

MEDICAL SERVICES

COMMISSION

2017/2018

ANNUAL REPORT





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BRITISH
COLUMBIA

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Function

The function of the 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 must have regard to the principles of the *Canada Health Act* and the principle of sustainability. Consistent with these principles is the fundamental belief that access to necessary medical care be solely based on need and not on the individual's ability to pay. The Commission reports to the Minister of Health.

Organizational Structure

The Commission 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 establishing payment schedules for practitioners, administering the MPA, 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 under the Physician Master Agreement.

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 2017/2018 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. 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 2017/2018

The *Frailty in Older Adults – Early Identification and Management* guideline addresses the early identification and management of older adults with frailty or vulnerable to frailty. The guideline facilitates individualized assessment and provides a framework and tools to promote patient-centered strategies to manage frailty and prevent further functional decline. The primary focus of the guideline is the community-based primary care setting, although the tools and strategies included may be useful in other care contexts.

The *Ultrasound Prioritization* guideline summarizes suggested wait times for common indications where ultrasound is the recommended first imaging test. The purpose is to inform primary care practitioners of how referrals are prioritized by radiologists, radiology departments and community imaging clinics across the province.

The *Opioid Use Disorder* guideline presents recommendations for the diagnosis and management of opioid use disorder in primary care with a focus on induction and maintenance of buprenorphine/naloxone (Suboxone®) opioid agonist treatment for adults and youth ≥ 12 years. This guideline was developed in collaboration with the BC Centre on Substance Use.

Guidelines Under Development

The following existing guidelines were under revision during 2017/2018:

- *Thyroid Function Tests in the Diagnosis and Monitoring of Adults*
- *Vitamin D Testing Protocol*
- *Testosterone Testing Protocol*
- *Osteoporosis*
- *Iron Deficiency*
- *C-Reactive Protein (replacing Erythrocyte Sedimentation Rate)*

New guidelines under development during 2017/2018 included:

- *Adverse Childhood Experiences*
- *Prostate Cancer (in partnership with the Family Practice Oncology Network)*

- *Alcohol Use Disorder (in partnership with the BC Centre on Substance Use)*

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 2017/2018 were:

- *Bugs and Drugs*® - Alberta Health Services
- *Perinatal Guidelines and Standards* – Perinatal Services BC
- *BC Inter-professional Palliative Symptom Management Guidelines* – BC Centre for Palliative Care
- *Provincial Guidelines for Biopsychosocialspiritual Withdrawal Management Services* – BC Ministry of Health

Promotion and Education

To further GPAC's strategic goals of increasing the exposure of BC Guidelines and supporting evidence-based high-quality patient-centered care, GPAC participated in the following promotional activities during 2017/2018:

- BC Nurse Practitioners Conference
- UBC Family Practice Resident Scholarship Day
- BC College of Family Physicians Fall Conference
- BC College of Family Physicians 8th Annual Medical Student and Resident Conference
- St. Paul's Hospital Continuing Medical Education for Primary Care Physicians
- UBC Medical Student Preparation for Practice

Additional 2017/2018 GPAC Highlights

- The need was identified to determine a standardized approach to creating BC Guidelines patient materials. In the fall of 2017 and spring of 2018, work was done to explore whether GPAC should continue producing patient materials, and to propose a standardized approach. A recommendation and proposed strategy were presented to GPAC in January 2018. This included continuing to produce selected patient materials on a limited basis, best practices, and a development strategy. Feedback from the committee members is being incorporated into a final strategy which will be presented for approval in May 2018.
- A communications package including Key Messages, Issues and Responses, Guidelines in Action, Accomplishments and Priorities, an Overview Presentation and a Key 2017 Updates rack card were developed. The communications package was provided to Ministry of Health Senior leaders including Dr. Robert Halpenny, Chair of the Commission.
- GPAC has continued to strengthen relationships with stakeholder organizations and improve alignment.

