2023 Contract Ratification - Member FAQs

Updated July 12, 2023

Q: When will the retroactive pay (3% effective April 1, 2023) be paid out?

A: We have no firm timeline, but we expect it will be paid out in Fall 2023.

Q: When does the parental leave benefit increase come into effect? How will those currently on leave be handled?

A: We've had some success in getting the parental leave benefit increase to be retroactive to April 1. The increase in the parental leave benefit ($2,000 per week for 26 weeks) will take effect April 1, 2023, assuming the Physician Agreement is ratified. But, please note that parental leave remains consecutive weeks off; there can be no stopping and starting the leave (this has always been a requirement within our parental leave program).

Here's what this means in practical terms:

- If someone is off as of now and still collecting benefits at time of signing of the new Agreement (assuming that it is ratified by members), they will be able to stay off for the additional time. Their payments will be increased immediately, and they will get the retroactive adjustment on all payments back to April 1.
- If they were off on parental leave at any point since April 1, they will get a retroactive adjustment of the payments they received since April 1.
- If they are no longer collecting benefits, regardless of whether they returned to work or not, they will not be eligible for any additional weeks. Our parental leave program has always required that the leave be taken in consecutive weeks, and that parameter remains. So their parental leave is essentially considered complete if their benefit payments have ceased.

Q: What is likely to happen in the case of a "no" vote?

A: That's a good question, and one we wrestle with of course. There's no clear path out of a "no" vote - either the parties come together and agree to pursue a second ratification (often with the same deal), government legislates a solution, or the matter goes to an arbitrator and the agreement is in a third party's hands. We have a few examples in recent memory in NS – I think of the teachers' strike a few years ago under Premier McNeil's leadership, or the much more recent education support workers' strike in HRM under Premier Houston's leadership. In both cases it took time to find a resolution, and the end result was not in fact anything more

than the original offer (in fact, I believe the teachers' resolution was legislated in the end and was less than the government's original offer).

Knowing that, the DNS Board of Directors weighs very carefully the decision about whether to recommend an agreement for ratification by members. In this case, the Board believes these are good agreements for Nova Scotia's physicians. We believe they offer *meaningful* improvements for family doctors and rural specialists in particular, while still being *reasonable* agreements for Halifax and Dartmouth based specialists. Of course, that very question is in your hands now – and in the hands of your peers.

Q: Why are only "rural" specialists receiving overhead support? What is the definition of rural? There are many FFS specialists within HRM that pay some of the highest overhead. This is unfair and will negatively impact recruitment.

A: I can assure we did not forget our central zone specialists. We pursued overhead support for all physicians, including those in the Central zone. Government's focus though was to stabilize both family medicine and rural specialty services. As a result, we were not able to get overhead support for the Central zone specialists. I fully expect that will be a focus for us in the next round of negotiations. As you know, we often work to get a "toehold" which we then leverage into expanded investment in future.

Q: What are Hospitalists getting in this deal?

A: There are a few specific changes for hospitalists. The across-the-board increases, changes to parental leave, etc. would of course apply to hospitalists just as they apply to all physicians. Specific to hospitalists, though, there are four things to be aware of:

1. Precepting funding now available to hospitalists – you'll see that there are some new investments in teaching which we're very excited about (a $5k annual stipend for qualified preceptors, plus the ability to bill a 5% premium on all services delivered while precepting, plus a continuation of the current daily stipend at $90 per day, but with a commitment to assess the daily stipend further in the Fall and some possible enhancements to come then). The $5k and the 5% are available to hospitalists as well (see clause 4(u), page 15-16 of the Phys Agreement), but the 5% would be shadow billable only. The daily stipend of $90 per day will be available to hospitalists as well once we complete the review in the Fall.
2. The facility on call increases will apply for hospitalists as well (see page 14 of the DNS summary of the agreements, or pages 41-42 of the Physician Agreement).
3. In addition, effective upon signing of the new Agreement, physicians (including hospitalists) will now be able to bill when they receive calls from allied health providers (or initiate calls to allied health providers) to discuss a patient issue. This would include calls from the inpatient nurses in the evenings. The calls must of course be documented

(note that the physician can "sign off" on the allied provider's note to satisfy this requirement), and for now, billings are capped at 15 per physician per week.

4. You'll also see on page 27 of the new Physician Agreement a clause that says the Parties are going to review deliverables for the Regional Hospitalist model (clause 12(ii)). That is work that will likely start in early Fall and it presents an important opportunity for Hospitalists and system leaders to discuss issues within the hospitalist area, and possible changes required to the current regional hospitalist model.

Q: What are Walk-In Clinic physicians getting in this deal?

