PHYSICIAN SERVICES MASTER AGREEMENT

BETWEEN:

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

OF THE FIRST PART

-and-

THE MEDICAL SOCIETY OF NOVA SCOTIA represented by the President of the Medical Society operating as Doctors Nova Scotia ("**DNS**")

OF THE SECOND PART

EXECUTION COPY

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AGREEMENT PREAMBLE

WHEREAS pursuant to the *Medical Society Act. 1995-96, c. 12, s. 1*, the Medical Society, carrying on activities as Doctors Nova Scotia, is recognized as the sole bargaining agent on behalf of duly qualified medical practitioners in the Province of Nova Scotia in respect of the payment of Insured Medical Services and other matters of common concern between the DOH and DNS and all medical practitioners covered by any such agreements, pursuant to the Act;

AND WHEREAS DOH has the power, pursuant to the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended (the "Act"), to negotiate 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 the Parties acknowledge the need to ensure that Insured Residents of the Province continue to have reasonable access to quality health care services and that fair and reasonable compensation be provided to Physicians for the provision of Insured Medical Services;

AND WHEREAS the Parties share the common goal of ensuring an adequate supply of Physicians and correcting any undersupply of Physician human resources in the Province;

AND WHEREAS the Parties recognize the shared obligation and responsibility to meet population and patient medical needs through evidence based quality care provided through an integrated, accountable, efficient and effective health care system;

AND WHEREAS the Parties are committed to the development of a culturally competent health system that is responsive to the needs of all the populations and people we serve;

AND WHEREAS DOH, together with the District Health Authorities ("DHAs"), and DNS wish to continue to work together in a relationship built upon transparency, constructive collaboration and mutual respect;

AND WHEREAS the Parties acknowledge and agree that the relationship envisaged by this Agreement requires ongoing dialogue and consultation on matters of significance to the provision of quality health care services, whether DOH funds such care directly or indirectly;

AND WHEREAS the Parties acknowledge that DOH 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 DHAs 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 acknowledge that the goals of DNS include maximizing Physicians' professional satisfaction and achieving fair compensation for Insured Medical Services rendered by Physicians;

AND WHEREAS the Parties have reached agreement with respect to Physician remuneration and such other issues regarding system improvement and change through:

(i) Supporting access and improvement to full service family practice;

(ii) Supporting access and improvement to services provided by Specialist Physicians;

(iii) Enabling shared care between and appropriate scopes of practice for General Practitioners, Specialist Physicians and other health care professionals;

(iv) Enabling the use of alternative payment plans to enhance patient care;

(v) Enabling the use of electronic technology for Physician practice to support patient care; and

(vi) Recognizing and including the District Health Authorities in appropriate discussions with the Parties concerning the delivery of patient care and implementation of system improvement and change.

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

1. DEFINITIONS

In this Agreement:

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

(b) "**AF**" means Alternative Funding, and includes funding mechanisms other than Fee-For-Service such as **Academic Funding Plans ("AFP's")** and **Alternative Payment Plans** ("**APP's**"), which provide for the provision of Insured Medical Services including, but not necessarily restricted to, contracts which have as a Party a DHA, the DOH, DNS, the IWK, or Dalhousie University, and a Physician, group of Physicians or an academic department of a post-secondary institution;

(c) **"Cumulative Annual Funding"** means total accumulated additional funding available for use pursuant to this Agreement;

(d) "**DHA**", means a District Health Authority as defined in the *Health Authorities Act, S.N.S. 2000, c. 6*, and includes the Isaac Walton Killam Health Centre (the "**IWK**");

(e) **"EMR"** means an Electronic Medical Record that is an electronic legal record of the clinical services provided to a patient that is created and maintained where the services are provided;

(f) **"EHR"** means an Electronic Health Record that combines the output of a number of information systems and that contains patient information from various health care providers and may include but is not limited to EMRs;

(g) "**Fee-For-Service**" means the payment of fees to Physicians for Insured Medical Services in accordance with the Tariff;

(h) "**Fee Schedule**" means the portion of the MSI Physician's Manual that lists all Insured Medical Services, their descriptions and codes, any special conditions, and their value in units as well as the Radiology, Pathology and Internal Medicine non-patient-specific fees;

(i) "**General Practitioner"** means a Physician registered with the College of Physicians and Surgeons whose name does not appear on the Medical Specialist Register;

(j) "**Health Care Facility**" means a hospital or facility which has been approved as a hospital under the *Hospitals Act, R.S.N.S. 1989, c. 208* ("*Hospitals Act"*);

(k) **"Incremental New Funding"** means new funds added in each Year of this Agreement;

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

(m)"**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 and that are identified for payment by a specific service code in the MSI Physician's Manual, or as Radiology, Pathology and Internal Medicine non-patient-specific fees, or pursuant to AF or paid through Sessional Fees;

(n) "**MASG**" means the Master Agreement Steering Group;

(o) "**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;

(p) "**MSI Physician's Manual**" means the document that contains the Preamble and the Fee Schedule for Insured Medical Services;

(q) **"New Fee"** is a fee for an Insured Medical Service that does not currently have a fee assigned;

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

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

(t) "**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;

(u) **"Rural Specialist"** means a Physician registered with the College of Physicians and Surgeons who conducts their practice in a location in accordance with guidelines established by the MASG;

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

(w) "**Shadow Billing**" means reporting by Physicians of Insured Medical Service encounter information to MSI in the format prescribed by DOH;

(x) "**Specialist"** means a Physician registered with the College of Physicians and Surgeons whose name appears on the Medical Specialist Register of Nova Scotia;

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

(z) "**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);

(aa) **"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, 2008 and continues to remain in force and effect for a period of five years, terminating on March 31, 2013.

(b) 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.

(c) Upon expiry of the term of this Agreement, the Tariff then in effect on March 31, 2013 and the provisions of Articles 5(a) and 5(b) shall remain in effect until such time as the Parties agree upon a new Agreement, or a new Agreement is established pursuant to Article 5(a).

3. REPRESENTATION

(a) Pursuant to section 7 of the *Medical Society Act*, *S.N.S. 1995-96, c. 12*, and other applicable authority, DOH recognizes DNS as the sole bargaining agent on behalf of Physicians in the Province who provide Insured Medical Services that are funded through DOH and/or a DHA in respect of all matters relating to:

(i) The Tariff or other systems of payment for Insured Medical Services, including AF agreements that may be entered into by the Parties, respecting the payment of compensation to Physicians for the provision of Insured Medical Services;

(ii) The provision of funding for physician compensation more particularly set out in Article 6 of this Agreement;

(iii) Insured Medical Services provided by Resident Physicians in the Province beyond those which are contracted for through the current collective agreement between the PARI-MP, the QEII Health Sciences Centre, the IWK, the Nova Scotia Hospital, the Cape Breton Health Care Complex, DHAs, and any other Hospital/Medical Centre/Community Centre involved in the Dalhousie University Post Graduate Medical Education Program; and

(iv) Any other matters which the Parties agree should be negotiated between DNS and DOH.

(b) DOH and DNS agree to negotiate in good faith and make every reasonable effort to conclude a subsequent agreement on matters set out in Article 3(a) prior to the expiry of this Agreement.

(c) DNS and DOH agree that the representation rights outlined in Article 3(a) do not include Physicians engaged by the Province for other than Insured Medical Services.

(d) DOH and DNS shall advise Physicians that they are required to comply with the provisions of this Agreement.

(e) DNS agrees that upon this Agreement coming into effect, Physicians who are covered by it should not limit their provision of Insured Medical Services for the purpose of influencing the Province or its agents to change the terms and conditions of the Agreement.

