

# MEDICAL SERVICES

COMMISSION

2016/2017

**ANNUAL  
REPORT**



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BRITISH  
COLUMBIA

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## **Function**

The function Medical Services Commission (Commission) is to facilitate, in the manner provided in the Medicare Protection Act (MPA), reasonable access throughout British Columbia to quality medical care, health care and prescribed diagnostic facility services for residents of British Columbia (BC), under the Medical Services Plan (MSP).

## **The Medical Services Commission**

Established under the *Medical Services Act, 1967*, and continued under the current MPA, the Commission oversees the provision, verification and payment of medical and health services in an effective and cost-effective manner through the MSP on behalf of the Government of BC. The Commission is accountable to government through the Minister of Health.

## **Organizational Structure**

In early 1994, the Commission was expanded from one member to a nine-member body. It consists of three persons nominated by the Doctors of BC, three public members appointed on the joint recommendation of the Minister of Health and the Doctors of BC to represent MSP beneficiaries, and three members to represent the government. This tri-partite structure represents a unique partnership among physicians, beneficiaries and government. It ensures that those who have a stake in the provision of medical services in BC are involved.

## **Responsibilities of the Commission**

In addition to ensuring that all BC residents have reasonable access to medical care and diagnostic services, the Commission is responsible for managing and monitoring the Available Amount, a fund which is set annually by government to pay practitioners on a fee-for-service basis for medical services provided to MSP beneficiaries. The Commission is also responsible for administering the MPA and investigating reports of extra billing; hearing appeals brought by beneficiaries, diagnostic facilities and physicians as required by the MPA; and arbitrating disputes that may arise between the Doctors of BC and the Government of BC.

## **Advisory Committees and Overview of Accomplishments**

The MPA allows the Commission to delegate some powers and duties to special committees, advisory committees and hearing panels established to assist the Commission in effectively carrying out its function. The following is a description of the responsibilities and an overview of the 2016/2017 accomplishments of some of the Commission's advisory committees, hearing panels and other delegated bodies.

## ***1. Guidelines and Protocols Advisory Committee***

The Guidelines and Protocols Advisory Committee (GPAC), an advisory committee to the Commission and a joint collaboration between the Doctors of BC and the Ministry of Health (MoH), is mandated to provide recommendations to BC practitioners on delivering high quality, appropriate care to patients. These recommendations are published as concise, evidence-based clinical practice guidelines under the brand name BC Guidelines, on the website [www.BCGuidelines.ca](http://www.BCGuidelines.ca). GPAC's overall goal is to maintain or improve the quality of medical care in BC, while making optimal use of medical resources.

### **Guidelines Approved by the Commission in 2016/2017**

The *Special Endocrine Testing (New)* guideline provides recommendations on the appropriate indications for testing of selected endocrine hormones in adults aged  $\geq 19$  years. The guideline is intended to provide direction to primary care physicians and help constrain inappropriate test utilization particularly as it pertains to so-called wellness and “anti-aging” practices. It is not intended to address the care of pediatric or transgender patients.

The *Chronic Obstructive Pulmonary Disease (COPD): Diagnosis and Management (Revised)* guideline provides recommendations for the diagnosis and management of adults aged  $\geq 19$  years with COPD. New and amended key recommendations include the use of spirometry to confirm airflow obstructions in all patients suspected of having COPD, the development of an exacerbation action plan with patients for pharmacologic therapies, and the use of routine follow-ups to evaluate patients' inhaler techniques.

The *Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 1: Approach to Care (Revised)* guideline presents palliative care assessment and management strategies for primary care practitioners caring for adult patients aged  $\geq 19$  years with incurable cancer and end stage chronic disease of many types, and their families.

The *Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 2: Pain and Symptom Management (Revised)* guideline presents strategies for the assessment and management of cancer pain, and symptoms associated with advanced disease, in patients aged  $\geq 19$  years. *Part 2* is divided into seven sections, providing recommendations for evidence-based symptom management with algorithms to facilitate quick access to the information required. Hyperlinked notes in the algorithm refer back to more detailed information within each symptom section. Pain, fatigue and weakness and depression are some of the key symptom areas that are addressed in the guideline.

The *Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 3: Grief and Bereavement (Revised)* guideline addressed the needs of adult patients with incurable cancer or advanced disease (but can be useful for adults dying of any cause), as well as the needs of their caregivers or family, including children. Information and tools are provided to improve a primary care provider's comfort and skills in dealing with this type of loss.

## Guidelines Under Development

The following existing guidelines were under revision during 2016/2017:

- *Frailty in Older Adults: Early Diagnosis and Management*
- *Thyroid Function Tests*
- *Vitamin D*
- *Testosterone Testing*

New guidelines under development during 2016/2017 included:

- *Ultrasound Prioritization*
- *PSA Testing*
- *Opioid Use Disorder*

## New Partner Guidelines

Partner guidelines are developed by other stakeholders independent of GPAC. After review by GPAC, they are posted on BCGuidelines.ca's Partner Guidelines web page.

