

AMA's Assessment of:

Government Proposed Initiatives on Physician Compensation

Communication to Section Presidents and Fees Representatives

This material has been prepared by AMA staff to inform Section Presidents and Fees Representatives of Alberta Health's consultation process and proposed changes. After reviewing this material, please provide your feedback to feedback@albertadoctors.org

This feedback will be summarized and presented to the AMA CC and the RF, to inform a broader response to government.

DECEMBER 6, 2019
ALBERTA MEDICAL ASSOCIATION
Version 2.2

1. Background

On November 14, 2019, AH provided a set of slides (attachment 1) to the AMA negotiating team called 'Insured Services Consultation'. The presenters from AH identified that they were interested in having a separate and distinct process from negotiations that would allow them to fulfill a need to consult with the AMA on a number of initiatives which they intend on implementing over the coming months.

The stated purpose for the discussion at the negotiating table was for AH to:

- Provide an overview of the consultation process including various options to consult with the AMA on a number of initiatives (which were also proposed); and
- Provide an overview of the proposed initiatives

In addition, AH provided a timeline for the consultation process to occur, ending Dec 20, 2019. In any consultation process, the AMA will share details with members as necessary in order to effectively consult.

On November 19, 2019, the AMA provided an initial response to government indicating, amongst other things:

- The AMA has stated that the several of the proposed items will have to be dealt with at negotiations. This consultation is not a replacement for negotiations;
- That AMA is seeking further detail on the proposed initiatives;
- A concern for government use of the term de-insuring vs de-listing;
- An indication that AMA would prefer to share the material with membership, physician leaders including a special RF and other health care providers; and
- A suggestion that the timeline for consideration of such a complicated set of material may require more time.

2. Objective

The Objective of this paper is to provide the following to AMA Section Presidents:

- A concern for broader implications.
- An initial item-by-item assessment of the government proposals.
- A high-level physician engagement plan, including the timelines, and process, leading up to a formal response to government on its proposed consultation process.

3. A Concern for the Broader Implications

The 'Insured Services Consultation' proposals were provided to the negotiating committee on November 14, 2019 with additional details provided on November 25, 2019 (AMA staff have done their best to include the details in this material). The proposals must be considered within the context of an environment that has been raising concerns amongst physicians. This environment includes but is not limited to:

- Physicians have had 5 years of 0 rate increases since 2011.
- Physicians are good stewards of the health system and this stewardship has resulted in savings that have significantly bent the cost curve.
- Mackinnon Report.
- Bill 21.
- 2020 budget for physicians that does not consider additional costs associated with routine population growth, population ageing or inflation.
- Most of the proposals will reduce compensation rates for physicians and therefore, must be negotiated with the profession.
- Some of the proposals are to de-insure certain services and we believe the patient and the public must be involved with these discussions.
- Some of the proposals are written in a way that suggests government policy should over-ride common sense – including due process.

4. An Initial Item-by-Item Assessment

Over the next few weeks, the AMA intends on engaging the profession towards providing government a response on a number of 'Insured Services Consultation' initiatives. AMA staff have provided an initial assessment of the proposed initiatives as follows:

I. 'Proposal 1' - Adjust the Complex Modifiers

Increase the base unit of time spent on managing the patients care for visits with time released modifiers and de-list CMXV15, CMXV20, and CMXC30. The rate for the base unit will not change.

AMA's interpretation of the proposal

- Although positioned as a policy change, this is effectively a rate change
- Delete CMXV15 and CMXV20 modifiers, change CMXC30 to CMXC45
- CMGP - Family physicians will be paid the same rate for a 25 - 34 minute visit as they are for a 15 minute visit.
- CMXV15 -Physicians will be paid the same amount for a 30 or more minute visit as they are for a 15-29 minute visit
- CMXV20 - Physicians will be paid the same amount for a 30 or more minute visit as they are for a 15-29 minute visit
- CMXC30 - For ALL specialties, physicians will be paid the same amount for a 45 minute visit as they are for a 30 minute visit (e.g. 03.04A, 03.08A)
- Possible scenarios:
 - Family Medicine - current rates 25 minutes of physician time managing the patient care
 $03.03A (\$38.03) + CMGP02 (\$18.48 \times 2) = \$74.99$
Under the proposed change:
 $03.03A (\$38.03) + CMGP01 (\$18.48) = \$56.06$
 - Internal Medicine - current rates 25 minutes of physician time managing the patient care
 $03.03F (\$63.58) + CMXV15 (\$15.70) = \$79.28$
Under the proposed change:
 $03.03F (\$63.58) = \63.58

History of AMA's Involvement

Complex modifiers were introduced in the early 2000s after the RVG Commission, in response to section concerns, suggested that there be a time release modifier on specific visit and consult codes that would recognize the complex nature of the work provided by the physicians. A fairly sophisticated study was completed over a 2 year period researching equity among fees. One of the areas of focus of the study was the concept of patient complexity/physician effort providing care for complex group of patients. The initial priority was to focus on in-patient complexity resulting in the introduction of the COMX modifier. The RVG also recognized 3 areas of complexity 1) total physician time related to patient management including the number of medical categories and written/oral communications. 2) In-patient hospital status 3) the number of secondary diagnosis. After formal recognition and acceptance of the study, the PSC and the Master Committee supported the introduction of

the complex modifiers for hospital in patients and select visit and consult codes.

The CMGP modifier is a variance of the CMXV modifiers and was introduced in 2009. SGP funded this item 100% through their allocated funds. The CMGP was not presented as a modifier that would recognize better patient outcomes, it built off the understanding that the complex modifiers were a way to recognize the physicians' time spent, over the average time, on providing services to a complex patient with an elevated level of need.

Current Situation

The complex modifier recognizes the time and the efforts spent on providing total physician care and coordination for the patient. The outcomes for patients with coordinated care and a primary care physician are much better, acute episodic care is diminished and patient engagement and satisfaction is higher. The Section of Family Medicine proposed higher rates for 03.03A and the first unit of CMGP linked to patient attachment in 2018 and 2019. This was not possible at the time due to the status of the Central Patient Attachment Registry (CPAR).

