THIS AGREEMENT DATED the 9th day of September, 2016

PHYSICIAN SERVICES MASTER AGREEMENT

BETWEEN:

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

OF THE FIRST PART

-and-

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

OF THE SECOND PART

AGREEMENT PREAMBLE

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

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

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

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

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

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

1. DEFINITIONS

In this Agreement:

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

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

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

(d) "**Clinical Services Reporting**" means reporting by Physicians of Insured Medical Service encounter information to MSI in the format prescribed by DHW;

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

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

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

(h) "**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;

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

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

(k) "**MASG**" means the Master Agreement Steering Group pursuant to the 2008 Master Agreement;

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

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

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

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

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

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

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

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

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

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

2. TERM OF AGREEMENT

(a) This Agreement shall take effect on April 1, 2015 and continues to remain in force and effect for a period of four (4) years, terminating on March 31, 2019.

(b) Only the rate increases referred to in Article 4.1(b) of this Agreement will take effect on April 1, 2015; all other elements of this Agreement will take effect upon execution by both Parties.

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

(d) Upon termination of this Agreement, the Tariff then in effect on March 31, 2019 and the provisions of Articles 4.1 (e) and 4.1 (k) shall remain in effect until such time as the Parties agree upon a new Agreement, or a new Agreement is established. Further, for the purposes of this Agreement all other provisions shall continue after termination until such time as the Parties agree upon a new Agreement, or a new Agreement is established.

3. RESPONSIBILITIES OF THE PARTIES

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

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

(c) Pursuant to section 7 of the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, and other applicable authority, DHW recognizes DNS as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia who provide Insured Medical Services that are funded through DHW and/or a Health Authority.

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

4. PHYSICIAN COMPENSATION

4.1 General and Fees

(a) **Unit Value System**

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

(ii) The portion of the Tariff, which includes the Preamble and the Insured Medical Services agreed to pursuant to the Act, will continue to be published with the actual fee represented in units and will be formalized in

regulations made pursuant to the Act, as necessary. The Tariff in effect as of April 1, 2015 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 value is currently 2.42 and the AU value is currently 20.55.

(b) **Rate Increases**

(i) The following annual increases will apply to the MSU, the AU, the Sessional hourly rates, the Intensive Care Unit ("ICU") minimum income daily guarantees, the Emergency Department ("ED") hourly rates, the Psychiatry hourly rates, the CAPP rates (including the mentor and ED assessment rates), the Collaborative Emergency Centre ("CEC") rates and Alternative Payment Plan annual rates effective April 1 of each year of this Agreement:

Fiscal Year	Rate Increases
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	0%
April 1, 2017 – March 31, 2018	1.0%
April 1, 2018 – March 31, 2019	1.5%

(ii) The rates for ICU and ED will be reviewed and may be adjusted by DHW, with the agreement of DNS.

(iii)The rates in effect as of April 1, 2015 are as outlined in Schedule "A" to this Agreement.

(c) **APP Increases**

(i) The rate for each Anaesthesia APP and Collaborative GP APP will increase by an annual amount of $10,000 effective upon signing of this Agreement, payable biweekly, and by a further $5,000 effective April 1, 2017. These amounts are for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(ii) The rate for each solo GP APP will increase by an annual amount of $8,000, effective upon signing of this Agreement, payable biweekly. This amount is for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(iii)The Parties agree that all other terms associated with the APP accountability model, continue in effect and may be revised as agreed by the MAMG.

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

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

(ii) The Fee Committee will be governed by the existing terms of reference for the Fee Schedule Advisory Committee established pursuant to the 2008 Master Agreement unless amended by FC.

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

(iv)Notwithstanding (ii) above, either Party may choose to add one additional member to the Committee.

(v) The Parties agree that the Fee Schedule may be adjusted from time to time as approved by the Fee Committee or by the MAMG if referred from Fee Committee.

(vi)The Parties agree that the following funds shall be provided by DHW to the Fee Committee exclusively for new fees, fee adjustments or preamble changes in response to applications:

Fiscal Year	Incremental New Funding
April 1, 2015 – March 31, 2016	$0
April 1, 2016 – March 31, 2017	$815,000
April 1, 2017 – March 31, 2018	$1,000,000
April 1, 2018 – March 31, 2019	$4,500,000

(vii) The Parties agree that the DHW will provide additional funding in the amounts outlined in the following table in order for Fee Committee to establish and/or enhance fees in the following areas.

