THIS AGREEMENT is effective this 1st day of April, 2017

BETWEEN

THE MINISTER OF HEALTH
FOR THE PROVINCE OF SASKATCHEWAN
(hereinafter called the "Minister")

- and -

THE BOARD OF DIRECTORS OF THE
SASKATCHEWAN MEDICAL ASSOCIATION
(hereinafter called the "Board")

WHEREAS section 48.1 of *The Saskatchewan Medical Care Insurance Act* provides for the making of an agreement between the Minister and the Board with respect to payments for insured services provided by physicians;

AND WHEREAS under *The Health Administration Act* the Minister may enter into agreements with the Board for the purposes of developing, coordinating and maintaining comprehensive health services in the province and for the education and training of health personnel;

AND WHEREAS the Minister and the Board have reached an agreement;

NOW THEREFORE this Agreement witnesses that the parties agree as follows:

SECTION 1: INTERPRETATION

In this Agreement:

(a) "Act" means *The Saskatchewan Medical Care Insurance Act*;

(b) "annualized" when used in relation to an amount of money to be made available under this Agreement, means that adjustments are to be made that would cause that amount of money to be paid for services over a period of twelve months;

(c) "base payment schedule" means the Payment Schedule that was in effect on March 31, 2017;

(d) "payment schedule" means the Payment Schedule made pursuant to clause 48(1)(c) of the Act that prescribes the rates of payments to be made under the Act in respect of insured services provided to beneficiaries by physicians;

(e) "insured services" means insured services, within the meaning of the Act, that are provided by physicians who reside in Saskatchewan;

(f) "fiscal period" means the 12 month period beginning April 1st of one year up to and including March 31st the following year; and

(g) "previous agreement" means the Agreement between the Minister and the Board respecting similar subject matter, dated February 10, 2016.

SECTION 2: TERM

1. The term of this Agreement is April 1, 2017 to March 31, 2022. Subject to Subsection 2, in the event that the parties have not agreed to a new Agreement prior to March 31, 2022, this Agreement shall continue until a new Agreement is entered into.

2. Part II of this Agreement can be terminated at any time in accordance with Section 15.

PART I INSURED SERVICES, PAYMENT SCHEDULE AND PHYSICIAN COMPENSATION

SECTION 3: PAYMENT SCHEDULE ADJUSTMENTS

1. Subject to sub-section 4, the Payment Schedule for the period:

   (a) from April 1, 2017 to March 31, 2018 is 0% greater than the aggregate annualized payment on the basis of the base payment schedule;

   (b) from April 1, 2018 to March 31, 2019 is 0% greater than the amount referred to in clause (a);

   (c) from April 1, 2019 to March 31, 2020 is a one-time payment, to eligible physicians, in lieu of a 1% retroactive amendment to the Payment Schedule:

      (i) Eligibility for the one-time payment will be determined by using a combination of the Retention Fund eligibility, Continuing Medical Education Fund eligibility, or alternate listing as mutually agreed;

      (ii) Eligible fee-for-service (FFS) and non-fee-for-service (NFFS) physicians to receive a one-time payment equal to 1% of total 2018-19 aggregate annualized payments, minus $300k withheld for administrative purpose (i.e., appeals and recalculations), divided by the number of eligible physicians; and

      (iii) Eligible part-time physicians will have the one-time payment prorated.

   (d) from April 1, 2020 to September 30, 2020 is a one-time payment, to eligible physicians, in lieu of a 2% retroactive amendment to the Payment Schedule:

      (i) Eligibility for the one-time payment will be determined by using a combination of the Retention Fund eligibility, Continuing Medical Education Fund eligibility, or alternate listing as mutually agreed;

      (ii) Eligible FFS and NFFS physicians to receive a one-time payment equal to 3.02% of 50% of total 2019-20 total aggregate annualized payments, divided by the number of eligible physicians; and

      (iii) Eligible part-time physicians will have the one-time payment prorated.

   (e) from October 1, 2020 to March 31, 2021 is 3.02% (1% compounded with 2%) greater than the amount referred to in clause (b); and

(f) from April 1, 2021 to March 31, 2022 is 2% greater than the amount referred to in clause (e).

2. All changes to the Payment Schedule:

   (a) subject to sub-section 3, are to be made in a manner to be determined by the Board; and

   (b) may be made using weighted averages and changing assessment rules rather than changing the amount to be paid for each individual service by the same amount or percentage.