A: The GPEW (the 25% premium for after-hours work) will now be available to walk-in clinics. We're pleased with that. Unfortunately, we were not successful getting the ME=CARE codes to apply for walk-ins when dealing with unattached patients.

Q: Why is the Tertiary Emergency rate now higher than the regional rate? The QEII has more support than we do at the regional centers. Most of the regional centers are having significant difficulties with staffing. If anything, the regional centers should have a higher rate to try and attract physicians to the hospitals farther away from Halifax that deal with constant issues with EHS and lack of specialty support.

A: The change in the tertiary rate came from a desire to ensure our tertiary rates are appropriately competitive with those in other provinces, where the tertiary centres do generally have a higher hourly rate. We're also mindful that we'll be putting in place the Service Agreement program which will provide up to $16k annually to an EM physician (outside the tertiary centres) who is prepared to sign a service agreement outlining their commitment to a minimum number of shifts in both regional and community emergency departments.

There are many (and conflicting!) views in this space. We (DNS, DHW and the NSH/IWK) heard them all and came to these decisions as a collective. I recognize that you might have made different decisions (perhaps a higher regional rate; perhaps obliterating the gap between the regionals and the level 3s, etc.). In the end, we were comfortable to make investments in the Level 3 rates that would start to close the gap with the regionals, while investing in this Service Agreement program to help ensure a predictable workforce for all EDs in a zone, and ensuring our tertiary rate continues to be competitive enough to recruit and retain talent there as well.

Q: Is the locum daily rate increase retroactive to April?

A: No, it comes into effect upon the signing of the contract, which we expect to take place at the end of July.

Q: Which codes will be retroactive to April 1? What else is retroactive to April 1, 2023?

A: There are three items that are retroactive to April 1, 2023:

(1) the year one 3% across-the-board increase, which will be applied to all APP rates, C/AFP Minister's funding, and fee codes billed since April 1, 2023;

(2) the new hourly rates for Emergency Medicine (as outlined in the table at page 26 of the Physician Agreement) and the new APP rates outlined in Schedule A (page 25 of the Physician Agreement); and

(3) the increase in the parental leave benefit (please note that the tentative agreement says the parental leave benefit increase will take effect upon signing of the new agreement, but DHW has agreed to have it apply retroactively to April 1st, as discussed above).

These retroactive adjustments will be applied and paid out to physicians by MSI/DHW likely in Fall 2023. Physicians are not required to do anything to apply for or secure that payment.

Q: Is it true that we can't use the visit multiplier for virtual visits? I like to book mental health related visits virtually because they tend to take a long time to talk about different issues. This frees up more office time for more direct patient visits.

A: Yes, it's true. You can't bill multiples for a general office visit done virtually, but you can bill psychotherapy codes for mental health virtual visits.

Q: The contract indicates that we can bill for the services of allied health-care providers based on the time that it takes them to provide the service - $25 or $50. Does this preclude us from billing standard MSI codes as well? E.g., if a nurse provides counseling for 25 minutes are we only able to bill $25 for that service? Do we then get paid $25? Or 30% of $25?

A: The contract includes funding for a new pilot project available to LFM and fee-for-service family physicians who hire an allied health-care provider (ACHP). In this pilot, family physicians can bill for the services provided by the AHCP to help offset the costs associated with employing them, to a maximum of $110,000 per year. But the opportunity to bill these new fee codes is only open to those approved to do so as part of this pilot.

The new codes will be:

- AHCP Service (simple) – $25
- AHCP Service (complex) – $52 (approx. 1 hour)

For LFM physicians, payment will be the full $25 or $52 (not 30% of those values). You cannot bill other fee codes for services delivered by allied providers. And again, please remember that the opportunity to bill the above fee codes ($25/$52) is only for those physicians approved as part of the pilot project (for which applications will be accepted in Jan/Feb 2024, and Jan/Feb 2025).

Q: How are retroactive payments going to work?

A: The retroactive payments will be paid out to physicians by MSI/DHW likely in Fall 2023. Physicians are not required to do anything to secure that payment.

Q: I do not believe the across-the-board increases (3% in year 1, 3% in year 2, 2% in year 3, 2% in year 4) keeps up with the cost of living. This will not help much to retain and recruit much needed physicians to our province.

A: Keeping pace with inflation is a clear goal and objective for DNS in negotiations. It can also be difficult to achieve with incomes at the level of most physician incomes. In the context of this negotiation, we strived to address the increasing cost of living by securing investment in a variety of different areas, including 10% in across-the-board increases along with significant additional investments in longitudinal family medicine and rural specialty services (through initiatives like new fee codes, overhead supports, precepting support, etc.).