4. RESPONSIBILITIES OF THE PARTIES

NOTE TO READER: Article 4 estimates the costs required to fund the new initiatives during each year of this Agreement. As part of the contract, DNS and DOH have agreed to specific funding amounts for certain initiatives. These amounts cannot be increased during the term of the Agreement. There are other parts of the contract where the funding estimates are based on historical utilization rates. For these initiatives, the contract does not prohibit increases if utilization increases.

(a) DOH is responsible for managing and funding Insured Medical Services and co-ordinating the activities of DHAs to ensure that Insured Medical Services can be provided by Physicians throughout the Province in accordance with this Agreement, in an integrated, accountable, efficient and effective health care system.

(b) DNS recognizes that DOH 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 DOH by the Nova Scotia Legislature and Department of Finance.

(c) DOH recognizes that the funds provided for the specific initiatives in this Agreement are in addition to the base funding provided for physician compensation as of March 31, 2008.

(d) DOH shall provide funding for the specific initiatives detailed in this Agreement in accordance with the estimated costs as follows, subject to Article 4(e):

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$21,800,000	$21,800,000
April 1, 2009 to March 31, 2010	$20,600,000	$42,400,000
April 1, 2010 to March 31, 2011	$20,600,000	$63,000,000
April 1, 2011 to March 31, 2012	$21,600,000	$84,600,000
April 1, 2012 to March 31, 2013	$23,600,000	$108,200,000
Total	**$108,200,000**	-

(e) DOH recognizes that the estimated costs for the initiatives contained in this Agreement and the Schedules are based on the assumption that utilization rates will remain at historical levels, and DOH funding of particular initiatives may change based on fluctuations in utilization.

(f) If costs incurred by DOH pursuant to this Agreement and the Schedules differ materially from the estimated costs contained in Article 4(d) for any fiscal year, the Parties agree that the MASG will review the difference and determine whether:

(i) Funds may be redistributed within the limits of incremental new funding allocated on a yearly basis; or

(ii) Amendment to this Agreement or the Schedules in accordance with the provisions of Article 12 of this Agreement is required; or

(iii) Such other action as may be required.

(g) Any redistribution of funds pursuant to Article 4(f) of this Agreement shall be used solely for investment in new or improved initiatives.

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

5. RESOLUTION OF DISPUTES

(a) Dispute Resolution in Relation to Negotiation of the next Agreement

(i) Subject to the Act, if on the expiration of this Agreement, the Parties have failed to reach a new Agreement, either Party may submit any matter in dispute to the final offer arbitration mechanism as provided in the Act. This article survives the expiry of this Agreement.

(b) Dispute Resolution During the Term of this Agreement

(i) Any dispute with respect to decisions made by the MASG will be resolved in accordance with Article 7 of this Agreement.

(ii) In the event that the dispute cannot be resolved by the MASG in accordance with the foregoing, the matter shall be resolved as follows:

(A) Either Party may submit the dispute to arbitration in accordance with the provisions of the *Commercial Arbitration Act*, *S.N.S. 1999, c. 5*. The decision of the arbitrator shall be final and binding;

(B) The arbitrator will commence the arbitration hearing within Twenty (20) days of appointment and conclude the hearing within Thirty-five (35) days of appointment, unless the parties mutually agree in writing to an extension of time. The arbitrator will be required to issue a decision within Ten (10) days following conclusion of the arbitration hearing.

6. PHYSICIAN COMPENSATION

6.1 General and Fees

(a) **Unit Value System**

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

(ii) The portion of the Tariff, which includes the Preamble and the Fee Schedule agreed to pursuant to the Act, will continue to be published with the actual fee represented in units and will be formalized in regulations made pursuant to the Act, as necessary. The Tariff in effect as of March 31, 2008 shall remain in effect except to the extent altered by the terms of this Agreement.

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

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

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

(iv) The MSU and AU values for the period commencing April 1, 2008 continuing through and until March 31, 2013 shall be as follows:

	Medical Service Unit (MSU)	Anaesthesia Unit (AU)	Annual Increase
Rate (2007/08)	$2.21	$15.75	n/a
April 1, 2008	$2.23	$15.91	1.0%
April 1, 2009	$2.26	$16.15	1.5%
April 1, 2010	$2.28	$16.31	1.0%
April 1, 2011	$2.33	$16.64	2.0%
April 1, 2012	$2.38	$16.97	2.0%

(v) Where this Agreement provides that the percentages above be applied to other contracts for Physician compensation, the actual percentage above shall be applied.

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

DOH shall provide funding for Fee Schedule Adjustments and New Fees as outlined in Schedule "A" – Fee Schedule Adjustments and New Fees.

(c) **Sessional Rate**

DOH shall provide funding for sessional payments for Physicians as outlined in Schedule "B" – Fee for Service Sessional Payments.

(d) **Canadian Medical Protective Association (the "CMPA") Assistance**

(i) The CMPA rebate program, administered by DNS, will be continued for the term of this Agreement.

(ii) DOH agrees to continue to provide funding to DNS for CMPA reimbursement in accordance with the following criteria:

(A) Resident Physicians who are funded by the Province will continue to receive a CMPA rebate equal to their full CMPA premium fees;

(B) All other Physicians will be eligible to receive a reimbursement of 90% of their CMPA premium fees in excess of $1,500.

(iii) DNS will have the responsibility to determine criteria and procedures applicable to Physicians working in the Province who practice in the Province for less than the full year.

(iv) Fifty percent (50%) of the annual estimated cost of reimbursement shall be paid by DOH to DNS on April 1 of each year of this Agreement and the remaining fifty percent (50%) shall be paid on October 1 of each year of this Agreement. Any adjustments required shall be made within sixty (60) days following the end of each year of this Agreement.

(v) DNS accepts any income earned on the funds provided by DOH pursuant to Article 6(d) in lieu of any administrative charges by DNS to DOH.

(e) **Retention and Recruitment Fund**

(i) Members of DNS will be offered Retention and Recruitment incentives, exclusive of CMPA rebates, that shall be administered by DNS and financed through a Retention and Recruitment Fund. The Retention and Recruitment Fund will be used to support programs including, but not limited to, health and dental plans, parental leave and retention and recruitment initiatives.

(ii) DOH shall provide funding to DNS for the Retention and Recruitment Fund as outlined in Schedule "C".

(iii) DNS accepts any income earned on the Retention and Recruitment funds provided by DOH in lieu of any administrative charges by DNS to DOH.

6.2 Fee Schedule Changes

(a) **Fee Code Amendments relating to Changing Methods of Communication**

The MSI Physician's Manual will be amended as of April 1, 2008 to recognize that methods of communication are changing and therefore all existing Nova Scotia telephone fee codes (e.g. home care, palliative care, supervision of long term anti-coagulant therapy, etc.), as well as any New Fees, will permit payment for communication by fax and email.

(b) **Complex Care Fee**

Effective April 1, 2008 there shall be a General Practice Complex Care Fee as outlined in Schedule "D".

(c) **"28 Day Rule"**

Effective April 1, 2008, subsequent hospital visits will be paid on a daily basis for 56 days after patient admission and the existing rule, limiting payment to five visits in seven days, will not apply until after 56 days.

(d) **Well Baby Visit**

DOH shall provide funding for an additional insured well-baby visit for children eighteen months of age, to be implemented effective April 1, 2008. Physicians shall receive compensation for insured well-baby visits at 18 months of age, provided the Physician examines the baby no less than 2 weeks prior to the baby attaining 18 months of age, and no more than 2 weeks after.

(e) **Evening and Weekend General Practitioner ("GP") Office Visit Incentive**

DOH shall provide funding for an evening and weekend GP office visit incentive program as outlined in Schedule "E" – Evening and Weekend GP Office Visit Incentive.