Questions for AH

- In the consultation package slide 8 states that "there is little no evidence that patient care has improved, which was the original intent of the modifier" please provide the reference and the measurable study that was used to substantiate such a claim.
- Why were 25, 35 and 45 minutes selected as the new base for visit codes?
- What are the current challenges with the modifiers as they are currently?

Impact or potential unintended consequences

Physician remuneration for services related to total patient care such as: referrals to specialists, reviewing and coordinating diagnostics, conferencing with team members, etc., still largely goes unrecognized in the SOMB. Codes that reflect this work are higher priced than the complex modifiers.

Physicians may limit their services per session, in order to keep the tasks that they can do within 25 or 45 minutes. This may in turn require patients to make multiple appointments.

Impact of these changes will be greater for physicians who are providing longitudinal, comprehensive, complex care for their patients than it will for other groups. This will include general practice physicians doing medical home-type work, and general internists to take care of some of the most complex patients.

Some groups (pediatrics, internal medicine and its subspecialties) paid for reductions in the complex modifier eligibility time out of their own allocations,

foregoing other changes because that was important to them. This change will disproportionately impact them, while allowing other specialties who chose to use their funds to increase other rates or introduce rule changes to retain the benefit of those dollars.

Costing Assumptions

- This item is costed as a stand-alone item, meaning that the accumulated impact and of this and other changes is unknown, but should be carefully considered.
- The difference in rates by the assignment of a longer base unit is included
- The difference in the rates for the proposed modifier application is included
- The costing assumes that the BCP payments will continue. The corresponding decrease to the BCP component has been calculated and included.
- RRNP decreases are NOT considered in the reported change
- Changes to WCB or other payments that follow the SOMB are not included.

Changes to physician payments

Total decrease affecting all physicians \$200,214,402 (about 5% of the physician base) this figure includes the estimated decrease affecting General Practice which makes up \$173M (about 11% of the GP base) of the total decrease.

AMA's advice

That the Medical Home be considered as a part of the change, mechanisms for limiting the complexity modifier could include such things as the Central Patient Attachment Registry and Clinical Risk Groupings to name just two.

The ultimate solution is to revisit the time-based review project and collaborate with all sections.

II. 'Proposal 2' – Delist¹ Comprehensive Annual Care Plans (03.04J)

Comprehensive annual care plans are written plans signed by both the patient and the care provider that lay out a plan to help patients understand and manage their complex medical conditions. AH is proposing to remove this service because the intended outcomes can be obtained through other available services under the SOMB.

AH's proposal states that the services will not be de-insured and will instead be considered a requirement of a comprehensive visit (03.04A)

AMA's Interpretation of proposal

This is a policy decision regarding the insurability of a service in the SOMB. In the past AH has worked with the AMA to delist services.

*** NEW*** This could be considered a rate change as the service is currently paid at \$190.17 as a stand-alone procedure, when a service is de-listed it is still considered and insured service, it is payable at\$0.

History of AMA's Involvement

The service was modeled after a similar service in BC, though the BC service requires physicians to take a course on CDM prior to being able to provide the service.

AH proposed the 03.04J as a dual benefit for the patient. It was a way to educate and engage them in self-management and awareness of their complex needs. AH's Bulletin (Special Edition) indicated it was a way to compensate physicians for the time and efforts to manage patients with complex conditions, assist in the overall coordination of good patient care, improve communication between patients and their primary care physicians, and improve collaboration among multiple health providers. AH published that the 03.04J payments would "provide the remuneration to support the continued development of chronic disease management and primary care strategies currently underway in Alberta."

Current Situation

Physicians engage their staff to collaborate in the development and maintenance of the care plan. Patients receive advice about self-management and overall principles to health improvement. The physician coordinates information in a single document that will educate and engage the patient in

¹ This document refers both to de-listing and de-insurance. The AMA interprets de-listing as an insured service that is NOT payable. De-insurance means the requesting party is responsible for payment. At the time of writing, AH had not confirmed this.

their overall health improvement and strategy while incorporating their values, beliefs, and living situation.

Questions for AH

- What were the anticipated intended outcomes of the 03.04J when introduced by AH?
- What codes will be used to provide the intended outcomes after the proposed change?
- Does the 03.04A require a care plan to be completed in order to submit a claim for 03.04A?
 - ***NEW***AH has clarified that care planning activities be a part of other visit services such as 03.04A but the completion of “Comprehensive care plan” is not required.
- Please provide the list of services that physicians are eligible to claim that will compensate for the preparation, collaboration and documentation of a care management strategy that will provide the intended outcomes.

Impact or Potential Unintended Consequences

- Coupled with the removal of the complex modifier, AH is removing the incentive for physicians to provide coordinated comprehensive care; these physicians care for the most complex patients, who otherwise would use emergency room and inpatient hospital care to a greater extent.
- Patient engagement and self-management declines leading to more episodic care rather than a coordinated comprehensive care strategy.
- Fewer educated patients resulting in more frequent use of more costly resources, including emergency room, hospital and specialist care.
- Polypharmacy issues with patients suffering from multiple comorbidities whose care is not being coordinated, resulting in increased visits and use of more expensive resources.

Costing Assumptions

- This item is costed as a stand-alone item, meaning that the accumulated impact of this and other changes is unknown, but should be carefully considered.
- The total billings for 03.04J are included
- 25% of the associated visits, including those for patients 75 and older, billed at the same time as the care plan are included in the estimated reduction.
- The costing assumes that the BCP payments will continue. The corresponding decrease to the BCP component has been calculated and included.
- RRNP decreases are NOT considered in the reported change
- Changes to WCB or other payments that follow the SOMB are not included.

Changes to physician payment

\$46.3M - General practice only (about 3% of the GP base)

AMA's advice

That the previous proposals put forward by the section of General Practice be considered prior to any changes. The section had proposed that only paneled patients through CPAR be eligible for the care plan within the Medical Home.

In addition, allowing claims only when there is an existing relationship between the physician and patient would focus the service on patients whose history and complexity the physician knows.

The AMA is of the opinion that any services that are slated for de-insurance or delisting be presented to the public for consultation.

III. 'Proposal 3' - De-Insure driver medical exam for patients 74.5 years or older

Alberta Health proposes to de-insure this service for Albertans in order to be consistent with the intent of the AHCIP.