New partner guidelines added in 2016/2017 were:

- *A Guideline for the Clinical Management of Opioid Use Disorder* – developed by the BC Centre on Substance Use and the MoH;
- *Accidental Hypothermia – Evaluation, Triage and Management* – developed by Dr. Doug Brown (an emergency physician at Royal Columbia Hospital) and the BC Accidental Hypothermia Working Group;
- *Upper Gastrointestinal Cancer (Suspected) Part 1: Esophagus and Stomach* – developed by the Family Practice Oncology Network;
- *Upper Gastrointestinal Cancer (Suspected) Part 2: Pancreatic Cancer, Neuroendocrine Tumours of the Pancreas and Duodenum, and Cancer of the Extrahepatic Biliary Tract* – developed by the Family Practice Oncology Network.

## Promotion and Education

To further GPAC's strategic goals of increasing the exposure of BC Guidelines and supporting evidence-based high quality patient-centred care, GPAC participated in the following promotional activities during 2016/2017:

- BC College of Family Physicians Fall Conference;
- St. Paul's Hospital Continuing Medical Education for Primary Care Physicians;
- UBC Family Practice Residents Program, Resident's Scholarship Day;
- UBC 4<sup>th</sup> Year Medical Students Preparation for Medical Practice;
- Divisions of Family Practice newsletters.

## **Additional 2016/2017 GPAC Highlights**

- A mobile app was developed, increasing accessibility and ease of use by making BC Guidelines available offline, increasing speed of access, and optimizing the user interface to the specific mobile device. The mobile app is intended to supplement the mobile version of GPAC's website.
- The top five most popular guidelines downloaded from GPAC's website during 2016/2017 were *Diabetes Care*; *Iron Deficiency*; *Warfarin Therapy Management*; *Thyroid Function Tests*; and *Chronic Kidney Disease*.

## **2. Advisory Committee on Diagnostic Facilities**

The Advisory Committee on Diagnostic Facilities (ACDF) provides advice, assistance and recommendations to the Commission in the exercise of the Commission's duties, powers and functions under s.33 of the MPA. The ACDF reviews applications from existing and proposed diagnostic facilities and makes recommendations to the Commission to approve or deny the requests.

Between April 1, 2016, and March 31, 2017, the ACDF considered 71 applications related to electrocardiography, nuclear medicine, pulmonary function, radiology, ultrasound, electromyography and polysomnography. Four applications were for new certificates of approval and other applications included requests to relocate existing sites, expand capacity, add services or transfer interest.

Of the total applications reviewed by the ACDF, 51 requests were approved, 12 were recommended to the Commission for denial and 1 application was deferred to the Commission for decision.

### **Ultrasound Policy Review**

The review of the current requirements/policies that govern approval of both public and privately-owned diagnostic outpatient ultrasound facilities continued in fiscal 2016/17. The review produced four sets of recommendations for potential revisions to the current outpatient diagnostic ultrasound facility policies in BC. Recommendations in the following policy areas were approved at the Commission's October 26, 2017 meeting:

- 1) The general requirements for an ultrasound Certificate of Approval (for privately-owned facilities). The Commission directed consideration of a rare exceptions requirement, which is currently being defined.
- 2) The removal of the restriction concerning non-cardiac Doppler studies at privately-owned facilities.
- 3) Further work be undertaken to determine if removing the current publicly-owned restriction to Echocardiography should be pursued. The Commission directed the MoH to bring forward a plan for this work by fall 2017.
- 4) Remove the restriction on privately-owned facilities to apply for "Distance-reading (Diagnostic Ultrasound Telemetry) policy; to remove the two year time limit on approval for current facilities. (New policy was approved at the Commission's December 7, 2016, meeting and has been fully implemented).

## **Polysomnography Policy**

An application for Four Channel polysomnography (with testing to be completed in a patient's home, as opposed to overnight sleep testing in an approved facility) was reviewed at the ACDF's March 10th, 2016, meeting and initiated discussions concerning requirements for a privately-owned facility to receive a Certificate of Approval for Polysomnography. A recommendation was made to amend the ACDF Policies and Guidelines to include a general requirement for polysomnography. The following language was approved:

Applications for a Polysomnography Certificate of Approval must provide for a minimum capacity of two beds appropriate for the purpose of overnight sleep testing.

This policy was approved by the Commission April 27, 2016. *Note: This policy was revised again in fiscal 2017/2018 to a minimum of three beds.*

## **Ultrasound Moratorium**

The moratorium on applications for outpatient diagnostic ultrasound facilities entered its fourth year and was set to end on June 1, 2017. *Note: The moratorium was subsequently extended to June 1, 2020.*

Requests for consideration under the moratorium exception criteria ("demonstrated urgent health or safety needs") continued, with the proponents seeking an exception becoming more varied. The majority of the proponents were net-new privately-owned facilities that did not meet the ACDF's policy requirement for privately-owned outpatient ultrasound facilities, i.e. holding a Category IV Radiology Certificate of Approval and having one or more appropriately credentialed radiologists on staff. Therefore the guidelines for accepting ultrasound moratorium exceptions requests for consideration under the moratorium exception criterion were revised. On April 27, 2016, the Commission approved a recommendation to only accept a moratorium 'request for exception' from facilities that hold a current ultrasound Certificate of Approval.

## ***3. Audit and Inspection Committee***

The Audit and Inspection Committee (AIC) is a four-member panel comprised of three physicians (one appointed by the Doctors of BC, one appointed by the College of Physicians and Surgeons of BC and one appointed by government) together with one member who represents the public. The Commission has delegated its powers and duties under s.36 of the MPA to the AIC to audit and inspect medical practitioners.

