THIS AGREEMENT DATED the ___ day of October, 2019

PHYSICIAN SERVICES MASTER AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA, as represented by the Minister of Health and Wellness ("**DHW**")

OF THE FIRST PART

-and-

DOCTORS NOVA SCOTIA, as represented by the President of Doctors Nova Scotia ("**DNS**")

OF THE SECOND PART

AGREEMENT PREAMBLE

Whereas DHW has the power, pursuant to the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended, to negotiate in good faith compensation for Insured Medical Services with professional organizations representing providers and may establish fees or other systems of payment for Insured Medical Services and, with the approval of the Governor-in-Council, may authorize payment in respect thereof;

And Whereas pursuant to the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, Doctors Nova Scotia is recognized as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia;

And Whereas the Parties acknowledge that DHW has an obligation to maintain and improve the health status of the population, to determine service organization, and to determine the allocation of provincial funding for health services consistent with this Agreement;

And Whereas the Parties agree that the Health Authorities are responsible for regional service planning and operations and allocation of fiscal, human and capital resources to meet the health service needs of Insured Residents;

And Whereas the parties, together with the Health Authorities, wish to continue to work together in a relationship built upon transparency, constructive collaboration and mutual respect;

THEREFORE in consideration of the terms of this Physician Services Master Agreement (the "**Agreement**"), the Parties agree as follows:

1. DEFINITIONS

In this Agreement:

(a) "**2008 Master Agreement**" means the Physician Services Master Agreement executed by the Parties in October 2008, as amended;

(b) "**Act**" means the *Health Services and Insurance Act*, 1989, R.S.N.S., c.197, as amended;

(c) "**Agreement**" means this document including all Schedules as amended from time to time in accordance with this Agreement;

(d) "**Family Physician**" means a physician registered with the College of Physicians and Surgeons whose name does not appear on the Medical Specialist Register, but includes those who have either a CCFP or CCFP-EM certification and shall include General Practitioners;

(e) "**Fee Committee**" means the Fee Committee as outlined in Article 4.1(c) of this Agreement;

(f) "**Health Authorities**" means the Nova Scotia Health Authority as defined in the *Health* Authorities *Act, S.N.S. 2014, c. 32*, and the IWK Health Centre;

(g) "**Insured Medical Services**" means insured medical services that Insured Residents are entitled to receive under the provisions of the Act and the regulations made pursuant thereto;

(h) "**Insured Residents**" are Residents of Nova Scotia as defined by the Act and the regulations made pursuant thereto;

(i) "**MAMG**" means the Master Agreement Management Group as outlined in Article 5 of this Agreement;

(j) "**MSI**" means the Medical Services Insurance program, administered on behalf of the Province, for the payment to Physicians for providing Insured Medical Services pursuant to the Act;

(k) "**MSI Physician's Manual**" means the document that contains the Preamble and Insured Medical Services, including their descriptions and codes, any special conditions and their value in units;

(l) "**New MD Committee**" means the joint DHW/IWK/NSHA committee that makes decisions about funding requests for new MD positions.

(m) "**New MD Priority Setting Committee**" means the joint Committee of the NSHA/IWK that reviews requests for new MD positions that represent an increase to the approved complement for a department/division and creates a priority listing of those positions which is forwarded onto the New MD Committee for final decision. The New MD Priority Setting Committee includes two representatives named by DNS, one urban and one rural.

(n) "**Physician**" means a medical practitioner under the *Medical Act*, S.N.S. 1995-96, c. 10 as amended, of Nova Scotia who is licensed by the College of Physicians and Surgeons of Nova Scotia to practice medicine in the Province, in good standing and not subject to any suspension of license;

(o) "**Preamble**" means the Preamble to the MSI Physician's Manual that provides the billing rules and is the authority for the proper interpretation of the Insured Medical Services;

(p) "**Resident Physician**" is a Physician registered with the College of Physicians and Surgeons in an educational category of the Medical Register and registered at a recognized university in Canada in a postgraduate course of study in medicine;

(q) "**Sessional Rate**" means the fee paid for eligible medical services of a Physician engaged on a time basis;

(r) "**Specialist**" means a Physician registered with the College of Physicians and Surgeons whose name appears on the Medical Specialist Register of Nova Scotia, excluding those who have either a CCFP or CCFP-EM certification;

(s) "**Tariff**" means the system of payment for Insured Medical Services as outlined in the MSI Physician's Manual and defined in the Act;

(t) "**Unit Value System**" means the representation of the actual fees for Insured Medical Services by separate unit categories: the Medical Service Unit (MSU) and the Anaesthesia Unit (AU);

(u) "**Year**" means the fiscal year of the Province of Nova Scotia, from April 1 to March 31.

2. TERM OF AGREEMENT

(a) This Agreement shall take effect on April 1, 2019 and continues to remain in force and effect for a period of four (4) years, terminating on March 31, 2023.

(b) The rate increases in Article 4.1(b)(i) will take effect on April 1, 2019; all other elements of this Agreement will take effect upon execution by both parties, or as otherwise stated herein.

(c) This Agreement and the attached Schedules constitute the whole Agreement between the parties unless duly modified in writing and signed by both parties. No representation or statement not expressly contained herein will be binding upon any party.

(d) Upon termination of this Agreement, the Tariff and the provisions of Articles 4.1(e) and 4.1(k) shall remain in effect until such time as the Parties agree upon a new Agreement, or a new Agreement is established. Further, for the purposes of this Agreement all other provisions shall continue after termination until such time as the Parties agree upon a new Agreement, or a new Agreement is established.

3. RESPONSIBILITIES OF THE PARTIES

(a) DNS recognizes that DHW oversees and directs funding for the health care system across the Province, within the limits of a budget that is a portion of provincial program spending allocated to DHW by the Nova Scotia Legislature and Department of Finance.

(b) DNS agrees to co-operate with the Health Authorities in facilitating the delivery of Insured Medical Services and will take all appropriate measures to encourage Physicians to comply with applicable agreements.

(c) Pursuant to section 7 of the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12, as amended 2012, c.26, and other applicable authority, DHW recognizes DNS as the sole bargaining agent for any and all duly qualified medical practitioners in the

Province of Nova Scotia who provide Insured Medical Services that are funded through DHW and/or a Health Authority.

(d) DHW and DNS agree to negotiate in good faith and make every reasonable effort to conclude a subsequent agreement prior to the expiry of this Agreement.

4. PHYSICIAN COMPENSATION, INVESTMENTS, AND INITIATIVES

4.1 General and Fees

(a) **Unit Value System**

(i) All costing, payments and statistical analysis will be based on "date of service" and more specifically, the Tariff in place on the date the Insured Medical Service is provided.

(ii) The portion of the Tariff, which includes the Preamble and the Insured Medical Services agreed to pursuant to the Act, will continue to be published with the actual fee represented in units and will be formalized in regulations made pursuant to the Act, as necessary. The Tariff in effect as of April 1, 2019 shall remain in effect except to the extent altered by the terms of this Agreement.

(iii) The units will continue to be categorized as follows:

(A) Medical Service Units (the "MSU") for all Insured Medical Services except anaesthesia services; and

(B) Anaesthesia Units (the "AU") for all anaesthesia services.

(iv) As of March 31, 2019 the MSU value was 2.48 and the AU value was 21.07.

(b) **Rate Increases**

(i) The following annual increases will apply to the MSU, the AU, the Sessional hourly rates, the Intensive Care Unit ("ICU") minimum income daily guarantees, the Emergency Department ("ED") hourly rates, the Psychiatry hourly rates, the Collaborative Emergency Centre ("CEC") rates, the Regional Hospitalist daily stipend rates, the Community Hospital Inpatient Program daily stipend rates, the Primary Maternity Care Program hourly rates, the Pathology List B payments and Alternative Payment Plan (APP) annual rates effective April 1 of each year of this Agreement, once each item is implemented and effective:

Fiscal Year	Rate Increases
April 1, 2019 – March 31, 2020	2%
April 1, 2020 – March 31, 2021	2%
April 1, 2021 – March 31, 2022	2%
April 1, 2022 – March 31, 2023	2%

(ii) The rates in effect as of April 1, 2019 are as outlined in Schedule "A" to this Agreement.

(c) **Fee Schedule Adjustments and New Fees**

(i) The Fee Committee (FC) will review requests for new fees, to amend current fees, and for additions, revisions or clarifications of the Preamble to the MSI Physician's Manual, including any changes to the wording of the MSI Physician's Manual that may be needed as a result.

(ii) The Fee Committee will be governed by the terms of reference for the Fee Committee in effect as of March 31, 2019, unless amended by FC.

(iii) Notwithstanding (ii) above and (iv) below, Fee Committee shall have decision-making authority to approve adjustments to the fee schedule for all items where the Committee reaches consensus and for which the Committee has sufficient budget. Items which exceed the Committee's budget or about which the Committee is not able to reach agreement will proceed to the MAMG for decision.

(iv) The Parties agree that $1.5 million shall be provided by DHW to the Fee Committee on April 1, 2021 exclusively for new fees, fee adjustments or preamble changes in response to applications.

(v) The Parties agree that base funding will not be reduced as a result of unspent fee schedule funding in a year**.** The Fee Committee shall, by October of each year and periodically thereafter as requested by MAMG, notify the MAMG of any projected funds that may be unused each fiscal year.

(d) **Alternate Payment Plans**

Per the Memorandum of Agreement regarding governance attached in Schedule "F", the Parties agree to negotiate a framework for contracting physicians on Alternative Payment Plans.

(e) **Canadian Medical Protective Association ("CMPA") Assistance**

(i) DHW agrees to continue to provide funding for CMPA reimbursement in accordance with the following criteria:

(A) All Resident Physicians who are funded by the Province will continue to receive full reimbursement of their CMPA premium fees unless in future they receive funding or coverage for this purpose from another source; and

(B) All other Physicians will be eligible to receive a reimbursement of 90% of their CMPA premium fees in excess of $1,750.

(ii) Reimbursement will be paid directly by DHW to eligible physicians based on electronic submission of information received from CMPA. DHW will communicate a payment schedule to Physicians and payments will be made on a timely basis and consistent with that schedule.

(f) **Targeted Investments**

The Parties have agreed to make Targeted Investments as outlined in Schedule "I".

(g) **Continuing Medical Education**

DHW will maintain current funding and criteria for the Professional Development Support Programs as outlined in the 2008 Master Agreement for both Family Physicians and Specialists. DHW may randomly withhold annual payments to select physicians pending submission of supporting documentation that CME activities were undertaken in order to substantiate payment.

(h) **Electronic Medical Record (EMR)**

DHW will provide a one-time Physician-specific EMR Investment Grant of $10,000 (Envelope "A" as outlined in Schedule "I" of the 2008 Master Agreement), for both Family Physicians and Specialists. The eligibility criteria for this Grant in effect at the time of execution of this Agreement shall continue unless changed by MAMG.

(i) **Continuity of Fees and Programs under the Expired Master Agreement**

The Parties agree that certain programs from the expired Master Agreement will be transitioned to fee codes, and others will continue in their current state, all as outlined in Schedule "B" to this Agreement.

(j) **Targeted Project Funding**

DHW agrees to provide targeted project funding in accordance with Schedule "C".

(k) **Benefits**

(i) DHW will fund 65% of all premiums paid to provide health and dental coverage in accordance with the plan in effect upon execution of this Agreement, and 100% of parental leave and professional support program (EAP type) expenses. Any benefits changes which result in increased premiums require approval of DHW to be eligible for continued financial support.

(ii) DHW will reimburse DNS based on monthly invoicing.