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, 2017, and March 31, 2018, the ACDF considered 72 applications related to electrocardiography, pulmonary function, radiology, ultrasound, electromyography and polysomnography. Most 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, 60 requests were approved, 10 were recommended to the Commission for denial. The Commission upheld the denial of those 10 applications.

Ultrasound Policy Review

The Committee continued its work connected to the remaining requirements/policies that govern approval of both public and privately-owned diagnostic outpatient ultrasound facilities. At its June 28, 2017 meeting, the Commission directed that consideration be given to a rare exceptions requirement, as an exception to the general requirements for an ultrasound Certificate of Approval for privately-owned facilities. The Ministry proposed that a "rare exception" policy should be limited to the provision of Nuchal Translucency (NT) ultrasound performed by an appropriately qualified (non-radiologist) medical practitioner and would allow NT ultrasound in a standalone outpatient diagnostic ultrasound facility without radiologist oversight. At the September 13, 2017 meeting, the Commission reviewed the recommendation, but deferred decision pending further consideration.

Doppler Studies (ultrasound) policy recommendations were approved at the Commission's October 26, 2016 meeting but were operationalized in 2017. A second Doppler wait-time survey was completed in May/June 2017 as previous data was more than 18 months old. This study was intended to help assess the need for additional Doppler services and to establish wait-time parameters for the non-cardiac Doppler services under consideration for Community Imaging Clinics (CIC). CICs were surveyed to establish a sonographer inventory including: number of ultrasound machines; number of full-time and part-time sonographers; and the number of sonographers that also work in health authority facilities. This inventory was provided to BCIT and used to help establish a consistent clinical placement requirement, based on the number of ultrasound machines at a CIC. A mutually satisfactory clinical placement agreement was pre-requisite for facility consideration for approval of non-cardiac Doppler studies fee codes.

The Commission formally approved seven CIC facilities to perform four non-cardiac Doppler fee codes at its October 25, 2017 meeting.

Pulmonary Function Policy Review

A review of the current requirements/policies that govern approval of privately-owned diagnostic outpatient pulmonary function facilities was initiated in fiscal 2017/18. This review focused on the medical appropriateness of the current rules pertaining to the use of pulmonary function testing in the delivery of publicly-funded outpatient care in British Columbia. A written report was commissioned as part of this review and in November 2017, Dr. Vicki Foerster submitted “Review of pulmonary function in BC”.

The review identified five strategies to improve access and reduce wait times for spirometry testing in B.C. Dr. Foerster’s report was brought forward to the April 18, 2018 meeting of the Commission along with a Ministry of Health response to the report, which included preliminary policy analysis, a detailed high-level work plan and a timeline for bringing forward recommendations to the Commission. Work on pulmonary function policy continues, with recommendations to be presented to the Commission in November/December 2018.

Polysomnography

In response to information that polysomnography facilities must operate a minimum of three-beds per technician to be feasible, the Commission approved a recommendation to revise the Committee’s two-bed minimum requirement for a Certificate of Approval for overnight testing to three-bed minimum at the April 5, 2017 meeting. Applicants are now required to apply for a minimum of three beds for overnight sleep testing.

Electrocardiography (ECG)

The implementation of the *Laboratory Services Act* on October 1, 2015 (and the removal of laboratory services from the *Medicare Protection Act*), created a significant administrative load for the regulation of ECG. ECG, while delivered in laboratories, remained as a standalone diagnostic service under the authority of the Commission. This meant for each laboratory providing ECG services, a new diagnostic facility number needed to be created for each physical location providing ECG. Functionally, if a laboratory wished to relocate services to another location, one application must be submitted to move the facility’s laboratory services and a separate application to move its ECG services.

Complicating the matter, the Ministry had been unable to create a unique ECG billing code, resulting in all ECG diagnostic facilities continuing to be provided a number reserved for laboratory medicine facilities. This created ongoing confusion for Ministry staff when seeking to move a current laboratory facility approval, or when approving ECG as a new, standalone service.