On December 1, 2006, s.10 of the *Medicare Protection Amendment Act 2003* was brought into force. This section expanded the audit and inspection powers of the Commission to include the power to audit clinics as corporate entities, rather than just physicians.

The AIC has responsibility for two types of audits. Patterns of practice audits are done to ensure that services billed to MSP have been delivered and billed accurately. Extra billing audits focus on whether beneficiaries are being charged for services in contravention of

the MPA. The AIC decides whether onsite audits are appropriate, and it outlines the nature and extent of the audits. It also reviews the audit results and makes recommendations to the Chair of the Commission for further appropriate action.

In 2016/2017, the AIC received and approved 12 new audit referrals related to medical practitioners. Audit reports from 14 inspections were reviewed by the AIC during this period and 12 cases were recommended for recovery.

- ***Billing Integrity Program***

The Billing Integrity Program (BIP) provides audit services to the MSP and the Commission. The Commission is authorized to monitor the billing and payment of claims in order to manage medical and health care expenditures on behalf of MSP beneficiaries. BIP monitors and investigates billing patterns and practices of medical and health care practitioners to detect and deter inappropriate and incorrect billing of MSP claims. In cooperation with the professions, BIP develops and applies monitoring, case finding and audit criteria, and assists the Commission in the recovery of any funds billed inappropriately. It carries out the audit and inspection function on behalf of the AIC.

In 2016/2017, the BIP conducted nine onsite medical practitioner audits. It negotiated settlements for 14 cases with dollars equaling \$8,128,081. A total of \$3,644,873 was recovered by BIP this year (including recoveries negotiated in previous years).

- ***Special Committees of the Medical Services Commission***

The Commission's authority to audit claims from health care practitioners is delegated to Special Committees for each of the following professions: acupuncture, chiropractic, dentistry, massage therapy, midwifery, naturopathy, optometry, physical therapy and podiatry. The Special Committees have been given all of the powers and duties necessary to carry out audits.

The Commission's authority to make orders in regard to practitioners under sections 15 and 37 of the MPA is delegated to the Health Care Practitioners Special Committee for Audit Hearings (HCPSCAH).

In 2016/2017, the HCPSCAH received and approved two new audit referrals related to health care practitioners. Audit reports from two inspections were reviewed by the HCPSCAH during this period and all three cases were recommended for recovery. The BIP did not conduct any onsite health care practitioner audits and negotiated settlements for five cases with dollars equaling \$1,507,761. A total of \$1,164,521 was recovered by BIP this year (including recoveries negotiated in previous years).

#### ***4. Patterns of Practice Committee***

The Patterns of Practice Committee (POPC) is a joint committee of the Doctors of BC and the Commission and acts in an advisory capacity to the Commission. The POPC prepares and distributes an annual statistical personal profile summary (mini-profile) to fee-for-service physicians and provides educational information to physicians on their

patterns of practice and the audit process. The POPC also provides advice to the MSP regarding inappropriate billing and scrutinizes MSP's process of detecting and deterring inappropriate billing. As well, the POPC listens to physicians who wish to raise their concerns about the audit process and provides feedback on the audit practices employed by the BIP and in conjunction with the College of Physicians and Surgeons of British Columbia; the POPC also nominates medical inspectors and audit hearing panel members.

The Commission endorsed the POPC's Terms of Reference at its May 25, 2016, meeting and suggested that the Commission Chair be invited to attend POPC meetings as a non-voting member on an ad hoc basis.

## ***5. Reference Committee***

The Reference Committee acts, on requests from physicians, in an advisory capacity to the Commission, on the adjudication of billing and payment disputes between physicians and the MSP. The Reference Committee does, on occasion, perform a similar service for patients billed directly by a physician and physicians providing services to third parties, such as insurance companies. Membership on the Reference Committee is limited to representatives of the Doctors of BC.

In 2016/2017, MSP received 21 new cases from the Doctors of BC, 13 of which are scheduled for referral to the Reference Committee in 2017/2018. During 2016/2017, the Reference Committee also closed four cases.

## ***6. Joint Standing Committee on Rural Issues***

The Joint Standing Committee (JSC) on Rural Issues is not a direct advisory committee to the Commission but some of the funding for its work comes from the Available Amount that is managed by the Commission.

The JSC oversees approximately \$116 million annually in rural incentive programs to sustain patient care and continuity of access in communities falling under the *Rural Practice Subsidiary Agreement*. Approximately \$48.3 million for rural premiums are funded through the Available Amount. The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of BC by addressing some of the unique, demanding, and difficult circumstances encountered by rural physicians and to enhance the quality of the practice of rural medicine.

In 2016/2017, the JSC implemented and supported a number of initiatives, including appointing Dr. David Snadden as the UBC Rural Chair responsible for providing academic leadership for rural health care in BC and developing a robust research and education program; supporting mentorship programs for physicians new to practice and an eMentoring program to encourage high school students to consider medicine as a career; enhancing the Practice Readiness Assessment program; and providing support for Rural Surgical and Obstetrical Services to enhance the health status of rural British Columbians and sustain health services in the communities in which they live.

## **7. Requisition Committee**

The Requisition Committee, established in 1997, is a joint committee of the Doctors of BC and the Ministry of Health. The Requisition Committee reports to the Doctors of BC's Board of Directors and the Commission and its mandate includes oversight for the establishment, maintenance and ongoing review of provincial Standard Outpatient Diagnostic Requisition forms for insured medical services. Final approval of all requisitions that are developed rests with the Commission.