QUESTIONS ABOUT PRECEPTOR PAYMENTS

Q: Preceptor payments – how do those work for physicians who are paid hourly or sessionally or are in a shadow billing arrangement (such as emerg, PMC, APP specialists, etc.)?

A: All physicians who are approved as preceptors, regardless of payment model, are eligible for the annual $5k payment. All physicians will also be eligible for the daily stipend ($90/day), but that change will not take effect until the current stipends have been reviewed and the billing rules have been changed. We hope to have that completed in the Fall. All physicians are also eligible to bill the 5% on billings, but for those in shadow billing arrangements (such as emerg, hospitalist, PMC, APPs), the 5% would count toward shadow billings only, it would not be paid on top.

Q: Preceptor payments – are any of the teaching stipends ($5k annually, 5% on billings when precepting, and $90/day) applicable when a physician is teaching RN or NP learners?

A: In our initial discussions with the government, we had only discussed med students, residents, PRAP physicians and Physician Assistant learners. In those cases, the teaching payments definitely apply. For now, the answer is "no" in relation to RN and NP learners - the teaching stipends will not apply to those learners. But we may have an opening to expand the stipends further when we're reviewing them in Fall 2023.

Q: What if a preceptor has multiple learners at one time?

A: A physician with more than one learner can bill the daily stipend for each learner at the current rate ($90/day). This is effective immediately. The working group that will be reviewing the stipends in Fall 2023 will need to consider what this will look like going forward (it may not continue to be the full daily stipend depending on the review).

Q: Is the 5% billable on all services delivered by a preceptor when a learner is present? For example, if a physician is billing the daily stipend, are all the encounters in that day billable with the 5%, even if for some of the services the learner may have stayed behind with Patient 1 while the physician moved ahead to Patient 2? (For example, Dr. X might book 20 people in a day. The learner will do some things with the preceptor, and some things on their own. Dr. X would bill 5% on the day, as opposed to trying to recall which services included the learner in the room and which did not?)

A: Yes, the 5% is on all billings delivered during the day that the preceptee is present. We would expect the majority would be at the same location. If the physician is doing additional work on the same day without the preceptee then the 5% doesn't apply.

QUESTIONS ABOUT THE LONGITUDINAL FAMILY MEDICINE (LFM) PAYMENT MODEL

Q: Why are all of the details on the LFM not finalized yet? Why should we vote for a contract that's not "fully baked" yet?

A: It's true that some of the details about the new LFM payment model are not yet settled and they cannot/will not be settled before the vote is done. Physicians will have to make a decision without those details. We know that's unsettling. But we (the negotiating team and the Board) believe that what we have nailed down definitively, is enough in and of itself to warrant supporting the contract. We continue to believe there was more risk of getting a lesser deal if we had put this off until the Fall, and we would have hated to see all the good in this contract go away because we ran out of time to settle some finer details that will have little impact to our members overall.

We know some physicians have concerns that the government will not finalize the outstanding details in good faith. But we feel confident that the most important parameters have been well defined and settled. We also know that the government will be highly motivated to get this right. Otherwise, they'll simply lose family physicians and be unable to recruit to replace them. That is untenable and will help to steer decisions in the right direction.

It's also worth noting that we've now settled many of the outstanding details in the past few weeks, as you'll see reflected in the FAQ below.

Q: Can you define "time" as it relates to the LFM model?

A: The LFM model pays you for your "time".

Clinical Time: Refers to any time a physician spends providing patient specific care. This can be both direct and indirect care and can be spent at the office or at home, during the day, in the evening, or over the weekend. As long as your focus and efforts are being spent on patient specific care, it's considered clinical time.

- Direct Care: refers to care provided directly to a patient (or designated decision maker) in a one-on-one setting, this can be in-person or virtually.
- Indirect Care: refers to care provided to a specific patient when they are not present (either in person or virtually). I.e. charting, reviewing diagnostic reports, reading consult letters, etc.

10% Clinical Support Service Time (often referred to as Administrative time): refers to services which are not patient specific, but provide benefit to the patient population and the health system. It could also include any time you spend administering your practice in terms of managing staff, etc. You will not have to calculate or submit this time yourself; it will

automatically be applied to your bi-weekly payments based on the number of clinical hours you submit.

Q: How will I claim my LFM hours? How do I determine my daily baseline numbers, i.e., number of hours of direct patient care, indirect patient care, paperwork, etc. while meeting the 2.8 encounters per hour expectation?