3. The Minister will advise the Board at the earliest opportunity of any recommendations regarding possible Payment Schedule changes. If the Minister disagrees with any determinations of the Board made pursuant to sub-section 2, the Minister may, after consultation with the Board, redistribute in the Payment Schedule not more than 15% of the total amounts mentioned in sub-section 1 (e) and (f).

4. All changes to the Payment Schedule required by any section in this Agreement shall be made in accordance with *The Insured Services (Physicians) Payment Schedule Review Regulations, 1989.*

5. During the term of Part I, the Minister will make funds available as required to make payments under the Payment Schedule that is established in accordance with this Agreement.

6. See Appendix "6" for a list of codes excluded from fee increases starting April 1, 2020:

SECTION 4: NEW ITEMS AND MODERNIZATION OF THE PAYMENT SCHEDULE

1. In addition to the funds to be made available pursuant to section 3, existing annualized funds remain available, from previous Agreements, for adjustments to the Payment Schedule for new service items added to the Payment Schedule, or items which are introduced or modified for the purpose of modernizing the Payment Schedule for the fiscal period beginning April 1, 2017;

2. The parties understand that if total adjustments to the Payment Schedule mentioned in sub-section 1 generate an annualized increase in payments of less than the amount specified in sub-section 1, the under-expenditure will be distributed among other programs by mutual agreement of the parties or added to the amount available in any subsequent agreement.

3. The parties understand that if adjustments to the Payment Schedule for new service items and modernization added to the Payment Schedule during the periods mentioned in sub-section 1 generate an annualized increase in payments of more than the amount specified in sub-section 1, the over-expenditure will be subtracted from the amount to be made available in the next applicable Payment Schedule referred in sub-section 1.

4. The parties agree to make every effort to implement payment schedule adjustments identified in sub-section 1 within the fiscal year in which the funds are made available. The Minister agrees that adjustments will be made retroactive to the date specified in this agreement, unless by mutual agreement of the parties, it is determined that the Minister pays the equivalent value of the retroactive adjustments by way of a one-time lump sum payment to the Board to be disbursed to physicians in a manner determined by the Board. In the event of payment to the Board as aforesaid, the Board shall advise the Minister of the details of the disbursement.

5. The parties acknowledge that the Minister may, after consultation with the Board, cause additional amounts of money to be made available for adjustments to the Payment Schedule for new service items added to the Payment Schedule during the term of this Agreement.

6. The parties agree to proceed with modernization of the Payment Schedule, within the principles of patient-centred care, appropriateness and fairness. A draft of the Project Charter for the modernization project is attached as Appendix "4". The parties agree that modernization of the Payment Schedule is to be revenue neutral, with any potential savings which result from an agreement on a new modernized Payment Schedule to be reinvested into the Payment Schedule.

SECTION 5: NON-FEE-FOR-SERVICE (NFFS) BARGAINING FRAMEWORK

1. A separate Letter of Agreement (LOA) (Appendix "1") has been established to articulate the process for negotiating non-fee compensation rates, ensure consistency in compensation rates, accountability, and performance expectations across the Province related to all clinical non-fee-for service (NFFS) compensation. It is to articulate the SMA's mandate to negotiate all NFFS compensation and contractual terms in Saskatchewan as sole and comprehensive negotiator for clinical physicians and to the greatest extent possible, ensure that physicians who do not "opt out" abide by this process.
2. The LOA has been established based on the principle of recognized bargaining rights for the SMA for NFFS compensation and related contractual terms funded by the Ministry of Health in:

   (a) The Saskatchewan Health Authority (SHA);

(b) The Saskatchewan Cancer Agency (SCA);

(c) The College of Medicine (CofM);

(d) Community Clinics; and

(e) Northern Medical Services (NMS).

SECTION 6: PRIMARY CARE PHYSICIAN COMPENSATION

1. The SMA and the Ministry have joint interest in the provision of high quality, patient-centered and team-based care to Saskatchewan citizens, and recognize the critical role family physicians play in the health care system. As such, the SMA and Ministry have committed to developing primary care compensation models that will facilitate advancement of the College of Family Physicians of Canada's Patient's Medical Home vision throughout Saskatchewan and that aligns with the province's Connected Care Strategy.

2. By September 15, 2020, a Primary Care Compensation Working Group will be established to develop and submit a primary care compensation proposal for the principals' (i.e., Deputy Minister of Health and SMA Board of Directors) consideration by January 31, 2022 (or a later date as mutually agreed).