Services required by a third party are not medically required, such as medical examinations required to obtain or renew an operator's license for patients 74.5 years of age or older.

AMA's Interpretation of proposal

This is a policy decision which has overarching impact to multiple other insured services that are mandated physician services as a result of legislation. In the past, AH has worked with the AMA to de-insure services such as wart removal.

This proposal could have unintended consequences in terms of seniors' mobility. Physicians may choose to provide this service to patients in conjunction with another insured service, which will not result in desired savings. I.e., this assessment will be combined with another insured patient visit, resulting in a similar expenditure.

History of AMA's Involvement

The Alberta Traffic and Safety Act requires that a physician complete a medical examination and form and submit the information to the review board for patients with a medical condition or over 74.5 years.

Research by the Traffic Safety Commission indicates that 74.5 years is the average age at which cognitive or reactionary functions may start to decline.

Alberta Health provides funding for other physician services that are mandated as a part of legislation by other Ministries. For example, the SOMB has listed fees for services required under the Personal Directives Act, Mandatory Testing and Disclosure Act, Certification under the Mental Health Act, all of which were funded by AH as a result of the legislative requirement placed on physicians. The driver's medical for patients 74.5 years and older has been an insured service listed in the Schedule as far back as 1977 (A-27 Senior citizen driver's examination - including completion of form (required after 69th birthday)).

Current Situation

As required by the Traffic Safety Act, patients 74.5 years and older are required to have a physician complete a medical examination and form on their behalf in order to maintain their drivers license. Patients must have this completed again when they are 80 and again every 2 years thereafter. Physicians are compensated through the SOMB for the completion of the examination and form completion for patients 74.5 years and older, and other

medical examinations, including prescription renewals, are often provided at the same encounter. Younger patients with medical conditions that require frequent medical review in order to maintain their driver licenses must pay for this service on their own. However, this expense can be attributed to the person's medical expenses which is a tax deductible item.

Questions for AH

- Is there another mechanism, similar to Saskatchewan's funding through the Solicitor General, to fund this item outside of the SOMB?
- Will regulations be implemented to maintain the rates of the service across the province?

Impact or Potential Unintended Consequences

- Patients may not be able to afford the cost of the service
- Varying costs may have patients clinic shopping in order to get the best price
- The patient's primary care physician is in the best position to provide an accurate and reliable assessment of a patient's condition; physicians who do not know the patient's history and complicating factors may not be able to provide a realistic assessment of the patient's cognitive and physical abilities thereby compromising the delivery of the service if patients shop for the best price.

Costing Assumptions

- This item is costed as a stand-alone item, meaning that the accumulated impact and of this and other changes is unknown, but should be carefully considered.
- The total cost of the 03.05H is included
- The costing assumes that the BCP payments will continue. The reported change is inclusive of the changes to BCP.
- RRNP decreases are NOT considered in the reported change

Changes to physician payment

The estimated change to payments for all physicians as \$4.4M of that figure, \$4.3M will be from the Section of General Practice

AMA's advice

That this proposal is not likely to gain any support from the physician membership or from the general public in particular seniors. There are potentially areas that would generate the same level of savings that would be less controversial.

IV. 'Proposal 4' - De-insure diagnostic imaging services referred from uninsured practitioner referrals

AH proposes to only permit practitioners providing publicly funded services through AHCIP to refer for DI services. This will preclude billing for services referred to radiologists from chiropractors, physical therapists and audiologists.

AMA's Interpretation of proposal

Regulated members of the Allied Health Professions Act are no longer eligible to send patients for imaging services. This may result in an increased burden on physicians and expense on the PSB if patients are sent to family physicians to enable these diagnostics to be ordered.

History

The original requests to have chiropractors, physiotherapists and audiologists added to the list of providers that are eligible to refer for consultation and diagnostics came from Alberta Health and was positioned as savings resulting from decreased family physician visits. In 2008, AH completed an analysis of the impacts of adding chiropractors to the referral list, reporting savings of \$45,000 in family medicine referral costs. AH has continued to add providers to the referrals required list as long as they are recognized under the Health Professions Act, including audiologists and physiotherapists. The rationale has been that direct-to-diagnostic provides more timely care rather than an intervening GP visit and associated savings.

Current Situation

Physiotherapists, audiologists and chiropractors can refer for consultations and for in-scope diagnostics. Physicians providing services can claim for referred services.

Physiotherapy for some services is provided through AHS and thereby publicly funded.

GR 3.3 states "Except for services known to be uninsured, the initial visit(s) to establish a diagnosis of the patient's condition is an insured service, including situations where the patient has been referred to another physician. After establishing a diagnosis during the initial visit(s), if the physician determines the service is not medically required, or is an uninsured service, all subsequent services related to the uninsured service such as preoperative tests, assessments, consultations, surgical procedures, anesthetic or surgical assists may not be claimed." In general, physicians would examine the patient first and confirm the diagnosis prior to determining if there was a need for further diagnostics. Therefore it is likely that a visit by a physician will be claimed whether a referral for diagnostics is generated or not.

If AH's desire is to de-insure DI services when not referred by non-insured or non-publicly funded practitioners, different requirements and rules would need to be applied.

Questions for AH

- What information was used to inform the proposed changes?
- How much is spent on diagnostic services referred from these providers?
- How will AH distinguish AHS-paid physiotherapy services which are publicly funded vs., those that are not?

Impact or Potential Unintended Consequences

There will likely be increased expenditures as a result of the requirement to have a physician provide the referral. Not every referral request will be granted as in some situations, the physician may examine the patient and determine a more appropriate course of care, however, estimated savings cannot be calculated as most of these requests will generate a family physician visit.

Costing Assumptions

In 2008, AH estimated cost savings of \$45,000 for the family physician visits avoided. This will have increased 10-years on.

Changes to physician payment

NEW \$7.2M in changes, the majority of images ordered from non-insured providers are ordered by chiropractors.

AMA's advice

This will likely increase costs as patients will visit their family physician to obtain the required referral.

The AMA is of the opinion that services that are slated for de-insurance be sent out for public consultation.