(f) **Hospital Care Fee Adjustment**

DOH shall provide funding for increased payments to Physicians for participation in Hospital Care as outlined in Schedule "F" – Hospital Care Fee Adjustment.

6.3 Program Initiatives

(a) **On-Call Programs**

DOH shall provide funding for On-Call Programs as outlined in Schedule "G" – On-Call Programs.

(b) **Locum Program**

DOH shall provide funding for a Locum Program as outlined in Schedule "H" – Locum Program.

(c) **EMR**

DOH shall provide funding to Physicians who use or adopt a system of EMR as outlined in Schedule "I" – Electronic Medical Records.

(d) **Comprehensive Care Incentives**

DOH shall provide funding for a Comprehensive Care Incentives Program, as outlined in Schedule "J" – Comprehensive Care Incentives.

(e) **Chronic Disease Management Incentives**

DOH shall provide funding for Chronic Disease Management Incentives as outlined in Schedule "K" – Chronic Disease Management Incentives.

(f) **Collaborative Practice Incentive Program (GP's)**

DOH shall provide funding for a Collaborative Practice Incentive Program for GP's as outlined in Schedule "L" – Collaborative Practice Incentive Program (GP's).

(g) **Professional Development Support Program (GP's)**

DOH shall provide funding for a Professional Development Support Program for GP's as outlined in Schedule "M" – Professional Development Support Program (GP's).

(h) **Practice Innovation Fund**

DOH shall provide funding for a Practice Innovation Fund as outlined in Schedule "N" – Practice Innovation Fund.

(i) **New Pressures**

DOH shall provide funding to address New Pressures on the Health Care System as outlined in Schedule "O" – New Pressures.

(j) **GP Alternative Payment Plans**

(i) DOH shall provide funding for an increase to APP's for GP's as outlined in Schedule "P" – GP Alternative Payment Plans.

(ii) Template GP APP Agreements shall be developed and approved for use by the Parties no later than April 1, 2009.

(k) **Continuing Care**

DOH shall provide funding for incentives for participation in Continuing Care as outlined in Schedule "Q" – Continuing Care.

(l) **Unattached and Orphan Patients Program**

DOH shall provide funding for an Unattached and Orphan Patients Program as outlined in Schedule "R" – Unattached and Orphan Patients.

(m) **Remuneration for Return Trip when Transporting**

DOH shall provide funding for the return trip of Physicians who have accompanied a patient being transported from one location to another, at the same rate as the trip to accompany the patient on transport. This shall be charged to the Emergency Call-Back Fund administered by DOH. The time paid for the return trip shall not exceed the patient transport time.

(n) **Fee for Service Conversion to APP**

The MASG will develop a process and principles whereby Fee for Service Physicians may convert to APP's as outlined in Schedule "S" – Fee for Service Conversion to APP.

(o) **Emergency Department Service and Compensation**

DOH shall provide funding for Physician compensation with respect to Emergency Departments as outlined in Schedule "T" – Emergency Department Service and Compensation.

(p) **Regional Hospital ICU**

DOH shall provide funding for Regional Hospital ICU APP's as outlined in Schedule "U" – Regional Hospital ICU.

(q) **Rural Specialist Incentive Program**

DOH shall provide funding for a Rural Specialist Incentive Program as outlined in Schedule "V" – Rural Specialist Incentive Program.

(r) **Telephone Consultations and Advice - Orthopaedics**

DOH shall provide funding in the amount of $200,000, for the period April 1, 2008 to March 31, 2009, to support a pilot project relating to orthopaedics remote consultation. The MASG will review the results of this pilot project and may develop additional programs for remote consultation in other areas.

(s) **Surgical Pathology**

DOH shall provide funding to increase the surgical pathology fee as outlined in Schedule "W" – Surgical Pathology.

(t) **Specialist Alternative Payment Plans**

(i) DOH shall fund an increase in Specialist Alternative Payment Plans as provided in Schedule "X" – Specialist Alternative Payment Plans.

(ii) Template APP Agreements shall be developed and approved for use by the Parties no later than April 1, 2009.

(u) **Professional Development Support Program Non-Rural Specialist**

DOH shall provide funding for Continuing Medical Education for Specialists who are not Rural Specialists, as outlined in Schedule "Y" – Professional Development Support Program Non-Rural Specialist.

7. GOVERNANCE

(a) With an interest in maintaining a health care partnership, DOH and DNS recognize that in the circumstances of an Agreement of this duration, the nature of the relationship between the Parties and the objectives which the Parties have acknowledged in the preamble to this Agreement, that changes to this Agreement and development of programs and strategies to support the stated objectives and allow for the fulfillment of the obligations of the Parties may be necessary over the term of this Agreement. The Parties also recognize that there is value in DHAs participating in the governance of this Agreement.

(b) DOH and DNS hereby establish a Master Agreement Steering Group ("MASG") to oversee the implementation of this Agreement during its term, to provide advice to DOH and DNS, and to provide ongoing strategic directions for the provision of physician services. Operation of the MASG shall be in accordance with approved Terms of Reference of the MASG.

(c) The MASG will be comprised of:

(i) Two members appointed by DOH (one of which is a co-chair of the MASG);

(ii) Two members appointed by DOH representing the DHAs; and

(iii) Four representatives appointed by DNS, including three Physician representatives and the CEO (one of which is a co-chair of MASG).

(d) Recommendations shall be:

(i) In the first instance by consensus of the MASG;

(ii) If consensus is not reached on an issue, a majority decision by the MASG shall be required for resolution;

(iii) In the event that a majority decision cannot be reached, then a ninth member may be appointed by the co-chairs for resolution of the issue;

(iv) In the event that the issue cannot be resolved in accordance with the foregoing, Article 5 of this Agreement shall apply.

(e) The MASG may form standing committees or working groups as required to address issues as follows:

(i) Fee Schedule Advisory Committee ("FSAC"); and

(ii) Such other Committees as may be established from time to time to implement this Agreement and the Schedules hereto.

(f) The MASG shall monitor expenditures for the specific initiatives contained in this Agreement in a timely manner, based on information provided by DOH.

(g) The MASG shall prepare an annual report detailing the Year's activities for the specific initiatives contained in this Agreement including financial reporting on expenditures, to be provided to the DOH, DNS and such other stakeholders as are acceptable.

(h) The Parties acknowledge and agree that the MASG is an oversight committee that is tasked with making recommendations to the Parties that are intended to be advisory in nature, unless otherwise expressly stated in this Agreement.

(i) The Parties must ensure that appropriate authority has been obtained from their respective organizations, in a timely manner, before making amendments to the Schedules of this Agreement

8. ACADEMIC FUNDING PLANS AND ALTERNATIVE PAYMENT PLANS

Payments to Physicians pursuant to Academic Funding Plans or Alternative Payment Plans are payments for Insured Medical Services that are not included in the Tariff or in the amendments to the Tariff provided for in this Agreement. In the event that an Academic Funding Plan or Alternative Payment Plan contract is terminated or upon the expiration of any such contract, not

renewed or re-negotiated, payment to Physicians for the provision of Insured Medical Services will be made pursuant to the Tariff.

9. ACCESS TO INFORMATION AND PRIVACY

(a) The Parties acknowledge and agree that the sharing of relevant information and data in a timely way is important to the achievement of the objectives established in this Agreement.

(b) The Parties agree to share relevant information that is requested by a Party. Relevant historical and predicative data prepared by any Party will be fully shared. In cases where the information is not readily accessible or is not provided on request, the matter may be referred to the MASG. Where the MASG provides prior approval, the Parties will expeditiously fill any such requests for data.

