This **AGREEMENT** made the ___ day of ___________, 2023

PHYSICIAN AGREEMENT

BETWEEN:

HIS MAJESTY THE KING 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, a body corporate continued by the *Doctors Nova Scotia Act*, SNS 1995-96, c 12 ("**DNS**")

OF THE SECOND PART

WITNESSETH:

WHEREAS DHW has the power, pursuant to the *Health Services and Insurance Act,* RSNS 1989, 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*, SNS 1995-96, c 12; as amended, 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 and Dalhousie University, wish to continue to work together in a relationship built upon transparency, constructive collaboration and mutual respect;

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

1. DEFINITIONS

In this Agreement:

(a) "**Act**" means the *Health Services and Insurance Act*, RSNS 1989, c 197, as amended;

(b) "**Agreement**" and "**Physician Agreement**" mean this Agreement, including all Schedules and Appendices, and any amendments made in accordance with this Agreement;

(c) "**Allied Health Care Practitioner**" means a regulated health professional;

(d) "**C/AFP**" means Clinical Academic Funding Plan;

(e) "**C/AFP Agreement**" means an Agreement between the Parties, the health authorities, Dalhousie University and C/AFP Department Heads concerning clinical and academic services to be delivered by C/AFP physicians and departments, and funding and other supports in respect of those services;

(f) "**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;

(g) "**Fee Committee**" means the Fee Committee described in Article 4(d)(i) of this Agreement;

(h) "**Health Authority**" means a health authority established or continued by the *Health Authorities Act*, SNS 2014, c 32, including the Nova Scotia Health Authority and the IWK Health Centre;

(i) "**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;

(j) "**Insured Residents**" means residents of Nova Scotia as defined by the Act and the regulations made under the Act;

(k) **"ME=CARE algorithm"** means the method used by DHW to determine patient attachment to an individual Physician to derive the Physician's panel of attached patients, including the following features which are subject to change only by agreement of the Parties:

   (i) the ME=CARE algorithm assigns a point value to every physician encounter with a patient, calculating a score using the points, and crediting the physician with the highest score with attachment to that patient;

   (ii) a patient can only be credited to one physician's panel;

(iii) the points awarded for each encounter are determined by the formula 10/(*m*+5), where *m* is the number of months between the panel evaluation date and the encounter date, such that recent appointments count for higher points;

(iv) in the event of a tie, the physician with the most recent ME=CARE encounter with the patient is credited with the attachment;

(v) once a physician's panel of attached patients has been determined according to the algorithm outlined in articles 1(k)(i)-(iv), the physician’s panel size will be increased by 10% to reflect patients who have not sought care from the physician in recent years but who would nonetheless consider the physician to be their most responsible provider;

(l) “**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;

(m) “**MSI Physician’s Manual**” means:

(i) the document published by DHW that contains a preamble and Insured Medical Services, including their descriptions and codes, any special conditions and their value in units, and

(ii) any updates or amendments to the MSI Physician’s Manual published from time to time by DHW;

(n) “**PAMG**” means the Physician Agreement Management Group established under Article 6 of this Agreement;

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

(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 a system of payment for Insured Medical Services under the Act, as set out in the MSI Physician’s Manual, including any changes made pursuant to this Agreement;

(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, 2023 and continue in force and effect for a period of four (4) years, terminating on March 31, 2027.

(b) The rate increases in Article 4(b)(i) will take effect on April 1, 2023; all other elements of this Agreement will take effect upon execution of this Agreement 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, all terms and conditions of this Agreement shall remain in effect until such time as the Parties agree upon a new Agreement to replace this Agreement, or a new Agreement to replace this Agreement is otherwise established.

(e) If there are significant challenges recruiting or retaining in particular specialties in the province, new and significant investments in physician services in other provinces, particularly the other Atlantic provinces, or any other risk to the Parties' shared goal of ensuring that continuous and competent, direct and indirect medical services be and remain available to the residents of Nova Scotia, the Parties may agree to consider whether any provision of this contract should be amended.

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* 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. The Parties recognize that physicians licensed to practice in Nova Scotia 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.

(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

(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 MSI Physicians' Manual will continue to be published with the actual fee for Insured Medical Services represented in units. The Tariff in effect as of April 1, 2023 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.

(b) Rates and 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, 2023 – March 31, 2024	3%
April 1, 2024 – March 31, 2025	3%
April 1, 2025 – March 31, 2026	2%
April 1, 2026 – March 31, 2027	2%

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

(iii) The applicable rate increases will apply to Longitudinal Family Medicine hourly and panel rates effective April 1, 2024.

(iv) Parties have agreed that the deadline for submitting service encounter claims for purposes of billing or shadow billing shall be reduced from 90 days to 60 days from the date of service. Physicians will be notified of this change at least 90 days in advance of the effective date. Parties agree to review the exception policy to ensure alignment and understanding.

(v) A medical practitioner who is licensed to practice in Nova Scotia under the Atlantic Registry and whose home College is not Nova Scotia is entitled to compensation for Insured Medical Services provided by the medical practitioner in Nova Scotia according to the applicable compensation model hereunder to which the Physician and DHW have agreed, including fee for service, locum, sessional, etc, as if the medical practitioner was a Physician, but is not entitled to any other benefit or compensation under this Agreement.

(c) **New interim fee codes**

Effective upon the signature of this Agreement by all Parties hereto, new interim fee codes will be available for the following services, in accordance with Schedule “B”:

(i) New patient intake visit;

(ii) Geriatric office visit;

(iii) Prolonged office visit for ME=CARE;

(iv) Prolonged nursing home visit;

(v) Telephone Prescription renewal:

(vi) Allied health care provider to physician;

(vii) Specialist advice – Consultant Physician – providing advice;

(viii) Specialist advice – Referring Physician – requesting advice.

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

(i) The Parties agree to continue a committee, called the “Fee Committee” to review requests for new fees, to amend current fees, and for additions, revisions or clarifications of 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 the Fee Committee. The Parties agree to review the Fee Committee process to identify opportunities for improved efficiency and additional supports required.

(iii) 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 as described in article 4(d)(iv).

(iv) The Fee Committee may approve new fees, fee adjustments or MSI Physicians' Manual changes, provided that the financial expenditure resulting from any such approval in a fiscal year may not exceed the Fee Committee's budget for that fiscal year, as follows:

a) 1 April 2023 – 31 March 2024: $1M;

b) 1 April 2024 – 31 March 2025: $2M;

c) 1 April 2025 – 31 March 2026: $1.5M;

d) 1 April 2026 – 31 March 2027: $1.5M.

(v) In addition to the amounts in (iv), the Fee Committee may also approve new fees, fee adjustments or MSI Physicians' Manual changes for purposes of transitioning the existing Collaborative Practice Incentive Program (CPIP) to fees that capture collaboration time. For that purpose, the Fee Committee will use the current CPIP funding (less the LFM portion), and may use a portion of the amounts in (iv) in addition if necessary.

(vi) For greater certainty:

a) the budget amount set out in article 4(d)(iv) for any given fiscal year is in addition to the amounts from previous fiscal years;

b) any budget amount set out in article 4(d)(iv) for any given fiscal year which is not committed by Fee Committee to new fees, fee adjustments or MSI Physicians' Manual changes shall be available to Fee Committee in the next fiscal year, in addition to the budget amount for that fiscal year set out in article 4(d)(iv); and,

c) budget funds set out in article 4(d)(iv) which are not spent in any fiscal year shall not carry forward to or be otherwise available to Fee Committee in any subsequent fiscal year.

(vii) The Fee Committee will consider new fees for the following:

a) in priority to all other proposed fees, replacement of the Collaborative Practice Incentive Program with fees capturing collaboration time;

b) physician-to-physician capacity-building, mentoring and maintenance of competency;

c) health authority requested quality or safety work, including physicians leading practice improvements or participating in NSH improvement initiatives within a health home model;

d) team development within a health home model;

e) family physician consults;

f) group medical visits;

g) extension of the Comprehensive Geriatric Assessment to patients in community;

h) goals of care discussions and end-of-life services in community;

i) shared care and co-management of patients;

j) centralized triage;

k) general internal medicine visit and consult codes, including access to the Complex Comprehensive Acute Care Hospital Discharge Fee, follow-up visit in office, subsequent hospital visit;

l) case management conferences;

m) prolonged specialist telephone advice;

n) LTC chart review

o) Substitute decision maker and,

p) other services assigned by PAMG from time to time.

(viii) The Fee Committee will review the new interim codes pursuant to article 4(c) and make recommendations for any adjustments in time that any such adjustments may be in place prior to April 1, 2026.

(e) **Longitudinal Family Medicine Payment Model**

(i) The Parties will implement a new payment model, titled “Longitudinal Family Medicine” (LFM), as detailed in Schedule “C” to compensate family physicians who choose to enrol in the LFM model.

(ii) The LFM model will replace primary care APPs, CEC and Group APPs for office-based Family Physicians as outlined in Schedule “C”. The Parties currently intend that the LFM model will take effect 1 October 2023, unless circumstances require the implementation date to be extended.

(iii) The model will be implemented through agreements between DHW, the NSH and individual physicians. DNS will be a signing party to the agreements.

(iv) In recognition of the transition to a new payment model, DHW will pay a one time LFM Bridging payment: to all APP family physicians who are practicing in a ME=CARE practice as of October 1, 2023. These physicians will be eligible to receive a grant of $10 per individual patient on the Physician's panel of attached patients as of September 30, 2023, as determined by DHW using the ME=CARE algorithm, to a maximum of $20,000.

(f) **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.

(g) **Continuing Medical Education**

DHW will provide funding for the Professional Development Support Programs as set out in Schedule "D".

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

(i) DHW will provide a one-time Physician-specific EMR Investment Grant for both Family Physicians and Specialists of $10,000, as a contribution to offset the Physician's out-of-pocket implementation costs associated with the acquisition of an EMR system meeting DHW-approved functional requirements. The eligibility criteria for this grant in effect at the time of execution of this Agreement shall continue unless changed by PAMG.

(ii) For physicians in the LFM payment model, EMR B and C are integrated into the LFM so will no longer be paid separately as an incentive program. EMR A will continue to be available to FPs within the LFM model.

