
**Alternative Payments Program
POLICY FRAMEWORK**

**Physician Compensation
Physician Human Resource Management
Medical and Pharmaceutical Services Division**

September 2005

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Section:	1	Policy Preamble	Issued:	September 2005

PREAMBLE:

This framework consolidates the policies of the Ministry of Health (MoH and/or Ministry) Alternative Payments Program (APP). The APP funds British Columbia's health authorities (HAs) for their direct or indirect payment of contracted service, sessional and salaried physicians. The document is written to assist those individuals who are responsible for administering or delivering health care programs and services funded by the APP, including but not limited to Ministry and health authority (HA) staff, physicians and the public having an interest in APP.

The APP Policy Framework translates the provisions of British Columbia's province-wide physician agreements into policy and integrates that direction with the APP's concurrent obligations under federal and provincial legislation, regulations and other policies governing the health care system.

The objectives of the APP Policy Framework document are to:

- clarify the terms and conditions of APP funding;
- broaden understanding of APP policies and service expectations; and
- stimulate identification, discussion and resolution of matters that potentially interfere with the most efficient, effective and appropriate delivery of the patient-focused, physician services funded through the APP.

For ease of reference only, the phrases, 'health authority' and 'health authorities', used throughout this document should be understood to also include all those health agencies and facilities, such as hospitals, that manage or administer the delivery of APP-funded services on behalf of their governing HA.

Individual policy statements may be issued separately from time to time in response to new or developing situations requiring policy direction or to clarify an existing policy statement. All statements within the APP Policy Framework should be read together; none stands alone. In any case where a statement appears inconsistent with another, the reader should contact the APP for clarification.

This framework should be read with other policy, legislation, and regulations governing the British Columbia health care system.

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Each policy statement in the framework has a standard structure and may consolidate a number of related policy directions under one subject or topic.

Headings	Description of Content
POLICY:	<ul style="list-style-type: none"> ▪ The first section is the formal statement of APP policy. ▪ It is the primary focus for reading and understanding. ▪ The statement provides program policy direction, specifies what is to be done, and who is responsible.
BACKGROUND:	<ul style="list-style-type: none"> ▪ The second section provides context for the policy, where necessary, including reference to situations, events or government direction requiring development of the policy.
GUIDELINES:	<ul style="list-style-type: none"> ▪ The third section gives parameters for implementing the policy or guidance for meeting its requirements. ▪ Guidelines may include some suggested processes.
REFERENCES:	<ul style="list-style-type: none"> ▪ The last section lists sources for information or documents mentioned. For brevity, it is not meant to be comprehensive but is provided for the convenience of the reader.

This framework formally confirms many longstanding APP policies, of which an ‘effective date’ is archived in historic program files and not easily retrieved for reference purposes. Instead, the framework uses a protocol of ‘date issued’ and adds an effective date only where a policy is new or a specific date is established for implementation.

In any situation where APP policy is not clear, readers are encouraged to seek assistance from the Physician Compensation Branch at:

2-1, 1515 Blanshard St
Victoria BC V8W 2C8
Telephone: 250 952-3200
Facsimile: 250 952-3486

Refer to Appendix A for an extensive glossary of terms relevant to APP.

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Section:	2	Mandate	Issued:	September 2005

POLICY:

APP:

Establishes, monitors and evaluates funding for British Columbia's Health Authorities in their contracting and management of physician services for situations where alternative funding is needed to maintain, stabilize or improve patients' access to medically necessary physician services.

BACKGROUND:

The APP is administered by the Physician Compensation Branch (PCB), which is part of the Physician Human Resource Management within the Ministry's Medical and Pharmaceutical Services Division (MPS).

APP works closely with staff administering other physician compensation programs, including, but not limited to, rural incentives, fee-for-service (FFS) and the Medical On-Call / Availability Program (MOCAP).

The activities of the APP contribute to MPS divisional goals / objectives, specifically:

High Quality Patient Care - *Patient-centered care tailored to meet the specific health needs of patients and patient sub-populations*

A Sustainable, Affordable Publicly Funded Health System - *Effective vision, leadership, direction and support for the health system; and Sound business practices to manage within the available budget while meeting priority needs of the population.*

The activities of the APP further contributes to the Ministry's Core Business Areas, as identified in the Ministry's 2005/06 - 2007/08 Service Plan, specifically:

Stewardship Objectives:

- **Strategic Direction:** *The Ministry's strategic direction for the health system must be well articulated and communicated to the public and to those who deliver services to the public. The Ministry is committed to leading and fostering a culture in which health system activities are evidence-based, well planned and understood, and in which accountability structures exist to ensure strategic directions guide service delivery activities.*

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BACKGROUND (CONTINUED):

- **Support:** *The Ministry supports its service delivery partners (health authorities and health professionals) to achieve the strategic priorities of the health system... the development of best practices for service delivery, and... policy frameworks to manage the health system and protect public health.*
- **Monitoring, Evaluation and Course Correction:** *The Ministry monitors and evaluates the delivery of services and the health of the population to ensure services delivered in the system meet the needs of the public. As part of a commitment to continuous improvement and evidence-based decision-making, the Ministry uses its evaluations of health system performance to inform strategic intervention and facilitate course correction where warranted.*

Corporate Management Objectives

- **Sound management practices in place:** *The Ministry is committed to following sound business practices in order to operate in the most effective and efficient manner possible.*
- **Managing within the available budget while meeting the priority needs of the population:** *We are committed to managing the health system efficiently and effectively to ensure scarce resources are spent where they will have the best impact.*

GUIDELINES:

All APP business, and any APP-funded physician service initiative, should be managed in a manner consistent with this policy framework, the intent of the provincial physician agreements concerning physician compensation, and the requirements of legislation, regulations and government policies.

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The Ministry's and individual HA's service and performance plans will guide HAs priorities for APP-funded services.

REFERENCES:

MoH 2005/06-2007/08 Service Plan, at: <http://www.bcbudget.gov.bc.ca/sp/hs/default.htm>

Provincial physician agreements are available at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

Medicare Protection Act/Medical and Health Care Services Regulation

Health Authorities Act/Regional Health Boards Regulation

Health Services Management Policy for Health Authorities, May 2002. With password access, a copy is available on the Ministry's intranet at:
http://admin.moh.hnet.bc.ca/acpolicy/pdf/hsmopol_rev.pdf

Financial Management Policy for Health Authorities, March 2002, available at:
<http://admin.moh.hnet.bc.ca/regfin/rham/index.html>

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Section: 3	Values and Principles	Issued: September 2005

POLICY:

All APP business, and any initiative funded through the APP, shall be consistent with the values and principles set out in the Ministry's Service Plan, its *Financial Management Policy for Health Authorities*, and the *Canada Health Act*.

BACKGROUND:

Seven core values guide British Columbia's health care system:

- patient focus
- equity
- access
- effectiveness
- efficiency
- appropriateness
- safety

These values guide the activities of PCB and the APP, as do the principles underlying the Ministry's objectives for financial management:

- probity (financial matters are handled in a proper and honest manner);
- prudence (funds are expended in a responsible manner);
- legality (statutory and regulatory provisions are complied with, and no more is spent than approved in the funding agreement);
- economy (resources are obtained in the appropriate quantity and quality and at the best price);
- efficiency (maximum results are produced for the minimum inputs); and
- effectiveness (organizational goals are met).

APP policy aligns with the principles of the *Canada Health Act (CHA)* for the provision of services under the Act. *Canada Health Act* principles are:

- accessibility;
- comprehensiveness;
- portability;
- universality; and
- public administration.



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Section: 3	Values and Principles	Issued: September 2005

GUIDELINES:

“Services should be coordinated around patient needs for safe, timely and effective care. Health authorities and health workers must work together to put patient needs first” (Picture of Health, 2002).

Refer to the following references for further guidance on values and principles.

REFERENCES:

MoH Service Plan, 2005/06-2007/08, available at:
<http://www.bcbudget.gov.bc.ca/sp/hs/default.htm>

Health Services Management Policy for Health Authorities, May 2002, available, with password access, on the Ministry’s intranet at: http://admin.moh.hnet.bc.ca/acpolicy/pdf/hsmpol_rev.pdf

Financial Management Policy for Health Authorities, which is available with password access on the Ministry Intranet at:
<http://admin.moh.hnet.bc.ca/regfin/rham/index.html>

The Picture of Health, Ministry of Health Planning, December 2002, at:
http://www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf

Canada Health Act, available at: <http://laws.justice.gc.ca/en/C-6/>

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Section:	4	Accountability	Issued:	September 2005

POLICY:

1. APP business and its funding shall be managed in such a manner as to explicitly demonstrate accountability for public funding.
2. The APP and funded HAs shall comply with government's and the Ministry's requirements for data collection, information reporting and performance monitoring, assessment and correction.

BACKGROUND:

"Accountability is the obligation to account for responsibilities conferred. In the public sector, this means that each manager, in both ministries and Crown corporations, is accountable to a superior for managing the responsibilities and resources provided. At its highest level, it means that government is similarly accountable to the Legislative Assembly for its performance in managing the responsibilities and resources entrusted to it. In turn, a responsibility of the Legislative Assembly, acting on behalf of the citizens it represents, is to assess that performance"¹

The provincial government has emphasized that the public has a right to know how and why decisions are made and dollars are spent. Government is undertaking a 'strategic shift' toward "greater accountability to the public for the management of government funding and services". "Health care services must be managed and delivered at the lowest cost that is consistent with quality care. A well-organized, well-run system, with performance targets and an accountability structure, will go a long way toward exposing inefficiency and correcting it" (*Picture of Health*, 2002).

Information is fundamental to accountability. The Ministry's Knowledge Management and Technology Division provides leadership in guiding clear definition of business needs, capacity for information collection and processing, and technologies to support accountability mechanisms.

¹ Source: Enhancing Accountability for Performance: A Framework and an Implementation Plan, Office of the Auditor General



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Section: 4	Accountability	Issued: September 2005

GUIDELINES:

Refer to Chapter 1.6 Risk and Crisis Management.
Refer to Chapter 3.5 Records and Reporting.

REFERENCES:

Enhancing Accountability for Performance in the British Columbia Public Sector, Office of the Auditor General (OAG) of British Columbia and Deputy Ministers' Council, at: www.bcauditor.com/PUBS/1994-95/SPECIAL/ENH_ACCT/sec-1.htm

Enhancing Accountability for Performance: A Framework and an Implementation Plan, Auditor General of British Columbia and Deputy Ministers' Council, at: www.oag.bc.ca/PUBS/1995-96/special/account/toc.htm

The Picture of Health, Ministry of Health Planning, December 2002, available at: www.healthservices.gov.bc.ca/cpa/publications/picture_of_health.pdf

Risk Management, Core Policy and Procedures, Office of the Comptroller General, Ministry of Finance, available at: http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/14_Risk_Mgmt.htm

Adopting Best Practices in Government Financial Statements, 2002/03, Report 10, OAG of British Columbia, available at: www.bcauditor.com/PUBS/2002-03/Report10/sec1.htm



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Section:	5	Scope of APP	Issued:	September 2005

POLICY:

1. APP funding is dedicated to physician compensation for the payment of *physician services* rendered to British Columbians eligible under the Medical Services Plan (MSP). '*Physician services*' is defined within the provincial physician agreements negotiated by the Ministry and British Columbia Medical Association (BCMA).
2. APP provides funding for a HA's base payment of physicians delivering a defined program of clinical care.
3. The APP does not fund or contract with physicians directly.
4. The APP does not provide funds for:
 - on-call payments;
 - statutory holiday, vacation or leave benefits;
 - any break or time spent away from the provision of the funded services;
 - administration, training, or research not associated with clinical activities;
 - program support; or,
 - any other activities unrelated to the provision of clinical servicesSome of the above may be funded through other programs, outside the APP.
5. APP does not fund physician incentive programs. Such incentives may be available and provided through other programs.
6. APP funds shall not be used for the payment of overhead costs, except where that overhead is explicitly contemplated in a HA's service agreement with the APP, and a detailed definition of the nature of the overhead and the level of funding dedicated to it are explicitly defined. Also see Chapter 4.11, Program Support.

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Section: 5	Scope of APP	Issued: September 2005

POLICY (CONTINUED):

7. Physicians' FFS compensation may not be mixed within APP-funded 'programs', except where FFS payment is explicitly contemplated in a HA's service agreement with the APP and a detailed definition of the nature of the FFS service is explicitly defined.
8. A HA may not add funds taken from its global budget to APP-funded programs, except where such funding is explicitly contemplated in its service agreement with the APP.

BACKGROUND:

APP's physician compensation funds are distributed through personal contracts or employment agreements between HA and physicians (or with physician groups) for situations where service stability and payment alternatives are needed to maintain or improve patients' access to necessary medical care.

Some examples of the types of clinical programs funded by APP are:

- Anaesthesia
- Addictions Treatment
- Emergency Rooms
- Geriatrics
- Hematology
- Internal Medicine
- Obstetrics/Gynaecology
- Oncology
- Pediatrics
- Primary Care
- Psychiatry
- Rehabilitation
- Student Health Services
- Diabetes

GUIDELINES:

A HA's acceptance of APP funding is premised on full programs of clinical care. See Chapter 3.4 FFS Exclusion.

Program type is not the sole criterion for funding clinical services through the APP. Refer to Chapter 2.4 Funding Criteria.

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Section:	6	Risk and Crisis Management	Issued:	September 2005

POLICY:

APP and HAs shall incorporate the principles and standards of the Ministry’s Enterprise Risk Management (ERM) into program business practices to proactively mitigate, to the extent possible, risk events that could potentially disrupt the delivery of physician services or inappropriate program expenditure.

BACKGROUND:

Ministry of Finance policy directs that: *Each Ministry is responsible and accountable to Treasury Board for developing, implementing and maintaining an Enterprise-wide Risk Management (ERM) process. This includes the systematic application of management policies, procedures and practices to the tasks of establishing the context, and to identifying, analyzing, evaluating, treating, monitoring and communicating risk.*

In the past, crisis situations have interfered with APP conducting its normal operations and applying consistent program policy. The OAG, in its 2003 report, *Alternative Payments to Physicians: A Program in Need of Change*, noted that “APP has been forced to respond in ways to prevent disruption of service that are outside of apparent policy parameters. Crisis situations for the Ministry and the public can arise when work action is threatened and puts the availability of health services at risk”. “Eight new contracts negotiated in the past three years have all circumvented the standard application process. In every case, there were previous applications submitted to APP, but they did not receive approval until being perceived as necessary to address some sort of crisis that could seriously impact access to a health service” (OAG).

The Ministry’s core business area—Corporate Management—commits programs to risk management through its Strategy #14, *Embed sound practices and a business management culture within the Ministry*, and in its related performance measure, #14: *Percentage of divisions with risk management plans*. Strategy 14 supports and sets targets for enterprise risk management. One hundred percent of Ministry Divisions will have a risk management plan in place by 2006/07.



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Section:	6	Risk and Crisis Management	Issued:	September 2005

GUIDELINES:

The Ministry does not support the continued use of APP funding as an ad hoc response to crisis management.

HAs should work proactively to identify service risks and develop management and crisis contingencies in cooperation with Ministry staff, including those in the Ministry's Program Management and Improvement Division for service areas not funded by the APP.

Both the APP and HAs may bring non-routine or intractable issues to the attention of the Physician Contract Administration Committee for review and resolution advice.

Legal and risk management needs to be considered in all contracting situations.

REFERENCES:

Risk Management, Core Policy and Procedures, Office of the Comptroller General, Ministry of Finance, available at:

http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/14_Risk_Mgmt.htm

MoH 2005/06-2007/08 Service Plan, available at:

<http://www.bcbudget.gov.bc.ca/sp/hs/default.htm>

Alternative Payments to Physicians: A Program in Need of Change. 2003-2004: Report 4. OAG of British Columbia. Available at:

www.bcauditor.com/PUBS/2003-04/Report4/HealthAlternative.pdf

Chapter: 2	Funding Arrangements	Page: 1 of 2
Section: 1	Service Agreements	Issued: September 2005

POLICY:

1. APP service agreements shall align with the provisions of the *Provincial Service Agreement* and with the obligations of legislation and other government and Ministry policies that concurrently govern the APP, its funding and the delivery of health care services within the British Columbia health system.
2. APP service agreements are intended to fund full programs for clinical services.
3. When authorized representatives of the APP and a HA sign a service agreement between them, they agree that the APP is making a set funding allocation available to the HA for its payment of eligible physician services delivered during the term of the agreement.
4. HAs having a service agreement with the APP shall:
 - (a) establish physician contracts for the delivery of the services and use the Template Service Contract provided in the *Provincial Service Agreement*, Appendix B, as the basis of that contract; or,
 - (b) establish salaried employment agreements for the delivery of the services and use the Standard Terms and Conditions of Employment, Appendix B, in the *Provincial Salary Agreement* as the basis or addendum of the agreement.
5. HAs shall provide the APP with a copy of all APP-funded physician contracts and salary agreements to notify APP which modality a HA has chosen for payment and the physicians it has retained for service delivery.
6. APP service agreements are provided only for those physician services being within the scope of the APP. Refer to Chapter 1.5, Scope of APP.

BACKGROUND:

A service agreement is a contractual document between the APP and an individual HA. It describes the services funded (Schedule A, Service Deliverables), the details of fund dispersion and payment (Schedule B, Payments), and the conditions of funding. (Chapter 3, Conditions of Funding.)

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Section: 1	Service Agreements	Issued: September 2005

BACKGROUND (CONTINUED):

HAs plan, manage and evaluate the delivery of health services, and contract with individual or groups of physicians to deliver APP-funded services. A service agreement is one option, or payment modality, used to obtain funding for physicians' compensation and support patients' access to necessary care.