A: There seems to be significant confusion around how to claim your hours, the 2.8 minimum average of encounters per hours per day, and how it relates to the number of hours a physician can claim. Here is a summary of the agreement we've reached to date:

- At the time of the conversion to LFM, physicians will be asked to self identify what their intended *clinical hours* per week will be over the next 6 months. If vacation plans are known, you should identify them upfront. If they're unknown it's not a problem. The smoothed hours that you will be paid every two weeks will be based on the number of intended hours you stated you would work.

- When communicating your intended hours, you can include all anticipated **clinical time** (both direct and indirect). As defined above, **clinical time** is defined as any time you are doing patient specific work and includes both direct and indirect patient care. **Direct clinical time** will be appointment time (office visits both in person and virtual) and **indirect clinical time** is patient specific "paperwork" time like reviewing labs, charting, etc. There is no need to distinguish between direct and indirect clinical time when identifying your intended hours of work to be smoothed. If you typically do an hour of paperwork at the office before you go home, you can include that as an hour of intended work. If you typically do an hour of work at home in the evening and are confident you will continue to do this work, then claim that upfront as well. You will need to monitor your own **direct:indirect** patient time ratio to make sure you don't slip below the 2.8 service encounter expectation in terms of average patients per hour but that's up to you to manage. DHW will not be monitoring the 2.8 encounters on a daily basis. They've told us they may review it monthly, but it will most likely be quarterly.

  Remember that the 2.8 service encounters per hour is a minimum required average per hour. Even if you greatly exceed that minimum requirement, you can only bill an LFM hour if you actually do patient specific work in that hour. We've been asked, for example, if a physician that sees 5 patients per hour would be able to bill additional hours under the LFM since they are so far above the minimum 2.8 service encounters per hour. The answer is no. You can only bill for the hours in which you are in fact providing clinical care (direct or indirect), regardless of how many patients per hour you are seeing.

- Once you've identified your intended clinical time, DHW will add 10% and those are the hours your bi-weekly smoothed payments will be based on. The additional 10% is for the clinical office admin time that you will now be paid for. (This work includes the old

CSS time like team meetings, QI, etc. but it also could include time spent hiring staff, meeting with your accountant, etc.) You will not need to claim any hours for this time. DHW will automatically apply it. They will not be monitoring how you use this time. You've earned this time as a longitudinal family medicine physician to use as you see fit.

Q: What is the biweekly payment in the LFM? Curious if you have a vacation booked, what would your base pay be?

A: Physicians will be asked to submit their "projected clinical hours" for each coming 6-month period. Your submission should be based on how many hours per day or week you intend to work, plus how many weeks in that 6-month period. Your hourly pay under the LFM will be "smoothed" based on what you submit (smoothed over that 6-month period, or 13 pay periods). If you plan to take some uncontracted time (vacation, leave, etc.) in that 6-month period, your bi-weekly payments would be slightly reduced to provide a smoothed, consistent income over the 6-month period. You will continue to receive the panel payment (per patient amount) bi-weekly regardless of any uncontracted time taken. You will receive 30% of your FFS billings every two weeks based on what you have claimed, so presumably, while on vacation you will not have FFS billings. Your total income during a vacation period would therefore reflect your smoothed bi-annual hours payments and your panel payments, likely with no FFS claims for that time period.

Q: What are "uncontracted hours"?

A: Physicians are independent contractors, regardless of which remuneration model they are paid under (APP, FFS, LFM). As such you don't get paid vacation, statutory holidays, sick time, or education leave. This is "uncontracted" time. The current APP model is based on 46 weeks per year of contracted time, and 6 weeks of work for uncontracted time. Annual hours based on 46 weeks of work per year are smoothed over 52 weeks. This is why it "appears" as though APP physicians get paid vacation when in fact they don't. The LFM model is expected to be set up very similarly based on your self identified intended hours of work. The target LFM income provided in the ratification material is based on 46 weeks of contracted time and 6 weeks of uncontracted time.

Q: Am I eligible for the LFM if I do not want to work 46 weeks per year?

A: Maybe not. It will depend. While the LFM model does allow for physicians to work part time, physicians will still be expected to provide SOME level of service throughout a 46-week period. (i.e., you can work 20, 40, or 60 hours per week, but will still need to be accessible to your practice and your patients (both virtually and in-person) over a 46-week period). DHW will be paying you an annual panel payment per patient and the expectation is you will be accessible to them. The LFM model will likely not be considered for those physicians who intend to take extended holidays or time away from their office-based family practice. Exception considerations will be given to physicians who support a local on-call service like hospitalists,

long term care/Care by Design, Community Hospital Inpatient Program (CHIP), Prenatal Maternity Care (PMC), or emergency room coverage. These services are heavily dependent on family physicians. All partners believe it will be important to ensure that participation in these call rotations, which sometimes require physicians to be on-call for a week at a time, will not be prohibited by the LFM and vice versa.