(iii) EMR A, B and C will continue for all other physicians (regardless of payment model) as an incentive program (total funding envelope will be reduced by the LFM value).

(iv) The parties agree to review the program prior to 2024 payments to identify opportunities to streamline and reduce administrative burden arising from current program design and parameters.

(v) The program will also be reviewed and considered by the Physician Agreement Management Group as the transition to OPOR begins. All parties are supportive of OPOR and will look for opportunities to streamline and enhance the OPOR implementation.

(i) **Other programs**

DHW will pay Physicians pursuant to the following programs, in accordance with Schedule "E":

(i) Rural Specialist Practice Support Program;

(ii) Facility On-call Program;

(iii) Surgical Assist Incentive Program.

(j) **Targeted Project Funding**

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

(k) **Benefits and Physician Wellness**

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

(ii) DHW will reimburse DNS for premiums and expenses set out in article 4(k)(i) no more often than monthly, upon presentation of an invoice for expenses incurred by DNS, in form and content satisfactory to DHW.

(iii) DHW will pay an administration fee of $400,000 per year, which represents 4% of the benefits program value of $10,000,000, to DNS monthly, in advance, upon presentation of an invoice from DNS, in form and content satisfactory to DHW.

(iv) DHW shall provide, at a minimum, 12 months written notice to DNS should DHW intend to modify in any way, including reduce or terminate, the health and dental funding referred to in (k)(i) above. For greater certainty, this notice requirement includes any intention, plan or goal, to reduce and/or terminate health and dental benefit funding established in this Agreement through negotiations for any successive Physician Agreement(s). It is further understood the purpose and intent of this Notice period is to provide physicians affected adequate time to secure alternate health and dental coverage, as necessary.

(v) DHW will fund a parental leave program, administered by DNS, for Physicians as follows:

a. To be eligible to enrol in the parental leave program, a Physician must have clinical insured billings (or alternate payment plan or clinical/academic funding plan payments) in Nova Scotia exceeding $50,000 during the calendar year prior to the Physician's application to the parental leave program, and must have

ceased to provide Insured Medical Services as a result of taking leave to parent a newborn or newly adopted child (“parental leave”).

b. Upon enrolment, a Physician who has ceased to provide Insured Medical Services while on parental leave will receive $2000 per week, for up to 26 weeks during which the Physician is not providing Insured Medical Services as a result of taking parental leave.

c. The 26 weeks may be spread over a maximum of 52 weeks from the date when parental leave is first taken.

d. Despite the requirement in articles 4(k)(v)a. and b. that the Physician must have ceased to provide Insured Medical Services, the Physician may receive payment for Insured Medical Services provided while on leave to a maximum of $1200 in any given week while on parental leave, without a reduction in the amount of the benefit payable under the parental leave program.

(vi) DHW will fund a Professional Support Program (EAP type) to make counselling and other support services available for both physicians and their families.

a. Effective 1 April 2023, DHW will reimburse DNS for expenses incurred by DNS in the delivery of the Professional Support Program up to $350,000 per year, no more often than monthly, upon presentation of an invoice for expenses incurred by DNS, in form and content satisfactory to DHW.

b. Effective 1 April 2024, the maximum reimbursement payable pursuant to article 4(k)(vi)(a) will increase from $350,000 to $700,000 per year.

(vii) The following persons are not eligible for any benefit or program under article 4(k):

a. a medical practitioner who is licensed to practice in Nova Scotia under the Atlantic Registry and whose home College, where they hold a Full license, is not Nova Scotia;

b. a medical practitioner who is licensed to practice medicine in Nova Scotia but who does not provide Insured Medical Services in Nova Scotia;

(viii) The Parties agree to establish a working group to better coordinate and enhance physician wellness initiatives in Nova Scotia. The working group will inventory existing wellness initiatives, identify any gaps and make recommendations to enhance physician wellness initiatives.

(l) **Community Hospital Inpatient Program**

DHW will provide compensation in respect of the Community Hospital Inpatient Program as described in Schedule “G”.

(m) **Primary Maternity Care Model**

DHW will provide compensation in respect of the Primary Maternity Care Model, as described in Schedule “H”.

(n) **Physician Administrative Review**

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

(o) **Travel Expenses**

When a Physician is required by a health authority in writing to travel for work, other than to the Physician's regular work site or sites or as part of the Physician's regular work, DHW will compensate Physicians for travel and expenses incurred by the Physician in the course of travel as follows:

(i) Kilometrage from the Physician's residence or regular work site (whichever is closer to the required non-regular work site) to the required non-regular work site, and return, at the then-prevailing Nova Scotia Government kilometrage rate;

(ii) Per diem of $100 per day, prorated by proportion of the day worked.

(iii) Accommodations at 100% to a maximum of $300 per night;

(iv) Travel time at $100 per hour to a maximum of 10 hours return trip (5 hours each way);

(v) Payment within a reasonable time after presentation of an invoice and supporting documentation as may be required by DHW in its discretion, in form and content satisfactory to DHW

(vi) No travel time or expenses are payable for travel that is less than one hour or for travel outside Nova Scotia.

(p) **Virtual Insured Medical Services**

DHW may amend or adjust rules and policies in respect of Insured Medical Services delivered by electronic communication, but shall not restrict the availability of such services or decrease the compensation payable in respect of such services unless DHW has provided three months prior notice in writing to DNS, and consulted with DNS about the changes.

(q) **Locum program**

Effective upon signing, compensation pursuant to DHW's locum programs shall be adjusted as follows:

(i) The minimum income for a locum Physician shall be as follows:

a. for a Family Physician the minimum daily income shall be $1200;

b. for a part-time Family Physician the minimum half-day income shall be $600;

c. for a Specialist the minimum daily income shall be $1600; and

d. for a part-time Specialist the minimum half-day income shall be $800;

(ii) A Physician who is required by a health authority to travel for purposes of a locum assignment shall be entitled to reimbursement for travel expenses incurred by the Physician, as demonstrated by evidence that may be required by DHW, as follows:

a. Kilometrage from the Physician's residence or regular work site (whichever is closer to the required non-regular work site) to the required locum work site, and return, at the then-prevailing Nova Scotia Government kilometrage rate (unless NSH has provided a rental car for physician's use);

b. per diem of up to $100 per day;

c. accommodations at 100% to a maximum of $300 per night;

d. airfare to and from Nova Scotia where required, 100% covered at regular economy fare up to a maximum of $1500;

(iii) A Physician who is required by a health authority to travel more than one hour for purposes of a locum assignment shall be entitled to compensation for travel time, paid at $100 per hour, to a maximum of 10 hours return (5 hours each way) per week;

(iv) A Physician who is required to obtain a license to practice medicine in Nova Scotia for purposes of a locum assignment, and who is not otherwise licensed to practice medicine in Nova Scotia, shall be entitled to reimbursement of CPSNS licensing fees as follows:

a. for a Physician who is eligible for a license to practice in Nova Scotia under the Atlantic Registry and whose home College is not Nova Scotia, the CPSNS Atlantic Registry license fee;

b. for a Physician from outside Nova Scotia who is not described in article 4(q)(iv)a., the CPSNS locum license fee;

(v) DHW shall make a contribution to a Physician who is replaced by a locum Physician, of $250 per day for the duration of the replacement;

(vi) A locum physician who shadow bills for Insured Medical Services more than the applicable minimum daily rate set out in article 4(q)(i) on a given day, including for Insured Medical Services delivered after hours, shall be entitled to payment of the amount of shadow billing greater than the applicable minimum daily rate set out in article 4(q)(i);

(vii) A locum physician who covers call while covering the locum is entitled to payment under the Facility On Call program, but is not entitled to payment for any services delivered while on call unless the physician's total shadow billings for the day and after-hours services exceed the minimum daily rate, as outlined in (vi) above;

(viii) The locum program is available to family physicians in all zones, including Central zone and expand to cover approved vacancies.

(ix) The Parties agree to review the locum guidelines and to consider if changes are needed in the following areas:

a. Application of the locum program for practices needing support to implement advanced access, and/or for parental and other leaves; and

b. General review and updating of the program guidelines, including access to comprehensive medicine incentives.

(x) The Parties recognize the need for greater practice and locum supports for physicians in longitudinal family practice. These enhancements to the locum program, including the expansion to Central zone family physicians, are made to bolster that support. The PAMG will monitor the results of these locum program changes and will explore the potential benefits and risks associated with establishing a pool of locum family physicians in future.

(r) **After hours premium**

The after hours premium set out at section 5.1.81 of the MSI Physicians' Manual shall be available in non-emergency circumstances for any after-hours work requested and approved by one of the health authorities to support the surgical strategy as confirmed by the health authority.

(s) **Rostering grant**

DHW will pay eligible Family Physicians a rostering grant as follows:

(i) Only Family Physicians who are compensated primarily through a fee-for-service arrangement, who are party to a ME=CARE declaration, who have provided Insured Medical Services during the year prior, and who are still practicing in a ME=CARE practice as of March 31 of the fiscal year with regard to which the grant is claimed are eligible. The first year payment will be made in two installments based on ME=CARE total patients as at September 30, 2023 and again as at March 31, 2024.

(ii) The amount of the grant is $20 per fiscal year, per individual patient on the eligible Physician's panel of attached patients during that fiscal year, as determined by DHW using the ME=CARE algorithm;

(iii) The grant is available up to a maximum of 2000 patients per eligible Physician per fiscal year; for greater certainty, no eligible Physician may receive more than $40,000 in any fiscal year;

(iv) The grant is payable within a reasonable time following the end of the fiscal year in which the patient appeared on the Physician's roster of attached patients.