The provincial government regularly negotiates with the BCMA for province-wide agreements, which set the terms and conditions of government-funded physician services.

The *Provincial Service Agreement*, specific to contracted-service physicians, and the *Provincial Salary Agreement*, specific to employed or salary-paid physicians, are subsidiary agreements to the *Working Agreement* with the BCMA.

GUIDELINES:

APP service agreements are generally suited to service environments or locations that are not appropriately supported by FFS payments.

Decisions to pursue a service agreement should be based on a variety of factors. The unique setting of communities and service locations, the availability or supply of physicians, and past experiences or attempts to provide the services are also factors considered when reviewing an application for APP funding. Also see Chapter 2.5, Applying for Funding, and the APP Funding Application.

Under the *Financial Administration Act*, funding allocations are conditional on the availability of government funds and on Treasury Board not controlling or limiting expenditure under the appropriation.

APP funds service agreements in accordance with the *Provincial Service Agreement*, Appendix A, Service Rates. These rates include twelve percent employment benefits. Also see Chapter 2.3, Salaried Arrangements.

REFERENCES:

Provincial Service Agreement. Copies may be obtained at:
www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf

Financial Administration Act [RSBC 1996]. Copies may be obtained at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

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Section: 2	Sessional Payments	Issued: September 2005

POLICY:

1. APP sessional funding shall align with the provisions of the *Provincial Sessional Agreement* and the obligations of legislation and other government and Ministry policies that concurrently govern the APP, its funding and the delivery of health care services within the British Columbia health system.
2. APP sessional allocations are intended to fund full programs for clinical services.
3. When authorized representatives of the APP and HA agree to a sessional allocation, with signing of a Detailed Funding Allocation Statement (DFAS), they agree that the APP is making a set number of sessions available to the HA from which eligible sessional claims may be paid during the fiscal year of the DFAS.
4. HAs having a sessional DFAS in place with the APP shall establish physician contracts for the delivery of sessions and use the Template Sessional Contract provided in the *Provincial Sessional Agreement*, Appendix A, as the basis of that contract.
5. Any APP-funded sessional contract that a HA may establish with physicians shall reflect the intent and provisions of the provincial physician agreements, including but not limited to the *Working Agreement* and its subsidiaries negotiated between the Ministry and the BCMA.
6. HAs shall retain copies of all APP-funded sessional physician contracts and provide them to the APP, on request.
7. APP sessions are provided only for those physician services being within the scope of the APP. Refer to Chapter 1.5, Scope of APP.

BACKGROUND:

HAs plan, manage and evaluate the delivery of health services, and contract with individual or groups of physicians to deliver APP-funded services.

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Section: 2	Sessional Payments	Issued: September 2005

BACKGROUND (CONTINUED):

The provincial government regularly negotiates with the BCMA for province-wide agreements, which set the terms and conditions of government-funded physician services.

The *Provincial Sessional Agreement*, specific to physicians paid by publicly funded sessions, is a subsidiary to the *Working Agreement* with the BCMA.

Sessional payment is one option, or physician compensation modality, used to support patients' access to necessary care. APP sessional funding is generally suited to service environments or locations that are not adequately supported by FFS or other payment modalities and, in particular, part time physician work or where the volume of services provided would not provide the service stability or dependable physician income required to maintain a clinical practice.

Sessional payments support contracted physicians' management of complex or time-consuming patient care by allowing them to bill for the actual amount of time spent with or on behalf of patients, instead of the number and type of services.

GUIDELINES:

The APP reimburses HAs on receipt of a *Claim for Reimbursement of Shareable Expenditures*, where:

- the HA has an approved funding arrangement with the APP;
- all relevant Certificates of Services are attached to the Claim;
- the HA's expenditures have not overdrawn the amount of the APP allocation; and
- the claim has been submitted within 90 days of service.

Decisions to establish sessional funding should be based on a variety of factors. The unique setting of communities and service locations, the availability or supply of physicians, and past experiences or attempts to provide the services through other modalities are also factors considered when reviewing requests for sessional funding.



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Section: 2	Sessional Payments	Issued: September 2005

GUIDELINES (CONTINUED):

In accordance with the *Financial Administration Act*, APP sessional funding allocations are conditional on the availability of government funds and on Treasury Board not controlling or limiting expenditure under the appropriation.

Also refer to:

- Chapter 2.5 Applying for Funding;
- Chapter 3.4 FFS Exclusion;
- Chapter 3.5 Records and Reporting;
- Chapter 5.3 Certificate of Services; and
- Chapter 5.4 Claim for Reimbursement of Shareable Expenditures.

REFERENCES:

Provincial Sessional Agreement, available at:
www.healthservices.gov.bc.ca/msp/legislation/pdf/sessional.pdf

Financial Administration Act [RSBC 1996]. Copies may be obtained at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

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Section: 3	Salaried Agreements	Issued: September 2005

POLICY:

1. APP no longer establishes new salaried funding agreements.
2. Any grand-parented salary agreement shall align with the provisions of the *Provincial Salary Agreement* and with the obligations of legislation and other government and Ministry policies that concurrently govern APP, its funding and the delivery of health care services within the British Columbia health system.

BACKGROUND:

An APP service agreement provides HAs with the flexibility to choose between retaining either contracted service or salaried physicians. (Refer to Chapter 2.1, Service Agreements.)

APP changed its salaried funding practice with recognition that its service agreement funding template and process could appropriately fund APP services deliverables through different payment modalities. Having one dual-purpose template and process is also more administratively efficient than maintaining two.

APP transferred some salaried funding to other program areas, to better align with mandates, and moved others, where salaried funding directly supported clinical services, to more efficient service or sessional agreements.

GUIDELINES:

APP funds its service agreements in accordance with payment ranges set out in the *Provincial Service Agreement*, Appendix A, Service Rates. These rates include twelve percent for salaried employment benefits. By funding at the service rate, APP gives the HA funding for either contracted-service or salaried physician payment, in accordance with the provincial physician agreements, and the choice of payment modality to fit with local circumstances.

REFERENCE:

Refer to the provincial physician agreements at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

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Section: 4	Funding Criteria	Issued: September 2005

POLICY:

1. The funding that may be available to a HA through the APP depends on the HA meeting the following criteria:
 - (a) the inability of FFS payments to adequately support the delivery of necessary patient services;
 - (b) a service need expressed within the HA's service plan;
 - (c) a clear description of the services for which funding is sought;
 - (d) definition of the services' intended outcome(s);
 - (e) identification of the performance measures and plan that will be used for assessing progress toward stated service outcomes; and
 - (f) physician compensation that aligns with the commitments expressed in the provincial agreements for service, sessional and salaried physicians, as negotiated by the provincial government and the BCMA.
2. Where the criteria of Paragraph 1 are met, consideration for approval is conditional upon:
 - (a) the overall APP budget;
 - (b) the availability of funds relative to existing APP commitments; and
 - (c) other priorities.
3. Physician services for which funds are requested must be in-scope for the APP. Refer to Chapter 1.5, Scope of APP.

BACKGROUND:

The OAG, in its report, *Alternative Payments to Physicians: A Program in Need of Change*, noted that in recent years the APP had not been "conducting its normal operations of reviewing and making approvals on applications based on funding criteria" and that new contract allocations "had all circumvented the standard application process". The Ministry cannot condone this departure from an accepted accountability mechanism and requires that all APP applications be assessed against defined funding criteria.



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Section:	4	Funding Criteria	Issued:	September 2005

GUIDELINES:

A HA should assess any application for APP funding in consideration of Ministry and HA strategic priorities and service plans.

Refer to Chapter 2.5 Applying for Funding.

REFERENCES:

MoH 2005/06-2007/08 Service Plan, available at:
<http://www.bcbudget.gov.bc.ca/sp/hs/default.htm>

Alternative Payments to Physicians: A Program in Need of Change. 2003-2004: Report 4. OAG of British Columbia. Available at:
www.bcauditor.com/PUBS/2003-04/Report4/HealthAlternative.pdf

Chapter: 2	Funding Arrangements	Page: 1 of 1
Section: 5	Applying for Funding	Issued: September 2005

POLICY:

1. A British Columbia HA shall sponsor any request for APP funding.
2. A HA shall apply to APP for consideration of funding for the following fiscal year, and use the APP funding application.
3. Applications for APP funding shall meet the criteria set out in Chapter 2.4 Funding Criteria, and be consistent with the Scope of APP Chapter 1.5.
4. Applications are considered on a case-by-case basis, against HA's strategic priorities and service plans (with demonstrated linkages to MoH's strategic priorities and service plans), and relative to the availability of APP funds.
5. Any application should explicitly evaluate the feasibility of a FFS transfer (Chapter 2.8) as a possible source for requested program funding.

BACKGROUND:

Each year, APP receives more funding applications than can be accommodated within its annual budget. An application may meet all funding criteria but not be funded if the APP budget is fully committed.

GUIDELINES:

The APP application requires specific details concerning the proposed program and the service concerns the requested funding is intended to address. It includes questions that, when answered, help define the program proposal and funding requirements.

Further assistance with APP's application is available by calling 250 952-3200. An APP administrator may be assigned to assist with the application process. Also see the APP Funding Application, and:

- Chapter 1.5 Scope of APP
- Chapter 2.4 Funding Criteria
- Chapter 2.6 Changing Allocations
- Chapter 2.7 Renewing Allocations
- Chapter 3.2 Service-Centered Funding



Chapter: 2	Funding Arrangements	Page: 1 of 1
Section: 6	Changing Allocations	Issued: September 2005

POLICY:

A HA shall apply to the APP for any change to an existing funding allocation and advise of its intentions prior to the end of the term of the allocation.

GUIDELINES:

Requests to change to existing service agreements require three months notice.

Also see:

Chapter 2.4 Funding Criteria

Chapter 2.5 Applying for Funding

Chapter 2.7 Renewing Allocations

Chapter: 2	Funding Arrangements	Page: 1 of 1
Section: 7	Renewing Allocations	Issued: September 2005

POLICY:

1. A request to renew an APP allocation is not an automatic continuation of funding.
2. Any renewal of an allocation shall be assessed for its continuing service need and against evidence that the funded program is still meeting funding criteria and achieving intended service or performance outcomes.
3. Any renewal of an allocation shall be undertaken through consultation between APP and funded HA.
4. A renewal is conditional on funding availability within the overall APP budget.
5. Any mutually agreed renewal of a service agreement allocation shall be implemented through a formal amendment or revision of the agreement.
6. Any mutually agreed renewal of a sessional allocation shall be confirmed with the HA's acceptance of the APP Detailed Funding Allocation Statement.

BACKGROUND:

The OAG, in its report, *Alternative Payments to Physicians: A Program in Need of Change*, recommended “the Ministry establish clear policies and guidelines for the contract application approval process and clear criteria for the evaluation of new or expired contracts”.

The OAG also recommended the development of “performance measures that focus APP towards results and ensure these measures contribute to those adopted for the Ministry overall” and “put in place ongoing program evaluation that demonstrates how APP adds value to the provincial health care system”.

GUIDELINE:

Where a previously funded program did not have service outcomes or performance measures defined at the time the original allocation was approved, performance targets and measures should be agreed between APP and HA, even if of a preliminary nature, at the time of any allocation renewal.

Chapter: 2	Funding Arrangements	Page: 1 of 2
Section: 8	Fee-For-Service Transfers	Issued: September 2005

POLICY:

1. HAs may seek approval through the APP to transfer funding from the FFS available amount to the APP to establish or support a program of alternative payments.
2. The amount of a FFS transfer is equal to the value of the payments made to a physician for the provision of the identified services in the twelve months immediately prior to the effective date of the transfer, except where physicians providing the previous services have retired, moved to another location or voluntarily withdrawn services and, therefore, the amount of transfer would not accurately represent the full value of twelve months of services.
3. APP shall submit requests and estimates for FFS transfers to the Ministry's FFS Transfer Review Committee for approval of the estimated FFS transfer amount and in accordance with the Terms of Reference and processes of the Committee.
4. No physician shall be compelled to accept a FFS transfer to an alternative payment arrangement.

BACKGROUND:

Section 9 of the *Second Master Agreement* between the provincial government, MSC and the BCMA provides for transfer of funds from the FFS available amount to physician payments made under the APP. The agreement permits the Ministry to make transfers independently with the proviso that the BCMA is notified of transfers in writing. If the BCMA disputes a transfer, it is arbitrated under the *Commercial Arbitration Act*.

GUIDELINES:

FFS transfers are subject to *Second Master Agreement*, the processes confirmed by the FFS Transfer Review Committee's Terms of Reference, and the policy described in Chapter 2.5 Applying for Funding.



Chapter:	2	Funding Arrangements	Page:	2 of 2
Section:	8	Fee-For-Service Transfers	Issued:	September 2005

GUIDELINES (CONTINUED):

The FFS Transfer Review Committee confirms the FFS transfer amount and notifies the BCMA.

The exact transfer amount should be finalized within ninety days following the transfer of services to the new APP funding modality.

Questions concerning FFS transfers may be directed to the APP at the address provided in Chapter 1.1 or by calling 250 952-3200.

REFERENCES:

Second Master Agreement (February 28, 2001). Copies are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/mas.pdf>

Terms of Reference, FFS Transfer Review Committee (revised, February 2004), available on request from the Transfer Review Committee or APP.

Physician Approval Form for Funding Transfers Between the MSP Available Amount and the Alternative Payments Program, available from the FFS Transfer Review Committee or APP.

Alternative Payments to Physicians: A Program in Need of Change. 2003-2004: Report 4. OAG of British Columbia. Available at:
www.bcauditor.com/PUBS/2003-04/Report4/HealthAlternative.pdf

Chapter: 2	Funding Arrangements	Page: 1 of 4
Section: 9	Full-Time-Equivalency	Issued: September 2005

POLICY:

1. The APP uses a Full-Time-Equivalency (FTE) unit to calculate the monetary funding value of the service or sessional allocation required to support a HA's delivery of a particular clinical program of patient care.
2. The calculated FTE amount is translated into a monetary value in consideration of the number of FTE units required, the specialty services of the program, and physician compensation rates defined in the provincial physician agreements.
3. The APP uses an FTE unit of 1,680 hours of funded service provided by contracted physicians.
4. A salaried FTE is specifically defined by the *Provincial Salary Agreement*, Article 3.3, as "1,957.5 paid hours of employment per year".

Emergency Room (ER) FTE

5. The maximum service time to be provided per year (or FTE) by a contracted ER physician under an APP ER service agreement is 1,680 hours per FTE.
6. An ER FTE consists of 1680 hours of clinical services for direct patient care. Physicians may use, if and when required, up to 340 of these hours for indirect patient care.
7. ER physicians funded by service agreements shall be paid on the range defined in the *Provincial Service Agreement*.

BACKGROUND:

An 'FTE' is the measure of work that is contributed by one individual or a combination of individuals' to equal one year of service or sessions.

Chapter: 2	Funding Arrangements	Page: 2 of 4
Section: 9	Full-Time-Equivalency	Issued: September 2005

BACKGROUND (CONTINUED):

The Ministry of Finance, Office of the Comptroller General, defines a FTE as “*the equivalent of one person working 1,827 hours in one year. Direct FTEs include employees whose salaries are paid directly from the Consolidated Revenue Fund. Indirect FTEs include employees whose salaries are substantially paid by government indirectly through government transfers to external employers*”.

The *Provincial Salary Agreement*, negotiated between the Ministry and BCMA, define, under Article 3.3, a salaried physician FTE as “*1,957.5 paid hours of employment per year*”.

The *Provincial Service Agreement* and *Provincial Sessional Agreement* do not explicitly define an FTE amount.

The *Provincial Service Agreement* speaks of a minimum 1,680 hours of work per year, with two exceptions where physicians provide a maximum 1,680 hours (see Guidelines below for exceptions).

The *Provincial Sessional Agreement* is silent on the number of sessions that a physician may provide per year.

GUIDELINES:

The compensation levels in the *Provincial Service Agreement*, Article 4.2, are predicated on physicians working a minimum of 1,680 hours per year. The agreement further communicates that the Ministry and BCMA both recognize that physicians often need to work more than 1,680 hours. APP expects that the HA and a physician would agree on what is a reasonable number of hours per year, not less than 1,680 hours per FTE position, for the particular type of practice a physician or group of physicians will provide, and that this would be recorded in the contract between them.

Chapter: 2	Funding Arrangements	Page: 3 of 4
Section: 9	Full-Time-Equivalency	Issued: September 2005

GUIDELINES (CONTINUED):

The Ministry's agreement with the BCMA does not contemplate paying physicians for hours worked in excess of 1,680 except under the following specific circumstances:

- Emergency Physicians and Hospitalists where the compensation is based upon a maximum of 1,680 hours per year under the *Provincial Salary Agreement*, Article 4.4.
- In situations where a physician is unable to obtain a locum and the HA and physician agree that for this reason the physician will need to work additional time over and above the hours that would normally be expected to work and agreed upon as being a reasonable expectation for that particular type of practice by the physician and the Agency and as outlined in their contract (*Provincial Salary Agreement*, Appendix 1, Template Service Contract, Article 12.2).

The above are the only two situations under which a HA may consider paying physicians for hours worked over and above 1,680 per year. In each such instance, the APP expects the HA to consult with it so that any such arrangements that are negotiated would be applied in a coordinated and equitable manner to physicians across the province.

HAs may pay up to seven FTEs only when there are seven physicians working in a group. If the HA's contract with a physician group enables them to receive funding for up to eight FTEs, but they only have seven physicians working, the maximum amount that the group could be paid is up to seven FTEs. If the group added an eighth physician, they could then be paid up to eight FTEs, subject to actual hours reported.

Situations where physicians attempt to bill more time than is contemplated in their contracts, for the purpose of obtaining additional funding to pay some colleagues in their group at a higher rate than what has been negotiated for their professional category, is not compatible with the provincial physician agreements. Where such situations occur, the Ministry expects HAs to immediately stop such over payments and recover any monies that have been advanced based upon improper billings.



