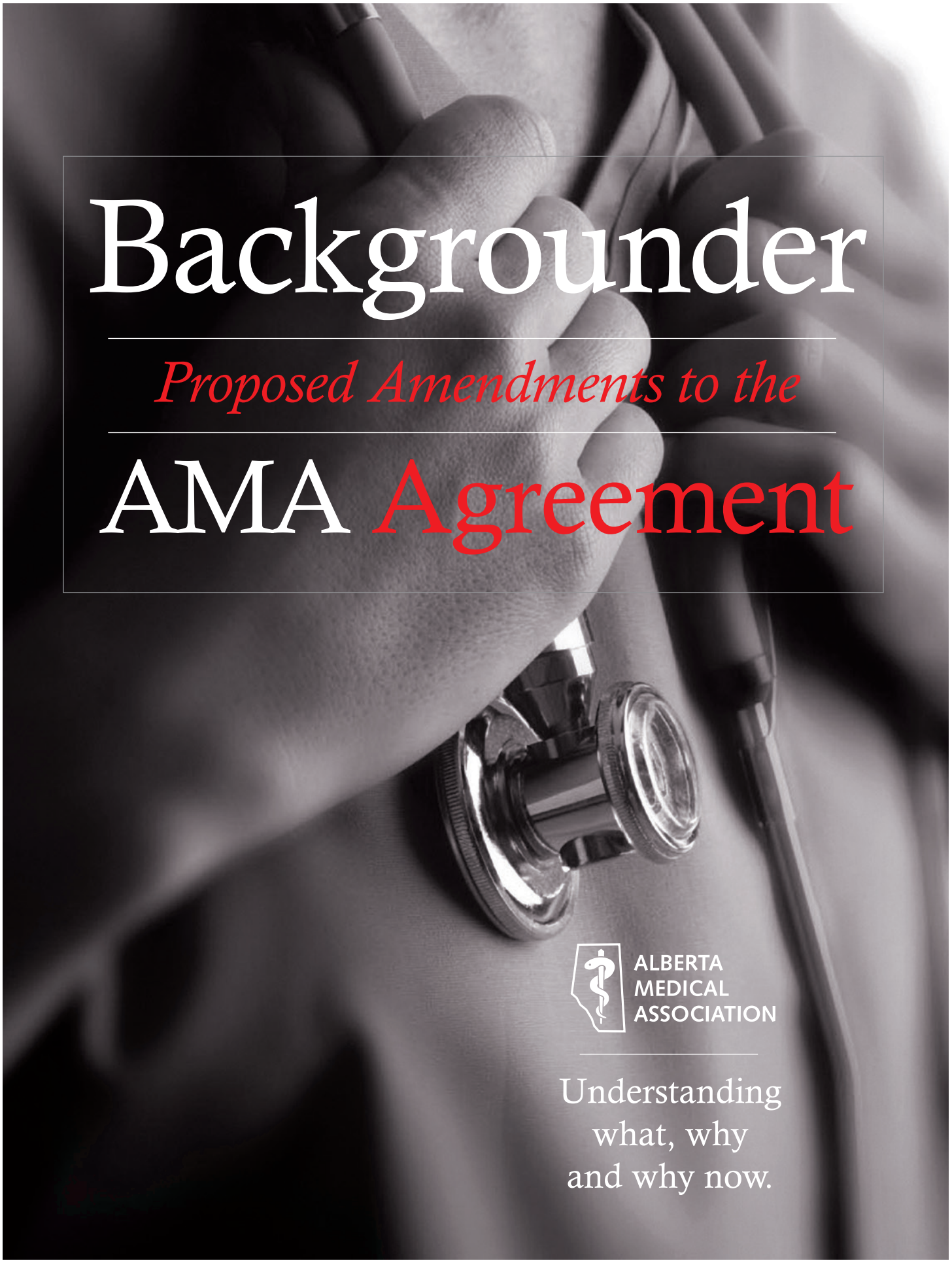


Backgrounder

Proposed Amendments to the

AMA Agreement

ALBERTA MEDICAL ASSOCIATION

Understanding what, why and why now.

Purpose & Outline

Note: There is a parallel tentative agreement being considered by physicians as part of the whole tentative amendments package. This is the Strategic Agreement (SA) and it deals with the relationship between independent contractor physicians and Alberta Health Services (AHS). You can review information about the SA on page 3 of the companion Overview document referenced at the bottom of the next column. The SA is not otherwise dealt with in this Backgrounder.

This backgrounder provides a description of the proposed amendments to the 2011-18 AMA Agreement which have been sent to physicians for a ratification vote closing Thursday, October 13, 2016.

The document describes the amendments not only in terms of what they are, but also showing the context in which they were developed and how the various pieces fit together. The overall goal of the amendments is to support a sustainable health care system that promotes fiscal stability and improves care for patients while keeping physician practices viable.