(c) In order to foster and encourage mutual cooperation, the Parties shall consult on ways and means to improve the timely collection and analysis of information and data and the method by which the data can be effectively and meaningfully communicated to each other. This process of consultation shall continue on an ongoing and regular basis.

(d) It is understood and agreed that the open sharing of information, statistics, advice and points of view exchanged in consultation requires respect for any confidentiality of such.

(e) It is understood and agreed that certain information exchanged between the Parties will be confidential information under the *Hospitals Act* and the *Freedom of Information and Protection of Privacy Act, S.N.S. 1993, c. 5*. The Parties will comply with any statutory requirements.

(f) DNS will be provided with electronic access to information on a monthly basis regarding Fee-For-Service billings and other payments made by DOH for Insured Medical Services, including the DOH's spreadsheets for Health Service Code, Non- Patient-Specific Health Service Code (bulk billings), Physicians Payments and Physician Payments by Service Location and, upon request by DNS, electronic access will be provided to other routinely provided DOH information which is in relation to Fee-For-Service billings and other payments made by the DOH including utilization and cost information. The Parties agree that this information will not be in patient identifiable form.

10. GENERAL

(a) **Physician Mobility**

Physicians have complete mobility rights to establish practice anywhere in the Province.

(b) **Audit and Appeal Mechanisms**

(i) DNS agrees that the DOH has the right to conduct audits of Physicians with respect to payments for Insured Medical Services including, but not restricted to, audits and value for money audits of payments made pursuant to Alternative Funding Program contracts.

(ii) DOH agrees not to introduce changes to the *Health Services and Insurance Act* affecting audits and appeals, and not to make changes to

regulations under that Act, affecting such audits and appeals, without first consulting DNS.

(iii) Subject to the provisions of the *Health Services and Insurance Act*, DOH and DNS agree to negotiate in good faith to agree on fair and appropriate criteria, consistent with Generally Accepted Accounting Principles ("GAAP"), for the conduct of such audits, and to reach agreement on appropriate processes for appeal by Physicians respecting such audits by March 31, 2009.

(iv) DOH recognizes the importance of patient confidentiality and agrees to require that MSI, in assessing claims, will not access patient records unless there is no other reasonable means of acquiring the information necessary to determine whether or not the service was rendered or was medically necessary and only to the minimal extent necessary to substantiate the claim.

(c) **Salary Arrangements**

(i) DOH and DNS are aware that Physicians may provide Insured Medical Services pursuant to salaried arrangements with District Health Authorities. Subject to the negotiation of appropriate financial and other contract terms and the provisions of the *Health Services and Insurance Act*, DOH and DNS do not object to such salaried arrangements and specifically, any arrangement that has District Health Authorities employing Physicians to provide Insured Medical Services.

(ii) DOH also agrees that it is appropriate for DNS and DOH to cooperate in the development of appropriate template contracts for the provision of Insured Medical Services by both employed and non-employed Physicians, in order to facilitate DOH and DNS agreement to become Parties to these arrangements, as required pursuant to section 13B of the *Health Services and Insurance Act*. To this end, DOH and DNS agree to meet to develop an appropriate and expeditious plan and time frames for the completion of this process.

(d) **Financial Records and Reporting**

DNS shall, in accordance with GAAP:

(i) keep and maintain financial records;

(ii) provide a semi-annual financial report to DOH with respect to the specific initiatives related to the expenditure of the funding provided for in Articles 6.1(d), 6.1(e) and 6.3(c); and

(iii) provide a full audited annual report to DOH with respect to the specific initiatives related to the expenditure of the funding provided for in Articles 6.1(d), 6.1(e) and 6.3(c)

11. NOTICE

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

If to DOH:	Minister of Health
With a copy to:	Deputy Minister of Health
If to DNS:	President of DNS
With a copy to:	Chief Executive Officer

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

12. AMENDMENTS

NOTE TO READER: If an amendment to the Agreement or the Schedules is required, Article 12 provides that DOH and DNS have the authority to amend the Agreement and its funding provisions in any manner they may mutually determine and mutually consent to in writing. In addition, DOH and DNS have given the MASG specific authority to amend any of the Schedules to the Agreement so long as such amendments do not increase the total amount of the estimated costs during any year. MASG can re-allocate funding within the Schedules attached to the Agreement but cannot amend the overall Agreement.

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

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

(c) Notwithstanding the provisions of Article 12(a), the Schedules attached to this Agreement may be amended from time to time by the MASG, by decisions made pursuant to the provisions of Article 7 of this Agreement, saving and accepting that the MASG in any Year during the term of this Agreement cannot increase the total amount of the estimated costs as described in Article 4(d) of this Agreement.

13. CONSEQUENTIAL AMENDMENTS

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

14. GOVERNING LAW

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

15. 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.

16. ENTIRE AGREEMENT

(a) This Agreement and the attached Schedules constitute the whole of the Agreement between the Parties unless duly amended as provided in Article 12.

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

(c) The following Schedules are incorporated into and form an integral part of this Agreement:

Schedule "A"	Fee Schedule Adjustments and New Fees
Schedule "B"	Fee for Service Sessional Payments
Schedule "C"	Retention and Recruitment Fund
Schedule "D"	Complex Care Fee
Schedule "E"	Evening and Weekend GP Office Visit Incentive
Schedule "F"	Hospital Care Fee Adjustment
Schedule "G"	On-Call Programs
Schedule "H"	Locum Program
Schedule "I"	Electronic Medical Records
Schedule "J"	Comprehensive Care Incentives
Schedule "K"	Chronic Disease Management Incentives
Schedule "L"	Collaborative Practice Incentive Program (GP's)
Schedule "M"	Professional Development Support Program (GP's)
Schedule "N"	Practice Innovation Fund
Schedule "O"	New Pressures
Schedule "P"	GP Alternative Payment Plans
Schedule "Q"	Continuing Care
Schedule "R"	Unattached and Orphan Patients
Schedule "S"	Fee for Service Conversion to APP
Schedule "T"	Emergency Department Service and Compensation
Schedule "U"	Regional Hospital ICU
Schedule "V"	Rural Specialist Incentive Program
Schedule "W"	Surgical Pathology
Schedule "X"	Specialist Alterative Payment Plans
Schedule "Y"	Professional Development Support Program Non- Rural Specialist

17. BENEFIT AND BINDING

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

Dated at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia, on this day of October, 2008.

SIGNED, SEALED AND DELIVERED in the presence of

_____
Witness

_____
Witness

_____
Witness

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

_____
Minister of Health

_____
Date

MEDICAL SOCIETY OF NOVA SCOTIA

_____
Dr. Don Wescott, President

_____
Date

_____
Dr. Don Pugsley, Chair, Board of Directors

_____
Date

SCHEDULE "A"

FEE SCHEDULE ADJUSTMENTS AND NEW FEES

1. DOH and DNS agree that the fee schedule may be adjusted from time to time, as approved by the MASG. The MASG shall consider the recommendations of the Fee Schedule Advisory Committee before granting such approval.

2. Fee Schedule Adjustment

   (a) The Parties agree that in relation to Fee Schedule Adjustments the following maximum funds will be provided by DOH:

Year	Incremental New Funding
April 1, 2008 – March 31, 2009	$500,000
April 1, 2009 – March 31, 2010	$500,000
April 1, 2010 – March 31, 2011	$500,000
April 1, 2011 – March 31, 2012	$500,000
April 1, 2012 – March 31, 2013	$0

   (b) The Parties agree that if monies are not spent in Fee Schedule Adjustments in any year that the remaining monies from that year will be added to the Retention and Recruitment Fund as a one time payment for jointly agreed initiatives as determined by the MASG prior to the close of Year end.

   (c) An amount equal to the one-time payment in Article 2(b) of this Schedule will be added to the next Year's provision for fee schedule adjustments.

