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Bill 30 entities:

An opportunity to improve quality and reduce costs of health care through new physician payment arrangements

Payments to physicians make up a quarter of all health care spending in Alberta. Most physicians in Alberta bill Alberta Health for each service they deliver and are reimbursed a fee for that service. Some physicians in Alberta are paid in a salary-type arrangement. Recent legislative changes to the Alberta Health Care Insurance Act allow Alberta Health to enter into other arrangements. These new types of entities and contracts present risks, but also an opportunity to introduce new physician payment arrangements in Alberta. This policy brief discusses evidence-informed strategies that should be included in these new payment arrangements to ensure we use our health care dollars wisely, deliver high quality care, and take physician experiences into account.

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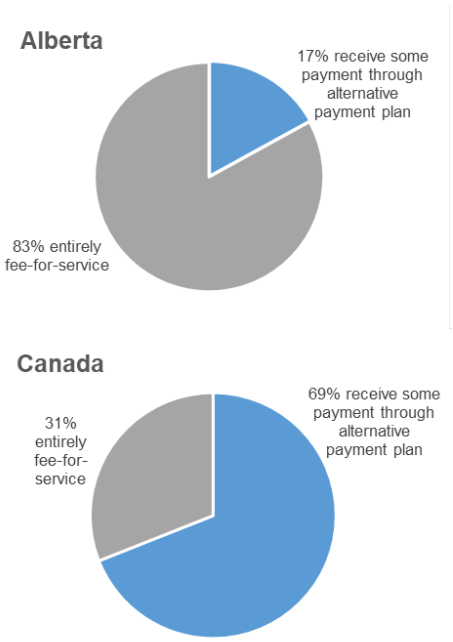
Lay summary

Payments to physicians make up a quarter of all health care spending in Alberta. Most physicians in Alberta bill Alberta Health for each service they deliver and are reimbursed a fee for that service. These physicians directly contract with Alberta Health, and their contract is governed by an arrangement between Alberta Health and the Alberta Medical Association. Some physicians in Alberta are paid a salary-type arrangement that is governed by a relationship between a physician group and Alberta Health.

Recent legislative changes to the Alberta Health Care Insurance Act allow Alberta Health to enter into arrangements not just with individual physicians or physician groups, but also with a new type of business entity. These new business entities will be paid by Alberta Health to deliver a specific type or set of services and then contract with physicians to deliver those services.

These new types of entities and contracts present risks, but also an opportunity to introduce new physician payment arrangements in Alberta. This policy brief discusses evidence-informed strategies that should be included in these new payment arrangements to ensure we use our health care dollars wisely, deliver high quality care, and take physician experiences into account.

Lastly, we recommend monitoring not only Bill 30 entities' relationships with physicians but also their relationships with patients to ensure these entities reduce costs, improve quality of care, and improve the sustainability and equity of our health care system.



Alberta has the **lowest** adoption of alternative physician payment models in Canada

Description of the issue

Physician payment models are key policy levers to influence health-system performance, including quality and costs. Reimbursing physicians a fee for each service that is delivered, called "Fee-for-service (FFS)", is the predominant way physicians are paid in Alberta and across Canada. Alternative payment models compensate physicians in more aggregated ways, such as for their time (salary), for providing comprehensive care to their patients (capitation), or for episodes of care (bundled payment). Payments to physicians are one of the three largest areas of health care expenditures and represent 23% of health care spending in Alberta.[1] As health care costs grow, many health care systems across the world are moving away from FFS to alternative payment models in an effort to reduce incentives to deliver expensive and excessive services, in turn improving financial sustainability and the value of the health care system.

In Alberta, only 17% of physicians (including general practitioners and different types of specialists) receive some payment through alternate methods (the lowest in Canada), compared to 69% across the rest of Canada[2]. In other provinces, it is common for physicians to receive payment through a combination of models. Across Canada, only 16% of medical specialists and 8% of surgical specialists receive a majority of their clinical payments through alternative payment plans.

The Alberta government and other stakeholders are currently exploring strategies to increase physician participation in alternative payment models. Recent changes to the Alberta Health Care Insurance Act[3] could increase participation in alternative payment models. The Alberta Health Care Insurance Act was amended by Bill 30[4] to allow Alberta Health to enter into arrangements with entities (other than individual physicians or professional corporations) that will be paid on a basis other than FFS and will enter into contracts with physicians to deliver services covered by these arrangements. The goal of this policy brief is to discuss options for new physician payment arrangements in the context of these recent amendments, including strategies to ensure efficiency and high quality care, and to attract and retain physicians.

