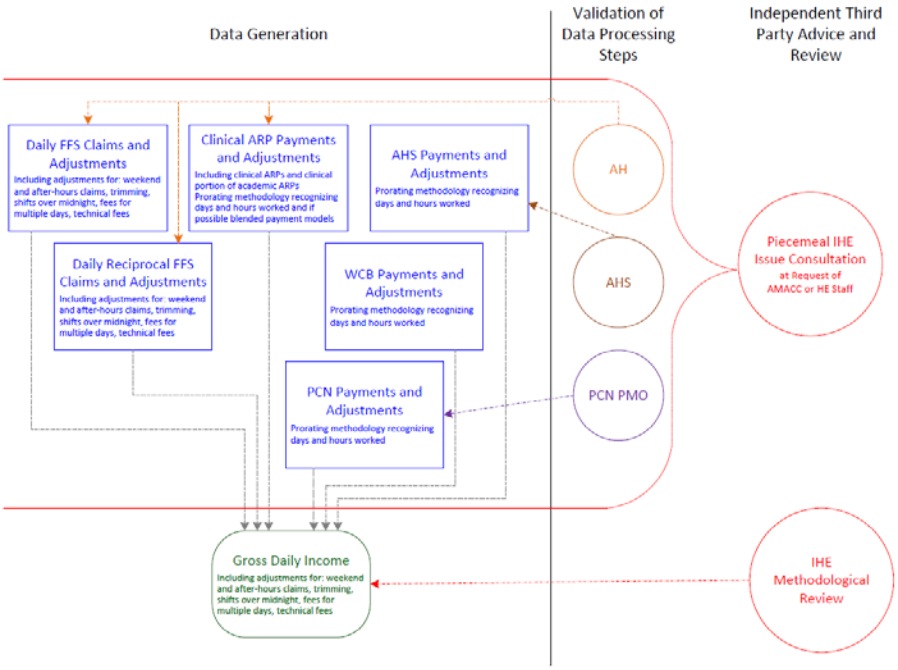
   Takes measures to check the quality, performance and reliability before it's implemented at key checkpoints.

The validation/verification process starts with section engagement and consultation through the AMA CC to capture and summarize the needs and expectations of the members for the outputs and utilization of the ANDI model. The complexity of the factors, data quality and potential revisions make the need to continually verify and test the model and its inputs a critical process in quality control.

Validation/Verification Process: Inputs Into and ANDI Measure



Validation/Verification Process: Inputs Into and Measure of Gross Daily Income Data



When the data is generated and prior to its input into the ANDI model, the data and the processing steps will be tested by the party generating the data (Alberta Health or Alberta Health Services) and AMA's HE staff. Should unexpected or unexplained issues arise from the data or the input process, these will be identified and analyzed to determine the next steps. In some cases, the issue may be followed up with a specific section, the party generating the data or the party collecting the data, it may be discussed at AMA CC or it may require third party consultation.

An additional validation process proposed would be to model "idealized hourly billing" potential of each section to test the validity of the ANDI model data and test the reliability of the data inputs.

Third party consultation refers to independent advisors that would provide analysis, advice, research and other consultative services on specific topics of expertise in health economics and policy, physician compensation, financial/mathematical analysis, systems modelling and health system reform. These advisors would be utilized in three ways; one would be at the request of HE staff/AMA CC to assist in a specific issue arising in the design, implementation or operations of the ANDI model and the second would be to provide verification of data compliance at specific stages in the design and implementation of the model.

Another consultation option would be to contract an independent advisor to complete a two part methodological review and assessment of the ANDI model to validate the design and outputs. In this process, the independent advisor would review the ANDI model in its preliminary design stage to provide insights and direction on its development, as well as recommendations /considerations arising from the expert review.

A second review would be conducted prior to implementation and operationalization of the ANDI. This review would provide an independent check that the model is meeting the AMA's stated objectives and specifications, is consistent and reliable in its outputs and provide recommendations for improvement before going live with the model.

Discussions for the third party independent advisors have been initiated with the Institute of Health Economics and the O'Brien Institute of the University of Calgary. Each of the organizations have the expertise and experience to provide the validation and verification services required by the income equity initiative. Even though the discussions with these groups are at early stages, it is anticipated that these third party independent advisors will be useful for the implementation of the model, assuming the RF approves the plan.

11. Legal Compliance Review

The income equity initiative is complex and complicated and its potential outcomes may be controversial and challenged by physician groups and/or stakeholders. The AMA has sought legal opinion to ensure that the AMA is in compliance with its constitutional, legislative and contractual obligations and that decisions arising from the income equity initiative are within the AMA's rights. The main purposes of the legal opinions are to:

- Inform the AMA of the legal effect of the possible implementation of the ANDI model;

- Confirm that the AMA is operating within its constitution, legislative and contractual obligations
- Identify the legal risks;
- Characterize compliance in the procedures of ANDI design and implementation;
- Identify the options available to the AMA, and
- Provide legal advice, when requested.