Chapter:	2	Funding Arrangements	Page:	4 of 4
Section:	9	Full-Time-Equivalency	Issued:	September 2005

GUIDELINES (CONTINUED):

Recoveries of overpayments or improperly paid monies should be managed in a sensitive manner so as not to pose undue hardship on the physicians concerned.

REFERENCES:

Provincial Service Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf>

Provincial Sessional Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/sessional.pdf>

Provincial Salary Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/salary.pdf>

Ministry of Finance, *Core Policy and Procedures Manual*, Office of the Comptroller General, available at: <http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/CPMtoc.htm>

Chapter: 3	Conditions of Funding	Page: 1 of 2
Section: 1	General Conditions	Issued: September 2005

POLICY:

1. The funding provided to British Columbia HAs through the APP is conditional upon the funded HA:
 - (a) continuing to meet all of the terms of the funding agreement with the APP;
 - (b) remaining consistent with the criteria upon which the funding was approved (refer to Chapter 2.4 Funding Criteria);
 - (c) ensuring that APP-funded physicians comply with the reporting required by the APP and Ministry;
 - (d) accounting for all APP funds provided (see Chapter 1.4 Accountability);
 - (e) assessing the degree of patient access that the funded services afford to British Columbians (refer to Chapter 3.5 Reporting);
 - (f) compensating physicians in a manner that is aligned with the provisions of the provincial physician agreements governing the working conditions and compensation of government-funded physicians;
 - (g) confirming that any APP-funded physician meets the requirements of licensure, qualification, and insurance (see 3.3 Practitioner Requirements);
 - (h) complying with all government statutes and policy governing the HAs and the use and administration of public funds; and
 - (i) communicating the conditions of APP funding into the HA's physician contracts and agreements, using the templates provided in the provincial physician agreements.
2. The Ministry may elect to recover funds in circumstances where the conditions of public funding are not met.
3. APP conditions of funding are not to interfere with a physician's professional clinical judgment concerning individual patients.

BACKGROUND:

The APP must account for the distribution of its budget through the evidence of records and reporting and ensure efficiency in all aspects of operations and program administration.



Chapter: 3	Conditions of Funding	Page: 2 of 2
Section: 1	General Conditions	Issued: September 2005

GUIDELINES:

The APP Policy Framework (of which this statement is one policy among others comprising the framework) and funding contracts set out the terms and conditions of APP funding.

HAs risk losing APP funding allocations if they cannot demonstrate that they are administering funds in a manner that is consistent with APP policies and the conditions of government funding.

REFERENCES:

Copies of the provincial physician agreements are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html>

Health Services Management Policy, May 2002. For those who have password access to the Ministry Intranet, a copy may be obtained at:
http://admin.moh.hnet.bc.ca/acpolicy/pdf/hsmopol_rev.pdf

Financial Administration Act. Copies are available at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Chapter:	3	Conditions of Funding	Page:	1 of 4
Section:	2	Service-Centered Funding	Issued:	September 2005

POLICY:

1. APP funds clinical care programs on the basis of *the services* planned to address patient population needs.
2. HAs identify to the APP all of the different specialty skills and related credentials that are required to deliver the program's patient services.
 - (a) Where a HA engages physicians whose specialty and skills are identified by the HA as required to the program's delivery, APP calculates its service funding in consideration of the specialty mix and relative proportions of the identified specialties.
3. APP funds the specialties identified as required to deliver the services and calculates its funding in consideration of the payment categories set by the *Provincial Service Agreement*. Where a HA engages a physician:
 - (a) whose specialty skills and credentials are identified by the HA as required to deliver the program's services, the APP funds the services at the *Provincial Service Agreement* payment category set for that physician's specialty.
 - (b) whose specialty credentials are lower than the specialty skills identified by the HA, the APP funds the services at the *Provincial Service Agreement* category set for that physician's specialty.
 - (c) whose specialty credentials are higher than the specialty skills identified by the HA as required to deliver the program's services, the APP funds at the *Provincial Service Agreement* category of the specialty services provided.
4. A HA shall manage all physician payments within its maximum funding allocation.
5. Where a HA appropriately has a choice of different specialties to deliver a program of services and chooses to change the mix or proportion of the identified specialty services, such changes will:
 - (a) be communicated to the APP; and
 - (b) not set any precedent for future funding allocations.

Chapter: 3	Conditions of Funding	Page: 2 of 4
Section: 2	Service-Centered Funding	Issued: September 2005

BACKGROUND:

A core value of British Columbia's health care system is patient-focused service.

Relevant financial management principles for public funds require meeting government's expectations for patient-centered services that address:

- economy (the appropriate quantity and quality of patient services are obtained at the best price);
- efficiency (patient results are maximized for the funds input); and
- effectiveness (goals for service delivery and patient-focus are achieved).

HAs identify patient population needs and service priorities within their regional health service planning activities. They consider and describe these needs and priorities when applying to the APP for program funding.

GUIDELINES:

When requesting funding, HAs need to identify to the APP the specialty skills and competences that are most appropriate and essential to the delivery of the candidate program of services.

After determining the necessary specialty skills and areas of added competence required to deliver the services, HAs should then identify the most appropriate credentials related to the services and engage those physicians who have the identified specialty or sub-specialty credentials.

When identifying the specialties best suited to deliver the service program, HAs should consider the accepted medical practice, care standards, and qualifications and skills appropriate to the service in accordance with the expectations of the College of Physicians and Surgeons of British Columbia (CPSBC).

Provincial Salary Agreement payment categories are generally grouped by specialty and sub-specialty credentialing and should not be confused with service settings. For example, Critical Care is one of the subspecialties listed under the Medical 4 category; however, other physician specialties, having different provincially negotiated payment categories, might also and necessarily work in the critical care setting to deliver a complete critical care program. Working in the same service setting does not mean that all specialties working in that setting are to be paid the same.

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Section:	2	Service-Centered Funding	Issued:	September 2005

GUIDELINES (CONTINUED):

Examples of Different Scenarios

1. An Internal Medicine specialist working in an Intensive Care Unit (ICU) is paid at Medical 3 category (which includes the Internal Medicine specialty) when his/her Internal Medicine specialty skills are identified as one of the mix of specialty skills required to deliver the ICU program. Similarly, a general practitioner (GP) required to provide GP services in the ICU program is funded for GP services, not for Internal Medicine or Critical Care Medicine services. However, a Critical Care sub-specialist, where a Critical Care Medicine sub-specialty designation is essential to the ICU program, is paid at Medical 4 (aligned with the Critical Care sub-specialty). And, a Neurosurgeon, where his/her sub-specialty Neurosurgery 'area of added competence' is not identified as required to deliver the ICU program—but where he or she is delivering specialty services required in the ICU—is paid for that specialty service delivered, not for the Neurosurgery sub-specialty competence.
2. Similarly, if a sub-specialty Paediatrician leaves a hospital-based tertiary care program to establish a community-based practice and is engaged to deliver a community Paediatrics program, APP funds the services at the *Provincial Service Agreement* Medical 2 category (which includes General Paediatrics) and not the Medical 3 (sub-specialty Paediatrics) level required of his/her former tertiary setting, where the added competence of a sub-specialty credential is required for tertiary care.
3. Some services may be appropriately delivered by any one of a number of different specialty sections, such as for pain management, where Internal Medicine or Anaesthesia services may be equally appropriate to patient care. In such cases, the HA identifies the accepted specialties and these different specialties are listed in the APP funding contract.
4. If patient care requires GP skills and that GP service is provided by a specialist, rather than a GP, APP funds for the GP service and not the credential of the specialist service provider.



Chapter:	3	Conditions of Funding	Page:	4 of 4
Section:	2	Service-Centered Funding	Issued:	September 2005

REFERENCES:

MoH 205/06-2007/08 Service Plan, available at:
<http://www.bcbudget.gov.bc.ca/sp/hs/default.htm>

Provincial Service Agreement, Appendix A (Service Rates) and *Provincial Salary Agreement*, Appendix A (Salary Rates). Copies of both agreements are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/mscagree.html>

CPSBC *Physician Resource Manual*, available at:
https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual

Chapter: 3	Conditions of Funding	Page: 1 of 1
Section: 3	Practitioner Requirements	Issued: September 2005

POLICY:

1. Any physician funded through a HA or other source receiving APP funds shall provide professional services and be available in a manner that is consistent with the conditions of APP funding, and such services and availability shall be referenced in a contractual agreement between the physician and the funded HA.
2. All physicians funded by the APP, whether directly or indirectly, must be:
 - (a) registered with and licensed by the CPSBC, in accordance with the *Medical Practitioners Act*; and
 - (b) enrolled as a practitioner with the MSP and hold a valid practitioner number, in accordance with the *Medicare Protection Act*.
3. Physicians funded by the APP, directly or indirectly, must be able to provide evidence of insurance under the Canadian Medical Protective Association (CMPA) or be otherwise adequately insured against acts of negligence and malpractice.

BACKGROUND:

APP policy governs the administration of program funds and service deliverables, not physicians' professional practice of medicine. The CPSBC governs medical practice in the province. It establishes professional standards, qualifications for registration and licensure and evaluates physician competence and conduct.

GUIDELINE:

HAs should be ready to verify to APP that any physician delivering funded services meets the above requirements.

REFERENCES:

Medical Practitioners Act at: www.qp.gov.bc.ca/statreg/stat/M/96285_01.htm

Medicare Protection Act at: www.qp.gov.bc.ca/statreg/stat/M/96286_01.htm

CPSBC, at: www.cpsbc.ca/



Chapter: 3	Conditions of Funding	Page: 1 of 2
Section: 4	Fee-For-Service Exclusion	Issued: September 2005

POLICY:

Physicians who are working under alternative payment arrangements must confirm to their respective HA, retaining their services, individual agreements not to bill FFS for any service or for any period of time for which the physician is paid utilizing APP funds.

FFS Waiver

1. Complete, signed FFS waivers shall be in place before a HA may submit any claim to the APP for physician services or sessions.
2. HAs shall renew physicians' FFS waivers annually or as outlined in term of contract.
3. HAs shall keep all FFS waivers on site for each APP-funded physician and make the waivers available to the APP, on request.
4. Physicians shall not bill FFS for any service or program deliverable included within a service agreement between the APP and a HA.
5. Physicians shall not bill FFS for any time used to calculate the FTE allocation in a service agreement between the APP and a HA.
6. The APP may consider a well-supported application for an exemption to the FFS exclusion requirement in very exceptional circumstances, where a HA can make a strong case that such an exemption would benefit patients' improved access to necessary care.
7. Where APP grants an exemption to the FFS exclusion under Paragraph 8, the nature and parameter of the exemption shall be explicitly defined within the service agreement between the APP and HA, and clearly and specifically referenced in the related physician contract or agreement.

BACKGROUND:

APP funding is dedicated to those clinical situations not well served by the FFS payment structure. The APP is intended for full programs of physician services.

Chapter:	3	Conditions of Funding	Page:	2 of 2
Section:	4	Fee-For-Service Exclusion	Issued:	September 2005

GUIDELINES:

The FFS waiver template is provided in the provincial physician agreements.

Exceptions to the FFS exclusion should be a rare occurrence and respond to very exceptional circumstances.

Some circumstances might—at first consideration—appear a candidate for an exemption to the FFS exclusion; however, more often they are situations suitable to a service agreement. Service agreements can define a program of services on the basis of patterns of service intensity. For example, in some facilities such as ERs, night shifts do not have sufficient service volumes to support a physician on a FFS-basis, but do have volumes during daytime shifts, when FFS is a better compensation support. A HA with a ‘medium volume’ ER may choose an APP service agreement to fund ER physicians during lower-intensity night shifts and allow FFS payment during daytime, higher-volume hours.

REFERENCES:

Provincial Service Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf>

Provincial Sessional Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/sessional.pdf>

Provincial Salary Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/salary.pdf>

Chapter: 3	Conditions of Funding	Page: 1 of 6
Section: 5	Records and Reporting	Issued: September 2005

POLICY:

1. HAs shall maintain service and expenditure records, including complete patient-based records and summary information concerning all APP-funded services.
2. HAs shall retain summary records on-site for at least six years plus the current fiscal year.
3. A patient-based record shall include:
 - (a) identification of the HA, site or facility, and payee identifier;
 - (b) patient personal health number (PHN), date of birth, and name;
 - (c) MSP enrolment number of the physician providing service;
 - (d) date of service;
 - (e) services/procedures provided (identified by payment schedule fee or program code);
 - (f) diagnostic (ICD9) and/or case mix group code;
 - (g) identification of the services for which payment is recoverable from a third-party payer (for example, Insurance Corporation of British Columbia (ICBC), Workers' Compensation Board (WCB), private-pay patients, out-of-country, or out-of-province payments where no reciprocal agreement is in place); and
 - (h) start and finish time of service.
4. HAs shall permit an authorized representative of the Ministry to inspect, review and copy all records, data, reports, documents and materials pertaining to the provision of services or sessions funded by the APP, whether complete or otherwise, but in consideration of legal statutes that constrain access to information and protect privacy.
5. HAs shall deliver reports to the APP:
 - (a) containing the information required in the service agreement with the APP within twenty eight days of the end of each quarter;
 - (b) identifying, on request, the work done and to be done by the HA or its physician contractors or employees in connection with the provision of funded services; and
 - (c) notifying the APP when contracting or employing any physician to provide funded services.

Chapter: 3	Conditions of Funding	Page: 2 of 6
Section: 5	Records and Reporting	Issued: September 2005

POLICY (CONTINUED):

6. A HA shall report, in writing, to the APP all its funding sources and amounts received, or to be received, with respect to services under a service agreement, including physician compensation paid by the HA or any of its subcontractors, affiliates or subsidiary organizations to subcontracted or employed physicians. Sources include, but are not limited to:
 - (a) the global budget of the HA;
 - (b) professional service contracts with other organizations;
 - (c) grants, endowments, stipends and honoraria; and
 - (d) third-party billings.
7. Reporting under Paragraph 6 shall be in writing and undertaken within sixty days of signing an APP agreement, or upon receiving knowledge of such sources.
8. HAs shall report compensation information to the APP for each funded physician, identified by name, MSP practitioner enrollment number and birth date, and include:
 - (a) all monetary payment including but not limited to salary, wages and fees;
 - (b) a full description of any benefit, perquisite and/or other compensation for which the physician is eligible or has been provided (for example, payments or reimbursements for Continuing Medical Education, CMPA, pensions, travel and/or housing).
9. Within 28 days of the end of each calendar month in the term of a service agreement, the HA shall provide the APP with a report on FTE coverage for the preceding month and cumulative for the term, in a format acceptable to the APP, indicating for each physician providing service:
 - (a) the daily number of service hours (excluding any period of time or break when services were not delivered);
 - (b) the amount paid to each contracted physician for the service; and
 - (c) the name, specialty and MSP practitioner enrollment number.
10. HAs shall, for APP-funded ERs and input to workload models under the provincial ER Framework:
 - (a) ensure that the amount of physician time spent on indirect care is recorded and reported 15-minute blocks; and
 - (b) maintain and report the records necessary for determining acuity levels.

Chapter: 3	Conditions of Funding	Page: 3 of 6
Section: 5	Records and Reporting	Issued: September 2005

POLICY (CONTINUED):

11. The following information is reported through the APP sessional claim process and is a condition of sessional payment:
- (a) agency, site, program, control and sub-control codes;
 - (b) physician name and MSP enrollment number;
 - (c) date of session delivery;
 - (d) duration of service, by hour and quarter-hour increments (for example, 0630-0645 h; 1145-1330 h or 1630-2000 h); and
 - (e) the dollar values of sessional amounts claimed.

Also see Chapter 5.3 Certificate of Services, and 5.4 Claim for Reimbursement of Shareable Expenditure.

BACKGROUND:

APP funding is approved with the condition that HAs will submit the reports the Ministry requires to account for public funding and services provided.

Consistent and comprehensive service records and reporting:

- provides information about utilization rates, patterns of physician practice, burden of illness across populations and distribution of, or access to, particular health services;
- is essential to determining acuity levels, building workload models, and calculating the health human resources and levels of related compensation necessary to provide patient services;
- is central to the Ministry's audit and comptroller functions, including service verification and billing integrity programs;
- forms the basis of health care research and service planning;
- provides the aggregated data necessary for health policy analysis and provincial, national and international health system comparisons;
- is automatic with the electronic submission of physicians' FFS claims payment, but has been inconsistent for physicians' alternative payments;
- is called 'shadow billing' when reporting does not trigger a payment process;
- safeguards the quality of health care by identifying risk for proactive management; and
- is fundamental to demonstrating accountability for public funding.

Chapter: 3	Conditions of Funding	Page: 4 of 6
Section: 5	Records and Reporting	Issued: September 2005

BACKGROUND (CONTINUED):

Good medical practice requires physicians to maintain service details as part of a clinical record. Contracted physicians must maintain an *Adequate Medical Record*, as defined by the MSC Payment Schedule, and in accordance with the *Rules made under the Medical Practitioners Act*.

The provincial subsidiary agreements with the BCMA confirm physicians' agreement and responsibility to transmit service (encounter) details, *in the same manner as that required for physicians billing FFS*, when physicians are contracted to provide government-funded physician services.

Encounter Reporting

A health service is a patient's encounter with the health care system. A clinical service is an encounter between patient and physician.

The basic information elements of a physician-patient encounter are:

- name and identity number of the patient;
- name and identify number of the physician service provider; and
- service particulars (including delivery location/facility, time, date, and duration of services, and associated diagnostic, fee item or service codes).