## **Other Delegated Bodies**

- ***Medical Services Plan***

The Commission delegates day-to-day functions such as the processing and payment of claims, to MAXIMUS BC (Health Insurance BC (HIBC)).

MSP and PharmaCare operations were transferred to MAXIMUS BC effective April 1, 2005. The Commission receives regular updates regarding HIBC's service level requirements and program performance. Policy direction and leadership authority remains within the responsibility of the MoH.

The government assists approximately 2 million people with payment of their MSP premiums. Regular premium assistance offers seven levels of subsidy, based on an individual's net income (or a couple's combined net income) for the preceding tax year, less deductions for age, family size, disability and any reported Universal Child Care Benefit and Registered Disability Savings Plan Income.

In the Government of BC's *Budget and Fiscal Plan 2016/17-2018/19*, changes to MSP premiums and regular premium assistance were announced that came into effect January 1, 2017. The changes included: no premiums for children; an increase to the maximum allowable adjusted net income to qualify for 100 percent premium assistance; three new income bands; and an increase to the maximum net income to qualify for some level assistance.

In 2016/2017, the MSP paid approximately 18,700 medical and health care providers \$3.14 billion dollars relating to nearly 98 million services, rendered on a fee-for-service basis. Medical practitioners can also be paid for services using alternative payment methods including salaries, sessional contracts and service contracts.

The *Medical Services Commission Financial Statement* (the "Blue Book") contains an alphabetical listing of payments made by the Commission to practitioners, groups, clinics, hospitals and diagnostic facilities for each fiscal year.

Copies of the *Medical Services Commission Financial Statement* are available online at: [www.gov.bc.ca/msppublications](http://www.gov.bc.ca/msppublications).

- ***Coverage Wait Period Review Committee***

New and returning residents are required to complete a wait period before provincial publically funded health benefits are activated. However, there are exceptional cases based on individual circumstances where the Commission may waive this requirement and enroll new residents before the coverage wait period has expired. The Commission has delegated the power to investigate and decide cases to the Coverage Wait Period Review Committee.

The Committee reviewed 112 waiver of the wait period requests between April 1, 2016, and March 31, 2017, and granted 9 approvals.

103 waiver requests were denied in 2016/2017 including 33 applications from new residents related to pregnancy and prenatal care during the wait periods. The onus is on families to have medical insurance in place before arrival in BC, or to budget in advance for the cost of the birth. 68 denials were related to conditions that were not diagnosed in the wait period and/or were not financially devastating.

Two waiver requests were undecided in 2016/2017 due to the panel requiring more information to make a decision and no further information ever being received.

## **Medical Services Commission Hearing Panels**

Commission members, or delegates of the Commission, may conduct hearings related to the exercise of the Commission's statutory decision-making powers.

Some hearings are required by the MPA, and some have been implemented by the Commission to afford individuals affected by its decisions the opportunity to be heard in person. Hearings are governed by the duty to act fairly.

Decisions of the Commission panels may be judicially reviewed by the Supreme Court of British Columbia.

### ***1. Beneficiary Hearings***

Eligibility (residency) hearings and panel reviews of claims for elective (non-emergency) out-of-country medical care funding are the two types of MSP beneficiary hearings currently conducted by the Commission.

#### **Eligibility (Residency) Hearings**

A person must meet the definition of resident in s.5 of the MPA to be eligible for provincial health care benefits. As per s.7 of the MPA, the Commission may cancel the MSP enrolment of individuals whom it determines are not residents of BC. Individuals whose MSP coverage is cancelled have the right to appeal to the Commission. Section 11 of the MPA requires that prior to making an order cancelling a beneficiary's enrolment, the Commission must notify the beneficiary that he or she has a right to a hearing.

The Commission has delegated the responsibility for holding residency hearings to one decision-maker.

The MoH's Eligibility, Compliance and Enforcement Unit investigated 1117 residency cases between April 1, 2016, and March 31, 2017, verifying BC residences for 127 cases. 990 non-resident accounts were identified, resulting in MSP account cancellations totaling \$2,998,692.76 in hospital, MSP and PharmaCare recoveries.

In 2016/17, the Commission received 24 new requests for eligibility (residency) hearings. Nine in-person hearings and 15 written hearings were held during this period, including some cases carried forward from previous fiscal years. Five hearing requests were withdrawn or cancelled in 2016/17 and 11 residency decisions were rendered by the Commission. Sixteen residency hearings are pending.

### **Out-of-Country Hearings**

Provincial coverage may be requested for medical treatment outside Canada, when medically necessary treatment services are not available for a BC resident anywhere in Canada. The appropriate attending specialist in BC may send an application and the medical documentation to apply for provincial coverage, on behalf of the patient. The MoH's Beneficiary Services Branch (BSB) will review the application on behalf of the Commission. The Commission publishes the *Medical Services Commission Out-of-Province and Out-of-Country Medical Care Guidelines for Funding Approval* (January 19, 2011) to explain the provincial coverage.

The Commission has established a review hearing process and a review can be requested when coverage has not been approved by BSB, for medical treatment outside Canada. The MPA does not impose a duty on the Commission to hear and decide requests to review but rather, it is the Commission's choice to offer the option for review hearings.