Any legal opinions and advice will be submitted to the AMA's Board of Directors for their review and determination of action.

12. Dispute Resolution Process

If the RF approves the IEI Implementation Plan, the dispute resolution process will be established, including the organization and implementation of a disputes resolution committee. Terms of Reference for the IEI Disputes Committee (IEI DC) are included as Appendix 3.

It is expected that the dispute resolution process and the IEI DC will be established and operational once the ANDI model has been tested and fully functional by the target date of July 2018.

Should a member, section or other AMA group feel that a decision, recommendation or act undertaken related to the IEI is unsatisfactory or unacceptable; the AMA CC recommends the following process for resolution:

AMA Process for Dispute Resolution	
Step 1	**Dissatisfied party reviews with AMA CC** The dissatisfied party will identify the situation that is of concern and discuss with Health Economics staff responsible for the IEI in preparation for a discussion with the AMA CC. Upon receipt of the complaint, the AMA CC will meet with representatives of the section with the intent of resolving the issue. Documentation outlining the situation, the issues and rationale and highlights of the discussion will be prepared and provided to both parties in advance of the meeting for clarity and understanding of the specific situation. If the situation/complaint cannot be resolved at this level, the parties will agree to elevate the dispute to Step 2.

Step 2	**Dissatisfied party and AMA CC representative(s) discuss with IEI Dispute Committee** Background documentation will be provided to the IEI DC and the parties to the dispute. In the event that the IEI DC determines that the complaint is of a similar nature to one that has already been formally dealt with in the dispute resolution process, the IEI DC will advise the complainant of the similarities and provide a written description of the previous resolution to the complainant. For disputes that are not similar in nature to another previously resolved, the dissatisfied party and representatives from the AMA CC will meet with the IEI DC within 30 days from the date of the meeting in Step 1, unless the parties mutually agree to another date. The IEI DC may invite opinions from subject matter experts or other parties relevant to the review. Background of the situation, the issues and rationale and highlights of the discussion and results of the discussion will be documented. The decision of the IEI DC will be provided to both parties within 30 days of the hearing. Should there be extenuating circumstances that delay the response within the 30 days, the IEI DC shall advise both parties and provide an alternative date for the decision. Documented results of the dispute resolution process at Step 2 will be provided to the AMA's Board of Directors within the reporting process. Should there be no resolution at Step 2, the dispute will be forwarded to the AMA Board of Directors with details of the dispute, actions to attempt resolution and recommendations from the IEI DC.
Step 3	**Recommendations arising from the dispute process provided to the AMA's Board of Directors** The Board of Directors will review the background and recommendations and provide direction for resolution. In its regular reporting to the AMA's RF, the Board will provide a summary of the internal disputes considered in the process and the resultant outcomes.

13. Income Equity Initiative Incremental Resources and Budget

It is anticipated that if the IEI plan is approved by the RF at its September 2017 meeting, much of the data collection, and further development and validation of the ANDI model will occur in the following year, as will the bulk of the costs associated with the initiative. The AMA's HE branch will manage the initiative, and either provide or contract the resources required.

One time project costs have been estimated at $1.3 million. The budget below outlines the activities and associated costs. Included in this estimate is the AMA's contribution to the PCC overhead study, the results of which will be used in the ANDI model.

AMA Income Equity Initiative Incremental Budget 2016/17 and 2017/18 Fiscal Periods	
Activity	**Budget Allocation**
PCC Overhead Study	$ 600,000
Physician engagement/consultation	250,000
Project contracted resources • Economists • Health Policy Analysts • Contractors: project/workload management	275,000
Review/Validation: External/Independent • Academics: health policy/economics • Legal	100,000
AMA CC and Physician Liaison	80,000
Total Estimated Budget	**$ 1,305,000**

14. AMA Member Ratification

Fully implementing the income equity initiative and its implementation plan within the proposed five year timeline will require a ratification vote of the membership. Timing of the ratification vote may be sometime after the Fall 2017 RF but before the proposed reallocation in 2019.

AMA CC is recommending that the timing and content of the ratification be at the discretion of the AMA Board of Directors.

15. Recommendations Summarized

In summary, the AMA CC is recommending that the Representative Forum approve the IEI Implementation Plan with its essential components of:

- That the definition of income equity, as outlined in Section 5 be adopted.
- That the ANDI formula as presented in Section 6 be adopted, including:
  - Clinical ARP and the clinical portion of academic ARP compensation included in the ANDI model.
  - AHS compensation where available included in the ANDI model.
  - That the process of trimming occurs within the model and the details and results of the studies brought to the Spring 2018 RF.

