Alberta Medical Association

Special Meeting of the Representative Forum

Chinook Ballroom
Calgary Airport Marriott In-Terminal Hotel
2008 Airport Road NE, Calgary

Saturday, June 10, 2017

AGENDA

9 a.m. **Breakfast** (Continental Breakfast available in the Foyer)

9:30 a.m. **Call to Order, Speaker's Remarks**

9:45 a.m. **President's Comments**

10 a.m. **AMA Compensation Committee Report**
Objectives: To receive an update on activities arising from the Spring 2017 Representative Forum (RF) resolutions related to income equity; To receive an update on development of the project plan to be presented at the Fall 2017 RF meeting

Background documents:

- Session Overview – Income Equity Strategy
  - Attachment 1: Income Equity Project Organizational Chart
  - Attachment 2: Project Plan Outline with Milestones and Timelines
  - Attachment 3: Initial Consultations and Planning for Engagement
  - Attachment 4: Income Equity FAQs – May 30, 2017

11 a.m. **Motions**
Objective: To consider motions related to equity

12 p.m. **Lunch** (Buffet Lunch available in the Foyer)

12:30 p.m. **Motions** *(continued)*
Objective: To consider motions related to equity

3:55 p.m. **President's Closing Remarks**

4 p.m. **Adjournment**

AMA Income Equity Strategy

Session Overview

Special RF June 10, 2017

PANEL:	AMA CC Co-Chairs	Dr. Steve Chambers and Dr. Jeff Way
	AMA President	Dr. Padraic Carr
	AMA CEO	Mr. Mike Gormley

OBJECTIVES: To provide an update of activities resulting from March 2017 RF, as well as an overview of project plan to achieve equity.

DIRECTION FROM RF (Three key motions):

- 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 Representative Forum.

PROGRESS re Income Equity and ANDI processes (AMACC activities): Dr. Way

- Review of RF Direction
- Board mandate to AMACC re Income Equity
- Process for reviewing data sets to be considered for the ANDI Model
- Process to arrive at an income equity definition
- Direction to the project manager regarding expectations of the project (implementation) plan
- Initial engagement and consultation process
- Advice re the FAQ document and process

PROJECT PLAN - Overview of development: Dr. Chambers

- Organization and project responsibility model – including PCC's role and potential negotiations position.
- Preliminary high level outline of the equity plan and milestones, sequencing and timelines
- Resource requirements / budget estimates
- Engagement and opportunities with sections