(iii) DHW will pay an administration fee of $300,000 per year, which represents 4% of the benefits program value of $7,500,000, payable to DNS monthly, in advance.

(iv) For the Health and Dental Program, the waiting period will be reduced from 180 days to 90 days.

(v) For the Parental Leave Program:

a. The billing cap will be increased from $1,000/month to $1,200/week;

b. Eligibility for the full benefit will be changed from two years to a billing threshold. Physicians must have clinical insured billings (or alternate payment plan or clinical/academic funding plan payments) exceeding $50,000 for the previous fiscal year; and

c. The value of the benefit will increase from $1,000/week to $1,500/week.

(l) **Remit Payments to DNS**

DNS may, at its sole discretion, direct DHW to remit any payments owing to an individual Physician under this Agreement to DNS in the event that the Physician has failed to pay their required DNS dues in a timely manner. Such payments could include any of the payments pursuant to this Article 4. DNS agrees that DHW is in no way liable for the remittance, nor for any challenges, legal or otherwise associated with them. In the event that DHW has engaged a third party to administer payments, DHW agrees to make every reasonable effort to effect any remittance requests through that third party. Any costs associated with these requests shall be the sole responsibility of DNS. DNS may choose to recover those costs from the Physician in question, as determined by DNS.

(m) **Community Hospital Inpatient Program**

A Memorandum of Agreement regarding the Community Hospital Inpatient Program is attached in Schedule "G". Funding for the Program will take effect on July 1, 2019.

(n) **Primary Maternity Care Model**

The Parties agree to develop a Primary Maternity Care Model, as outlined in Schedule "H".

(o) **Physician Administrative Review**

DHW will review current physician administrative requirements in an effort to reduce unnecessary administrative burden and maximize physician resources to support public policy health objectives.

5. GOVERNANCE

5.1 A Memorandum of Agreement regarding governance is attached in Schedule "F".

5.2 A Master Agreement Management Group (MAMG) will be established to oversee the implementation and operation of this Agreement. The terms of reference and decision making will be as outlined in Schedule "D".

6 ACCESS TO INFORMATION

6.1 The Parties agree to share relevant information that is requested by a Party. Relevant historical and predicative data prepared by any Party will be fully shared. In cases where the information is not readily accessible or is not provided on request, the matter may be referred to the MAMG.

6.2 DNS will be provided with electronic access to information on a monthly basis regarding Fee-For-Service billings and other payments made by DHW for Insured Medical Services, including the DHW's spreadsheets for Health Service Code, Physicians Payments and Physician Payments by Service Location and, upon request by DNS, electronic access will be provided to other routinely provided DHW information which is in relation to Fee-For-Service billings and other payments made by the DHW including utilization and cost information. The Parties agree that this information will not be in patient identifiable form. DHW agrees to consider all reasonable requests from DNS for changes to the format of this data.

6.3 Notwithstanding the general provisions in Articles 6.1 and 6.2, DHW and DNS will develop a Data Sharing Agreement, which will include the ability to share physician-identifiable information, that will take precedence to the extent of any conflict.

7. PHYSICIAN RESOURCES

7.1 NEW MD COMMITTEE: Over the period of this Agreement, the Department of Health and Wellness will provide $9,050,000 to the New MD Committee (or its equivalent) for recruitment of new physicians on a provincial basis, including C/AFP, fee for service and Alternative Payment Plan physicians, as follows:

Fiscal Year	Amount
April 1, 2019 – March 31, 2020	0
April 1, 2020 – March 31, 2021	$3,650,000
April 1, 2021 – March 31, 2022	$2,750,000
April 1, 2022 – March 31, 2023	$2,650,000

7.2 Effective April 1, 2020, the following six (6) physician FTEs will be funded from the New MD Committee funding outlined in clause 7.1:

Department	FTE
C/AFP Department of Medicine, Central Zone	2.0 Medical Oncologists
C/AFP Department of Diagnostic Imaging, IWK	1.0 Radiologist
Department of Medicine, Eastern Zone	1.0 Physiatrist
C/AFP Department of Radiation Oncology, Central and Eastern Zones	2.0 Radiation Oncologists

7.3 Over the period of this Agreement, the equivalent of the cost of 3.0 FTE from the New MD Committee funding outlined in clause 11.3 of the C/AFP Agreement will be made available to C/AFP and fee for service academic departments to offset some of the increased resources required to comply with the Royal College's competency based medical education standards. The funding will be allocated to the academic departments at the discretion of the Dean of the Faculty of Medicine, in consultation with the Committee of C/AFP Department Heads.

7.4 MURRAY HYBRID FORMULA REVIEW: The Parties agree to periodically review the Murray Hybrid formula in place in Nova Scotia. A subcommittee of the New MD Committee will conduct the reviews and make recommendations to the New MD Committee. The subcommittee will include representation of emergency department physician leaders from at least two zones.

8. CLINICAL ACADEMIC FUNDING PLANS AND ALTERNATIVE PAYMENT PLANS

Payments to Physicians pursuant to Clinical Academic Funding Plans or Alternative Payment Plans are payments for Insured Medical Services that are not included in the

Tariff or in the amendments to the Tariff provided for in this Agreement. In the event that a Clinical Academic Funding Plan or Alternative Payment Plan contract is terminated or upon the expiration of any such contract, not renewed or re-negotiated, payment to Physicians for the provision of Insured Medical Services will be made pursuant to the Tariff. Privileges for the same geographic location cannot be withdrawn from or denied to Physicians by DHW or the Health Authorities in these circumstances.

9. AUDITS

9.1. DNS agrees that the DHW has the right to conduct audits of Physicians with respect to claims for Insured Medical Services including claims submitted by Physicians pursuant to Clinical Academic Funding Plan and Alternative Payment Plan contracts, within the terms outlined in Schedule "E" to this Agreement. All other contractual performance and compliance issues affecting Clinical Academic Funding Plan and Alternative Payment Plan Physicians shall be resolved pursuant to the terms of those contracts.

9.2. The Parties agree that per the Preamble to Schedule "E" an important focus of billing audits is to educate physicians on proper billing practices. It is agreed that first-time audits (e.g., an audit of a physician for the first time on a given fee code) will be primarily for the purposes of education, with a commitment to discuss with the physician the appropriate use of that code and what needs to be documented to support it. If MSI believes there is evidence of fraud, or evidence to suggest that a physician knowingly or intentionally disregarded billing rules, MSI will be permitted to pursue clawback of funds paid to the physician, and the physician will be permitted to challenge the audit findings through Schedule E of this Agreement. The Master Agreement Management Group will establish an Audit Committee to review the audit process and make recommendations on (1) criteria that should govern first-time audits, and (2) administrative penalties to be levied in the event of documentation and/or administrative errors in billing. The Committee will provide a report to MAMG within six months of the execution of this Agreement.

10. NOTICE

a) All notices, requests, demands or other communications (collectively, "Notices") required or permitted to be given by one Party to the other Party pursuant to this Agreement shall be given in writing by personal delivery or by registered mail, postage prepaid, or by facsimile transmission to such other Party as follows:

If to DHW:	Minister of Health and Wellness
With a copy to:	Deputy Minister of Health and Wellness
If to DNS:	President of DNS
With a copy to:	Chief Executive Officer

b) All Notices shall be deemed to have been received when delivered or transmitted, or, if mailed, Forty Eight (48) hours after 12:01 a.m. on the day following the day of the mailing thereof. If any Notice has been mailed and if regular mail service is interrupted by strikes or other irregularities, such Notice shall be deemed to have been received

Forty Eight (48) hours after 12:01 a.m. on the day following the resumption of normal mail service, provided that during the period that regular mail service is interrupted all Notices shall be given by personal delivery or by facsimile transmission.

11. AMENDMENTS

a) This Agreement may be amended upon Notice at any time by the mutual written consent of the Parties.

b) No amendment or modification of this Agreement will become effective unless reduced to writing and duly executed by the Parties hereto.

12. CONSEQUENTIAL AMENDMENTS

The Parties agree that the Preamble, the Fee Schedule and any fee codes will be amended where necessary, to implement this Agreement.

13. GOVERNING LAW

This Agreement will be governed by, and construed in accordance with, the laws of the Province of Nova Scotia.

14. HEADINGS

The headings of the Articles of this Agreement have been inserted for reference only and do not define, limit, alter or enlarge the meaning of any provision of this Agreement.

15. ENTIRE AGREEMENT

a) This Agreement and the attached Schedules constitute the whole of the Agreement between the Parties unless duly amended as provided in Article 11.

b) No representation or statement not expressly contained in this Agreement will be binding upon any Party.

16. BENEFIT AND BINDING

This Agreement shall enure to the benefit of and be binding upon the Parties hereto and their respective successors and assigns.

Dated at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia, on this ___ day of October, 2019.

SIGNED, SEALED AND DELIVERED in the presence of

_____
Witness

_____
Witness

_____
Witness

HER MAJESTY THE QUEEN in right of the Province of Nova Scotia as represented in this behalf by the Department of Health and Wellness

_____
Minister of Health and Wellness

_____
Date

DOCTORS NOVA SCOTIA

_____
Per:
President

_____
Date

_____
Per:
Chair, Board of Directors

_____
Date

SCHEDULE "A"

RATES EFFECTIVE APRIL 1, 2019

A. Sessional hourly rates: $151.80 for Family Physicians and $177.10 for Specialists.

B. ICU minimum daily income guarantee: $2,143.59.

C. Regional Hospitalist Program Daily Rate: $1,345.89/day.

D. Psychiatry hourly rates: $156.74 for certified and $115.60 for non-certified.

E. Emergency hourly rates: $200.77 for regional sites, $187.70 for Cobequid, $174.66 for other hybrid funding sites, $135.94 (daytime) and $154.31 (nighttime) for Level 3 sites, and $77.18 for Level 4 sites on-call.

F. GP Alternative Payment Plan annual rate (solo): $254,791, GP Alternative Payment Plan annual rate (collaborative): $262,059, GP Alternative Payment Plan annual rate (12 week contract): $66,467, GP Alternative Payment Plan annual rate (6 Month): $127,396, and GP Alternative Payment Plan annual rate (Other Family Physician): $246,426.

G. Palliative Care/Geriatrics Alternative Payment Plan annual rates: $262,059 for Family Physicians with no additional training, $268,778 for Family Physicians with post-graduate certification, and $289,114 for certified Specialists.

H. Neonatology Alternative Payment Plan annual rate: $296,735.

I. Obstetrics/Gynecology Alternative Payment Plan annual rate: $346,546.

J. Pediatrics Alternative Payment Plan annual rate: $299,142.

K. Anesthesia Alternative Payment Plan annual rates: $293,044 for Category 1 and $277,089 for Category 2.

L. CEC hourly funding rate: $151.92/hr.

SCHEDULE "B"

TRANSITION AND CONTINUATION OF

2008 MASTER AGREEMENT PROGRAMS

I. PROGRAMS TRANSITIONING TO FEE-BASED INITIATIVES

a) The funding for the following programs will transition to fee-based initiatives:

   i) Collaborative Practice Incentive Program;

   ii) Electronic Medical Records Envelopes B and C (collectively, the "Transitioning Programs").

b) The Fee Committee will be provided with the budget applicable to these Transitioning Programs and the Committee will decide on appropriate fee codes and fee values to support physicians in providing care. First priority areas will be collaborative practice and utilizing electronic medical records. The Fee Committee and/or MAMG may establish working groups to provide advice on the Transitioning Programs and fee codes.

c) The Transitioning Programs shall end when new fees are approved by the Fee Committee or MAMG (on referral from Fee Committee) and put in effect by DHW.