  - PCN physician compensation related to insured clinical services.
  - PCC's overhead study.
  - Daily Working Hours study.
    - With the understanding that the results of the hours of work study and information on after-hours work be incorporated into the ANDI model, with specifics presented to the Spring 2018 RF.
  - Post-graduate training, including residency and fellowship.
- That the median of section averages be used as a target for the ANDI model.
- That the concept of an equity band be adopted and initially set at +/- 25% and this band is reviewed each year prior to reallocation.
- That a risk assessment of the impact on patient access be made prior to any reallocation.
- That new policy be considered by the AMA Board anticipating that ANDI reallocation coincides with allocation.
- That five annual adjustments (reallocations) be implemented, commencing April 1, 2019.
- That an ongoing reporting and tracking mechanism be developed and provided to membership as a progress report.
- That the income equity strategy considers all initiatives that have the potential to impact physician income prior to reallocation.
- That the recommended process for dispute resolution be adopted.
- That the process for validation and verification be adopted, AND
- That ANDI implementation carefully monitors for unintended consequences.

16. Unresolved Items and Unanswered Questions:

At the time of this plan documentation, there are several areas where issues related to the income equity initiative have been unresolved or unanswered. The AMA CC has identified and flagged these items as ongoing discussion topics to ensure that these can either be fully addressed or the model be redesigned to allow for any potential adverse effects to be mitigated. Examples of outstanding issues at the time of this writing include:

- How to manage annual swings in utilization by section.
- How to manage changes that are expected to uniquely impact sections in future years, including, e.g.:
  - Peer review.

  - SOMB rule changes review.
  - Loss of retention benefit.
- How to manage changes to the timelines that may occur, e.g.:
  - Data challenges.
  - Lack of agreement with our partners.
- How to measure and manage unintended consequences.
- What limits, if any, will be placed on reallocations to/from any section.
- How the allocation for new negotiated revenues will be incorporated.
- How frequently the equity target and bands will be evaluated.
- Determination of the process for reviewing and making decisions on the proposed reallocations.
- Whether the ANDI model will be considered in negotiations with Alberta Health.
- What structures and processes to include health partners/stakeholders will be required to ensure an effective partnership and successful implementation of the ANDI model.

17. Appendices

Appendix 1

RESOLUTIONS ARISING FROM THE SPRING 2017 REPRESENTATIVE FORUM (RF) WITH BOARD DIRECTION: MARCH 23-24, 2017

Peer Review

RF17S-17

Moved by Dr. Robert G. Davies, seconded by Dr. Glen Sumner

> THAT the AMA reaffirm the original intention of the Billing Peer Review as a physician-led non-punitive process as per the Amending Agreement. Alberta Health involvement should only occur when AMA processes have failed to remedy an identified and internally confirmed recalcitrant problem, rather than having routine Alberta Health involvement in the discussion of this committee.

CARRIED

Equity

RF17S-18

Moved by Dr. Darryl D. LaBuick, seconded by Dr. Robert E. Korbyl

> THAT an implementation plan to achieve intersectional income equity be presented for approval to the Fall 2017 Representative Forum.

CARRIED

RF17S-19

Moved by Dr. Scott F. Beach, seconded by Dr. Raj S. Padwal

> THAT intersectional income equity, as will be defined by the implementation plan, be achieved within five years or less.

CARRIED

RF17S-20

Moved by Dr. Tobias N. Gelber, seconded by Dr. Roger C. Rampling

> THAT reallocation be a mechanism to achieve intersectional income equity.

CARRIED

RF17S-21

Moved by Dr. Glen Sumner, seconded by Dr. Robert G. Davies

> THAT the AMA consider, as a long-term priority, the development of value-based physician reimbursement models.

CARRIED

RF17S-22

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Laurie M. Parsons

> THAT AMA, in order to secure funding for income equity initiatives, focus on clinical value of services rather than applying across-the-board fee cuts.

CARRIED

Income Adjustment Models/ANDI

RF17S-23

Moved by Dr. Allan L. Bailey, seconded by Dr. Sean M. Gregg

> THAT to aid in allocation decisions, the AMA adopt the concept of an adjusted net daily income model as an additional tool.

CARRIED

RF17S-24

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Magnus Murphy

> THAT AMA affirms its commitment to a transparent and inclusive process of determining the data and underlying mechanisms of any income redistribution models.