From April 1, 2016, to March 31, 2017, BSB received 3352 applications for out-of-country, elective medical treatment. BSB approved provincial coverage for 3197 applications and provincial coverage was denied for 155 applications. The Commission currently has two review hearings pending, to review provincial coverage for out-of-country medical treatment.

## ***2. Diagnostic Facility Hearings***

Under s.33 of the MPA, the Commission may add new conditions or amend existing ones to an approval of a diagnostic facility. This may be done either on application by the facility owner, or on the Commission's own initiative. Before taking action, the Commission is required to provide the owner of the facility an opportunity to be heard [s.33(4)]. A hearing before the Commission is usually requested for one of the following two reasons:

- The ACDF has recommended to the Commission that an application to amend or add conditions to an existing approval be denied; or
- The ACDF has recommended to the Commission that an approval

be suspended, amended or cancelled because the facility owner is alleged to have contravened the MPA, the regulations, or a condition on the approval.

Diagnostic facility hearings are conducted before either a single-person or three-person Commission panel, depending on the type of appeal.

No diagnostic facility appeals were filed or hearings held in 2016/2017.

### ***3. Hearings Related to Medical Practitioners***

Audit hearings and de-enrolment for “cause” are the two types of Commission statutory hearings related to medical practitioners.

#### **Audit Hearings**

Under s.37 of the MPA, the Commission may make orders requiring medical practitioners or owners of diagnostic facilities to make payments to the Commission in circumstances where it determines, after a hearing, an amount due to (a) an unjustified departure from the patterns of practice or billing of physicians in this category; (b) a claim for payment for a benefit that was not rendered; or (c) a misrepresentation about the nature or extent of benefits rendered. These hearings are the most formal of all the administrative hearings currently done by the Commission. Practitioners are usually represented by legal counsel and the hearings may last one to two weeks.

Since the introduction of the Alternative Dispute Resolution (ADR) process in 2000, fewer billing matters proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) negotiation to encourage medical practitioners and the Commission to reach a negotiated settlement of s.37 disputes.

In 2016/2017, there were no audit hearings.

#### **De-enrollment of Medical Practitioners for “Cause”**

One medical practitioner was de-enrolled for “cause” in 2016/2017.

### ***4. Hearings Related to Health Care Practitioners***

Audit hearings and de-enrollment for “cause” are the two types of Health Care Practitioners Special Committee for Audit Hearings (HCPSCAH).

#### **Audit Hearings**

The HCPSCAH under s.4 of the MPA exercises the Commission’s hearing powers over health care practitioners. Under s.37 of the MPA, the HCPSCAH may make orders requiring health care practitioners to make payments to the Commission in circumstances where it determines, after a hearing, an amount due to (a) an unjustified departure from the patterns of practice or billing of practitioner in this category; (b) a claim for payment for a benefit that was not rendered; or (c) a misrepresentation about the nature or extent

of benefits rendered. These hearings are the most formal of all the administrative hearings currently done by the HCPSCAH. Practitioners are usually represented by legal counsel and the hearings may last one to two weeks.

Since the introduction of the ADR process, fewer billing matters proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) negotiation to encourage medical practitioners and the Commission to reach a negotiated settlement of s.37 disputes.

No hearings were held by the HCPSCAH in 2016/2017.

### **De-enrolment of Health Care Practitioners for “Cause”**

In 2016/2017, two de-enrolments of health care practitioners for “cause” were reached through settlement.

## **Other 2016/2017 Commission Highlights and Issues**

The Commission held eight regular business meetings between April 1, 2016 and March 31, 2017.

- ***Physician Master Agreement and Subsidiary Agreements***

As a result of negotiations between the Government of BC and the Doctors of BC, a comprehensive *2014 Physician Master Agreement* (PMA) (including five subsidiary agreements) is in effect until 2019. The PMA provides a consolidated agreement structure and administrative committees with health authority representation. The Commission is a signatory to the PMA and subsidiary agreements.

Copies of the negotiated agreements are available online at:  
<http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/negotiated-agreements-with-the-doctors-of-bc>.

The Physician Services Committee (PSC) is the senior body that oversees the relationship between the government and the Doctors of BC and the implementation and administration of the PMA and subsidiary agreements. The Chair of the Medical Services Commission attends PSC meetings as a non-voting member.

- ***Medical Services Commission Payment Schedule***

The *MSC Payment Schedule* is the list of fees approved by the Commission payable to physicians for insured medical services provided to beneficiaries enrolled with the MSP. Additions, deletions, fee changes or other modifications to the *MSC Payment Schedule* are implemented in the form of signed Minutes of the Commission (MoC).

In 2016/2017, 99 MoCs related to the *MSC Payment Schedule* were approved, resulting in 14 new fee items. Forty-eight of the total MoCs approved contained amendments to regular fees and 14 were related to fee item extensions. Twenty-one of the total MoCs

approved were for allocation and/or retroactive changes; Economic Stability Dividend allowances; allocations to fees paid to Doctors of BC Specialist Sections that have difficulty recruiting and retaining specialist physicians in BC; and disparity allocations to fees paid to Specialist Sections in order to address interprovincial and intersectional disparity among fee-for-service specialists. One MoC amended General Practice Services Committee fees and two MoCs revised Specialist Services Committee fee items.

In response to a recommendation from the Office of the Auditor General's 2014 *Oversight of Physician Services* report, the MoH continues to work on developing a framework and process that will see components of the *MSC Payment Schedule* reviewed on an ongoing basis.