The Commission considered four factors in favour of deregulating ECG services: (1) ECGs could be provided by any appropriately qualified practitioner on their own patients

without approval; (2) other more complex electrodiagnostic procedures are not regulated; (3) the Diagnostic Accreditation Program does not accredit facilities solely for provision of ECGs; and, (4) deregulation would significantly reduce administrative burden for Ministry staff and client applicants.

At its January 17, 2018 meeting, the Commission approved deregulation of this service, effective February 14, 2018.

Ultrasound Moratorium

On May 17, 2017, the Commission approved an extension to the temporary moratorium on applications for new, expanded or relocated outpatient diagnostic ultrasound facilities, until June 1, 2020. This extension continued to provide for exceptions to the moratorium, based on a criterion of “demonstrated urgent health or safety needs”.

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 on-site 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 2017/2018, the AIC received and approved 9 new audit referrals related to medical practitioners. Audit reports from 13 inspections were reviewed by the AIC during this period and 13 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 2017/2018, the AIC received and approved nine new audit referrals related to medical practitioners. 13 audit reports were reviewed by the AIC during this period and were all recommended for recovery. The BIP conducted nine on-site medical practitioner audits. It negotiated settlements for 18 cases with dollars equaling \$7,665,000. A total of \$8,571,604 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 2017/2018, the HCPSCAH received and approved three new audit referrals related to health care practitioners. An audit report from one inspection was reviewed by the HCPSCAH during this period and this case was recommended for recovery. The BIP conducted two on-site health care practitioner audits and negotiated settlements for two cases with dollars equaling \$300,000. A total of \$16,649 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 2017/2018, MSP received 12 new cases from the Doctors of BC, 8 of which are scheduled for referral to the Reference Committee in 2018/2019. During 2017/2018, the Reference Committee also closed 45 cases.

6. *Joint Standing Committee on Rural Issues*

Under the Rural Subsidiary Agreement (RSA), the Joint Standing Committee on Rural Issues (JSC) was established with the goal of enhancing the availability and stability of physician services in rural and remote areas of British Columbia. This is advanced by addressing some of the unique and difficult circumstances faced by physicians in these areas, and by enhancing the quality of the practice of rural medicine and services delivered to rural patients and communities.

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

The JSC currently oversees approximately \$140.6 million annually in rural incentives and programs to sustain patient care and continuity of access in communities falling under the *Rural Practice Subsidiary Agreement*. Approximately \$48.6 million for rural premiums are funded through the Available Amount.

The JSC is comprised of members from Doctors of BC and the Ministry of Health, including health authority representation. The JSC advises the BC Government, Doctors of BC and the health authorities on matters pertaining to rural medical practice.

In 2017/2018, the JSC implemented, supported and updated a number of initiatives, including:

- enhancing the valued rural locum programs by increasing daily rates based on their remoteness/rurality;
- implemented province-wide rural site visits to engage physicians and stakeholders;
- added 128 First Nations communities to the list of eligible Rural Subsidiary Agreement communities;
- activating and developing rural research nodes within three regions of BC in collaboration with the Rural Coordination Center of BC and the UBC Rural Chair,

- creating and funding rural research grants to support grassroots rural origin physician-led research initiatives;
- provided on-going full financial support and resourcing, physician leadership and representation, to the Practice Readiness Assessment (PRA-BC) Program including the Steering Committee/Exams and Evaluations; and
- implemented an initiative to support those physicians providing Medical Assistance in Dying (MAiD) services in and to rural communities by removing barriers of travel expenses and funding and supporting physician mentoring to increase access to care.

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.

In the Government of BC's *Budget 2017 Update*, changes to MSP premiums were announced that came into effect January 1, 2018. The changes resulted in MSP premiums being reduced by 50 percent and an increase in the income threshold for households to be exempt from MSP premiums.

The Regular Premium Assistance program 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. The qualifying threshold was increased by \$2,000, which means that families with an annual adjusted net income of \$26,000 or less will pay no MSP premiums.