CARRIED UNANIMOUSLY

RF17S-25

Moved by Dr. Wendy L. Tink, seconded by Dr. Shelley L. Duggan

> THAT AMA update its definition of complexity to include evidence of complexity of ambulatory care across disciplines, for presentation at a future Representative Forum.

CARRIED

Fee Adjustments

RF17S-26

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Magnus Murphy

> THAT AMA recognize the danger to its members from unintended consequences of performing multiple and uncoordinated fee and cost adjustments concurrently.

CARRIED

SOMB Fee Components

RF17S-27

Moved by Dr. Glen Sumner, seconded by Dr. Jonathan B. Choy

> THAT the AMA actively work with Alberta Health to separate technical or overhead compensation and professional fees in the Schedule of Medical Benefits.

CARRIED

RESOLUTIONS ARISING FROM THE SPECIAL REPRESENTATIVE FORUM (RF) JUNE 10, 2017

RFSp17-01

Moved by Dr. Michal S. Kalisiak, seconded by Dr. John S. Bradley

> THAT AMA seek a reassurance from the government that any funds re-appropriated for the purpose of income equity initiatives will not be claimed back by the government instead of being used for income equity.

CARRIED

RFSp17-02

Moved by Dr. Jennifer J. Williams, seconded by Dr. John S. Bradley

> THAT in the spirit of Patients First®, the AMA provide data on the anticipated impact that profession changing decisions such as relativity, reallocation and equity (ANDI), and remuneration will have on the quality of patient care, patient access, and wait times in conjunction with the implementation of ANDI.

CARRIED

RFSp17-03

Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang

> THAT while moving forward within the AMA with income equity based on the ANDI model or variant, the average hours of qualifying work per day and the income from it in each section be assessed with a methodology developed in conjunction with sections and results validated by sections.

CARRIED

RFSp17-04

Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang

> THAT before implementing equity based on the ANDI model or variant, section overhead estimates must be redeveloped in conjunction with sections and results validated by sections.

CARRIED

RFSp17-05

Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang

> THAT the AMA share all data, calculations, and assumptions related to the ANDI approach with a third party consulting firm agreed to by the board, for that firm's ongoing review and opinion on the appropriateness of ANDI considerations, including an opportunity for sections to contribute material directly to that firm for consideration.

REFERRED TO THE BOARD

RFSp17-06

Moved by Dr. Robert G. Davies, seconded by Dr. John T. Huang

> THAT in conjunction with implementing income equity based on the ANDI model or variant, the years of recognized FRCS/FRCP and CCFP fellowship training be counted in addition to residency training.

CARRIED

RFSp17-07

Moved by Dr. Jennifer J. Williams, seconded by Dr. Michal S. Kalisiak

> THAT if ANDI or similar model is finalized as a model to be employed to achieve equity and/or reallocation, it must be ratified by the general membership prior to implementation.

CARRIED

RFSp17-08

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Graham M. D. Campbell

> THAT any income equity adjustment based on ANDI model or variant, factor in physician supply and patient access.

CARRIED

RFSp17-09

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Arun K. Abbi

> THAT any income equity adjustments based on the ANDI model or variant be iterative.

CARRIED

RFSp17-10

Moved by Dr. Graham M.D. Campbell, seconded by Dr. Arun K. Abbi

> THAT work hours and overhead calculations should exclude time spent doing private billing or third party payer work (e.g., patient pay procedures, workers compensation, insurance forms whereby a third party or patient pays).

REFERRED TO THE BOARD

RFSp17-11

Moved by Dr. Timothy G. Prieur, seconded by Dr. John S. Bradley

> THAT ANDI calculations include alternate relationship plan physicians and salaried physicians.

CARRIED

RFSp17-12

Moved by Dr. Duncan J. McCubbin, seconded by Dr. Arun K. Abbi

> THAT ANDI calculations include modifiers that take into consideration differences in expected career longevity.

CARRIED

RFSp17-13

Moved by Dr. Duncan J. McCubbin, seconded by Dr. Laurie M. Parsons

> THAT the AMA and Alberta Health take all after hours work, inclusive of all primary fee codes and modifiers, out of any ANDI calculations.

REFERRED TO THE BOARD

RFSp17-14

Moved by Dr. Luc R. Berthiaume, seconded by Dr. Howard Evans

> THAT the AMA provide all its members the details of an equity implementation plan prior to Fall Representative Forum 2017 for appropriate review and feedback.

CARRIED

RFSp17-15

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Jennifer J. Williams

> THAT AMA educate the Representative Forum and membership about the specific mechanisms of re-allocation and results of CANDI and MANDI implementation in Ontario and British Columbia, respectively, to learn from challenges faced and to generate evidence-based ideas prior to implementation in Alberta.