[1] https://www.cbc.ca/news/canada/calgary/alberta-health-spending-history-1.5289747
[2] https://www.cihi.ca/sites/default/files/document/physicians-in-canada-report-en.pdf
[3] *Alberta Health Care Insurance Act*, SA 2000, c A-20
[4] Bill 30, Health Statutes Amendment Act, 2020, 2nd Session, 30th Legislature, Alberta, 2020 (assented to 29 July 2020), SA 2020, c27

Background

Physician payment models in Alberta: Where we have been and where we are going

There are two main types of physician payment models in Alberta: (1) FFS and (2) Alternative Relationship Plans (ARP) (see Figure 1). Physicians paid FFS are independent contractors with Alberta Health. Their contract is governed by an agreement between Alberta Health and the Alberta Medical Association (AMA). The fee paid for a service is defined by the AMA's Schedule of Medical Benefits. Aside from providing the service itself, physicians paid FFS have no specific accountability requirements (e.g., quality of care, patient outcomes or experience).

ARPs are arrangements between Alberta Health and a group of physicians who are responsible for their own internal governance. However, physicians remain independent contractors. Currently, Alberta Health requires that physicians in ARPs track the amount of time spent providing services as well as identify and report on key performance indicators (though currently these are not actively enforced). ARPs involve multiple ways to pay physicians. There are four types of ARPs: (1) annualized, (2) sessional (3) blended capitation, and (4) capitation (See table on the right for additional details). While most annualized ARPs pay physicians an annual salary, there are examples of alternative payment arrangements. For example, the Hospitalist model includes a salary *and* additional compensation for overnight call shifts and additional amounts paid if the number of patients on a physician's roster exceeds specific targets.

Types of Alternative Relationships Plans

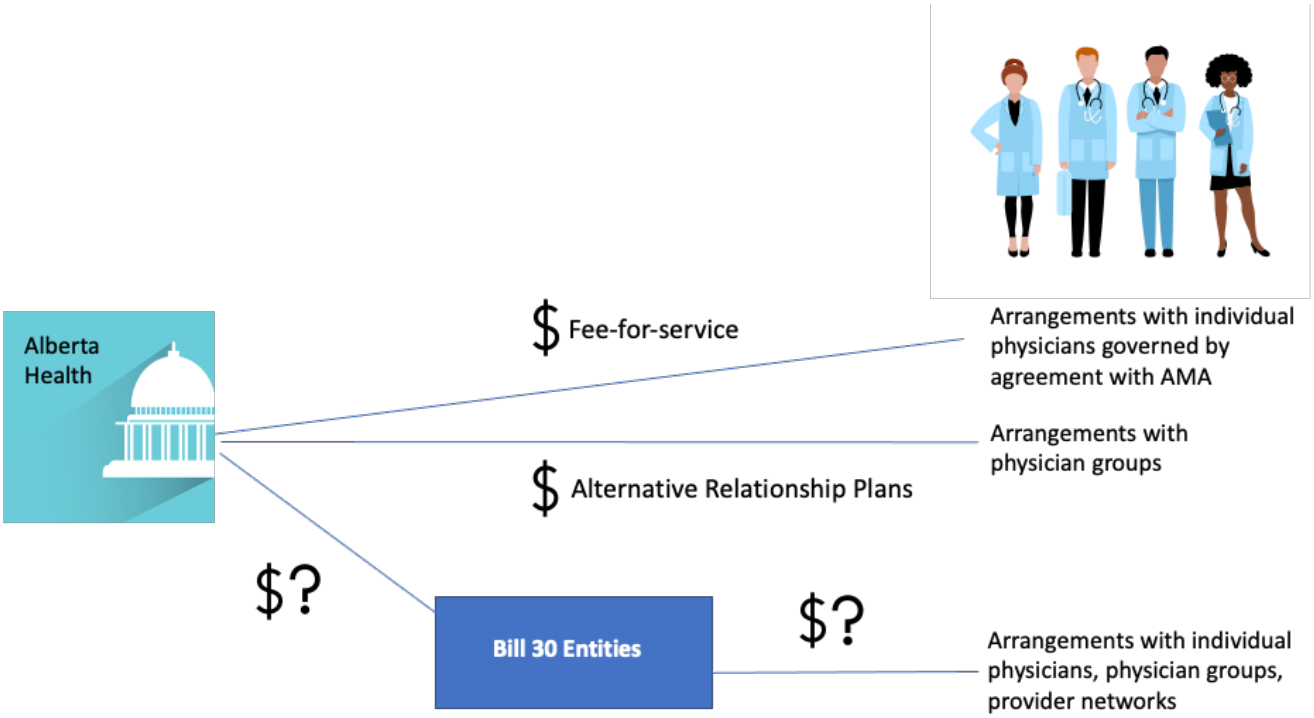
Annualized ARPs typically compensate physicians using an annual salary-like model based on the Provincial Based Payment Rate (PBPR), which varies by specialty and clinical workload.