3. The intent of this Working Group will be to identify innovative compensation models that include:

   (a) the objectives of the Connected Care Strategy and principles of the Patient's Medical Home as per Appendix "2" (e.g., enhanced ability for collaboration among physicians and other health professionals who are part of a Health Network);

   (b) an integrated approach to meeting the care needs of patients and communities, improved prevention and management of chronic disease, strengthened physician leadership and quality improvement capability, etc.);

   (c) approaches that are in concert with a new NFFS Bargaining Framework referred to in Section 5;

   (d) evaluative benchmarks; and

   (e) timelines for implementation.

4. The Working Group will recognize that new compensation models will be available to all interested family physicians. In developing compensation models, the Working Group will consider as its funding sources the amounts allocated for existing, funded primary care contracts as per the GP Compensation Grid and all currently existing program funds targeted for family physicians, with the aim to develop a proposal that would be cost neutral when individual contracts are compared to the value of the existing primary care contracts. Family physicians currently on Primary Health Services Agreements will be provided the option to move to a new payment model should they choose.

5. The principals reserve the right to reject all or part of the proposal.

6. The Working Group will be responsible for drafting a Terms of Reference and Charter or work plan (with timelines and deliverables) that will be approved by the principals.

7. The Working Group will work with the Saskatchewan Health Authority, the Saskatchewan Cancer Agency, eHealth Saskatchewan and other health system partners to ensure both broad consultation and applicability of the strategy. The Working Group, unless otherwise agreed to by principals, will be comprised of:

   (a) Five SMA representatives (determined via the Section of Family Practice) – one of whom will be the Chair

   (b) Two SHA representatives (Physician Executives from Integrated Urban and Integrated Rural Health)

   (c) Two Ministry of Health representatives (via a senior Medical Services Branch (MSB) and Connected Care Strategy Branch (CCSB) staff member)

8. Sufficient research, policy, administrative and liaison support will be resourced through supernumerary staff positions and external contractors as needed fully via the SMA's Accumulated Programs Fund. Estimated costs for this support is $500K.

9. Members of the Working Group will be responsible to liaise and communicate with their respective constituencies. Quarterly reporting to the principals will include progress towards proposal completion.

SECTION 7: RURAL EMERGENCY ROOM (ER) PILOT SITE STABILIZATION

1. The parties acknowledge the increasing clinical demands in some rural hospital emergency rooms (ER). These clinical demands are often cause for concern in relation to on-call workload, compensation and training supports. These issues are in turn affecting rural physician recruitment and retention and destabilizing emergency room services in rural Saskatchewan.

2. The parties agree to establish a modernized approach to the provision of ER coverage that addresses current workload concerns, improves physician job satisfaction and recruitment/retention, provides stability of ER services in rural Saskatchewan, and provides an expectation for ongoing emergency support for the surrounding communities.

3. The parties agree to pilot an hourly rate model of $185/hr with a physician dedicated to the emergency room during the daytime and evening hours (8am – midnight) at nine pilot sites.

4. The details of the agreed to pilot can be found in Appendix "3".

5. The parties agree that changes to the program parameters can be made if mutually agreed to by the principals.

SECTION 8: ON-CALL COVERAGE PROGRAMS

1. The rates of payment in effect on March 31, 2017 for the Specialist Emergency Coverage Program (SECP) and the Emergency Room Coverage Program (ERCP) (also known as the Rural Emergency On-Call Program) (as outlined in Schedules "D" and "E") will be maintained as identified in sub-sections (a) and (b) below.

   (a) Fees for the Specialist Emergency Coverage rotations:

      (i) Tier 1 - $200,000 per call rotation, per annum; and

      (ii) Tier 2 - $150,000 per call rotation, per annum.

      (iii) Call rotation amounts will remain the same for the term but the Ministry of Health, as recommended by the Specialist Emergency Coverage Program Committee, will fund any additional call rotations. The parties, due to the unknown of overall programming utilization, will not unreasonably withhold rotation approval.

   (b) Fees for the Emergency Room Coverage rotations:

      (i) Category A - $200,000 per call rotation, per annum; and

      (ii) Category B - $150,000 per call rotation, per annum.

2. The Minister shall cause to be made available funds for the purpose of supporting the Emergency Room Coverage Program as set out in Schedule "E".

3. The parties mutually commit to proceed with a review of all existing Specialist Emergency Coverage Program rotations, for effectiveness and to ensure they reflect current provincial health system needs.

