



# AMA Compensation Committee's Proposed Adjusted Net Daily Income (ANDI) Model

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## Introduction

The AMA Compensation Committee (AMACC) is proposing the implementation of a new allocation model to address differences in income earning capacity between sections.

## Proposed ANDI Model

The Adjusted Net Daily Income (ANDI) model provides a method to compare daily income earning capacity between sections, and then allocate funding to address relativity differences. Models of this type are currently in place in Ontario and British Columbia.

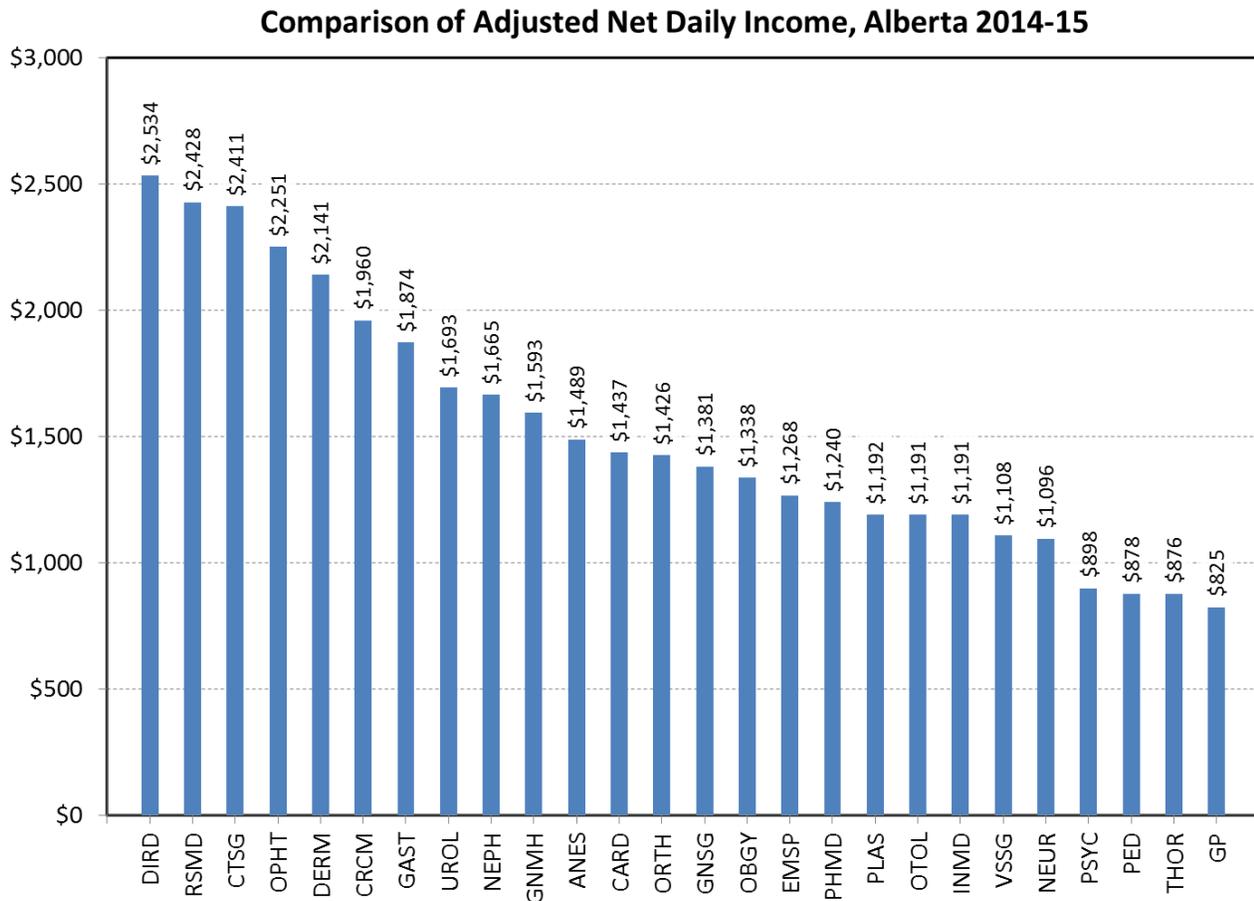
Data are collected on average gross fee-for-service billings per section, removing low outlier billings (i.e., days when physicians billed less than 5% of the average for their section) and removing from the analysis claims for after-hours premiums, surcharges and callbacks. The specific services provided after hours are still included. AMACC is proposing to exclude only the "overtime" amounts.

