Financial Cuts to Physicians and Healthcare in Alberta

The Edmonton Zone Medical Staff Association

April 8, 2020

Beginning in October 2019, the Government of Alberta and Alberta Health Services have been significantly cutting physician compensation and healthcare services.

The cuts are not an exact per cent across all physicians. Individual services, benefits and programs have been cut. Each physician's individual total compensation cut depends on how frequently these health services are used by their patients. It also depends on the type of physician and their location. It is further compounded by how each physician runs their office. Each physician may have different fixed costs of rent, staff and overhead to pay, regardless of a change in revenue from government cuts. This results in a range of total compensation cuts anywhere from 20-60% for the individual physician. The cuts are particularly hard hitting for rural and family medicine physicians.

For some physicians these cuts mean incurring debt to continue practicing, which has resulted in physicians giving 90 days of notice to leave. For others it means discontinuing certain services and/or resigning from working within a hospital. Some of the cuts also mean the public will be required to pay as the government no longer insures the service. Decisions to discontinue services or closing a practice are individual and tremendously difficult to go forward with.

The list of cuts are below:

<u>October 1, 2019</u>

	Before	After October 1, 2019
Specialist On-call Program	Specialist physicians received $18.27 per hour to be on-call for emergency care.	The rate was 37% cut to $11.50.

<u>March 31, 2020</u>

	Before March 31/20	After March 31, 2020
Out-of-country health services	Alberta healthcare covered all out-of-country services for residents listed under Alberta Health Care Insurance Plan.	Any services outside of Canada that are not with an emergency physician and/or hospital will not be reimbursed to the public. This has not been confirmed.
Complex Modifiers	Complex modifiers support patient care when requiring longer visits with physicians. For example: Family physicians bill an in-person visit under 15 minutes and then an additional $18.48 (the complex modifier) for time afterward.	This cut has been postponed. For example, this was to be a 50% cut for family physicians from $18.48 to $9.24. Physicians are providing virtual care during CoVID-19 rather than in-person care, where possible. Physicians are not able to bill complex modifiers or the business cost fee with virtual care. This is up to a 30% cut for family physicians.
Good Faith Claims	Healthcare was insured for Alberta residents who are believed to have coverage, but could not prove it.	There is no government health insurance for people who cannot confirm their health card or Alberta residency. These people will be personally billed for any healthcare received. It negatively impacts homeless people and new Albertans during CoVID-19 when healthcare must be provided to prevent the

		spread. Often homeless people are not able to produce identification.
Complex Annual Care Plan	Patients with multiple conditions such as diabetes and obesity could agree to a joint plan with their physician to manage and understand their complex medical conditions.	Annual plans are no longer funded. The government directed physicians to bill for a comprehensive visit of less time. Comprehensive visits are an assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. The government is requiring shorter visits rather than comprehensive care for patients. This is an 8 - 79% cut from $190.17 to $40.14 - $174.86.
Claim Submission Time	Physicians had 180 days to submit billing to the government.	Physicians have 90 days.
Driver's Medical Examination for Patients 74.5 Years of Age or Older	The government fee paid physicians $85.58-117.01 per exam.	No longer funded by government. Patients now pay fees. .
Diagnostic Imaging services	Government funded diagnostic imaging services that were referred by a chiropractor, physiotherapist, or audiologist.	Patients now pay these fees.
Daily Patient Visit Cap	There was no maximum number of visits per day policy.	The government cut all types of services after 50 visits. The 51st to 64th visit are 50% cut to any type of service. No visits are paid by government after 65 per day. Rural areas, Grande Prairie and Fort McMurray offices do not have a maximum. This does not apply to virtual care. This is a maximum of visits and phone calls (to patients, long term care facilities, homecare, pharmacies, etc). A physician can have a reasonable number of patients in a day and exceed the cap.
Facility Based Health Service	Previous governments recognized that physicians have office expenses at their own clinics that are fixed costs. These costs continue when a physician works at a public facility (hospital, nursing home, etc); therefore, government continued to provide funding for office expenses.	Physicians will no longer receive compensation for their office overhead while working in a public facility. Physicians have begun to stop working in these facilities and stay in their offices providing care because their office expenses are fixed and do not pause when working in a facility. These services are: 1) Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient. Individual fees are cut up to 50% with the fee range changing from $25.09 - $78.90 to $18.50 - $67.07.