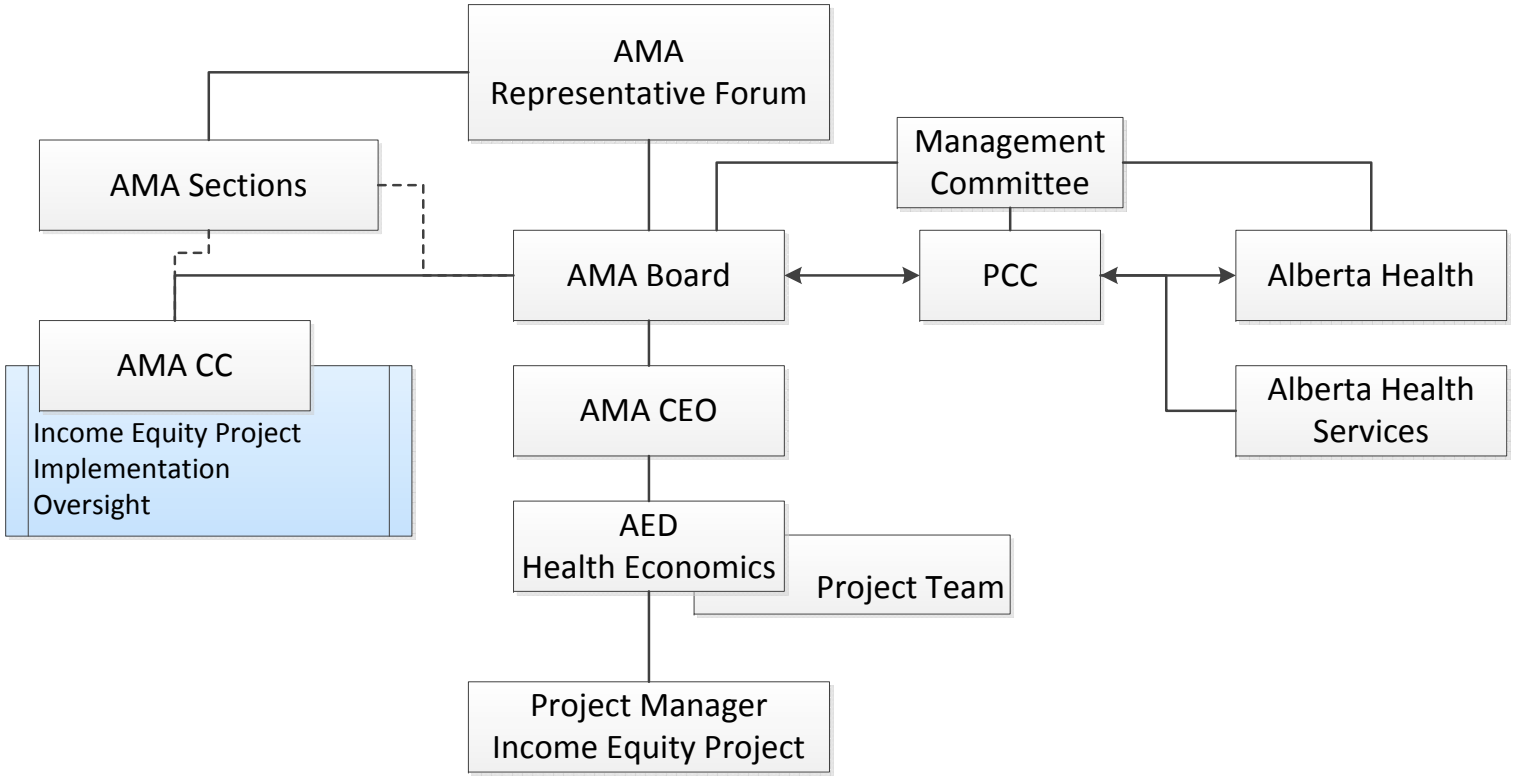
Opportunity for Q&A on the project plan, process and future activities: All

Supporting Documents:

Attachment 01 – Income Equity Project Org Chart
Attachment 02 - Project Plan Outline with Milestones and Timelines
Attachment 03 - Initial Consultations and Planning for Engagement
Attachment 04 – Income Equity FAQs – May 30, 2017