Through encounter reporting, HAs can receive summary and comparative information and, with it, enhanced ability to demonstrate accountability and make decisions that best support regional access to services. Physicians can receive aggregated or contextual information, ensure their work is being appropriately acknowledged relative to the practices and compensation of professional colleagues and make individual judgments of equity and fairness.

Without reporting, the APP cannot adequately respond to physicians requesting a representative pattern of practice report or their own practice profiles.

Reporting is critical to determining the correct allocation of physician resources. The diagnostic ICD-9 codes within an encounter report help determine acuity levels and related physician workloads. With acuity and workload information, a workload model may be constructed. Workload models assist in calculating the number of physicians and funds required to provide patient services.

Chapter:	3	Conditions of Funding	Page:	5 of 6
Section:	5	Records and Reporting	Issued:	September 2005

GUIDELINES:

The APP service agreement defines reporting requirements, including electronic encounter reporting using the Teleplan system for all patient services delivered.

Encounter reports use:

- the fee codes as listed in the MSC Payment Schedule;
- “E” as a Payment Mode value to identify all service encounters (non-FFS) claim records; and.
- zero dollars (\$) as a billed amount.

Summary records need not be routinely submitted to the APP but should be easily and quickly available on request for audit and inspection purposes. They should be maintained in a format that can be sorted by practitioner number and date of service, and be verified against clinical records.

For physician income earned under an APP agreement to be included in a physician’s benefits entitlement under the BCMA’s Contributory Professional Retirement Savings Plan, HAs should provide an annual report of physician income for the previous year to the BCMA Benefits Manager. For more information, contact the Manager at:

BCMA
115 - 1665 West Broadway
Vancouver BC V6J 9Z9
Telephone: 604 736-5551
Fax: 604 736-2961

Contact APP or Physician Compensation Branch with any questions concerning reporting expectations at:

2-1, 1515 Blanshard St
Victoria BC V8W 2C8
Telephone: 250 952-3200
Facsimile: 250 952-3486



Chapter:	3	Conditions of Funding	Page:	6 of 6
Section:	5	Records and Reporting	Issued:	September 2005

REFERENCES:

Copies of the provincial physician agreements are available at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

MSC Payment Schedule. Copies are available at:
www.healthservices.gov.bc.ca/msp/infoprac/physbilling/payschedule/

Financial Administration Act, at: www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Medical Practitioners Act, at: www.qp.gov.bc.ca/statreg/stat/M/96285_01.htm

Medicare Protection Act, at: www.qp.gov.bc.ca/statreg/stat/M/96286_01.htm

Chapter:	3	Conditions of Funding	Page:	1 of 2
Section:	6	Monitoring and Evaluation	Issued:	September 2005

POLICY:

1. The APP shall monitor and evaluate compliance with its conditions of funding in accordance with the government's expectations and agreements, Ministry and program policy and legislation concerning the administration of public funding.
2. The APP shall not release payments for claims exceeding approved allocations.
3. HAs funded by the APP shall ensure mechanisms are in place for determining and reporting that:
 - (a) the agreed programs of services are delivered in accordance with the services deliverables and costs defined in its agreements with the APP; and
 - (b) the funds provided to HAs contracted and employed physicians are provided in a manner consistent the conditions and payment rates defined within the provincial physician agreements.
4. HAs shall be able to provide complete documentation and records of fund disbursement to the Ministry for audit and inspection purposes.
5. HAs shall be able to account for all funds provided by the APP and for all physician services rendered, reported and paid under an alternative payment arrangement, including payments for any indirect or non-patient care.

BACKGROUND:

Monitoring the delivery of health care programs is critical to ensuring funded individuals, programs and organizations are accountable for their use of public funds and contributions to HA, Ministry and health system goals.

Monitoring and evaluation are two activities in a full cycle of accountability that includes planning, implementing, monitoring, reporting, evaluating and modifying performance relative to goals and outcome targets.

The 2003 OAG report regarding the APP emphasized that "*without adequate monitoring and compliance policies and procedures, and without appropriate data collection and analysis tools, there is a risk of financial loss through over compensation or conducting unnecessary investigations*".

Chapter: 3	Conditions of Funding	Page: 2 of 2
Section: 6	Monitoring and Evaluation	Issued: September 2005

GUIDELINES:

HAs should keep a declining balance of claims against program allocations to ensure utilization is within the limits of allocated funding and use the Payment Detail Statement to monitor utilization of services and payments. Refer to Chapter 5.6 Payment Notices and Payment Detail Statements.

The APP can work with HAs on the development of monitoring and evaluation approaches appropriate to their APP-funded services.

Also see Chapter 1.4 Accountability.

REFERENCES:

Financial Administration Act. A copy is available at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Medicare Protection Act. A copy is available at: www.qp.gov.bc.ca/statreg/stat/M/96286_01.htm

Alternative Payments to Physicians: A Program in Need of Change. 2003-2004: Report 4. OAG of British Columbia. Available at:
www.bcauditor.com/PUBS/2003-04/Report4/HealthAlternative.pdf



Chapter: 3	Conditions of Funding	Page: 1 of 1
Section: 7	Confidentiality	Issued: September 2005

POLICY:

Ministry and HA staff, physicians, or any person or organization involved with the APP or administering its funds or programs, shall treat as confidential and not disclose patient information except where required or permitted by law.

BACKGROUND:

The *Freedom of Information and Protection of Privacy Act* prohibits unauthorized collection, use or disclosure of personal information by public bodies.

APP and Ministry staff are bound-by-oath as a condition of public service employment. Swearing the employment oath serves to ensure that employees understand and accept their obligations to the public, including confidentiality.

The templates included in appendices to the provincial physician agreements contain articles setting out the expectations for patient information confidentiality.

The *Guidelines for Conduct of Government Appointees to BC Agencies, Boards & Commissions* outlines the expectations for conduct for anyone appointed by the provincial government to an agency, board, or commission. Maintaining confidentiality is an explicit expectation of conduct.

GUIDELINES:

HAs must use the templates provided in the provincial physician agreements when retaining government-funded physician services.

REFERENCES:

Freedom of Information and Protection of Privacy Act, at:
www.qp.gov.bc.ca/statreg/stat/F/96165_01.htm

Provincial physician agreements, at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

Guidelines for Conduct of Government Appointees to BC Agencies, Boards & Commissions.
Office of the Premier, Board Resourcing and Development Office, at:
www.fin.gov.bc.ca/oop/brdo/guidecond.htm

Chapter: 3	Conditions of Funding	Page: 1 of 1
Section: 8	Conflict of Interest	Issued: September 2005

POLICY:

1. HAs shall uphold the expectations for conduct set out in the *Governance Policy for Health Authorities*, Chapter 4.2 Conflict of Interest.
2. HAs shall manage any conflict of interest in a manner to comply with the *Guidelines for Conduct of Government Appointees to BC Agencies, Boards & Commissions*.
3. Physicians delivering APP-funded services shall abide by the provincial physician agreements and the article, Conflict of Interest, included therein.

BACKGROUND:

APP service agreements with HAs contain, Appendix 1 Guidelines for Conduct, developed by the Board Resourcing and Development Office; this appendix includes guidance to avoid any real or perceived conflicts of interest.

Ministry staff are bound-by-oath as a condition of public service employment. Swearing the employment oath serves to ensure that employees understand their obligations to the public, including avoidance of any conflict of interest in the performance of their public service.

GUIDELINE:

HAs must use the templates provided in the provincial physician agreements when retaining physicians to provide government-funded services.

REFERENCES:

Guidelines for Conduct of Government Appointees to BC Agencies, Boards & Commissions.
Office of the Premier, Board Resourcing and Development Office, at:
www.fin.gov.bc.ca/oop/brdo/guidecond.htm

The *Governance Policy for Health Authorities* is available, with password access to the Ministry Internet, at: <http://admin.moh.hnet.bc.ca/acpolicy/pdf/govpolha.pdf>

Copies of the provincial physician agreements are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/mscagree.html>



Chapter: 3	Conditions of Funding	Page: 1 of 1
Section: 9	Consequence of Default	Issued: September 2005

POLICY:

1. The APP may withhold payment or terminate funding if a HA does not comply with all conditions of funding.
2. The Ministry may elect to recover funds where conditions of funding are not met.

BACKGROUND:

Compliance with the terms, provisions and expectations of provincial legislation, policy and agreements is a condition of provincial funding. A HA risks losing its APP funding allocation if it cannot clearly demonstrate that it is administering the allocation in a manner consistent with APP policies and the conditions of government funding.

GUIDELINES:

When a HA recognizes that it is or anticipates being in default, it should contact APP immediately.

The APP will apply reasonableness in any assessment of policy non-compliance; however, when presented with a concern for non-compliance, a HA should advise APP how and when such a default will be addressed.

Legal and risk management needs to be considered in all contracting situations.

REFERENCE:

Financial Administration Act at: www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Chapter: 4	Physician Compensation	Page: 1 of 2
Section: 1	Physician Contracts	Issued: September 2005

POLICY:

1. A HA shall establish a written agreement with all physicians who deliver publicly funded services, including physician services funded by the APP.
2. When retaining physicians, a HA shall use the:
 - (a) Template Service Contract, Appendix B, *Provincial Service Agreement*, when contracting physicians to deliver publicly funded services;
 - (b) Template Sessional Contract for Physician Services, Appendix A, *Provincial Sessional Agreement*, when contracting physicians to deliver publicly funded sessions; and
 - (c) Standard Terms and Conditions of Employment, Appendix B, *Provincial Salary Agreement*, when employing physicians to deliver publicly funded services on a salary-basis.
3. A HA shall not remove any article, section or paragraph of the provincial physician agreements referenced in Paragraph 2 (a), (b) and (c) when establishing local physician contracts or employment agreements.
4. A HA may add language to its physician contracts or agreements to address particular local or physician circumstances so long as that language does not alter or diminish the full intent of the provincial physician agreements, does not counter the conditions of APP funding, and the rationale for added language is service-centered and improves patient access to physician services.
5. A HA shall explicitly extend the intent and deliverables of its service agreement with the APP to the physician contract or agreement negotiated by the HA to deliver the APP-funded physician services.
6. A HA shall not contract with a physician to provide APP-funded services until the HA has received approval of an APP allocation.
7. At any time, the APP may request a HA to provide copies of the physician contracts and employment agreements that the HA has negotiated with physicians to deliver funded services and may withhold payments pending receipt of the requested contracts or agreements.



Chapter:	4	Physician Compensation	Page:	2 of 2
Section:	1	Physician Contracts	Issued:	September 2005

BACKGROUND:

The provincial physician agreements define the terms and conditions for retaining physicians to deliver government-funded services. These terms and conditions are not negotiable at the local level.

GUIDELINES:

HAs should not change the body of the provincial physician agreement templates when contracting physicians to deliver APP-funded services. APP staff can help with definition of physician contract schedules to respect the provincially negotiated templates, address physician service deliverables and reflect the particulars of the funding agreement between APP and HA.

Physician agreements should be in place before services are delivered.

Refer to Chapter 3 Conditions of Funding.

REFERENCE:

Copies of the provincial physician agreements are available at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

Chapter:	4	Physician Compensation	Page:	1 of 2
Section:	2	Provincial Agreements	Issued:	September 2005

POLICY:

The APP is administered in accordance with the provisions of the provincial physician agreements and in compliance with the legislation governing the health care system, provincial and Ministry strategic priorities and policies, and the commitments of health service plans.

BACKGROUND:

A number of formal agreements define the provincial government's relationship with physicians in British Columbia, physicians' working conditions and their compensation when publicly funded.

The *Second Master Agreement* of 28 February 2001 provides the framework for negotiation and consultation with physicians and confirms agreement to:

- enhance and maintain the principles of medicare;
- ensure a stable and long-term relationship with physicians;
- ensure and enhance the delivery of medically required services to British Columbians in an efficient, high quality and effective manner;
- ensure that physicians are appropriately compensated for services provided under MSP and APP;
- ensure that the medical care system continues to function well; and
- contribute to achieving a mix and distribution of physicians based upon the needs of British Columbians.

The *Working Agreement* is an economic agreement with British Columbia physicians. It sets out the provisions for fees, on-call payments and physician benefits, including disability and malpractice insurance, education funds, retirement savings plan contributions and maternity leave.

Subsidiary agreements to the *Working Agreement* address matters specific to the interests of GPs, physicians practicing in rural areas and physicians on alternative payment arrangements, including contracted service, sessional and salaried physicians.



Chapter: 4	Physician Compensation	Page: 2 of 2
Section: 2	Provincial Agreements	Issued: September 2005

GUIDELINES:

This policy framework and the funding agreements that the APP establishes with HAs to fund physician service deliverables are written to align with the expectations of legislation, provincial and Ministry policy, strategic priorities, health service plans, and the provisions of the provincial physician agreements.

Any situation of a perceived conflict between various policies or agreements concerning physician compensation should be brought to the attention of PCB for policy clarification or advice to remedy.

REFERENCE:

Copies of the provincial physician agreements are available at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html



Chapter: 4	Physician Compensation	Page: 1 of 2
Section: 3	Rates and Fees	Issued: September 2005

POLICY:

1. Physician services funded under the APP shall align with the provisions for compensation set by the provincial physician agreements.
2. When a new rate, fee or compensation category is set as the result of a new provincial agreement negotiated with the BCMA, APP payments will be reconciled accordingly to the effective date of the new provincial agreement, unless an explicit provision of the agreement directs otherwise or a higher rule of law or provincial governance prohibits its implementation.
3. HAs shall consider the placement criteria within the provincial physician agreements when negotiating individual physician agreements.

BACKGROUND:

APP integrates the provisions of provincial physician agreements with its concurrent obligations under legislation, regulation and other policy that governs the British Columbia health care system.

GUIDELINES:

The APP calculates its funding allocations in consideration of the availability of funds, the compensation rates and ranges defined in the provincial physician agreements, the FTE amount needed to deliver a program of services, and the specialties required to deliver the services. Also refer to Chapter 2.9 Full-time Equivalency, Chapter 3.2 Service-Centered Funding, and Chapter 4.5 Specialist Credential.

The rates for contracted-service physicians are listed in the *Provincial Service Agreement*, Appendix A, Service Rates, and include twelve percent for benefits.

The fee value of a session is listed within the *Provincial Sessional Agreement*, 4.0, Fees, according to a sessional physician being either a GP or a specialist.



Chapter:	4	Physician Compensation	Page:	2 of 2
Section:	3	Rates and Fees	Issued:	September 2005

GUIDELINES (CONTINUED):

HAs may employ physicians on a salary-basis to deliver services. Salary rates are listed in the *Provincial Salary Agreement*, Appendix A, Salary Rates. APP funds according to *Provincial Service Agreement*, which provides a higher rate in lieu of employment benefits than the salary rate; this service rate funding allows HAs the choice of retaining either contracted or employed physicians. When a HA chooses to employ physicians, the twelve percent higher service rate provided by the APP allows for the HA's payment of employment benefits.

The Health Employers Association of British Columbia (HEABC) can assist HAs in interpreting compensation expectations under the provincial physician agreements and in applying range placement criteria. The HEABC may be contacted at:

HEABC
200 - 1333 West Broadway
Vancouver BC V6H 4C6
Telephone: 604 736-5909
Fax: 604 736-2715

Also see Chapter 4.4 Compensation Range.

REFERENCES:

Provincial Service Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf>

Provincial Sessional Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/sessional.pdf>

Provincial Salary Agreement. Copies may be obtained at:
<http://www.healthservices.gov.bc.ca/msp/legislation/pdf/salary.pdf>

Chapter: 4	Physician Compensation	Page: 1 of 1
Section: 4	Compensation Range	Issued: September 2005

POLICY:

Physician compensation placement and progression along the range is the responsibility of the HAs that retain physicians to deliver services.

BACKGROUND:

Article 4.5 of the *Provincial Service Agreement* and Article 4.3 of the *Provincial Salary Agreement* set out the criteria for consideration of individual physician's placement on the provincial compensation range.

GUIDELINES:

A HA's placement of one physician on the provincial compensation range does not translate directly into the level of funding provided in an APP allocation. A funding allocation is the product of a number of considerations, with the capacity of its budget overriding all other. When an allocation is approved for a HA, the HA will decide how best to distribute that allocation among its retained physicians and meet the provisions of the provincial physician agreements for range placements.

A HA's initial placement of a physician on the range should consider:

- local recruitment and retention concerns;
- an individual physician's experience and achievement;
- the nature of services, including the time of day or night when the services are provided; and
- clinically related teaching, research and administrative activities.

Progression, over time, along the compensation range should consider:

- a physician's demonstrated performance;
- local recruitment and retention concerns; and
- a physician's increased experience and achievement since initial placement.

The HEABC can assist with applying the placement criteria. See Chapter 4. 3.

REFERENCE:

Copies of the provincial physician agreements are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/mscagree.html>

Chapter: 4	Physician Compensation	Page: 1 of 6
Section: 5	Specialist Credential	Issued: September 2005

POLICY:

1. APP calculates its service agreement funding amounts based on the compensation categories and rates set by the *Provincial Service Agreement*.
2. The compensation category that the APP uses for calculating a funding amount, for a contract between the APP and a HA, is based on the specialty or sub-specialty service deliverables of the contract.
3. Physicians who deliver APP-funded specialty or sub-specialty services shall have obtained and provide proof of the specialty or sub-specialty credential that attests to their qualification to deliver such services.
4. Where the Royal College of Physicians and Surgeons of Canada (RCPSC) provide certification for an area of added competence (sub-specialty), a physician delivering such sub-specialty services shall:
 - (a) provide proof of the RCPSC Certificate of Special Competence credential;
 - (b) be registered with the CPSBC with a full, temporary or special practice license, not an educational license as sub-specialty education must be complete; and
 - (c) be listed in the CMR.
5. Where the RCPSC provides accreditation for a sub-specialty residency program through its Accreditation Without Certification program, a Specialist, who has successfully completed such an RCPSC-accredited program, shall:
 - (a) meet the requirements of Paragraph 4 (b) and (c), above;
 - (b) register with the RCPSC, its required Attestation of Completion form and, in so doing be recognized as a sub-specialist; and
 - (c) be considered for APP sub-specialty-level funding.
6. Where a physician has not successfully completed an RCPSC accredited specialty or sub-specialty program and is not recognized as a specialist or sub-specialist by the RCPSC, but where a HA believes the physician has successfully obtained added specialty or sub-specialty competence, the Ministry will fund HA's for physicians performing specialty – sub-specialty roles when the following criteria has been met:

POLICY (CONTINUED)...