(t) **Allied Health Care Practitioners**

The Parties agree that DHW shall develop a pilot program to compensate a Family Physician who employs an Allied Health Care Practitioner to deliver health care services

to the Physician's patients, under an arrangement approved by the Nova Scotia Health Authority and DHW, including the following parameters:

(i) The pilot shall be available as of 1 April 2024, and terminate upon the termination of this Agreement;

(ii) Proposals for approval of the arrangement by the Nova Scotia Health Authority and DHW must be submitted by the Physician between January 1 and February 29, 2024 for implementation of a proposed arrangement commencing on or after 1 April 2024, and between January 1 and February 28, 2025, for implementation of a proposed arrangement commencing on or after 1 April 2025;

(iii) If the proposal is approved, the Physician will be entitled to bill for health care services delivered by the Allied Health Care Practitioner to the Physician's patients, to a maximum of $110,000 per year per Allied Health Care Practitioner, at the following rates:

a. $25 for a simple service (a service delivered in under one hour);

b. $52 for a complex service taking one hour or more.

(iv) For greater clarity, a Physician cannot bill for health care services delivered by an Allied Health Care Practitioner if the Allied Health Care Practitioner is paid by the Nova Scotia Health Authority or another third party.

(u) **Teaching**

(i) Effective upon signing of this Agreement, DHW will pay a Physician who is approved by Dalhousie University and DHW to precept, and who agrees to be available as reasonably required to act as preceptor for Dalhousie University medical and residency students and/or oversee a practice ready assessment, an annual payment of $5000, payable once the physician is approved by Dalhousie and has committed to precept.

(ii) If it is determined by Dalhousie or DHW that additional preceptors are no longer required, Dalhousie or DHW may not add additional physicians to the roster. In that circumstance, the $5000 annual payment will not be available to physicians not already part of the roster.

(iii) Effective 15 September 2023, a Physician who is engaged by Dalhousie University to teach undergraduate medical school students or resident physicians, or to oversee a practice-ready assessment, will be paid a premium of 5 per cent on all billings for Insured Medical Services provided by the Physician when a student or assessee is present in person with the Physician. For greater certainty, for purposes of the LFM the premium will result in a total payment of 35% of fee-for-service billings for Insured Medical Services provided by the Family Physician when a student or assessee is present in person with the Physician.

(iv) Weekly and daily preceptor stipends currently in effect, will continue in effect pending any changes arising from article 4(u)(v).

(v) The Parties will establish a Working Group to review the weekly and daily preceptor stipends currently in effect:

a. The Working Group will consider all current rates, funding sources and the relative values and intensity of the time and work involved for preceptors.

b. The Working Group will recommend appropriate preceptor stipends for each category of learner (undergraduate, various post-graduate levels, core versus elective rotations, practice ready assessment program participants, etc.).

c. The Working Group will consider using the updated rates as a proxy for education and assessment activities within an C/AFP through shadow billing.

d. The Working Group will conduct a specific review of funding currently provided for precepting by physicians working in fee for service academic departments and divisions, with a view to rectifying any gaps.

e. The Working Group will aim to complete its review by November 30, 2023.

f. The Working Group will include recommendations on how to implement any new stipends most effectively and aligned with available funding and budget processes.

(vi) As an interim strategy until the review is completed and implemented, fee for service physicians who are part of an academic department or division will be eligible to bill the teaching stipends as per the physicians manual, and will be eligible for the premium of 5 per cent on all fee-for-service billings for Insured Medical Services provided by the Physician when a student or assessee is present in person with the Physician but will not be eligible for the other payments described in this article 4(u).

(vii) All physicians (including FFS, APP, hospitalist and emergency department physicians) are eligible for the payments described in article 4(u) with the exception of physicians compensated through a Clinical Academic Funding Plan.

(viii) The PAMG will review the teaching initiatives contained in this article 4(u) after one year of implementation to assess the functionality and outcomes achieved. Changes may be made with agreement of all Parties.

(v) **First through the Door**

(i) Core specialty physicians in regional hospitals that are significantly under their target complement may be eligible to participate in an incentive structure, titled “First through the Door”, designed to both remunerate for the demands associated with keeping the service afloat and attract new physicians to the area.

(ii) Definitions: For purposes of the First through the Door incentive program:

a. A new recruit is a core specialty physician new to the regional hospital who has entered into a letter of offer with the Nova Scotia Health Authority to take on a permanent practice in an eligible service;

b. An existing core specialty physician is in permanent practice at a regional hospital who is agreeable to continue in practice and support the service and site as best as possible during a period of high vacancy, as determined by DHW;

c. Base pay is the regular payment for the core specialty physician in the regional setting according to this Agreement, including a contract rate or fee-for-service arrangement. Base pay for a FFS physician will be calculated based on the average of the prior three years.

(iii) Program Eligibility & Details:

a. The following core specialties at regional hospitals: GIM, General Surgery, Anesthesia, and other specialties and sites in DHW’s discretion;

b. Deliverables for the incentive payment will be defined by the Nova Scotia Health Authority and the Physician involved, and will include inpatient coverage, call coverage, volume of services, and other services required by the Nova Scotia Health Authority;

c. The Nova Scotia Health Authority and the Physician involved must be actively recruiting and/or supporting recruitment efforts;

d. First through the Door program payments are additional to any recruitment incentives for which the physician(s) are eligible.

(iv) Remuneration: A defined incentive structure will be payable as follows:

a. When the service is completely vacant a 20% increase to base pay for a new recruit will be offered to a new recruit.

b. If a service is between 99%-80% vacant a 10% increase to base pay will be offered to an existing core specialty physician and a new recruit.

c. If a service is between 79% and 60% vacant a 5% increase to base pay will be offered to an existing core specialty physician and a new recruit.

(v) Term: The First through the Door incentive will remain in place as follows:

a. For a new recruit the First through the Door incentive will be paid for three years after the Physician's start date regardless of vacancy status. If at the end of the initial three-year period, vacancies still exist as outlined in article 4(v)(iv) then the Physician's incentive payment will be determined with reference to the payment available to an existing core specialty physician, as set out in article 4(v)(iv).

b. For an existing core specialty physician, the First through the Door incentive will be paid as long as the vacancies remain at a level set out in article 4(v)(iv) at the amount set out in article 4(v)(iv), and for three months after a vacancy has been alleviated to a lower vacancy level as set out in article 4(v)(iv).

c. If the vacancy worsens while a new recruit or existing core specialty physician is being paid the First through the Door incentive, the physician may be paid the highest bonus available as set out in article 4(v)(iv).

(w) **Succession planning**

(i) DHW will consider written proposals brought forward by a health authority for a TIP-TOP (Transition Into Practice – Transition Out of Practice) plans, and where a temporary increase in FTE complement for purposes of succession planning is determined by DHW to be in the best interests of the health care system. DHW will approve or reject proposals in DHW's discretion, subject to the following:

a. Cross over may be up to two years;

b. The proposal must not entail any additional operational or capital costs to a health authority;

c. The proposal must include a plan to support the TIP-TOP period, including both service delivery and remuneration arrangements, including expanded Physician deliverables during any period of cross over.

(ii) A proposal may be made by any Physician regardless of funding model. Physicians can initiate a proposal by contacting their Department Head.

(iii) Stable funding may be provided to the physicians for the period of overlap where needed.

5. PHYSICIAN RESOURCES

(a) Requests for new or additional physician resources can be made through the health authority business case processes as outlined in Schedule "I", subject to amendment or adjustment by DHW or a health authority from time to time.

(b) **Physician Resources for Emergency Departments**

(i) The Murray Hybrid (MH) formula will continue to be used to calculate funded emergency department hours for tertiary and regional hospitals as well as for community hospitals that have opted to use this formula.

(ii) Left Without Being Seen volumes will be included as Category 4 volume in the MH formula, effective October 1, 2023.

(iii) Indirect patient care will be adjusted from 4% to 7%, effective October 1, 2023 for all Murray Hybrid EDs, including the tertiary C/AFP EDs.

(iv) Any increase in funded hours resulting from the MH formula changes pursuant to articles 5(b)(ii) and (iii) must be used solely for purposes of increasing physician resources and not to increase the hourly rate of pay in the emergency department.

(v) DHW will provide to each MH site a breakdown of its MH data and calculations to promote a better understanding of the MH formula, effective immediately.

(vi) On or before June 1 of each year the Medical Director at each Murray Hybrid Emergency site will report the following for the previous Fiscal Year to DHW:

a. Disbursements to physicians;

b. Audited financial statements;

c. Scheduling;

d. Aggregate hours staffed;

e. Payment rates, if different from those set out in the Master Agreement.

(vii) Despite article 5(b)(vi), the report that would be due on or before June 1, 2023 pursuant to article 5(b)(vi) is due on or before September 30, 2023.

(viii) The Parties will establish a working group to oversee a review of the Murray Hybrid Formula to identify any improvements required to ensure the formula is providing adequate resources for MH emergency departments. The Review is to be completed and recommendations delivered to the Parties by June 30, 2024. The working group will ensure that all system partners and

physicians are appropriately engaged. The review will include but not be limited to the following:

a. Today's emergency department environment and challenges, and their impacts on MH baseline funding;

b. Seasonal surges and system surges, sometimes caused by closures in nearby emergency departments;

c. Opportunities to shorten the lag time and the period of data used to populate the MH formula;

d. Resourcing implications of medical education and assessment need to be considered,

e. The potential impact of other system investments/support (eg. Virtual ED, EHS, primary care)

f. Volume of boarded patients and Failure to Admit patients in the MH formula;

g. Eligibility of all sites to the formula including CDU and teaching factors;

h. Accountability;

i. Funding transparency;

j. Leadership funding and structure; and

k. Considering a hub and spoke funding model (combining regional and community emergency department funding to enable upstaffing at regional hospitals with commensurate community coverage).

(ix) DHW will maintain, or increase to the extent supported by the MH formula, current MH funded hours at each MH-funded site until the review of the formula is complete and any recommended changes made by DHW.

(x) DHW will provide compensation to level 3 and level 4 emergency department sites to address high volume days as well as instances where a physician is in detention with a patient. Details will be confirmed by DHW by October 1, 2023.

(xi) The Parties agree to explore a new emergency department funding model based on a blended approach of base hourly rate plus share of fee for service billings or compensation tied to volumes.