Fiscal Year	Transition of Programs	Complex Care	Surgical Emergency Premium	Non Face to Face	Methadone
April 1, 2016 – March 31, 2017	$4,270,000	$0	$0	$0	$300,000
April 1, 2017 – March 31, 2018	$10,070,000	$1,000,000	$500,000	$1,500,000	$700,000
April 1, 2018 – March 31, 2019	$0	$0	$0	$1,500,000	$0

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

(ix)The Parties agree that Fee Committee will review the billing rules for the surgical emergency premium to consider and ensure that the rules governing the premium appropriately support the intent of the premium in circumstances where procedures or consults are done in, or moved to off-hours due to factors beyond the control of the physician.

(x) The Parties agree that, upon application, the Fee Committee will review enhancement of the fees for multiple and bilateral surgical procedures, with any incremental cost to be covered by the funds allocated to Fee Committee as assigned in (vi) of this section.

(xi)The Parties agree that non face to face for physicians will be introduced on a pilot basis. Full parameters and guidelines will be developed by Fee Committee with priority areas that include seniors' care, mental health and chronic care. The program will be reviewed for effectiveness after the end of the second year of the pilot. The Fee Committee will develop, implement, manage, and evaluate interim fees related to the provision of non-face-to-face care, consistent with the following terms:

A. Specialists:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the Specialist.

(iii)The rate for physician to physician interactions will be 25 MSU and for Specialist to patient interactions will be 11.5 MSU.

(iv) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

B. General Practitioners:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Telephone interactions with patients will be billable only where the patient is 65 years of age or older and/or is suffering from mental illness or chronic disease.

(iii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the General Practitioner.

(iv) The rate will be 11.5 MSU.

(v) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

C. The interim fees will take effect on April 1, 2017.

D. The Fee Committee will develop an evaluation framework to be shared with the MAMG prior to the new fees taking effect.

E. The Fee Committee will conduct an evaluation of the interim fees 18 months after implementation.

F. The Parties agree that if the MAMG concludes based on the evaluation that the interim fees will be discontinued, then the Parties shall jointly reallocate the actual 2018/19 expenditure on these fees to other non face-to-face patient care initiatives.

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

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

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

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

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

(f) **Continuing Medical Education**

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

(g) **Electronic Medical Record (EMR)**

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

(h) **Physician Manual Modernization Project (PMMP)**

DNS will provide the balance of funds available in the year-end transfer account monitored by the MASG to support the PMMP, with DHW providing all remaining funds to complete the Project (Phase 5). Working with DNS, DHW will develop an implementation plan that includes projected costing.

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

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

(j) **Targeted Project Funding**

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

(k) **Benefits**

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

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

(iii) The balance currently held as excess in the DNS Recruitment and Retention Fund under the 2008 Master Agreement will be drawn down to an appropriate reserve as jointly agreed by the Parties after consultation between the Parties' auditors. Any surplus above the agreed reserve will be used to fund the DHW portion of the costs of benefits until the agreed reserve is reached.

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

(l) **Remit Payments to DNS**

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

5. GOVERNANCE

5.1 A Master Agreement Management Group (MAMG) will be established to oversee the implementation and operation of this Agreement.

5.2 The terms of reference and decision making will be as outlined in Schedule "D".

6. ACCESS TO INFORMATION

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

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

7. CLINICAL ACADEMIC FUNDING PLANS AND ALTERNATIVE PAYMENT PLANS

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

8. AUDITS

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

9. NOTICE

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

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

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

10. AMENDMENTS

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

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

11. CONSEQUENTIAL AMENDMENTS

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

12. GOVERNING LAW

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

13. 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.

14. 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 10.

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

15. 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 9th day of September, 2016.

SIGNED, SEALED AND DELIVERED in the presence of

Witness

Witness

Witness

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

Minister of Health and Wellness

September 8, 2016

Date

DOCTORS NOVA SCOTIA

Per:
President

Sept. 9/2016

Date

Per:
Chair, Board of Directors

Sept 9/16.

Date

SCHEDULE "A"

RATES EFFECTIVE APRIL 1, 2015

A. Sessional hourly rates: $145.20 for General Practitioners and $169.40 for Specialists.

B. ICU minimum daily income guarantees: as outlined in the Regional Hospital Intensive Care Unit and Comprehensive Care Alternate Payment Plan Options and Operating Guidelines, signed by the Parties on December 16, 2008.