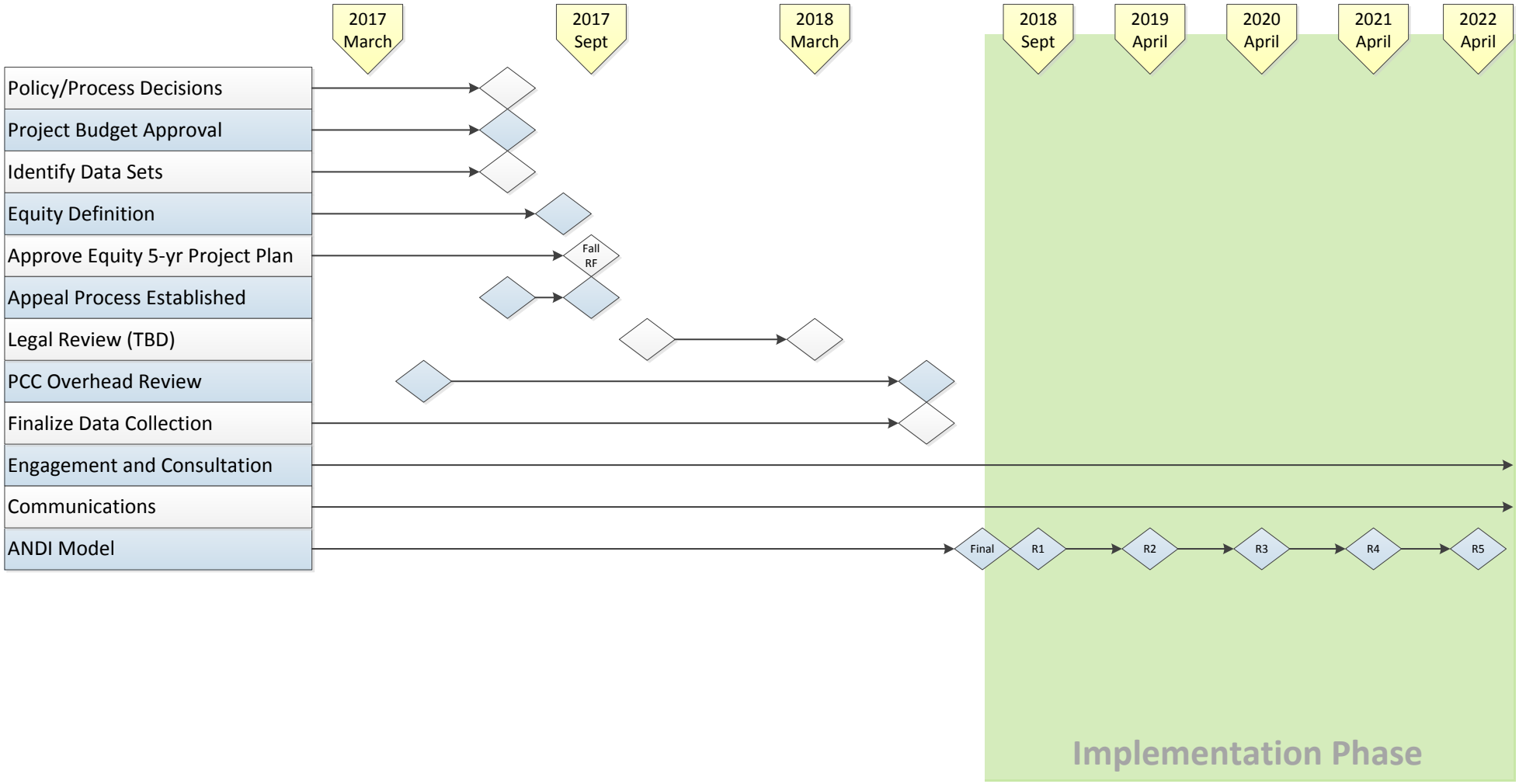
Attachment 01

AMA Income Equity Project Organization June 2017

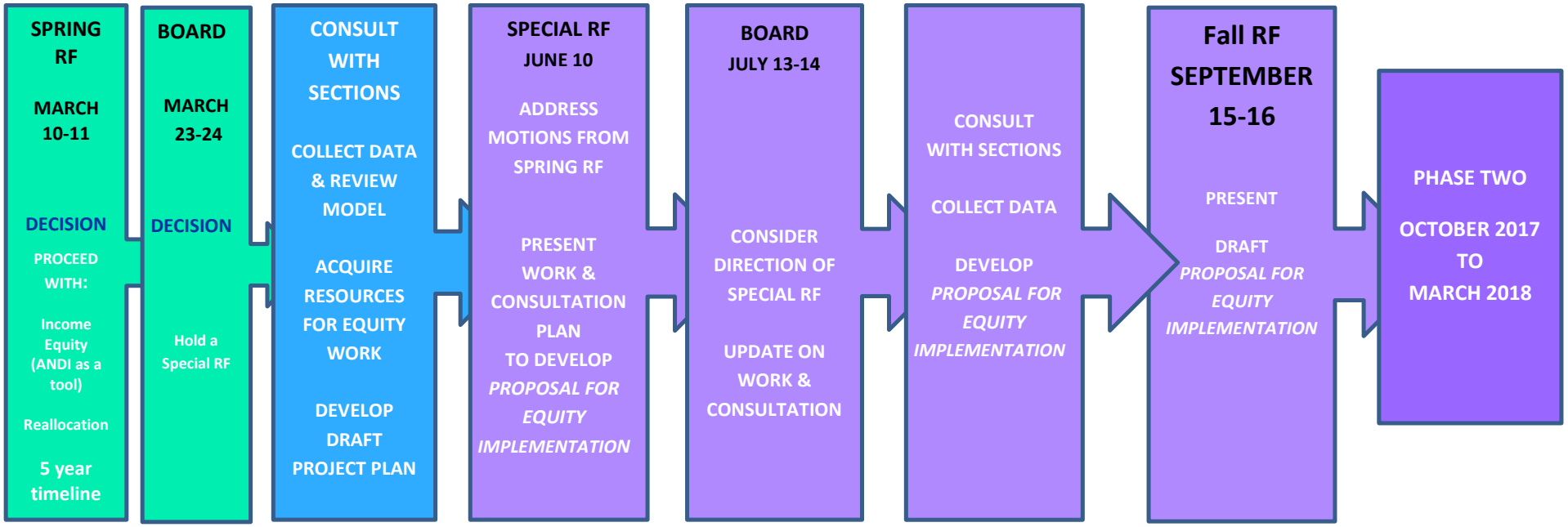


AMA Income Equity Project Timelines – To Get Us to The 5-Year Plan

Attachment 02



Moving to Income Equity
Initial Consultations and Planning for Engagement
March – September 2017



Completed

In Progress

Future Process

Income Equity – Frequently Asked 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 will be the de facto method that is developed to deliver fee/income equity?

A1: The RF has carried a motion that approves the use of an ANDI model towards income equity. It also directed that reallocation be used to achieve income equity. This is direction to the Board from the RF. The Board will continue to make it clear that the examples provided at the Spring RF were examples only, and the necessary data is still being collected. For example, the PCC is in the process of launching an RFP to improve the overhead model and there will be further engagement of all sections to do this. New and improved data will result in changes to the ANDI calculated results.

Q2: Does the AMA regard reallocation as an effective means to achieve income equity?

A2: With any representative organization, there is always a balance between representing the interests of the whole and those of individual members when those views may be different. Representation includes more than just fees. It also involves section negotiations, benefits, and advocacy for members and patients. At a time when the AMA is increasingly taking on stewardship roles, ensuring that the health care system remains sustainable is also in the best interests of all members and patients. At the Spring RF, a motion was carried that, "reallocation be a mechanism to achieve intersectional income equity." It is up to the Board to determine how it will meet the direction provided by the RF and the Board will do so while maintaining a unified approach. The Board is also committed to listening to all members in order to act in the best interests of the profession.

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?

A3: Most medical associations have long recognized their roles with respect to managing an equitable fee schedule. That being said, the AMA believes the Alberta government also has an interest in achieving physician income equity. As a medical association we must examine what is occurring in other provinces and determine whether it is more appropriate for us to reallocate, or to wait for government to reduce the highest paid sections using less sophisticated means of comparison, and without concern for transfer or cost neutrality. The ANDI model reallocates monies, and is not a means to take funds out of the system. The intent is to ensure reallocation occurs (not cost savings) and that we are able to demonstrate success in moving towards equity as an organization and a profession.

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

A4: At this stage, the AMA does not have a position with regards to including ANDI reallocation in our negotiations of the next Master Agreement, and we will need to further consult with sections and seek further direction from RF. However, we do recognize the need to ultimately have government support any allocations or reallocations in the future.

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?)***

A5: While all sources of data are being considered to help inform the ANDI reallocation, the focus will be on income sources that are either part of the physician services budget (PSB) or linked to the PSB, and which can be realistically measured. Other sources – such as private billing – would be helpful and, if obtainable, will be used to better understand the time (FTE) and overheads that are specifically related to the physician services budget. It is certainly our intent to gather all available data to inform our models.