For a plain-language overview of the structure of the tentative amendments within the AMA Agreement, please see the companion document ***Overview: Tentative Amendments to the 2011-18 AMA Agreement.***

Considerations *in amending the* AMA Agreement

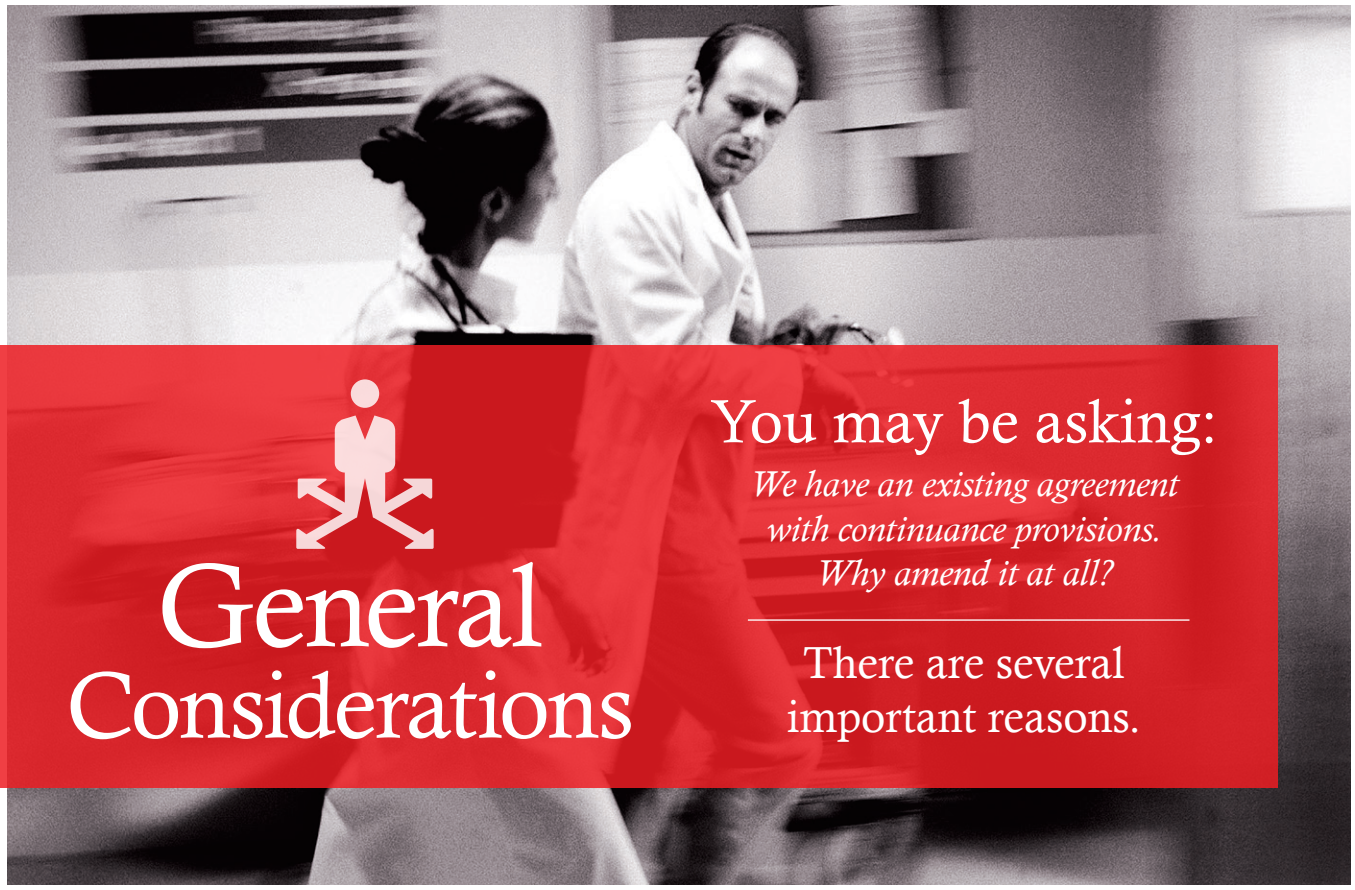
The AMA Agreement

It is important to note that ***what you are voting on is a set of proposed amendments*** *to the existing 2011-18 AMA Agreement.*

The AMA Agreement came into effect April 1, 2011. It dealt with several issues in contention at the time between the AMA and government, resulting in the following:

- Recognition of the AMA.
- Detailed provisions to address the way in which prices are established for medical services paid by Alberta Health (AH):
  - A negotiation process for establishing the overall price level, including binding arbitration.
  - The Physician Compensation Committee (PCC) which has the authority to change relative prices.
  - Financial terms, including annual price adjustments, agreed to through March 31, 2018.
- General provision for consultation between the AMA and AH on health system issues, including three Consultation Agreements: Provincial Electronic Medical Records; Primary Medical Care/Primary Care Networks (PCNs); and System-Wide Efficiencies and Savings (SWES).
- Continuance, by which we mean the terms for the financial reopener and ongoing provisions around recognition of the AMA and dispute resolution.

In terms of the proposed amendments to the AMA Agreement, the above points remain in place for the most part. Most importantly, recognition and dispute resolution are maintained.



General Considerations

You may be asking:

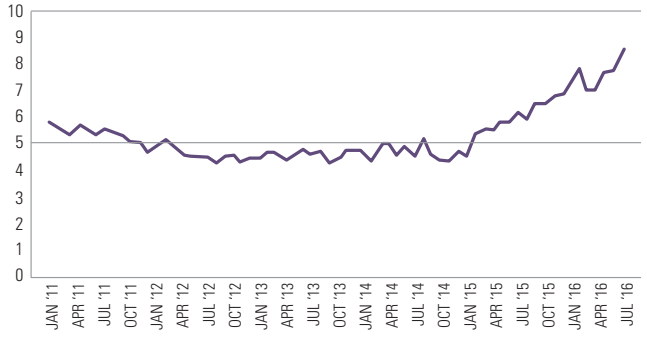
We have an existing agreement with continuance provisions. Why amend it at all?