CARRIED

RFSp17-16

Moved by Dr. Robert E. Korbyl, seconded by Dr. Arun K. Abbi

> THAT the AMA request physicians to submit personal and professional corporation tax returns for the last three years to an independent third party accounting firm in an effort to obtain reliable and transparent data on physician income and overhead costs to help with the AMA Compensation Committee and future allocations.

REFERRED TO THE BOARD

RFSp17-17

Moved by Dr. Michal S. Kalisiak, seconded by Dr. Mariusz Sapijaszko

> THAT the results of the Schedule of Medical Benefits and Physician Compensation Committee initiatives as well as those of Peer Review Process be calculated and accounted for prior to the first iteration of ANDI or the chosen fee equity approach.

CARRIED

RFSp17-18

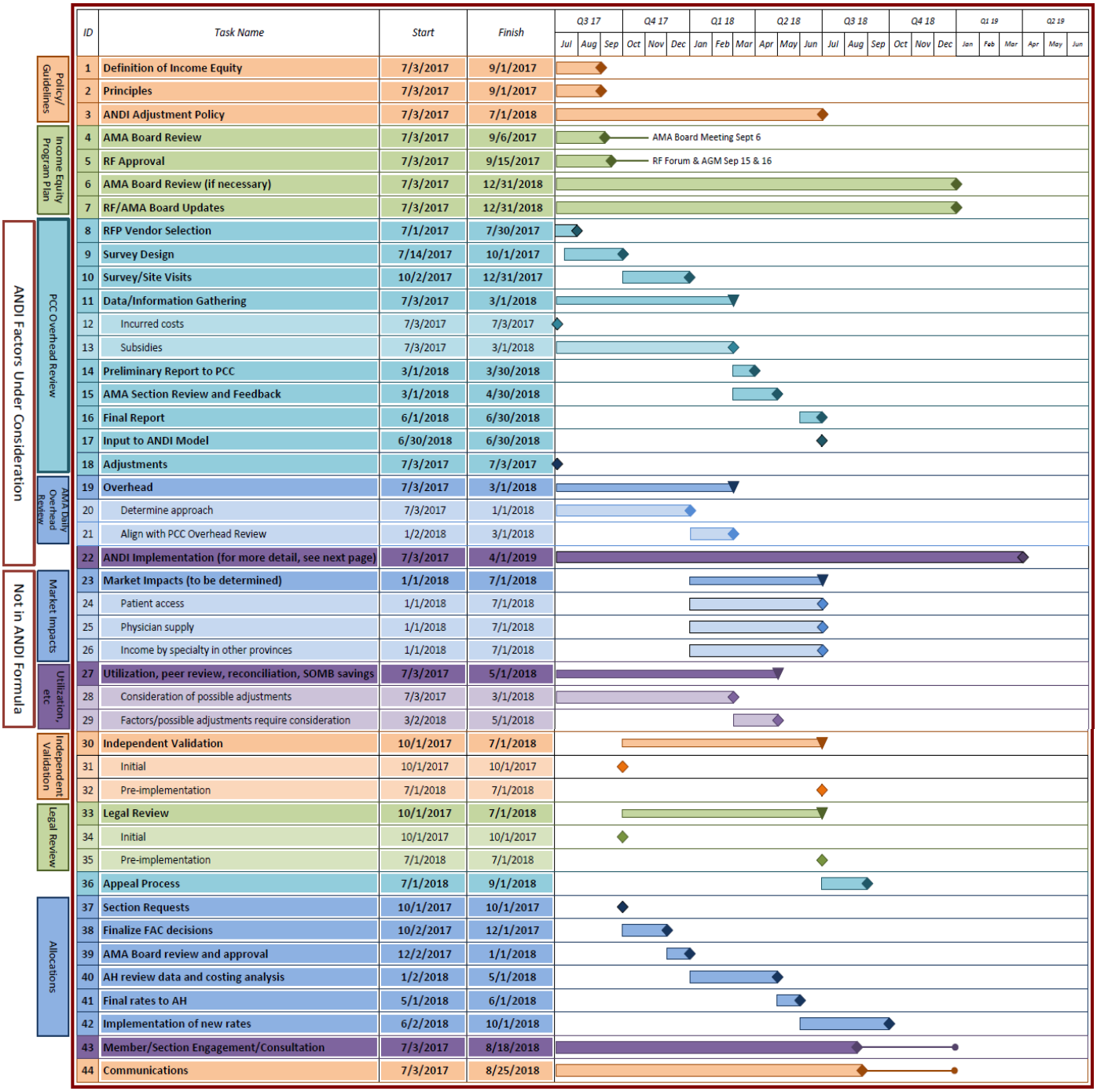
Moved by Dr. Michal S. Kalisiak, seconded by Dr. Jennifer J. Williams

> THAT the AMA dedicate time at an upcoming Representative Forum to focus on stewardship, system efficiency and system savings other than via decreases to the physician services budget.