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Section:	5	Specialist Credential	Issued:	September 2005

POLICY (CONTINUED):

- (a) If a physician is providing professional services in a practice area that is recognized in Canada as Specialty or Sub-specialty practice area (refer to categories recognized by the Royal College of Physicians and Surgeons of Canada); and
- (b) The physician's license and registration by the College of Physicians and Surgeons of British Columbia is consistent with the physician practicing in that Specialty or Sub Specialty area; and
- (c) The physician has completed a relevant Specialty – Sub-specialty fellowship program or formal training program recognized by an accrediting body acceptable to the College of Physicians and Surgeons of British Columbia and to the Health Authority; and
- (d) The physician is granted privileges by a Health Authority to practice in that Specialist – Sup-specialist area and is employed/contracted by that same Health Authority to perform services in that same Specialist – Sub-Specialist practice area.

BACKGROUND:

In accordance with the 2006 *Provincial Service Agreement* for the purposes of physician compensation, a “Specialist” is a certificant or fellow of the RCPSC (Article 3.10). The 2006 *Provincial Salary Agreement* provides the same definition.

Physicians who are providing “Specialist Services”, as defined within the provincial physician agreements, but who are not certificants or fellows of the RCPSC, may appeal through the BCMA-MoH Liaison Committee for Specialist compensation (under Article 4.7 *Provincial Service Agreement*, or Article 4.6 *Provincial Salary Agreement*); however, this option is for non-certified specialists only and not for those who are already certificants or fellows of the RCPSC and seeking compensation at a different specialty or sub-specialty level. The MoH Liaison Committee process is not an avenue to bypass provincially negotiated compensation placement categories.

Accreditation is a process of quality assurance. Accreditation recognizes that a post-secondary educational institution maintains the standards that qualify its graduates for acceptance into more specialized education or for professional practice. An accredited institution or program meets expected functional, structural and performance standards. A *credential* (or *certificate*) granted from an *accredited* institution *certifies* (or *attests*) that its recipient has successfully achieved the accepted standard of education.

1 Accrediting bodies acceptable to the College of Physicians and Surgeons of British Columbia are determined from time to time by the College and include the Royal College of Physicians and Surgeons of Canada and equivalent national accrediting Colleges and Boards.

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Section:	5	Specialist Credential	Issued:	September 2005

Three bodies credential physicians or accredit medical training in Canada:

1. The RCPSC sets standards for specialties in Canada.
2. The College of Family Physicians of Canada (CFPC) certifies practitioners of family medicine.
3. The Medical Council of Canada (MCC) grants the Licentiate of the Medical Council of Canada (LMCC) qualification.

RCPSC

The RCPSC oversees the education, standards and certification of all medical and surgical specialists and sub-specialists in Canada, except for specialists in family medicine. The RCPSC sets the national requirements for specialty and sub-specialty education; accredits residency programs; assesses the acceptability of residents' education and postgraduate training credentials; and, for those eligible, conducts certifying examinations. The RCPSC does not license or discipline its members.

A specialist may be either a certificant or fellow of the RCPSC. A *certificant* has met the RCPSC credential standard, has an acceptable medical qualification, has completed the defined period of specialty residency education and successfully completed an RCPSC specialty examination, but has either not applied or been accepted as a *fellow* of the RCPSC. A certificant must apply to the RCPSC; fellowship is not automatic with certification. If accepted, a *fellow* is then required to maintain career-long learning, competence, and best patient practices in specialty and sub-specialty care through the RCPSC Maintenance of Certification Program.

The RCPSC accredits sub-specialty residency programs. Accreditation involves an evaluation process but not a national, formal examination. It also recognizes but does not certify specialists who complete sub-specialty training under Accreditation Without Certification programs. The RCPSC website lists subspecialties and the particular medical schools accredited or recognized to train different subspecialties.

“While recognizing the existence of differing circumstances in the various provinces and regions of the country, and the need to provide room for innovation to meet changing requirements, the [RCPSC] Accreditation Committee holds that local circumstances cannot justify accreditation of a substandard program” (RCPSC, Accreditation of Residency Program).



Chapter: 4	Physician Compensation	Page: 4 of 6
Section: 5	Specialist Credential	Issued: September 2005

BACKGROUND (CONTINUED):

Canadian College of Family Practice (CCFP)

The CCFP accredits family medicine residency programs and certifies those physicians who are qualified to practice family medicine. The CCFP also provides a Certificate of Special Competence in Emergency Medicine.

MCC

The MCC evaluates the competence of physicians to practice medicine in Canada. It grants the LMCC and maintains the CMR. The LMCC is recognized by medical licensing bodies across Canada and is a licensing requirement for each. The CMR records all the qualifications achieved over the course of a physician's career. The MCC ensures uniform national standards for qualification and portability across Canada; however, it is the role of provincial colleges, not the MCC, to grant licenses to practice medicine.

CPSBC

The CPSBC is a self-regulating governance body. It has the provincial mandate to oversee the practice of medicine, surgery and midwifery in British Columbia and determine the qualifications required for registration and licensure. The CPSBC establishes provincial standards for medical care and monitors, evaluates and disciplines its members to ensure the competence and conduct required to maintain registration and licensure. CPSBC programs include periodic peer review, accreditation of diagnostic facilities, monitoring of hospital privileges and prescribing practices, establishment and maintenance of education standards, and evaluation of ethical issues.

The CPSBC assesses the eligibility of foreign-trained physicians for temporary British Columbia registration. To be eligible, a physician must have graduated from a medical school approved by the CPSBC, successfully completed the MCC evaluating examination, confirmed eligibility to write the RCPSC exams, be board-certified in the United States if trained in the United States and have a position offer from a British Columbia community that has been not be successful finding a suitable Canadian physician.



Chapter: 4	Physician Compensation	Page: 5 of 6
Section: 5	Specialist Credential	Issued: September 2005

BACKGROUND (CONTINUED):

The CPSBC requires physicians applying for British Columbia registration and licensure first be Licentiates of the MCC. The CPSBC provides five registration options, each with different eligibility criteria:

1. Full register (for independent practice);
2. Temporary register (with terms and conditions for practice);
3. Osteopathic register (for osteopathic physicians);
4. Educational purpose register (medical students, residents, visiting professors or specialists, and research or clinical fellows, clerkships and trainees); and
5. Special register (for senior academic appointments to the Faculty of Medicine, UBC, and exceptional circumstances at the discretion of the CPSBC Council)

Faculty of Medicine, University of British Columbia (UBC)

UBC is the primary facility for physician education in British Columbia. It has satellite programs at the University of Northern British Columbia and University of Victoria. UBC offers fifty-seven RCPSC-accredited residency programs across a broad range of specialties and uses teaching facilities at the Vancouver Hospital and Health Sciences Centre, St. Paul's Hospital, British Columbia Children's and Women's Hospitals and the British Columbia Cancer Agency. Some smaller community hospitals are also integrated into programs of family medicine, paediatrics, psychiatry, obstetrics and gynecology, ophthalmology and general surgery.

The Faculty leads clinical departments in the province's major teaching hospitals, develops and disseminates guidelines for practice and continuous quality improvement, and promotes critical and rigorous approaches, new therapies and technologies, and greater capacity for evaluation.

GUIDELINES:

A HA must ensure that it retains only those physicians who are qualified with the appropriate credential to deliver the services and, thus, must confirm each physician's credentials through the bodies responsible for setting standards and accreditation for medical education.

Chapter: 4	Physician Compensation	Page: 6 of 6
Section: 5	Specialist Credential	Issued: September 2005

GUIDELINES (CONTINUED):

The APP provides physician compensation options within the larger context and broader MoH mandate that concerns the delivery of safe and effective patient services, quality assurance, and a sustainable health care system.

It is not the role of the APP, PCB, MoH or the HAs to be certifying an individual physician's medical qualifications or to be accrediting a facility's medical training, education or residency programs. It is the role and responsibility of the respective professional colleges to accredit education programs and certify only those physicians who have successfully completed the training necessary to meet medical care and education program standards.

REFERENCES:

The RCPSC: http://rcpsc.medical.org/residency/accreditation/arps/arp_e.php

- The RCPSC maintains a web-accessible, searchable list of fellows, accredited universities, specialties, sub-specialty certificates of special competence, and recognized programs of sub-specialty accreditation without certification. To confirm specialist *certificants* (only fellows are listed in the web-accessible database) follow the links to the RCPSC membership department for contact information.

College of Family Physicians of Canada: <http://www.cfpc.ca/english/cfpc/home/default.asp?s=1>

MCC: <http://www.mcc.ca/english/news/index.html>

CPSBC: <http://www.cpsbc.ca/>

Faculty of Medicine, University of British Columbia: <http://www.med.ubc.ca/index.htm>

Chapter:	4	Physician Compensation	Page:	1 of 1
Section:	6	Clinical Associates	Issued:	September 2005

POLICY:

1. Clinical associates who are required to hold a particular specialty designation to deliver APP-funded specialty services shall be paid at the rate of the specialty designation.
2. Clinical associates shall not be designated the Most Responsible Physician.

BACKGROUND:

The *Provincial Service Agreement* and *Provincial Salary Agreement* set physician compensation rates and specialty payment categories. Where the agreements are silent on the compensation of a particular physician groups, such as clinical associates, the APP may provide policy interpretation and direction to assist with physician service and budget planning.

GUIDELINES:

HAs retaining clinical associates should:

- notify the APP of all clinical associates;
- provide the APP with person-specific information, before a clinical associate provides services, including name and category of license;
- employ clinical associates only in clinical settings where all physicians work under salaried or service agreements, with no fee-for-service work;
- ensure that clinical associates provide only direct patient care and are not involved in research studies; and
- support of clinical associates within current APP funding allocations.

REFERENCES:

Provincial Service Agreement, available at:

[//www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf](http://www.healthservices.gov.bc.ca/msp/legislation/pdf/service.pdf)

Provincial Salary Agreement, available at:

[//www.healthservices.gov.bc.ca/msp/legislation/pdf/salary.pdf](http://www.healthservices.gov.bc.ca/msp/legislation/pdf/salary.pdf)

Chapter: 4	Physician Compensation	Page: 1 of 2
Section: 7	Clinical Fellows	Issued: September 2005

POLICY:

1. The APP recognizes clinical fellows and has adopted the CPSBC definition and limitations, including but not limited to, the length of time that clinical fellows are permitted to work in Canada as stipulated by the CPSBC and Human Resources Canada.
2. The APP does not fund clinical fellows for residency positions or support any accreditation towards the RCPSC or College of Family Physicians.
3. The APP requires that the HA obtain and make available to the APP documentation from UBC, CPSBC and affected institutions, and from the clinical fellow, confirming his or her status as a clinical fellow as defined by the CPSBC and acceptance that no credit for APP-funded clinical work will be sought from the RCPSC or colleges of Family Practice.
4. The APP shall fund clinical fellows only where there are appropriate specialists to oversee the activities of the fellow, with no program specialist supervising more than one fellow, and only at a level that does not exceed the number of vacant FTE originally approved for the service in question.

BACKGROUND:

Clinical fellows are certified specialists in their country of origin and have postgraduate credentials recognized by the CPSBC. The CPSBC and Human Resources Canada usually permit fellows to work in Canada for two years.

GUIDELINES:

The HAs should align their payment of clinical fellows to the Resident V rates established by Professional Association of Residents of British Columbia (PARBC); however, the APP will not *automatically* tie its future funding of clinical fellows to PARBC Resident V contract increases.

The PARBC Resident V salary rate is \$61,733.74, effective 1 April 2003. Payment of PARBC contract increases should be first discussed with the APP before HAs commit to any increase in the rate for clinical fellows.



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Section:	7	Clinical Fellows	Issued:	September 2005

GUIDELINES (CONTINUED):

HAs utilizing the services of clinical fellows should:

- (a) notify the APP of all clinical fellow appointees;
- (b) provide the APP with person-specific information, before a clinical fellow begins to provide services, including name and category of license;
- (c) employ clinical fellows only in clinical settings where all physicians work under salaried or service agreements, and no fee-for-service work;
- (d) ensure that clinical fellows provide only direct patient care and are not involved in research studies; and
- (e) keep support of clinical fellows within current APP funding allocations.

REFERENCE:

Article 21, *Remuneration Schedule and Categories of Residents*, Collective Agreement between the Health Employers Association of British Columbia and the Professional Association of Residents of British Columbia, at: www.par-bc.org/

Chapter:	4	Physician Compensation	Page:	1 of 2
Section:	8	Program Support	Issued:	September 2005

POLICY:

The APP budget is directed to the payment of physician's clinical services and does not include program support or infrastructure funding.

BACKGROUND:

It is recognized that a clinical service is delivered in an infrastructure environment extending beyond the APP-funded physician's service to include the necessary support of other health system human and financial resources, such as office staff, materials, technologies, facilities and other such 'overhead' expenses.

The Ministry provides the HAs with program support funding within their global operating grants, and HAs determine the most appropriate distribution of operating funds to support health service delivery.

Program support for APP-funded physician services was transferred out of the APP to the HAs operating grants in 2004/05.

Physicians who bill FFS are paid by fee items, which have consideration of 'overhead' built-in through the process of fee-setting between the BCMA and the Medical Services Commission (MSC) and published in the MSC Payment Schedule.

Maintaining patient-based service data (encounters) is a physician responsibility defined in the MSC Payment Schedule, with its requirement for an 'adequate medical record', and in Part V, *Rules Made under the Medical Practitioners Act*, published by the CPSBC.

The *Provincial Service Agreement*, Article 5.0, Overhead and Infrastructure, directs that physician contracts "...*must include clear and specific provisions...*" identifying the respective responsibilities of the HA and the physician "...*regarding the provision of support, technology, material and supplies*".

Chapter: 4	Physician Compensation	Page: 2 of 2
Section: 8	Program Support	Issued: September 2005

GUIDELINES:

The HAs should manage any decisions concerning program support in a manner that best supports patients' access to physician services, with particular consideration of traditionally disadvantaged patient populations, such as those seeking primary care in urban centre clinics, and that that commitment be explicitly articulated in the HA's service plan.

Consideration of program support may be more relevant to general practice than specialists', as specialists more often work in a hospital setting, where facility and supporting staff expenses are more broadly dispersed.

HAs and physicians should confirm between them the support required, in consideration of the service environment, local circumstances and any established guideline, and define the support that will be provided (including an explicit statement of no support, if appropriate) in the physician contract.

It is recommended that any 'projected' support be based on evidence of past experience, records or financial statements.

Maintaining a patient-based record is accepted good medical practice and, therefore, cannot be considered a separate or new expense of physician service.

Refer to Chapter 3.5 Records and Reporting.

REFERENCES:

Copies of the provincial physician agreements are available at:
<http://www.healthservices.gov.bc.ca/msp/legislation/mscagree.html>

Medical Practitioners Act, at: www.qp.gov.bc.ca/statreg/stat/M/96285_01.htm

MSC Payment Schedule, available at:
www.healthservices.gov.bc.ca/msp/infoprac/physbilling/payschedule/

Rules Made under the Medical Practitioners Act, Part V, Practitioners' Records:
www.cpsbc.ca/cps/physician_resources/legislation/rules/part/13

Chapter:	4	Physician Compensation	Page:	1 of 2
Section:	9	Leaves and Locums	Issued:	September 2005

POLICY:

1. The APP does not provide funds for physician locums, statutory holidays, vacations or any other leave coverage.
2. Physicians who are retained by the HAs to deliver APP-funded services shall ensure that all required reporting, including that for encounters, continues for the duration of any locum tenens or subcontracted physician:
 - (a) When a locum tenens is funded through the Rural GP Locum Program (RGPLP) for the delivery of services under an APP agreement, encounter reporting is automatic with the RGPLP payment, which is administered through the Teleplan FFS claims system.
 - (b) When a locum tenens or subcontracted physician is funded by the HA and/or arranged by a physician retained by the HA for the delivery of services under an APP agreement, complete encounter reports *with a zero billing amount* shall be submitted through the Teleplan system for the services provided by the locum tenens or subcontracted physician.

BACKGROUND:

Locum funding previously provided through the APP was transferred to the RGPLP during 2001/02 and 2002/03. The RGPLP is administered by the PCB according to policies and governance of the Joint Standing Committee (JSC) on Rural Issues.

The JSC on Rural Issues was established as a provision of the 2001 *Subsidiary Agreement for Physicians in Rural Practice*, a provincial agreement negotiated with the BCMA on behalf of rural physicians.

The RGPLP assists GPs, who are working in small rural communities with seven or fewer physicians, to obtain locums for up to twenty-eight days per year for vacation relief and continuing medical education.

The Ministry established a separate Rural Specialist Locum Program (RSLP) also administered through the PCB, Rural Practice Programs.



Chapter: 4	Physician Compensation	Page: 2 of 2
Section: 9	Leaves and Locums	Issued: September 2005

BACKGROUND (CONTINUED):

Health Match BC maintains a list of physician vacancies and locum opportunities throughout British Columbia regions.

GUIDELINES:

HAs and physician should work together to ensure locum coverage.