Q: What happens when an LFM physician is providing other community services outside the office, such as ED shifts, hospitalist or other inpatient work, etc.?

A: If an LFM physician is providing other community services outside the office (and outside their LFM practice) such as ED, hospitalist, PMC, CHIP, hospice sessional, etc. they will be paid for that work under the respective remuneration model for those services. There are still a couple of answers yet to be defined regarding long term care of your own LFM patients, Youth Health Centre work that has traditionally been paid under the APP, and FFS walk-in clinic work. We'll have an answer within the next couple of months on those specific questions.

Q: Is the CME stipend in or out of the LFM base pay?

A: The CME stipend is paid outside of the LFM payment model, so the annual $2,000 payment is paid on top of the LFM model.

Q: What happens when an LFM physician sees patients in their office who are not attached to their practice (such as consults for sexual health referrals, etc.)?

A: That's something we haven't finalized yet. We will need clarity before the LFM can launch in October. The LFM Schedule says, "Unattached patients: The parties will finalize details of how compensation for unattached patients will apply to LFM physicians." We expect that one of the options would be to bill 100% FFS for those patients (but not to claim LFM hours). Another option would be to claim the LFM hours plus 30% FFS. We'll have an answer within the next couple of months.

Q: What about home visits - how are they dealt with in the LFM?

A: Home visits are part of LFM and these patients are considered part of the panel. So a physician would count home visits as part of their LFM hours and bill 30% FFS for all home visits.

Q: What do physicians lose in terms of bonuses and grants within the LFM? For example, do we lose the EMR grant, and the CDM, if the code still exists? Are they only worth 30%?

A: Compensation under the LFM model includes some new money and some that was previously provided as grants or bonuses on top of the APP rate. Now, it is all included in the LFM funding:

- Overhead support
- EMR envelopes B, C
- Collaborative Practice Incentive Program
- Chronic disease management (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

Physicians paid via the LFM model 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
- 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
- Preceptor funding (annual payment, premium on billings and daily stipends)

Q: I'm curious about vacation and billing targets as it applies to current APP contracts in the six (or more) months between the contract being ratified and the implementation of the LFM.

a) **Will I get a bonus if I hit my 80%, prorated to the time contributed, before my contract gets taken away?**
No. The 5.6% bonus has been "baked into" the LFM rate already, when we agreed on a target average income of $365k under the LFM. This was done to ensure APP physicians would not lose the income potential of the 5.6% bonus with the transition to the LFM. There is also the one-time rostering incentive that will be paid to APP physicians this year, to bridge to the new LFM model.

b. **What about vacation - not all of us have taken 50% of our vacation days that we would theoretically be entitled to under our existing APP. Will we be reimbursed for this if we worked extra if our vacation was booked after October 1?**
No. APP physicians do not technically have "vacation" entitlements. Instead, APP physicians are paid for 46 weeks of contracted time, and APP payments are smoothed over 52 weeks of the year. With the transition to the LFM happening mid-year, this

raises a legitimate question about the 6 weeks of uncontracted time under the APP. We have confirmed with the government that if a physician has not used any of their uncontracted hours at the time of transition, there will not be a reimbursement for those weeks. However, we anticipate that most APP family physicians will have used at least half of those uncontracted weeks, taking some well-deserved and much-needed time away from your practices over the summer months.

Q: I believe that family physicians currently paid via an APP are paid for 46 weeks, spread over 52 weeks of pay - will this be the same with our baseline pay in the LFM?

A: The LFM model is built on 46 weeks of clinical work/year. Twice per year, DHW will ask members to identify their intended hours of work for the next 6-month period. You will have the option of disclosing any intended vacation if you have your dates. Your total intended hours of work for the 6 months will be smoothed over 13 bi-weekly payments so you continue to be paid even though you're taking some uncontracted time. If you disclose vacation up front and those uncontracted hours were included in your smoothed income, and you didn't take any more uncontracted time than expected, then you're golden. If you weren't sure of your vacation time at the beginning of the 6-month period and ended up taking some uncontracted time you hadn't expected to take, then your paid hours may be higher than what you worked and claimed in the end. In this case, your payments will be adjusted for the next 6-month period to account for the discrepancy (that's why we did 6-month terms for the reconciliation of hours so that adjustments could be made over the course of the year to account for vacation/uncontracted time). Our advice would be to account for uncontracted time upfront as best you can. This really isn't all that different from the current APP that pays a total of 1,725 annual hours over 46 weeks of the year (with payments smoothed over 52 weeks). Except in the new LFM, if you don't actually take 6 weeks off, you'll get paid what you actually worked.