CARRIED

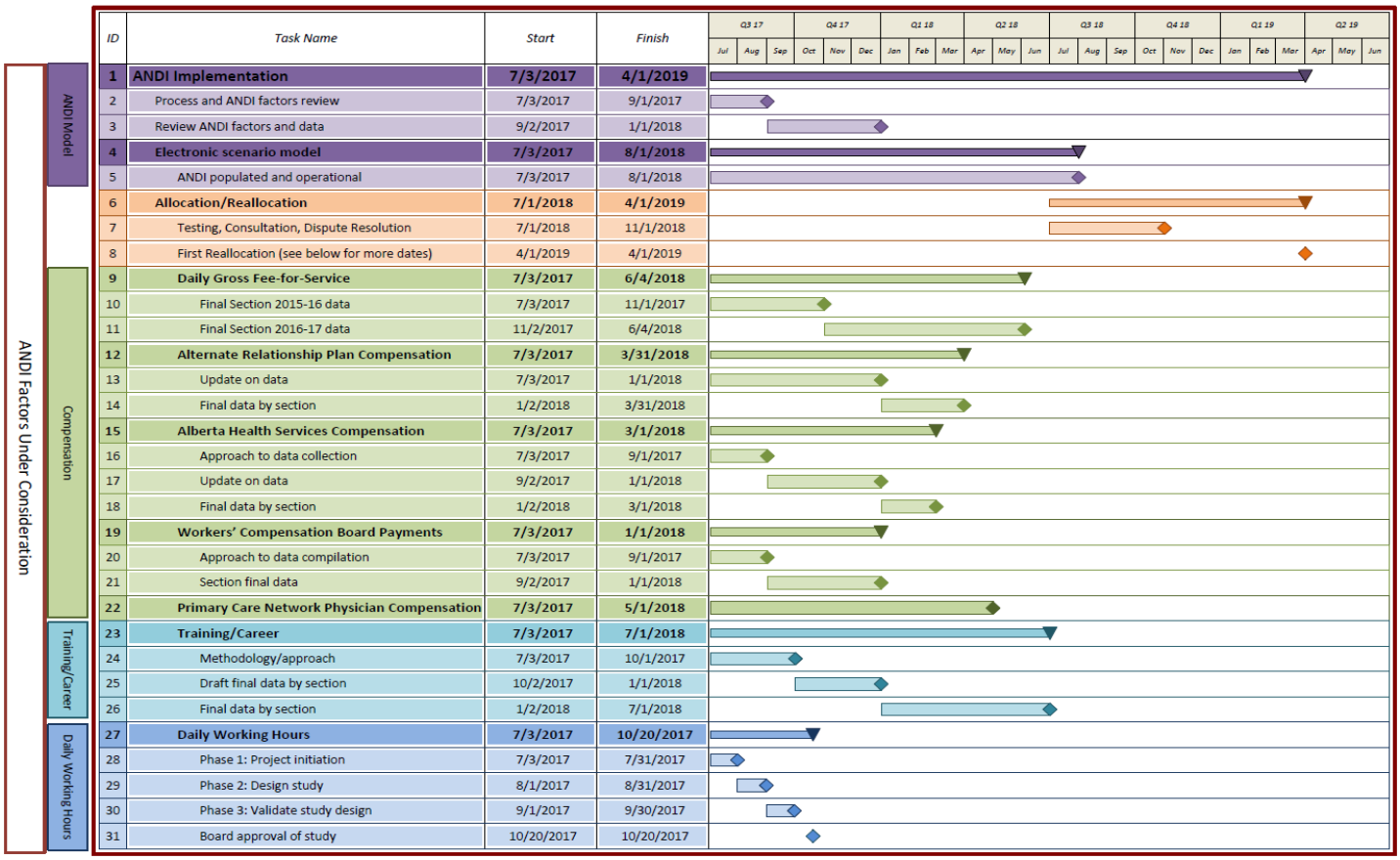
Appendix 2

AMA Income Equity Initiative



ID	Task Name	Start	Finish
1	Definition of Income Equity	7/3/2017	9/1/2017
2	Principles	7/3/2017	9/1/2017
3	ANDI Adjustment Policy	7/3/2017	7/1/2018
4	AMA Board Review	7/3/2017	9/6/2017
5	RF Approval	7/3/2017	9/15/2017
6	AMA Board Review (if necessary)	7/3/2017	12/31/2018
7	RF/AMA Board Updates	7/3/2017	12/31/2018
8	RFP Vendor Selection	7/1/2017	7/30/2017
9	Survey Design	7/14/2017	10/1/2017
10	Survey/Site Visits	10/2/2017	12/31/2017
11	Data/Information Gathering	7/3/2017	3/1/2018
12	Incurred costs	7/3/2017	7/3/2017
13	Subsidies	7/3/2017	3/1/2018
14	Preliminary Report to PCC	3/1/2018	3/30/2018
15	AMA Section Review and Feedback	3/1/2018	4/30/2018
16	Final Report	6/1/2018	6/30/2018
17	Input to ANDI Model	6/30/2018	6/30/2018
18	Adjustments	7/3/2017	7/3/2017
19	Overhead	7/3/2017	3/1/2018
20	Determine approach	7/3/2017	1/1/2018
21	Align with PCC Overhead Review	1/2/2018	3/1/2018
22	ANDI Implementation (for more detail, see next page)	7/3/2017	4/1/2019
23	Market Impacts (to be determined)	1/1/2018	7/1/2018
24	Patient access	1/1/2018	7/1/2018
25	Physician supply	1/1/2018	7/1/2018
26	Income by specialty in other provinces	1/1/2018	7/1/2018
27	Utilization, peer review, reconciliation, SOMB savings	7/3/2017	5/1/2018
28	Consideration of possible adjustments	7/3/2017	3/1/2018
29	Factors/possible adjustments require consideration	3/2/2018	5/1/2018
30	Independent Validation	10/1/2017	7/1/2018
31	Initial	10/1/2017	10/1/2017
32	Pre-implementation	7/1/2018	7/1/2018
33	Legal Review	10/1/2017	7/1/2018
34	Initial	10/1/2017	10/1/2017
35	Pre-implementation	7/1/2018	7/1/2018
36	Appeal Process	7/1/2018	9/1/2018
37	Section Requests	10/1/2017	10/1/2017
38	Finalize FAC decisions	10/2/2017	12/1/2017
39	AMA Board review and approval	12/2/2017	1/1/2018
40	AH review data and costing analysis	1/2/2018	5/1/2018