Q6. If considering revenue and work hours beyond those related to SOMB billings, how does the AMA intend to identify these fairly and inclusively from all members across all Sections?

A6: As above, we are prioritizing ANDI towards payments to physicians that are within or linked to the physician services budget. Other data sets will be helpful and we hope to develop fair methods of collection over the months ahead. Consultation with sections will be ongoing. The model will also be subject to change as data changes or new data becomes available over the years ahead.

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?

A7: The AMA Compensation Committee will discuss and advise on this matter. Clearly, data availability quickly becomes an issue when considering payments outside of the fee schedule. We also need to be cognizant of market factors. Further consultation with sections and RF advice will help to clarify as well. We will keep you apprised as more information on this particular question becomes available.

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?

A8: We are also respectful of a motion carried by RF (in fall 2016) that, "in the context of seeking long term intersectional income equity, that the sharing of the $100 million cost reduction should be equitably apportioned throughout all sections." With the right timing using latest data, it is presumed that those sections that have identified SOMB adjustments will accordingly experience reduced expenditures within the timeframe necessary to be included in the ANDI data. As such, it is hoped that undesirable distortions will be a non-issue. However, the Board will be considering this along with the timing of the ANDI reallocation and, if necessary, will consider other distribution methods in favor of the motion. As mentioned above, we will attempt to examine all income sources in determining our model, and this will necessarily involve consultation with sections.

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?

A9: This has not yet been determined - we will need to consult with sections and seek further direction from RF and sections. However, we will not know the full impact of SOMB changes until the June 2018 reconciliation.

Q10. Will ANDI be an annual, daily, or hourly rate calculation?

A10: ANDI is by definition a daily rate calculation. However, we have heard from many physicians of the importance of gaining a better understanding of the hourly contributions that physicians are making. The AMACC is exploring ways to estimate hours worked and we are hopeful this can be accomplished to the satisfaction of the profession.

Q11. What proportion of allocations will be determined by ANDI?

A11: This is not yet determined. Since the RF has directed that reallocation be used towards establishing equity, we have yet to see whether the Board and RF will want more or less reliance on using allocation for these purposes. The weighting of various allocation factors during any given year is usually determined by the Board prior to that year's allocation.

Q12. How will work hours and revenue from those be measured and validated, and how will the AMA accurately and fairly match included income with relevant work hours?

A12: The AMACC is exploring ways to estimate hours worked. Since we are looking at ANDI specifically as it relates to PSB, it will be important to capture the hours worked data accordingly.

Q13. How will overhead be measured and validated, and how will that be used in ANDI and in other future allocations?

A13: The previous model of measuring overhead, known as the Physician Business Costs Model, was developed in 2009 using data that sections provided at the time and is due for an upgrade. As such, the PCC is in the process of launching an RFP to research and estimate physician overhead costs. The AMA and AH have recognized that this will take a significant amount of work and the parties are prepared to commit up to $1M towards this effort. As presented at RF and in recent documents, overhead is a major consideration for ANDI. It is not yet clear how this data will be used for future allocations. The RFP provides latitude for the consultants to propose an approach to data measurement and validation. At this point, we're anticipating that there will need to be some on site (i.e. in clinic) validation of overhead data.

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?

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? Is 4% variance for additional Specialist training sufficient, or should it be a 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?

A14, 15, 16, 17: The AMACC has brought forward an example that has been adopted in BC and Ontario. However, this is provided as an example only and it will need to be determined how or if these figures will be applied in Alberta. It is hoped that training specifics (including longevity) as related to ANDI will be clarified over the next year. We will continue to update the profession as the AMACC develops recommendations in this regard.

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 (i.e. the intensity, consistency, or pace of the average work day in a section)?