3. New Fees

   (a) The Parties agree that in relation to New Fees, the following maximum funds will be provided by DOH:

Year	Incremental New Funding
April 1, 2008 – March 31, 2009	$1,000,000
April 1, 2009 – March 31, 2010	$500,000
April 1, 2010 – March 31, 2011	$1,000,000
April 1, 2011 – March 31, 2012	$1,000,000
April 1, 2012 – March 31, 2013	$0

(b) The Parties agree that if monies are not spent on New Fees in any Year that the remaining monies from that Year will be transferred to the Retention and Recruitment Fund as a one-time payment for jointly agreed initiatives as determined by the MASG prior to the close of Year end.

(c) An amount equal to the one-time payment in Article 3(b) of this Schedule will be added to the next Year's provision for New Fees.

4. The Parties will establish a Fee Schedule Advisory Committee ("FSAC"), which will be constituted with DNS and DOH representatives.

5. During the term of this Agreement, DNS and DOH have the right to take forward any fee recommendations to the FSAC.

6. The FSAC has no authority to change the value of Medical Service Units or Anaesthesia Units, although such values may be changed as a result of Fee Adjustment or New Fee funds not expended.

SCHEDULE "B"

FEE FOR SERVICE SESSIONAL PAYMENTS

1. Sessional Rates

(a) The Sessional Rate for General Practioners shall be as follows:

Year	Units	Rate
April 1, 2008 to March 31, 2009	56	$124.88
April 1, 2009 to March 31, 2010	57	$128.82
April 1, 2010 to March 31, 2011	58	$132.24
April 1, 2011 to March 31, 2012	59	$137.47
April 1, 2012 to March 31, 2013	60	$142.80

(b) The Sessional Rate for Specialists shall be as follows:

Year	Units	Rate
April 1, 2008 to March 31, 2009	66	$147.18
April 1, 2009 to March 31, 2010	67	$151.42
April 1, 2010 to March 31, 2011	68	$155.04
April 1, 2011 to March 31, 2012	69	$160.77
April 1, 2012 to March 31, 2013	70	$166.60

2. Expanded Sessional Rate Funding

(a) During 2008/2009 payments shall be implemented for:

(i) Provincial chronic pain program services;

(ii) As an option for surgical assists;

(iii) Case conferences; and

(iv) Such additional services as may be determined by the MASG.

(b) Payments may be implemented as a time based fee or sessional payment upon recommendation of the MASG.

3. The MASG shall define eligible activities, criteria and administration for the expanded payments.

4. DOH shall provide maximum funding for expanded payments as follows:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$500,000	$500,000
April 1, 2009 to March 31, 2010	$0	$500,000
April 1, 2010 to March 31, 2011	$150,000	$650,000
April 1, 2011 to March 31, 2012	$0	$650,000
April 1, 2012 to March 31, 2013	$50,000	$700,000

SCHEDULE "C"

RETENTION AND RECRUITMENT FUND

1. DOH will provide funding to DNS for the Retention and Recruitment Fund in the following maximum Annual Amounts:

Year	Base Funding	Incremental New Funding	Total Annual Funding
April 1, 2008 - March 31, 2009	$4,500,000	$1,700,000	$6,200,000
April 1, 2009 - March 31, 2010	$6,200,000	$300,000	$6,500,000
April 1, 2010 - March 31, 2011	$6,500,000	$300,000	$6,800,000
April 1, 2011 - March 31, 2012	$6,800,000	$300,000	$7,100,000
April 1, 2012 – March 31, 2013	$7,100,000	$200,000	$7,300,000

2. Payment of the annual amount shall be made on a monthly pro rata basis through direct deposit.

3. Effective April 1, 2008, $200,000 a Year from the Retention and Recruitment Fund shall be used to fund information technology and practice support.

4. Effective April 1, 2010, $200,000 a Year from the Retention and Recruitment Fund shall be used for new Member Services as approved by the MASG.

5. If the funds allotted pursuant to Articles 3 and 4 of this Schedule are not spent in the applicable Year, DNS shall apply any unspent funds as approved by the MASG.

6. Any monies defaulting to the Retention and Recruitment Fund in any Year shall be used for new and improved initiatives, as approved by the MASG, recognizing that there is no continuing obligation on the part of DOH to make additional payments beyond the Year of transfer.

SCHEDULE "D"

COMPLEX CARE FEE

1. There shall be a new General Practitioner Complex Care Visit Fee paid at 21 MSU's for an office visit, other than at walk-in clinics, for patients with three or more chronic diseases under active management. A minimum of 15 minutes must be spent with the patient.

2. Active management means the patient requires ongoing monitoring, maintenance or intervention to control, limit progression or palliate a chronic disease.

3. The Complex Care Visit Fee shall apply to patients with at least three of the following chronic diseases, unless otherwise approved by MASG:

   (a) Asthma;

   (b) COPD;

   (c) Diabetes;

   (d) Chronic liver disease;

   (e) Hypertension;

   (f) Chronic kidney disease;

   (g) Congestive heart failure;

   (h) Cancer;

   (i) Dementia;

   (j) Chronic neurological disorders; and

   (k) Ischemic heart disease.

4. Chronic neurological disorders include progressive degenerative disorders (such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease), stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia and epilepsy.

5. The fees will be billable to a maximum of four times per patient per Year by the General Practitioner or Practice that is providing on-going comprehensive care to the patient.

6. The costs of implementation of Complex Care Visit Fees will be monitored by MASG, to ensure the incremental costs associated with this initiative remain within the limits of the annual estimated costs.

7. The General Practitioner Complex Care Visit Fee will be eligible for the General Practitioner Evening and Weekend Office Visit Incentive.

8. Rules and eligibility will be defined and approved by MASG.

SCHEDULE "E"

EVENING AND WEEKEND GP OFFICE VISIT INCENTIVE

1. Eligible Services

   (a) Effective April 1, 2008, DOH shall provide funding for a 25% incentive for eligible evening and weekend General Practitioner office visits for the following services:

HSC 03.04 (010)	Complete Examination
HSC 03.03 (025)	Office Visit
HSC 03.03A	Geriatric Office Visit (for patients aged 65+)
HSC 03.04 (0286)	Complete Pregnancy Exam
HSC 03.03 (0287)	Routine Pre Natal Visit
HSC 03.03 (0285)	Post Natal Care Visit
HSC 03.03 (030)	Well Baby Care
PSYC 08.41	Hypnotherapy
PSYC 08.44	Group Therapy (4-8 members)
PSYC 08.45	Family Therapy (2 or more members)
PSYC 08.49A	Counselling
PSYC 08.49B	Psychotherapy
PSYC 08.49C	Lifestyle counselling

   (b) Complex Care will be added as an eligible office visit once a fee code is established.

2. Location and Type of Practice

   (a) Evening and weekend services eligible for incentive funding are office visit services provided in a community-based office in which the General Practitioner maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals.

   (b) General Practitioners may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible General Practitioners within the same practice location, providing the patient's record can be accessed and the encounter is recorded.

   (c) General Practitioners shall not receive the evening and weekend office visit incentive for any services provided at a walk-in clinic. Walk-in clinics include clinics/offices with extended hours of operation, where there is no requirement for an appointment, providing episodic care with little or no follow-up, no standard patient roster and the patient list is constantly changing.

3. Eligible Time Periods

   (a) Eligible time periods for evening and weekend office visit incentive funding shall be 6 – 10 p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday).

   (b) To be eligible, General Practitioners must offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours.

4. Only one incentive may be claimed per patient encounter notwithstanding the number of services provided during the encounter.