II. PROGRAMS CONTINUING IN MODIFIED FORM

Rural Specialist Retention

a) The Rural Specialist Retention Incentive Program will continue in its current form, subject to the following changes:

   i) The payment to each qualifying specialist will increase to $12,000 effective the date of approval of this Agreement by the DNS Board of Directors, and to $16,000 effective April 1, 2021.

Facility On-Call

a) The Facility On-Call program rates will continue in its current form. All approved on-call rotas will be reviewed by the Health Authority to ensure they align with patient care and service coverage requirements. All required rotas continue to be funded (unless determined to no longer be required) and other eligible rotas are able to be funded through the program. Effective upon approval of this Agreement by the DNS Board of Directors, Alternative Payment Plan Specialists will be eligible to bill fee for service for all services provided while on-call. This includes but is not limited to Obstetric

Gynecology, Pediatrics, Geriatrics, Palliative Care, Neonatology, Critical Care/ICU, Medical Oncology, Hematology and Anesthesia.

III. PROGRAMS CONTINUING IN CURRENT FORM

a) All other fee-based and program funding in effect on the date of execution of this Agreement shall continue with the same terms and conditions as those in effect on the date of execution, unless the Parties agree otherwise. This includes but is not limited to the following programs, some or all of which may be reviewed by MAMG:

i) GP Surgical Assist Program;
ii) Nova Scotia Provincial Locum Program and Enhanced Locum Program;
iii) Emergency Department Services and Compensation;
iv) Regional Hospital Intensive Care Unit Payment Plan;
v) Evening and Weekend GP Office Visit Incentive;
vi) Continuing Care;
vii) MyHealthNS stipend;
viii) Regional Hospitalist Model;
ix) Family Physician Alternative Payment Plan 5.6% Incentive (per March 2018 commitments).

SCHEDULE "C"

TARGETED PROJECT FUNDING

Goal: Targeted funding must be accountable to Nova Scotians and support quality patient care and system priorities.

Parameters for all Project Funding

- Project work (including deliverables) supporting the three areas identified below and approved by MAMG
- Project work will align with DNS fiscal year (Sept-Aug)
- Quarterly reports to MAMG summarizing work done and time spent.
- Maximum amount allocated for each fiscal year, to be paid to DNS on a quarterly basis.
- Maximum amounts identified below are fixed overall but may be adjusted between priority areas as agreed by MAMG.
- DNS agrees to conduct a reconciliation at each year-end to ensure time spent equates to time paid. Reconciliation to be based on time spent and agreed upon hourly amount
    - Agreed upon hourly amount for physicians is based on $160.00 per hour
    - Agreed upon hourly amount for staff is $75 per hour (time to be reported based on half-days)

Project Funding:

1. Fee Schedule

Purpose: Support to FC and fee schedule related items

Amount: Maximum annual amount ($330,000)

Project work to include:

- Research required to support FC applications (Typically a medical professional)
- General Support to FC
    - Track all applications to FC
    - Responsible for timely communication to applicants (at the direction of FC)
- Support for the Application Process, including but not limited to:
    - Make applications available to physicians
    - Ensure communication to physicians on a regular basis on the application process
    - Liaison between FC and physician to ensure applications are complete
- Work between DHW/MSI medical consultants on billing issues
    - Mediating potential disputes between physicians and MSI/DHW
    - Working with DHW/MSI to address fee related issues
- Other work as agreed

2. Clinical Practice Support

Purpose: Projects that support physicians attempting to transition their practices in alignment with health system change and priorities.

Amount: Maximum annual amount ($500,000)

Project work to include but not be limited to:

- Support for physicians transitioning to an EMR. Includes expectation that staff will need to visit physicians' offices to support the transition.
- Support for physicians to ensure maximum use of EMR.
- Support for physicians to eliminate office Fax machines
- Other areas as agreed to

Some of this project work will need to take place in physician's offices. Others will require a liaison function as between DHW, the Health Authorities, DNS and physicians to support physicians in transitioning their practices in ways that align with health system priorities.

3. Physician Initiatives

Purpose: Joint initiatives between DNS and DHW that support physicians and residents

Amount: Maximum annual amount $625,000

Initiatives to include:

- Bursary program
- Retirement and succession planning
- Support through MSI for billing education sessions
- Medical student engagement
- Physician leadership
- Other initiatives as directed by the MAMG

SCHEDULE "D"

MASTER AGREEMENT MANAGEMENT GROUP

Principles:

- Governance structure designed to foster and support an ongoing collaborative relationship between DNS and DHW
- Agile and flexible structure with ability to adjust as the system evolves
- Ensure accountability and transparency in contract management
- Intended to be in alignment with the MOA attached as Schedule "F".

Master Agreement Management Group (MAMG)

- Per the MOA attached as Schedule "F", the Group will meet to review and revise these Terms of Reference

    - Mandate guidelines pending review and revision:
    - To oversee the implementation and operation of the Master Agreement
    - To discuss any implementation issues arising from the Master Agreement
    - To establish working groups and engage contractors and/or consultants as required to investigate issues of importance to the ongoing implementation and oversight of the Master Agreement
    - To receive reports on Master Agreement initiatives, including:
        - DHW to provide quarterly financials on the Agreement
        - DHW and DNS to provide reports on the performance of programs (uptake; outcomes; etc.)

- Decisions of the MAMG shall be:

    - In the first instance by consensus.
    - If consensus is not reached on an issue, then by majority.
    - In the event that a majority decision cannot be reached, then a ninth member will, at the request of either Party, be appointed by the co-chairs for resolution of the issue. The Parties must agree on the ninth member.
    - The ninth member will chair those portions of the MAMG meeting(s) which involve consideration of the unresolved issue, will decide how best to conduct the meeting(s) and to resolve the issue, and will have all powers granted pursuant to the *Commercial Arbitration Act*. This is not intended to be a formal arbitration. There shall be no legal counsel and no calling of evidence. The rules of natural justice do not necessarily apply, except in the discretion of the ninth member.
    - The decision of the MAMG reached through this process shall be final and binding on all Parties.
    - In the event that the Parties have a dispute with respect to the interpretation or application of an MAMG decision, or that either Party has a dispute with respect to the conduct of the other Party regarding the interpretation,

application or administration of this Agreement, the dispute shall be resolved pursuant to this MAMG decision-making process.

- Standing Committees:
  - MAMG may agree to establish standing committees as necessary.

- Composition and frequency of MAMG meetings:
  - To be composed of 4 DNS representatives and 4 DHW representatives.
  - To meet at least quarterly.
  - DHW to continue to prepare agendas and meeting materials in consultation with DNS.

SCHEDULE "E"

Claims Monitoring and Resolution Mechanism

Preamble

In May 2013, the DHW and DNS jointly commissioned Mr. John Carter, FCA to review the claims monitoring and resolution mechanisms that were in place in Nova Scotia at that time. The resulting report, *The Physician Audit and Appeal in Nova Scotia*, recommended a number of improvements based on best practices across the country to ensure appropriate accountability, while at the same time reducing claims payment wait time in some areas.

An implementation team was struck to execute the report's recommendations, and was comprised of representatives from DNS, the DHW and Medavie Blue Cross (the claims administrator for Medical Services Insurance or MSI), as well as Mr. Carter. This collaborative process has resulted in a new appeal process (Schedule E) that will guide future audit and pre-payment assessment appeals.

All parties agree that it is the physician's responsibility to ensure claims are appropriate and consistent with the MSI Physician's Manual and clarifications articulated in the Physicians' Bulletins and that they meet required minimum standards for billing purposes. To assist the physicians and in the spirit of ongoing collaboration DNS and DHW acknowledge that education of physicians about appropriate billing is a joint responsibility and that together, all parties will continue to work on mechanisms to educate physicians.

1. For the purposes of this Schedule "E":

    a) **Audit Period** is limited to the twenty-four (24) months prior to the commencement of the audit, unless otherwise extended pursuant to Article 20;

    b) **Claims** means both fee for service and shadow service claims;

    c) **Days** means business days;

    d) **Implementation Date** means thirty (30) calendar days after Schedule "E" is fully executed by both DNS and DHW;

    e) **MSI** means Medical Services Insurance as administered by Medavie Blue Cross and any successor organization operating on behalf of the Province of Nova Scotia in respect of the payment to physicians for insured medical services;

    f) **Monitoring** includes both pre-payment assessment of Claims and post payment audit of Claims;

    g) **Party** means DHW or the physician;

h) **Post payment audit of Claims** includes any automated and/or manual systems and process in place to review Claims submitted by physicians after a Claim has been paid; and

i) **Pre-payment assessment of Claims** includes any automated (rules in the billing system) and/or manual systems and processes in place to review Claims submitted by physicians prior to payment.

2. DHW, through MSI, shall conduct Monitoring of Claims intended to determine whether:

a) the service was an insured service in Nova Scotia;

b) the service was performed;

c) the service was medically necessary;

d) the service was correctly represented in the Claim for payment; and

e) the service meets the requirements set out in:

i. the Preamble of the MSI Physician's Manual, and

ii. any relevant clarification provided to physicians in the MSI Physicians Bulletin

3. DHW, through MSI, shall ensure that the Claims monitoring and resolution process as outlined herein is followed.

Pre-Payment Assessment

4. If a physician's Claims are adjusted or rejected as the result of a Pre-Payment Assessment, the physician will be notified electronically by MSI through the adjudication response (the "MSI Result").

5. The physician is deemed to receive the MSI Result five (5) days after the day the MSI Result is sent.

6. If Pre-Payment Assessment results in adjustment or rejection of a Claim due to rules that are in the billing system, it cannot be disputed by an individual physician. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration.

7. If Pre-Payment Assessment results in adjustment or rejection of a Claim for any other reason (including but not limited to Claims assessed as part of the pre-payment assessment of multiple Claims [same patient, same day, same provider] or Claims assessed as part of a random pre-payment assessment process), the physician can dispute the adjustment and/or rejection as provided herein.

8. In order to dispute a MSI Result, the physician must, within ten (10) days after receipt of the MSI Result, contact MSI in writing to initiate the Request for Pre-payment Assessment Review. If the physician fails to contact MSI within that time, he/she is deemed to agree with the MSI Result and forfeits further rights to Facilitated Resolution or Arbitration.

9. Once a Pre-Payment Assessment Review is initiated this will be considered by both the DHW Medical Consultant and the DNS Medical Consultant within fifteen (15) days of receipt of the Request for Pre-Payment Assessment Review.

10. If both the DHW and DNS Medical Consultants determine that the dispute involves a policy decision the MSI Result cannot be disputed by an individual physician and that physician will be notified by DHW, with a copy to DNS. A policy decision includes but is not limited to items specifically negotiated by DNS and DHW. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration. The physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal.

11. If one or both of the DHW and DNS Medical Consultants determines that the dispute does not involve a policy decision then the pre-payment assessment will move directly to Facilitated Resolution, commencing at Clause 31.

12. If both the DHW and DNS Medical Consultants agree that the Claims being submitted by a physician indicate a pattern of deliberate non-compliance with the MSI Physician's Manual and/or MSI Bulletins, that physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal on that matter.

Post-Payment Audit

13. A physician may be identified for post-payment audit (the "Audit") in a variety of ways, including but not limited to:

    a) Service Verification Letters;
    b) Case Mix Grouping - Peer Profiling;
    c) Referral;
    d) Periodic Random Selection;
    e) Use of New Fee Codes;
    f) Specific Fee Codes identified for audit.