Questions concerning the RGPLP or RSLP may be directed to the:

Physician Compensation Branch
Ministry of Health
2-1 1515 Blanshard St
Victoria BC V8W 3C8
Telephone: 250 952-3200
Fax: 250 952-3486

Health Match BC may be contacted at: www.healthmatchbc.org/default.asp

REFERENCES:

Policy governing the RGPLP and the Rural Specialist Locum Program is available at <http://www.healthservices.gov.bc.ca/pcb/rpp.html>

Rural Programs: A Guide for Rural Physician Programs in British Columbia is available at http://www.healthservices.gov.bc.ca/cpa/publications/rural_programs.pdf

Chapter: 4	Physician Compensation	Page: 1 of 2
Section: 10	Physician Incentives	Issued: September 2005

POLICY:

APP-funded physicians shall have access to provincially negotiated physician incentives in a manner that is equitable to fee-for-service physicians' access and in accordance with the eligibility criteria established for the individual programs.

BACKGROUND:

The Ministry has negotiated provincial agreements with the BCMA that make provisions for a variety of physician incentives. These financial incentives, and others, are intended to maintain or improve British Columbians' equitable access to medically necessary services throughout the province and support comprehensive patient health care delivery.

Physician incentive programs include:

- Rural Retention Program (RRP)
- Rural Education Action Plan (REAP)
- Rural Continuing Medical Education (RCME)
- Northern and Isolation Travel Assistance Outreach Program (NITAOP)
- BC Loan Forgiveness Program (not exclusive to physicians)
- Advanced Maternity Fellowship (not exclusive to physicians)
- Full Service Family Practice Incentive Program (including the GP Obstetrical Care Incentive Program; the Chronic Care Quality Improvement, Structured Collaborative Participation Funding; and Chronic Care Practice Enhancement Project)

The first seven, above, are administered by PCB.

As of 31 March 2003, the APP no longer funds the Psychiatric Geographical Differential Premium (also called the Psychiatric Premium or Geographic Differential Payment Rate). A new psychiatry premium was established under the RRP, effective 1 April 2003. The RRP premium replaces the psychiatric premium formerly administered under the APP.



Chapter:	4	Physician Compensation	Page:	2 of 2
Section:	10	Physician Incentives	Issued:	September 2005

GUIDELINES:

Direct any questions concerning rural physician incentives and the MOCAP to:

Physician Compensation Branch
Ministry of Health
2-1, 1515 Blanshard St
Victoria BC V8W 3C8
Telephone: 250 952-3200
Fax: 250 952-3486

More information is available at: <http://www.healthservices.gov.bc.ca/pcb/rpp.html>

REFERENCES:

Rural Programs, 02-04, A Guide for Rural Physician Programs in British Columbia, prepared by the JSC on Rural Issues, available at:

http://www.healthservices.gov.bc.ca/cpa/publications/rural_programs.pdf

Full Service Family Practice Incentive Program:

www.healthservices.gov.bc.ca/cdm/practitioners/fullservice.html

Ministry of Advanced Education, BC Student Loan Forgiveness Program at:

www.aved.gov.bc.ca/student/services/student/finish/debt_red/bc_nurse.htm

Advanced Maternity Fellowship:

www.bcwomensfoundation.org/maternity_fellowship.html

Chapter: 5	Program Administration	Page: 1 of 2
Section: 1	Service Deliverables	Issued: September 2005

POLICY:

1. A HA shall describe its programs of physician services in the form of clear and comprehensive statements of intended service deliverables.
2. The service deliverables of an APP service agreement with a HA, as expressed in its Schedule A, shall be communicated with the same intent in the contracts established between the HA and the physician(s) who are retained to deliver the services.

BACKGROUND:

A deliverable is a predefined, measurable, tangible, verifiable outcome or product that must be produced or delivered to complete a project, agreement or contract. When a deliverable is defined in the context of a public service program, it is frequently referenced as a service deliverable.

Clearly articulated service deliverables are foundational to measuring performance and determining whether the public funds provided through government programs contribute to the achievement of health goals and patients' access to the health care system. Refer to Chapter 1.4, Accountability.

The OAG, in its 2003 report, *Alternative Payments to Physicians: A Program in Need of Change*, emphasized that monitoring deliverables is essential to expected budget and fund allocation management.

APP funds programs of physicians' clinical service deliverables. A clinical program may comprise a variety of related service deliverables necessary for successful program delivery.

GUIDELINES:

Any APP funding agreement is dependent on the HA first developing and providing the APP with its definition of the intended deliverables, among meeting other APP funding criteria. Refer to Chapter 2.4 Funding Criteria.



Chapter: 5	Program Administration	Page: 2 of 2
Section: 1	Service Deliverables	Issued: September 2005

GUIDELINES (CONTINUED):

The HA should discuss expected service deliverables with the APP and confirm mutual agreement in Schedule A of the APP service agreement (contract) template. The template has a standard format for service deliverables.

For sessional allocations, the HA should describe the intended service deliverables within an application to the APP. Confirmation of the requested sessional program is communicated to the HA in the APP's funding allocation statement. Refer to Chapter 5.2 Detailed Funding Allocation Statement.

Contact APP staff for assistance developing service deliverables. Also refer to Chapter 2.5 Applying for Funding.

REFERENCE:

Alternative Payments to Physicians: A Program in Need of Change. 2003-2004: Report 4. OAG of British Columbia. Available at:
www.bcauditor.com/PUBS/2003-04/Report4/HealthAlternative.pdf

Chapter: 5	Program Administration	Page: 1 of 2
Section: 2	Detailed Funding Allocation Statement	Issued: September 2005

POLICY:

1. APP sends a computer-generated Detailed Funding Allocation Statement (DFAS) each fiscal year to confirm all APP funding that is approved for a HA.
2. An authorized representative of the HA shall review the DFAS and indicate the HA's agreement and acceptance the funding levels as indicated on the DFAS by signing and returning it to the APP.

BACKGROUND:

APP uses a hierarchy of coding to administer program funding and the payment process. APP codes include the agency, site, program, control, and sub-control. A block of coding uniquely identifies a funding allocation.

The following lists codes found on the Detailed Funding Allocation Statement.

- Agency: An APP-assigned agency code, along with the name of the legal entity to which APP is providing funding.
- Site: An APP-assigned site code for the location of service delivery, along with the name of the name of the facility where service is delivered. In some cases, Agency and Site may be the same.
- City: The name of the city where the Site, above, is located.
- Program Code: A block of three identifying codes for program (5 digits), control (3 digits), and subcontrol (3 digits). Please refer to the glossary for a definition of each code
- Description: An abbreviated description of the three codes referenced under Program Code, above. Depending on the payment modality and location of service, this field heading may also provide information, such as:
- number of sessions per annum associated with the allocation;
 - number of sessions for current fiscal year, if the allocation is less than annual allocation; Northern and Isolation Allowance rate; details of service agreement funding; and, practitioner numbers and names of salaried physicians.

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Section: 2	Detailed Funding Allocation Statement	Issued: September 2005

BACKGROUND (CONTINUED):

- From:** A date field that indicates when funding for the current year begins, either by fiscal year, actual start date for mid-year funding, or date of new service agreement term.
- To:** A date field that indicates when funding ends, usually referring to service agreement funding, but may reflect a short term or temporary commitment.
- Annualized FTE Budget:** A number indicating the FTE funded by APP and projected for the current fiscal year.
- FTE Adjustment:** Indicates prorated FTE when the end date for funding is prior to the end of the fiscal year.
- Salary Class:** Where relevant, indicates the classification of individual salaried physicians
- Rate(s):** Indicates the payment rate associated with the classification referenced under Salary Class, above, and expressed as an annualized figure per FTE.
- Employment FTE:** Indicates the percentage of FTE for which a salaried physician is funded.
- MSP%:** Indicates the portion of funding that APP will reimburse, generally fifty or one- hundred percent.

GUIDELINES:

If a funding allocation changes during the year, the APP will update the statement and request the HA's signed confirmation of the change.

APP staff can assist HAs if they have any difficulty interpreting the information provided on the DFAS. Individual code numbers also can be confirmed by contacting the APP at 250 952-3200.



Chapter: 5	Program Administration	Page: 1 of 2
Section: 3	Certificate of Services	Issued: September 2005

POLICY:

1. A Certificate of Services (sessional) form shall be completed for each physician whose sessions are funded by the APP before the APP may reimburse a HA for its payment of physician sessions.
2. HAs shall forward all Certificates of Services to the APP with a Sessional Claim for Reimbursement of Shareable Expenditure.
3. APP requires two different signatures to confirm the delivery of sessions and certify the accuracy of the information provided—the sessional physician and the HA’s Authorized Signing Authority.
4. If the sessional physician is also an Authorized Signing Authority, the physician’s supervisor shall certify the Certificate of Services. The signing authority cannot be a physician for whom the reimbursement is claimed.

BACKGROUND:

Provincial contract administration and monitoring policies require maintenance of records or other documentation to support account verification and payment.

A completed Certificate of Services identifies the:

- sessional physician by name and by practitioner number;
- period of service delivery (e.g., From: April 1, 1998, To: April 30, 1998);
- names and APP-assigned codes for agency, program, site, control, and sub-control (refer to the glossary for the meaning of APP codes);
- sessional rate;
- individual dates of service;
- time period, by hour and quarter-hour increments, per service day;
- amount billed per day, calculated by dividing the sessional rate by 3.5 and multiplying by the number of hours of service; e.g., 2 hours of service at the sessional rate of \$295 is billed as \$168.57 ($\$295/3.5 \times 2 = \168.57); and
- sum of all daily amounts listed for the certificates’ time period, recorded as the total amount.



Chapter: 5	Program Administration	Page: 2 of 2
Section: 3	Certificate of Services	Issued: September 2005

GUIDELINE:

If the Authorized Signing Authority is not the original person who committed the HA to its agreement with APP, he or she must be someone who is fully aware of all conditions of funding. Upon signing, the signing authority is guaranteeing that the claim represents only those expenses that meet the conditions of funding. Refer to Chapter 3 Conditions of Funding.

REFERENCES:

Core Policy and Procedures Manual, Office of the Comptroller General, at:
www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/CPMtoc.htm

Financial Administration Act, at: www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Chapter: 5	Program Administration	Page: 1 of 2
Section: 4	Claim for Reimbursement of Shareable Expenditure	Issued: September 2005

POLICY:

1. HAs shall submit to the APP a Claim for Reimbursement of Shareable Expenditure for reimbursement of APP-funded physician payments.
 - (a) When submitting a Sessional Claim for Reimbursement of Shareable Expenditure, a HA shall attach all Certificates of Services to support the claim. Refer to Chapter 5.3 Certificate of Services.
 - (b) Where a HA has an existing salaried allocation with the APP and that allocation has not yet ended or been transferred to another payment modality, the HA shall submit a Salaried Claim for Reimbursement of Shareable Expenditure.
 - (c) A salaried claim for 'overhead' shall only apply where 'overhead' is explicitly described and approved in an existing agreement with the APP.
 - (d) A Salaried Claim for Reimbursement of Shareable Expenditure does not require a supporting Certificate of Services.
2. An Authorized Signing Authority of the HA shall certify with his or her signature the accuracy of a Claim for Reimbursement of Shareable Expenditure and guarantee the claim represents only those expenses that meet the conditions of funding.
3. The Authorized Signing Authority shall not be represented on the claim as a physician for whom reimbursement is being claimed.
4. If the Authorized Signing Authority is not the same person who signed the funding agreement between the HA and APP, the signing authority shall be someone who is fully aware of all the agreement's conditions of funding.

BACKGROUND:

Provincial contract administration and monitoring policies require maintenance of records or other documentation to support account verification and payment.

Chapter:	5	Program Administration	Page:	2 of 2
Section:	4	Claim for Reimbursement of Shareable Expenditure	Issued:	September 2005

GUIDELINES:

A Claim for Reimbursement of Shareable Expenditure identifies the:

- names and APP-assigned codes for agency, program, site, control and sub-control;
- period of the claim (for example, April 1-30, 1998); and
- names and practitioner numbers of all the physicians who provided funded services during the period of the claim; and the following, under Guidelines, dependent on whether the payment modality is salaried or sessional.

A complete sessional claim also records the:

- physician's payment rate in the *Sessional Rate* column (see Chapter 4.4);
- total of the *Sessional or Contract* column, which lists individual physician's sessional payments (taken from the claim's attached Certificates of Service);
- portion of funding that APP has agreed to reimburse, generally 50 or 100 percent, in the *%Time Shareable* column (the percentage should be the same as that referenced in the *%MSP* field on the DFAS; see Chapter 5.2); and
- total of the *Shareable Portion of Payment* column, which lists the product of the value in the *Sessional or Contract* column multiplied by the *%Time Shareable* column.

A complete salaried claim also records the:

- portion of time worked each year, expressed in tenths (e.g., a physician working full-time (one FTE) is noted as 10/10; half-time or .5 FTE as 5/10);
- each physician's FTE salary rate in the *Annual Full-time Equivalent Salary Rate* column (should be the same as *Rate (\$)* on the DFAS; see Chapter 5.2);
- monthly salary rate (divide *Annual Full-time Equivalent Salary Rate* by 12);
- portion of funding that APP agreed to reimburse, noted in the *%Time Shareable* column (generally 50, 75, or 100 percent and should be the same as referenced in *%MSP* field on the DFAS);
- *Shareable Portion of Payment* (multiply the *Monthly Salary* column by the *%Time Shareable* column);
- *Overhead* amount (multiply the *Shareable Portion of Payment* column multiplied by agreed percentage), which applies only to 5.4.1 (b) and (c); and
- reimbursement amounts per physician in the *Total* column (*Shareable Portion of Payment* column, plus the *Overhead* column, then sum all totals on claim).

Chapter: 5	Program Administration	Page: 1 of 1
Section: 5	Notification of Claim Adjustment/Return	Issued: September 2005

POLICY:

The APP shall send a Notification of Claim Adjustment/Return to any HA that submits a claim that cannot be processed.

BACKGROUND:

The *Financial Administration Act* governs requisitions for payment and refusals.

GUIDELINES:

The Notification of Claim Adjustment/Return form indicates the reason for the returned claim.

Reasons for claim rejection may include:

- a claim being submitted more than 90 days past date-of-service;
- a claim duplicates or overlaps a previous claim for the same service;
- a claim is not signed by the physician service provider;
- a claim is not signed by the HA's Authorized Signing Authority;
- a claim does not have original signatures (reproduced signatures, such as stamps, cannot be accepted for certification of the accuracy of a claim or compliance with APP's conditions of funding);
- a claim is not accurate; for example, it contains incorrect rates or coding; and/or
- a sessional claim does not have Certificates of Services attached.

If, after reading the Notification of Claim Adjustment/Return, a HA is still uncertain why its claim has not been reimbursed or what is required before resubmitting it, contact the APP for clarification at: 250 952-3200.

REFERENCE:

Financial Administration Act. Copies are available at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm



Chapter: 5	Program Administration	Page: 1 of 1
Section: 6	Payment Notices and Payment Detail Statements	Issued: September 2005

POLICY:

1. APP sends a funded HA a Payment Notice each time a payment to the HA is made, advising it of the amount deposited directly into the HA's account, or a cheque is mailed, by the Office of the Comptroller General, Ministry of Finance and Corporate Relations.
2. The APP attaches a Payment Detail Statement to each Payment Notice, identifying the individual services for which payments have been made.

GUIDELINE:

HAs may contact the APP at 250 952-3200 if they have any questions about the status of payments.

REFERENCE:

Financial Administration Act. Copies are available at:
www.qp.gov.bc.ca/statreg/stat/F/96138_01.htm

Chapter: 5	Program Administration	Page: 1 of 2
Section: 7	Third-Party Billings/Claims	Issued: September 2005

POLICY:

1. Where physicians' services are provided during a program or period of time funded by the APP, and those services have been or will be paid by a third party, a portion of such third-party payments shall be reimbursed to the APP.
2. HAs shall:
 - (a) collect all third-party billings for physician services performed under an APP-funded program;
 - (b) remit fifty percent of third-party payments to the APP on a quarterly basis;
 - (c) retain fifty percent of third-party payments as compensation to the HA for its administrative cost; and
 - (d) provide a full accounting of third-party payments with each quarterly remittance, including the total amount and the percentage of third-party funds collected by the following billing categories:
 - i* services that would be benefits under MSP, but rendered to non-beneficiaries;
 - ii* services that would be benefits under MSP, but are the responsibility of a third-party, such as the WCB or ICBC; and
 - iii* services that would not be benefits under MSP.

BACKGROUND:

Reimbursement of third-party payments avoids a double-payment situation. For example, some physician services are paid from sources other than the APP or MSP. The WCB pays for treatment of patients' injuries received while on-the-job, and ICBC pays for treatment of injuries received in motor vehicle accidents. Physicians also receive payments through private billings to patients who are not eligible for government-insured benefits.

A physician may retain one hundred percent of fees received for a third-party service when that service is provided outside of the scope of an APP-funded program or service.



Chapter: 5	Program Administration	Page: 2 of 2
Section: 7	Third-Party Billings/Claims	Issued: September 2005

GUIDELINE:

Reimbursement cheques for third-party billings should be made payable to the Minister of Finance and be submitted to the APP within sixty days of the last day of the fiscal year and at the end of the term of an APP funding agreement.

REFERENCE:

Provincial physician agreements, at:
www.healthservices.gov.bc.ca/msp/legislation/bcmaagree.html

Chapter: 5	Program Administration	Page: 1 of 1
Section: 8	Allocation Utilization	Issued: September 2005

POLICY:

1. The APP shall periodically review the utilization of its funding allocations.
 - a. Where an allocation is not being fully utilized, or has been used inappropriately for services outside the scope of agreed service deliverables, the APP shall seek an explanation from the funded HA.
 - b. Where an allocation is used inappropriately, the APP shall request the HA to address the discrepancy and, if the HA's service and expenditure utilization cannot be realigned with its original conditions of funding, the funding may be terminated.
 - c. Where an allocation is not used to the level anticipated in its original funding request, the APP may reduce or terminate the allocation.
2. The APP may seek recovery of any inappropriate expenditure.

