Insured Services Consultation

November 14, 2019

Alberta

Purpose

- To provide an overview of the consultation process including various options to consult with Alberta Medical Association (AMA) on the proposed initiatives.
- To seek mutual agreement between Alberta Health and the AMA on the method and format of consultation.
- To provide an overview of the proposed initiatives.

Governing Authority

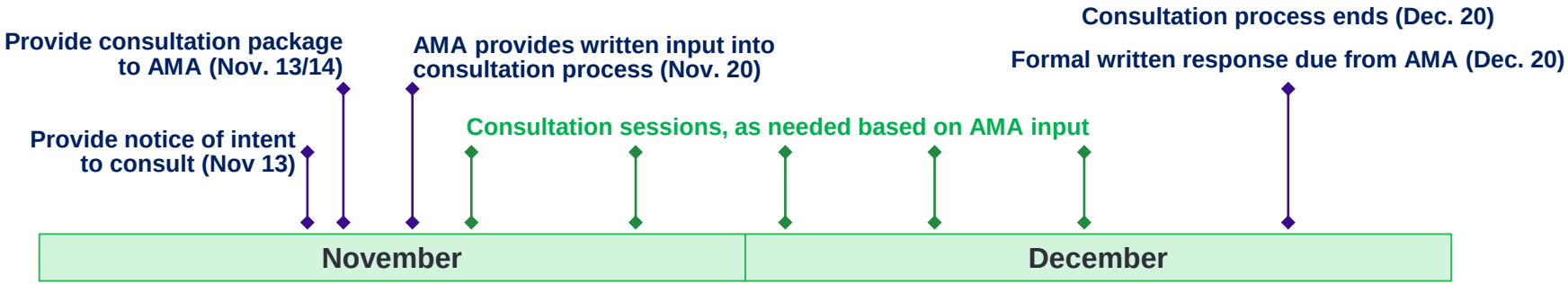
- The *Alberta Health Care Insurance Act* (AHCIA) gives the Minister of Health the authority to determine insured services described in the Schedule of Medical Benefits *(Sec 3 of the AHCIA and Sec 3 of the Medical Benefits Regulation).*
- The agreement between Alberta Health and the AMA establishes financial and working relationship between Alberta Health and Alberta's physicians, as represented by the AMA. However, the authority to approve rates and insured services rests with the Minister.
  - Nothing in this AMA Agreement shall in any manner whatsoever fetter the legislative and regulatory power and authority of the Government of the Province of Alberta and/or the Minister of Health *(Article 21 of the AMA agreement).*
- As of December 2018, Alberta Health is legally required to consult with the AMA under the AHCIA:
  - Exclusively on physicians compensation matters; and
  - Non-exclusively on all other matters that touch and concern physicians.

Insured Services Consultation

- The proposed initiatives for consultation have been developed based on:
  - government's commitment to ensure provision of medically necessary services;
  - practices in other Canadian jurisdictions;
  - payments that are off-side with provincial legislation; and
  - the ability to improve fiscal responsibility and accountability set out in Alberta's 2019-23 fiscal plan.
- Alberta Health is requesting a written response from the AMA providing:
  - Concise response describing implementation considerations; and
  - Any other suggestions or approaches to achieving savings from the Physician Compensation and Development Budget.

Proposed process and timeline

- Consultations to take place over a four week period.
- AH will work with AMA to define how AMA wishes to be engaged in consultation.
  - Options could include using existing Allocation Working Group, reviving the SOMB Committee, or other processes agreed to by AMA and AH.
  - Request that AMA submit proposed process for engagement by November 20, 2019.



AMA's formal feedback is requested in **writing** by December 20, 2019

Proposed initiatives for consultation

Proposal 1 – Complex Modifiers

Proposal	Implementation	
Complex modifiers provide additional compensation (above the base rate of a standard visit) to physicians by using time as a measure for payment for the management of complex patients. Alberta Health proposes to increase the base time requirements with a complex patient in order to use complex modifiers, in the interest of providing equitable compensation and improving patient care. See next slide for a summary of proposed changes.	February 1, 2020	The changes are fully implemented through ministerial approval of an amended SOMB.

