AMA Overhead Study 2021: Frequently Asked Questions

Updated March 9, 2021

What is the purpose of the overhead study?

Overhead represents a major component of physician compensation and the AMA will use the results of this study to inform work in several areas including advocacy (e.g., fee-for-service, ARP, and AHS compensation negotiations; context around the public disclosure of physician payments information) and fee schedule management activities such as allocation, income equity and fee relativity.

What physician services are included in the overhead model?

The AMA Overhead Model focusses on overhead required to support publicly insured clinical services paid through the Physician Services Budget (PSB). Two payment models are used in the PSB: fee-for-service and ARP payment. We chose to focus on the PSB as this is the expenditure amount of primary interest in negotiations and allocation. It is important to note that physicians on salary contracts, including laboratory physicians and oncologists, still incur overhead. Professional fees contained in Layer 1

are a good indicator of overhead expenses for these physician (unless contracts specify an amount to offset these expenses).

What if I bill under more than one section?

Physicians are assigned to an economic section based on the section skill code identified on their claims. Some physicians claim services from two or more sections in a year. All claims for these physicians are assigned to a single section based on the section with the physician's highest summed annual claims amount from fee-for-service claims plus the assessed value of shadow claims. This is the same approach we have used in the past for allocation. A mapping from skill code to economic section is included in the study report under the Appendix > Overhead Measurement Approach > Section Overhead.

Why use the model practice approach and not a survey?

It is time consuming and expensive to redo a survey every time practice patterns or costs change, and a survey doesn't tell us anything about the underlying practice characteristics. Surveys only provide the final accounting sum, and tax rules allow substantial variance within accounting categories. We cannot test "what if" scenarios or policy implications with just an accounting total.

Who was involved in the study?

In 2019 the AMA Board tasked the Overhead Working Group to develop a revised physician overhead model. The seven-physician group worked closely with the AMA Compensation Committee and a panel of physicians from the economic sections to develop additional overhead policy, define model components, and identify model costs.

Further information on the study development process can be found in the study report under the Appendix > Overhead Measurement Approach > Study Development Process.

Has government been involved?

This study has been AMA-led and, as of February 2021, Alberta Health has not been involved in design, collection, or reporting of results. Going forward, we intend to present the model to government, as it will be important to agree on overhead costs for various aspects of physician compensation. The study approach incorporates many of the elements from the 2010 Physician Business Cost Model (PBCM) including the model

office concept that was previously developed with government and was the basis of past allocations and relativity work.

We are aware that AHS is also working on their own overhead review and we look forward to meeting with them to discuss our approach.

What if the model practice estimate does not match what we believe is expected on average for our section?

Model costs are not intended to represent any individual physician, but rather represent section or sub-section typical costs for full-time physicians with reasonably efficient practices.

We encourage you to discuss the results with the overhead team through overhead@albertadoctors.org and with your section head. If an economic section believes the estimate presented for their model practice is more than 15% over or under typical costs of that practice, they are invited to notify AMACC of their intent to file a dispute. The section is be expected to present supporting data and analysis. The process for filing disputes with AMACC will be communicated following Representative Forum.

We continue to refine the aggregation methodology whereby physicians are assigned to practices in the model and aggregated at the economic section level. Right now, we are focussing on ensuring the cost estimates for the individual practices in the model are accurate and we will continue to work on the aggregation approach.

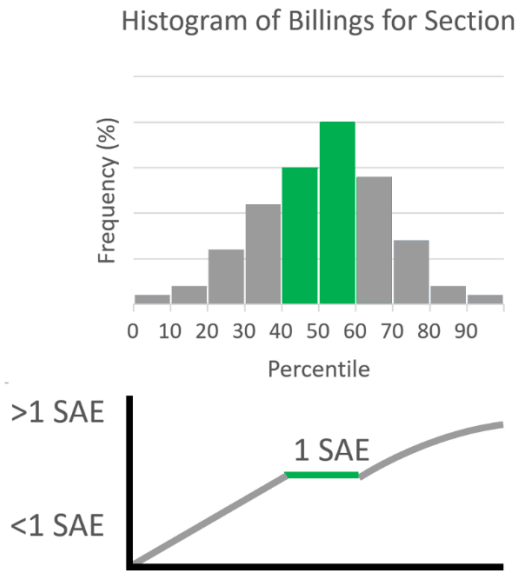
How does the overhead study link with the Income Equity Initiative (IEI)?

Physician overhead is a major component of the Income Equity Initiative and it is anticipated that data from this study will be incorporated into the IEI. Further work is required to refine the aggregation approach to develop daily overhead estimates before the results of the overhead study can be included in the IEI analysis. Additional IEI components also need to be completed including the Hours of Work Study and the Market Study.

The AMA Board is committed to completion of the IEI studies and bringing a completed model to the Representative Forum and AMA membership for approval. Ultimately, implementation of any fee or payment adjustments will also require the approval of Alberta Health.

What is the section allocation equivalent (SAE)?

The section allocation equivalent (SAE) is the AMA's full-time-equivalent metric, and it uses physician payments as a proxy for activity for each economic section. The AMA's SAE builds upon work from Canadian Institute for Health Information (CIHI).



The CIHI full-time-equivalent uses the 40th to 60th percentiles of annual billings.

The AMA SAE goes further and looks at the 40th to 60th percentiles of daily billings for 8 different day types: Monday through Sunday, and "odd" days such as holidays.

These eight types of days are aggregated using the actual number of billing days for each economic section from the Alberta Health billing data.

For the purposes of calculating the SAE, the number of billing days is capped at 209. This cap was supported by sections who considered their workloads excessive due to physician shortages.

A physician that bills in this annual rage is considered 1 SAE. Those who bill above the 60th percentile will have an SAE greater than 1 and those who bill less than the 40th percentile will have an SAE less than one.

Who do I contact with questions?

Please send your questions or feedback to overhead@albertadoctors.org.