(xii) The Parties agree to develop a Regional and Community Emergency Department Service Agreement in conjunction with the MH formula review. The Program will be available, on a voluntary basis, to emergency physicians

prepared to sign a service agreement outlining their commitment to a minimum number of shifts in both regional and community emergency departments. In exchange for signing a service agreement, full time emergency physicians will be eligible to receive an annual payment of up to $16,000 (depending on the level of commitment) in alignment with the physician retention incentive. Service agreements may include a provision for payment of physicians in the event of last-minute shift cancellations beyond the physician's control. The parties will work to launch the program by April 1, 2025 or sooner if possible.

6. GOVERNANCE

The Parties will establish a Physician Agreement Management Group (PAMG) to oversee the implementation and operation of this Agreement and the C/AFP Agreement. The terms of reference of the PAMG are as outlined in Schedule "J".

7 REMIT PAYMENT 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 may include any of the payments pursuant to 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.

8 ACCESS TO INFORMATION

8.1 Subject to applicable law, 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.

8.2 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.

8.3 The Parties agree that information disclosed under this article 8 will not be in patient identifiable form. DHW agrees to consider all reasonable requests from DNS for changes to the format of this data.

8.4 The Parties will continue to adhere to and comply with an Information Sharing Agreement between them, entered into in March 2021, subject to any amendment, expiry or termination of the Information Sharing Agreement.

8.5 The Parties will explore access to Physicians' EMR data to enable and facilitate reporting and accountability, including increased visibility for the work and services that Physicians provide, and automated reporting, provided that such access will not include personal health information and will not increase Physicians' administrative burden. The use and interpretation of the EMR data will be jointly governed and overseen by the Parties. The Parties will complete their analysis on or before April 1, 2024.

9. ALTERNATIVE FUNDING ARRANGEMENTS

If a physician's individual or group alternative funding arrangement ends and is not replaced by another alternative funding arrangement the Physician or group is eligible to bill MSI for Insured Medical Services. Privileges for the same geographic location cannot be withdrawn from or denied to Physicians by DHW or the Health Authorities in these circumstances, unless independently authorized under the relevant *Medical Staff By-laws*.

10. AUDITS

10.1. DHW has the right to conduct audits of Physicians with respect to claims for Insured Medical Services or any other fees or charges payable by DHW, including claims or reports submitted by Physicians pursuant to Clinical Academic Funding Plan and Alternative Payment Plan contracts, within the terms outlined in Schedule "K" to this Agreement. All other contractual performance and compliance issues arising in respect of Clinical Academic Funding Plan, Alternative Payment Plan or LFM payment arrangements shall be resolved pursuant to the terms of the applicable contracts.

10.2. The Parties agree that per the Preamble to Schedule "K" an important focus of billing audits is to educate Physicians on proper billing practices. Therefore, where:

a. a Physician has not been audited in respect of the relevant fee code before, and

b. a billing issue revealed by the audit has not been identified in a prior audit of that Physician;

the audit will be primarily for the purposes of education, with a commitment to discuss with the Physician the appropriate use of the relevant code and what needs to be documented to support it.

10.3. An audit may be for educational purposes in respect of one or more codes or billing issues described in article 10.2, but for recovery purposes in respect of another code or billing issue dealt with in the same audit.

10.4. Despite article 10.2, if DHW believes there is evidence of fraud, or evidence to suggest that a Physician knowingly or intentionally disregarded billing rules, article 10.2 shall not apply, and Schedule "K" of this Agreement shall apply.

11. SET-OFF & RECOVERY

DHW may deduct or otherwise set off any amount owing to DHW by a Physician, or any association, partnership, professional incorporation or entity through or in association with which a Physician may practice medicine, from any amount that is payable by DHW to the Physician or

any association, partnership, professional incorporation or entity through or in association with which the Physician may practice medicine. For greater certainty, amounts owing to DHW shall not be deducted from funding provided for physician health and benefits or parental leave benefits provided by DNS, or deducted from Targeted Project Funding or Professional Support Program funding provided to DNS.

12. NOTICE

12.1 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

12.2 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.

13. AMENDMENTS

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

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

14. CONSEQUENTIAL AMENDMENTS

The Parties agree that the MSI Physicians' Manual will be amended where necessary, to implement this Agreement.

15. GOVERNING LAW

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

16. 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.

17. ENTIRE AGREEMENT

17.1 This Agreement and the attached Schedules constitute the whole of the Agreement between the Parties unless duly amended as provided in article 13.

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

18. BENEFIT AND BINDING

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

18.2 DNS is entering this Agreement as the sole bargaining agent for Physicians, pursuant to its authority according to the *Doctors Nova Scotia Act*, SNS 1995-96, c 12, and the Parties acknowledge and agree that the terms of this Agreement are for the benefit of, and bind, Physicians.

IN WITNESS WHEREOF the parties hereto have caused the Agreement to be executed by their respective officers duly authorized in that behalf on the dates hereinafter set forth.

	HIS MAJESTY THE KING in right of the Province of Nova Scotia
______________________________	______________________________
(signature of witness)	*(signature)*
Name:______________________________	Name:______________________________
	Title: ______________________________
	Date: ______________________________

	DOCTORS NOVA SCOTIA
______________________________	______________________________
(signature of witness)	*(signature)*
Name:______________________________	Name:______________________________
	Title: ______________________________
	Date: ______________________________

SCHEDULE "A"

NEW RATES, RATE INCREASES AND RELATED COMMITMENTS

New Rates

The following new rates and rate increases are effective April 1, 2023 and will increase annually in accordance with article 4(b)(i):

(1) New Addictions APP for family physicians:

- i) Family physician with no Certificate of Added Competence (CAC): $286,442
- ii) Family physician with CAC: $310,000

(2) Increased Palliative APP rate:

- i) Family physician with no CAC: $286,442
- ii) Family physician with CAC: $310,000
- iii) Royal College Specialist: $340,000

(3) Increased Geriatrics APP rate:

- i) Family physician with no CAC: $286,442
- ii) Family physician with CAC: $310,000
- iii) Royal College Specialist: $340,000

(4) Increased GP Oncology APP rate:

- i) $286,442

(5) Increased FP Psychiatry hourly rate:

- i) $165.62

(6) New General Surgery APP:

- i) $421,425, plus if a General Surgeon shadow bills above the contract value, they will be paid the full value of all additional billings
- ii) If the province begins to struggle to recruit General Surgeons, this APP rate may be revisited by the Parties

(7) New Emergency Department rates:

	Current	April 1, 2023
Tertiary	n/a	$260.01
Regional	$241.91	$250.29
Cobequid	$226.16	Same as Regional
Hybrid	$210.46	Same as level 3
Level 3 – Daytime	$161.22	$208.94
Level 3 – Nighttime	$185.93	$218.23
Level 4 – Daytime	FFS	$165.62 **
Level 4 – Nighttime	$93.00	$95.79

** Physicians working daytime shifts in Level 4 EDs can either bill FFS or can receive the hourly rate, with no ability to bill FFS for services delivered in the emergency department at the same time. The parties will finalize details of how compensation for emergency services will apply to LFM physicians in areas where it is applicable.

Effective upon the signing of this Agreement by all Parties hereto, any arrangement or agreement which provides for compensation for ED Insured Medical Services in place with DHW or a Health Authority at any site in the Province which differs from the ED hourly rates set out in Schedule "A" is terminated and DHW will reconcile funding owed based on 4(b)(iii) less the amount already paid through the special arrangement.

Related Commitments:

(8) New payment model for General Internal Medicine:

i) The Parties agree to establish new payment model as follows for Core Internal Medicine hospital work. Details and deliverables will be finalized and the new payment model implemented by October 1, 2023. The model will provide a daily minimum income guarantee of $1600/day for covering daily inpatients, ED consults and other applicable work in hospital, will be paid in addition to facility on call and will consider the work of other subspeciality physicians on site.

ii) All parties agree to establish a new payment model for core cognitive internal medicine office based practice. Details and deliverables will be finalized and the new payment model implemented by February 1, 2024. The model will provide a daily minimum income guarantee of $1600/day for non procedural specialists (such as Endocrinology, Rheumatology, Infectious Disease, GIM, or IM covering a Generalist practice). Not able to bill any out-of-office services in those hours. Must be participating equitably in the acute care coverage model (inpatient, call coverage) to

be eligible to participate in this daily minimum income guarantee. Should be billing a minimum of 1 patient per hour, on average. If less, will trigger discussion and physician could be deemed ineligible to participate in this payment model. All in-office work must be billed under this model. Physicians would sign a declaration or contract confirming their agreement with the above. Existing sessional arrangements will continue outside of this daily model.

(9) All Specialist APPs - If a specialist on an APP shadow bills above the value of their APP contract, they will be paid the full value of all additional billings.

(10) Psychiatry - The Parties commit to review and modernize the District Contract Psychiatry Guidelines.

(11) ICU APP - The Parties commit to review and modernize the ICU APP guidelines.

(12) Accountability and Expectations:

i) The Parties agree to review all alternative funding models to assess and improve upon expectations and reporting mechanisms. This includes sessional arrangements.

ii) The Parties agree to develop deliverables for physicians on the Regional Hospitalist payment model on a site-by-site basis, to clearly outline the scope and services delivered at each site. A physician representative at each site will be engaged in this work. The work is targeted for completion by December 31, 2023.

(13) GPEW:

i) Effective upon signing of the Agreement, family physicians are eligible to bill the GPEW regardless of whether the family physician is a ME=CARE provider and regardless of whether they have billed ME=CARE for the service.

ii) For greater certainty, this includes physicians working in walk-in clinics.

(14) Long Term Care:

i) As outlined in article 4(c) and Schedule B, new interim fee codes for long term care services will take effect upon the signature of this Agreement.