SECTION 9: PAYMENT FOR PAST SERVICES

1. As a one-time payment in lieu of a retroactive amendment to the payment schedule for April 1, 2019 to March 31, 2020, the Minister will pay to physicians, or physician professional corporations a one-time payment in an amount equal to:

   (a) 1% of the total 2018-19 aggregate annualized payments made by the Minister to the physician or physician professional corporation for insured services provided to beneficiaries under the Act and for contracted clinical services during the period of April 1, 2019 to March 31, 2020, less any amount that has been reassessed for that period under the Act;

   (b) Divided by the numbers of eligible physicians as determined by using a combination of the Retention Fund eligibility, Continuing Medical Education Fund eligibility, or alternate listing as mutually agreed, which determines eligibility based on Ministry funded clinical services and continuity of practice activity. Eligible part-time physicians will have the one-time payment prorated.

2. As a one-time payment in lieu of a retroactive amendment to the payment schedule for April 1, 2020 to September 30, 2020, the Minister will pay to physicians, or physician professional corporations, a one-time payment in an amount equal to:

   (a) 3.02% of the first 6 months of the total 2019-20 aggregate annualized payments made by the Minister to the physician or physician professional corporation for insured services provided to beneficiaries under the Act and for only contracted clinical services during the period of April 1, 2020 to September 30, 2020, less any amount that has been reassessed for that period under the Act;

   (b) Divided by the numbers of eligible physicians as determined by using a combination of the Retention Fund eligibility, Continuing Medical Education Fund eligibility, or alternate listing as mutually agreed, which determines eligibility based on Ministry funded clinical services and continuity of practice activity. Eligible part-time physicians will have the one-time payment prorated.

3. The amounts referred to in sub-sections 1 and 2 will be paid not later than December 31, 2020.

SECTION 10: SMA DUES CHECK-OFF

In accordance with *The Saskatchewan Medical Association Dues Check-off Regulations, 1996*, the amount to be deducted by the Minister or any other person from physician payments, for services rendered by the Board on behalf of physicians who are not members of the Saskatchewan Medical Association, is 75% of the annual membership dues established by the Board.

SECTION 11: MISCELLANEOUS

The Board or the Minister may, at any time prior to the expiration of the term set out in Part I, or at any other time agreed to by the parties require the establishment of a Medical Compensation Review Committee by giving written notice to the other party.

PART II OTHER PHYSICIANPHYSICIAN BENEFIT PROGRAMS AND SERVICE INCENTIVES

SECTION 12: OTHER PROGRAMS

1. In addition to the amounts of money to be made available pursuant to Part I of this Agreement, the Minister shall cause programming funding to be made available. Physician programs are separated into two types:

   (a) Census-based Physician Programs - Expenditures in programs are directly correlated to the number of physicians qualifying for and/or utilizing program entitlements
      (i) Specialist Emergency Coverage Program (see Section 8);
      (ii) Canadian Medical Protective Association;
      (iii) Continuing Medical Education;
      (iv) Retention Fund;

(v) Parental Leave;
(vi) Chronic Disease Management;
(vii) Quality & Access Fund
(viii) Family Physician Comprehensive Care Program (FPCP) and Metro On-call; and,
(ix) GP-Specialist.

(b) Non-Census Based Programs - Expenditures follow guidelines and program delivery which are not directly and entirely correlated to the number of physicians qualifying for or utilizing funding:

(i) Rural & Regional Practice (also known as Rural & Remote Initiatives) and Specialist Recruitment & Retention
(ii) Clinical Quality Improvement Program (CQIP)
(iii) Electronic Medical Record (EMR) Program

2. The Census-based Physician Programs are funded based on utilization/census values stated in the prior year's actual audited financial statements. This annual right-sizing/recalculation may result in re-allocating existing funding from under-utilized programs to over-utilized programs.

3. Census-based Physician Programs will be funded based on program utilization effective 2020-21, rather than based on historical budget amounts:

(a) Census-based Physician Programs and the associated program parameters for 2019-20 will remain unchanged unless otherwise mutually agreed upon;
(b) The 2020-21 Census Based Physician Programs budget will be set based on the 2019-20 budget;
(c) An in-year reconciliation payment (or reduction) will be made once the 2019-20 audited financial statements are available or current year actuals are known, to ensure adequate census-based program funding is available;
(d) To support over-utilized programs, funds would first be secured from under utilized programs;
(e) If additional funds are required due to utilization pressures, the Ministry of Health will fund the pressure in-year via a end of year top up to the float outlined in sub-section 3(g) and address shortfalls through additional program funding;
(f) If actuals are less than the prior year budget, the in-year periodic/quarterly payments from the Ministry to the SMA will be adjusted to reflect the reduction in utilization; and
(g) A one-time float of $2M from existing SMA Accumulated Programs Fund will be available to cover program expenditures administered by the SMA in excess of program budgets until audited statements are available. This float will be replenished by the Ministry of Health as part of the annual reconciliation process.