As above, DHW will want physicians to commit to 46 weeks of service per year if they are moving to LFM. This is because they will want to ensure they're buying timely access with their panel payments. We've negotiated that LFM physicians can take a total of 6 weeks uncontracted time without their panel payments being adjusted but any extended leave beyond that will likely result in a reconciliation.

a) Do those six weeks include mandatory public holidays (i.e., when we have to close as we don't have staff working on those days)?

A: Yes, statutory holidays are included in the six weeks of uncontracted time, just as they were included in the APP.

b. Same goes for when the clinic is closed due to those statutory holidays but a lot of us still cover our desktops those days (how to account for this?)

A: You are allowed to bill clinical hours for indirect patient time at home, in the evening, at the cottage or at the soccer field during stat holidays or anytime, providing that you're actually doing patient specific indirect care. We do not expect that evening and weekend indirect patient care can be claimed as premium evening/weekend hours, unless patient services (visits) have been delivered in the evening/weekend as well.

Q: I'm taking on new patients (or have been in the last few months) but I'm also behind in my billing. Will my panel roster number be reassessed at some point before the transition to the LFM? If so, when?

A: Yes, DHW will be running updated panel numbers in advance of conversion to LFM (likely about 4 weeks before "go live" in October).

Q: How will I actually claim the LFM hours though - what's the mechanism? And how will the hours I claim for 6 months be reconciled with the hours I actually work in those 6 months?

A: When submitting your daily FFS billings, you will be asked to bill a fee code for the number of clinical hours **worked** per day. As above, when **claiming** actual hours worked, you should include all actual clinical time worked (both direct and indirect) based on the definitions outlined above. There is no need to distinguish between direct and indirect patient time when claiming hours at this point (but this may change as we further define the operational guidelines over the next couple of months). To reiterate, you will need to monitor your own **direct : indirect** patient time ratio to make sure you don't slip below the 2.8 "danger zone" in terms of average patients per hour. That is up to you to manage. DHW will be providing quarterly reports with your "stats" that will help you manage that. DHW will not be monitoring the 2.8 visits on a daily basis. They've told us they may review it monthly, but It will most likely be quarterly. The 2.8 is a minimum average per hour.

The 6-month reconciliation will be based on number of hours paid versus number of hours worked/claimed. If your hours worked are more than what you stated you would work, you will be paid the additional hours (plus 10% to account for office admin/CSS time). We still have not decided how working less hours than intended will be dealt with (i.e., claw back, reduced hour payment over the next 6 months, etc. It's likely your payments will be adjusted for the next 6 months to account for it). To reiterate, the reconciliation will only be related to clinical hours paid versus clinical hours claimed/worked. The minimum number of patient encounters will not be a factor in the reconciliation but will be monitored.

Note for monitoring purposes, the calculation of whether you met the 2.8 service encounters per hour will not include the 10% office admin time. It will only be calculated based on the 90 percent clinical time.

Q: What will my bi-weekly payments look like under the LFM?

A: Biweekly payments will include:

1. Projected hours worked - smoothed over a 6-month period, so your bi-weekly payments for hours worked will be the same for each 6-month period
2. Panel payments - calculated each quarter based on your panel size at that time.
3. 30% of FFS billings - this amount will be variable based on actual FFS billings. You'll get paid as you bill. Most physician's clinic schedules look fairly similar day to day, week to week, but there will be some slight variability.

The reason why the panel numbers are being reconciled quarterly is to ensure you get the benefit of an increase in panel size throughout the year. You will bill the initial "new patient" encounter and the patient will then get added to your panel when the quarter rolls over. While this means there will be some quarterly variability in bi-weekly payments, we felt it would benefit physicians more to allow for in-year enhancements to the panel calculation.

FFS billing accounts for the least amount of total remuneration under the new model so we anticipate it should be feasible to budget from a business perspective. For example: if you're a full-time physician who intends to work 40 daytime hours per week with a panel of 1000, your bi weekly pay will be:

- Base hours: 80 x $92.70 = $7,416
- 10% Office Admin = $7416 x 1.10 = $741.60
- Quarterly panel payment: 1000 x $103.00 divided by 26 pay periods = $3962
- Total predictable bi-weekly income (before any FFS earnings) = **$12,119.60 every two weeks**.
- FFS earnings will be additional over and above this amount.

For comparison purposes: current APP family physicians receive roughly **$10,696 every two weeks** with no option to bill FFS on top. The above projections will depend on how many actual days are in a pay period but it's a decent representation of what you could expect for a "typical" pay period.

