March 21, 2017

Dear Dr. Carr, AMA Board, AMA Compensation Committee, and AMA Negotiations Committee:

Thank you for the presentations, comments, and materials provided to date to Section Presidents, RF delegates, and AMA membership on the subject of fee/ income equity and the Adjusted Net Daily Income (ANDI) model. Income equity, as defined by any differences in income that is justified by reasonable factors, is a principle with broad support. However, the selection of factors, the relative weight assigned to each, the methods of calculation, and the approach to adjustments are all a fundamentally subjective exercise and therefore are potentially influenced by various non-empirical pressures and biases.

Unfortunately, we are extremely concerned that the way in which the ANDI model was presented has already created a significant expectation of redistribution from certain Sections to certain other Sections. This expectation is likely now embedded even though the data required to support specific conclusions or actions has not been gathered. The AMA could have presented their ANDI model for discussion without the inclusion of Section identifiers but chose otherwise. The AMA could have presented versions of the same model to depict more inequity or less inequity but chose otherwise. *Justitia est caecus* seems to have been excluded as a principle at the inception of this process. As a result, we are concerned that the ANDI process has already been prejudiced towards a certain, predetermined outcome. This raises the following questions:

> Q1: How does the AMA intend to manage expectations for redistribution that have already been established? Or is redistribution a foregone conclusion and the ANDI model be the de facto method that is developed to deliver fee/income equity?

Further, we have fundamental concerns about the AMA's fiduciary responsibilities, established by its own Constitution and Bylaws, as it pertains to being the representative agent for *all* physicians in financial negotiations.

> Q2: How does the AMA regard selective negative allocation as an effective representation of the financial interests of those physicians selected for negative allocation?

This representation issue is relevant to all members in broader negotiations with government, and the upcoming Master Agreement renewal. Government is sure to be pleased when the AMA has segmented its own membership by identifying certain groups of doctors for fee reductions and will presumably agree. We suspect they will be somewhat less likely to agree that any other group of doctors is undervalued. And we are sure they will want to claim any money earmarked for redistribution as a necessary cost saving measure (IE. PCC IFR and SOMB process). To us, this approach seems to weaken our collective bargaining position. Questions that arise from these concerns include:

> Q3: Does the AMA believe that it is possible that funds identified by ANDI for reallocation will instead be designated by government as cost savings, and not be redistributed to other physicians?

> Q4: Does the AMA intend to include ANDI and negative allocation explicitly in the next Master Agreement?

The AMA's only mechanism to effect income equity lies in the Physician Services Budget. This raises philosophical questions regarding the goals and scope of the ANDI process that have not been clearly defined but need to be:

> Q5. What is the intended scope of the ANDI process in terms of sources of revenue and the hours required to generate that revenue, specifically:
> -only SOMB payments?
> -all payments made in the Physician Services Budget including ARPs?
> -AHS payments to physicians including stipends or other incentives? PCN funding as well?
> -all other payments to doctors (WCB? Patient pay?)
>
> Q6. If considering revenue and work hours beyond that related to SOMB billings, how does the AMA intend to identify that fairly and inclusively from all members across all Sections?
>
> Q7. Does the AMA intend to adjust *SOMB rates* downward in a Section by whatever amount necessary, to ensure that net daily income *from all sources* in that Section does not exceed that allowed within its ANDI model?
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> Q8. Does the AMA regard SOMB adjustment in isolation of other payments / rates as an appropriate tool to achieve equity on total income, or does it foresee other undesirable distortions in the SOMB arising directly from the ANDI process?

There are a number of more technical questions and concerns raised by the data and methodology proposed, pertaining to whether and how this will be a fair, open, objective, and data driven process. Specific answers are required:

> Q9. In respect to the unknown impact of PCC IFR and SOMB rule change changes, what billing period will the first ANDI adjustment be based on? April 1, 2017 to March 31, 2018 or other?
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> Q10. Will ANDI be an annual, daily, or hourly rate calculation?
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> Q11. What proportion of allocations will be determined by ANDI?
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> Q12. How will work hours and revenue from those be measured and validated, and how will the AMA match included income with relevant work hours accurately and fairly?
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> Q13. How will overhead be measured and validated, and how will that be used in ANDI and in future allocations otherwise?
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> Q14. What years of training are relevant to establishing skills acquisition and opportunity cost calculations (medical school, residency, fellowship training) and how will that be measured and validated?
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> Q15. Will career longevity limitations in certain fields be accounted for, and how?

Q16. How will the per year skills acquisition premium be determined, and then applied to differences in training? There is a very low level of acceptance amongst Specialists for only 4% variance per year of additional training, when compared with expected income advantages per year of additional study in our society generally. We would propose a significantly higher percentage correction.

Q17 Further, how will the ANDI process precisely adjudicate physician training years when there is significant variation even amongst the same specialty group?

Q18. What is the most reasonable rather than expeditious negative adjustment threshold, taking into consideration not just the sum of potential component errors within ANDI calculations, but also harder to measure yet equally important factors including specifically **productivity** (ie the intensity, consistency, or pace of the average work day in a Section)?

Q19. What is the impact on validated Section fee equity / INRV processes when ANDI adjustments are made on Sections (up or down), and is fee equity or income equity the priority when these concepts are in conflict?

Q20. How will there be an opportunity to measure and mitigate undesirable impacts on physician supply, patient care quality, patient access, or wait times if ANDI is to be fully achieved in just “5 years or less”?

Q21. What is the accountability mechanism should quality of patient care quality, patient access, or wait times deteriorate in Sections receiving negative allocations from ANDI?

Q22. What is the accountability mechanism should patient care quality, patient access, or wait times not improve in Sections receiving positive adjustments from ANDI? (IE. is there any “Patients First” vision to ANDI?)

We strongly believe in a united profession. Further, we believe that the AMA should represent all of its members and Sections fairly, honestly, and transparently. This should be the case regardless of specialty, number of members per Section, income level, choice of work hours, or practice pattern (academic or private practice). We appreciate your review of our specific concerns and await your consideration of the above questions.

We need to hear from the Board and know that the organization that represents us shares our values.

Sincerely,

Glen Sumner
President, Section of Cardiology

Robert Davies
President, Section of Diagnostic Imaging

John Huang
President, Section of Ophthalmology

Earl Campbell
President, Section of Plastic Surgery

Howard Evans
President, Section of Urology

Magnus Murphy
President, Section of Obstetrics and Gynecology

Chris Keeling
President, Section of Dermatology
and Dermatologic Surgery

Warren Yunker
Representative, Section of Otolaryngology,
Head and Neck Surgery

Anand Bala
President, Section of Gastroenterology

Luc Berthiaume
President, Section of Intensive Care

John Colebrook
President, Section of Emergency Medicine