(15) Force Majeure: The parties agree that temporary APPs will be available for FFS or hourly-paid physicians who experience sustained income loss due to factors beyond their control. Program parameters are:

i) Available to procedural-based physicians where, due to factors beyond the control of the physician, they are unable to deliver their typical procedures and virtual service

delivery is impractical or inadequate and there are no reasonable alternatives available.

ii) Entrance: Available once there has been a sustained (four-week) drop in billings to 80% of the Physician's average regular billings averaged over the prior three years, or below, calculated on a facility basis.

iii) Exit: As above; sustained billings above 80% of the Physician's average regular billings averaged over the three years prior to entering into the temporary APP, for four weeks or more.

iv) Voluntary: Individual physicians would have the choice whether to change payment models if the entrance conditions are met. A physician that opts into the APP and wishes to return to fee-for-service will be able to do so with notice to DHW.

v) Rates: The rates would match the APP rate in effect (Anesthesia, ObsGyne, Gen Surg) where applicable. If there is no APP rate, the closest/most appropriate rate as determined by DHW will be used. Surgical Assistants eligible as well (using the FP Sessional rate, annualized). If a physician shadow bills more than the rate payable under the temporary APP, the physician will be paid the difference.

vi) Services: Deliverables need to be discussed and agreed with the NSH and DHW. Physicians availing of the temporary APP option must be prepared to deliver any services for which they are qualified, where and as needed, while in receipt of the temporary APP. Deliverable requirements could include non-clinical support services if not doing direct surgical work.

(16) Stable core specialist resources: DHW and NSH will be investing to ensure stable resources for supporting core regional specialties. Our shared objectives are to ensure a sustainable call burden, to improve our ability to recruit and retain, and to ensure resources to teach, assess and mentor colleagues and future physicians.

(17) Start-up APP for FFS Specialists: New FFS specialists are eligible for a 12-week start-up APP, with the rate based on the Specialist Sessional rate. TIP-TOP situations will be assessed on their own merit.

SCHEDULE "B"

NEW INTERIM FEE CODES

NEW PATIENT INTAKE VISIT

A New Patient Intake Visit (includes face to face and non-face to face time), may be billed when a Family Physician accepts a new patient into his/her office practice and arranges an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing patient-physician relationship and to construct the patient's medical record. Includes review of clinical documents prior to the visit and establishment of medical record on the same day.

Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of the service must be completed on the same day.

If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit.

The fee cannot be billed with existing patients where ME=CARE has been billed by that family physician or collaborative practice. If a physician has billed a patient as ME=CARE previously, the NPIV billing will be rejected, and an explanation will be provided to bill appropriately with ME=CARE.

For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code NPIV. For New Patient Intake Visits that are greater than 30 minutes the physician bills a maximum of 5 multiples, up to 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, total encounter time must be documented in the health record and on the text field of the claim.

The NPIV fee code can only be billed once per patient per physician.

Not applicable for virtual care.

The New Patient Intake visit is eligible for the GPEW premiums.

Cannot bill this fee with any other visit code or procedure at the same encounter.

Fee: Visit fee of 34 MSUs, multiples of 17 MSUs per 15 minutes to a maximum of 5 multiples.

GERIATRIC OFFICE VISIT

3.03A
20.99 MSU

This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients aged 65 or older with whom they have an ongoing relationship. This fee code does not have multiples. For visits that are longer than 15 minutes in the office, physicians can bill prolonged office visits (03.03 + MU).

If billing 03.03 + MU for patients aged 65 or older, you must include start and stop times are required in the text field of the claim and documented in the patient's health record. Otherwise, 3.03A does not require start and stop times.

Evening and weekend premiums (GPEW) apply to this code.

Location = office (OFFC)

PROLONGED OFFICE VISIT FOR ME=CARE

3.03
17 MSU + MU (17 MSUs per 15 minutes)

This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients with whom they have an ongoing relationship. Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits. Each office visit can be billed to a maximum of 60 minutes (68 MSUs) per patient per day. This would include a base visit plus up to 3 multiples of 15 minutes each. Prolonged office visits are paid in 15-minute time blocks or portion thereof. 80% of the time must be direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention.

Multiples	Total Time
MU = 2	30 minutes
MU = 3	45 minutes
MU = 4	60 minutes

Start and stop times are required for any visit that bills multiples. These start and stop time must be included in the text field when the claim is submitted. Start and stop times are not required for visits that do not require multiples. Multiples are not applicable for virtual care.

Evening and weekend premiums (GPEW) apply to this code including multiples.

Location = office (OFFC)

The prolonged office visit can be billed for patients aged 65 and over when the visit is longer than 15 minutes. This code plus multiples is billed instead of 3.03A.

PROLONGED NURSING HOME VISIT

3.03

This service is paid to physicians who are delivering patient care to residents in nursing homes. This fee is to be billed for all residents of the nursing home, whether first patient or extra patient. Each nursing home visit can be billed up a maximum of 60 minutes per patient per day. This would include a base visit plus up to 3 multiples of 15 minutes each. Prolonged nursing home visits are paid in 15-minute time blocks or portion thereof. 80% of the time must be direct physician to patient contact. Prolonged nursing home visits are not to be confused with active treatment associated with detention.

Multiples	Total Time
MU = 2	30 minutes
MU = 3	45 minutes
MU = 4	60 minutes

Start and stop times are required for any visit that bills multiples. These start and stop times must be included in the text field when the claim is submitted. Start and stop times are not required for nursing home visits that do not require multiples.

Location = nursing home (NRHM)

Remove PT=FTPT and PT=EXPT

Time 0800-1700	21.3 MSU + MU (17 MSU per 15 minutes)
Time 1701-2000	28.3 MSU + MU (22.95 MSU per 15 minutes)
Time 2001-2359	28.3 MSU + MU (22.95 MSU per 15 minutes)
Time 0000-0800	38.3 MSU + MU (25.5 MSU per 15 minutes)

TELEPHONE PRESCRIPTION RENEWAL

This service is billable by a Family Physician when the physician is requested by a patient to communicate a prescription renewal by telephone, fax or email without seeing the patient. Documentation on the patient’s chart must include the name of the pharmacy, as well as the drug, dose and amount prescribed. This service may not be billed if the physician sees the patient (face to face or virtually) on the same day. A physician may bill for this service no more than four times per year per patient.

4 MSUs

ALLIED HEALTH CARE PROVIDER TO PHYSICIAN

This service is billable when a physician has a conversation with an Allied Health Care Practitioner, either face to face, by phone, email or fax to provide advice on a patient with whom the physician has an established relationship to determine management decisions. These allied health care providers must work outside of the physician's practice. This fee code is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine. This would also include the physician's time to update the patient's chart.

Telephone calls initiated by the patient's family member may not be billed under this code.

All interactions must be recorded in the patient's chart, including the time of the call, the name and professional capacity of the allied healthcare worker involved, the medical issue addressed and the advice given. Physicians may use a copy of the documentation from the allied health care worker to support this HSC claim, but it must be reviewed and "signed off" by the physician. The physician should add any needed clarifications or corrections to this documentation as an addendum. Claims, outside the pharmacy pilot, can only be made for physician interaction and not for staff (clerks, nurses, etc.) of the physician.

With regards to pharmacists, this code is for discussion of patient care and is not prescription renewal, clarifying illegible prescription or switching to a generic form of a drug. This fee code cannot be billed with Telephone Prescription Renewal.

This code may be billed once per patient per day per physician. In total, the code may not be billed more than 15 times per physician per week. Note that this cap of 15 times per week will be reviewed by the Fee Committee within 18 months of implementation of the code to assess whether the cap is reasonable and/or necessary. Not to be billed on the same day as a visit unless the status of the patient has changed in the intervening time. If there has been a visit on the same day, a comment must be made in the text field of the billing submission regarding the intervention.

7.5 MSUs

SPECIALIST ADVICE – CONSULTANT PHYSICIAN – PROVIDING ADVICE
SPECIALIST ADVICE – REFERRING PHYSICIAN – REQUESTING ADVICE

This health service code may be reported for a two-way telephone (or other synchronous electronic communication) or face to face conversations regarding the assessment and management of the patient but without the consulting physician seeing the patient.

This health service code may also be reported for asynchronous communication regarding the assessment and management of a patient, but only when utilizing a health authority-approved platform and consistent with all other billing requirements. This is billable once per patient issue regardless of the number of asynchronous interactions.

The referring provider may be a nurse practitioner, midwife, optometrist, family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case.

The referring physician or provider must document:

1. The patient demographic information
2. The date and time of the communication with the consultant
3. The clinical concern
4. The advice received from the consultant – including the name of the consultant.

The referring physician or provider must provide an electronic or written copy of this documentation to the consultant within 7 days of the service.

The consultant physician must review the documentation from the referring physician or provider within 14 days of the service. If clarification or corrections are indicated in the documentation, the consulting physician must provide a written addendum to provide this clarification and return it to the referring physicians within 21 days of the service. Both physicians are responsible for retaining medical record pertaining to this HSC.

There must be a two-way (verbal or asynchronous) exchange between the referring and consulting providers reviewing the clinical situation followed by a management decision and documentation of the exchange available in the patient's chart within 30 days of the service.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines

The HSC includes a review of the patient's relevant history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. The health service includes a discussion of the relevant physical findings as reported by the referring provider.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The Referring Physician HSC may be reported when the communication with the consultant physician occurs on the same day as a patient visit -or other service.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow

- Medical student

The service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two way medical discussion.

Documentation Requirements

• The referring physician must document that the referring physician has communicated the reason for the consultation and relevant patient information to the specialist.

• Both the specialist consultant and the referring provider must document the patient name, identifying data, date and encounter time in their respective charts or EMRs.

• The names of the referring physician or provider and the consultant physician must be documented by both physicians.

• The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented by the referring physician and the specialist.

• A written report must be sent to the referring provider by the specialist consultant.

• The referring physician's billing number must be noted on the claim from the consultant. This is not required for the referring physician's claim.

03.09K	Specialist Advice – Consultant Physician – providing advice	25 MSU
03.09L	Specialist Advice – Referring Physician – requesting advice	13 MSU

SCHEDULE "C"

LONGITUDINAL FAMILY MEDICINE PAYMENT MODEL

The Longitudinal Family Medicine payment model (LFM) is focused on improving access and attachment and positioning Nova Scotia to both retain and recruit to office-based, longitudinal family medicine.

Eligibility

The LFM will be available to all family physicians providing office-based, longitudinal family medicine in Nova Scotia.

Physicians can work full-time or part-time within the LFM.