V. 'Proposal 5' - DI Billing Appropriateness

AH observed lack of clarity in rules governing the DI imaging codes resulting in overbilling by physicians. AH identified in appropriate billing combinations for certain services including code stacking. AH is proposing to clarify the rules and restrictions to ensure accurate billing practices related to DI imaging services.

AMA's Interpretation of proposal

Without recognition of appropriate and inappropriate claims situations in each proposal, this collection of changes is effectively a rate change.

Consultation with the section is required prior to moving ahead with the proposal to avoid unintended or unknown consequences.

History

This proposal is NOT the result of AH reviewing claims data, but is taken directly from the Section Submission Summary from the Section of Radiology that was submitted in good faith to the Allocation Working Group in 2017 and thoroughly reviewed with the section in 2018. Despite the AMA's attempt to develop policy regarding a monitoring and adjustment strategy as well as a shared savings strategy from SOMB changes that are the result of ambiguous wording, AH rejected both attempts at policy and ultimately the radiology package.

Current Situation

Physicians are able to bill for these services when they are provided in combination within the current rules. AMA recognizes that there are some instances where improvements can be made in determining what codes can be claimed in combination.

Questions for AH

- Please confirm what information AH used to form the basis of the proposal?
- What clinical information was used to determine the appropriateness of the proposed preclusions?
- Have all exclusions been clearly documented and included in the proposal? What is the mechanism to address conflicts in the stated changes?

Impact or Potential Unintended Consequences

Sections will be discouraged by this approach and be reluctant to modernize their fee schedules for fear that any potential shifts in money from a lower valued service to a higher valued service will not be able to be reallocated back into the section.

This type of proposal is damaging to the relationship between AH and physicians

This proposal highlights the need for a policy regarding shared savings from SOMB changes. While improvements to the SOMB in areas of ambiguity are encouraged, there may be some legitimate reasons why a specific billing pattern is utilized. By providing a mechanism to achieve shared savings, it is more likely that sections will be engaged in the improvements of the SOMB as a whole.

Costing Assumptions

- This item is costed as a stand-alone item, meaning that the accumulated impact and of this and other changes is unknown, but should be carefully considered.
- The vice versa effects of these proposed changes have been included
- Additional missing vice versa changes are NOT included.

Changes to physician payment

The estimated changes to payments would be \$9.2M, \$9.1M (about 2% of the DI base) directly from radiology and \$140K from Obstetrics and Gynecology.

AMA's advice

Policy should be established regarding a Monitoring an Adjustment Strategy that will provide clear expectations and outcomes for all stakeholders making significant SOMB changes.

Policy should be established regarding Shared Savings as a result of sections making changes to the SOMB that result from ambiguity or lack of clarity in the SOMB. Not all billing patterns as a result of ambiguity are inappropriate and sections should be given the opportunity to redistribute funds as a result of funding shifts between existing and new items and combinations of items.

Consultation with the appropriate medical specialties is required to insure that barriers to care are not being created as a result of targeted code changes as opposed to a comprehensive review of a modality.

VI. 'Proposal 6' - Daily Caps

AH is proposing to implement a daily cap of 65 patients. The rationale being that physicians who provide excessive visits per day may compromise their own health and safety as well as patient care.

AH has stated that this cap will include ALL "V" category codes that are billed in location types POFF (office) and RCPO (Regional Contract Practitioner Office). This proposal will NOT be applied to rural and remote communities (claims eligible for RRNP Variable Fee will not count to the threshold)

AMA's Interpretation of proposal

The B.C. capping limitations only include services equated to 03.02A, 03.03A, 03.04A, 08.19G.

Alberta Health's proposals include ALL "V" category codes. This will expand to services that include, ALL phone calls, 13.99J medical emergency detention time, ALL Electronic communication codes, ALL family and team conference codes, time extenders on complex care (03.03FA, 03.08I, 03.08J), ALL obstetrical and oncology visit services.

History

The Section of General Practice explored the concept of a daily cap on the number of payable visits. The section spent considerable time contemplating the merits of such a proposal and the consequences and or impacts that would result in the implementation of the cap. The section did present a strategy to stratify the visit limitation across the day with the intent of providing good patient outcomes and maintaining the cap. The proposal was rejected at the AWG by AH due to lack of time to implement the proposal.

Current Situation

Daily caps do not exist in the FFS environment. There are situations where an increased number of visit services may be provided by a physician e.g., rural AB few physicians providing coverage, one is suddenly ill, partner sees their patients; maternity leave coverage without a locum; no locum coverage available, physician sees their scheduled patients then offers walk-in clinic service to avoid patients in the ER.

Questions for AH

- Please provide the literature that supports the rationale that physicians' wellbeing and patient safety is compromised after 65 patients per day.
- Please define excessive as it applies to number of visits?
- Does the proposal consider the time frame in which a physician can see 65 patients in a day?
- Is this a defined cap across all specialties?

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- What has the experience in BC provided? What are the lessons learned from their capping initiative? Were the intended outcomes achieved?
- Is the proposal physician based?
- Is there a link between the NP program and this proposal?
- Will a daily cap be applied to NP's providing visit services as well?

Impact or Potential Unintended Consequences

- Reduced access
- Fragmented care
- No consideration for physician shortages in specific communities
- Could drive utilization to more expensive environments such as UCC/ACCC, emerg
- Patients may lose attachment with their primary care provider.

Costing Assumptions

NEW AMA estimates the change to physician payments will be \$15.5M

Changes to physician payment

Alberta Health estimates this to be \$26M.

AMA's advice

More consideration and consultation with BC should be explored to determine if this is a worthwhile initiative. Verify the claims that physician well-being and patient safety are compromised at a certain threshold.

Engage sections in meaningful consultation. This will have rate implications to membership (\$/day) and therefore must be negotiated with the profession.

Any proposal must allow for exceptions.

VII. 'Proposal 7' - Overhead

AH is proposing to separate overhead from all hospital based services to support equitable payments for physicians. This proposal includes the removal of facility-based overhead cost component for selected HSCs.

AMA's Interpretation of proposal

This is a rate reduction.