41	Final rates to AH	5/1/2018	6/1/2018
42	Implementation of new rates	6/2/2018	10/1/2018
43	Member/Section Engagement/Consultation	7/3/2017	8/18/2018
44	Communications	7/3/2017	8/25/2018

AMA Income Equity Initiative
ANDI Factors - Detailed



ID	Task Name	Start	Finish
1	**ANDI Implementation**	**7/3/2017**	**4/1/2019**
2	Process and ANDI factors review	7/3/2017	9/1/2017
3	Review ANDI factors and data	9/2/2017	1/1/2018
4	**Electronic scenario model**	**7/3/2017**	**8/1/2018**
5	ANDI populated and operational	7/3/2017	8/1/2018
6	**Allocation/Reallocation**	**7/1/2018**	**4/1/2019**
7	Testing, Consultation, Dispute Resolution	7/1/2018	11/1/2018
8	First Reallocation (see below for more dates)	4/1/2019	4/1/2019
9	**Daily Gross Fee-for-Service**	**7/3/2017**	**6/4/2018**
10	Final Section 2015-16 data	7/3/2017	11/1/2017
11	Final Section 2016-17 data	11/2/2017	6/4/2018
12	**Alternate Relationship Plan Compensation**	**7/3/2017**	**3/31/2018**
13	Update on data	7/3/2017	1/1/2018
14	Final data by section	1/2/2018	3/31/2018
15	**Alberta Health Services Compensation**	**7/3/2017**	**3/1/2018**
16	Approach to data collection	7/3/2017	9/1/2017
17	Update on data	9/2/2017	1/1/2018
18	Final data by section	1/2/2018	3/1/2018
19	**Workers' Compensation Board Payments**	**7/3/2017**	**1/1/2018**
20	Approach to data compilation	7/3/2017	9/1/2017
21	Section final data	9/2/2017	1/1/2018
22	**Primary Care Network Physician Compensation**	**7/3/2017**	**5/1/2018**
23	**Training/Career**	**7/3/2017**	**7/1/2018**
24	Methodology/approach	7/3/2017	10/1/2017
25	Draft final data by section	10/2/2017	1/1/2018
26	Final data by section	1/2/2018	7/1/2018
27	**Daily Working Hours**	**7/3/2017**	**10/20/2017**
28	Phase 1: Project initiation	7/3/2017	7/31/2017
29	Phase 2: Design study	8/1/2017	8/31/2017
30	Phase 3: Validate study design	9/1/2017	9/30/2017
31	Board approval of study	10/20/2017	10/20/2017