There are several important reasons.

GENERAL ECONOMIC ENVIRONMENT AND TRENDS

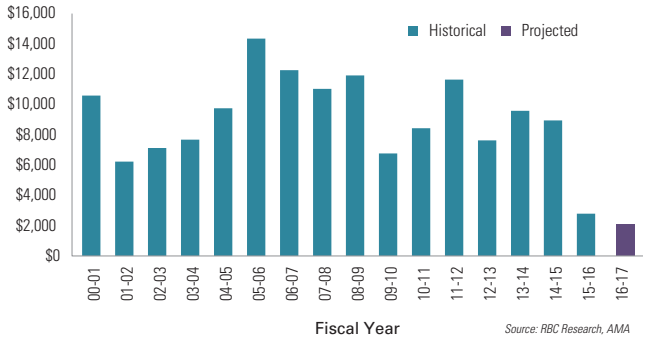
The severe fiscal straits of Alberta have been reported extensively in the media – some economic indicators appear in the charts addressing resource revenue, provincial deficit and unemployment. Health consumes 39.8% of the total provincial budget and continues to climb.

Alberta Monthly Unemployment Rate *(%)*



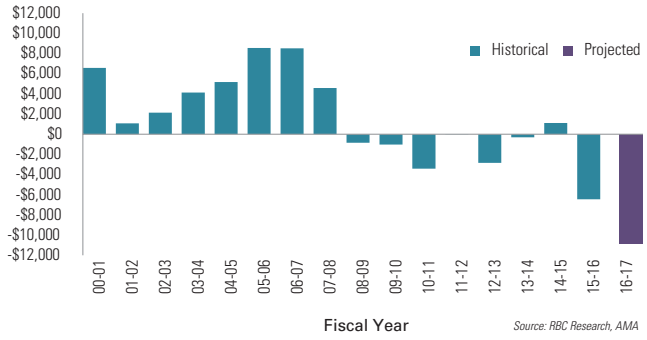
Source: Statistics Canada, AMA

Alberta Non Renewable Resource Revenue *($Billions)*



Source: RBC Research, AMA

Alberta Provincial Surplus/Deficit *($Millions)*



Source: RBC Research, AMA

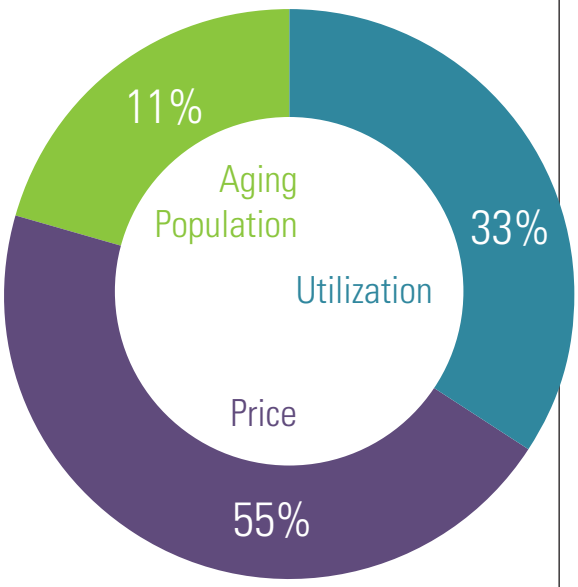
HEALTH EXPENDITURES

Against the background of the province's economic circumstances, we can also look into the increases in health expenditures. In general:

- Alberta has higher costs per capita than other provinces, especially for acute care.
- Health expenditures have been rising faster than the growth in the general economy and are rising more quickly than total government spending.
- While inflation, population growth and aging explain some of the increase, much of it has risen from the increased utilization of services per Albertan.
- Increased utilization involves many factors. Improved access to physicians and services – measured by physicians per capita – has increased significantly in Alberta over the past few years.

Government has stated its intent to reduce the rate of overall growth in health expenditures. This is the challenge for all provincial governments; Alberta's economic situation adds extra urgency.