Jurisdictional Comparison			
AB - Current	**BC**	**SK**	**ON**
Various time-based complex patient modifiers.	Visit and consultation fees are adjusted for patient age.	Visit and consultation fees are adjusted for patient age.	Comprehensive Care Premium (10%) for enrolled patients.

Proposal 1 – Complex Modifiers (cont.)

Rationale for Proposal

- Since the introduction of complex modifiers in 2009, there is little to no evidence that patient care has improved, which was the original intention of the modifier. While it is recognized that patient complexity is increasing these patients could be better served by Alternative Relationship Plans (ARPs).
- The addition of complex modifiers compensate physicians for additional time they spend to examine a patient. For example: currently, a complex modifier is allowed for services 15 minutes or greater. The duration of 15 minutes is not sufficient time to indicate that a patient is complex. A longer duration depending on the services provided (e.g. extending the duration from 15 to 25 minutes for a general practice office visit) would help both improving the outcome for the patients and budget management for the government.
- For general practitioners, the minimum complex patient visit (CMGP) time requirements would increase from 15 to 25 minutes.
- For specialists, the complex patient visit (CMXV) time requirements would increase by 15 minutes, and physicians would no longer be able to use the CMXV15 and CMXV20 modifiers.
- For consultation services, the complex patient (CMXC) time requirements would increase from 30 minutes to 45.
- This is considered a policy change and under the purview of the Minister.

Proposal 2 – Comprehensive Annual Care Plans

Proposal	Implementation	
Comprehensive annual care plans are written plans signed by both the patient and their care provider that lay out a plan to help patients understand and manage their complex medical conditions. Alberta Health is proposing to remove this service because the intended outcomes can be obtained through other available services under the Schedule of Medical Benefits (SOMB).	February 1, 2020	The changes are fully implemented through ministerial approval of an amended SOMB.

Jurisdictional Comparison		
AB - Current	**BC**	**SK, ON, QC**
May be claimed once annually, in addition to a visit.	Complex Care Planning and Management Fee, payable once per calendar year	Not covered.

Proposal 2 – Comprehensive Annual Care Plans (cont.)

Rationale for Proposal

- As part of a currently available service, comprehensive annual visit, a physician is expected to complete a full history and physical examination of a patient. As part of this visit, the physician is to provide appropriate advice to the patient to help them manage their care and treatment.

- Therefore, Alberta Health is proposing removal of the comprehensive annual care plan to eliminate duplication.

Proposal 3 – Driver Medical Exam for patients 74.5 years or older.

Proposal	Implementation	
The Alberta Health Care Insurance Plan (AHCIP) provides coverage for medically required health services. 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. Alberta Health proposes to remove this service to be consistent with the intent of AHCIP.	February 1, 2020	The changes are fully implemented through ministerial approval of an amended Schedule of Medical Benefits.

Jurisdictional Comparison

AB - Current	BC	SK	ON	QC
Covers medical examination required to obtain or renew an operator's license for patients 74.5 years of age or older.	Completing the Driver Medical Examination Report is not covered by provincial health care.	The physician fee schedule does include a fee code for the completion of a medical report, regardless of age. However, these fees are paid through the fee schedule on behalf of Saskatchewan Government Insurance (SGI).	No physician involvement. Ministry of Transportation requires seniors follow a four-step process to renew their driver's licence.	Medical examination by a physician and a vision test by an optometrist/ ophthalmologist is required at a cost to the patient.

Proposal 3 – Driver Medical Exam for patients 74.5 years or older. (cont.)

Rationale

- This provides a consistent approach to medical exams under the Alberta Health Care Insurance Plan.
- Many Albertans that are under the age of 74.5 years require a medical examination to obtain or renew an operator's license for medical reasons, and these exams are not covered.
- Requiring patients with a medical condition such as epilepsy to pay out of pocket for a medical exam, while not requiring Albertan’s over the age of 74.5 years is inconsistent for Albertans.

Proposal 4 – Payments for Diagnostic Imaging (DI) Services from Uninsured Practitioners Referrals

Proposal	Implementation	
Non-insured or non-publicly funded practitioners including chiropractors, physical therapists, and audiologists are able to refer patients for publicly funded Diagnostic Imaging services such as X-rays, ultrasounds etc. Alberta Health proposes to only permit practitioners providing publicly funded services through the Alberta Health Care Insurance Plan to refer for DI services.	February 1, 2020	The changes are fully implemented through ministerial approval of an amended SOMB.