		2) Prenatal visit cut up to 21% for individual fees with the fee range changing from $37.02 - $68.45 to $29.25 - $60.68. 3) Repeat office visit or scheduled outpatient visit in a regional facility for referred cases only. Individual fees are cut up to 33% with a fee range changing from $32.34 - $115.27 to $32.34 - $89.91. 4) Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient. Individual fees are cut up to 50% with a fee range changing from $40.14 - $174.86 to $31.71 - $134.64. 5) Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof. This is a cut of 27% from $52.32 - $62.74 to $38.19 - $45.83 per 15 minutes. 6) Minor consultation individual fees are cut up to 33% with a fee range changing from $40.52 - $149.97 to $33.23 - $149.97. 7) Comprehensive consultation individual fees are cut up to 40% with a fee range changing from $79.23 - $210.41 to $64.97 to $210.41. 8) Obstetrical consultation individual fees are cut up to 21% with a fee range changing from $92.55 - $209.38 to $73.11 - $189.94. 9) Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physciatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed. The individual fees are a cut of 33% with the fee range changing from $12.45 - $54.63 to $8.59 - $49.99. 10) Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed. This is a 30% cut from $60.12 - $72.14 to $42.08 - $50.50. 11) Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed. This is a cut up to 22% from $52.22 - $189.58 to $52.22- $147.87. 12) Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof. The individual

		fees are a cut of 30% with the fee range changing from $47.54 - $57.05 to $34.70 - $44.01. 13) Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed. The individual fees are a cut of 27% with the fee range changing from $58.74 - $209.16 to $48.75 - $163.14
Medical Liability Reimbursement	Every physician requires insurance to practice. The rate of insurance varies by the level of risk for each type of physician. This benefit was for all physicians to pay the first $1,000 and government reimbursed the balance.	50% of total amount for all physician insurance will be given to the Alberta Medical Association to divide between physicians. How it will be divided has not been determined. Insurance for each physician varies. As an example of how this affects physicians, the Mom Care Docs group of 14 family physicians who provide low risk obstetrics, will have to do 220 deliveries just to cover the cost of the liability insurance. Given that their volume is not as high as obstetricians this will make it more difficult to be sustainable.
Continuing Medical Education	This program reimburses costs incurred with maintaining and enhancing knowledge skills and competency. It is $2,684 per physician per year.	No longer funded by government.
Clinical stipends in Alberta Health Services facilities	Physicians received stipends in these facilities. The amount varies.	This is postponed.
Diagnostic Imaging Billing	Ultrasound billing was not restricted with these codes.	1) Billing for a thyroid or parathyroid ultrasound cannot be billed with a code for a limited soft-tissue study, site unspecified, any single site, not organ related ultrasound. This is $66.67 - $86.79 less. 2) A maximum of one call for head and/or neck, soft tissue ultrasound is $103.28 - $134.26 less for each additional service. 3) Billing for kidneys, ureters and bladder ultrasound may not be billed with: a. abdominal, single organ study, limited or follow up ultrasound ($102.90 - $133.70 less); b. female pelvis, including endo-vaginal (EV) scan ultrasound (same restriction) ($176.12 - $228.96 less); or c. female pelvis, transvesical scan ultrasound ($127.17 - $165.32 less). 4) Billing for female pelvis, transvesical scan ultrasound cannot be billed with: a. kidneys, ureters and bladder ultrasound ($173.03 - $224.94 less); or

		b. female pelvis, translabial or endo-vaginal (EV), additional benefit ultrasound ($66.67 - $86.67 less). 5) Billing for a female urinary bladder ultrasound cannot be billed with: a. abdominal, single organ study, limited or follow up ultrasound ($102.90 - $133.70 less); or b. female pelvis, translabial or endo-vaginal (EV), additional benefit ultrasound ($66.67 - $86.67 less). 6) Billing for a first trimester obstetrical ultrasound, excluding detailed fetal assessment or nuchal translucency measurement, cannot be billed with female pelvis, translabial or endo-vaginal (EV), additional benefit ultrasound ($66.67 - $86.67 less). 7) First trimester obstetrical ultrasound, excluding detailed fetal assessment or nuchal translucency measurement, cannot be billed with female pelvis ultrasound, including endo-vaginal (EV) scan ($176.12 - $228.96 less). 8) First trimester obstetrical ultrasound/early fetal screening cannot be billed with female pelvis, including endo-vaginal (EV) scan ultrasound ($176.12 - $228.96 less).

March 31/21

	Before	After March 31/21
Business Cost Program	This program is funding for the business costs of physicians with offices. It is $2.95 per select office visit and consultation to a maximum of 50 per day.	The program is cut for subsequent visits and extended visits of complex modifiers.
Rural, Remote and Northern Program	Supports the recruitment and retention of physicians to live and practice in rural remote and northern areas of the province. There are two types: 1) A premium added to each service provided. 2) A flat-fee payment.	The flat fee is ending. A new list of eligible communities and varying amounts will change.
Complex Modifiers	Complex modifiers support patient care when requiring longer visits with physicians. For example: Family physicians bill an in-person visit under 15 minutes and then an additional $18.48 (the complex modifier) for time afterward.	This cut been postponed. A second cut on March 31/21 is to replace the March 31/20 cut. Rather than 15 minutes with a patient before a complex modifier is effective, it will be 25 minutes and then an additional $18.48 complex modifier is used. For visits between 15-25 minutes, this is a 100% cut of $18.48.