C. Psychiatry hourly rates: $149.90 for certified and $110.55 for non-certified.

D. Emergency hourly rates: $192.00 for regional sites, $167.04 for other hybrid funding sites, $147.62 for Level 3 sites and $73.81 for Level 4 sites.

E. GP Alternative Payment Plan annual rate: $235,667.

F. Palliative Care/Geriatrics Alternative Payment Plan annual rates: $235,667 for General Practitioners with no additional training, $242,093 for General Practitioners with post-graduate certification, and $261,541 for certified Specialists.

G. Neonatology Alternative Payment Plan annual rate: $283,780.

H. Obstetrics/Gynecology Alternative Payment Plan annual rate: $331,416.

I. Pediatrics Alternative Payment Plan annual rate: $286,082.

J. Anesthesia Alternative Payment Plan annual rates: $265,299 for Category 1 and $250,041 for Category 2.

K. CAPP rates: shall be the rates as approved and in effect as of April 1, 2015.

L. CEC rates: shall be the direct funding provided by DHW for each CEC as of April 1, 2015.

SCHEDULE "B"

TRANSITION, TERMINATION AND CONTINUATION OF

2008 MASTER AGREEMENT PROGRAMS

I. PROGRAMS TRANSITIONING TO FEE-BASED INITIATIVES

(a) The funding for the following programs will transition to fee-based initiatives as outlined in Article 4:

(i) Comprehensive Care Incentive Program (CCIP)

(ii) Collaborative Practice Incentive Program

(iii) Electronic Medical Records Envelopes B and C

(iv) Unattached and Orphan Patients Program (collectively, the "Transitioning Programs")

(b) The Fee Committee will be provided with a budget as outlined in Article 4.1(d)(vi) and the Committee will decide on appropriate fee codes and fee values to support physicians in providing care. First priority areas will be participating in comprehensive care, collaborative practice, utilizing electronic medical records and addressing the issue of unattached and orphan patients.

(c) For purposes of the CCIP, the Fee Committee will set fees that ensure the $6 million CCIP budget is reallocated in support of primary care. The Parties have completed an initial assessment for home visits, nursing home visits, inpatient care, maternity and newborn care, and visits with children under the age of two. Additional fees to support comprehensive care will be determined by the Fee Committee, with the following areas as priority: tray fees for certain in-office procedures, care plan oversight for care of patients in nursing homes, travel fees for home and nursing home visits, visits with children at five years old, and geriatrics visits.

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

II. PROGRAMS BEING TERMINATED

(e) DHW will terminate the Community Remote Practice On-Call program on a staged basis. Effective upon execution of this Agreement, the pro-rated annual amount for General Practitioners currently eligible for this program will be reduced to $20,000. Effective April 1, 2017, the annual amount will be reduced to $10,000 and effective April 1, 2018 the bi-weekly payments will be terminated.

(f) DHW and the Health Authorities will develop a new Community On-Call Program, subject to DNS approval of the rates. Funding for any such Program will be secured by DHW outside the parameters of this Agreement.

III. PROGRAMS CONTINUING IN MODIFIED FORM

Rural Specialist Retention

(g) The Rural Specialist Incentive Program will continue in its current form. The MAMG will review the Program to better incent recruitment in addition to retention. Program modifications are effective no earlier than April 1, 2017.

Complex Care Visit and Chronic Disease Management Fees

(h) The Chronic Disease Management and Complex Care Visit Fees will continue in their current form until revised by the Fee Committee. The Fee Committee will review and revise the fees to ensure they are more reflective of the level of service required to manage chronic/complex illness and available for the care provided to a greater portion of the chronically ill patient population, and will utilize the additional $1 million investment pursuant to article 4.1(d)(vii) to enhance or add new fees to support complex and chronic care.

Facility On-Call

(i) The Facility On-Call program rates will continue in its current form. All approved on-call rotas will be reviewed by the Health Authority to ensure they align with patient care and service coverage requirements. All required rotas continue to be funded (unless determined to no longer be required) and other eligible rotas are able to be funded through the program.