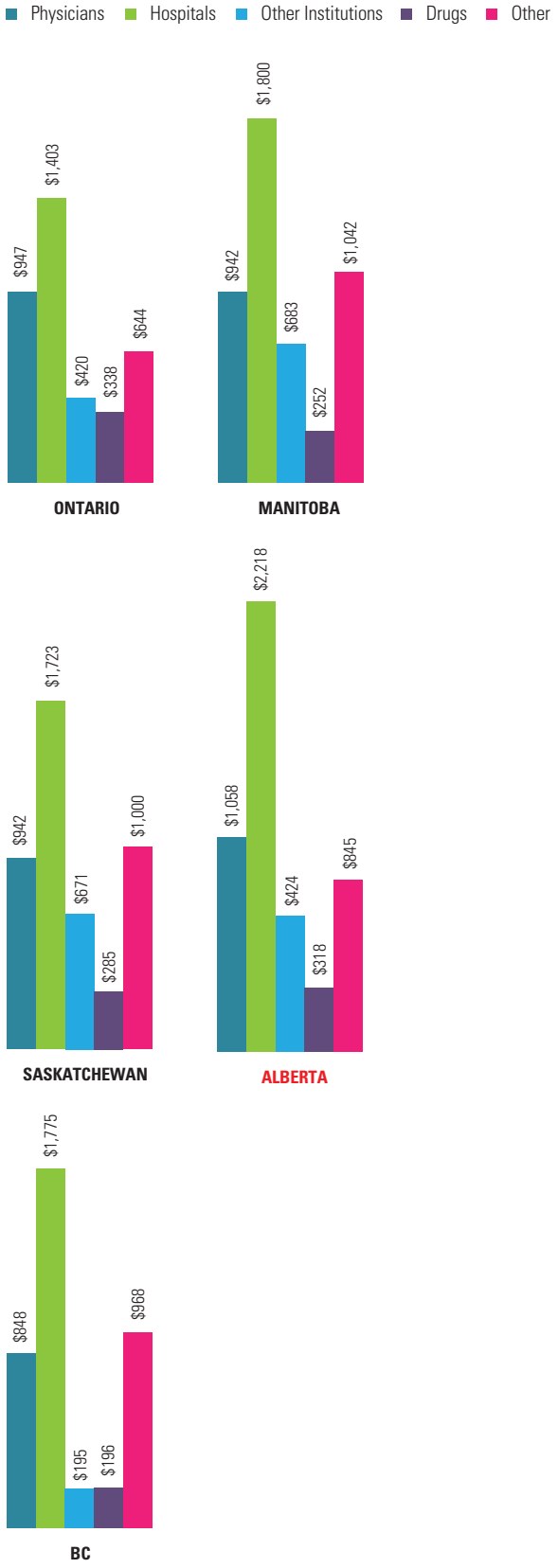
Drivers of Per Capita Physician Expenditure Increase 2014-15



Source: CIHI National Physician Database 2014-15, AMA

Per Capita Provincial Government Health Expenditures by Use of Funds

Current Dollars, 2015



Sources: CIHI National Health Expenditure Trends 2015, AMA

STEWARDSHIP AND PATIENT ADVOCACY

Government could apply any number of tools to restrain health expenditures in ways that do not involve physicians. For example, access of physicians to operating rooms or diagnostic services could be constrained, capital investment can be reduced or under funded or services could be deinsured. All these tactics have been used in the past.

If, however, the goal is not simply financial sustainability, but also to sustain quality and access, then physician participation is critical. Physicians bring expertise in the benefits and limitations of medical care. Working with patients, they have the responsibility to ensure that whatever resources are available are used to best effect.

TOWARD AN INTEGRATED SYSTEM

Short-term efforts to save dollars typically rely on cuts to fees or reduced access for patients. Whatever immediate impact they may have, they are not sustainable because they do not truly address the underlying issue that drives costs upward in the first place.

Much of the attention for longer-term, sustainable reform has focused on developing a strong primary care foundation within an integrated system. Through primary care networks (PCNs), Alberta has the beginnings of this transition – and creating a patient's medical home for every Albertan – but more needs to be done. This includes creating some level of standardization among PCNs, enhancing resources to deliver a broader scope of services and encouraging stronger links between community-based primary care and the rest of the system (specialist, hospital/facility, acute care, other programs and services, etc.).