Further Reallocation Dates:

Second Reallocation:	April 2020
Third Reallocation:	April 2021
Fourth Reallocation:	April 2022
Fifth Reallocation:	April 2023

Appendix 3

Income Equity Initiative
Income Equity Initiative Disputes Committee
Terms of Reference
DRAFT FOR AMA BOARD APPROVAL
(implementation post RF September 2017)

Background/Purpose:

The Income Equity Initiative Disputes Committee (IEI DC) is formed by and accountable to the AMA Board of Directors within the project framework of the AMA's Income Equity Initiative. The Income Equity Initiative is an AMA strategy to achieve intersectional equity by 2023. The Adjusted Net Daily Income (ANDI) model is being developed within the project to provide a method to compare daily income earning capacity among sections, and then allocate funding to correct any disparities among sections.

The IEI DC will convene on an as required basis to review, investigate and wherever possible, resolve disputes forwarded to the committee by the AMA's Compensation Committee (AMA CC). The AMA CC is the first step in the dispute resolution process for the implementation of the AMA's income equity initiative. It is expected that the AMA CC will respond to those complaints or enquiries from sections that require additional information, a more complete explanation of a topic/issue or a gap occurring in a communications, process or activity within 30 days of receipt of a written complaint.

Where a dispute arises between a section(s) and the AMA CC regarding a recommendation, decision or proposed activity concerning the implementation of the income equity initiative that is not resolved at the AMA CC, the dispute will then be forwarded to the IEI DC.

Membership:

The chair will be appointed by the AMA Board of Directors (Board).

Six section representatives shall be appointed by the Board through a process established by the Board.

Administrative support for the oversight group will be provided by AMA Health Economics.

Accountability and Reporting:

The IEI DC will be accountable to the AMA Board of Directors.

Written reports shall be provided to the Board with a summary of each dispute reviewed, its outcome and any recommendations to the Board.

Term:

The term of the IEI Disputes Committee is project limited to the final allocation of the AMA's Income Equity Initiative or by dissolution of the committee at the notice of the Board.

Responsibilities:

1. To review and further investigate any disputes forwarded by the AMA CC or possibly, the Board concerning the AMA's Income Equity Initiative.
2. Make recommendations to the Board regarding the committee's findings on the referred dispute.
3. Provide advice, background information and recommendations to the board for improvement in the IEI implementation that have been identified during the review process.
4. Provide reports summarizing the IEI DC's activities, outcomes and recommendations.
5. To consider issues of importance referred to it by the AMA CC or Board.

Confidentiality:

Confidentiality is the safe guarding of private information of the AMA and its stakeholders. Members will refrain from disclosing information that is identified as confidential outside the Dispute Resolution Committee meetings.

Conflict of Interest Disclosure:

Members must declare conflicts of interest prior to the discussion at any time a conflict of interest or potential conflict of interest arises.

A conflict of interest refers to situations in which personal, occupational or financial considerations may affect or appear to affect the objectivity or fairness of decisions related to the committee activities. A conflict of interest may be real, potential or perceived in nature. Individuals must declare potential conflicts to the chair of the committee and must either absent themselves from the discussion and voting, or put the decision to the committee on whether they should absent themselves.

Meeting Schedule:

Meetings will be at the call of the Chair.

Appendix 4

DRAFT
AMA Income Equity Status Report
For the period ending: _____

AMA: *Health Economics*
Project Name: *AMA Income Equity Strategy*
Project Responsibility: *Jim Huston, AED, Health Economics*
Project Implementation Oversight: *AMA Compensation Committee*
Project Executive Oversight: *AMA Board of Directors*

1. Project Description (Overview)

2. Key Indicators

OVERALL PROJECT STATUS												
KEY INDICATORS (by reporting period)	**Scope**			**Schedule**			**ANDI Model Development**			**Outcomes**		
	Last/Current/Next			**Last/Current/Next**			**Last/Current/Next**			**Last/Current/Next**		

Reason for Yellow or Red Indicator:

Planned Action:

Impact to Business:

3. Project Status Summary

4. Major Accomplishments during the Reporting Period

1.
2.
3.

5. Planned Objectives for Next Reporting Period

1.
2.
3.

6. Milestones/Deliverables (DATE)

Milestones/Deliverables	Original Due Date	Actual / Forecast Date	Variance Explanation

7. Issues/Risks

I = Issue R = Risk	Description	Ref.	Owner	Due Date	Actual/ Forecast Date	Status	Flag?

8. ANDI Model (key performance indicators under development)

9. Engagement Strategy Status

Activity	Planned	Implemented	Status

10. Communication Strategy Status

Activity	Planned	Implemented	Status