The following adjustments are then applied:

1. **Overhead costs for each section** – Overhead is removed from the daily billing data using estimates from the Physician Business Cost Model (PBCM). It is noted that the Physician Compensation Committee (PCC) is considering an upgrade to the PBCM, a process which will take about one year to complete.
2. **Skill acquisition modifier for additional training** - Before comparing with general practitioners (GPs), specialist data is netted downward by 4 percent per year of additional post-secondary training (over and above the three years that GPs train), to recognize the additional training for the level of complexity associated with specialist work. The training modifier can also be considered as an adjustment for the level of complexity of work. This modifier is based on expert panel opinion in Ontario and British Columbia (BC).
3. **Opportunity cost of training** – Before comparing with GPs, specialist data are also netted downward by the opportunity cost of taking additional specialist training (based on actuarial comparisons in Ontario of lost earnings during specialist residency training).
4. **Further adjustments being considered** – Along with implementation of the ANDI model as presented in this paper, the AMACC will consider further enhancements over the next few years and prior to redistributing funds between sections. Examples of further enhancements include adjusting for:
  - Differences in daily hours worked – the AMACC is interested in exploring methods to measure and account for variability between sections for hours of work per day.
  - Non-Fee-For-Service (FFS) components such as Workers Compensation Board (WCB) payments and Alberta Health Services (AHS) compensation – the AMACC is interested in incorporating this information should it be accessible.

- Improving the estimates of skill acquisition - There is some opportunity to work with Ontario (and possibly BC) in updating skill acquisition and opportunity cost modifiers over time.
- Alternative Relationship Plan (ARP) and Academic ARP (AARP) - More work needs to be done to incorporate ARP and AARP compensation, particularly for sections with higher proportions of physicians participating in these plans.

Calculating a preliminary ANDI comparison for Alberta using 2014/15 data yields the following chart:



After adjustments are made, there is **an approximate 3.1:1 spread from the highest earning to the lowest earning section.**

Note that ARP-dominated sections (e.g. Neurosurgery, Rheumatology, Infectious Diseases and Endocrinology/Metabolism) have been removed from these initial estimates, as the limited amount of fee-for-service earnings in these sections is not a good reflection of earning capacity.

## How the ANDI Model is used in Allocation

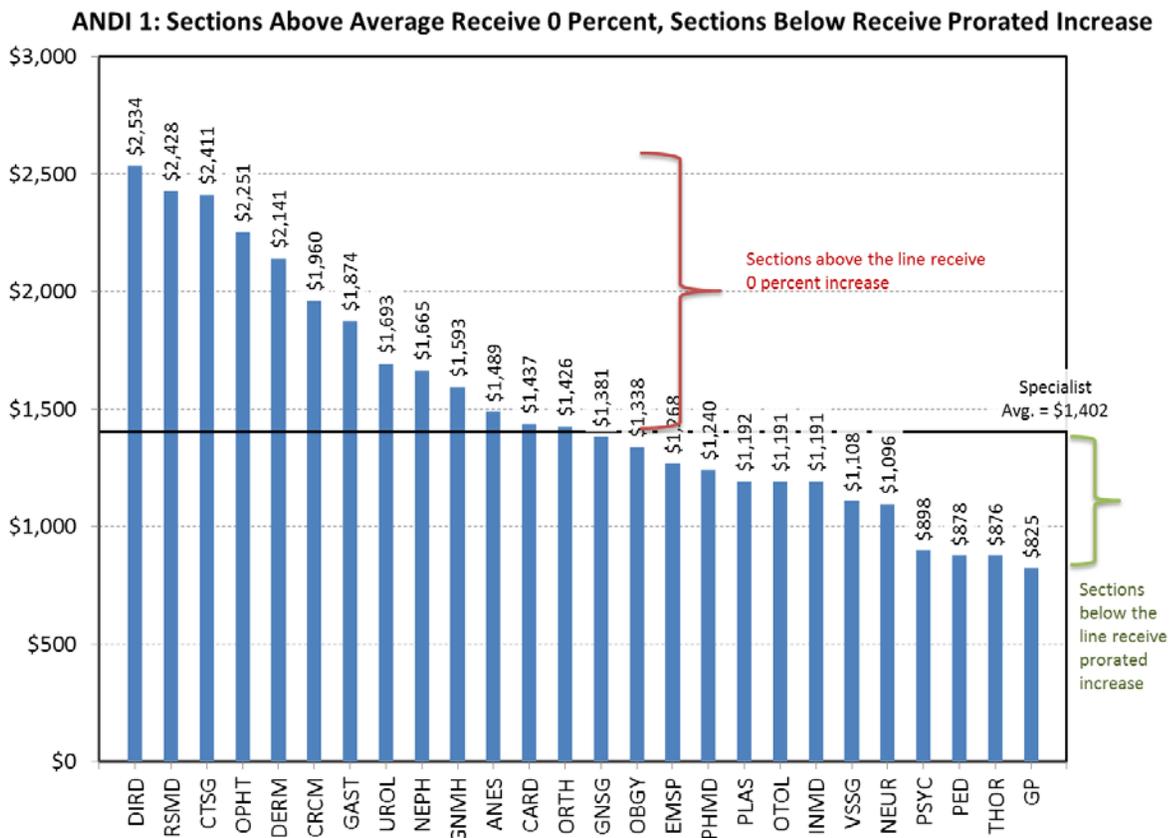
ANDI models provide a facility for scaling allocation adjustments. Once implemented, an Alberta ANDI model would provide a great number of possibilities for allocation based upon policy parameters established by the AMA Board and PCC. These parameters can be varied to meet specific allocation objectives.