4. Subject to section 15 in addition to the amounts of money to be made available pursuant to Part I of this Agreement, regarding Census-based programming, the Minister shall cause to be made available:

(a) Canadian Medical Protective Association (CMPA) - In recognition of the costs related to Canadian Medical Protective Association dues:

(i) the actual costs of CMPA dues for eligible fee-for-service physicians and eligible physicians on alternate payment arrangements as defined in Schedule B providing

clinical/insured services in Saskatchewan for the 2017 calendar year and each year thereafter, in accordance with the formula set out in Schedule B;

(ii) upon receipt from the Board of invoices of actual expenditures, the Minister will make a payment to the Board on a quarterly basis for the term of the contract with such payments to be adjusted as necessary to provide the funding required by this section;

(iii) the Minister will make a payment to the Board for the 2017 calendar year and each calendar year thereafter to compensate for the Board's actual costs of administration of the CMPA Program, up to a maximum of $107,000 in any calendar year. The Board will invoice the Minister quarterly for such costs and will provide to the Minister within 30 days such information and records as the Minister may request to substantiate any administrative costs claimed; and

(iv) the benefits to physicians from this Program will be administered in accordance with Schedule "B".

(b) Continuing Medical Education (CME) - For the purpose of supporting the Continuing Medical Education Fund:

(i) $4,650,000 for the fiscal period beginning April 1, 2020 and ending March 31, 2021 with the intent to rebase in 2020-21 when the 2019-20 audited financial statements are available;

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on prior year actuals as detailed in the audited financial statements. Individual entitlement rates/amounts will remain the same for the term but any growth in utilization rates or in physician supply will be funded by the Ministry;

(iii) payments will be made on a quarterly basis for the term of the Agreement; and

(iv) the benefits to physicians from this fund will be administered in accordance with Schedule "C".

(c) Retention Fund - For the purposes of providing a Physician Long-Term Retention Fund:

(i) $8,837,000 for the fiscal period beginning April 1, 2020 and ending March 31, 2021 as per the 2016 actuarial report commissioned by the SMA;

(ii) $8,837,000 for each succeeding fiscal period beginning April 1, 2021 unless adjusted as new actuarial reports become available;

(iii) payments will be made on or before July 1st of each year; and

(iv) the benefits to physicians from this fund will be administered by the Board in accordance with Schedule "G", which Schedule may not be amended without the written agreement of the Minister.

(v) Utilization funding will be provided according to the required annual contributions as determined by periodic actuarial review, which captures variables like physician

supply growth and retention. Individual entitlement amounts will remain the same for the term.

(vi) The parties acknowledge that the Ministry made year-end payouts for under-utilized programs for the 2017-18, 2018-19, and 2019-20 fiscal years. These year-end payouts contributed to the SMA's Accumulated Programs Fund and will be used as a one-time retroactive payment to properly account for the funding shortfall identified in the 2016 actuarial review for the Physician Retention Fund.

(d) Parental Leave - For the purpose of providing Parental Leave Benefits:

(i) $1,596,000 for the fiscal period beginning April 1, 2020 and ending March 31, 2021;

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on prior year actuals as detailed in the audited financial statements. Individual entitlement rates/amounts will remain the same for the term but any growth in utilization rates or in physician supply will be funded by the Ministry;

(iii) payments will be made on a quarterly basis for the term of the Agreement; and

(iv) the benefits to physicians from this fund will be administered in accordance with Schedule "F".

(e) Chronic Disease Management - For the purpose of providing enhanced management of patients with chronic diseases:

(i) $3,000,000 for the fiscal period beginning April 1, 2020 and ending March 31, 2021. This funding will be utilized as follows:

- Chronic Disease Management – Quality Improvement Program Payments to qualifying fee-for-service and non-fee-for-service physicians; and

- Annualized program maintenance funding, and future development costs.

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on the actual Quality Improvement Payments to qualifying physicians, and annual program maintenance and development costs. Individual Quality Improvement Payment entitlement rates/amounts will remain the same for the term, and any growth in utilization rates or in physician supply will be funded by the Ministry.

(iii) the benefits to physicians from this fund will be administered in accordance with Schedule "I".

(f) Quality & Access Fund - For the purpose of improving quality and access for Saskatchewan residents:

(i) $3,000,000 for the fiscal period beginning April 1, 2020 and ending March 31, 2021;

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on prior year actuals as detailed in the audited financial statements;

(iii) payments will be made in accordance with the terms outlined in Schedule "K";

(iv) one-time initiatives that enhance quality and/or access can also be approved, by mutual agreement of the parties, to constitute utilization under this fund.