IV. PROGRAMS CONTINUING IN CURRENT FORM

(j) All other fee-based and program funding in effect on the date of execution of this Agreement shall continue with the same terms and conditions as those in effect on the date of execution, unless the Parties agree otherwise. This includes but is not limited to:

- GP Surgical Assist Program
- Nova Scotia Provincial Locum Program
- Emergency Department Services and Compensation
- Regional Hospital Intensive Care Unit Payment Plan
- Evening and Weekend GP Office Visit Incentive
- Continuing Care

SCHEDULE "C"

TARGETED PROJECT FUNDING

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

Parameters for all Project Funding

- Project work (including deliverables) supporting the three areas identified below and approved by MAMG
- Project work will align with DNS fiscal year (Sept-Aug)
- Quarterly reports to MAMG summarizing work done and time spent.
- Maximum amount allocated for each fiscal year, to be paid to DNS on a quarterly basis.
- Maximum amounts identified below are fixed overall but may be adjusted between priority areas as agreed by MAMG.
- DNS agrees to conduct a reconciliation at each year-end to ensure time spent equates to time paid. Reconciliation to be based on time spent and agreed upon hourly amount
    - Agreed upon hourly amount for physicians is based on $150.00 per hour
    - Agreed upon hourly amount for staff is $70 per hour (time to be reported based on half-days)

Project Funding:

1. **Fee Schedule**

Purpose: Support to FSC and fee schedule related items

Amount: Maximum annual amount ($330,000)

Project work to include:

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

2. **Clinical Practice Support**

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

Amount: Maximum annual amount ($500,000)

Project work to include but not be limited to:

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

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

3. Physician Initiatives

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

Amount: Maximum annual amount $625,000

Initiatives to include:

- CME (effective April 1, 2017 transition this funding to Labour and Advanced Education)
- Bursary program
- Retirement and succession planning
- Support through MSI for billing education sessions
- Medical student engagement
- Physician leadership
- Other initiatives as directed by the MAMG

SCHEDULE "D"

GOVERNANCE

Principles:

- Governance structure designed to foster and support an ongoing collaborative relationship between DNS, DHW and the NSHA/IWK
- Agile and flexible structure with ability to adjust as the system evolves
- Ensure accountability and transparency in contract management

Committee:

Master Agreement Management Group (MAMG)

- Mandate:
  - To oversee the implementation and operation of the Master Agreement
  - To discuss any operational issues arising from the Master Agreement
  - To establish working groups and engage contractors and/or consultants as required to investigate issues of importance to the ongoing implementation and oversight of the Master Agreement
    - Determine specific projects to be funded in a year when DHW identifies funds available from under-utilization trends in fee schedule
  - To receive reports on Master Agreement initiatives, including:
    - DHW to provide quarterly financials on the Agreement
    - Quarterly reports from DNS on work done and invoiced from Project Funding initiatives
    - DHW/NSHA to provide reports on the performance of programs (uptake; outcomes; etc.)
  - To oversee an evaluation of the non face-to-face patient care program and make decisions arising out of the results of that evaluation
  - To make decisions on matters arising during the life of the Agreement. Examples we can anticipate:
    - Approval of the community on-call rate once the program is designed
    - Decisions on how to allocate funds that may become available during the life of the agreement from CMPA in the event of a reduction in CMPA fees, and the non face-to-face budget in the event that the program evaluation does not support its continuation
    - Issues that Fee Committee may refer to MAMG

- Decisions of the MAMG shall be:

(i) In the first instance by consensus.
(ii) If consensus is not reached on an issue, then by majority.
(iii) In the event that a majority decision cannot be reached, then a ninth member will, at the request of either Party, be appointed by the co-chairs for resolution of the issue.
(iv) The ninth member will chair those portions of the MAMG meeting(s) which involve consideration of the unresolved issue, will decide how best to conduct the meeting(s) and to resolve the issue, and will have all powers granted pursuant to the *Commercial Arbitration Act*. This is not

intended to be a formal arbitration. There shall be no legal counsel and no calling of evidence. The rules of natural justice do not necessarily apply, except in the discretion of the ninth member.

(v) The decision of the MAMG reached through this process shall be final and binding on all Parties.

In the event that the Parties have a dispute with respect to the interpretation or application of an MAMG decision, or that either Party has a dispute with respect to the conduct of the other Party regarding the interpretation, application or administration of this Agreement, the dispute shall be resolved pursuant to this MAMG decision-making process.

- Standing Committees:
  - MAMG may agree to establish standing committees as necessary.
  - APP Working Group to continue. Recognizing this is a priority area the mandate of this group will be determined by MAMG.