SCHEDULE "F"

HOSPITAL CARE FEE ADJUSTMENT

1. DOH shall provide funding for increased payments to Physicians for their participation in Hospital Care.

2. Hospital Care shall be a category of the Comprehensive Care Incentive Program.

3. Effective April 1, 2008, DOH shall increase the number of MSU such that:

   (a) First in-patient visit by the General Practitioner shall be increased to 30 MSU;

   (b) Subsequent hospital visit by the General Practitioner shall be increased to 16 MSU; and

   (c) Discharge fee paid shall be increased to 10 MSU.

SCHEDULE "G"

ON-CALL PROGRAMS

1. DOH shall make available new funding in the maximum amount of $700,000 for the period of April 1, 2008 – March 31, 2009, to support continuation of the Facility On-Call program in effect as of March 31, 2008.

2. Persons eligible to participate in this Program include Physicians who have privileges at the relevant Health Care Facility and who are required to provide on-call services for Health Care Facility patients.

3. MASG shall design and implement a new On-Call program to commence May 1, 2009 which will replace and incorporate funding from the existing Facility On-Call, Remote On-Call and GP On-Call funding into one program.

4. DOH shall provide a maximum increase of $4.3 million for the new Facility On-call program annualized, beginning May 1, 2009, as follows:

   May 1, 2009 – March 31, 2010 - $3,950,000
   April 1, 2010 – March 31, 2011 - $350,000

5. If the replacement Program does not take effect on May 1, 2009, $3,950,000 additional monies will be expended on the existing Facility On-Call Program for the period May 1, 2009 – March 31, 2010, or until such time as a replacement program takes effect.

6. If a replacement program is still not in effect as of April 1, 2010, $350,000 additional monies will be expended on the existing Facility On-Call Program for the period April 1, 2010 – March 31, 2011, or until such time as a replacement program takes effect.

Year	Base Funding	Incremental New Funding	Total Annual Funding
2008-2009	Facility On-Call $6,250,000 Remote On-Call $988,076 GP On Call $550,000	$700,000	$8,488,076
2009-2010	$8,488,076	$3,950,000	$12,438,076
2010-2011	$12,438,076	$350,000	$12,788,076

7. The Community Remote Practice On-Call program in effect as of March 31, 2008 will remain in place until April 30, 2009, for Physicians who are currently paid through the program. No new Physicians will be added to the Program.

SCHEDULE "H"

LOCUM PROGRAM

1. In addition to revenues from Fee For Service, DOH shall provide maximum increased funding for locum programs as follows:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$300,000	$300,000
April 1, 2009 to March 31, 2010	$0	$300,000
April 1, 2010 to March 31, 2011	$500,000	$800,000
April 1, 2011 to March 31, 2012	$500,000	$1,300,000
April 1, 2012 to March 31, 2013	$0	$1,300,000

2. The new Locum Program shall be developed and implemented by MASG effective April 1, 2010.

3. As of July 1, 2008, the minimum daily guarantee rate shall be as follows:

    (a) General Practitioners - $600; and

    (b) Specialists - $1,200.

4. General Practitioners who obtain the services of a locum Physician may receive $180 per day for office overhead.

5. In addition to the minimum daily guarantee rate locum Physicians may receive reimbursement for mileage at the prevailing Provincial government rate and a per diem of $130.

SCHEDULE "I"

ELECTRONIC MEDICAL RECORDS

1. DOH shall provide maximum funding for EMR related initiatives as follows:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$1,500,000	$1,500,000
April 1, 2009 to March 31, 2010	$1,500,000	$3,000,000
April 1, 2010 to March 31, 2011	$1,500,000	$4,500,000
April 1, 2011 to March 31, 2012	$1,500,000	$6,000,000
April 1, 2012 to March 31, 2013	$1,500,000	$7,500,000

2. The EMR funding provision consists of three specific funding envelopes:

   (a) A one-time Physician-specific "EMR Investment Grant" of $5300, intended to help offset the out-of-pocket implementation costs associated with the acquisition, after March 31, 2008, of an EMR system meeting accepted functional requirements;

   (b) An annual Physician-specific "EMR Participation Grant" of $2,000, commencing April 1, 2008, to recognize the time and effort associated with capacity building for EMRs meeting accepted functional requirements; and

   (c) An annual Physician-specific "EMR Utilization Grant", effective April 1, 2009, of an amount to be determined, to recognize and value the extent of defined EMR functionality utilization.

3. The MASG shall develop guidelines for functional requirements and eligibility criteria for the EMR funding outlined in Article 2 of this Schedule.

4. Any monies not used at the end of the year allocated, will be transferred to DNS for the sole use of EMR related initiatives.

SCHEDULE "J"

COMPREHENSIVE CARE INCENTIVES

1. The MASG shall establish a Comprehensive Care Incentive Program ("CCIP"), consisting of financial incentives for General Practitioners to provide a comprehensive breadth of services for their patients.

2. DOH will provide the following maximum funds for the CCIP:

Period of Time for Calculation of eligible services	Incremental New Funding	Cumulative Annual Funding
April 1, 2007-March 31, 2008	$600,000	$600,000
July 1, 2008 –June 30, 2009	$1,400,000	$2,000,000
July 1, 2009 - June 30, 2010	$2,000,000	$4,000,000
July 1, 2010 – June 30, 2011	$2,000,000	$6,000,000
July 1, 2011 – June 30, 2012	$2,000,000	$8,000,000

3. To be eligible for compensation under the CCIP the Physician must:

   (a) Have an office based practice, as determined by the MASG;

   (b) Provide comprehensive services for local practice population;

   (c) Have remuneration for insured services as a practising Physician of at least $100,000 or, if paid through an APP, minimum shadow billings of $100,000 in the previous 12 month period; and

   (d) Meet activity thresholds as determined by the MASG.

4. CCIP payments will be calculated by DOH/MSI based on Physician billings. The first payment under the CCIP program will be made no later than December 31, 2008, and will be based on services provided between April 1, 2007 and March 31, 2008. Eligible Service Areas for April 1, 2007 to March 31, 2008 are:

   (a) Nursing Home Care;

   (b) Hospital Care/Acute Care;

(c) Obstetrical Deliveries; and

(d) Maternity/Newborn Visits.

5. CCIP program thresholds for services provided April 1, 2007-March 31, 2008 are as follows:

	CCIP Service Categories/Areas			
	Nursing Home	Hospital Care	Obstetrical Deliveries	Maternity/Newborn Visits
Activity Thresholds	Measure:	Measure:	Measure:	Measure:
	Total # services	Total $ value of services provided	Total # deliveries	Total # services:
				# prenatal
				# postnatal
				# post partum
				# newborn
				# well baby
Threshold 1	10	$2,500	4	10
Threshold 2	35	$15,000	15	35
Threshold 3	165	$30,000	35	105

6. In order to receive an annual CCIP payment for the period April 1, 2007-March 31, 2008, Physicians must reach at least the first activity threshold (Threshold 1) for a minimum of two CCIP service categories; for example, nursing home services and deliveries, or hospital care and well baby visits. Physicians who qualify for an annual CCIP payment will be remunerated according to the following payment grid.

CCIP Payment Grid	
Activity	**Number of Service Areas***

Thresholds			
	Two	Three	Four
Threshold 1	$100	$400	$600
Threshold 2	$200	$700	$1,350
Threshold 3	$500	$1,000	$1,500

*in addition to an office practice

7. For the period April 1, 2007-March 31, 2008, to calculate the annual CCIP payment, the number of qualifying service categories/areas provided by the Physician (two, three or four) is determined first. This establishes the payment structure to be used for each service; for example, if a total of four services areas were provided, then a service reaching Threshold 1 would be paid at $600, Threshold 2 at $1,350 and Threshold 3 at $1,500. The total annual CCIP payment to the Physician would be the sum of the applicable payments for each service area. The more service areas provided in total, the higher the payment amount provided for each service area reaching a specific activity threshold.