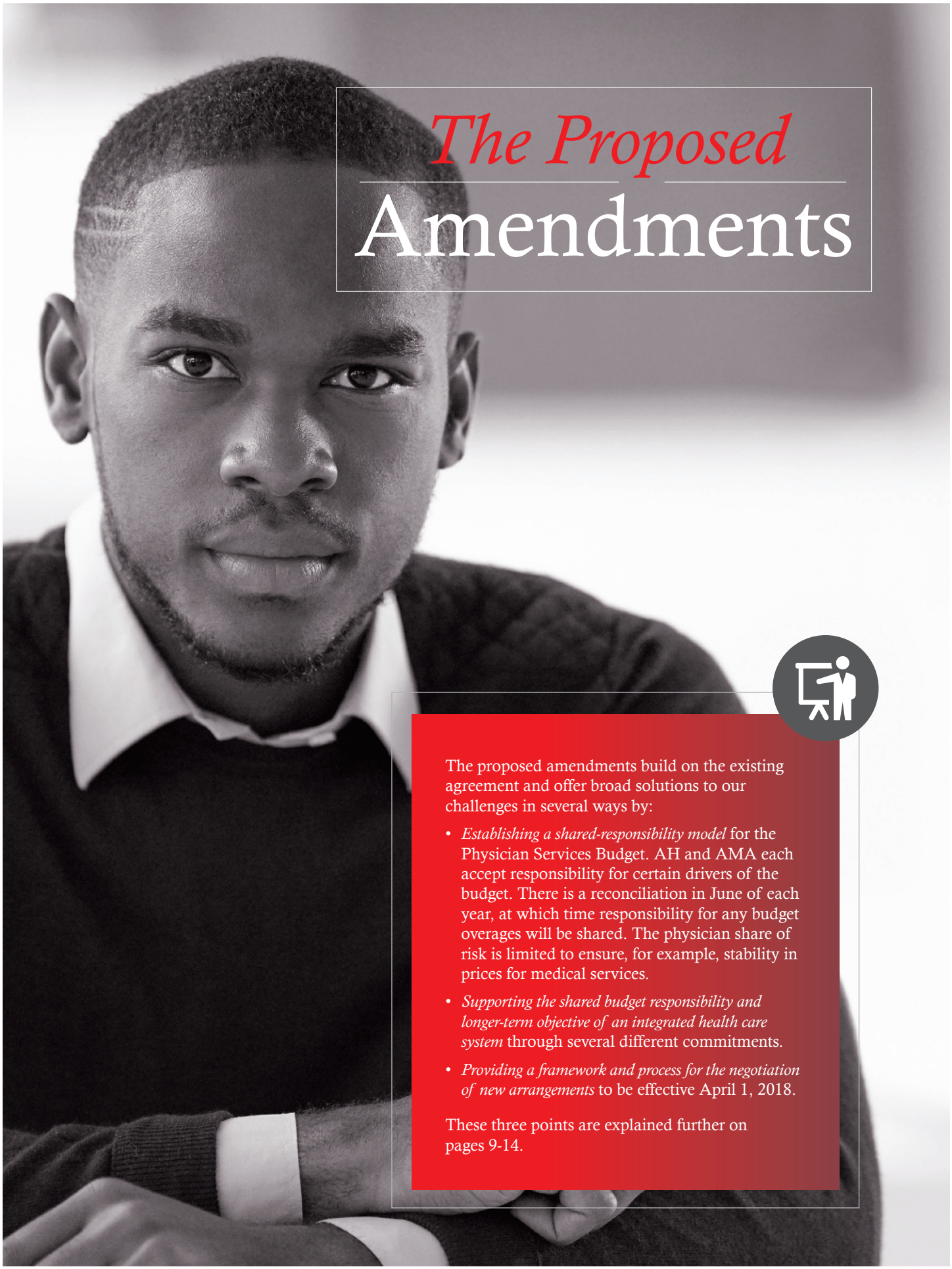
Why *now?*

The previous section points to a need for action, but not directly to the issue of timing. You might ask: *Can't things wait until March 2018?*

The challenges we have discussed are not diminishing – they are growing. Leaving matters as they are will simply aggravate the problem and reduce the range of options for managing them as this tentative amendments package attempts to do. For example, a key initiative proposed is a needs-based physician resource plan. Today we know that new graduates are beginning to have problems finding positions. The growth in physician numbers in Alberta is outstripping – by wide margins – both population growth and the output of medical training. It would not be prudent to let this continue to grow ad hoc when we have means to develop a needs-based and well-informed plan.

Additionally, whatever our own sense of urgency, it is unlikely that government will leave things as they are. As we have seen in other provinces, unilateral action by governments can damage not only relationships with the profession, but also cause harm to patients. Medical expertise is required to ensure that, whatever actions we pursue, the impact on patient care is minimized. At the very least, all decisions should be based on the best-available information about what that impact could be.

Finally, beginning now sets the stage for the negotiation of financial and other arrangements for March 2018. It makes sense to make a start toward dealing with some of the immediate challenges, commence some work on longer-term problems and settle on a clear negotiating process. In effect, an early start provides an 18-month controlled experiment through which we can assess results and fine-tune approaches – or devise new ones to replace those not working as expected.



The Proposed Amendments

The proposed amendments build on the existing agreement and offer broad solutions to our challenges in several ways by:

- *Establishing a shared-responsibility model* for the Physician Services Budget. AH and AMA each accept responsibility for certain drivers of the budget. There is a reconciliation in June of each year, at which time responsibility for any budget overages will be shared. The physician share of risk is limited to ensure, for example, stability in prices for medical services.
- *Supporting the shared budget responsibility and longer-term objective of an integrated health care system* through several different commitments.
- *Providing a framework and process for the negotiation of new arrangements* to be effective April 1, 2018.

These three points are explained further on pages 9-14.

Shared Budget Responsibility

There are three pieces to the shared-responsibility model

A. "Available Amount"

B. "Actual Expenditures"
(services, benefits and programs)

C. "Reconciliation"
(that is, establishing what happens if the Available Amount and Actual Expenditures don't match)

A. AVAILABLE AMOUNT

The Available Amount is the amount that Actual Expenditures are reconciled against and includes the payments for medical services (fee-for-service [FFS] and alternative relationship plan [ARP]) as well as programs (e.g., Towards Optimized Practice[TOP]). This is prior to the "Withholds" (which are described in Section C, Reconciliation).

The Available Amount is not fixed, but determined according to a formula laid out in the proposed amendments. For the first year of the amendments period, April 1, 2016 to March 31, 2017, the formula starts with what was actually spent in 2015-16. To this is added a "General Inflator" based on the cost of living, the "Impact of New Physicians" and what are termed "Contingencies."

The Impact of New Physicians is a calculation based on how many net new physicians enter practice, multiplied by the average cost that this generates. The Contingencies reflect other things for which government has accepted responsibility. Examples include: the off-loading of any services from AHS to the community; epidemics; new services introduced; or deinsurance.

Available Amount 2016-17

2015-16 Actual Expenditures
+
General Inflator
+
Impact of New Physicians
+
Contingencies

Available Amount 2017-18

2016-17 Available Amount
+
General Inflator
+
Impact of New Physicians
+
Contingencies

The calculation for the 2017-18 Available Amount is similar, but the starting point (the "Base") is the 2016-17 Available Amount. To that is added the General Inflator, Impact of New Physicians and Contingencies.

The financial management goal is, effectively, the Available Amount. The Reconciliation section below (Section C) explains how it works.