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

SCHEDULE "E"

Claims Monitoring and Resolution Mechanism

Preamble

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

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

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

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

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

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

   c) **Days** means business days;

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

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

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

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

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

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

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

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

   b) the service was performed;

   c) the service was medically necessary;

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

   e) the service meets the requirements set out in:

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

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

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

Pre-Payment Assessment

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

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

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

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

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

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

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

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

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

Post-Payment Audit

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

    - Service Verification Letters;
    - Case Mix Grouping - Peer Profiling;
    - Referral;
    - Periodic Random Selection;
    - Use of New Fee Codes;
    - Specific Fee Codes identified for audit.

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

Periodic Review

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

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

On-Site Audits

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

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

Audit Scope

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

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

Notification of Audit Results

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

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

    b) the financial implications of the Audit; and

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

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

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

Audit Review

24. Where the physician disagrees with the Audit Result, the physician will, within twenty (20) days of receipt of the findings, contact MSI in writing to initiate the Audit Review (Notice of Audit Review). The Notice will include the basis for the disagreement and provide documentation, including all relevant clinical documentation, to support that position. If

the physician fails to provide the Notice to MSI within that time, s/he is deemed to agree with the Audit Result and forfeits further rights to Audit Review, Facilitated Resolution, or Arbitration. If deemed to agree with the Audit Result then any associated recovery shall be made from future payments to the physician. The purpose of the Audit Review is to ensure that MSI has all information/documentation relevant to the Audit.

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

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

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

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

27. The Notice of Determination shall include:

    - a statement of the findings of the Audit, including any adjustments made as a result of the Audit Review;
    - detail of all outstanding issues that have not been resolved; and
    - a form that may be used by the physician to object to the Notice of Determination.

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

29. If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date he/she receives the Notice of Determination, submit an objection in writing to MSI (the "Notice of Dispute"). In the Notice of Dispute, the physician may only make representations related to matters referred to in the Notice of Determination, or which are related directly thereto. If the physician fails to contact MSI within that time, he/she is deemed to agree with the Audit Result and forfeits further rights to Facilitated Resolution or Arbitration. Any associated recovery shall be made from future payments to the physician.

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

Facilitated Resolution

31. When MSI receives a Notice of Dispute, or where either the DHW Medical Consultant or the DNS Medical Consultant determines that a pre-payment assessment dispute does not

involve a policy decision per Clause 11, the Facilitated Resolution stage will begin. MSI will notify both the DHW and DNS Medical Consultants.

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

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

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

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

    - legal representatives will not attend the Facilitated Resolution;
    - agreement may only be reached with consensus between the DHW Medical Consultant and the physician;
    - if agreement is reached, the Facilitator will document the terms of the agreement (the Agreement) and the DHW Medical Consultant and the physician will sign the Agreement, at which time the Agreement will become binding on both Parties;
    - if agreement is not reached, the physician has thirty (30) days to provide notice of intent to proceed to Arbitration as outlined herein. If no notice is provided, the physician is deemed to agree with the Audit Results and forfeits further rights to Arbitration.

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

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

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

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

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

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

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

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

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

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

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

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

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

49. DHW and DNS agree to review the process one (1) year after its implementation, and agree that, unless the Parties agree otherwise, Schedule "E" will terminate upon termination of the Physician Services Master Agreement.

50. Without limiting the generality of the foregoing, if after one (1) year the Facilitated Resolution phase does not successfully resolve 65% of the files it receives, specifically excluding the files which reach Facilitation by way of the Transition Process, the Facilitated Resolution phase will be removed from Schedule "E", unless both DHW and DNS agree otherwise.

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

Transition Provisions

52. With the exception of any Arbitrations that are already scheduled as of the Implementation Date of the revised Schedule E, any portion of the claims monitoring process as defined herein that remains outstanding at the Implementation Date shall be governed by the revised Schedule E.

53. With the exception of any Arbitrations that are already scheduled as of the Implementation Date, each physician for whom any portion of the claims monitoring process is ongoing will be notified fifteen (15) days in advance of the Implementation Date.

54. Within twenty (20) days of the Implementation Date, each physician must communicate a request to proceed to the next step in the claims monitoring process, otherwise any outstanding Audit or Pre-payment assessment will be confirmed.

    a) For greater certainty:

        i. a physician who has received and disagrees with an Audit Result shall submit to MSI a Notice of Audit Review to initiate Audit Review as outlined herein;

        ii. a physician who has received and disagrees with a Notice of Determination shall submit a Notice of Dispute in writing to MSI, and Facilitated Resolution shall proceed as outlined herein;

iii. a physician who has submitted a Notice of Dispute but has not yet had Arbitration scheduled shall proceed with Facilitated Resolution as outlined herein.

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

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

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

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