History of AMA's Involvement

The AMA has a long history on multiple projects associated with overhead measurement and analyses. The physician business costs model (PBCM) implemented in 2010, represents the most recent accepted measurement and was used prior to 2018 for the purposes of allocation, negotiations, and to communicate our general understanding for the physician model office.

In 2010, the consultant developer of the PBCM recommended a data refresh every five years. The PBCM data are now considered outdated and PCC has taken several steps to review the model, including internal AH and AMA reviews as well as an independent review (by MNP). Each of these reviews identified several significant concerns with the PBCM.

A consulting firm (Deloitte) was engaged by the parties to develop a new overhead model and in doing so, the goal was to address the concerns of the parties. The results of this study were provided Spring 2019 and after significant concerns from physician and government stakeholders, the study was deemed unusable.

AMA agreed to take on an initiative that would be led by an 'Overhead Working Group' to redesign and redevelop the model based upon a model office concept. PCC understands the process and is continually updated on all progress, while anticipating final results by December 2020.

Current Situation

The AMA distribution of the micro allocation takes into consideration the OH experienced by physicians by section. The total micro allocation distribution of funds considers that each section will fund overhead on a fee-by-fee basis through INRV valuation of their fees.

Questions for AH

- Please provide the AHS cost setting overhead.
- Individual fees paid for physician services include a component for complexity, intensity, overhead and time – each of these components may change depending on whether the patient is seen in a hospital setting vs a community based clinic. This implies that while overhead may be less in the hospital, the physician may spend more time with

that patient and, depending on the hospital setting the patient may be more complex and sometimes more intense. Thus the compensation components could be different for different settings.

- AHS already charges overhead for the majority of physicians practicing in hospital settings and this has generally been accepted as a reasonable amount for overhead that the physician would otherwise receive through the physician services budget. Why would government calculations be any more accurate?
- What overhead estimate is being used? What version of the PBCM and what year of data is being accessed.
- Will the potential savings from this initiative be transferred from the PSB to AHS?
- What is a community code and a hospital code? Is it a modifier?

Impact or Potential Unintended Consequences

- The calculation and application of the OH component may vary across the province and changes to the rates may unfairly disadvantage some physicians or some locations.
- AHS contracts will require renegotiation and re-evaluation for relevance
- Currently there is not an OH estimate that stakeholders accept as credible.
- May have increased costs, physicians may choose to do more services in the community where the service will be billed to the PSB.
- Deducting overhead amounts from services provided in AHS facilities may inappropriately remove physician compensation that supports their community office or their personal overhead. E.g., surgical procedures have had rates assigned to them that reflect their provision in AHS facilities; it would be inappropriate to deduct overhead from these services as the overhead paid through them supports physicians' community offices and related expenses.
- In the case of physicians who have their offices in AHS and other publicly run facilities, there have been variable approaches to either recovering overhead amounts from these groups or using the offer of office space and other overhead expenses at reasonable or discounted rates as a recruitment and retention mechanism. The impact of these changes would need to be carefully considered so as to account for the impact of either of these initiatives.

Costing Assumptions

The AMA does not have enough information to form the basis of an analysis.

Changes to physician payment

AH estimates \$83M (about 2% change in the base) change in payments in 2020/2021. The AMA recognizes that this is not one-time savings; the reduction in payments will continue and compound every year following implementation.

AMA's advice

This proposal is risky as the likelihood of greater negative consequences and additional expenditures outweighs the prospective of savings. There is low confidence that any party would be able to calculate an OH component that would be agreeable for implementation. There are other opportunities to evaluate potential savings.

VIII. 'Proposal 8' - Clinical Stipends provided through AHS

AH is proposing to have AHS discontinue stipends to AHS-contracted physicians. AH has directed AHS to notify physicians on January 1, 2020 (90 days' notice period) that clinical stipend agreements will expire on March 31, 2020. The stated rationale is that clinical stipends for physicians paid by AHS are for insured services and therefore are inappropriately compensating physicians for services they are already paid to provide through the Schedule of Medical Benefits.

AMA's Interpretation of proposal

AHS proposal is to remove stipends and the AMA interprets this removal as compensation matter which must be negotiated as per the terms of the Strategic Agreement. The manner in which this proposal is made suggests that government can unilaterally make policy that is contrary to the Strategic Agreement. This new policy would be in violation of the Physicians' right to meaningful association under 2d Charter of Rights and Freedoms.

There is also a danger that AH could instruct AHS at any time to reduce or end these clinical stipends (including income guarantees) or to cease negotiating them as part of recruitment and retention.

History of AMA's Involvement

AHS uses clinical stipends to recruit and retain physicians in areas of practice where:

- i. There is significant variability in ability to bill.
- ii. There are challenges in recruiting physicians to fill the desired/needed role.
- iii. The number of physicians required to maintain a reasonable call schedule is greater than the number of physicians required to appropriately serve the patient population, resulting in a reduced ability to have an appropriate and attractive income when compared with other locations.

Stipends are needed to remunerate physicians for those services for which the SOMB provides minimal or no remuneration. They are intended to recognize all of the value-added items physicians perform that are not compensated by the SOMB. Other reasons for which stipends were originally introduced vary by physician group. They include such things as: compensation for carrying a pager 24/7; helping to offset overhead costs for those taking time away from their clinic practice; referrals to specialists; reviewing and coordinating diagnostics; conferencing with team members; hand-over charge; unscheduled family and team conferences; phone calls from residents/NP/CA/ER doctors about patients; discharge dictation summaries; teaching; rounds; etc. Today, they continue to remunerate physicians for

procedures or tasks necessary for the success of AHS programs but for which the SOMB provides minimal or no remuneration.

Current Situation

In 2016/2017 CPSA licensed physicians numbered 10,425. As of March 31, 2017, AHS had a total of 8,162 physician members of the medical staff, including locums. Of these 7,471 made up the core (non-locum) workforce. [Reference: AHS Physician Workforce Plan & Forecast 2017-2018]

As of 2015/2016, AHS had begun working on a database of physician payments organized by zone, program, physician group and by physician, and attempts were being made to standardize the database across zones. At that time, the following information was provided to AMA but to-date, no updates have been made since:

The total number of Medical Affairs Clinical Service Payment Programs in 2014/15 (does not include Physician On Call (POC), Calgary Laboratory Services (CLS) or Diagnostic Imaging (DI) – 347

The number of physicians that received compensation for providing clinical services as part of one or more of the clinical service payment programs in 2014/15 (does not include POC, CLS or DI and duplicates have been removed) – 3216

NEWThe total expenses for the clinical service payment programs in 2014/15 (does not include the expenses for POC, CLS, or DI) - \$187,344,096. However, the AMA is in the process of confirming with AHS, which programs are targeted and there is some suggestion that this amount could be about \$50,000,000.