Q: If we do paperwork for a colleague on vacation, can we bill for this?

A: We anticipate that you will be able to bill for this (mindful, as always, about the requirement to meet 2.8 service encounters for every hour billed). Details need to be sorted before launch of the LFM and will be communicated once they're finalized.

Q: How will they account for rostered patients who see the doctor once every five years because they are young and healthy?

A: DHW has already increased all panel sizes by 10% to account for these very patients (the "well" population that you don't see as often). When DHW calculates your panel based on ME=CARE billings, they automatically add 10% to account for this. Also, remember that once a patient is on your panel they will only be removed from your panel if another physician bills ME=CARE for that patient more often than you. So if a patient is simply "well" and not in need of care, they will remain on your panel as one of your patients.

Q: How are you going to account for rostered patients who get prenatal care with another family physician (FP) who works in the same model? What about when rostered patients see other FPs in duty clinics?

A: We know this is an issue and are working with DHW on it to ensure your panel is not affected in these circumstances. Will be resolved before the LFM is launched on October 1.

Q: How much more reporting is going to be required - the yearly paperwork is bad enough. Will it be quarterly?

A: There is no additional or extra reporting. It will be automated for the most part. We expect that there will be less administrative burden to the LFM model than the APP model.

Q: How are we expected to document faxes/phone calls that we are now allowed to bill for LFM in case we get audited?

A: You are expected to use the billable codes that are available and to follow the billing rules outlined in the Physician Agreement (see page 32 of the Physician Agreement for the ALLIED HEALTH CARE PROVIDER TO PHYSICIAN billing rules).

Q: How does the community modifier increase our income? Is the modifier multiplied by our entire outcome to be paid yearly?

A: Yes the modifier will be applied to all LFM income and paid annually.

Q: Will there be billing codes for collaborative meetings?

A: Yes this is on the "to do list" for the Fee Committee. The Fee Committee will be asked to explore several additional codes to capture currently "invisible work" post-ratification. The Fee

Committee will explore several fee codes that better compensate physicians for the work they are doing or recognize work that is currently not compensated appropriately, including:

- Physician-to-physician capacity building, mentoring, maintenance of competency
- NSH/IWK Health–requested quality/safety work
- Collaboration time
- Team development
- Family physician consults
- Group medical visits
- Multiples on specialist telephone advice
- Triage
- Shared care/co-management of patients (for example, high-risk obstetrics rounds, organ transplant rounds)
- General internal medicine visit and consult codes (including complex discharge, follow-up office visit and subsequent hospital visit)
- Care of the elderly
- Long-term care (case management conferences, chart reviews)
- End-of-life care

Q: How is the 30% billings going to be paid? Will it be paid in arrears every 2 weeks or is it going to be based on your billings from the previous year? If so, what happens if you over bill or under bill that amount the following year?

A: Your payment will be based on actual in-year billings paid out when you bill it. Typically, it's paid every two weeks based on actual real time billings.

Q: How often are the panel fees paid out and the roster size determined?

A: The panel payment will be paid out bi-weekly but will be smoothed quarterly. This means your bi-weekly panel payment will be adjusted each quarter based on panel size at the beginning of the quarter.

Q: I'm worried about losing patients on my roster due to working In a collaborative practice where my colleague can bill a ME=CARE code for a patient. This may de-incentivize same day access and cross coverage as those who do more same day access coverage or have learners whose schedules sometimes allow for more same day access apts will be "stealing" roster patients from others.

A: The ME=CARE algorithm is evolving, and we've already done some work to address the shared-care model in the algorithm. DHW has done many panel validation exercises over the

last year and have found them to be within a few percentage points of accuracy in collaborative practices. This work is still underway, and details will be shared with physicians as soon as they're finalized, before the model goes live in October. We're confident the collaborative practice/shared care impact on the algorithm will get addressed through further evolution of the algorithm prior to "go live".

Q: Can you provide examples of what an average expected day looks like to meet the LFM contract expectations? I.e., what is the minimum amount of patient encounters you need to meet your contract?

A: It's up to individual physicians to determine what works best for them and their practice. The LFM is a flexible payment model that will support you in working effectively and efficiently as you see fit. If you'd like to discuss your particular situation, please reach out to your physician advisor.

Q: What is ME=CARE?

A: ME=CARE is a fee code modifier established in 2018/2019 to incentivize patient attachment to a provider

ME=CARE allows physicians to be paid at 15% premium on most office-based billing codes when seeing a rostered/attached patient. As a condition of billing ME=CARE, physicians commit to providing comprehensive primary health care to that attached patient. Physicians can claim ME=CARE for a patient of a provider for whom they share a collaborative practice. Allied health providers do not bill ME=CARE when shadow billing.