(g) Family Physician Comprehensive Care Program (FPCCP) and Metro On-call - For the purpose of recognizing Full-Service Family Physicians and the Metro On-Call Program, in accordance with Schedule "L":

(i) $14,300,000 for the fiscal period of April 1, 2020 to March 31, 2021;

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on actual FPCCP payments made to qualifying physicians. The annual payment is claim system generated based on in-year billings and/or clinical payments. Individual entitlement rates/amounts will remain the same for the term but any growth in utilization rates or in physician supply will be funded by the Ministry;

(iii) funding made available in sub-clause (i) and (ii) above will provide for payments to fee-for-service and non-fee-for-service physicians.

(h) GP-Specialists - For the purpose of recognizing General Practitioner Specialists, in accordance with Schedule "J":

(i) $1,000,000 for the fiscal period of April 1, 2020 to March 31, 2021.

(ii) for each succeeding fiscal period beginning April 1, 2021, annual funding will be based on prior year actuals paid by the Minister to qualifying physicians; Individual entitlement rates/amounts will remain the same for the term but any growth in utilization rates or in physician supply will be funded by the Ministry; and

(iii) funding made available in sub-clause (ii) above will provide for payments to fee-for-service and non-fee-for-service physicians.

5. The recruitment & retention physician programs (sub-section 6(a)) are not entitlement programs; rather they are programs with clear guidelines and funding requirements as directed by committees. The overall program funding envelope amount and program parameters do not change from the previous agreement.

6. In addition, regarding Non-Census based programming, the Minister shall cause to be made available:

(a) Rural & Regional Practice and Specialist Recruitment & Retention - For the purpose of providing programs and incentives to be agreed to by the parties for Rural and Remote Initiatives and to enhance the recruitment and retention of specialists:

(i) $5,140,000 for the fiscal period beginning April 1, 2020;

(ii) $5,140,000 for each succeeding fiscal period;

(iii) the parties agree to develop and monitor such programs and incentives in accordance with the terms outlined in Schedule "A" and Schedule "H";

(iv) payments will be made on a quarterly basis upon invoice from the SMA for the term of the Agreement.

(v) If underspent in any given year, the excess for that year is kept by the Ministry of Health and the budget will remain at $5,140,000 for the following year.

(b) Clinical Quality Improvement Program (CQIP) - For the purpose of providing program funding to target Clinical Quality Improvement for physicians;

(i) $1,000,000 for the fiscal period beginning April 1, 2020;

(ii) $1,000,000 for each succeeding fiscal period;

(iii) payments will be made on a quarterly basis upon invoice from the SMA for the term of the Agreement or subject to sub-section 2; and

(iv) If underspent in any given year, the excess for that year is kept by the Ministry of Health and the budget will remain at $1,000,000 for the following year.

(v) the benefits to physicians from this fund will be administered in accordance with Schedule "M".

(c) Electronic Medical Record (EMR) Program - For the purpose of providing EMR in physician practices:

(i) $9,300,000 for the fiscal period beginning April 1, 2020;

(ii) $9,300,000 for each succeeding fiscal period;

(iii) payments will be made on a quarterly basis for the term of the Agreement or subject to sub-section 2;

(iv) the Electronic Medical Record Agreement signed March 27, 2008 outlines further detail on commitments and process with respect to Information Technology; and

(v) the funding outlined in c(i) represents both the Board's 30% contribution negotiated through MCRC and the Ministry's 70% contribution outlined in the Electronic Medical Record Agreement.

(vi) If underspent in any given year, the excess for that year is kept by the Ministry of Health and the budget will remain at $9,300,000 for the following year.

(vii) Individual entitlement amounts will remain the same and over the duration of this agreement. The Ministry, SMA and eHealth will examine the most effective administration for support to the EMR program and develop a recommendation for the principals to ensure the same level of support is provided to both fee-for-service, non-fee-for service and other users of the EMR.

7. The parties agree that any programs or incentives developed and implemented within the terms of section 12, sub-sections 4(e), 4(f), 4(g), 4(h), 6(a), 6(c) (i.e., Chronic Disease Management, Quality & Access Fund, FPCCP and Metro On-call, GP-Specialists, Rural & Regional Practice and Specialist Recruitment & Retention, and EMR Program):

   (a) may be administered by the Minister;

   (b) that any amounts to be paid to individuals may be paid directly to those individuals by the Minister; and

   (c) that where amounts have been paid to the Board for programs or incentives, the amounts actually expended by the Minister for the purposes of any such programs and incentives will be reimbursed to the Minister by the Board through:

      (i) the off-set of such amount from the monies payable to the Board under sub-sections 4(e), 4(f), 4(g), 4(h), 6(a), 6(c); or

      (ii) a direct payment from the Board within thirty days of the date that the Minister advises the Board of the amount so expended.