These numbers indicate that a significant proportion of Alberta's physicians are engaged by AHS and their contractual relationships arguably fall within the scope as contemplated by the Strategic Agreement.

Questions for AH

- Clinical ARPs are voluntary; some physician groups may not want to enter into a new cARP or join an existing one. What options are available to them?
- AHS states they are proposing to discontinue these stipends in accordance with their contractual obligations - what contractual obligations are being referred to?
- Ask AHS if they have any concerns about the viability of this initiative given the recruitment/retention aspect, and it is possible these payments could continue or be reinstated under another name and approach due to challenges in recruiting and retaining physicians in certain roles, positions and specialties.

Impact or Potential Unintended Consequences

Stipends are meant to remunerate and recognize physician services related to total patients that are not recognized in the SOMB (e.g., for uninsured or non-insured clinical services). ARPs, with their focus on clinical service provision will not address the many reasons that clinical stipends are paid. In addition, AH has had great difficulty in moving forward with ARP proposals on a timely basis, which makes it very difficult to see that the April 1, 2020 timeline could reasonably be met by AH. Selective application of a grace period to those groups chosen by AH will make the process open to political influence.

If stipends are removed the result may be:

- Difficulty recruiting or retaining these physicians
- Reduced access
- Decreased services
- Program closure

Costing Assumptions

The total expenses for the clinical service payment programs in 2014/15 (does not include the expenses for POC, CLS, or DI) - \$187,344,096

Estimated Changes to Payments

The total amount of physician stipends. AH estimates the amount to be \$55M.

AMA's advice

That this proposal is not likely to gain any support from the physician membership or from the general public if the result is reduced access and decreased services.

If new rates or compensation amounts are sought, these must be negotiated through the terms of the Strategic Agreement as intended.

In these cases, the AMA believes that AHS has an obligation to notify the AMA and the physicians involved. Physicians have the right to choose their representatives for negotiations. The Strategic Agreement provides the framework for all of this.

IX. 'Proposal 9' - Submission of claims within 60 days of service

AH is proposing to reduce the claims submission deadline from the current 180 days to 60 days. Health Practitioners currently have 180 days from the date of service, or from the date a patient was discharged from the hospital, to submit a fee-for-service claims. AH will reduce the limitation period to 60 days for FFS claims submission.

AMA's Interpretation of proposal

This is a policy item and AH may, with advance notice, make changes to the submission deadline.

History

AH has in the past proposed the implementation of a reduced submission period, in 2007 and 2016. In both instances the proposed changes were presented as a reduction from 180 days to 90 days which is consistent with other provinces.

Current Situation

Physicians currently have 180 days following the date of service to submit a claim, an additional 180 days from the last date of communication (for valid claims) to resubmit for payment. AH's claims system does not record refused claims, therefore if a claim is submitted and "HELD" by AH, changes cannot be made to a claim once it is held. The claim is often held for 180 days and then ultimately refused. When a physician submits the claim again, (within the 180 days of the last Statement of Assessment the claim appeared on (as stated in 3.2 of the Physicians Resource Guide) it is refused by AH as out of date. This is not in keeping with the current submission process.

Questions for AH

- Please provide rationale as to the selection of 60 days rather than the previously socialized concept of 90 days. This is out of line with other provincial submission deadlines and not in alignment with the information on slide 4 "The proposed initiatives for consultation have been developed based on: practices in other Canadian jurisdictions.
- Will the same procedure i.e., allowance for an additional period of time for resubmission of valid claims following the last date of communication?
- Will there be any changes to the AH position regarding claims submission past the proposed time?

Impact or Potential Unintended Consequences

Initially some physician claims may not be submitted in time resulting in lost income.

When considered alongside some of the challenges physicians have had with billing software and AH communications, this timeline could mean significant and real hardship for some physicians.

Improvements to AH's claim system and Hlink portal to make it more responsive with billing software to ensure that claims that are submitted are actually received.

Costing Assumptions

None at this point. The AMA continually responds to physician requests for exemption of the 180 day rule on behalf of physicians. There will be some physicians that will be affected to some degree as a result of this drastic change.

Changes to physician payment

AH states that there will be \$0 saved from this change and the change is to facilitate data and forecasting assessments by the Ministry.

NEW according to AH, the majority of claims are currently received within 60 days, about 5% of claims are received between day 61 -90.

AMA's advice

60 days to submit for payment is not consistent with any other province and would be unfair to physicians. While not completely agreeable, the AMA would suggest that any decreases to the timeframe for claims submission should be in line with other provinces, e.g., 90 days. Significant notice would have to be given as well as an opportunity to be flexible with the allowance for out dated claims to be submitted for a certain amount of time. The changes would have to be on a go-forward and not be retroactive prior to the date of implementation.

There should be some level of consultation with billing providers and EMR vendors to determine whether or not the timeframe is reasonable.

Improvements to the claims system to maintain a record of refused claims so that corrections may be made within any prescribed time frame.

X. 'Proposal 10' - Non-invasive Diagnostic Fees in AHS facilities

Fees paid for non-invasive diagnostic tests such as ECG performed in AHS facilities differ from facility to facility.

AH proposes that on April 1, 2020, AHS standardize all fees paid (except where there is an existing commitment between AHS and practitioner) for non-invasive diagnostic tests performed in all AHS facilities to match the fees established and paid by Alberta Health to all other non-AHS physicians. As an example, SOMB lists \$9.83 as the fee for interpreting ECG results, so AHS will pay this amount to any physician performing this service in an AHS facility.

Their rationale is

- i. To improve accountability, AHS will move to standardize all fees for non-invasive diagnostic tests performed in a hospital to ensure consistent compensation among hospital and non-hospital physicians.
- ii. Standardization reduces costs for the health system.