Q: For new-to-practice doctors with a smaller panel size or with new physicians taking over an existing panel, what is the plan for fair compensation in the first 1-2 years with ME=CARE codes?

A: Physicians who are new to family practice will be entitled to a guaranteed minimum income under the LFM for their first year of **active family practice**. The minimum guarantee will be based on intended hours plus the physician's target panel size (that is, the panel they are building toward), plus 30% of fee-for-service billings. See details on page 37 of the Physician Agreement. Note: any extended leave of absence within the first year of practice such as parental leave, will lead to a "pause" in your time accrual toward your first year of active family practice deadline, which will result in a date extension.

Q: How is DHW calculating panel/roster sizes?

A: DHW refers to the formula they use to calculate panel size as the ME=CARE Algorithm. Here are the details:

For all encounters using the ME=CARE Health Service Modifier since the inception of the code in 2018/19, DHW determines:

- Number of encounters with each provider
- Last encounter date with each provider

The patient is counted in the provider panel with the most encounters. If tied, the patient is counted in the provider panel with the most recent encounter.

Provider ID	Patient ID	Modifier Code	Last Encounter	# of Encounters
Provider A	Patient 1	ME CARE	Jan 25, 2009	1
Provider B	Patient 1	ME CARE	March 3, 2021	3
Provider C	Patient 1	ME CARE	Feb 7, 2022	3
Provider D	Patient 1	ME CARE	Nov 2, 2022	2

The original algorithm identified a gap specifically related to situations where a new provider took over a practice of a physician retiring from family practice who may or may not be fully retiring. It was taking a significant amount of time for patients to become attached to the new provider via the algorithm. It's now been refined.

To further refine patient panel allocation, visits that have occurred more recently are now weighted more heavily than visits that occurred in the past. This was meant to increase the likelihood of patient allocation to current providers. We expect further evolution of the model before the LFM is implemented.

Other than assuming a retiring physician's practice, there are a few other practice phenomena that may impact individual physician panel calculations:

- If you took an extended leave from your practice (i.e., parental leave), particularly if you had an APP locum and/or a FFS physician cover your practice who billed and/or shadow billed ME=CARE for your patients, some of your patients may be getting assigned to the locum.
- If you're in a collaborative practice/shared care model and you and your colleagues provide intermittent care to one another's patients.
- If you refer your pre-natal and/or well-baby care to a family physician colleague who bills ME=CARE.

DHW is committed to working on ways to address these scenarios in advance of LFM implementation. More details to follow in the coming months.

Q: I don't agree with the government's calculation of my panel size. I believe my panel is larger. How can I address that?

A: If you feel that the government's calculation of your panel is not accurate you can request a panel validation. To take part:

- Email: psaccountability@novascotia.ca. Let them know you have some concerns that your calculated panel may not be accurate and express your desire to participate in a validation exercise.
- You can expect to hear back initially from DHW within 1-3 business days.
- You will be asked to export a list from your EMR including patient name, DOB and HCN. DHW will send you a secure link by which you can securely email your list confidentiality.
- Your individual panel report will be calculated and sent back to you within 7-10 business days.
- Once you've received your report, DHW will sit down with you to review and discuss if requested.
- Once you've identified any outstanding discrepancies with your report, all parties will determine a plan to resolve them in advance of LFM implementation.

Q: Will there still be reports sent out to physicians like the APP accountability quarterly reports?

A: Yes. They will look very familiar for APP family physicians, but they will be refined to include LFM specific data. Here's what you can expect to see on the reports (please note this list is not exhaustive and may be added to as the LFM operational guidelines are finalized:

- Total Contract Earnings (which will include hours paid, panel disbursements).
- Total clinical hours paid, total clinical hours claimed/worked (and associated discrepancy)
- Total panel number and total panel payments.
- Total FFS earnings
- Average # encounter per day.

It may also include other pertinent information like the number of unattached patients on the Need a Family Practice Registry in your catchment area.

These reports will be sent to LFM physicians quarterly.

Q: What happens if we don’t average 2.8 service encounters per hour?

A: A minimum of 2.8 service encounters per hour is the expectation. This will be monitored and DHW will report on it. If a physician is consistently unable to meet that minimum expectation, this will trigger a meeting with the NSH (and possibly DHW) to discuss the reasons and possible support that is available to you. If there is no clear rationale or plan to remedy the issue, the government could choose to terminate the LFM agreement, and the physician would have to revert to fee-for-service. Remember though, when you’re spending time with more complex patients you will be billing multiples, which will count as separate service encounters.