Where you will find it in the *Overview: Tentative Amendments to the 2011-18 AMA Agreement*

The following items can be found under Element 5 pages 6-8.

- Available Amount definition.
- The formula for Net New Physicians.
- The 2016-17 Base.
- The General Inflator, which is equal to cost-of-living-adjustment (COLA).
- The Contingencies.

B. ACTUAL EXPENDITURES

Actual Expenditures are just that: they are the amount spent by AH on medical services (FFS or ARP), benefits (parental leave, medical liability reimbursement, etc.) and programs (Physician and Family Support Program, TOP, Practice Management Program, etc.).

The amendments include three initiatives designed to reduce cost while maintaining value for patients.

- A list of Schedule of Medical Benefits (SOMB) rule changes will be developed to reduce expenditures by $85 million in 2017-18. These changes will be based on best evidence obtained from efforts such as Choosing Wisely Alberta and a survey of section leaders that took place in 2012 under the SWES Consultation Agreement (which is under the 2011-18 AMA Agreement). The commitment is to establish a list that the parties estimate will find the desired savings. The amendments describe a process that initially engages the profession, but ends, if required, with two arbitrators named in the amendment package.
- Savings from the first round of the individual fee review process of the Physician Compensation Committee (PCC), worth about $15 million per year, will be contributed to the SOMB rule savings target. SOMB rule savings are the only price reductions being considered as part of the $100 million under the SOMB rules initiative. The proposed amendments recognize this as a one-time exception to the general provision for PCC that fee adjustments are budget neutral.
- The Peer Review initiative is intended to inform physicians about billing rules and norms. It works with, but is distinct from, the audit activity that is carried out exclusively by AH. While the AH audit focuses on transgressions and individuals, the Peer Review initiative is intended as preventive medicine to prevent audits. The Peer Review will build on efforts and knowledge already delivered by the AMA to support accurate billing practices such as billing seminars from AMA staff, "Billing Corner" articles in MD Scope and the AMA Fee Navigator online billing tool.

Actual Expenditures

- What is spent in the year:
  - *Services*
  - *Benefits*
  - *Programs*
- Three initiatives to reduce cost but maintain value:
  - *SOMB Rules ($100 million annualized)*
  - *Individual Fee Review (completed): One time ($15 million)*
  - *Peer Review ($20 million in 2016-17, $35 million in 2017-18)*

Where you will find it in the *Overview: Tentative Amendments to the 2011-18 AMA Agreement*

- What is included with Actual Expenditures is defined in Element 5 pages 6-8.
- The SOMB Rules initiative is detailed in Element 6 pages 8-10.
- The Peer Review initiative is detailed in Element 3 pages 4-5.
- The one-time contribution of the PCC individual fee review is dealt with in Element 6 page 8.

C. RECONCILIATION

The Reconciliation process compares the Available Amount with the Actual Expenditures and establishes the consequences when the two amounts are out of sync.

The Withholds are fundamental to the Reconciliation process. The Withholds are payments that will not be made until the Reconciliation process is completed each year. The amount of the Withhold that is paid out depends on how closely the Available Amount and Actual Expenditures match.

For 2016-17, the Withhold is the 2016 Retention Benefit. If Actual Expenditures in that year are less than or equal to the Available Amount, the full Retention Benefit will be paid out. If Actual Expenditures exceed the Available Amount, then some of the Retention Benefit will be withheld, up to its total value. This is the maximum amount that can be withheld in 2016-17.

The situation is similar in 2017-18, except that the Withhold in that year is the value of the 2017 Retention Benefit and the value of the April 1, 2017 COLA. If Actual Expenditures are less than or equal to the 2017-18 Available Amount, then both the 2017 Retention Benefit and April 1, 2017 COLA are paid in full, the latter on a retroactive basis. If Actual Expenditures exceed the Available Amount, then first the Retention Benefit is withheld and then the COLA, up to their full values.

There are three important things to note regarding the Reconciliation process:

- The savings initiatives (see page 10) are best efforts in nature, that is, there is no guarantee that they will be achieved. It is, however, in the interests of physicians and government that they be reached: for physicians so that the remaining Retention Benefit and COLA can be paid; for government because it will assist in staying on budget.
- The maximum amounts that physicians can "lose" are the two remaining Retention Benefits and the April 1, 2017 COLA. While we are not downplaying the impact of the potential loss, we hope there is perceived value in the loss being limited.
- "Withhold" means just that – the amount that is held back until Reconciliation is completed. That period will be 60 days after the end of the fiscal year. Most importantly, therefore, in the 2017-18 fiscal year, there will not be an automatic SOMB price adjustment on April 1, 2017. Rather, following the Reconciliation for 2017-18, there may be an adjustment that is implemented retroactively to April 1, 2017. That Reconciliation is scheduled to be complete by June 1, 2017.

Withholds

- 2016 Retention Benefit
- 2017 Retention Benefit
- April 1, 2017 COLA (SOMB, ARPs, some benefit program rates)

Reconciliation

- If Actual Expenditure is LESS than Available Amount:
  - *Pay out COLA and Retention Benefit*
- If Actual Expenditure is MORE than Available Amount:
  - *Withhold some or all of COLA and Retention Benefit*

Where you will find it in the *Overview: Tentative Amendments to the 2011-18 AMA Agreement*

- The Reconciliation process is defined in Element 5 pages 6-8.
- The Withholds are defined in Element 5 pages 6-8.