- ***Strategic Planning***

The Commission identified its objectives and priority directions for 2016/2017 at a strategic planning session held in March 2016.

The Commission's objectives for 2016/2017 involved managing the Available Amount; promoting quality, appropriate and accessible patient care; and ensuring that beneficiary services are equitable. Some strategies for the Commission included providing input into the setting of the Available Amount; initiating a fee review process; improving integration of its advisory committees and receiving regular reports on the initiatives the committees undertake throughout the year; and promoting an increased supply of sonographers.

- ***BC Services Card***

The BC Services Card (BCSC) project was initiated in 2009 to create a provincial identity solution and replace the BC CareCard with security-enhanced photo identification. The project is a partnership involving the MoH, HIBC, The Ministry of Technology, Innovation and Citizens Services and the Insurance Corporation of BC. In February 2013 the BCAC launched. The next stage of the project is currently under way and is anticipated to conclude in early 2018 at which point the majority of BC residents will either have obtained a BCSC or have had an opportunity to do so. As of March 31, 2017, 3.5 million out of 4.8 million MSP beneficiaries had been issued a BCSC.

In 2016/17, a major focus of activity was ensuring that BC residents are notified of the expectation that they will obtain a BCSC. In the years immediately following the card's launch, focus was primarily on new and returning BC residents, holds of BC driver licenses and BC identification cards and newborns. This has been expanded to include the balance of other potentially eligible BC residents by early 2018.

- ***Presentations to the Commission***

Throughout 2016/2017, the Commission received presentations on several additional issues including:

- An update from the MoH with respect to medical assistance in dying, specifically the federal legislation that received Royal Assent on June 17, 2016, determining that physician assisted dying is no longer a prohibited act, the eligibility criteria as well as safeguards with respect to medical assistance in dying and additional work BC has been doing to align with the federal legislation;
- The role of the Eligibility, Compliance and Enforcement Unit– part of the MoH’s Audit and Investigations Branch – as it carries out independent compliance audits and investigations to ensure only BC residents access funded MSP benefits.
- An overview regarding the shortage of diagnostic medical sonographers in BC including environmental factors such as education, compensation and new graduate expectations that affect the supply and demand of sonographers and the mitigating strategies and solutions to resolve the shortage;
- A briefing on virtual care (telehealth/telemedicine) and a discussion of the evidence that indicates a strong interest among patients and providers and an increase in positive patient outcomes as a result of this technology;
- An overview of BC’s Advanced Medical Imaging Strategy and the current status of MRI exam volumes, wait times, capital and machines.

- ***Commission-Related Legal Cases***

As part of its oversight of the MSP, the Commission monitors legal issues that arise as a result of MSP or MoH-related decisions and is sometimes actively involved in litigation as a named party. The following cases were considered and/or participated in by the Commission during 2016/2017.

### ***Extra Billing/Private Clinic Issues***

The purpose of the MPA is to preserve a publicly managed and fiscally sustainable health care system for BC in which access to necessary medical care is based on need and not on an individual’s ability to pay. Extra billing occurs when an MSP beneficiary receives a medically necessary benefit from an enrolled physician and is charged for it or for services in relation to that benefit by a person or entity (e.g., a clinic). Extra billing violates the MPA. Section 17 of the MPA prohibits a person from charging a beneficiary for a benefit or for materials, consultations, procedures, the use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit.

Sections 10 and 11 of the *Medicare Protection Amendment Act 2003* were brought into force through regulation on December 1, 2006. These sections contained an expansion of the audit and inspection powers in s.36 of the MPA and included a new s.45.1 giving the Commission the power to seek an injunction from a Court regarding contravention of certain stated provisions including the prohibition against extra billing.

### **Extra Billing Investigations**

The Commission has developed processes for dealing with cases that come to its attention when concerns or complaints of extra billing arise.

In 2016/2017, one new case of suspected extra billing involving a program charging patients an enrolment fee to participate in group medical visits was investigated by the Commission.

9 extra billing clinic audits ordered by the Commission between 2008 and 2011 remained pending during 2016/2017.

### **Extra Billing Litigation**

The private clinic litigation that commenced in the Supreme Court of British Columbia in January 2009 and which raised a *Canadian Charter of Rights and Freedoms* (the Charter) challenge to the validity of the extra billing prohibition in the MPA was ongoing throughout 2016/2017.

In January 2009, legal proceedings were commenced against the Commission, the Minister of Health Services of BC, and the Attorney General of BC (the government) alleging that sections 14, 17, 18, and 45 of the MPA are in breach of s.7 and s.15 of the *Charter*. Sections 14, 17, and 18 relate to direct and extra billing, and s.45 prohibits private insurance for medical services covered by the MSP. The current plaintiffs in this action (there have been several changes over the years) are Cambie Surgeries Corporation (Cambie), Specialist Referral Clinic (Vancouver) Inc. (SRC), and four individual patients.

The plaintiffs initially sought to prevent the Commission from conducting an audit of Cambie and SRC until the constitutional challenge had been resolved, but were unsuccessful. The audit began in January of 2011. On May 20, 2012, the MoH auditors presented their completed audit report to the Commission. The audit report identified numerous violations of the MPA at both clinics, and supported the Commission's counterclaim for an injunction against the two clinics.