BACKGROUND:

Utilization is a measure of the volume and type of health care services used within a defined timeframe and resource allocation. The term is often used in the context of program management, where multiple variables, such as service volumes, types, delivery locations and practitioner specialty, are consistently recorded and considered for determining the most appropriate funding allocation.

Monitoring and confirming appropriate utilization of services and expenditures, and remedying circumstances of default or non-compliance with funding conditions, are critical to demonstrating accountability for public funding and achieving provincial health system goals.

GUIDELINE:

The APP routinely monitors allocation utilization. Utilization rates of twenty percent, above or below, anticipated utilization levels trigger more intensive scrutiny. In such cases, the APP will contact a HA to determine the cause and discuss possible remedies; however, HAs should be proactive in identifying and remedying utilization issues. APP will be reasonable and receptive to recommendations for resolving and correcting utilization issues.

Chapter: 5	Program Administration	Page: 1 of 1
Section: 9	Term	Issued: September 2005

POLICY:

1. An APP funding allocation is available only for the time within the term of the agreement between the APP and HA.
2. The APP may recover the value of a claim paid against a funding allocation with an expired term or an allocation that has been revoked.

BACKGROUND:

APP monitors the HAs compliance with conditions of funding and in accordance with the government's expectations, Ministry policies and provincial legislation concerning the administration of public funding. Also see Chapter 3.6 Monitoring and Evaluation.

GUIDELINES:

The APP cannot release payment for claims outside of the term of an allocation.

Service Agreements

The term of an APP service agreement is defined in its Article 2 Term and Renewal. The term may be a part- or multi-year. Term duration is mutually agreed with the signing of the agreement.

Sessional Arrangements

The term of sessional funding is the remainder of the current fiscal year in which the allocation was agreed. The committed annual allocation is prorated from the date of agreement. The term of sessional funding is confirmed with the HA's signing and return of the DFAS.

APP manages sessional funding allocations as ongoing commitments, rolling them over to the next fiscal to ensure continuity of claims payment; however, a HA should contact the APP prior to the end of a sessional term to confirm that sessional funding continues and sessional deliverables in the next fiscal will continue to meet the original conditions of APP sessional funding.

BACKGROUND:

The APP may use terms with meanings particular to government practice and the public service environment or specific to the business of APP and physician compensation. Some terms are formally defined within the provincial physician agreements.

The following alphabetical listing defines key terms used in this policy framework. The chapter is based on the Glossary of Terms published by the APP in 1999 and revised to incorporate the terms of policy and agreements since that time. Italics within definitions indicate words also defined elsewhere in the glossary.

GLOSSARY OF TERMS:

Activities

- the procedures or steps taken to carry out a *program*.

Adequate Medical Record (also see *Clinical Record*)

- a standard for determining the sufficiency of a clinical record, where another physician of the same specialty who is unfamiliar with both the patient and the attending physician can, based on a review of the record, determine the date and location of any service recorded and identify the patient, the attending physician, the presenting complaint (including symptoms and history), any results of a systematic inquiry, the extent of prior physician examinations, the results of those examinations or investigations (including positive and negative findings), and a summation of both the patient's problem and the physician's management plan.
- the expectation for an adequate medical record extends to all publicly funded physicians;
- determination of 'adequacy' varies relative to an assessor's perspective or mandate (for example, an administrative perspective for payment eligibility versus a quality assurance or 'good medial practice' perspective).

Administrative Service

- an office or program management service that supports, but does not directly deliver patient care and, therefore, does not result in an entry into a medical record.

Agency

- the legal entity (usually a HA) with whom the APP contracts and funds to deliver local physician services;
- in the context of subsidiary agreements to the *Working Agreement*, 'agency' means all hospitals, institutes or other government-funded bodies contracting with physicians;

- under the *Financial Administration Act*, ‘agency’ is a public body, including ministries, taxpayer-supported and commercial Crown corporations and their subsidiaries, and local agencies such as school districts, HAs, universities and colleges but not central agencies.
- an agency has responsibility and is accountable for meeting all conditions of its public funding.

Allocation

- a specific level of funding dedicated to a particular *program*;
- for APP-funded programs, allocations are normally expressed as a measure of a *full-time equivalency* (FTE).

Alternative Payments

- methods or modalities of payment, other than fee-for-service, for physician services provided in circumstances where the fee-for-service modality does not adequately support the delivery of health care (for example, service contracts, salaried employment and sessional payments);
- APP offers physician payment options through HA funding.

An Agreement Between the Government of British Columbia and the BCMA with Respect to Salaried Physicians in Government Service (also see Provincial Salaried Agreement and Salaried Payment)

- an agreement that set conditions of payment for salaried physicians in government service;
- a new *Provincial Salaried Agreement*, a subsidiary to the 2001 *Working Agreement*, became effective 1 April 2001.

Annualized FTE Budget (also see Full-Time Equivalent)

- a projected measure of the total human resource needed to deliver government-funded services, where a full-time equivalent (FTE) is that portion of work that, individually or as a combination of different individuals’ efforts, is equivalent to the contribution of one person for one year (in some organizations referred to as a person-year);
- also the name of a field within the *Detailed Funding Allocation Statement* that identifies the *FTE*, or decimal portion thereof, that the APP agrees to fund in a given year.

APP Payment System

- the combined processes, both manual and electronic, that validate APP claims against existing funding allocations for programs and pays them where appropriate;

- a computer program that links databases of practitioners and funding allocations together to facilitate claims payment and uses automated systems for utilization management reports, expenditure projections and generation of *Payment Notices* and *Payment Detail Statements*.

Audit (also see *Clinical Record Review*)

- a periodic business process used to confirm the appropriate use and responsible management of allocated resources or funding;
- audit programs review accounting and record-keeping practices, make recommendations for improvements and, if appropriate, initiate corrective actions such as the recovery of funding and/or legal proceedings.

Authorized or Approved Signing Authority

- an individual who has the legal authority to represent an *agency* and commit that agency to the actions for which he or she is signing its commitment;
- in cases where an APP form requires the signature of an *Authorized Signing Authority*, this authority should be either the same individual who signed acceptance of the original APP funding agreement or an individual who is fully apprised of all the terms and conditions of that agreement.

Available Amount

- the amount of funding allocated by *the MSC* for the payment of *fee-for-service* physicians in a specified fiscal year established under Section 25 of the *Medicare Protection Act* and includes any adjustments that may be specified with the *Working Agreement* negotiated with the *BCMA*;
- APP funding for physician services is not part of the *Available Amount*; however, portions of the *Available Amount* may be transferred in or out of the APP budget in response to a physician's choice for fee-for-service billing or payment through another modality, such as a service or sessional contract with a HA.

Benchmark

- a standard or reference point against which something is measured;
- a term used in setting of long-term goals for a broad range of societal and economic policies and as a measure of efficiency when comparing key aspects of an organization's performance with that of similar organizations.

Billing Number (see *Practitioner Number*)

British Columbia Medical Association (BCMA)

- a professional organization in British Columbia which represents the working and compensation interests of its physician members;
- most but not all physicians in British Columbia are members of the BCMA.

Business Plan (Also see *Performance Management System, Vision, Mission, Mandate, Goal* and *Objective*)

- a document prepared for a program or organization describing its business mandate and objectives relative to an organization's vision, mission and goals, and identifies the activities that will be undertaken to meet those objectives, the allocation of resources to the activities, and the measures that will be used to assess performance and progress toward achievement of the objectives.
- may include statements of relevance, client and stakeholder profiles, critical linkages, risk assessment and contingency plans.

Business Case

- a common requirement for evidence-based program and business planning and funding allocation;
- a rationale, usually confirmed in a formal document or project charter, intended to generate organizational support for and participation in a business or project initiative to address a particular business or program issue or take advantage of an opportunity;
- elements may vary but usually include background information, project description, objectives, scope definition, expected outcomes, stakeholder identification and interests description, strategic alignment and linkages to organization's vision and mission, environmental scan and analysis, assessment of options, business and operations impact, risk assessment, cost-benefit analysis, assumptions, conclusions and recommendations, an implementation strategy and an formal review and approval process.

Canada Health Act

- federal legislation committing British Columbia and all provinces and territories to the Canadian system of medicare, which provides medically necessary physician and hospital services to residents, through the establishment of publicly administered, provincial/territorial health insurance programs;
- a federal act whose purpose is "to establish criteria and conditions that must be met before full payment may be made under the Act . . . in respect of insured health services and extended health care services provided under provincial law".

Call-back (also see *On-call*)

- a situation where a physician is called back from scheduled time off to provide unexpected direct patient care services;
- "call-back" is not the same as "on-call", where a physician is scheduled to be available, but may not necessarily result in providing a patient service;
- refer to the *Medical On-Call/Availability Program* administered through the Physician Compensation Branch for more information on payment of call.

Certificate of Services

- a mandatory form that the APP uses to justify its payment of sessions;
- requires the attending physician and the funded agency's *Authorized Signing Authority* to certify, with their signatures, the accuracy of the time period (example: 0845 to 0930 h) and amount of time (example: 45 min) spent delivering the sessionally funded services.

Claim (also see *Claim for Reimbursement of Shareable Expenditure and Notification of Claim Adjustment/Return*)

- in its general sense, a standardized form or written request for monetary reimbursement for time spent delivering a health care service.

Claim for Reimbursement of Shareable Expenditure (also see *Sessional Payment and Salaried Payment*)

- a form (one version for sessional payment and another for salaried) that must be submitted to the APP by an *agency* for reimbursement of monies paid to the agency's contracted physicians for providing funded services;
- captures service and practitioner detail.

Client

- an individual or organization who receives or uses a program's products or services.
- government programs may have both external and internal clients.

Client satisfaction

- an organizational measure, often assessed through a survey, of the extent to which the needs and expectations of clients are met.

Clinical Record Review (also see *Peer Review, Implicit and Explicit*)

- a systematic peer review of the clinical records kept by individual physicians and health organizations that, for purposes of quality assurance, focuses on care processes and outcomes rather than on *administrative* data.

Clinical Records

- a compilation of patient histories recording all consultations, diagnostic tests and treatments that patients have received;
- clinical records must be an *Adequate Medical Record* as required by the *MSC* and meet the *Rules Made under the Medical Practitioners Act*;
- clinical records should be accessible to all practitioners involved in a patient's care.

Coding (also see Control or Sub-Control Name/Number)

- in general, a system of abbreviation, normally numeric, used for identifying particular health care services or cost-centre responsibilities;
- facilitates quantifying, tracking, payment, and ease of overall management of health care resources, such as facilities, staff, time and funding;
- APP employs a coding hierarchy of *agency, site, program, control* and *sub-control* for administrative and program management purposes.

Compliance

- the expectation that the resources allocated to a health care program are used in a manner that is consistent with the conditions and terms for which the resources were intended, as a condition of funding, and/or in a formal agreement, such as in the legally binding service agreement or contract.

Conditions of Funding

- the requirements on which funding is contingent and guaranteed by the agency receiving funds with its signing of the *Detailed Funding Allocation Statement* and/or service agreement by an *Authorized Signing Authority*;

Contract (also see Required Elements and Service Agreement)

- a legal document that commits the signing parties to carry out the actions or deliver the services described therein, in accordance with the terms, conditions, schedules, and legislation referenced, and, with signing, to accept responsibility for any penalties that may be incurred with *non-performance* of contracted services or *violation* of contract conditions;
- an agreement between two or more parties that creates, modifies or nullifies a legal relationship.

Control Name/Number (also see Sub-Control Name/Number)

- an APP *administrative code*, within the coding hierarchy of *agency, site, program, control* and *sub-control*, which is used to support payment and track APP-funded services, where the *Control Name* and *Control Number* further describe the type of service rendered within a particular program of health care (e.g., *control code* for paediatric services (502) describes the services provided within a psychiatry (00121) program);
- a level of detail to distinguish a particular APP funding *allocation*.

Critical Success Factors

- the conditions or elements that must to be in place in order to succeed.

Deliverables

- an encompassing term used to refer to all of the expected measurable services or outputs of a mutually agreed contract or agreement;
- set out in an agency's application for APP funding and defined in Schedule A of a service agreement.

Detailed Funding Allocation Statement

- an APP computer-generated statement sent to all funded agencies at the beginning of each fiscal year, or during the year if a funding *allocation* changes, confirming the level of funding (expressed as an FTE or portion thereof) and the particulars of service and service delivery location.

Directive (Also see *Policy*)

- a statement of policy (often interim) from an authoritative source but which has not been formally or regularly published.

Double-Billing

- a duplication of billing or of a claim to more than one payer or government program for the same health care service (for example, submitting a *claim* for payment through the APP and *fee-for-service* payment, or being paid by APP and a third-party, such as the WCB);
- subject to full recovery of payment and/or penalty.

Effectiveness

- the extent to which a program or service meets its stated objectives;
- an aspect of performance that describes how well the organization's activities are contributing to achieving the intended outcomes.

Efficiency

- an aspect of performance that describes the relationship between inputs and outputs or outcomes, or the relationship of inputs to inputs (examples: cost per client served; equipment costs per square mile of brush cleared; number of management staff to operations staff).

Evaluation

- an objective and systematic assessment of the effectiveness and efficiency of a program or policy, including assessment of results and impacts (both intended and unintended), implementation in accordance with prior agreed plans and objectives, and whether funding has been used as agreed;
- provides information for program modifications and decision-making, including the extent to which the program continues to serve a useful purpose or need for more cost-effective options to achieve same result;

- may include formal-rational, interpretive, summative or normative evaluation approaches and techniques, such as peer review, case study, survey and cost-benefit analysis, among others
- there is a considerable literature published on program evaluation.

Extra-billing (also see *Canada Health Act*)

- an instance where a physician bills a patient for a service that, according to the *Canada Health Act*, the patient is entitled to as a medicare benefit;
- subject to full recovery from the offending physician and/or a penalty;
- any province or territory not remedying *Canada Health Act* violations may be penalized with a reduction in its federal transfer amount.

Fee-For-Service

- a physician payment modality that provides compensation by fee item, according to the number and type of services rendered to patients;
- the *MSC Payment Schedule* lists fee item amounts for services provided to *MSP* beneficiaries.

Fee-For-Service Waiver

- a signed statement confirming that neither a physician nor *agency* will bill *fee-for-service* for any APP-funded services rendered during the time claimed to the APP;
- waivers must be renewed between physicians and agencies, in writing, on an annual basis.

Financial Administration Act

- a British Columbia statute governing the administration of all matters relating to the financial affairs of the province, including administration of all assets (including assets held in trust), revenues and expenditures, accounting and reporting systems, and the establishment and maintenance of financial controls.

Fiscal Year

- a budget period commencing April 1 and concluding March 31.

Full-Time-Equivalent or FTE

- a 'service year' or measure of that portion of work contributed by one (or combination of work effort to equal one) individual for one year;
- in some organizations referred to as a person-year;
- specific to physician service agreements, an FTE is a minimum of 1680 hours per year, except for emergency medicine FTE, which is a maximum of 1680 hours per year;
- for sessional payments, APP translates an FTE to 520 sessions per year;
- for salaried payments, an FTE is 1957.5 hours per year.

Funding Statement (see Detailed Funding Allocation Statement)

Geographic Differential Payment Rate or GDPR (see Psychiatry Premium)

General Practitioner (also see Physician and Specialist)

- A physician who is not a specialist.

General Practice Services (also see Physician Services)

- defined by the provincial physician agreements to mean clinical and related teaching, research and clinical administration generally recognized as being within the practice scope of a GP.

Goal (also see Objective)

- a general statement of desired results or outcomes to be achieved over an unspecified period of time.

Guideline

- provides policy or program parameters or processes for implementation, and suggestions or information to assist with policy compliance.

Health Authority

- in accordance with the *Health Authorities Act*, the regional entity having authority and legal responsibility delegated by the Minister of Health Services for the planning, delivery and monitoring of health care services in correspondingly defined regions of British Columbia;
- the Ministry of Health provides HAs with funding to deliver locally planned and managed health care services.

Impact

- the result or consequence of program activities, positive and negative.

Indicator (see Performance Indicator)

In-direct Care

- patient-specific service provided when the patient is not present (example: report-writing, patient conferences and telephone consultations).

In-direct Care and Non-Patient Care Service Records

- a component of the *APP Service Records Requirement*;
- documentation of the services a physician provides for instances where services are not rendered directly to a patient (examples: case conference or health promotion/education service);
- a necessary distinction in service records that allows more accuracy in the collection of data needed to determine equitable APP funding allocations, provide appropriate physician compensation and, ultimately, improve health care delivery.

Inputs

- resources used to carry out a *program* (examples: number of hospital beds; number of full-time employees; amount of funding per student)

Mandate (Also see *Mission*)

- a business ‘purpose’ statement describing the nature and scope of an organization or program’s activities to which resources are focused.
- a well-written mandate should answer: What are you aiming to achieve? Why are you doing what you aim to achieve? Who is the client or customer that the organization’s efforts will target or address? How will you do what you aim to achieve? (‘How’ can include where and when.)

Master Agreement (see *Second Master Agreement*)

Medical On-Call/Availability Program (MOCAP)

- a provincial physician compensation program resulting from the *Subsidiary Agreement for Physicians in Rural Practice*;
- the MOCAP is administered through the Physician Compensation Branch.

Medical Practitioners Act

- a provincial statute governing the delivery of medical services in accordance with the principles of medicare and the *Canada Health Act*;
- recognizes a responsibility for judicious use of medical services in order to maintain a fiscally sustainable health care system;
- confirms that access to necessary care be based solely on need and not on ability to pay.