One policy decision, for example, is to determine how much of total negotiated increases should be dedicated to the ANDI adjustment, and how much should be dedicated to the other allocation pools (such as overhead, per-SAE, priority items, or other categories). In Ontario and BC where these models have been deployed, the ANDI component has represented from 50% to 100% of total allocation funds available.

The board and PCC can then determine the scale and speed of ANDI adjustments. The analysis below outlines some potential options.

### 1. Provide an increase to only those sections earning less than the specialist average

Ontario and British Columbia models have been typically used to target only lower earning sections. An average adjusted net daily income is calculated for all specialists (the black line in the chart below) which forms the baseline upon which section earnings are evaluated. Sections above the baseline receive a zero percent increase in ANDI funding. Sections below baseline receive an increase based on how far they are away from this target (and how much money is available for allocation). For example, a section that is 20 percent below the target would receive twice the percentage increase of a section that is only 10 percent below target.



One benefit of this approach is that no section receives less than 0 percent, potentially making the allocation more palatable to some. The approach also has drawbacks:

- Adjustment is potentially very slow, particularly in an environment of low increases. Assuming that overhead cost increases are covered through another allocation pool, the expected timeframes to achieve ANDI equity among sections are as follows:

Scenario	# of Years to Reach Equity*
1. 2% per year ANDI allocation and assuming that sections' fee utilization does not increase over time	<b>36 years</b>
2. 2% per year ANDI allocation and assuming that each section's utilization grows at ½ the average annual rate experienced over the 2008-2014 period to a max of 2.5%.	<b>972 years</b>

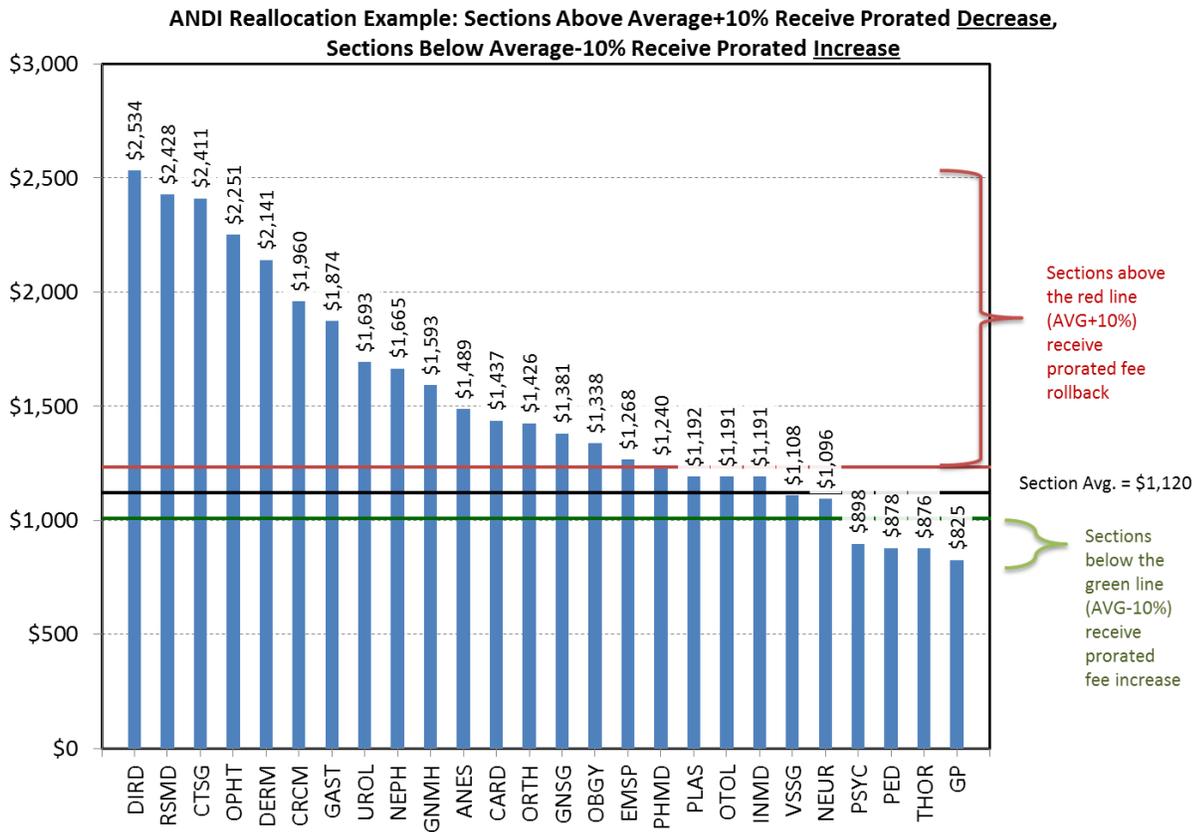
\* All sections within ±10 percent of ANDI line (i.e.; they are within 10% of the 'all-specialty average net daily income' after adjusting for differences in overhead, skills/complexity, training, after hours work)