8. The Board:

   (a) will maintain separate interest-bearing accounts for the funds referred to in sub-sections 4(b), 4(c), 4(d), 6(a) and 6(c) (i.e., CME, Retention Fund, Parental Leave, Rural & Regional Practice and Specialist Recruitment & Retention, and EMR Program) and deposit those funds in accounts and not mix such funds with any other funds without the approval of the Minister;

   (b) acknowledges that interest earned on the funds referred to in this section, with the exception of sub-section 4(c), shall accrue to the benefit of the Minister and notwithstanding sub-section 8 may be used for the purposes which the Minister directs. In the event that the Minister does not provide written direction within 90 days of the expiration of this Agreement the Minister shall be deemed to direct the interest be recontributed to the program for which the fund giving rise to such interest was established;

   (c) will provide on an annual basis by no later than July 31st audited financial statements and reports on each fund prepared in accordance with Canadian generally accepted accounting principles; and

   (d) will make every effort to develop programs and initiatives during the term of the Agreement.

9. No sums may be expended from the accounts referred to in sub-section 8 unless:
   (a) the Minister and the Board agree to the programs and/or incentives and designated funding for such programs and/or incentives; and
   (b) any administrative costs associated with the programs and/or incentives are approved in writing by the Minister. The Board will provide to the Minister such information or access to any accounts and records as the Minister may request to substantiate the validity of any administrative costs assessed by the Board.

10. The Minister and the Board may periodically review all existing and new programs and incentives, which have been established pursuant to sub-section 1 and may, by mutual agreement, amend or terminate any such program or incentive.

11. The Minister and the Board agree to a third-party review of the programs referred to in section 8(1)(b) and section 12(4)(h) (i.e., ERCP and GP-Specialists) by March 31, 2022 (or at a later date as mutually agreed by the principals due to COVID-19 delays). The Minister and Board agree to fund these reviews from the SMA's Accumulated Programs Fund. A joint oversight structure will provide input into program review design and receive recommendations from the third party.

12. The Board acknowledges and agrees that the Minister's obligation with respect to the funds described in clause 4(c) is limited to providing for the funding specified in the particular clause. The Board warrants that it is solely responsible for ensuring the funds are sufficient to meet the obligations to its members. Without limiting the generality of the foregoing, the Board agrees:

    (a) that the Minister is not responsible for any shortfall or deficit in any of the funds, except as outlined in sub-section 4(c);

    (b) provided the Minister makes the payments to the funds specified in this Agreement, the Board, nor its members, will make no claims, take no actions or make any demands whatsoever against the Minister which in any way relate to or arise out of the administration of any of the funds, including claims or demands respecting the sufficiency of any of the funds or any benefits or payments to be provided from the funds; and

    (c) the Board will indemnify and save harmless the Minister from any claims, actions or demands of any nature and kind which may be made against the Minister and which relate in any way to or arise out of the administration of any of the funds, including claims or demands respecting the sufficiency of any of the funds or any benefits or payments to be provided from the funds.

13. The parties acknowledge that, at the time of execution of this Agreement, the amounts referred to in this Part which relate to the fiscal periods prior to and including April 1, 2019 to March 31, 2020 have been fully paid.

14. The parties acknowledge that, at the time of execution of this Agreement; the Parental Leave and Continuing Medical Education programs had expenditures that exceeded their in-year program budgets for the 2017-18, 2018-19, and 2019-20 fiscal years. It is also acknowledged that these programs had accumulated surpluses prior to the 2017-18 fiscal year, therefore;

    (a) The outstanding estimated net shortfall of approximately $906,000 will be funded by the SMA's Accumulated Programs Fund.

    (b) The CME liability balance as at December 31, 2019 is recognized as a potential future utilization pressure for the Ministry of Health under the census-based funding model contemplated in this MOU.

    (c) The parties acknowledge that the Ministry of Health made year-end payouts for underutilized programs for the 2017-18, 2018-19, and 2019-20 fiscal years. These year-end payouts contributed to the SMA's Accumulated Programs Fund and will be used to properly account for the over-expenditures identified for the Parental Leave and CME program.