Supports and Other Commitments

Several amendments support the shared budget responsibility and savings initiatives. Other amendments serve this purpose, but also attempt to place the system on a longer-term footing in balancing cost with access and quality.

PRIMARY CARE AND INTEGRATED DELIVERY

This document has already pointed out that combining financial and quality aspects in the definition of sustainability depends on our ability to continue to strengthen primary care within an integrated system. The tentative amendments include several vehicles:

- Agreement to develop a framework covering all PCNs and a ratification process for physicians on that matter.
- A commitment to develop provider and patient registries by end of 2017, tools that are key for numerous delivery initiatives.
- Development of a voluntary blended capitation compensation model for primary care.
- Additional support for change management programs of approximately $1.5 million a year.
- A new Integrated Care Consultation Agreement.
- Rationalization of numerous committees dealing with care delivery, clarifying their roles and responsibilities and with a commitment that the AMA will have representation on all.
- AMA representation on senior committees for the Academic ARP.

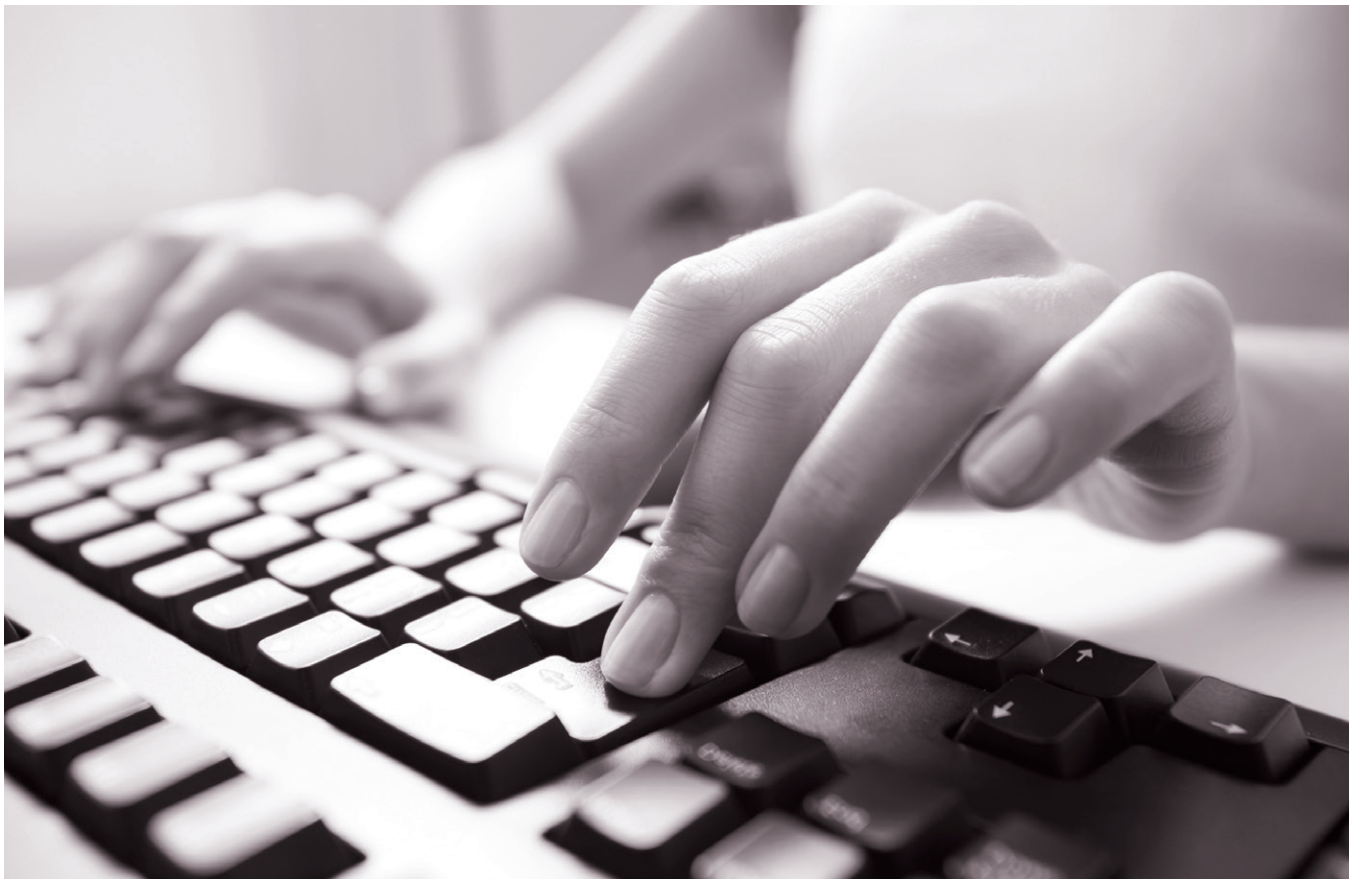
Other Commitments

- Primary care and integrated delivery
- Physician supply
- Access to information
- Governance of the AMA Agreement
- The AMA Agreement and 2018

PHYSICIAN SUPPLY

Alberta requires a needs-based human resource plan for physicians. We have reached the point where not all graduates can find positions and there continue to be problems of specialty mix and geographic distribution. The proposed amendments include a terms of reference for a Physician Resource Planning Committee, with representation from the AMA, College of Physicians & Surgeons of Alberta (CPSA), resident physicians, medical students and others.