In 2017/2018, the MSP paid approximately 19,355 medical and health care providers 3.2 billion (or \$3,208,847,100) dollars relating to nearly 100 million (or 100,243,899) 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.

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

New and returning residents are required to complete a wait period before provincial publicly 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 117 waiver of the wait period requests between April 1, 2017, and March 31, 2018, and granted 7 approvals.

108 waiver requests were denied in 2017/2018 including 11 applications from new residents related to pregnancy and prenatal care during the wait periods (2 were sponsored). 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. 95 denials were related to conditions that were not diagnosed in the wait period and/or were not financially devastating (15 were sponsored). Of the 108 waiver requests, 9 were not MSP benefits; the requests were for palliative care or community care which is paid through the Health Authorities.

Two waiver requests were undecided in 2017/2018 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 728 residency cases between April 1, 2017, and March 31, 2018, verifying BC residences for 100 cases. 496 non-resident accounts were identified, resulting in MSP account cancellations totaling \$4,459,770 in hospital, MSP and PharmaCare recoveries.

In 2017/2018, the Commission received 29 new requests for eligibility (residency) hearings. Seven in-person hearings and 17 written hearings were held during this period, including some cases carried forward from previous fiscal years. Two hearing requests were withdrawn and six were cancelled in 2017/2018. The Commission rendered 26 residency decisions and 12 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, 2017, to March 31, 2018, BSB received 3,504 applications for out-of-country, elective medical treatment. BSB approved provincial coverage for 3,273 applications and provincial coverage was denied for 231 applications. The Commission

currently has one 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 and no hearings were held in 2017/2018.

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 2017/2018, there was one audit hearing related to medical practitioners.

De-enrollment of Medical Practitioners for “Cause”

In 2017/18, three medical practitioners were de-enrolled for “cause”.

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 health care practitioners and the Commission to reach a negotiated settlement of s.37 disputes.

In 2017/2018, there were no audit hearings related to health care practitioners.

De-enrolment of Health Care Practitioners for “Cause”

In 2017/2018, one de-enrolment of a health care practitioner for “cause” was reached through settlement.

Other 2017/2018 Commission Highlights and Issues

The Commission held eight regular business meetings between April 1, 2017 and March 31, 2018.

- ***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 2017/2018, 78 MoCs related to the *MSC Payment Schedule* were approved, resulting in 57 new fee items. Two MoCs introduced new General Practice Services Committee (GPSC) fees and five GPSC fees were deleted.

Following a report from the Auditor General, MSP has obtained agreement with each section that all fee items with a time requirement have documentation of the start and end time recorded as part of the claims information. This requirement will result in consistent time-related reporting, improve billing accuracy and efficiently identify inappropriate billing, and reduce need for full on-site audits. As a result, 131 fee items had a note added requiring start and end times be entered into the billing claim and patient's chart.

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 2017/2018 at a strategic planning session held in April 2017.

The Commission's objectives for 2017/2018 involved:

- facilitating reasonable access to quality medical care;
- managing and monitoring the Available Amount;
- administering the MPA;
- hearing appeals initiated by beneficiaries, diagnostic facilities or physicians; and
- arbitrating disputes between the Doctors of BC and the Government of BC in relation to the PMA and facilitating adherence to the agreement.

Some strategies for the Commission included:

- aligning the efforts of the working group;

- establishing full Commission membership;
- aligning the efforts of the working committees with the “Triple Aim”: experience of the patient, experience of the practitioner, cost effective and high quality as related to the cost;
- introducing tools to help practitioners;
- implementing an advised audit approach;
- confirming the process for referrals to the Special Investigations Unit;
- completing audits of private clinics;
- establishing measures of hearing timeliness and process; and
- ensuring that provisions in the PMA agreement are completed.