Funding

Blended payment: Physicians in the LFM model will be paid a blended payment that is calculated based on hours worked, services delivered and panel size:

- Hours worked: $92.70 per hour (weekdays); $139.05 per hour (evenings/weekends)
- Services delivered: 30% of fee-for-service billings
- Panel size: $103 per patient

Accounting for patient complexity: The LFM model includes a community complexity modifier to account for age, sex and socio-economic status factors in different communities. Over the coming months, the Parties will work to refine this complexity modifier to account for complexity at panel/patient level. Payment rates within the model may be adjusted as a result, with agreement of the parties.

Payment

Income smoothing: The Parties are committed to ensuring reasonable income smoothing as part of the LFM model. While these details are subject to change based on agreement of the Parties, the current proposed approach is as follows:

- Biweekly payments
- Hours worked: Smoothed based on contracted/intended hours every six months; reconciled at the end of every six-month period to ensure hours paid matched hours worked
- Services delivered: Based on actual billing claims submitted (no smoothing)
- Panel size: Smoothed quarterly (payment based on panel size at the beginning of each quarter)

Included in the LFM: The following payments and programs are rolled into the LFM and not payable in addition:

- EMR envelopes B, C
- Collaborative Practice Incentive Program

- Chronic disease management program payment (physicians in the LFM model will receive 30% of the value as part of their fee-for-service billings)
- 5.6% bonus for physicians who shadow billed more than 80% of APP contract value

Excluded from the LFM: Physicians in the LFM can continue to bill for the following work provided outside the LFM:

- Work under the regional hospitalist model or Community Hospital Inpatient Program (CHIP)
- Work under the regional Primary Care Maternity (PMC) program
- Long Term Care work (Care by Design etc.).
- Emergency department work
- Work in other sessional arrangements (such as sexual health clinics, primary care centres, urgent care centres, MAID, etc.)
- EMR envelope A (one-time grant)
- Surgical Assist Incentive Program
- Walk in Clinics outside of LFM catchment area
- Teaching payments, including the $5,000 annual retainer, daily teaching stipends and the 5% premium on billings outlined in Article 4(u) of the Physician Agreement.

<u>Expectations</u>

While these details are subject to change based on agreement of the Parties, the current expectations of physicians in the LFM are:

1. After-hours care: Providing care during evening and/or weekend hours is encouraged. This could include providing virtual services or other community services the physician is providing outside of the LFM, such as working at primary care centres, urgent care centres or emergency departments. The deliverables template will include each physician's plan to meet this community need.

2. Virtual care: The majority of patient services delivered within the LFM model will be delivered in-person, though virtual services remain appropriate in various circumstances. This will be monitored by the Implementation Working Group and action will be taken if the Group becomes aware of challenges related to in-person patient access.

3. Hours claimed: 90% of hours billed under the LFM will be time delivering direct and indirect clinical services; up to 10% may be billed for time spent on Clinical Support Services.

4. Throughput: Physicians will complete a minimum of 2.8 service encounters per hour on average (applicable only to the direct and indirect clinical care hours claimed; not applicable to the 10% Clinical Support Services time claimed). A complex visit (03.03 with multiples) will count as multiple service encounters. The Parties will monitor the service encounter target of minimum 2.8 as new fee codes are implemented to assess required changes.

5. EMR access: Doctors Nova Scotia and the provincial government will explore using EMR data to support and facilitate reporting and accountability under the LFM model, as outlined in article 8.5 of the Physician Agreement.

Services

Office-based: The LFM is primarily a payment model for office-based, longitudinal family medicine practice.

Other community services: The parties will finalize details of how compensation for other community services will apply to LFM physicians.

Unattached patients: The parties will finalize details of how compensation for unattached patients will apply to LFM physicians.

Leave of absence

An LFM Physician shall not take leave or otherwise be absent from practice or reduce services for greater than six weeks in total during a year, without the prior written approval of the Minister and the Nova Scotia Health Authority, which approval shall not be unreasonably denied.

Any approved leave of absence greater than 6 weeks will be an unpaid break in service.

An LFM Physician shall make every reasonable effort to ensure necessary medical coverage during any absence of the Physician greater than two weeks, in accordance with applicable requirements, standards and guidelines of the College of Physicians and Surgeons of Nova Scotia.

The Minister is not required to approve frequent, or seasonal leaves.

Reporting

LFM Physicians will receive a quarterly report from government including:

- Total Number Daytime Hours worked;
- Total Number Evening and Weekend Hours worked;
- Billing amount for the year-to-date;
- Physician's current Panel and Panel payment amount; and
- The number of unattached patients within the community in which the Physician practices.
- Other items as developed

New to practice physicians

Physicians who are new to family practice will be entitled to a minimum annual income under the LFM calculated on hours worked plus target panel size. The physician will also receive 30% of eligible fee-for-service billing claims. The minimum income guarantee will be in place for one year after the date upon which the Physician enters into the LFM agreement.

A physician is new to family practice if they are within one year of having commenced longitudinal family practice in the province or in their community. Any parental or other extended leave is excluded from the calculation of one year in practice.

If a new to practice physician earns above the income guarantee based on actual hours worked or patients attached, while meeting all other terms of the agreement, they will be paid the higher amount of actual income earned.

The Minister may extend the time period for which the minimum annual income applies where a request for extension is received in writing from a Physician within 3-months prior to the expiry of the 1-year period.

Transition year for some APP/CEC family physicians

Not all APP/CEC contracts are suited to transitioning to the LFM model at this time. Some physicians who are currently on APP serve special populations that, either because of the nature of the practice or their location, might not be as well-served by the LFM in its current form. As a result, the Parties have identified approximately 90 physicians currently being paid under an APP who will move to a year of transition while the Parties consider necessary adjustments to the LFM for these practices and communities.

During that transition year, these physicians will be paid $324,450 plus 30% of all eligible fee-for-service billings.

The Parties will identify transition communities. It is expected to include but not limited to:

- Guysborough
- Neil's Harbour
- Sherbrooke
- Canso
- Physicians providing service in Indigenous communities
- Existing/former CEC sites
- Group APP Contracts (North End Community Clinic, Duffus, Digby)

Termination

A physician's participation in the LFM model may be terminated by the physician or by DHW with three months' prior written notice. DHW may terminate the agreement with immediate effect if a physician fails to comply with the terms of the agreement, but shall consult with the NSH and DNS prior to giving notice to the physician in this circumstance.

If an LFM agreement is terminated by either party, the physician is eligible to revert to a fee-for-service funding arrangement.

Governance

Responsibility for oversight of the model rests with the PAMG.

An Implementation Working Group will be established by the PAMG.

The PAMG will receive a report and assessment on the model and lessons learned within two years of the launch of the model.

SCHEDULE "D"

CONTINUING MEDICAL EDUCATION PROGRAMS

DHW will make a contribution to Physicians for Professional Development Support Programs as set out in this Schedule. DHW may randomly withhold annual payments to select physicians pending submission of supporting documentation that CME activities were undertaken in order to substantiate payment.

Eligibility Criteria -General

To be eligible for the incentive the Physician must be actively practicing in Nova Scotia at the time of payment. "Actively practicing" means the physician has billings or alternative payment for insured medical services up to the time of CME payment.

Eligibility and Payment -General Practitioners

- Eligibility as a general practitioner (GP) is established by license.
- Must maintain a license and have billings or contract-based funding of $100,000 or more in the calendar year (January 1- December 31) prior to payment.
- All eligible GPs shall be entitled to a CME payment of $2,000 per year.

Eligibility and Payment - Non-AFP Specialists

- Physician qualifies as a non-AFP specialist.
- Must maintain a license and have actual fee-for-service billings of $150,000 or more in the calendar year (January 1- December 31) prior to payment.
- All eligible Non-AFP Specialists are entitled to a CME payment of $4,000 per year.

SCHEDULE “E”

OTHER PROGRAMS

1. RURAL SPECIALIST PRACTICE SUPPORT PROGRAM

The Rural Specialist Practice Support Program is funding to support rural specialist practice and retention.

For purposes of this Program:

> “rural specialist” means a physician registered with the College of Physicians and Surgeons of Nova Scotia, whose name appears on the Medical Specialist Register of Nova Scotia, or who is formally recognized by DHW as a functional specialist for the purpose of the Rural Specialist Practice Support Program, who conducts their practice in a location specified in accordance with established guidelines (which guidelines may be revised by the PAMG);
>
> “functional specialist” means a physician who functions as a specialist and would be replaced by a health authority with a specialist, not including a general practitioner with one year of additional training (e.g. in palliative care, emergency medicine, geriatrics);
>
> “actively practicing” means the Physician has billings during the period from March 1" of the payment year to the time of the retention payment.

Tier 1 – Practice Support ($25k annually)

To be eligible for a Rural Specialist Practice Support incentive payment of $25,000 per year, a Physician:

a) Must be a rural specialist;

b) Must have total MSI billings or equivalent payment through a rural specialty contract of $150,000 in the fiscal year prior to the payment;

c) Must participate in facility on-call schedule as required;

d) Must be actively practicing in NS as of April 1st of the year of payment;

e) Must have an office outside the hospital that is paid for by the physician, or have a private office within an NSH facility that is paid for by the physician;

f) Must utilize Ocean and the centralized referral process as part of the practice if applicable to the physician’s specialty

g) Must be actively using a DHW-approved EMR.

Note: The Parties will negotiate key performance indicators regarding waittimes and access, as developed for specialities province-wide, with a goal of integrating those KPIs as eligibility criteria on 1 April 2024.

Tier 2 – Retention ($16k annually)

To be eligible to receive a Rural Specialist Retention incentive payment of $16,000 per year, a Physician:

a) Must be a rural specialist;

b) Must have total MSI billings or equivalent payment through a rural specialty contract of $150,000 in the fiscal year prior to the payment;

c) Must participate in facility on-call schedule as required;

d) Must be actively practicing in NS as of April 1st of the year of payment;

e) Must have NSH privileges for 3 consecutive years as a Rural Specialist as of March 31 prior to the payment.

2. FACILITY ON-CALL PROGRAM

The Facility On-Call program rates will continue in their current form and the following new rates wlll be effective October 1, 2023:

(i) Category 1 on call: $350 weekdays (M-Thurs); $500 weekends (Fri, Sat, Sun) and statutory holidays.