14. An Audit may occur by way of periodic review of MSI data (periodic review) and/or an on-site visit.

Periodic Review

15. A physician will not be notified in advance of an audit conducted by way of periodic review of MSI data.

16. The results of the Audit will be provided to the physician in writing (the "Audit Result") where, in the auditor's opinion, the periodic review showed the physician's billing to be inappropriate.

On-Site Audits

17. Any physician identified for an on-site Audit will be notified in writing that an Audit will occur and which fee codes will be included in the Audit. The Audit will be scheduled at a mutually agreeable time. The auditor may require inspection of any books, accounts, documents, reports, invoices and patient records in any form, including electronic that are maintained by or on behalf of the physician (the "Records") to clarify or verify services for which Claims have been submitted.

18. The results of the Audit will be provided to the physician in writing (the "Audit Result").

Audit Scope

19. The auditor may, acting objectively and with reasonable notice, extend an audit of a physician's practice to cover fee codes that were not originally selected if the audit results suggest potential for additional incorrect billings. The reasons for extending the fee codes audited must be provided to the physician with the notice of the extension and cannot be challenged as a part of the Audit and Appeal process.

20. The Audit Period may be extended in exceptional circumstances.

Notification of Audit Results

21. For the purposes of Clauses 16 and 18, notice of the Audit results will include:

    a) a detailed summary of each Claim deemed to be inappropriate with explanatory comments as to the nature of the deficiency;

    b) the financial implications of the Audit; and

    c) details on what steps may be taken to resolve the matter, which will include a link to an electronic copy of this Schedule “E”.

22. The physician is deemed to receive the Audit Result five (5) days after the day it is sent by regular post.

23. A cover letter that identifies the physician, and states that a notice of the Audit Result has been issued, will be copied to DNS; the notice itself, as well as any additional details, will be sent to the physician alone.

Audit Review

24. Where the physician disagrees with the Audit Result, the physician will, within twenty (20) days of receipt of the findings, contact MSI in writing to initiate the Audit Review (Notice of Audit Review). The Notice will include the basis for the disagreement and provide documentation, including all relevant clinical documentation, to support that position. If the physician fails to provide the Notice to MSI within that time, s/he is deemed to agree with the Audit Result and forfeits further rights to Audit Review, Facilitated Resolution, or Arbitration. If deemed to agree with the Audit Result then any associated recovery shall be made from future payments to the physician. The purpose of the Audit Review is to ensure that MSI has all information/documentation relevant to the Audit.

25. MSI will review all information and documentation provided as part of the Notice of Audit Review. After the Review, the MSI Medical Consultant may do one of the following:

    a) In order to ensure an efficient and effective Audit Review process, if, in the sole discretion of the MSI Medical Consultant, the Notice provided by the physician does not provide any new information that may change the Audit Result, the MSI Medical Consultant will issue a Notice of Determination and the matter may be referred directly to Facilitated Resolution (without an Audit Review meeting between the MSI Medical Consultant and the physician).

    b) Request a meeting with the physician, either by telephone or in person, to facilitate the documentation review process; such meeting to be scheduled within fifteen (15) days of receipt of the Notice of Audit Review.

26. Upon review of all additional information/documentation provided to MSI by the physician, MSI will issue a Notice of Determination.

27. The Notice of Determination shall include:

    a) a statement of the findings of the Audit, including any adjustments made as a result of the Audit Review;

    b) detail of all outstanding issues that have not been resolved; and

    c) a form that may be used by the physician to object to the Notice of Determination.

28. A cover letter that identifies the physician, and states that a Notice of Determination has been issued, will be copied to DNS; the Notice itself, as well as any additional details, will be sent to the physician alone.

29. If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date he/she receives the Notice of Determination, submit an objection in writing to MSI (the "Notice of Dispute"). In the Notice of Dispute, the physician may only make representations related to matters referred to in the Notice of Determination, or which are related directly thereto. If the physician

fails to contact MSI within that time, he/she is deemed to agree with the Audit Result and forfeits further rights to Facilitated Resolution or Arbitration. Any associated recovery shall be made from future payments to the physician.

30. The physician is deemed to receive the Notice of Determination five (5) days after the day it is sent by regular post.

Facilitated Resolution

31. When MSI receives a Notice of Dispute, or where either the DHW Medical Consultant or the DNS Medical Consultant determines that a pre-payment assessment dispute does not involve a policy decision per Clause 11, the Facilitated Resolution stage will begin. MSI will notify both the DHW and DNS Medical Consultants.

32. DHW and DNS will agree upon a list of Facilitators in a separate document. The Facilitator will be chosen from that list by starting at the top and moving down until a non-conflicted Facilitator is located that is available to begin the Facilitated Resolution within sixty (60) days. In the event none of the Facilitators are available within sixty (60) days' time, the next available non-conflicted Facilitator will be chosen. For each subsequent Facilitated Resolution, the search for available Facilitators will commence at the point on the list that is immediately after the Facilitator most recently chosen to participate.

33. The Facilitated Resolution will proceed on a "without prejudice" basis and will commence on a date agreed upon by DNS and DHW that is no later than sixty (60) days after appointment of a Facilitator; if agreement on a Facilitated Resolution date is not reached, the Facilitated Resolution will commence on the first business day following expiry of the sixty (60) days.

34. The Facilitated Resolution will proceed in accordance with Schedule C of the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) with the exception of CAA Clauses 2, 15 and 16, and with the Facilitator having the same duties and powers as a CAA mediator.

35. The Facilitated Resolution will involve only the DHW Medical Consultant, the DNS Medical Consultant, MSI audit personnel, the physician, and the Facilitator. For the sake of certainty:

    a) legal representatives will not attend the Facilitated Resolution;

    b) agreement may only be reached with consensus between the DHW Medical Consultant and the physician;

    c) if agreement is reached, the Facilitator will document the terms of the agreement (the Agreement) and the DHW Medical Consultant and the physician will sign the Agreement, at which time the Agreement will become binding on both Parties;

    d) if agreement is not reached, the physician has thirty (30) days to provide notice of intent to proceed to Arbitration as outlined herein. If no notice is provided, the

physician is deemed to agree with the Audit Results and forfeits further rights to Arbitration.

36. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Facilitated Resolution, unless DHW and DNS agree on an alternative arrangement.

37. If either DHW or the physician do not participate in the Facilitated Resolution, the non-participating party is deemed to have forfeited its claim against the other and the matter is concluded, excepting however where both the DHW and the physician, acting reasonably, agree to reschedule the Facilitated Resolution, it may be rescheduled to a date that is no later than thirty (30) days after the originally scheduled date.

Arbitration by Resolution Panel

38. Upon receipt of notice to proceed to Arbitration, the dispute will be finally determined by Arbitration presided over by a Resolution Panel (the "Panel"). The Arbitration will proceed in accordance with the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) except as specifically altered herein. The parties agree that only matters contained in the Notice of Determination which are contested in the Notice of Dispute will be subject to Arbitration.

39. The Panel will be comprised of three individuals, one from each of the Lawyer, Non-Physician, and Physician Categories, as set out in a document agreed upon by both DNS and DHW, and once constituted, shall be an arbitrator under the CAA. All three individuals will be chosen to form the Panel by starting at the top of each Category's list and moving down until a non-conflicted Member from each Category is located that is available to participate in the Arbitration within sixty (60) days' time. In the event none of the Members in a particular Category are available within sixty (60) days' time, the next available non-conflicted Member in that Category will be chosen. For each subsequent Panel, the search for available Members will commence at the point on each Category list that is immediately after the Member most recently chosen to participate on a Panel. The Panel Member chosen from the Lawyer Category will serve as Chair of the Panel.

40. For the Lawyer Category, there will be a roster of no less than three lawyers jointly appointed by DNS and DHW. Each lawyer will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

41. For the Non-Physician Category, there will be a roster of no less than three non-physicians jointly appointed by DNS and DHW. Each non-physician will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

42. For the Physician Category, there will be a roster of no less than ten physicians jointly appointed by DNS and DHW. The physicians will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

43. The physician is entitled to have legal counsel present at the Arbitration. If the physician elects to do so, DHW may also have legal counsel present.

44. The Panel will determine the dispute based on the Physician's Manual, including the Preamble thereto and MSI Bulletins. Relevant written correspondence/documents between MSI and the physician may be considered. Only that version of the Manual and those Bulletins that were in effect at the time the services in dispute were provided will be considered.

45. The Panel will determine the dispute by majority vote.

46. The decision of the Resolution Panel shall be final and binding on the physician and DHW. The Chair will provide a written decision, signed by all members of the Panel, within ten (10) days of the conclusion of the Arbitration.

47. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Arbitration, unless DHW and DNS agree on an alternative arrangement. Notwithstanding the above, the Panel may apportion non-legal expenses as it sees fit.

48. Any amounts owing to either the physician or DHW as a result of the decision of the Panel will be due and payable on the date of the Decision, and will bear interest from that day at the prime rate as calculated by the Minister of Finance from time to time, based upon the variable reference rates of interest declared by the five largest Canadian financial institutions or their successors as their rates for Canadian dollar consumer loans, plus an additional 2%. The prime rate is calculated by ignoring both the highest and the lowest of those five rates and taking the average of the remaining three rates.

49. Any dispute that ceases to follow the processes set out in this Schedule "E", or the initiation of any insolvency steps by the Physician, will result in the commencement of collection procedures as outlined herein.

50. DNS and DHW agree that, pursuant to s. 7 of the Doctors Nova Scotia Act, this Schedule "E" is an agreement which DNS may enter into that binds its members.

51. Physicians are only permitted to challenge pre-payment assessment of claims and/or post-payment audit of claims through the processes outlined in this Schedule.

52. The results of any arbitration, facilitated resolution or decision pursuant to clauses 6, 10, 12, 19, 20, and 25(a) are final and conclusive, and are not open to question or review by a court or other body on any grounds, including by way of judicial review.

53. Any deadline in this Schedule may be altered or waived with the agreement of the DHW Medical Consultant and the DNS Medical Consultant.

54. The Parties may amend this Schedule by agreement.

SCHEDULE "F"

Memorandum of Agreement regarding Governance

MEMORANDUM OF AGREEMENT

Between

Doctors Nova Scotia (DNS)

-and-

Her Majesty the Queen in right of the Province of Nova Scotia,
as represented by the Minister of Health and Wellness (DHW)

-and-

The Nova Scotia Health Authority (NSHA) and The IWK Health Centre (IWK),
together referred to as the 'Health Authorities'

WHEREAS the Parties have been negotiating a new Master Agreement and a new Clinical/Academic Funding Plan Agreement;

AND WHEREAS the Parties wish to establish a collaborative, consultative and collegial framework for working;

AND NOTWITHSTANDING any previous agreements and any previous disputes between the Parties with respect to the roles and responsibilities of the Parties.

Now therefore the Parties agree as follows:

1. Physicians licensed to practice in NS are entitled to have representation in the negotiation of their contracts with DHW and the Health Authorities, including their remuneration, the benefits and services they are entitled to receive, the level of services to be provided taking into account the best interests of Nova Scotians, and specific performance deliverables and reporting requirements that are needed to ensure the level of service provided is consistent with the DHW and Health Authorities' expectations.

2. DHW and the Health Authorities recognize DNS as the sole bargaining agent for all physicians licensed to practice in NS who provide insured medical services that are funded through DHW and/or a Health Authority.

3. Whether a physician is paid on a fee-for-service basis, or by other systems of payment including alternative payment plans (APPs) and clinical/academic funding plans (C/AFPs), DNS represents the interests of all physicians on the negotiation of their contract.