- ***BC Services Card***

The BC Services Card (BCSC) project was initiated in 2009 to create a provincial identity solution and to replace the BC CareCard with security-enhanced photo identification. The project is a partnership involving the MoH, the Ministry of Citizens Services and the Insurance Corporation of BC. In February 2013 the BCSC launched with a five-year planned rollout. By February 2018, it was anticipated that a majority of BC residents would obtain a BCSC. As of March 31, 2018, 90% of MSP beneficiaries had been issued a BCSC.

In 2017/18, a major focus of activity was ensuring that BC residents are notified of the expectation that they renew their enrollment in the MSP and obtain a BCSC. On February 22, 2018 MoH and HIBC introduced policies related to Two-Step Enrolment and Modified Enrolment and Renewal of Enrolment. Following implementation of these policies, the BCSC project began transitioning the project in to operations.

- ***Presentations to the Commission***

Throughout 2017/2018, the Commission received presentations on several additional issues including:

- An overview of the significant elements related to virtual care including new models of care, compensation models, clinical and professional standards, supporting technology, virtual care framework options, development of policy directions, and security of personal health information;
- A briefing on the provincial Surgical Services Strategy including the concept of catching up and keeping up with surgical demand and improving the patient experience through clearer navigation of the system and easy to understand information;
- An overview of the BC Patient Safety and Quality Council highlighting the council’s history, the scope of their mandate, their philosophy, examples of how the philosophy is put into action and priorities for the coming years;
- The responsibilities of the College of Physicians and Surgeons of BC and their current priorities. An update on the College’s Prescription

Monitoring Program and implementation of two-factor billing was provided;

- An update on the BC Services Card project including corporate goals, legislative framework and statistics;
- An overview of the Medical Imaging Access and Quality Improvement Project; and
- A briefing on the BC Health System Strategy highlighting the two areas of strategic focus which include primary and community care and access to surgical services.

- ***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 2017/2018.

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 a power for the Commission the power to seek an injunction from a Court regarding contravention of certain stated provisions, including the prohibition against extra billing (s. 45.1).

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 2017/2018, the Commission commenced audits of three private clinics to determine compliance with the extra billing provisions of the MPA.

Multiple additional extra billing clinic audits ordered by the Commission remained pending during 2017/2018.

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 2017/2018.

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 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 resumed in April 2018.

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.

In May 2017, PCRM amended its petition to seek judicial review of the Commission's December 9, 2015, decision to deny the application.

The Court hearing for the judicial review occurred in late-March 2018, and the judge reserved his decision.

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. The settlement of this matter concluded in mid-2017.

Appendices

Appendix 1: Members of the Medical Services Commission as of March 31, 2018

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 Crown Agencies and Board Resourcing and Office's website at <https://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/central-government-agencies/crown-agencies-and-board-resourcing-office>.

Government of British Columbia Representatives:

- Dr. Robert Halpenny (Chair)
- Dr. Heather Davidson (Deputy Chair) *(new OIC appointment December 2017)*
- Mr. Colin Kinsley

- Alternate Members:
 - Ms. Stephanie Power (1st Alternate) *(new OIC appointment May 2018)*
 - Dr. Ian Rongve (2nd Alternate) *(new OIC appointment May 2018)*
 - Ms. Marie Ty (3rd Alternate) *(new OIC appointment May 2018)*

Doctors of BC Representatives:

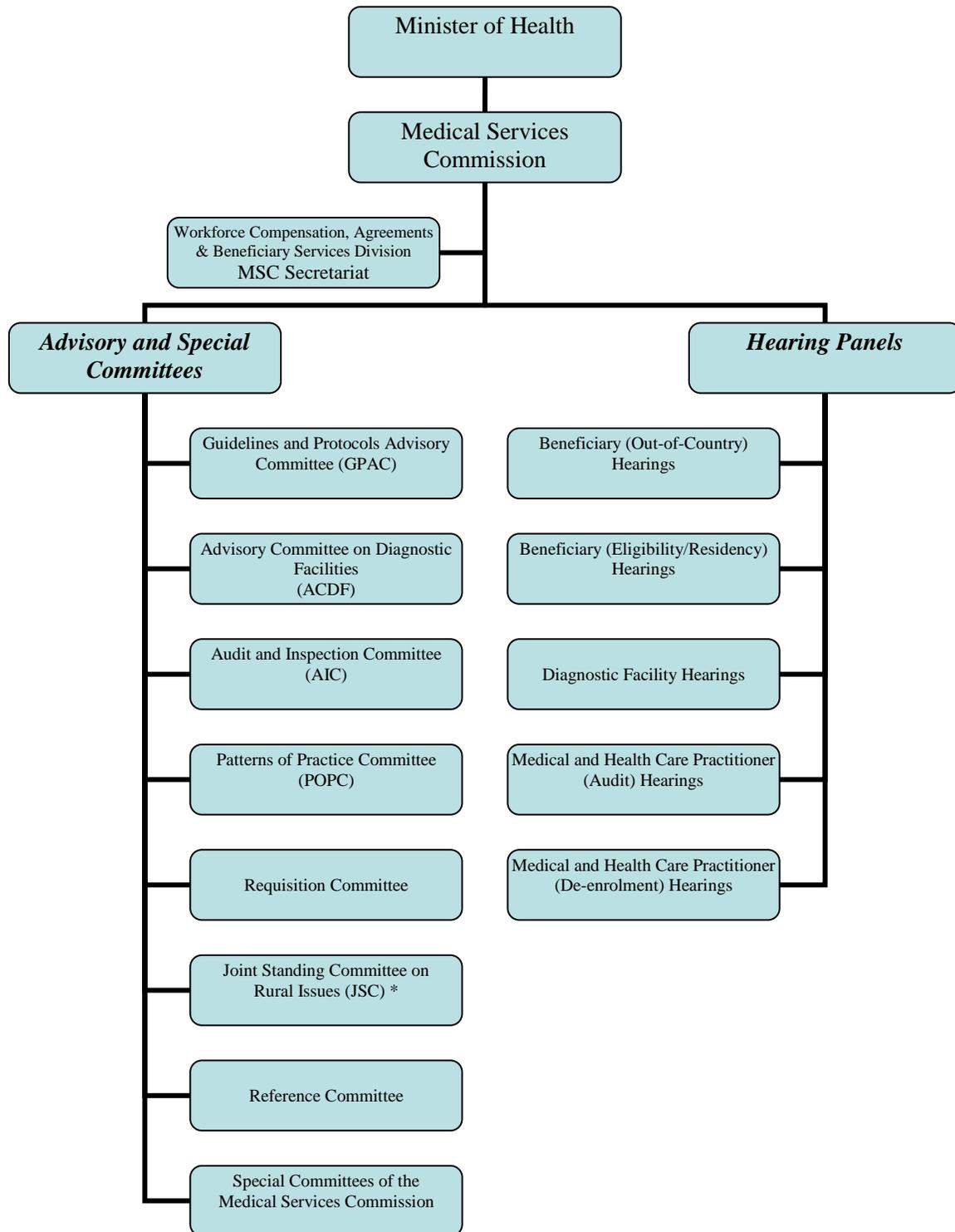
- Dr. William Cavers *(new OIC appointment September 2017)*
- Dr. William Rife
- Dr. Matthew Chow

- Alternate Members:
 - Dr. Alan Ruddiman (1st Alternate) *(new OIC appointment September 2017)*
 - Dr. Eric Cadesky (2nd Alternate) *(new OIC appointment September 2017)*
 - Mr. Allan Seckel (3rd Alternate)

Public (Beneficiary) Representatives:

- Ms. Ellen Godfrey *(new OIC appointment December 2017)*
- Mr. Kenneth Werker
- Vacant

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 Medical Services Commission.

Appendix 3: Medical Services Commission Mailing Address and Website

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

Email: MSC@gov.bc.ca

Fax: 250 952-3268

Further information regarding the Commission can be found online at:
www.gov.bc.ca/medicalservicescommission.