Jurisdictional Comparison

AB - Current	BC	SK	ON	QC
Alberta pays for DI referred by non-insured or non-publicly funded practitioners except AHS does not accept referrals from Chiropractors for publicly funded MRI.	Not publically funded.	Not publically funded.	Not publically funded.	Not publically funded.

Proposal 4 – Payments for Diagnostic Imaging Services from Uninsured Practitioners Referrals (cont.)

Rationale

- Chiropractic and most physical therapy services are not publicly funded. Patients must pay for these services out-of-pocket, with many relying on third-party insurance.
- Physicians will still be able to refer patients for publicly funded Diagnostic Imaging services.

Proposal 5 - Diagnostic Imaging Billing Appropriateness

Proposal	Implementation	
Alberta Health has observed that lack of clarity in rules governing the diagnostic imaging codes results in over billing by physicians. For example, Alberta Health has identified inappropriate billing combinations for certain services including code-stacking (billing multiple fee codes for which it is only appropriate to bill a single fee code). Alberta Health is proposing to clarify the rules and restrictions to ensure accurate billing practices related to diagnostic imaging services. See next slide for a list of proposed changes.	May 1, 2020	The changes are fully implemented through ministerial approval of an amended Schedule of Medical Benefits.

Jurisdictional Comparison

AB - Current	BC	SK	ON	QC
The lack of clarity in current rules may result in over billing by practitioners.	The Joint Clinical Committees (3),are mandated to make recommendations on appropriate care.	Proceeding with modernization of the Payment Schedule, using appropriateness as one of their guiding principles.	Bilateral committee reduce medically unnecessary / inappropriate services. • $100M in changes by May 1, 2019 (for FY19/20). • $360M in changes by Sept 30, 2019 (20/21).	No clear specific appropriateness work underway.

Proposal 5 - Diagnostic Imaging Billing Appropriateness (cont.)

Rationale for Proposal

- The proposed change is required to provide correct interpretation of the billing codes so that the claims are submitted for the correct services in accordance with the Schedule of Medical Benefits.
- The proposed changes are:
  - X301 – May not be claimed with X338
  - X303 – Max one call
  - X311 – May not be claimed with X312, X314, X315
  - X315 – May not be claimed with X311, X324
  - X316 – May not be claimed with X312, X324
  - X317 – May not be claimed with X324
  - X318 – May not be claimed with X314
  - X319 – May not be claimed with X314
  - X320 – May not be claimed with X311, X324

Proposal 6 – Daily Caps

Proposal	Implementation	
Currently there is no limit on the number of visits that a physician can claim in one day. Alberta Health is proposing to implement a daily cap of 65 patients (no compensation for treating more than 65 patients in a day). Payments for physicians treating more than 50 patients are discounted by 50 per cent.	May 1, 2020	The changes are fully implemented through ministerial approval of an amended SOMB.

Jurisdictional Comparison

AB - Current	BC	SK	ON	QC
No daily cap.	Allows a maximum of 65 visits per day.	No daily cap.	No daily cap.	No daily cap.

Proposal 6 – Daily Caps (cont.)

Rationale for Proposal

- Physicians who provide excessive visits per day may compromise their own health and safety as well as patient care.
- A limit must be placed on physician claims to improve well-being of physicians and patient safety.

Proposal 7 – Overhead

Proposal	Implementation	
Payments for claims submitted in the community or hospital setting include a component of overhead and are paid the same rate; however, overhead is appropriate in the community setting, as the physician is responsible for their own equipment. Physicians providing identical services in publicly funded facilities such as Alberta Health Services (AHS) and Covenant Health also receive overhead for which the cost is borne by the publicly funded facility. Alberta Health proposes to separate overhead from all hospital based services to support equitable payments for physicians.	May 1, 2020	The changes are fully implemented through ministerial approval of an amended Schedule of Medical Benefits.