MSC

- a tripartite body, established under the *Medicare Protection Act*, with representative members from government, physicians and the public and having the mandate to facilitate reasonable access to quality medical care, health care and diagnostic facility services, for residents throughout British Columbia under the *MSP*;
- the MSC aims to manage the provision and payment of medical services in an effective and cost-efficient manner.

MSP

- British Columbia’s publicly administered health care insurance program, which, in accordance with the federal *Canada Health Act*, provides eligible residents with coverage for the medically necessary, medical, surgical and diagnostic services of physicians;
- MSP provides limited supplementary benefits beyond the requirements of federal legislation for the services of certain other health care providers.

Mission (also see *Mandate*)

- statement of an organization's direction at highest level; reason for being.

Non-Patient Care

- activities that do not involve the care of an individual patient (for example, quality assurance, utilization management or program planning activities).

Non-Performance (also see *Violation*)

- a default on the expected delivery of contracted services (deliverables) or a violation of the terms and conditions of funding, as previously defined by contract, memorandum of understanding or other binding agreement.
- may trigger some form of penalty and/or funding recovery.

Notification of Claim Adjustment/Return

- an APP form that is attached to a rejected claim and returned to the originating *agency* with a reason for the claim's rejection.

Objective

- a 'SMART' (Specific, Measurable, Achievable, Realistic and Time-based) action statement of results or change to be achieved during a time period.

On-call (also see *Call-back*)

- the status where a physician is scheduled for being available, but where, in most cases, the physician may remain off-site, such as at home, unless his or her services are required;
- on-call is not reimbursable under APP funding arrangements;
- refer to the *Medical On-Call/Availability Program* administered by the Physician Compensation Branch for information regarding payment of call.

Organizational Culture

- the underlying assumptions, beliefs, values, attitudes, behaviours, expectations and practices shared by members of an organization.

Outcomes

- the consequences or state that results from a program's activities or business outputs;
- the impact of the program on its clients or the public;
- may be immediate, ultimate or graduated over time.

Outputs

- measurable direct products or services delivered by an organization, program or activity (for example, the number of medical students graduated; number of physician services provided).

Overhead (see Program Support)

Payment Detail Statement (also see Payment Notice)

- a computer-generated report attached to a *Payment Notice* that identifies service information using *codes* for *program, site, control* and *sub-control*.

Payment Notice

- a computer-generated notice that advises an APP-funded *agency* of the total amount of payment it will receive from the Ministry of Finance.

Peer Review, Implicit and Explicit

- evaluation of the performance of a professional by a colleague of the same profession;
- an implicit or explicit review of clinical practice undertaken by one or several members of the same health discipline, where an implicit review considers whether care met a reasonable professional standard and an explicit review considers whether certain specific criteria for care were met (for example, an implicit review asks whether the frequency of service was appropriate, given the clinical condition of the patient, and an explicit review asks whether a recommended assessment, such an ophthalmologic evaluation for a diabetic patient, was received at the recommended interval).

Performance Agreement

- an agreement between organizational levels that sets out performance objectives and targets to which the organization's units must contribute.
- agreements are for a specified time period and reflect strategic priorities.

Performance Goal (Also see Goal and Objective)

- expected performance expressed as a tangible, measurable *objective*, against which actual achievement can be compared, often expressed as a quantitative standard, value or rate;
- sometimes used interchangeably with *performance target*, however, a performance target is usually more specific or detailed.

Performance Indicator

- a quantitative parameter used to ascertain the degree of performance (sometimes misused as a synonym for performance measure) but less precise than a performance measure;
- often used as an intermediate measure of achievement.

Performance Management

- the use of performance measurement information to help set performance targets; allocate and prioritize resources; confirm or change policy or program directions to meet performance goals; and report on progress.

Performance Management System

- the combined elements, processes, linkages and policies that support the establishment and implementation of performance management in an organization, including business planning, performance agreement negotiations, performance indicators, measures and target setting, monitoring, and reporting, modification, and incentives or penalties for corrections against predefined performance measures and expectations.

Performance Measure

- a quantitative or qualitative characterization of performance specific and relevant to an organizational *goal* or *objective*.

Performance Measurement

- a process of assessing progress toward achieving predetermined goals, including measures of the economy of acquiring resources, the efficiency with which resources are transformed into *outputs* (services or products), the quality of outputs and the effectiveness of operations in contributing to program objectives and organizational goals.
- evaluating demonstrated performance against goals, standards, historical performance or like organizations

Performance Target (Also see *Performance goal*)

- a metric for the amount of performance or degree of change required to successfully achieve a *performance objective*.

Personal Health Number or PHN

- a unique number assigned on a lifetime basis to each British Columbia resident upon her or his initial enrollment with the *MSP*.

Personal Sessional Contracts (see *Service Provider Agreements, Sessional Agreements and Required Elements*)

- the same as *Service Provider Agreements* or local physician contracts, but specific to sessional payments governed by the *Provincial Sessional Agreement*, a subsidiary of the *Working Agreement* with the BCMA.

Physician

- specifically defined in the provincial physician agreements as “a medical practitioner who is and remains a member in good standing of the CPSBC, whose services require him/her to have a medical degree and who is not providing exclusively administrative services, but does not include any member who is an undergraduate or an intern, resident, clinical fellow or clinical trainee in a postgraduate training program”.

Physician Services

- specifically defined within the provincial physician agreements as “clinical and related teaching, research and clinical administrative services provided by *Physicians*”.

Policy

- a statement of mandatory program or business expectations, responsibility assignment, definition of limits, and a basis for consistent decision-making to achieve program goals and realize an organization’s *mission* and *vision*.

Practitioner Number

- a unique identifying number assigned by the *MSP* to each health care practitioner who bills for services eligible as a *MSP* benefit or funded through the *APP*;
- sometimes referred to as a *billing number*.

Practitioner Records (see *Clinical Records*)

Professional Services

- any service, treatment, test or procedure that is accepted within the scope-of-practice of a particular health care profession and provided by an accredited health care practitioner, licensed and registered to practice in British Columbia.

Program (also see *Coding* and *Utilization*)

- the name of an *APP* code used to track and identify health care programs to which *APP* funds are directed (e.g., 00044 Emergency).
- a set of *activities* having clearly defined, dedicated resources and measurable objectives that are coherent and consistent.
- more generally, a formal ongoing government or partnership initiative created to deliver or maintain a certain service, or group of services, for the benefit of the general public, or for a specified target population, supported in whole or in part by public funds and having staff dedicated to achievement of the program’s mandate;

Program evaluation (See *Evaluation*).

Program Support

- expenses incurred for the operation and maintenance of a health care facility, clinic, service or office infrastructure system.

Project Charter (See Business Case)

Proration

- a proportional distribution, usually used to calculate a distributed rate of payment or allotment by hour, month or *FTE*;
- a percentage discount of fees used to manage utilization and meet legislated requirements to stay within defined annual budgets;
- an adjusted payment based on the actual delivery of services versus the expected delivery of services;
- a temporary reduction to payment under the MSC Payment Schedule pursuant to Section 24(1) and (2) of the *Medicare Protection Act*.

Provincial Salary Agreement

- A subsidiary to the *Working Agreement*, setting the terms and conditions that apply to physicians, who are contracted on a salaried-basis to provide to *physician services* funded by the provincial government.

Provincial Service Agreement

- A subsidiary of the *Working Agreement*, setting the terms and conditions that apply to physicians retained on a contracted-service basis to provide *physician services* funded by the provincial government.

Provincial Sessional Agreement

- A subsidiary of the *Working Agreement*, setting the terms and conditions that apply to physicians contracted to provide *sessions of physician services* funded by the provincial government.

Quality Assurance

- a cyclic, systematic process that uses standards for measuring quality, analyzing any deficiencies found, and taking corrective actions to improve performance, followed by re-measurement to confirm that the intended improvements and standards of quality were achieved.

Rules Made under the Medical Practitioners Act

- a provision of the *Medical Practitioners Act* requires the Council of the CPSBC, in its role of governance, control and administration of the affairs of the CPSBC, to make rules pertaining to medical practice in British Columbia.

Rural Retention Program

- the *Subsidiary Agreement for Physicians in Rural Practice* consolidated physician retention incentives into one program, now administered through Rural Programs in the Physician Compensation Branch.

Salaried Payment (also see *Claim for Reimbursement of Shareable Expenditure*)

- an employment agreement for physician services compensated on a salary-basis with funds provided by the provincial government;
- conditions for physicians' salaried payment set in the *Provincial Salaried Agreement* as a subsidiary of the *Working Agreement* with the BCMA.

Schedule

- that part of a formal agreement or contract setting out the particulars of service deliverables, fees or rates of payment, and any other item that the signing parties believe needs specific acknowledgement and definition beyond the standard contract body.

Second Master Agreement

- the agreement between the provincial government, the *MSC* and the *BCMA* that defines the relationships of its signing parties and the roles and responsibilities for retaining physician services.

Service Agreement or Service Contract

- a performance contract;
- a legally binding document setting out the expectations, levels of funding, and all terms and conditions of funding for delivering certain specified health care services (*deliverables*) through an *agency* compensated by funds provided by the provincial government, but does not include contracts for payment on a *fee-for-service* basis.

Service Plan

- a multi-year, high-level corporate document that outlines the vision, mission, values and key strategic priorities for the medium to long term, identifies strategies for achieving goals and objectives, and guides program *business plan*.

Service Provider Agreements (See *Template Service Contract* or *Template Sessional Contract*)

Service Records Requirement (also see *Clinical Records*, *Summary Records*, *Practitioner Records*, and *In-Direct Care and Non-Patient Care Service Records*)

- maintenance of complete service records to meet a condition of funding;
- demonstrates proper use of resources and accountability to the public for its funding of health care.

Service Year (see *Full Time Equivalent*)

Session (also see *Provincial Sessional Agreement*)

- 3.5 hours of a physician's professional clinical service;
- may be an accumulation of lesser time intervals adding up to 3.5 hours or other amounts of a full quarter of an hour.

Sessional Agreement (see *Provincial Sessional Agreement*)

Sessional Contract

- a contract between a physician and *agency* for delivery of sessionally paid services funded by the provincial government.

Sessional Payment (also see *Certificate of Services*)

- a physician compensation modality, where APP payment is made based on a contracting HA's submission of a *Certificate of Services*, recording the amount of physician time to deliver funded services, and with completion of a *Claim for Reimbursement of Shareable Expenditure*;
- payment is made based on a proration of the standard 3.5-hour session, rounded down to the quarter hour.

Sessional Rate (also see *Session*)

- a sessional rate is time-based and set by the *Provincial Sessional Agreement*.

Site (also see *Coding*)

- a particular facility where APP-funded *physician services* are delivered;
- one level of service identification used within the APP hierarchy of codes (*agency, site, program, control* and *sub-control*) used for claims payment (for example, 00289 is the site code for Vernon Jubilee Hospital).

Specialist

- defined by the provincial physician agreements as "a Physician who is a certificant or fellow of the RCPSC".

Specialist Services

- defined by the *Provincial Service Agreement* and *Provincial Salary Agreement* as "clinical and related teaching, research and clinical administrative services generally recognized as requiring *Specialist* expertise".
- defined by the *Provincial Sessional Agreement* as "medical or administrative services generally recognized as requiring the expertise of a specialist".

Stakeholder

- any individual or group interested in or potentially affected by a program's services, activities or decisions or, conversely, could affect or impact the program through the stakeholder's decisions and activities.

Sub-Control Name/Number (also see *Coding and Control Name/Number*)

- an APP administrative code, within the coding hierarchy of *agency, site, program, control* and *sub-control* used to support payment and tracking of funded physician services;
- the *Sub-Control Name* and *Sub-Control Number* provides greater refinement of the service delivery record by identifying the service provider's practitioner group and/or the setting of service delivery (e.g., 29 Medical Health Officer-GP);
- a level of detail to distinguish a particular APP funding *allocation*.

Subsidiary Agreements

- provincial physician agreements negotiated pursuant to Article 11.1 of the *Second Master Agreement* and as subsidiaries to the *Working Agreement*.
- address issues of unique application to particular groups of physicians.

Subsidiary Agreement for Physicians in Rural Practice (RSA)

- a subsidiary agreement to the *Working Agreement* negotiated with the *BCMA* to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia by addressing some of the uniquely demanding and difficult circumstances attendant upon the provision of those services by physicians.

Summary Records (also see *Service Records Requirement, Clinical Records, and In-Direct Care and Non-Patient Care Service Records*)

- a compilation of all APP-funded services, including patient names, *PHN*, date-of-service, name of physician(s) who provided service, and practitioner number(s);
- must be verifiable through clinical records, easily available if called upon for audit purposes, and retained by agencies for a minimum of six years.

Template Service Contract

- a legal instrument that commits the signing parties to an agreement to provide compensation for the delivery of agreed *physician services*.
- subject the *Provincial Service Agreement* (Articles 6.5 and 6.6), all contracts between HAs and physicians for physician services must be in the form of the template service contract set out in Appendix B of that Agreement.
- supports accountability in the use of publicly funded health resources.

Template Sessional Contract

- a legal instrument that commits the signing parties to an agreement to provide sessional compensation for delivery of agreed physician services.
- subject the *Provincial Sessional Agreement* (Articles 6.5 and 6.6), all contracts between HAs and physicians for physician sessions must be in the form of the *Provincial Sessional Agreement*, Appendix A, Template Sessional Contract for Physician Services.
- supports accountability in the use of publicly funded health resources.

Utilization (also see *Service Records Requirement*)

- a measure of the volume and type of service used in a defined timeframe;
- a term often used in the context of program management, where elements, such as service volumes, types, delivery locations, and practitioner specialties are consistently recorded and considered for determining the most appropriate allocation of public funding.

Violation (also see *Non-Performance*)

- a default on the terms and conditions of funding, as defined by contract, memorandum of understanding or other binding agreement, which can potentially incur some form of penalty or recovery of funding as a consequence of the violation or default.

Vision

- an organization's desired or intended future state; a snapshot of the future to which an organization's efforts and resources are ultimately directed to achieve.

Working Agreement

- according to the *Second Master Agreement* means "the Agreement(s) established from time to time between the Government of British Columbia, the MSC, and the BCMA for the purpose of determining compensation, reserve accounts, on-call issues, Physician Benefit Plans and any other issues which the parties agree to negotiate at the Working Agreement(s) negotiations, and includes *subsidiary agreements*".

Appendix B	Rates for Calculating Service Agreement Allocations ²	Page: 1 of 1 Effective: 1 April 2001
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Physician Specialty	Compensation Range		
	Low	Mid	High
General Practice General Practice	\$151,200	\$170,240	\$189,280
Medical 1 Medical Health Officer 1 Hospitalists	\$133,000	\$149,700	\$166,300
Medical 2 Physical Medicine Psychiatry General Pediatrics Medical Health Officer 2	\$168,000	\$188,720	\$204,440
Medical 2a Emergency Medicine	\$172,000	\$193,500	\$215,000
Medical 3 Rheumatology Neurology Dermatology Internal Medicine Sub-specialty Pediatrics Haematology	\$192,640	\$216,720	\$240,800
Medical 4 Anaesthesia Radiation, Medical & Hematological Oncology Critical Care	\$235,200	\$264,880	\$294,560
Surgical 1 Plastic Surgery Obs/Gyn Otolaryngology Orthopaedic Surgery Urology General Surgery Ophthalmology	\$254,240	\$285,600	\$316,960
Surgical 2 Neurosurgery Vascular Surgery Thoracic Surgery Cardiac Surgery Sub-specialty Orthopaedics	\$308,000	\$363,440	\$418,880
Diagnostics 1 Pathology	\$234,700	\$264,100	\$293,400
Diagnostic 2	\$237,000	\$266,500	\$296,000

² Source: Appendix A, *Provincial Service Agreement*, November 4, 2002



Appendix C	Rates and Fees for Calculating Sessional Allocations ³	Page: 1 of 1
		Effective: 1 April 2001

Physician Specialty		GP	Specialist
Standard	Sessional	\$347.77/session	\$410.24/session
	Hourly	\$99.36	\$117.21
Forensic	Sessional	\$377.23/session	\$445.61/session
	Hourly	\$107.78	\$127.32

³ Source: *Provincial Sessional Agreement*, November 4, 2002

Appendix D Rates for Calculating Salaried Allocations⁴

Page: 1 of 1

Effective: 1 April 2001

Physician Specialty	Compensation Range		
	Low	Mid	High
General Practice	\$135,000	\$152,000	\$169,000
Medical 1 Medical Health Officer 1 Hospitalists	\$118,800	\$133,700	\$148,500
Medical 2 Physical Medicine Psychiatry General Pediatrics Medical Health Officer 2	\$150,000	\$168,500	\$187,000
Medical 2a Emergency Medicine	\$154,000	\$173,000	\$192,000
Medical 3 Rheumatology Neurology Dermatology Internal Medicine Sub-specialty Pediatrics Haematology	\$172,000	\$193,500	\$215,000
Medical 4 Anaesthesia Radiation, Medical and Hematological Oncology Critical Care	\$210,000	\$236,500	\$263,000
Surgical 1 Plastic Surgery Obs/Gyn Otolaryngology Orthopaedic Surgery Urology General Surgery Ophthalmology	\$227,000	\$255,000	\$283,000
Surgical 2 Neurosurgery Vascular Surgery Thoracic Surgery Cardiac Surgery Sub-specialty Orthopaedics	\$275,000	\$324,500	\$374,000
Diagnostics 1, Pathology	\$209,600	\$235,800	\$262,000
Diagnostics 2, Radiology	\$211,000	\$237,500	\$264,000

⁴ Source: Appendix A, *Provincial Salary Agreement*, November 4, 2002