- Giving all sections above the target a zero percent increase may be considered to be inequitable by some sections. As an example, the Section of Orthopaedic Surgery with an adjusted net daily income of \$1426 per day would have received the same zero percent increase as the Section of Diagnostic Imaging at \$2534 per day. This could be addressed by establishing the baseline at the top earning section (i.e., that section receives 0 percent) and providing all other sections with an increase scaled according to their distance from this baseline. The downside is that adjustments would be even slower than those listed in the table.

## 2. Using ANDI for Redistribution

ANDI models can also be used to redistribute funding between sections in an environment of low or zero increases, by reallocating funding from high earning sections (by having them reduce fees) to lower earning sections.

Using the ANDI model, this could be achieved by setting the baseline at the 'all section' average. Any sections above the "average +10%" line would receive a scaled decrease. Any section below the "average -10%" line would receive a scaled increase. The ±10 percent band recognizes that there will always be some variability or uncertainty associated with the data.



If we used as an example, a 5 percent cut in fees for the highest earner, the adjustments would range from a low of -5% for the highest ANDI section to a high of +3.4% for the lowest ANDI section.

Depending on the size of the negative adjustment, this has a potential to reach intersectional equity in a much shorter timeframe. Assuming overhead costs are covered though another allocation pool, the adjustment periods to reach ANDI equity are as follows:

Scenario (profession receives)	Top earning section receives	Adjustment period*
0 percent overall increase in fees, utilization not increasing	-5 percent per year	<b>18 years</b>
0 percent overall increase in fees, with each section's utilization increasing at ½ the annual rate experienced over the 2008-14 period to a max of 2.5%	-5 percent per year	<b>30 years</b>
2 percent overall increase in fees, with each section's utilization increasing at ½ the annual rate experienced over the 2008-14 period to a max of 2.5%	-5 percent per year	<b>18 years</b>

\* All sections within ±10 percent of ANDI line (i.e. they are within 10% of the all specialty average net daily income after adjusting for differences in overhead, skills/complexity, training, after hours work)

While it's theoretically possible to move to ANDI equity in a shorter period of time using more aggressive reallocation, the AMACC recognizes that it's likely not realistic given market factors and the potential for unintended consequences. That said, the AMACC supports moving toward equity goals more aggressively than in the past.

## AMACC Recommendation

The AMACC recommends that the AMA Board of Directors adopts and applies the ANDI methodology as follows:

- Within a rapid timeframe (e.g., five-year plan) to significantly improve intersectional equity.
- Targets and timelines should be debated and clearly communicated to the profession (e.g., will reduce ratio of high to low earning sections from current 3.1: 1 to "x").
- Targets and timelines should recognize:
  - That it will take a significant adjustment period to reach equity;
  - That the adjustment parameters (e.g., time period, scale of adjustments) will need to be monitored and adjusted as we move forward with annual adjustments (i.e., to adjust for factors such as future utilization increases);
  - That there is a level of uncertainty of the known components (such as time and overhead) as well as timelines of the work underway to reduce this uncertainty (such as the overhead review); and
  - That the magnitude of the difference between high and low sections is significantly larger than the uncertainty of the known components.

More specifics on the AMACC recommendation will be discussed at the upcoming RF.