(ii) Category 2 on call: $300 weekdays (M-Thurs); $350 weekends (Fri, Sat, Sun) and statutory holidays.

(iii) Category 3 on call: $200 weekdays (M-Thurs); $250 weekends (Fri, Sat, Sun) and statutory holidays. Category 3 call back $150.

(iv) Category 4 call back: $350

All current program parameters will continue. A working group will be established to review and update the Facility On Call Guidelines, which will include:

- Incorporating multi-site and/or provincial call coverage;
- Virtual care implications;
- Multiple sites being covered by a single physician;

- Multiple lines being covered by a single physician;
- Multiple physicians covering a single service due to demand/volume;
- General review and alignment of the guidelines with system needs and reality.

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.

Specialists on individual Alternative Payment Plan are 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, Medical Oncology, Hematology and Anesthesia.

3. SURGICAL ASSIST INCENTIVE PROGRAM

The Surgical Assist Incentive Payment provides an incentive payment for all family physicians who carry out surgical assists.

All family physicians who provide surgical assists during the year will receive an incentive payment for providing elective (non-premium time) surgical assists. Qualifying surgical assist payments up to a maximum of $40,000 per physician per year will be eligible for an incentive payment.

Surgical Assist Incentive Payment - Eligibility Criteria

- Family physicians who meet the criteria of total billings/payments for Insured Medical Services of $100,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 40% of their individual qualifying surgical assist payments.

- Family physicians who do not meet the criteria of total billings/payments of $100,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 20% of their individual qualifying surgical assist payments.

The Parties agree to establish a committee to review and update as required the Surgical Assist Incentive Program, the current fee codes applicable to surgical assists, and the program and/or fee codes needed to support second surgeons for purposes of maintenance of competency and skill and mentorship. The review will be completed by October 1, 2024.

SCHEDULE "F"

TARGETED PROJECT FUNDING

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

<u>Parameters for all Project Funding</u>

- Project work (including deliverables) supporting the three areas identified below under Project Funding and approved by PAMG will be reviewed by PAMG to align with health system priorities.
- Project work will align with DNS fiscal year (Sept-Aug)
- Quarterly reports to PAMG 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 PAMG.
- 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 $165.62 per hour
    - Agreed upon hourly amount for staff is $75 per hour (time to be reported based on half-days)

<u>Project Funding:</u>

1. <u>Fee Schedule</u>

<u>Purpose</u>: Support to FC and fee schedule related items

<u>Amount</u>: Maximum annual amount ($330,000)

<u>Project work to include</u>:

- 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 $368,000

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 PAMG

SCHEDULE "G"

COMMUNITY HOSPITAL IN-PATIENT PROGRAM

General Program Guidelines

1. Eligible Sites

The Community Hospital In-patient Program funding model is currently available at the following community hospitals:

- Fishermen's Memorial Hospital
- Inverness Consolidated Memorial Hospital
- New Waterford Consolidated Hospital
- Northside General Hospital
- Queens General Hospital
- Roseway Hospital
- Soldiers Memorial Hospital
- Strait Richmond Hospital;

each a "Community Hospital"; together the "Community Hospitals".

The parties agree that any CHIP-eligible sites (Hants Community Hospital and Digby General Hospital) wishing to convert to the CHIP funding model are still eligible to do so and can opt in by delivering notice from its Representative Physician, as identified in its Service Delivery Plan, to the Minister and the NSHA in writing.

2. General Requirements

Physician groups participating under the program must provide:

- daily on site* comprehensive care for all inpatients (attached and unattached) in the hospital that include:
  - o physician support 7 days a week to meet patient care needs and system flow requirements;
  - o a presence which aligns with timing of daily bed management decisions by other hospital staff (as pre-arranged and mutually agreed);

  ** Physicians are not required to remain on site all day once the required in-person care, system flow and bed management activities are satisfied. However, they must be able to return to the site as needed for direct patient care.*
- 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 and veteran beds, 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 section 7 of these Guidelines, or, with the prior written agreement of the NSHA and the Minister, temporarily suspend its participation in the Community Hospital In-Patient Model.

3. 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 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 and veteran beds, 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).

4. 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.

5. Cash Flow and Disbursement

The physician group will be responsible for submitting claims via the monthly workbooks for the daily stipend and on-call payments as provided in the Appendix. 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.

6. 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.

7. Termination

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 receive compensation for inpatient care on a fee for service basis.

Appendix

Community Hospital Inpatient Program

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	$99.75 per avg daily admission at each site	$111.29 per avg daily discharge at each site	$52.53 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 most recent fiscal year data	Average discharge MRP inpatient billing per admission, assuming 75% are billed as comprehensive discharges, based on most recent fiscal year 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 of 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

Rates in the table below are in effect as of April 1, 2023, and include MSU increases. Participating physicians will continue to be paid the Facility On Call stipend and any eligible afterhours FFS billings on top of the daily stipend, if applicable.

CHIP Daily Rate for Participating Sites (2023-24)					
Site	**Daily Rate (2023-24)**	**Weekday Call**	**Total Weekday Rate**	**Weekend/ Holiday Call**	**Total Weekend/ Holiday Rate**
Fishermen's	**$ 1,233.77**	$350	$ 1,583.77	$500	$ 1,733.77
Inverness	**$ 1,689.08**		$ 2,039.08		$ 2,189.08
New Waterford	**$ 1,141.66**		$ 1,491.66		$ 1,641.66
Northside	**$ 2,651.24**		$ 3,001.24		$ 3,151.24
Queens	**$ 1,396.98**		$ 1,746.98		$ 1,896.98
Roseway	**$ 745.58**		$ 1,095.58		$ 1,245.58
Soldiers Memorial	**$ 1,283.26**		$ 1,633.26		$ 1,783.26
Strait Richmond	**$ 949.90**		$ 1,299.90		$ 1,449.90
** Daily rate annual review for 2023-23 to commence in July 2023*					

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. Funding changes are aligned to the April-March Fiscal year.

The rates are subject to change once the billing window has closed in accordance with the annual review process. Any increases resulting from each annual review will be retroactive to April 1 of the year in which the review occurred.

2. On-Call Stipends

The Community Hospital Inpatient Program provides a daily call stipend in accordance with Category 1 facility on-call rate.

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 Agreement. The MSU increase effective April 1, 2023 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.

SCHEDULE "H"

PRIMARY MATERNITY CARE

The Primary Care Maternity Care Program (PMC) is a funding model that covers the provision of a comprehensive regional primary maternity care program at regional hospitals.

Overview

The scope of services provided includes but is not limited to:

a. Provision of comprehensive Primary Maternity Care Services including prenatal, intrapartum (deliveries and obstetrical surgical assists), postpartum, neonatal, and infant care (up to six weeks as required);
b. Provision of comprehensive Primary Maternity Care Services for unattached and attached patients (including newborns) as required to meet community needs;
c. Provision of 24/7/365 Primary Maternity Care on-call service; and
d. Consultation and collaboration with Obstetricians when necessary.

Eligibility

The PMC program is currently available to family physicians providing primary maternity care at the following regional hospitals:

- The IWK, Halifax*
- South Shore Regional Hospital, Bridgewater
- St. Martha's Regional Hospital, Antigonish
- Cumberland Regional Hospital, Amherst
- Yarmouth Regional Hospital, Yarmouth

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

* IWK daily stipend is funded as 5.0 FTE APP for 24-hour coverage (call included).

The parties agree that the PMC payment model will be available to any Regional Hospital that wishes to convert their PMC services to this alternative payment model (Kentville, Cape Breton, Truro, New Glasgow), if all parties are agreed that a PMC payment model is in the best interests of the system.

Prior to funding being approved, each hospital shall submit a site plan to the NSHA for review and approval. The site plan should contain, without limitation, how they will provide the Core Services including prenatal, intrapartum, postpartum, neonatal and infant care; how they will accept patients; and how they plan to provide 24/7/365 coverage. It will also describe how funding will be distributed to participants of the program.

Funding

Physicians participating in the PMC program are paid a daily stipend based on number of daily funded hours. The number of funded hours varies by site and is dependant on annual volumes of PMC activities, time weights per activity and the negotiated PMC hourly rates in the 2023-2027 Physician Agreement. Each PMC visit is weighted at 35 minutes and deliveries and obstetric surgical assists are weighted at 150 minutes. An additional 10% of time is added to the total to account for direct clinical services which are not captured under PMC billing codes (e.g., inpatient visits and discharges). The resulting hours account for 80% of total daytime PMC funding. A further 20% is funded to support clinical capacity building. Daily daytime site funding is eligible for the annual rate increases specified in the Physician Agreement.

The Primary Care Model provides a daily call stipend in accordance with Category 1 facility on-call rate.

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:

(i) the physician group is required to provide 24/7/365 coverage;
(ii) a written on-call schedule must be provided in advance to the Zone Medical Director;
(iii) physicians must respond to calls within 10 minutes by phone and be able to be on site within 20 minutes if called in;
(iv) 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.

Fiscal Year	Hourly Rate
April 1, 2023 – March 31, 2024	$ 161.04
April 1, 2024 – March 31, 2025	$ 165.87
April 1, 2025 – March 31, 2026	$ 169.19
April 1, 2026 – March 31, 2027	$ 172.57

IWK

The IWK PMC group are paid via an annual group funding arrangement (with rates as adjusted by MSU increases), for 24/7/365 coverage

Fiscal Year	Annual Rate
April 1, 2023 – March 31, 2024	$ 1,432,211

April 1, 2024 – March 31, 2025	$ 1,475,177
April 1, 2025 – March 31, 2026	$ 1,504,681
April 1, 2026 – March 31, 2027	$ 1,534,774

The daily stipends will also be reviewed annually by DHW and adjusted as required, based on patient data via shadow billing. The analysis and decision(s) arising from the review of the daily stipends will be shared with DNS and the physicians participating in the Primary Maternity Care Model. Funding changes are aligned to the April-March Fiscal year.