A18: The AMACC is considering a reasonable threshold (or equity comfort zone) for ANDI, based upon an assessment of the level of confidence in the figures used to determine ANDI. This threshold may start relatively wide but could reduce over time as our level of confidence in the measurements improves.

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?

A19: Sections will continue to maintain a level of responsibility for the intra-sectional (fee) equity concerns. As ANDI is focused on inter-sectional (income) equity, and assuming sections manage relativity of fees within, we see these initiatives as complementary and don't anticipate many conflicts to arise.

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, 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? (i.e. is there any "Patients First" vision to ANDI?)

A20, 21, 22: A motion was carried at the RF that, "AMA recognize the danger to its members from unintended consequences of performing multiple and uncoordinated fee and cost adjustments concurrently." With respect to this motion, it will be important for the ANDI process to consider market impact. Obviously, this implies the need to closely monitor and be aware of potential unintended consequences and make any necessary adjustments along the way. With the Amending Agreement, we have established the Physician Resource Planning Committee to assess needs and physician supply. Our ongoing monitoring of other factors will likely come from various sources, including consultation with sections, as is the case now. If unintended consequences to patient care appear to arise, we will obviously need to examine the root causes of these very carefully. Every situation is likely to be different, and may require unique solutions.

Q23: What if different sections (i.e. family physicians versus specialists) do not agree with the approaches being taken to achieve income equity?

A23: The Board has been given clear direction from the RF, but it is important that we proceed in a tempered and measured way. We need to go forward respecting the views of all of our members, and the Board has committed to ongoing consultation with sections throughout the process. At the Spring RF, many specialty groups spoke in favour of addressing income equity. The motions and discussion at our latest RF demonstrate the importance of - and the appreciation for - a unified approach towards income relativity. At times, there will likely be disagreement on approaches. However, there is strength in unity when it comes to representing the profession as a whole; making sure the health care system remains sustainable for our members and the patients we serve.

Q24: Will the income equity process address uneven section contributions to the SOMB Rules Initiative?

A24: A motion was made at the RF that, "with regards to the Amending Agreement Schedule of Medical Benefits (SOMB) initiatives, the AMA will implement a plan to move towards equality of contributions amongst all sections, no later than April 1, 2018." This motion was referred to the board due to lack of time and may be brought forward and discussed at the Special RF on June 10.

Q25: How will the AMA ensure that we are comparing 'apples to apples' when it comes to including overhead in the ANDI model?

A25: The PCC is in the process of launching an RFP to research and estimate physician overhead costs. The AMA and AH have recognized that this will take a significant amount of work and the parties are prepared to commit up to $1M towards this effort. The business costs methodology will continue to evolve over time, but this next stage should bring us a lot more certainty. Once an appropriate vendor is selected, the next step will be to collect and analyze the data working with each section to produce a modernized version of the Physician Business Cost Model. The results of the new overhead model will be applied to the ANDI application to assist the profession with its equity related decisions. Determining accurate overheads is a necessary step in moving forward with the direction from our RF.

Q26: ANDI does not reflect the relative work efficiency, nor the hours of work performed by various groups of physicians (including groups within the same section). How will the AMA address this?

A26: AMACC is interested in finding ways to estimate the hours that each section is performing, along with numerous other data sets. They are engaging sections in this discussion and intend to develop a reliable ANDI methodology that has considered the concerns from all sections, while balancing the need to have reliable results.

Q27: Changes in practice and technology for some procedures can result in substantial increases in volume in a short amount of time. Until such time that these issues can be properly addressed, through intra-sectional relativity or the income equity process, has the AMA considered implementing a sliding scale reduction to temporarily deal with these rapid changes in billing patterns?

A27: We understand that some sections are considering a volume-based discounting method as part of their INRV (allocation) process. The sliding scale is just one of many approaches that can be taken. However, this approach may not work with all fee codes that have experienced a significant increase in utilization (such as recently new codes, for example). The AMA will rely on sections to manage these options as they have a much better understanding of their procedures, their codes and the impacts that these kinds of changes would have.