8. The MASG shall add other CCIP eligible service areas and make such other amendments to the program they deem desirable from time to time over the term of the Agreement.

SCHEDULE "K"

CHRONIC DISEASE MANAGEMENT INCENTIVES

1. DOH and DNS shall implement new Chronic Disease Management ("CDM") Incentives to recognize the additional work to General Practitioners, beyond office visit payments, for providing guidelines-based care to patients with chronic diseases.

2. MASG shall approve eligibility criteria, bonus payment rates, data sharing, frequency of payments and potential integration with proposed Complex Care fee code. The strategy shall be developed by December 31, 2008, with approval by the MASG and implemented by April 1, 2009.

3. Priorities to be addressed by the incentives shall include, but are not limited to, diabetes, chronic heart failure and hypertension. If MASG does not have the strategy in place by December 31, 2008, diabetes will be the first selected disease entity to be funded effective April 1, 2009.

4. DOH shall provide maximum additional funding for CDM incentives over the term of this Agreement as follows:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$0	-
April 1, 2009 to March 31, 2010	$2,000,000	$2,000,000
April 1, 2010 to March 31, 2011	$2,000,000	$4,000,000
April 1, 2011 to March 31, 2012	$2,000,000	$6,000,000
April 1, 2012 to March 31, 2013	$2,000,000	$8,000,000

SCHEDULE "L"

COLLABORATIVE PRACTICE INCENTIVE PROGRAM (GP's)

1. DOH shall provide funding to the following maximum amounts for a Collaborative Practice Incentive Program for General Practitioners.

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$0	-
April 1, 2009 to March 31, 2010	$0	-
April 1, 2010 to March 31, 2011	$3,000,000	$3,000,000
April 1, 2011 to March 31, 2012	$0	$3,000,000
April 1, 2012 to March 31, 2013	$3,000,000	$6,000,000

2. A Collaborative Practice group is a practice with a minimum of three Physicians, and one other practicing licensed health care professional providing services on a full time basis as determined by the MASG.

3. Under this incentive program, eligible Physicians shall receive a payment of $5,000 per Physician per year. To be eligible a Physician must bill or shadow bill a minimum of $100,000.

4. The MASG shall develop and approve guidelines for the Collaborative Practice Support Incentive program, including additional incentives.

5. The MASG shall determine the use of any unspent funds in the manner provided for in Article 4(f) of this Agreement.

SCHEDULE "M"

PROFESSIONAL DEVELOPMENT SUPPORT PROGRAM (GP'S)

1. DOH shall provide funding for a Continuing Medical Education ("CME") Recognition Payment for General Practitioners who are non-AFP Physicians, as follows:

   (a) A new General Practice Professional Development Support Program will be funded effective April 1, 2008;

   (b) The General Practice Professional Support Program payment replaces the existing APP CME allowance; and

   (c) Payment entitlement is dependent upon a minimum billing or contract based funding for the provision of Insured Medical Services of $75,000 in the previous Year, and maintenance of a license.

2. Eligible General Practitioners are entitled to payment each Year of this Agreement in the amount of $2,000 for CME support.

SCHEDULE "N"

PRACTICE INNOVATION FUND

1. DOH shall provide maximum funding in the amount of $2,500,000 for the period April 1, 2011 – March 31, 2012, for a Practice Innovation Fund.

2. The Practice Innovation Fund shall be used in support of Physician practice innovations which have the objectives of increasing patient access, improving patient satisfaction or reducing wait times.

3. MASG will approve guidelines for the application and use of the funding provided by DOH for the Practice Innovation Fund.

SCHEDULE "O"

NEW PRESSURES

1. DOH shall provide funding to deal with New Pressures that may arise, in the following maximum amounts:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2008 to March 31, 2009	$0	-
April 1, 2009 to March 31, 2010	$0	-
April 1, 2010 to March 31, 2011	$600,000	$600,000
April 1, 2011 to March 31, 2012	$700,000	$1,300,000
April 1, 2012 to March 31, 2013	$3,000,000	$4,300,000

2. DOH shall expend these monies in a manner as determined by the MASG in each of those Years on Physician Compensation in relation to such New Pressures.

3. The Parties agree that if monies allocated are not spent on New Pressures in any Year that the remaining monies from that Year will be transferred to the Retention and Recruitment Fund as a one-time payment for jointly agreed initiatives as determined by the MASG prior to the close of Year end.

4. Any monies identified for New Pressures that are unspent on termination of this Agreement may be used for increases to the MSU or AU.

SCHEDULE "P"

GP ALTERNATIVE PAYMENT PLANS

1. DOH shall provide funding for increases to General Practitioner APP's as follows:

Date	Amount
April 1, 2008 to March 31, 2009	MSU increase plus $5,000
April 1, 2009 to March 31, 2010	MSU increase plus $10,000
April 1, 2010 to March 31, 2011	MSU increase plus $5,000
April 1, 2011 to March 31, 2012	MSU increase
April 1, 2012 to March 31, 2013	MSU increase

2. General Practice APP increases apply to all APP's including Family Physicians, General Practitioners/Nurse Practitioners, General Practitioner palliative care, General Practitioner geriatric, Clinician Assessment For Practice Program and group APP contracts.

3. Funding is also provided for the clinical portion of the Department of Family Medicine at Dalhousie University.

SCHEDULE "Q"

CONTINUING CARE

1. Continuing Care taking place in a nursing home shall be a category of the Comprehensive Care Program for April 1, 2008 – March 31, 2009.

2. A new incentive program to support enhanced Continuing Care shall be developed by the MASG by January 1, 2009, for implementation April 1, 2009.

3. In order to facilitate service improvement in Continuing Care, DOH shall provide additional funding for incentive payments for Continuing Care as follows:

Date	Incremental New Funding	Cumulative Annual Funding
April 1, 2009 to March 31, 2010	$500,000	$500,000
April 1, 2010 to March 31, 2011	$500,000	$1,000,000
April 1, 2011 to March 31, 2012	$0	$1,000,000
April 1, 2012 to March 31, 2013	$0	$1,000,000

SCHEDULE "R"

UNATTACHED AND ORPHAN PATIENTS

1. The current program for Unattached and Orphan Patients ("UOP") shall remain in effect unless otherwise determined by the MASG.

2. Effective July 1, 2008, General Practitioners may receive a one time bonus payment of $150 per year for each new Orphan Patient taken into their practice for a minimum of one year following a hospital encounter with that Orphan Patient. General Practitioners must be in practice for a minimum of one year prior to the initial visit with the Orphan Patient to establish eligibility.

3. The MASG shall develop and approve further eligibility criteria for the UOP Program.

SCHEDULE "S"

FEE FOR SERVICE CONVERSION TO APP

1. DOH and DNS will continue to support conversion from fee for service to Alternative Payment Plan, subject to requirements of the DOH.

2. The MASG shall establish criteria, effective April 1, 2009, that will enable any interested General Practitioner to convert to an Alternative Payment Plan.

3. DOH will provide $200,000 for the period April 1, 2009 – March 31, 2010 to support initiatives in support of Fee for Service conversions to Alternative Payment Plans.

SCHEDULE "T"

EMERGENCY DEPARTMENT SERVICE AND COMPENSATION

1. Emergency Departments (EDs) referred to in the previous Master Agreement as Level 1 and Level 2 EDs are herein referred to as "Tertiary and Regional EDs", and EDs previously referred to as Level 3 and Level 4 EDs are herein referred to as "All Other EDs".