4. For greater certainty, the elements of any physician's contract which the Parties will negotiate include but are not limited to:

    a. The insured professional services that physicians will deliver to Nova Scotians and all other terms and conditions related to the provision of insured professional services by physicians (for example, will services be provided on a full time or part time basis; in the physician's clinic or at a hospital or nursing home; during the day, night or weekend, etc.);
    b. The academic, research and administrative responsibilities that C/AFP physicians are required to fulfill in addition to the provision of insured professional services delivered to Nova Scotians;
    c. What physicians will be paid for delivering those services, as well as academic, research and administrative responsibilities as appropriate;
    d. The benefits and services to which physicians are entitled; and
    e. The accountability framework that outlines the expectations and responsibilities of all parties.

5. DHW and DNS will continue a Master Agreement Management Group (the MAMG) and a Clinical/Academic Funding Plan Management Group (the C/AFPMG) to oversee the implementation of the Physician Services Agreements and this MOA.

6. The Parties agree that they will convene a meeting of the MAMG and the C/AFPMG within thirty (30) days of the signing of this agreement.

7. The MAMG and C/AFPMG will confirm what, if any working groups are needed to be established immediately and will also confirm the terms of reference for these working groups.

8. Members of the (MAMG) will negotiate a framework for contracting physicians on alternative payment plans that ensures consistency and fairness, administrative ease of contracting, accountability, and care tailored to the needs of the community.

9. A dispute resolution process that allows for the joint appointment of an additional person with a 'tie-breaking vote' is available whenever the MAMG is unable to reach a decision by consensus with respect to Article 5. A similar dispute resolution process will be available to the C/AFPMG for purposes of resolving any disputes arising from or pertaining to this MOA.

10. The Parties will meaningfully consult with DNS regarding the operation of the health care system in Nova Scotia as it relates to the provision of insured professional services by physicians, before making any decision that impacts physicians and their delivery of insured professional services. "Meaningful consultation" means the Parties will ensure that concerns and input of physicians are represented by DNS and considered.

11. This Memorandum of Agreement will be overseen by the MAMG and the C/AFPMG and shall expire on the signing of the next Master Agreement unless the Parties agree to extend this agreement.

12. This agreement can be amended or rescinded by the agreement of the Parties prior to its expiry.

13. The Parties agree that this Memorandum of Agreement should be reviewed and discussed periodically. The Parties will review this agreement after the first two years and annually, as needed after that.

Dated at Halifax, Nova Scotia, this _____ day of October 2019.

Doctors Nova Scotia

The Minister of Health and Wellness
For the Province of Nova Scotia

The Nova Scotia Health Authority

The IWK Health Centre

SCHEDULE "G"

Memorandum of Agreement regarding the Community Hospital Inpatient Program

This **MEMORANDUM OF AGREEMENT**, dated this _____ day of October, 2019, BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA, as represented in that capacity by the Minister of Health and Wellness (the "Minister")

OF THE FIRST PART

- and –

DOCTORS NOVA SCOTIA, a body corporate constituted by the *Doctors Nova Scotia Act*, SNS 1995-96, c 12, on behalf of duty qualified medical practitioners in Nova Scotia

OF THE SECOND PART

- and -

NOVA SCOTIA HEALTH AUTHORITY, a body corporate established by the *Health Authorities Act*, SNS 2014, c 32 ("NSHA")

OF THE THIRD PART

WITNESSETH THAT:

(a) WHEREAS Doctors Nova Scotia is the sole bargaining agent for medical practitioners in Nova Scotia, for the purpose of entering into agreements with the Minister that bind its members;

(b) AND WHEREAS the Minister and Doctors Nova Scotia are currently negotiating a new Master Agreement (the "**new Master Agreement**") to provide for physician compensation for insured professional services;

(c) AND WHEREAS the Minister wishes to implement the Community Hospital In-Patient model outlined in the attached schedules (the "**Community Hospital In-Patient Model**") for physician professional services delivery and compensation in certain community hospitals in advance of the new Master Agreement;

(d) AND WHEREAS the Minister and Doctors Nova Scotia agree that during the term of this Memorandum of Agreement and the new Master Agreement the Community Hospital In-Patient Model will not be implemented in facilities other than those listed in section 1 of this Memorandum of Agreement, that Category 1 on-call rates will not be increased, and that Category 1 on-call rates will not be expanded to other sites except where demonstrably justified

according to the requirements for Category 1 on-call described herein;

NOW THEREFORE, in consideration of the mutual covenants made herein, and other consideration the receipt and sufficiency of which is acknowledged by the Parties, the Parties hereby agree as follows:

1. The Minister and NSHA will make the Community Hospital In-Patient Model available to physician groups only at the following community hospitals:

    1.1. Inverness Consolidated Memorial Hospital;
    1.2. Strait Richmond Hospital;
    1.3. New Waterford Consolidated Hospital;
    1.4. Northside General Hospital;
    1.5. Fishermen's Memorial Hospital;
    1.6. Soldiers Memorial Hospital;
    1.7. Queens General Hospital;
    1.8. Hants Community Hospital; and,
    1.9. Roseway Hospital;

(each a "**Community Hospital**"; together, the "**Community Hospitals**").

2. A physician group which is eligible pursuant to Article 1 may opt into the Community Hospital In-Patient Model by delivering notice from its Representative Physician, as identified in its Service Delivery Plan, to the Minister and the NSHA in writing.

3. The Parties agree that the facility stipends and the compensation rate methodology as set out in Appendix "B" of this Memorandum of Agreement will be the sole funding for physicians under the Community Hospital In-Patient Model for the provision of all in-patient care services (other than LTC) as specified in Appendix "A" of this Memorandum of Agreement.

4. Where a physician group at a Community Hospital which has adopted the Community Hospital In-Patient Model pursuant to Article 2 has had its site delivery plan approved by NSHA and the Minister as required by Appendix "A" on or before 15 February 2020, then upon implementation of the site delivery plan in accordance with Appendix "A":

    4.1. each physician in the physician group who provided inpatient services at the Community Hospital from 1 July 2019 to the date when the Community Hospital adopted the Community Hospital In-Patient Model (the "retroactivity period") shall be entitled to retroactive compensation in accordance with Article 5 of Appendix "B"; and,

    4.2. each physician in the physician group who provided on-call services at the Community Hospital prior to the physician group adopting the Community Hospital In-Patient Model shall be entitled to retroactive on-call compensation for the retroactivity period, calculated as the difference between:

4.2.1. the amount claimed by the physician as compensation for being on-call during the retroactivity period; and

4.2.2. the amount of compensation that would have been paid to the physician in on-call rates under the Community Hospital In-Patient Model for the on-call days worked by the physician during the retroactivity period.

5. The Community Hospital In-Patient Model will not be made available other than in the Community Hospitals.

6. Category 1 On-Call rates shall be $300/day for weekdays, and $400/day for all weekends and holidays for the provision of call for a 24-hour period from 08:00 through to 08:00 the next day.

7. This Memorandum of Agreement shall be effective from the date when it is executed by the last of the Parties to do so, and shall remain in force until the termination or expiry of the new Master Agreement.

8. A physician group that participates in the Community Hospital In-Patient Model may terminate its participation by giving three months' prior written notice from its Representative Physician to the Minister and the NSHA. Upon termination, the members of the physician group shall:

   8.1. revert to fee for service for their inpatient care; or

   8.2. for physicians who are on an alternate payment plan, revert to their full alternative payment plan FTE allotment and provide inpatient services as required by their alternative payment plan agreement, as immediately prior to the physician group enrolling in the Community Hospital In-Patient Model.

9. The Minister, or NSHA with the Minister's prior written approval, may terminate the participation of one or more physician groups in the Community Hospital In-Patient Model upon three months' prior written notice to the group's Representative Physician, and the other Parties to this Memorandum of Agreement.

IN WITNESS WHEREOF the Parties hereto have executed this Agreement by their duly authorized representatives:

	HER MAJESTY THE QUEEN in the right of the Province of Nova Scotia
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____
	DOCTORS NOVA SCOTIA
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____
	NOVA SCOTIA HEALTH AUTHORITY
_____ *(signature of witness)* Name:_____	_____ *(signature)* Name:_____ Title: _____ Date: _____

Appendix "A"

Community Hospital Inpatient Program
General Program Guidelines

1. General Requirements

Physician groups participating under the program must provide:

- on site comprehensive care for all inpatients (attached and unattached) in the hospital that include:
  - physician support 7 days a week to meet patient care needs and system flow requirements;
  - on site presence to align with timing of daily bed management decisions by other hospital staff (as pre-arranged and mutually agreed);
- comprehensive on call coverage and response for all hours where physicians are not on site for all inpatients;
- collaborative care with other providers;
- effective discharge planning in concert with inter-professional team;
- participation in quality improvement and patient safety reviews, programs and activities;
- best practice documentation in the clinical record for all visits, admissions, and discharges as well as best practice physician daily 'hand-off' structure and process;
- assistance to site leads to support bed utilization management including supporting the timely transfer patients, when the level of acuity is appropriate, from Regional Hospitals, including orphan and/or unattached patients.

All physicians at an eligible Community Hospital must participate in the program and all beds, other than LTC, at that facility must be covered by the program.

Quality patient care and safety is the overall goal of the Community Hospital In-Patient Model. In the event the physician group believes it is unable to sustain services as required by this Schedule without undue burden on the providers or undue risk to patient care and safety the physician group may terminate its participation in the Community Hospital In-Patient Model in accordance with Article 8 of the Memorandum of Agreement, or, with the prior written agreement of the NSHA and the Minister, temporarily suspend its participation in the Community Hospital In-Patient Model.

2. Daily Services

The daily stipend for inpatient coverage at Community Hospitals is intended to be inclusive of the provision of inpatient care for all patients, whether attached or unattached and any and all patients transferred into the facility through the regional network of care. It covers:

- required clinical care of all inpatients (acute, ALC, restorative care, transitional care, attached and unattached) other than LTC, admitted in the facility;

- time spent supporting indirect patient care (e.g. collaboration with other members of the hospital health care team);
- time spent delivering clinical support services (e.g. admission and discharge planning, working with in-hospital multidisciplinary team, participation in quality improvement and patient safety reviews, programs and activities, supporting bed utilization decisions and inter-hospital transfers);
- time spent building local inpatient care capacity (e.g. mentoring new physicians and trainees).

3. Site Delivery Plan

Physicians from each participating Community Hospital will develop a site-specific delivery plan to ensure that all inpatients at the facility are covered 24/7/365. This includes:

- the names of the participating physicians;
- the name of a Representative Physician who is authorized by all of the physicians in the group to deal with the Department and the NSHA on their behalf in regard to inpatient care and the Community Hospital In-Patient Model;
- confirmation that physician remuneration is consistent with the daily stipend and will not exceed the overall site budget and level 1 Facility On-Call payment rates;
- the approach to providing quality care to all inpatients across the different units of the hospital, including attached and unattached patients – the approach may be a hospitalist model (i.e. single physician coverage on a daily basis), or a model whereby physicians follow their own patients with clarity of who will provide coverage on off hours, weekends and holidays, or a mixed model (i.e. physicians following their own patients throughout the week, but having single coverage on the weekends/holidays). The plan for coverage must include:
    - the proposed model for on-site presence of participating physicians;
    - the proposed approach to on-call coverage and response;
- the process for ensuring a quality physician "hand-off" for physicians taking over call from call or coverage from another physician;
- The process for and commitment to ensuring collaborative care with other members of the hospital health care team;
- the process for timely admission and discharge planning in concert with hospital multidisciplinary team, the patients family/support network, and community-based staff, agencies and supports;
- planned participation in quality improvement and patient safety reviews, programs and activities;
- A clear commitment to engagement in and facilitation of bed utilization and inter-hospital transfers in collaboration with site lead;
- A clear commitment to participation in the Community Hospital In-Patient network/collaborative (if one exists) dedicated to enhancing skills and mentoring new physicians and trainees in quality in patient care; and,
- An internal plan and methodology for allocation among participating physicians of compensation provided under the Community Hospital In-Patient Model.