Sessional ARPs compensate physicians based on an hourly flat rate across specialties.

Blended capitation and capitation models are population-based models targeted to primary care physicians. The capitation model covers a specific basket of services to patients and does not adjust payment based on patients' characteristics (i.e., "risk adjustment"). The blended capitation model includes 15% FFS and 85% capitation, which is adjusted for patient characteristics.

Recent amendments to the Alberta Health Care Insurance Act enable Alberta Health to enter into direct arrangements with a new type of entity, referred to here as "Bill 30 entities". Potential entities include Alberta Health Services, municipalities, or for-profit commercial entities, such as a pharmacy, surgical centre, international hospital chain, or physician group. Alberta Health will pay the Bill 30 entity and the entity will then be responsible for contracting with physicians to deliver health services.

Figure 1. Current and future physician payment arrangements



What should we consider in contractual arrangements beyond payment model?

Bill 30 entities will occupy a new role in the health care marketplace and the regulatory environment addressing their relationships with Alberta Health and physicians remains undefined. Managed poorly, this could create a risk for Albertans. However, managed well, it could present an opportunity to incentivize changes in the delivery of health care services in addition to changes to payment models. As the government develops agreements with these entities and determines how best to regulate them, the

following health care system reform goals highlighted in recent Alberta reports[5,6] and initiatives[7] could be considered to align health system and physician objectives:

- Incentives to enter into alternative payment arrangements
- Improving patient and physician experiences
- Reducing health care spending
- Improving health care quality
- Increasing health care access
- Performance measurement and management
- Establishing new service delivery sites (e.g., outpatient surgical centre) or enhancing existing models of care (e.g., patient-centered medical home).

Given the current challenges in the relationship between physicians and Alberta Health, relating to the lack of a provincial agreement, engaging physicians around new models of care and new payment models would be important.[8]

Research and evidence

Our research group recently completed a series of studies on specialist physician payment in Alberta and across Canada and the United States. A systematic review[9] found payment model appears to affect utilization of specialty care, although the association with other outcomes (e.g., access, quality, patient satisfaction, etc.) was unclear due to mixed results or lack of evidence. Table 1 lists key areas of impact and summarizes conclusions based on existing studies.

[5] Alberta Health Services Performance Review: final report. Available at: https://open.alberta.ca/dataset/c0724ccd-832e-41bc-90d6-a0cd16bc6954/resource/c934a00c-a766-41f5-8c69-2c2ac449eb84/download/health-ahs-review-final-report.pdf
[6] Report and recommendations: Blue Ribbon panel on Alberta's finances. Available at https://open.alberta.ca/dataset/081ba74d-95c8-43ab-9097-cef17a9fb59c/resource/257f040a-2645-49e7-b40b-462e4b5c059c/download/blue-ribbon-panel-report.pdf
[7] Burak et al. Continuing Professional Development Framework Project Plan for Alberta. October 2020. Available: https://www.royalcollege.ca/rcsite/cpd/moc-program/moc-framework-e (This is not the correct link--Is Alberta specific one available online?)
[8] Quinn AE, Manns BJ. Commentary: Improving the Sustainability of Healthcare in Canada through Physician-Engaged Delivery System Reforms. Healthcare Policy = Politiques de Sante. 2021 Feb;16(3):43-50. DOI: 10.12927/hcpol.2021.26434.
[9] Impact of payment model on the behaviour of specialist physicians: A systematic review: https://pubmed.ncbi.nlm.nih.gov/32115252/

Table 1 Areas of impact of FFS and alternative specialist payment models

Area of Impact	Conclusions Based on Systematic Review
Clinical utilization	FFS is a useful model for increasing utilization because it incentivizes physicians to deliver more services, which may contribute to improved quality of care when low utilization is contributing to the occurrence of preventable adverse events.
Access to care	FFS is useful to increase access to care when waitlists or wait times are a challenge because it incentivizes physicians to deliver more services to earn additional income.
Appropriateness	Salary and capitation reduce incentives to deliver expensive, low value services and appear useful in reducing elective surgeries, which may be useful for low-value surgeries or procedures.
Team-based care	Salary payment models can enable physicians to work more effectively within team-based care models. Team-based care models (e.g., medical homes) can include a variety of health care providers (e.g., physicians, nurses, physician assistants) and encourage delivery of health care services that often aren't compensated by traditional fee schedules.
Health care costs	Episode-based payment models, in which costs for a package of care (e.g., pre-op, operative and post-operative care) were also bundled, led to lower total health care costs. Salary models facilitate budget-setting; however, that does not necessarily mean salary payment is less costly than other payment models. A mixed model (FFS + salary) in Quebec led to a significant increase in physician income for non-clinical activities (which was a goal of the payment reform).