In addition, the audit report indicated that some of the physicians at both clinics appear to have been involved in double billing (i.e., billing both the patient and MSP in connection with the same service). The Commission therefore instructed the auditors to undertake a further audit of those physicians, focusing on the issue of double billing. The audit identified significant amounts of extra billing by both clinics.

The Commission sought an interim injunction against Cambie and SRC in the fall of 2012. Procedural delays caused by the plaintiffs caused the Commission to agree to defer the injunction application in favour of a speedy trial of the constitutional claim. The trial began on September 6, 2016, and was originally expected to run for approximately 24 weeks. In September of 2016 the plaintiffs discontinued their claim against the Minister of Health and the Commission, leaving the Attorney General of BC as the sole defendant. In February of 2017 the trial judge ordered that no more witnesses could be called until a number of pending applications could be dealt with. The trial was subsequently adjourned and is not likely to resume until late 2017.

Numerous parties have been granted leave by the Court to intervene in this litigation. One group of individuals had earlier petitioned the Court to compel the Commission to enforce the MPA provisions against private clinics; their petition has been put into abeyance pending the outcome of the constitutional challenge, but they have been granted the right to intervene. Another group of intervenors includes the British Columbia Health Coalition, Canadian Doctors for Medicare, two physicians, and two patients. The final intervenor is the British Columbia Anaesthesiologists' Society.

In March of 2016, the Attorney General of Canada announced her decision to participate in the litigation as well, in accordance with the *Constitutional Question Act*.

### ***Pacific Centre for Reproductive Medicine***

In March 2013, the Commission denied an application by Pacific Centre for Reproductive Medicine (PCRM) for approval as a Category IV diagnostic facility under the MPA which would enable Maternal Fetal Medicine (MFM) physicians to bill MSP for certain specified ultrasound services. In June 2013, PCRM filed a petition for judicial review of that decision and in February 2014, after discussions among legal counsel, PCRM discontinued its court proceeding. In April 2014, PCRM submitted a new application to the Commission for a temporary certificate of approval.

After communications between counsel for PCRM and the Commission, the Commission advised PCRM in May 2014 that it would be proceeding with its own investigations regarding MFM physicians and ultrasounds. The Commission also invited PCRM to work with it in order to clarify the exact nature of the application, specifying certain areas of concern.

On May 30, 2014, PCRM renewed its petition for judicial review of the Commission's March 2013 decision.

A hearing was held in November 2014, and on January 16, 2015, the Supreme Court of British Columbia handed down its decision. The court held:

*I conclude the hearing of the present judicial review application ought to be adjourned. I do so assuming the Commission will proceed in good faith and with reasonable dispatch reflecting the spirit of its letter of May 7, 2014.*

Following this decision, PCRM took up the Commission's offer to work with it (through its MoH representatives) to clarify and refine its application, resulting in a new application being filed on April 20, 2015.

Prior to the Commission rendering a decision with respect to PCRM's application, it invited PCRM representatives to attend its June 2015 meeting to provide Commission members with additional background information related to the application and to allow an informal opportunity for questions and/or further clarification.

In deciding this matter, the Commission considered all of the common law, statutory and regulatory elements related to PCRM's application and reviewed all relevant information

and documentation. The Commission issued its decision on December 9, 2015, denying PCRM's application for a certificate of approval.

PCRM is expected to amend its petition to seek judicial review of the Commission's December 9, 2015, decision to deny the application

### ***Class Action Lawsuit***

This is a class proceeding brought against the Province of BC and the Commission by Dr. James Halvorson, a Cowichan District Hospital emergency room physician, on behalf of fee-for-service medical practitioners enrolled in the MSP claiming payment of fees for services provided to patients whose enrolment as beneficiaries of MSP had been cancelled by the Commission for non-payment of premiums (during the period 1992-1996) or a period of no-contact (for the period from 1996 to the present).

The proceeding was originally filed in 1998 and has a lengthy procedural history. A certification hearing was held in 2012, during which the parties reached an agreement on the terms of a Consent Order, which was approved by a justice of the Supreme Court of British Columbia on July 12, 2012. The Consent Order certified the action as a class action, and certified two threshold legal issues concerning the authority of the Commission to de-enroll beneficiaries for non-payment of MSP premiums.

On October 27, 2015, Ministry of Justice legal counsel, acting on behalf of the MoH and the Commission, attended mediation of the Halvorson matter and a tentative settlement of up to \$7.5 million under the *Crown Proceeding Act* (subject to Treasury Board and Supreme Court approval) was reached.

Treasury Board and Cabinet approved the settlement in March 2016.

The Supreme Court approved the settlement on July 11, 2016. The settlement agreement provided that doctors who are in the plaintiff class would have until January 13, 2017, to submit claims to participate in the settlement. As of that date, approximately 2,100 physicians had filed claims. However, approximately 141 claims were received after the cut-off time of 2:00 pm. Pacific time. There were numerous complaints from members of the plaintiff class that they were not aware of the class action, or had not received notice of it until early January, 2017. On March 3, 2017 the Court extended the claims period to April 17, 2017.

## Appendices

### *Appendix 1: Members of the Medical Services Commission as of March 31, 2017*

Medical Services Commission representatives and alternate members are appointed by Order of the Lieutenant Governor in Council (OIC). Additional information regarding Commission appointments is available on the Board Resourcing and Development Office's website at [www.brdo.gov.bc.ca](http://www.brdo.gov.bc.ca).