All physicians providing inpatient services at a Community Hospital are expected to participate in the program and contribute to the site delivery plan. Site delivery plans must be approved by the Zone

Head for Family Medicine, the Zone Medical Executive Director, and the Senior Medical Director of Medicine and must be consistent with NSHA Policies and Procedures. A copy of the site delivery plan will be provided to DHW for review and sign off prior to implementation.

The site delivery plan must be signed by all participating physicians. Each physician added to the group after the initial plan is approved will be required to sign a Declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program.

4. Cash Flow and Disbursement

The physician group will be responsible for submitting claims for both retroactive compensation in accordance with article 4 of the Memorandum of Agreement and the daily stipend as provided in Appendix "B". Funds will be disbursed to the group or to individual physicians as identified by the group's Representative Physician. Decisions on distribution of funds will be the sole responsibility of the physician group provided the plan and methodology is clear in the site delivery plan as required above.

MSI will establish monthly transfers of funding to the physician group or individual physicians according to the invoices received as outlined above.

5. Reporting Requirements

Physicians are required to shadow bill for 100% of services provided and are responsible for any and all costs associated with the submission of shadow billings.

On a quarterly basis, the physician group must provide to the Minister a summary of all program financial disbursements to individual physicians, including disbursement of the Category One On-Call stipend according to the reporting protocols currently in place for the Facility On-Call Program;

NSHA will provide the physician group a monthly report on key metrics regarding inpatient care at each facility.

NSHA will prepare and provide to the DHW a quarterly report on key metrics on quality and safety of patient care, and key utilization indicators (LOS, readmissions within 30 days, transfers in and out, etc). Examples of quality indicators may include:

- hospital standardized mortality rate;
- C. Difficile infection rates;
- patient falls;
- re-admission rates 7 days, 30 days;
- rate of connection with community family physician within 1 week of discharge;
- number of attached and unattached patients.

A process will be established to develop other relevant metrics which will be tracked by all participating facilities across the province.

Appendix "B"

Facility Stipends and Compensation Rate Methodology

1. Daily Stipends

The daily stipend for each Community Hospital will be established using the following formulae:

Daily Stipend Formula:

Admission $ + Discharge $ + Ongoing Care Beds $ = daily stipend at each site

	Admission $	Discharge $	Ongoing Care Beds $
Rate	$89.47 per avg daily admission at each site	$99.82 per avg daily discharge at each site	$47.12 per ongoing care bed at each site
Based on	Average admission MRP inpatient billing per admission, assuming 75% are billed as geriatric admissions, based on 18/19 FY data	Average discharge MRP inpatient billing per admission, assuming 75% are billed as comprehensive discharges, based on 18/19 FY data	Assumes amount paid for 03.03 Subsequent Daily Hospital Visit billed for inpatient days 4-7

Ongoing Care Bed Count formula:

Physician Resource Weighted beds – average daily admissions – average daily discharges = ongoing care bed count for each site

Physician Resource Weighted Bed Count formula:

[(# of medical unit beds multiplied by medical unit bed occupancy rate multiplied by # visits required per week for medical unit beds)
+
(# of RCU and TCU unit beds multiplied by RCU and TCU unit bed occupancy rate multiplied by # visits required per week for RCU and TCU unit beds)
+
(# of ALC unit beds multiplied by ALC unit bed occupancy rate multiplied by # visits required per week for ALC unit beds)]

divided by 7 days = weighted bed count for each site

The Physician Resource Weighted Bed formula and the Ongoing Care Bed Count formula will be used in the annual review of the daily stipend described below.

As at September 30, 2019, the weekly visit assumptions for each unit/bed type are:

Average visits required per bed type	
Unit Type	MD Visits per patient per week
Medical Unit	7
RCU and TCU Units	2.5
ALC units	1.5

As at September 30, 2019, the following data was used to calculate the Community Hospital In-Patient Model daily rates:

Site	Physician Resource Weighted Beds	Avg Daily Admissions	Avg Daily Discharges	Avg Daily Ongoing Care Beds	Daily Stipend Funding	Daily Category 1 On-Call Payments*	Daily Site Total Funding	Annual Site Total Funding (including on-call)
Inverness	28.0	2.06	2.08	23.85	$1,515	$332	$1,847	$674K
Strait-Richmond	14.6	1.72	1.75	11.10	$852	$332	$1,184	$432K
Northside	45.4	2.51	2.52	40.36	$2,378	$332	$2,710	$989K
Fisherman's	18.0	0.88	0.88	16.23	$932	$332	$1,263	$461K
Soldiers	20.5	1.91	1.97	16.62	$1,151	$332	$1,483	$541K
Queens	22.7	1.94	1.96	18.76	$1,253	$332	$1584	$578K
Hants	25.9	1.82	1.86	22.18	$1,393	$332	$1,725	$630K
Roseway	11.0	0.79	0.78	9.41	$592	$332	$924	$337K
New Waterford	19.9	0.90	0.91	18.09	$1,024	$332	$1,356	$495K

* This is the average daily call rate, calculated based on $300 for weekdays and $400 for weekend days and holidays, provided that Category 1 requirements described below are met.

The daily stipend will be reviewed in the event of any permanent changes to either the number or the designation of beds at a particular facility. Any changes to the daily stipend as the result of planned changes in bed number of designations will be implemented effective the date of the bed change. Notice of change will be provided to physicians and all signatories of this MOA 3 months in advance.

The daily stipends will also be reviewed annually by DHW and adjusted as required, based on utilization data provided to the DHW by the NSHA and using the formulae above. The analysis and decision(s) arising from the review of the daily stipends will be shared with DNS and the physicians participating in the Community Hospital In-Patient Model in advance of the end of each fiscal year. Funding changes are aligned to the April-March Fiscal year.

2. On-Call Stipends

The Community Hospital In-Patient Model provides a daily stipend of $300/day for weekdays, and $400/day for all weekends and holidays for the provision of call availability for a 24-hour period from 08:00 through to 08:00 the next day.

Physicians receiving this payment are expected to adhere to the guidelines defined for Category 1 call coverage as defined under the Facility On-Call Program, specifically:

- the physician group is required to provide 24/7/365 coverage;
- a written on-call schedule must be provided in advance to the Zone Medical Director;
- physicians must respond to calls within 10 minutes by phone and be able to be on site within 20 minutes if called in;
- physicians who have been called back to a facility to attend to a patient are eligible to bill fee-for-service for any services delivered outside of standard working hours, which for the purpose of this program is defined as 1700h through to 0800h the following day.

For the purposes of Community Hospital In Patient Model, any physician seeking to take on more than one call shift per day must have the prior written approval of the NSHA and must, as determined by the NSHA in the NSHA's sole discretion, be able to adhere to the criteria associated with category 1 on call.

3. MSU Funding Adjustments

The daily stipends will be increased each year based on the MSU increases as defined in the Physician Master Agreement. The MSU increase effective April 1, 2019 will be applied to the daily stipends.

4. Remuneration Principles

a. Fee-for-service physicians will not submit fee claims for inpatient services provided between 0800h and 1700h. Instead, these services will be shadow billed as outlined in Appendix A.

b. Services provided during the hours of 1700h through to 0800h the following day, when on call, can be claimed fee-for-service for all physicians, in addition to the daily stipend and on-call stipend.

c. Physicians on an alternative payment plan (APP) will see a reduction in their APP contract FTE equivalent to the lesser amount of:

   i. The portion of APP deliverables relating to inpatient services outlined in their APP deliverables, or

   ii. The total amount of shadow billing for inpatient services offered by that physician at the Community Hospital during the year prior to enrollment in the Community Hospital In-Patient Model.

5. Retroactive Compensation

a. For physicians who delivered inpatient care at the Community Hospital pursuant to an alternative payment plan during the retroactivity period:

$$Retro\ Payment = [Stipend\ in\ Retro\ Period] * [APP\ billing\ share] - [APP\ Inpatient\ \$]$$

- **Stipend in Retro Period** = Daily (non-call) stipend calculated at site multiplied by # days in retro period

- **APP billing share** = % of total inpatient billings (shadow & FFS) made by APP group in retro period
- **APP inpatient $** = Sum of each APP physician's APP FTE dedicated to inpatient work. This is the FTE amount that will be reduced from their contract when they join CHIP.
- **Retro Payment** = the amount that the APP group of physicians gets to divide amongst themselves.

b. For physicians who delivered inpatient care at the Community Hospital on a fee for service basis during the retroactivity period:

$$Retro\ Payment = [Stipend\ in\ Retro\ Period] * [FFS\ billing\ share] - [FFS\ Inpatient\ \$]$$

- **Stipend in Retro Period** = Daily (non-call) stipend calculated at site multiplied by # days in retro period
- **FFS Billing Share** = % of total inpatient billings (shadow & FFS) made by FFS physicians who will be part of the physician group in the retro period.
- **FFS Inpatient $** = Sum of all the FFS inpatient billings made by the FFS physicians who are part of the physician group during the retro period.
- **Retro Payment** = the amount that the FFS group of physicians gets to divide amongst themselves.

c. Once a physician group has implemented a site delivery plan as provided by article 4 of the Memorandum of Agreement, the Department of Health and Wellness will calculate the retroactive payment as noted above. The Department will provide its calculations to the physician group and the physician group will be responsible for submitting a claim for retroactive compensation to MSI as per Appendix A, clause 4.

SCHEDULE "H"

Primary Maternity Care Model

1. The Parties agree that new funding and a new funding model are necessary to support Primary Maternity Care (PMC) at various regional hospitals and at the IWK Health Centre.

2. The Department of Health and Wellness shall make $2,500,000 annually available for PMC, as follows:

    a. $500,000 effective the date the DNS Board of Directors approves this Agreement, and
    b. an additional $2,000,000 effective April 1, 2020.

3. Effective September 1, 2019, PMC services provided by the IWK Department of Family Medicine at the IWK Health Centre will be paid pursuant to the proposal submitted by the group on November 23, 2018 (funding equivalent to five Family Physician (Collaborative) Alternative Payment Plan (APP) contracts (with rates as adjusted by MSU increases since the date of the proposal), for 24/7/365 coverage).

4. The Parties agree to finalize the terms of a province-wide PMC funding model (the "PMC funding model"), including service delivery expectations, by November 30, 2019. The Parties will use proposals submitted by the PMC groups at the IWK and South Shore as a guide in developing that model. The hourly rate for daytime PMC services will be $147.33 (plus MSU increases as applicable). The model may include the following elements, but these could change during the development of the model in November 2019:

    a. A daily stipend in the amount of a fixed number of daytime hours multiplied by the above-noted hourly rate, for one physician providing PMC services at each site each day.

    b. Call funding at the Category 1 On-Call rates: $300/day for weekdays, and $400/day for all weekends and holidays for the provision of call availability for a 24-hour period from 08:00 through to 08:00 the next day.

    c. Fee for service payment for PMC services delivered outside of the daytime funded hours.

    d. Physicians working a PMC shift will not be eligible to bill fee for service or to receive alternate funding for PMC services provided during the daytime funded hours.

    e. Physicians working a PMC shift will be required to shadow bill for 100% of services provided.

f. It is recognized that PMC services may be provided by physicians who are not covering the PMC daytime or call shift on a given day. Those services will be billed or shadow billed and paid as appropriate to those physicians outside the PMC funding model.