Jurisdictional Comparison			
AB - Current	**BC**	**SK**	**ON**
Most overhead is incorporated into fee codes; some instances exist where services are split into hospital and office specific.	Overhead incorporated into fees, with visit and consultation services separated: in office and out of office.	Saskatchewan does not tend to differentiate fees based on location of a service (including visits or consultations).	Overhead is included in most fees; includes having different fee codes for office and hospital inpatients consultations.

Proposal 7 – Overhead (cont.)

Rationale for Proposal

- Physicians will continue to be compensated for overhead through payments through the Schedule of Medical Benefits (SOMB).
- Physicians practicing in an AHS-run facility are currently compensated for overhead, even though the overhead costs are paid by the government. This results in inappropriate compensation for the services provided in a publicly funded facility.

Proposal 8 – Clinical Stipends provided through Alberta Health Services (AHS)

Proposal Description	Implementation	
AHS is paying extra money (stipends) to some contracted physicians in addition to their payments from Alberta Health. AHS is proposing to discontinue these stipends in accordance with their contractual obligations.	January 1, 2020	Notify physicians that clinical stipends agreements will expire on March 31, 2020 (90 days notice period)

Rationale

- Clinical Stipends are incentives intended to top up payments for physicians. These exist from the time when Alberta had various regional health authorities and each regional health authority could offer incentives to attract and retain physicians. With AHS being the health authority for the entire province these stipends are not equitable and do not make sense.
- AHS will allow some physician groups a grace period to allow them sufficient time to work toward establishing an Alternative Relationship Plan to ensure that patient care is not disrupted.

Proposal 9 - Submission of Claims within 60 days of Service

Proposal	Implementation	
Currently Physicians have 180 days from the date of service to submit a Fee For Service (FFS) claim to Alberta Health for payment. An additional 180 days is allowed after the last transaction from each claim. The current 180 day limit causes complications in forecasting, calculating accruals, and monitoring and managing expenditures. Alberta Health proposes to reduce this limit to 60 days.	February 1, 2020	Amendment come into force

Jurisdictional Comparison

	AB	SK	ON	MB	YK	NT	NU	BC	QC	NB	PE	NS	NL
Time limit for practitioners to submit and resubmit fee-for-service claims	180 days							90 days					

Rationale

- A 60-day time limit will facilitate improved budgeting/forecasting, policy and planning decisions, earlier publication of the Statistical Supplement, and the inclusion of more recent Alberta Health Care Insurance Plan (AHCIP) benefits on the Statement of Benefits Paid (a product used by patients).

Proposal 10 – Non-Invasive Diagnostic Fees in Alberta Health Services (AHS) Facilities

Proposal	Implementation	
Fees paid for non-invasive diagnostic tests such as ECG performed in AHS facilities differ from facility to facility. Alberta Health is proposing that Alberta Health Services (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, Schedule of Medical Benefits 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.	April 1, 2020	AHS will standardize all fees

Rationale

- 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.
- Standardization reduces costs for the health system.

Proposal 11 – Stop Accepting Good Faith Claims

Proposal	Implementation	
Alberta practitioners can submit claims to the Alberta Health Care Insurance Plan (AHCIP) under the good faith policy for services provided to Alberta residents who the practitioner believes are eligible for coverage under the AHCIP at the time of service but cannot provide proof of coverage. Alberta Health proposes the discontinuation of the current Good Faith Policy to reduce incidence of non-collectable billing claims and to shift the responsibility for accurate registration verification and billing procedures to Alberta Health Services (AHS) and physicians	January 1, 2020	The change is fully implemented through an effective communications plan to practitioners and system changes to deactivate Good Faith Indicator.

Jurisdictional Comparison

AB - Current	BC	SK	ON	QC
Physician claims can be billed to the AHCIP in situations where the patient did not produce proof of AHCIP coverage at the time of service, but physician believes patient is eligible for coverage.	No good faith policy	No good faith policy.	No good faith policy.	No good faith policy.

Proposal 11 – Stop Accepting Good Faith Claims (cont.)

Rationale

- Elimination of Good Faith policy ensures payment for health services is provided only to eligible Alberta residents; improves accountability by Alberta Health Services and Physician's Offices for their hospital registration and billing procedures.
- It reduces the financial risk to Alberta Health in the form of loss of revenue from erroneous payments and contributes to the long term fiscal sustainability of the health system ensuring accurate physician billing.