AMA's Interpretation of proposal

AH standardizing fees is interpreted to be a compensation matter. The manner in which this proposal is made is contrary to the Strategic Agreement and potentially in violation of the Physicians' right to meaningful association under 2d Charter of Rights and Freedoms. AHS negotiated contracts with MIC and RADS; the same is required for other radiology providers in the province.

History

Rates vary throughout the province in AHS facilities. Previously when Alberta had various regional health authorities, each regional health authority negotiated their own contracts with providers.

Current Situation

There are also non-invasive diagnostic services such as EEGs, ECGs, etc. related to cardiology, neurology, etc. These rates were negotiated by each individual health authority with either individual physicians or physician groups.

Questions for AH

- How does this affect physicians in cARPs?
- How do the rates compare between the three large providers and the rest?
- How will rates for EEG, ECGs, etc. be affected?

Impact or Potential Unintended Consequences

- Reduced access.

- Increased wait times.
- Patients who are unable to afford private tests will face longer wait times. By the time they undergo testing, their condition(s) may have advanced to the extent that more comprehensive care is required, resulting in higher costs to the health care system.
- This will likely result in higher costs as services listed under GR 6.5 will result in additional contracts to significantly more providers e.g., slit lamp exams, vital capacity etc. There may be instances whereby the contract rates must be increased as it is not suitable to move all contracted rates to the lowest common denominator.

Costing Assumptions

This could result in off-loading of services from AHS to the PSB or vice versa.

Changes to physician payment

It is unclear how physician payments will change because AMA does not know the rates paid to providers who hold contracts with AHS for services.

AMA's advice

If AH wishes to change rates for providers, these must be negotiated. In these cases, the AMA believes that AHS has an obligation to notify the AMA and the physicians involved. Physicians have the right to choose their representatives for negotiations. The Strategic Agreement provides the framework for all of this.

XI. 'Proposal 11' - Stop accepting Good Faith Claims

Elimination of Good Faith Policy ensures payment for health service is provided only to eligible Alberta residents; improves accountability by AHS and physician's offices for their hospital registration and billing procedures.

AMA's Interpretation of proposal

While positioned as a policy decision, this is a devaluing of physician services for patients that present to AHS facilities and require care.

History

The Good Faith Policy allows physicians to submit claims within 30 days of the date of service for patients that are believed to be residents of Alberta.

After a large number of complaints from physicians the trilateral SOMBS formed the ad hoc Remuneration for Services Provided to Unregistered Patients Working Group. This WG reviewed in detail the challenges of registering patients and claims submission/rejections. A list of recommendations was made to the Physician Services Committee but ultimately not supported by AHS.

Current Situation

The Alberta Health, *Physicians Resource Guide 2018* states that "The Good Faith Policy was developed to minimize the risk of Alberta practitioners not being paid for service provided to Alberta residents who the practitioners believes are eligible for coverage under the AHCIP at the time of service but cannot provide proof of coverage." This is consistent with the Hospital Act (Section 38 (3)). This policy does not apply to non residents of Alberta or Out of Country patients. This policy is also consistent with AH's application of payment when physicians are required under legislation to provide services Section 38 (4) of the Hospital Act. The Act also states that. "Notwithstanding anything in this or any other Act, no person shall, in an emergency, be refused admission to an approved hospital or be refused the provision of any services by an approved hospital by reason only of the fact that the person is not entitled to receive insured services." This statement therefore requires that physicians provide services to patients who attend hospital as emergency, admitted patients or follow-up clinic patients, whether they are insured patients or not.

Questions for AH

- Other provinces that have done away with Good Faith policies often have non-fee-for-service remuneration models in place, which mean that the impact of this decision is significantly reduced. What is AH's plan to mitigate against these significant impacts for physicians providing services in AHS and Covenant facilities?

- What impact will this have on cARPs serving marginalized populations (Boyle McCauley Health Centre, Hope Mission, etc.)?

Impact or Potential Unintended Consequences

This initiative will significantly disadvantage physicians who practice in emergency rooms, ICUs, and providing inpatient services, and provide services to people without health care insurance. Typically those who can't produce evidence of health insurance are also unable to pay for their services, leaving physicians in the situation of being required by the Act to provide services for which they will not be paid, but will be medically-legally liable. Most of these claims occur in AHS facilities where there are no requirements for the registration clerks to determine eligibility. As part of this initiative, AHS needs to be instructed and held responsible for properly collecting patient information. In turn, patients need then to be held responsible for registering and maintaining their health care coverage as many simply don't think it's important.

For patients who are indigent and have no fixed address, this change will mean that physicians will essentially be required to see them at no cost to the health system. This mocks the reality that these individuals have some of the most complex needs and require significant physician resources.

Costing Assumptions

Other provinces who have done away with Good Faith policies often have non-fee-for-service remuneration models in place, which mean that the impact of this decision is significantly reduced. The AMA has no way to cost this proposal without additional information from AH.

Changes to physician payment

Alberta Health estimates that the changes to payments are \$2.1M in 2020/21. This cost will compound year over year.

AMA's advice

A change of this nature is unfair to physicians that are obligated by law to provide service. Onsite real time registration of transient or homeless population should be made available. The development of health care cards with security functions should be mandatory.

AHS must be a willing partner in the proper registration of patients at admission, triage or registration.

5. High-Level Engagement Plan

There are a number of planned activities occurring prior to a fulsome response to government's insured services proposal. These activities are summarized as follows:

- **Development of an Initial Assessment - November 26, 2019:**
 - An item-by-item assessment has been developed by staff.
- **Collect Preliminary Input from Section Presidents and Fees Reps:**
 - **November 26 – December 6, 2019:** Communication to Section Presidents and Fees Reps, seeking feedback. Feedback will be collected and provided to the AMA CC.
- **AMA Compensation Committee:**
 - **November 27, 2019:** AMA CC to review the government proposals and provide feedback.
 - **December 7, 2019** AMA CC to provide a second report to the RF
- **Special RF:**
 - **December 7, 2019:** RF to receive presentations and provide feedback on relevant topics.
- **Follow-up Communication to Membership:**
 - **December 16, 2019:** A communication to general membership, to include highlights from the Dec 7th RF and next steps.
- **Response to Government:**
 - **December 20, 2019:** A response to government based on the experience and learnings from the RF, Section Presidents, General Membership, AMACC, Board, etc.