5. The PMC funding model will be made available to family physicians providing primary maternity care at the following regional hospitals:

   2.1 South Shore Regional Hospital, Bridgewater
   2.2 St. Martha's Regional Hospital, Antigonish
   2.3 Cumberland Regional Hospital, Amherst
   2.4 Yarmouth Regional Hospital, Yarmouth
   2.5 Cape Breton Regional Hospital, Sydney

   (each a "**PMC Hospital"**; together, the "**PMC Hospitals**").

6. Family physicians providing PMC services at the South Shore Regional Hospital will be eligible for payment pursuant to the PMC funding model effective the date the DNS Board of Directors approves this Agreement. It is anticipated that the daily funded hours for the South Shore Regional Hospital will be twelve (12), for a daily stipend of $1768 ($147.33 x 12 hours), subject to confirmation by the Parties as they finalize the terms of the PMC funding model.

7. Effective April 1, 2020, the PMC funding model will be made available to family physicians providing PMC services at the following regional hospitals:

   a. St. Martha's Regional Hospital, Antigonish

   b. Cumberland Regional Hospital, Amherst

   c. Yarmouth Regional Hospital, Yarmouth

   d. Cape Breton Regional Hospital, Sydney

   (each a "**PMC Hospital"**; together, the "**PMC Hospitals**").

8. If the Parties determine while finalizing the PMC funding model that the full $2,500,000 annually earmarked for the PMC funding model in clause 2 is unlikely to be spent, based on the daily stipend determined for each of the PMC Hospitals in clause 7, the anticipated unspent monies will be allocated to Fee Committee and will be reserved for enhancements to primary care fee codes.

9. Should additional funding become available, the Parties agree that the PMC funding model could be extended to other regional hospitals with PMC services.

SCHEDULE "I"

Targeted Investments

Targeted Investments

In addition to the across the board increases (ATB) made to physician renumeration rates the following specialities covered by the Master Agreement will receive additional investments as outlined below.

(i) Anesthesia

The annual Alternative Payment Plan (APP) rates for a 1.0 FTE in Anesthesia will increase according to the following schedule:

	April 1, 2019	Date of Board Approval	April 1, 2020	April 1, 2021	April 1, 2022
Rate Category 1	$293,044	$321,301	$335,158	$349,292	$356,278
Rate Category 2	$277,089	$303,702	$316,800	$330,160	$336,763
% Increase	2.0%	9.6%	4.3%	4.2%	2.0%

The Anesthesia Unit billed by Fee-for-Service Anaesthetists will increase according to the following schedule (new AU rates are inclusive of ATB increases and targeted investments):

	April 1, 2019	Date of Board Approval	April 1, 2020	April 1, 2021	April 1, 2022
AU Value	$21.50	$21.56	$22.71	$23.88	$25.30
% Increase **(from previous investment)**	2.0%	0.3%	5.3%	5.2%	5.9%

(ii) Emergency

The hourly rates funded to Emergency Departments across the province will follow the schedule below (rates are inclusive of ATB and Master Agreement targeted investments):

	April 1, 2019	April 1, 2020	April 1, 2021	April 1, 2022
Regional/Tertiary* Sites	$200.77	$232.51	$237.16	$241.91
Cobequid	$187.70	$217.38	$221.73	$226.16
Hybrid Funding Sites	$174.66	$202.28	$206.33	$210.46
Level 3 Daytime	$135.94	$154.96	$158.06	$161.22
Level 3 Night	$154.31	$178.71	$182.28	$185.93
Hospital - Level 4	$77.18	$89.39	$91.18	$93.00

*Under the C/AFP Agreement Departments may utilize the C/AFP Targeted Funding to increase the C/AFP Tertiary rate

(iii) **Psychiatry**

The hourly rates funded to District Psychiatrists will follow the schedule below (rates are inclusive of ATB and targeted investments):

	April 1, 2019	**Date of Board Approval**	**April 1, 2020**	**April 1, 2021**	**April 1, 2022**
Certified	$156.74	$186.91	$204.20	$209.59	$213.83
Non-Certified	$115.60	$137.85	$150.60	$154.57	$157.70
% Increase **(from previous years rate)**	2.0%	19.2%	9.2%	2.6%	2.0%

Upon DNS Board of Directors Approval of the agreement and movement to the new hourly rates the District Psychiatry Stabilization and Critical Vacancy payments will end. Hours claimed prior to Board approval will be paid at the rates effective April 1, 2019 and be included in the stabilization and critical vacancy formula. Hours claimed after Board approval will be paid at the new rates.

Psychiatry fee codes billed by Psychiatrists billing Fee-for-Service will be increased by the rates outlined in Appendix 1. The rate increases for year 1 will take effect the date the DNS Board of Directors approves this Agreement.

(iv) **Obstetrics and Gynecology**

The APP rates for a 1.0 FTE in Obstetrics and Gynecology will increase according to the following schedule (rates are inclusive of ATB and targeted funding):

	April 1, 2019	**April 1, 2020**	**April 1, 2021**	**April 1, 2022**
Annual Rate	$346,546	$382,554	$401,128	$409,150
% Increase **(from previous years rate)**	2.0%	10.4%	4.9%	2.0%

Selected Obstetrics and Gynecology fee codes will be increased by the rates outlined in Appendix 2.

(v) **Family Practice**

Effective April 1, 2020, the funding rate for Family Physicians working in the psychiatry hospitalist program at the Abbie Lane Memorial Hospital, The Nova Scotia Hospital and The East Coast Forensic Hospital will increase to match the APP collaborative rate per FTE ($262,059 as of April 1, 2019). Those physicians will also be able to bill fee for service for services delivered while on call.

As of date of DNS Board of Directors approval of this Agreement, Family Physicians providing hospitalist services through the IWK Newborn Service will be paid consistent with the Regional Hospitalist Program (daily rate of $1345.89 as of April 1, 2019, plus call at Category 1 level and ability to bill fee for service for services delivered while on call).

Alternative funding arrangements will be made available to physicians working in Primary Maternity Care programs as outlined in Schedule "H".

Increases will be made to Comprehensive Primary Care fee codes as outlined in Appendix 3. The rate increases for year 1 will take effect the date the DNS Board of Directors approves this Agreement.

As of the date of ratification of this Agreement, family physicians billing the delivery fee codes (eligible codes outlined in Appendix 2) will be eligible to claim the detention modifier (RO=DETE) for any obstetrical delivery that requires the physician to be in attendance of the patient for three or more hours, notwithstanding clause 5.2.75 of the Physician's Manual (2014).

(vi) **Blended Capitation**

The Parties agree that a blended capitation funding model for primary care will be developed and will begin to be rolled out by April 1, 2021. The model will be developed by the MAMG (or a subcommittee at MAMG's discretion). The following elements of the model have been agreed by the Parties:

- The model will be designed to promote and support comprehensive family medicine, greater attachment, access and quality for patients, and greater recruitment, retention and professional satisfaction for physicians.

- The model will provide fixed remuneration in the form of a capitation rate per patient per year (age and sex adjusted capitation weights; designed to represent 70% of earnings), as well as fee for service at a rate of 30% of services billed.

- The model will include an access bonus.

- All family physicians will be eligible for consideration to convert to the model, as long as they:

    - Commit to provide comprehensive continuous primary healthcare services across the life span, based on patient needs and responsive to documented needs of the geographic community they serve;

- Commit to use an Electronic Medical Record; and
- Have an appropriate team size (to be determined by MAMG)

- MAMG will develop all remaining details of the model, including elements that have been agreed in negotiations and those that are still being discussed.

- Transition to the blended capitation model will be voluntary. Physicians currently paid through either fee for service or Alternative Payment Plan will have the opportunity to convert to the blended capitation model if they are interested and meet the eligibility criteria as defined above. APP contracts will not be terminated by government or permitted to expire if the primary purpose for doing so is to force a physician to choose between FFS or blended capitation.

DHW agrees to provide funding for the model in the following amounts:

Fiscal Year	**Funding**
April 1, 2019 – March 31, 2020	$0
April 1, 2020 – March 31, 2021	$0
April 1, 2021 – March 31, 2022	$3,300,000
April 1, 2022 – March 31, 2023	$4,000,000

(vii) **Teaching stipend**

Funding is provided to recognize physician involvement in medical education and training. This funding will be used to remunerate preceptors who are not in an Alternative Funding Plan for providing medical education and training across the province. $600,000 will support increased physician involvement in medical education and $300,000 for resident teaching.

Effective April 1, 2020, fee for service physician preceptors who assume teaching responsibility for a Medical Student will be paid $450 per week. Fee for service physician preceptors who assume teaching responsibility for a Resident elective will be paid $250 per week. Physician preceptors on an Alternative Payment Plan will be recognized for their time spent teaching Medical Students and Residents by allowing them to bill a weekly fee code that will be developed by April 1, 2020, that will allow APP physicians to shadow bill the value of the teaching stipends outlined above.

APPENDIX 1

CHANGES to PSYCHIATRY FEE CODES (FEE VALUES INCLUDE MSU ATB INCREASES)

	Year 0		Year 1		Year 2		Year 3		Year 4	
	MSU	Fee	MSU	Fee	MSU	Fee	MSU	Fee	MSU	Fee
Routine psychiatric visit (08.5B)										
	35.8	**$88.78**	38.16	**$96.52**	42.68	**$110.11**	43.41	**$114.26**	43.56	**$116.93**
Psychotherapy (08.49B) - Psychiatrists only (no investment in GP version)										
	35.8	**$88.78**	38.32	**$96.93**	43.25	**$111.60**	44.46	**$117.02**	44.76	**$120.15**
Comprehensive consultation (03.08)										
	75	**$186.00**	82.30	**$208.19**	94.85	**$244.74**	103.24	**$271.70**	105.75	**$283.87**
Child psychiatric assessment (08.19A)										
	39.32	**$97.51**	42.08	**$106.46**	48.87	**$126.08**	50.23	**$132.20**	50.57	**$135.74**
Group therapy (08.44)										
	9	**$22.32**	9.63	**$24.37**	11.66	**$30.08**	11.99	**$31.54**	12.07	**$32.39**
Therapeutic/ Diagnostic Interview relating to a child (08.19B)										
	35.78	**$88.73**	38.30	**$96.87**	43.23	**$111.54**	44.44	**$116.95**	44.73	**$120.08**

APPENDIX 2

CHANGES TO OBSTETRIC AND GYNECOLOGY FEE CODES

Gynecology fee code changes:

			Year 0		Year 1		Year 2		Year 3		Year4	
Fee Code		Description	MSU	Fee Value ($2.48 per MSU)	MSU	Fee Value ($2.53 per MSU)	MSU	Fee Value ($2.58 per MSU)	MSU	Fee Value ($2.63 per MSU)	MSU	Fee Value ($2.68 per MSU)
1	03.03V	Medical Abortion/Termination of early Pregnancy	47.50	**$117.80**	47.50	**$120.16**	62.63	**$161.59**	67.03	**$176.41**	67.03	**$179.94**
2	80.89A	Abortion - incomplete; examination of the uterus without D&C or anaes.	25.00	**$62.00**	25.00	**$63.24**	32.96	**$85.05**	35.28	**$92.85**	35.28	**$94.71**
3	79.1	Conization of cervix including colposcopy	51.00	**$126.48**	51.00	**$129.01**	67.24	**$173.50**	71.97	**$189.41**	71.97	**$193.20**
4	87.21	Dilation and curettage for termination of pregnancy	71.00	**$176.08**	71.00	**$179.60**	93.61	**$241.54**	100.19	**$263.69**	100.19	**$268.97**
5	81.09	Other dilation and curettage	42.50	**$105.40**	42.50	**$107.51**	56.04	**$144.58**	59.98	**$157.84**	59.98	**$161.00**
6	81.09A	Endocervical curettage	10.00	**$24.80**	10.00	**$25.30**	13.19	**$34.02**	14.11	**$37.14**	14.11	**$37.88**
7	98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition	12.00	**$29.76**	12.00	**$30.36**	15.82	**$40.82**	16.93	**$44.57**	16.93	**$45.46**
8	81.69A	Endometrial biopsy	19.00	**$47.12**	19.00	**$48.06**	25.05	**$64.64**	26.81	**$70.57**	26.81	**$71.98**
9	80.4C	Lacroscopic Hysterectomy	300.00	**$744.00**	300.00	**$758.88**	395.55	**$1,020.59**	423.36	**$1,114.19**	423.36	**$1,136.47**
10	80.3	Total abdominal Hysterectomy	240.00	**$595.20**	240.00	**$607.10**	316.44	**$816.48**	338.69	**$891.35**	338.69	**$909.18**
11	80.4A	Vaginal hysterectomy - Uterus-total vaginal w/ rectocoele /cystocoele repair	287.00	**$711.76**	287.00	**$726.00**	378.41	**$976.37**	405.01	**$1,065.91**	405.01	**$1,087.23**
12	80.4	Vaginal hysterectomy - (subtotal)	240.00	**$595.20**	240.00	**$607.10**	316.44	**$816.48**	338.69	**$891.35**	338.69	**$909.18**
13	80.2A	Subtotal abdominal hysterectomy with or without adnexa	240.00	**$595.20**	240.00	**$607.10**	316.44	**$816.48**	338.69	**$891.35**	338.69	**$909.18**
14	80.3A	Uterus-total abdominal with rectocoele and/or cystocoele repair	287.00	**$711.76**	287.00	**$726.00**	378.41	**$976.37**	405.01	**$1,065.91**	405.01	**$1,087.23**
15	80.3C	Abdominal hysterectomy with salphingophorectomy including bilateral	400.00	**$992.00**	400.00	**$1,011.84**	527.40	**$1,360.79**	564.48	**$1,485.59**	564.48	**$1,515.30**
16	77.19C	Laparoscopic ovarian cystectomy	150.00	**$372.00**	150.00	**$379.44**	197.78	**$510.30**	211.68	**$557.09**	211.68	**$568.24**
17	86.3A	Surg Removal of Extrauterine (Ectopic) Preg. by any means (incl. tubal preg.)	130.00	**$322.40**	130.00	**$328.85**	171.41	**$442.26**	183.45	**$482.82**	183.45	**$492.47**
18	78.1A	Salpingectomy for morbidity, not for sterilization	130.00	**$322.40**	130.00	**$328.85**	171.41	**$442.26**	183.45	**$482.82**	183.45	**$492.47**
19	10.16	Insertion of vaginal pessary	23.50	**$58.28**	23.50	**$59.45**	30.98	**$79.95**	33.16	**$87.28**	33.16	**$89.02**
20	80.19A	Other excision or destruction of lesion of uterus myomectomy	160.00	**$396.80**	160.00	**$404.74**	210.96	**$544.32**	225.79	**$594.23**	225.79	**$606.12**
21	82.81A	Culposcopy	8.50	**$21.08**	8.50	**$21.50**	11.21	**$28.92**	12.00	**$31.57**	12.00	**$32.20**
22	78.39A	Interruption or removal of fallopian tubes for purposes of sterilization	105.00	**$260.40**	105.00	**$265.61**	138.44	**$357.21**	148.18	**$389.97**	148.18	**$397.77**
23	77.51	Removal of both ovaries and tubes	195.00	**$483.60**	195.00	**$493.27**	257.11	**$663.39**	275.18	**$724.22**	275.18	**$738.71**
24	80.81	Hysteroscopy	42.50	**$105.40**	42.50	**$107.51**	56.04	**$144.58**	59.98	**$157.84**	59.98	**$161.00**
25	77.19A	Salpingectomy and salpingo-oophorectomy	130.00	**$322.40**	130.00	**$328.85**	171.41	**$442.26**	183.45	**$482.82**	183.45	**$492.47**

Obstetric fee code changes:

			Year 0		Year 1		Year 2		Year 3		Year4	
Fee Code		Description	MSU	Fee Value ($2.48 per MSU)	MSU	Fee Value ($2.53 per MSU)	MSU	Fee Value ($2.58 per MSU)	MSU	Fee Value ($2.63 per MSU)	MSU	Fee Value ($2.68 per MSU)
26a	87.98	Delivery (RF=REFD,SP=OBGY)	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
26b	87.98	Delivery (SP=OBGY or SP=GENP;RF=REFD)	200.00	**$496.00**	200.00	**$505.92**	263.70	**$680.40**	282.24	**$742.79**	282.24	**$757.65**
27	86.1	Cervical Caesarean section	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
28	84.79	Other vacuum extraction	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
29	86.1A	Caesarean section with tubal ligation	280.00	**$694.40**	280.00	**$708.29**	369.18	**$952.56**	395.13	**$1,039.91**	395.13	**$1,060.71**
30	84.71	Vacuum extraction with episiotomy	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
31	84	Low forceps delivery without episiotomy	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
32	84.1	Low forceps delivery (with episiotomy)	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
33	84.8	Other specified instrumental delivery	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
34	84.29	Other mid forceps delivery	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
35	84.21	Mid forceps delivery (with episiotomy)	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
36	84.53	Total breech extraction	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
37	84.51	Breech extraction, unqualified	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
38	84.52	Partial breech extraction	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
39	84.61	Partial breech extraction with forceps to aftercoming head	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
40	84.62	Total breech extraction with forceps to aftercoming head	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**
41	84.9	Unspecified instrumental delivery	260.00	**$644.80**	260.00	**$657.70**	342.81	**$884.52**	366.91	**$965.63**	366.91	**$984.94**

Both Gynecology and Obstetric fee code changes:

			Year 0		Year 1		Year 2		Year 3		Year4	
Fee Code		Description	MSU	Fee Value ($2.48 per MSU)	MSU	Fee Value ($2.53 per MSU)	MSU	Fee Value ($2.58 per MSU)	MSU	Fee Value ($2.63 per MSU)	MSU	Fee Value ($2.68 per MSU)
42	81.8	Insertion of intra-uterine contraceptive device	32.00	$79.36	32.00	$80.95	42.19	$108.86	45.16	$118.85	45.16	$121.22
43	81.01	Dilation and curettage following delivery or abortion	57.00	$141.36	57.00	$144.19	75.15	$193.91	80.44	$211.70	80.44	$215.93
44	81.61	Aspiration curettage following delivery or abortion	57.00	$141.36	57.00	$144.19	75.15	$193.91	80.44	$211.70	80.44	$215.93

OB/GYN Consultation fee code changes:

			Year 0		Year 1		Year 2		Year 3		Year4	
Fee Code		Description	MSU	Fee Value ($2.48 per MSU)	MSU	Fee Value ($2.53 per MSU)	MSU	Fee Value ($2.58 per MSU)	MSU	Fee Value ($2.63 per MSU)	MSU	Fee Value ($2.68 per MSU)
45	03.08	Comprehensive Consultation (Prolonged)	35.1	$87.05	35.10	$88.79	37.60	$97.02	40.10	$105.54	40.10	$107.65
46	03.07	Limited Consultation	24.5	$60.76	24.50	$61.98	27.00	$69.67	29.50	$77.64	29.50	$79.19
47	03.07	Repeat Consultation (Prologonged)	22.5	$55.80	22.50	$56.92	25.00	$64.50	27.50	$72.37	27.50	$73.82

APPENDIX 3

COMPREHENSIVE PRIMARY CARE FEE CODE MSU CHANGES

		Year 0		Year 1		Year 2		Year 3		Year 4	
Fee Code Description		MSU	Fee Value ($2.48 per MSU)	MSU	Fee Value ($2.53 per MSU)	MSU	Fee Value ($2.58 per MSU)	MSU	Fee Value ($2.63 per MSU)	MSU	Fee Value ($2.68 per MSU)
1	Office Visit (ME=CARE)	14.76	**$36.60**	15.28	**$38.64**	15.95	**$41.15**	16.96	**$44.64**	16.96	**$45.54**
2	Geriatric Office Visit (ME=CARE)	18.26	**$45.28**	18.90	**$47.81**	19.73	**$50.91**	20.99	**$55.23**	20.99	**$56.33**
3	Office Visit (After-Hours; ME=CARE)	18.45	**$45.76**	19.10	**$48.30**	19.94	**$51.44**	21.20	**$55.80**	21.20	**$56.92**
4	Geriatric Office Visit (After-Hours; ME=CARE)	22.83	**$56.62**	23.63	**$59.77**	24.67	**$63.66**	26.24	**$69.05**	26.24	**$70.43**
5	Office Visit - Well Baby Care (ME=CARE)	14.76	**$36.60**	15.28	**$38.64**	15.95	**$41.15**	16.96	**$44.64**	16.96	**$45.54**
6	Office Visit - Well Baby Care (After-Hours; ME=CARE)	18.45	**$45.76**	19.10	**$48.30**	19.94	**$51.44**	21.20	**$55.80**	21.20	**$56.92**
7	Office Visit - Prenatal Care (ME=CARE)	14.76	**$36.60**	15.28	**$38.64**	15.95	**$41.15**	16.96	**$44.64**	16.96	**$45.54**
8	Office Visit - Prenatal Care (After-Hours; ME=CARE)	18.45	**$45.76**	19.10	**$48.30**	19.94	**$51.44**	21.20	**$55.80**	21.20	**$56.92**
9	Office Visit - Postnatal Care (After-hours; ME=CARE)	23.75	**$58.90**	24.58	**$62.18**	25.67	**$66.22**	27.30	**$71.83**	27.30	**$73.27**
10	Subsq. Inpatient Care Visit (Days 2, 3)	23	**$57.04**	23.81	**$60.22**	24.85	**$64.13**	26.43	**$69.57**	26.43	**$70.96**
11	Subsq. Inpatient Care Visit - Newborn Infant (Days 2, 3)	23	**$57.04**	23.81	**$60.22**	24.85	**$64.13**	26.43	**$69.57**	26.43	**$70.96**
12	Subsq. Inpatient Care Visit - Post-Partum (Days 2, 3)	23	**$57.04**	23.81	**$60.22**	24.85	**$64.13**	26.43	**$69.57**	26.43	**$70.96**
13	Subsq. Inpatient Care Visit (Days 4 -7)	19	**$47.12**	19.67	**$49.74**	20.53	**$52.98**	21.84	**$57.47**	21.84	**$58.62**
14	Subsq. Inpatient Care Visit - Post-Partum (Days 4 - 7)	19	**$47.12**	19.67	**$49.74**	20.53	**$52.98**	21.84	**$57.47**	21.84	**$58.62**
15	Subsq. Inpatient Care Visit (Daily to 56 days)	16	**$39.68**	16.56	**$41.89**	17.29	**$44.61**	18.39	**$48.39**	18.39	**$49.36**
16	Subsq. Inpatient Care Visit (Weekly after Day 56)	16	**$39.68**	16.56	**$41.89**	17.29	**$44.61**	18.39	**$48.39**	18.39	**$49.36**