This is a critical piece of work. The shared budget responsibility model makes government responsible for the budgetary impact of new physicians. If this is to be done in a way that meets the requirements of Albertans, it is important that we get a handle on what is needed and where.



AMA ACCESS TO INFORMATION

Several of the initiatives under the proposed amendments require the AMA to have improved access to information from AH. The amendments provide for creation of an information sharing agreement to enable this.

Important areas that will require enhanced data sharing include the SOMB Rules Initiative, Peer Review and physician resource planning.

Where you will find it in the *Overview: Tentative Amendments to the 2011-18 AMA Agreement*

- Primary care and integrated delivery Elements 13A and 13B page 15.
- Physician supply Element 3 page 4.
- Data sharing Element 3 page 4.
- Governance of the AMA Agreement Element 8 page 11.
- The AMA Agreement 2018 Element 2 page 3.

GOVERNANCE

All of the stakeholders in the health care system need to work more closely together for system improvement. There are a number of places where this will apply if the amendments are ratified:

- AHS will join the Management Committee and the Physician Compensation Committee. The voting procedures, however, will remain unchanged.
- The new Integrated Care Consultation Agreement includes AH, AHS and AMA.
- An Advisory Committee will be established that includes HQCA, CPSA, the universities and others. It will meet regularly with the Management Committee already established under the AMA Agreement.

Providing a framework and process for the AMA Agreement and 2018

In considering all these amendments, physicians should remember that the AMA Agreement continues. This is important because of the strong protections it includes: recognition, continuance and dispute resolution. Discussions for March 31, 2018, when the financial arrangements conclude, will begin upon ratification of the tentative amendments.

The Impact on Practices: Financial Scenarios

The amendments put some future compensation payment at risk in the form of the Withholds of the April 1, 2017 COLA and the remaining Retention Benefits. (See page 11). In effect, increased utilization could absorb the Withhold amounts.

Hence, the minimum risk is easy to describe. Determining the likelihood is more complex because it is dependent on a number of things: physician supply growth; monitoring and application of the Contingencies (See page 9); the actual effectiveness of the Peer Review (See page 10) and SOMB rules initiative which are not guaranteed (See page 10).

The effectiveness of the SOMB rules initiative is the critical element. Payment of the Withholds is dependent on success in finding actual savings.

While it is not possible to say with certainty what will happen, the AMA has run a number of financial scenarios to get a sense of potential outcomes. This analysis suggests:

- For the year in which we currently operate – the 2016-17 fiscal year – it is very unlikely that the 2016 Retention Benefit will be paid out. This is due to two factors: (i) we have not yet seen the full impact of new physicians who entered the system before April 1, 2016 and (ii) there is not sufficient time for the savings initiatives to completely kick in.
- For 2017-18, there is an opportunity for some payment of the Withholds – particularly with respect to the April 1, 2017 COLA. This could occur as long as the initiatives are reasonably effective in reducing utilization; that is, the results of the initiatives are not simply absorbed by other utilization growth/activity.

The savings initiatives – particularly with respect to SOMB rules – represent one of the more challenging aspects of the tentative Amending Agreement. This arises from the tight timelines and the complexities of assessing the impact of any proposal on patients and physicians.

The initiatives, however, are also a key opportunity for the profession to bring its medical expertise to bear. While it is possible for government to undertake many of these initiatives on their own, it would be best that the work be informed with best-available evidence provided by physicians.

Placing the Retention Benefit at risk may cause some service access issues and be viewed as a retrogressive step in terms of physician payment relativity. While not to diminish these concerns, it should be noted that the Retention Benefit is slated to end in 2018 under the existing AMA Agreement. Further, although the program appears to have been helpful in maintaining service access, it is clear that with some recent medical graduates having difficulty finding positions that a broader needs-based approach to issues of recruitment and retention is required. Finally, physician payment relativity is a worthy goal to pursue, but most appropriately through the Physician Compensation Committee.

Concluding Comments

ALBERTA MEDICAL ASSOCIATION

The proposed package of amendments to the AMA Agreement is intended to be a proactive approach to some of the challenges facing Alberta, both in the general economy and within the health care system. It puts some short-term cost-saving measures in place and also launches key strategies for the long term. It positions the AMA and government for future negotiations, providing an 18-month window to implement and assess new approaches.

What is being proposed builds on an already strong AMA Agreement. It introduces a shared budget responsibility model with an allocation of responsibility and authority. Some important and specific new provisions and strategies build on the existing general model of consultation with the profession.

This additional consultation is significant and goes well beyond simple commitments to work together. The amendments provide for enhanced data sharing, a mechanism (and physician ratification process) for a PCN framework, a needs-based physician resource plan and direct involvement in the provincial Academic ARP. There are other items we could list, but the point is that the amended AMA Agreement is much more than a statement of "we want to partner." It is a detailed and pragmatic description of the partnership and how it will work.

There is risk. The amendments bring stability to current prices and most programs, but some future amounts may now need to be applied to cover utilization instead of the April 1, 2017 SOMB fee adjustment or the two remaining Retention Benefit payments.

There is also risk, however, in not taking action and not approving the amendments. The question for the profession is this: Which approach will do a better job of serving physicians and patients? The choice is yours.