H:\.... A Plan for AMAs Response to the Insured Services Consultation V1 FINAL.docx

NEW

Cost Estimates of Insured Services Consultation presented by AH on November 14, 2019
Data is for the year ended March 31, 2019

December 5, 2019

Specialty	Proposal 1 - Complex Modifiers incl. CMXV15, CMXV20, CMGP01, CMXC, BCP	Proposal 2 - Comprehensive Annual Care Plans incl. 03.04, 1/4 of visits, BCP	Proposal 3 - Driver Medical Exam for patients 74.5 years or older incl. 03.05H, BCP	Proposal 4 - De-insure DI services referred by a non-insured or non-publically funded practitioner	Proposal 5 - DI Billing appropriateness incl. X301, X303, X311, X315, X316, X317, X318, X319, X320	Proposal 6 - Daily Caps 51 - 65 = 50%, >65 = 0 payment	Proposal 7 - Overhead	Proposal 9 - Submission of Claims within 60 days of Service	Proposal 10 - Stop Accepting Good Faith Claims	Total	SAE Counts	Total Per SAE
Anaesthesiology	\$513,992	\$0	\$0		\$0	\$250,148	\$67,797	The rest of the country is on 90 days.	Communication will need to go to patients so that they carry their AHCIP Card with them to all visits. Issues with Hospital claims, especially emergency room.	\$831,937	382.0	\$2,178
Cardiology	\$1,288,746	\$0	\$86		\$206	\$2,392	\$2,902,705			\$4,194,134	115.5	\$36,313
Cardiovascular & Thor. Surg.	\$45,430	\$0	\$0		\$0	\$0	\$0			\$45,430	12.6	\$3,606
Critical Care Medicine	\$95,898	\$0	\$0		\$0	\$0	\$19			\$95,917	54.9	\$1,747
Dermatology	\$267,667	\$0	\$0		\$0	\$517,102	\$35,625			\$820,394	49.6	\$16,540
Emergency Medicine	\$4,392,330	\$0	\$0		\$0	\$0	\$53,018			\$4,445,348	362.1	\$12,277
Endocrinology/Metabolism	\$191,858	\$0	\$0		\$0	\$0	\$109,767			\$301,625	6.6	\$45,701
Gastroenterology	\$484,472	\$0	\$0		\$0	\$8,588	\$2,302,946			\$2,796,006	47.2	\$59,237
General Practice	\$173,377,125	\$46,317,171	\$4,370,185		\$2,786	\$10,300,019	\$21,389,634			\$255,756,920	4,195.7	\$60,957
General Surgery	\$1,131,822	\$0	\$0		\$0	\$0	\$4,736,911			\$5,868,733	166.3	\$35,290
Generalists Mental Health	\$0	\$0	\$0		\$0	\$0	\$0	\$0	13.2	\$0		
Infectious Diseases	\$94,125	\$0	\$0		\$0	\$0	\$0	\$94,125	17.0	\$5,537		
Internal Medicine	\$4,815,640	\$0	\$15,421		\$0	\$56,718	\$11,700,598	\$16,588,377	348.1	\$47,654		
Nephrology	\$198,091	\$0	\$86		\$0	\$1,140,772	\$480,266	\$1,819,214	29.4	\$61,878		
Neurology	\$946,142	\$0	\$0		\$0	\$0	\$1,972,044	\$2,918,185	60.0	\$48,636		
Neurosurgery	\$50,362	\$0	\$0		\$0	\$511	\$14	\$50,887	7.1	\$7,167		
Obstetrics & Gynaecology	\$2,923,778	\$0	\$0		\$140,098	\$161,088	\$2,202,256	\$5,427,219	236.6	\$22,938		
Ophthalmology	\$577,569	\$0	\$0		\$0	\$3,037,700	\$401,113	\$4,016,382	123.8	\$32,443		
Orthopaedic Surgery	\$1,544,330	\$0	\$0		\$0	\$7,516	\$3,681,244	\$5,233,090	160.4	\$32,625		
Otolaryngology	\$677,109	\$0	\$0		\$0	\$350	\$580,591	\$1,258,051	63.2	\$19,906		
Paediatrics	\$3,603,788	\$0	\$0		\$0	\$4,197	\$3,635,316	\$7,243,300	256.8	\$28,206		
Pathology	\$30,254	\$0	\$0		\$0	\$0	\$65,882	\$96,136	3.8	\$25,299		
Physical Medicine & Rehab.	\$838,511	\$0	\$0		\$0	\$17,265	\$678,289	\$1,534,065	41.1	\$37,325		
Plastic Surgery	\$262,647	\$0	\$0		\$0	\$0	\$1,555,845	\$1,818,492	62.1	\$29,283		
Psychiatry	\$629	\$0	\$0		\$0	\$10,149	\$16,604,951	\$16,615,729	497.5	\$33,398		
Radiology	\$33,782	\$0	\$0	\$7,000,000	\$9,112,395	\$0	\$78,805	\$16,224,982	291.2	\$55,718		
Respiratory Medicine	\$880,518	\$0	\$0		\$0	\$0	\$1,248,375	\$2,128,892	43.0	\$49,509		
Rheumatology	\$66,160	\$0	\$0		\$0	\$0	\$52,022	\$118,182	5.2	\$22,727		
Thoracic Surgery	\$109,558	\$0	\$0		\$0	\$0	\$366,007	\$475,565	12.9	\$36,865		
Urology	\$623,188	\$0	\$0		\$0	\$6,523	\$1,977,497	\$2,607,208	56.2	\$46,392		
Vascular Surgery	\$137,575	\$0	\$0		\$0	\$0	\$120,465	\$258,040	14.5	\$17,796		
Total	\$200,203,094	\$46,317,171	\$4,385,778	\$7,000,000	\$9,255,485	\$15,521,037	\$79,000,000	\$0	\$0	\$361,682,566	7,735.6	\$46,756

RRNP has not been calculated as we do not have exact location of the physicians
FFS only