#### **Government of British Columbia Representatives:**

- Dr. Robert Halpenny (Chair)
- Mrs. Sheila Taylor (Deputy Chair)
- Colin Kinsley\*
  
- Alternate Members: Ms. Heather Davidson, Ms. Athana Mentzelopoulous,  
Ms. Stephanie Power

\* New OIC appointment – April 2016

#### **Doctors of BC Representatives:**

- Dr. Bryan Norton
- Dr. William Rife
- Dr. Matthew Chow\*
  
- Alternate Members: Dr. Charles Webb\*, Dr. Trina Larsen Soles\*,  
Mr. Allan Seckel

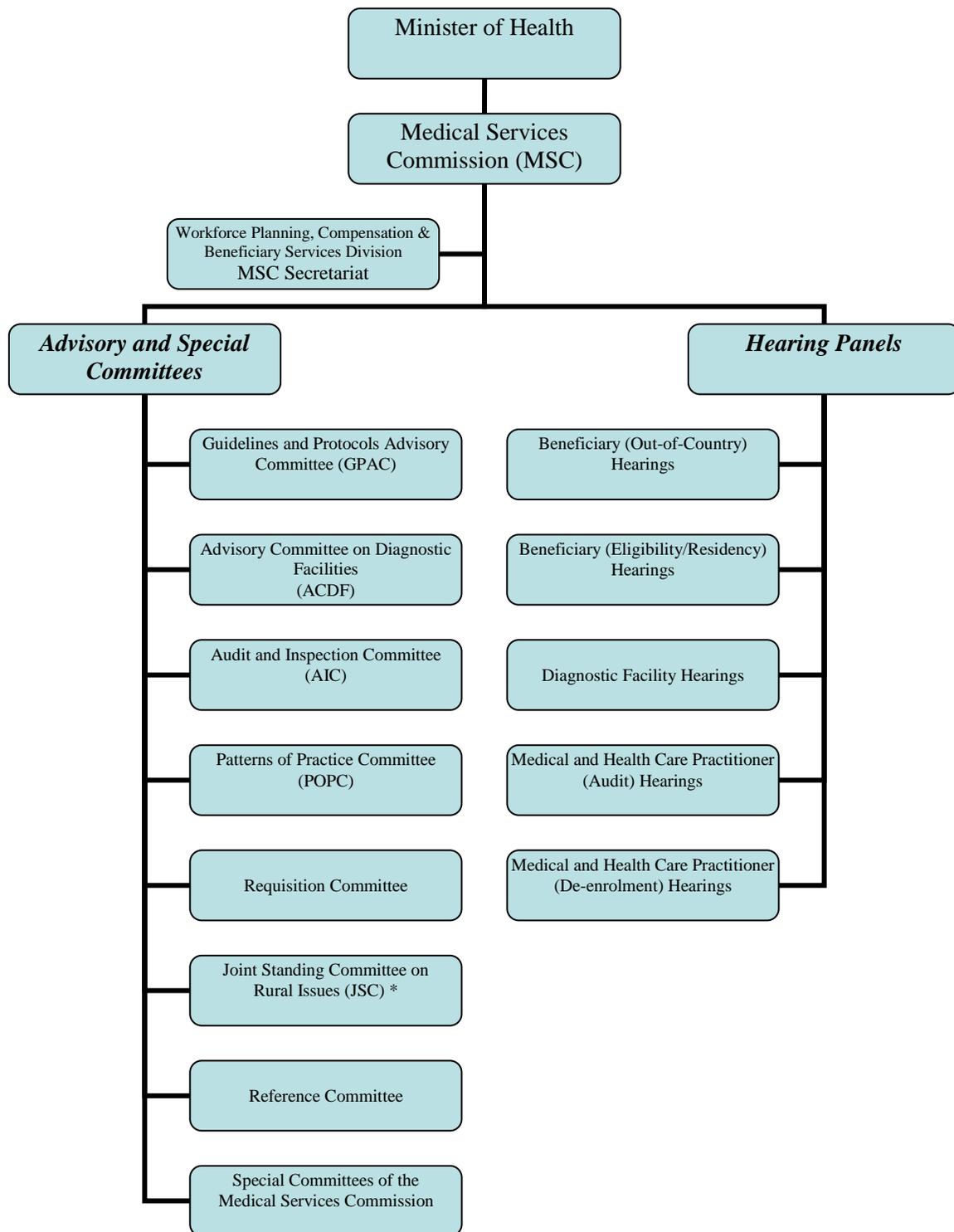
\* New OIC appointments – October 2016

#### **Public (Beneficiary) Representatives:**

- Dr. Jillianne Code\*
- Mr. Kenneth Werker\*
- Vacant

\* New OIC appointments – June 2016

**Appendix 2: Medical Services Commission Organization Chart**



\* Some of the funding for the work of the JSC comes from the Available Amount managed by the MSC.

***Appendix 3: Medical Services Commission Mailing Address and Website***

1515 Blanshard Street  
PO BOX 9649 STN PROV GOVT  
Victoria BC V8W 9P4

Telephone: 250 952-3126

Fax: 250 952-3268

Further information regarding the Commission can be found online at:  
[www.gov.bc.ca/medicalservicescommission](http://www.gov.bc.ca/medicalservicescommission).