Two Alberta population-based cohort studies[10,11] found salary-based physicians saw sicker patients for more appropriate reasons, but after adjusting for differences in patients, there was no difference in follow-up visits rates nor quality or costs of care. However, there was significant outcome variation between physicians, indicating unobserved physician characteristics had a larger impact on utilization and quality outcomes than these payment models.

[10] Association of Specialist Physician Payment Model With Visit Frequency, Quality, and Costs of Care for People With Chronic Disease: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2754254

[11] The association between payment model and specialist physicians' selection of patients with diabetes: a descriptive study: http://cmajopen.ca/content/7/1/E109.full

Interviews with specialist physicians in Alberta[12] indicate physicians select payment models based partially on job attributes beyond payment model (e.g., flexibility, autonomy), and the way they practice is tied to factors beyond payment model (e.g., practice setting/model, wellness and fulfillment, and altruism/intrinsic motivation). To optimize payment models to improve patient care, physicians suggested that those responsible for developing payment models (1) develop and integrate **accountability metrics that are similar** across payment models, (2) **involve physicians** in developing these measures, (3) incorporate financial and **non-financial incentives** into payment models, (4) **blend** different payment models together, and (5) consider **non-payment-related options** to incentivize good practice and disincentivize undesired behaviour for each payment model.

The following key points of alignment between the systematic review, quantitative studies, and qualitative studies can inform Bill 30 entities' physician payment approaches:

Strategic considerations. Organizations should consider their goals and compensate physicians using a single or mixed payment model that incentivizes them to align their treatment decisions with organizational goals. See Table 1.

Variation in clinical practice. Physician characteristics contribute to differences in the way physicians practice, and to utilization and quality outcomes. Payment arrangements could consider stronger financial incentives than FFS and salary-based payment models, and non-payment-related options, to reduce unwarranted differences in practice and outcomes.

Non-financial incentives. While finances do influence physicians (e.g., income certainty from ARPs), many other factors influence physicians' payment model preferences and practice patterns, including flexible work arrangements, autonomy, and access to other health professionals. As new alternate payment models are designed or introduced, there are opportunities to embed important non-financial incentives within physicians' contracts to support physicians to make treatment decisions guided by patients' needs, and work-life balance decisions guided by their personal needs, to reduce the motivations embedded in a FFS system to overprovide care at the expense to all Alberta tax-payers.

[12] Factors that influence specialist physician preferences for fee-for-service and salary-based payment models: A qualitative study: https://www.sciencedirect.com/science/article/pii/S0168851021000014

Accountability measures. To optimize payment models to better support patient care, well-defined and fair accountability metrics are required. These can be integrated with existing or new payment models. Additional research and extensive physician engagement across relevant specialties are required to facilitate this process.

Policy options

Expanding the use of alternative physician payment models in Alberta can present opportunities to introduce and encourage new physician payment models, which can be leveraged to improve the value of health care in the province by improving quality and reducing or maintaining costs. It is also important to consider how to encourage physicians to participate in these new payment models and contracting arrangements because there has been little uptake of alternative payment plans in Alberta to date. This section addresses three intersecting elements that are relevant when considering new payment arrangements: (1) ensuring efficiency, (2) ensuring high quality of care, and (3) strategies to attract and retain physicians.

1. Ensuring efficiency

Bill 30 entities will manage their own health care expenditures. Thus, Bill 30 entities may not be interested in paying physicians with whom they contract using a FFS model, because of the likelihood of increasing utilization and the inability to set costs prospectively. This would presumably depend on the services provided by the Bill 30 entity as well as the goals of the entity (e.g., increasing urgent surgeries, reducing low-value surgeries, or supporting a medical home for patients with chronic diseases). Assuming that most Bill 30 will be given a budget to provide physician and non-physician care, two potential models that could be considered are bundled payment or a salary-based blended payment.