PMC Daily Rate for Participating Sites (2023-24)							
(2023-2024 hourly rate used: $161.04)							
	Daily funded hours	Daily Rate	**Weekday Call**	**Total Weekday Rate**	**Weekend/ Holiday Call**	**Total Weekend/ Holiday Rate**
IWK**	24	$3,913.14	NA	$3,913.14	NA	$ 3,913.14
South Shore Regional	12	$1,932.48	$350	$2,282.48	$500	$ 2,432.48
Yarmouth Regional	12	$1,932.48		$2,282.48		$ 2,432.48
St. Martha's Regional	8.9	$1,433.26		$1,783.26		$ 1,933.26
Cumberland Regional	6.1	$ 982.34		$1,332.34		$ 1,482.34
Cape Breton	N/A					
** Daily rate annual review for 2023-23 to commence in July 2023*						
*** IWK is funded with 5.0 FTE APPs for 24-hour coverage*						

Rates in the tables above are in effect as of April 1, 2023, and include MSU increases. Participating physicians (other than the IWK) will continue to be paid the Facility On Call stipend and any eligible afterhours FFS billings on top of the daily stipend, if applicable. The rates are subject to change once the 90-day billing window has closed in accordance with the annual review process. Any increases resulting from each annual review will be retroactive to April 1st of the reviewing fiscal year (e.g., the review for 2022-23 will be in July 2023; should 2022-23 data reflect increased level of patient activity in 2022-23, any applicable increase in daily stipend will be applied in 2023-24 – retroactively to April 1, 2023).

Ability to Bill Fee for Service

There are no specific onsite requirements for this program, but the scheduled PMC physicians must be able to report onsite within 20 minutes of being called. PMC service physicians can provide PMC services offsite in their own offices on the days they are on PMC service; any of those services are to be shadow billed to the program's business arrangement. Physicians are expected to schedule the majority of their PMC services on the day(s) they are the designated PMC physician(s).

If the scheduled PMC physicians are called back to the site outside of daytime hours to provide urgent care, they will be able to bill fee-for-service (using the appropriate after-hours modifiers) for this work. No fee-for-service can be billed for regularly scheduled PMC work or urgent work that occurs during daytime hours by the designated PMC physician(s) on service that day. If an additional physician is required on site to provide PMC services or to provide PMC care to their own patients on a day that they are not a designated PMC physician on service, they are allowed to bill fee-for-service for that work.

Total annual daytime PMC fee-for-service billings by PMC physicians are not expected to exceed 10% of total annual site funding.

SCHEDULE "I"

Physician Resources

- Requests for new physician resources can be made through the existing NSHA/IWK Business Case Process, following the defined process submission templates and timelines.

- Any physician may submit a request for new/additional physician resources, however all requests must:
    - Utilize the approved Business Case Templates (these can be obtained through your Department Head, your local Medical Affairs lead or the Zone Medical Executive Director)
    - Identify and include all physician and operational costs required to support the new physician position as part of the overall business case
    - Clearly address health system needs and align with health system priorities
    - be collaboratively developed and supported by the relevant NSHA or IWK Department Head and relevant operational Director/Manager
    - be supported by the relevant Zone Medical Executive Director and Vice President Operations for zone-based business cases or the Sr. Medical Director and Sr. Director for Networks or Programs within the NSHA or the Vice President of Medicine, Quality and Safety for the IWK.

- All IWK/NSHA supported business cases will be submitted to the DHW for review and final funding decision.

- Urgent physician resource requests outside of the standard NSHA/IWK Business Case Process must be submitted to the VP Medicine, Quality and Safety for the IWK or the Zone Medicine Executive Director and the Sr. Director of Medical Affairs for the NSHA.

    - Urgent physician resource requests should only be submitted if there is significant health system risk/change that can only be addressed with the immediate addition of additional physician resources;
    - Urgent physician resource requests must meet the same requirements as the above noted business case requirements.

- Any urgent requests supported by the VP Medicine/EVP Medicine will be submitted to DHW for review and final funding decision.

- Other resource requests can be made through this same business case process, such as requests for Allied Health Care Providers, technology investments or other innovations that would improve service delivery in terms of quality, efficiency or productivity.

SCHEDULE "J"

PHYSICIAN AGREEMENT MANAGEMENT GROUP

Objectives

- The PAMG will provide a governance structure designed to foster and support an ongoing collaborative relationship between DNS and DHW.
- DHW and DNS recognize the importance of collaborative relationships with the health authorities and Dalhousie University.
- PAMG will provide an agile and flexible structure with ability to adjust as the system evolves.
- PAMG will ensure accountability and transparency in contract management.

Mandate

- PAMG will oversee the implementation and operation of the Physician Agreement and the C/AFP Agreement.
- PAMG will discuss any implementation issues arising from the Physician Agreement and the C/AFP Agreement.
- For greater certainty, PAMG's mandate is limited to the matters upon which the Parties have substantively agreed in the Physician Agreement and the C/AFP Agreement, and does not include oversight, supervision, discussion or consideration of any matter which any of the Parties to the Physician Agreement or the C/AFP Agreement have agreed or otherwise committed to negotiate, review, update, study, explore, confirm, establish, or agree upon, etc., in future through any procedure or mechanism whatsoever.
- PAMG will establish working groups and engage contractors and/or consultants as required to investigate issues of importance to the ongoing implementation and oversight of the Physician Agreement and the C/AFP Agreement.
- PAMG may receive reports on Physician Agreement and C/AFP Agreement initiatives, including:
  - quarterly financials on the Physician Agreement prepared by DHW;
  - reports on the performance of programs (uptake; outcomes; etc.) prepared by any Party to the Physician Agreement.
- The PAMG may review and revise these Terms of Reference from time to time.

Membership

- The PAMG will consist of the following members:
  - Five members appointed by DHW;
  - Five members appointed by DNS.

- The PAMG may by consensus invite other persons, including but not limited to a representative of a health authority, Dalhousie University, or an AFP department, to attend and address a meeting of the PAMG, but for greater certainty such person shall not be a member of the PAMG and shall not vote on any matter before the PAMG.

- DHW and DNS may by consensus invite additional staff to join the meetings in a non-voting capacity.

Decisions

- Decisions of the PAMG shall be, in the first instance, made by consensus of all members.
- If consensus is not reached on an issue, then by majority of all members.
- In the event that a majority decision cannot be reached, then an eleventh 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 eleventh member.
- The eleventh member will chair those portions of the PAMG 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 eleventh member.
- The decision of the PAMG 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 a PAMG 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 PAMG decision-making process.

Committees

- The PAMG may establish standing or *ad hoc* committees as necessary.

Meetings

- The PAMG will meet at least quarterly.
- DHW will prepare and circulate agendas and meeting materials in consultation with the other Parties to the Physician Agreement as appropriate.

SCHEDULE “K”

Claims Monitoring and Resolution Mechanism

Preamble

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:

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

   b) **Claim** means a fee for service or shadow service claim or report, including for any insured medical service or any other fee or charge payable by DHW;

   c) **Days** means business days;

   d) **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;

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

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

   g) **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

   h) **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;

e) the service and Claim met the requirements set out in the MSI Physician's Manual; and,

f) the service and Claim were in accordance with the Physician's contractual obligations.

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 Physician 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, the physician 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 Physician 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 process under this Schedule 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 Section 32.

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 processes under this Schedule 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 (e.g, from another physician, a health authority, the College of Physicians and Surgeons of Nova Scotia);
    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, or failing agreement, a date and time within normal business hours determined by the auditor, with prior notice in writing to the Physician. 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.

Audit Results

21. If the auditor determines that 5 per cent or more of the Claims audited were inappropriate, the auditor may extrapolate the percentage of inappropriate billings across all of the physician's billings for the code or codes found to be the subject of an inappropriate Claim, and any financial implication of the Audit will be calculated on the basis of the extrapolation.

22. For the purposes of Sections 16 and 18, the Audit Result will include:

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

    b) the financial implications of the Audit, which may include an amount owing to DHW, a reduction in shadow billing reporting, or a reduction of future funding, in respect of any inappropriate Claim; 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.

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

24. 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

25. Where the physician disagrees with the Audit Result, the physician may, 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 twenty days, the physician is deemed to agree with the Audit Result and forfeits further rights to Audit Review, Facilitated Resolution, or Arbitration, and in addition to any other remedy available, DHW may recover any amount found owing from future payments to the physician.

26. The purpose of the Audit Review is to ensure that MSI has all information/documentation relevant to the Audit. 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.

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

28. 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; and,

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

29. 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.

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

31. 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 does not deliver a Notice of Dispute within twenty days, the physician is deemed to agree with the Notice of Determination and forfeits further rights to Facilitated Resolution or Arbitration. Without limiting any other remedy available to DHW, DHW may recover any amount found owing from future payments to the physician.

Facilitated Resolution

32. 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 Section 11, the Facilitated Resolution stage will begin. MSI will notify both the DHW and DNS Medical Consultants.

33. 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.

34. 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.

35. 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 Sections 2, 15 and 16, and with the Facilitator having the same duties and powers as a CAA mediator.

36. 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 (in writing) as outlined herein. If no notice is provided, the physician is deemed to agree with the Notice of Determination and forfeits further rights to Arbitration.

37. 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.

38. 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.

39. The Parties agree to review by June 30, 2024 and recommend any changes to PAMG regarding the ongoing need for Facilitated Resolution as part of the audit appeal process once the parties have had adequate time to assess the implications of the Qualifying First Time Audit provision in article 10.2 of the Physician Agreement.

Arbitration by Resolution Panel

40. If the physician delivers a Notice of Dispute, 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 provided herein. Only matters contained in the Notice of Determination which are contested in the Notice of Dispute will be subject to Arbitration.

41. The Panel will comprise 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.

42. 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.

43. 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.

44. 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.

45. The Physician and DHW are entitled to be represented by legal counsel at the arbitration.

46. The Panel will determine the dispute based on the MSI Physician's Manual and applicable legislation. Relevant written correspondence/documents between MSI and the physician may be considered. Only the version of the Manual that was in effect at the time the services in dispute were provided will be considered.

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

48. 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.

49. 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.

50. 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.

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

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

53. 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.

54. The results of any arbitration or decision pursuant to Sections 6, 10, 12, 19, 20, and 26(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.

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

56. The Parties may amend this Schedule by agreement.