2. DOH shall provide funding for Tertiary and Regional EDs as follows:

(a) The QEII and IWK Tertiary EDs will continue to be funded on the basis of the provisions of the ED AFP;

(b) Funding for Regional Hospital EDs (Funded Hours) will be based on the Emergency Physician (EP) coverage formula as determined by the MASG;

(c) DOH payment levels for Funded Hours will be based on 70 Medical Service Units (MSU's) per hour effective April 1, 2008;

(d) Up to 365 hours of Emergency Call Back Hours can be accessed by Regional EDs each year through the established process;

(e) A stipend of $20,000 will be provided to Regional EDs in recognition of effort involved in, for example, EP schedule preparation and management, organization of ED morbidity and mortality reviews, other ED CME, and Practice Plan management; and

(f) Specific funding guidelines, administrative guidelines and reporting requirements for Regional EDs will be as established by the MASG.

3. DOH shall provide funding for All Other EDs as follows:

(a) Consolidated ED Funding Option

(i) Effective April 1, 2008, "Billable Hours" related funding, as defined in the April 1, 2004 to March 31, 2008 Master Agreement, as well as the ED related contract funding that was available as at March 31, 2008 to Digby, Fisherman's Memorial and Straight Richmond Hospitals, as well as any related ED day-time Fee For Service (FFS) billings, will be considered to be theoretically "consolidated" for each DHA, and available for redistribution within each DHA, or among contiguous DHAs, as recommended by affected DHAs to be used for Emergency and Urgent Physician Care;

(ii) Billable Hours related funding will continue on the basis of arrangements in effect as at March 31, 2008. Overall funding amounts associated with these funding arrangements will increase each April 1st, effective April 1, 2008, at a rate commensurate with the Master Agreement MSU increase. There will be no MSU value change for these Billable Hours.

(b) Billable Hours to Funded Hours Conversion Option

(i) DHAs will have the option of converting Emergency and Urgent Physician Care funding from the Billable Hours methodology to the EP coverage formula Funded Hours methodology established by the MASG.

(c) Specific funding guidelines, administrative guidelines and reporting requirements for the Consolidated ED Funding Option and the Billable Hours to Funded Hours Conversion Option will be as established by the MASG.

SCHEDULE "U"

REGIONAL HOSPITAL ICU

1. DOH shall provide funding for Alternate Payment Plan (APP) options, which are designed to provide stable and predictable funding for internal medicine and related Specialists providing care in the Province's hospitals, effective April 1, 2008.

2. These APP options are an alternative to fee-for-service-only payment arrangements for Physicians providing Intensive Care Unit (ICU) specific services as well as hospital Emergency Department and other hospital In-Patient Services.

3. Tertiary and Regional Hospital ICUs are categorized into different Levels as designated by the DOH:

   (a) Level 1: ICUs with a commitment to education and research and provincial critical care leadership, in which care is provided to complicated, critically ill patients who require ongoing treatment;

   (b) Level 2: ICUs that serve large communities in which there are some clinical resource limitations and where such ICUs are "closed" to patient access and patient care by non-designated ICU Physicians; and

   (c) Level 3: ICUs that encompass all other critical care capabilities in the remaining Regional Health Centres.

4. Level 1 ICUs continue to be funded in accordance with the provision of the AFP Agreement for Physicians providing care in such ICU's.

5. The APP options available to Physicians providing services in Level 2 and Level 3 ICUs and the associated funding rates, guidelines and reporting requirements are described in the "Regional Hospital Intensive Care Unit and Comprehensive Regional Hospital Care Alternative Payment Plan Options and Operating Guidelines" approved by the MASG.

SCHEDULE "V"

RURAL SPECIALIST INCENTIVE PROGRAM

1. DOH shall provide funding for retention payments for Rural Specialists who meet the following requirements:

   (a) Have DHA privileges for 3 consecutive years as a Rural Specialist;

   (b) Participate in a District Facility Call Schedule as required;

   (c) Have a minimum $125,000 in annual MSI billings or equivalent payment through a rural speciality contract; and

   (d) Satisfy any additional requirements that may be developed and approved by the MASG.

2. All eligible Rural Specialists shall be entitled to a retention payment as follows:

Date	Amount
April 1, 2008 - March 31, 2009	$3,000
April 1, 2009 - March 31, 2010	$3,000
April 1, 2010 - March 31, 2011	$5,000
April 1, 2011 - March 31, 2012	$5,000
April 1, 2012 - March 31, 2013	$8,000

3. For those who become eligible for a retention payment upon 3 consecutive years of practice as a Rural Specialist, the first year of eligibility shall be prorated from the 3rd year anniversary.

4. All Rural Specialists who have a minimum $125,000 in annual MSI billings or equivalent payment through a rural specialty contract shall be entitled to the following annual CME payments:

Date	Amount
April 1, 2008 - March 31, 2009	$2,000
April 1, 2009 - March 31, 2010	$2,000
April 1, 2010 - March 31, 2011	$4,000
April 1, 2011 - March 31, 2012	$4,000
April 1, 2012 - March 31, 2013	$4,000

5. CME payments will be based on the previous years' billings.

SCHEDULE "W"

SURGICAL PATHOLOGY

1. Effective April 1, 2008 there will be a 35% increase in the Surgical Pathology fee when three or more separate surgical specimens are submitted from the same anatomical site and for complex cancer staging cases.

2. Effective April 1, 2010, a further 15% increase will be applied to the Surgical Pathology fee when three or more separate surgical specimens are submitted from the same anatomical site and for complex cancer staging cases.

SCHEDULE "X"

SPECIALIST ALTERNATIVE PAYMENT PLANS

1. Payments for FTE Regional Hospital-Based Psychiatry APP's shall be at an hourly dollar rate as follows:

Date	Non-Certified Amount/Hour	Certified Amount/Hour
April 1, 2008 to March 31, 2009	$93.08	$129.50
April 1, 2009 to March 31, 2010	$94.47	$131.44
April 1, 2010 to March 31, 2011	$98.31	$135.66
April 1, 2011 to March 31, 2012	$100.28	$138.37
April 1, 2012 to March 31, 2013	$102.29	$141.13

2. DOH shall provide funding for increases to APPs in anaesthesia, geriatric specialist and palliative care specialist APP's as follows:

Date	Amount
April 1, 2008 to March 31, 2009	MSU % increase + $15,000
April 1, 2009 to March 31, 2010	MSU % increase + $10,000
April 1, 2010 to March 31, 2011	MSU % increase + $5,000
April 1, 2011 to March 31, 2012	MSU % increase
April 1, 2012 to March 31, 2013	MSU % increase

3. DOH shall provide funding for increases to Specialist APPs for paediatrics, obstetrics/gynaecology and neonatology as follows:

Date	Amount
April 1, 2008 to March 31, 2009	MSU % increase + $5,000
April 1, 2009 to March 31, 2010	MSU % increase + $10,000
April 1, 2010 to March 31, 2011	MSU % increase + $5,000
April 1, 2011 to March 31, 2012	MSU % increase
April 1, 2012 to March 31, 2013	MSU % increase

SCHEDULE "Y"

PROFESSIONAL DEVELOPMENT SUPPORT PROGRAM NON-RURAL SPECIALIST

1. A new Professional Development Support Program is introduced for non-AFP Specialists who are not Rural Specialists, who bill MSI at least $125,000 in the previous Year.

2. All eligible Specialists shall be entitled to the following annual CME payments:

Date	Amount
April 1, 2008 - March 31, 2009	$2,000
April 1, 2009 - March 31, 2010	$2,000
April 1, 2010 - March 31, 2011	$4,000
April 1, 2011 - March 31, 2012	$4,000
April 1, 2012 - March 31, 2013	$4,000