Bundled payments (which typically cover a number of related services to treat an acute or chronic episode of care) would be a good fit for entities focused on delivering procedures (e.g., knee surgeries). Most bundled payment models[13] are designed at an organizational level, such as a hospital being paid a set rate for services necessary before, during, and after a surgery. However, there are examples of bundled payment models at the physician-level that reduce health care costs.[14] Using these models as an example, physicians could still be reimbursed FFS, but Bill 30 entities could set episode-level spending targets for

[13] The Impact Of Bundled Payment On Health Care Spending, Utilization, And Quality: A Systematic Review. Health Affairs 2020 39:1, 50-57
[14] Effects of episode-based payment on health care spending and utilization: Evidence from perinatal care in Arkansas. https://doi.org/10.1016/j.jhealeco.2018.06.010

care that covered physician and non-physician services, and designate an accountable physician. The designated physician would be responsible for all (risk-adjusted) spending (including facility spending) and could be penalized if the episode was over-budget or rewarded if an episode was under-budget.

Examples of defined episodes of care are knee replacement surgery plus aftercare, such as follow-up appointments and rehabilitation, or maternity care. Similar to FFS, there is a risk of increasing the volume of episodes of care. However, in the context of the Alberta Surgery initiative where the government has committed to reduced surgical wait-times through providing more surgical procedures, then increasing service volume through chartered surgical facilities may be a desired goal. Information on whether the physicians met their target costs, or went under or over, could initially be used for physician education and then, eventually, used to reward or penalize physicians.

In contrast, a salary-based blended payment model could be a good fit for entities operating in practice areas where the goals are to either (1) reduce low-value procedures or (2) facilitate team-based care and other physician-led delivery system innovations. Paying physicians either an annual salary or a per-patient capitated rate have been shown to reduce elective procedures (so paying for lower value elective procedures in this way can be effective at reducing low value care). Salary-like models currently used by ARPs encourage appropriate patient-selection and coordination between providers.[15] However, improving quality of care would likely require additional elements (see below) because our research found FFS and ARP physicians deliver a similar quality of care to similar patients and that physician characteristics beyond payment model are associated with variation in quality outcomes.

In addition to a base-salary payment, Bill 30 entities could consider high-cost patient or procedure payments or performance-based incentives. Risk contracts (e.g., performance-based incentives and penalties) and risk adjustment will be important considerations in these alternative payment models.

2. Ensuring high quality care

Performance metrics could be put in place between Alberta Health and Bill 30 entities and/or between Bill 30 entities and physicians. These metrics could include quality/performance, cost/value, equity, and access

[15] The association between payment model and specialist physicians' selection of patients with diabetes: a descriptive study: http://cmajopen.ca/content/7/1/E109.full

requirements. Bill 30 entities would be well-positioned and motivated to ensure physicians are delivering efficient care, and could encourage the systematic connection of performance indicators with payment arrangements. This could promote accountability for quality across the health care marketplace in Alberta.

Aligning physician care with quality indicators fits nicely with the College of Physicians and Surgeon's Continuing Professional Development Framework, which could form the foundation of an accountability framework between the minister and Bill 30 entities based on physician-endorsed specialty-focused competencies. This accountability framework could be used in a phased approach. First, the framework could be used for physician education purposes, using an audit and feedback approach. Next, the framework could be used for performance monitoring, potentially including public reporting. Lastly, the performance indicators could be tied to payment.

3. Strategies to attract and retain physicians

The nature of the contractual relationships between Bill 30 entities and physicians will guide payment arrangement policies. Physicians could be staff and only work for that one entity, or they could continue to function more as consultants, working for AHS as well as multiple Bill 30 entities, or even other entities in the health care marketplace.

Attracting physicians as contractors or employees is an important area to consider in new payment arrangements. Our research has not indicated a clear pathway forward, but there are some key elements to consider:

a) Alternate payment models that are fair and transparent and competitive with other options for physicians,
b) Provision of facility/staff to eliminate overhead and/or the need to be involved in business decisions,
c) Flexible work hours,
d) Audit and feedback to physicians to improve practice,
e) Physician leadership/mentoring,
f) Wellness programs, and
g) Innovative delivery models.

Concluding recommendation

In closing, it is important to acknowledge the needs and experiences of the patients our health care system is intended to serve. It will be critical for Alberta Health to seek Bill 30 entities in areas of need for Albertans, rather than allow the establishment of additional services in areas that are not priorities for Albertans. Additionally, patients in Alberta (and across Canada) are typically allowed a free choice of providers. While this is a foundational element of health care in Alberta, it also contributes to patients having limited cost or quality consciousness when selecting providers.

Further, our research in Alberta found a relationship between the way physicians are paid and which patients they see.[16] There is a possibility that physicians working for Bill 30 entities will be motivated to select lower risk patients in order to save money.[17] It will be essential to monitor not only Bill 30 entities' relationships with physicians but also their relationships with patients to ensure these entities reduce costs while improving the quality of care to improve the sustainability and equity of our health care system.

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