SECTION 13: CRITICAL GOOD FAITH COVERAGE POLICY

1. The intent of Critical Condition Good Faith Coverage Policy is to minimize the risk of Saskatchewan practitioners not being paid for services provided to un-insured Canadian residents and/or visitors to Saskatchewan from out of country.

2. The Ministry of Health has no legislative authority to make payment for these services, pursuant to the *Medical Care Insurance Act* (MCIA) and related regulations. However, it is acknowledged that Saskatchewan physicians who are compelled to provide services to patients for emergency or acute critical conditions are at risk of not being paid for the provision of services without supports in place.

3. The Critical Condition Good Faith Policy only applies to treatment services provided to patients in-hospital for emergent or urgent acutely critical conditions. Service for conditions that are terminal but not acutely critical are not considered part of this policy. Treatment provided in clinics in the community is excluded. All services that are not medically required are excluded.

4. Saskatchewan and Canadian Residents
   (a) The intent of this section is to cover two scenarios: one where patients are likely to be covered under the MCIA as beneficiaries, and one where patients choose not to be or are ineligible for Saskatchewan coverage or another province's coverage until Saskatchewan coverage takes effect.
      i. In situations where it is presumed that the Saskatchewan resident or out of province resident will likely be eligible for coverage (i.e., they have had coverage in the past but have relocated and there is sufficient evidence to suggest that instatement processes will 'catch up' with patient's resident status), the physician will hold billings until such time as coverage is re-instated. If the physician confirms the resident has not achieved beneficiary status within 180 days of the service, the physician can apply for reimbursement as per 4(a)ii below.
      ii. In situations where it is presumed that the Saskatchewan or out of province patient chooses not to be covered as a Saskatchewan or other province beneficiary or has extenuating circumstances (such as being caught in the waiting period between refugee status with confirmed documentation), physicians can invoice for services to be paid at the Physician Payment Schedule rate to the Saskatchewan Medical Association for re-imbursement.

5. The parties agree that a fund to a maximum of $50,000 will be established out of the SMA's Accumulated Programs Fund to cover the costs of invoiced items as per 4(a)ii only. The parties agree to review this program after the expiration of this Agreement.

6. Out of Country Patients:

   (a) The Ministry of Health will direct the Saskatchewan Health Authority to assist physicians in invoicing patients for the services they have provided. Physicians may invoice out of country patients per the SMA's uninsured fee guide.
   (b) This policy covers only those situations where the patient from outside of Canada is treated for an emergent or urgent critical condition (i.e., conditions that are terminal but not emergent are excluded).
   (c) Services provided must be medically required. No elective services should be provided in hospital, and any follow-up elective/non-emergent services provided

out of hospital will be invoiced to the patient as per the SMA's uninsured fee guide. Elective services include labs and diagnostics performed to rule out an emergent condition.

SECTION 14: PROGRAM ACCOUNTABILITY AND QUALITY IMPROVEMENT

1. The Government is committed to reviewing all of its programs and services. The goal of the review is to ensure that programs are effective, efficient, meeting their intended purpose and are still relevant.

2. The 3rd party reviews are to be completed by the expiration of this Agreement. The Ministry of Health and the SMA agree that the following programs will be externally reviewed: ERCP and GP-Specialists.

3. The SMA and Ministry of Health will co-determine the program evaluation methods and provide joint oversight to the program review process.

4. The SMA and Ministry of Health agree to fund these reviews from the SMA's Accumulated Program Funds.

SECTION 15: REDISTRIBUTION AND TERMINATION OF PART II

1. Subject to sub-section 2 the Minister may terminate Part II of this Agreement by providing to the Board at least six months written notice of the Minister's intention to terminate.

2. No notice of termination referred to in sub-section 1 shall provide for a termination date other than March 31st of the applicable year.

3. Where on the date that Part II of this Agreement is terminated the Minister shall cause the sums referred to in section 12 to be made available as part of the Payment Schedule in place at that time.

PART III VIRTUAL CARE AND DATA

SECTION 16: CARE PROVIDED THOUGH VIRTUAL TECHNOLOGY

1. A separate LOA (Appendix "5") for Virtual Care has been established with the intent to improve patient access and health outcomes through collaborative care and technology, for the provision of care with and on behalf of patients.

2. The parties agree to pilot the following services as temporary fee codes effective by January 2021 or earlier via a staggered approach, funded through the establishment of $6M from the SMA's Accumulated Programs Fund to implement the following services via temporary fee codes:
   (a) Physician-to-Patient visits via Telephone/Video
      (i) Assessments and Follow-up visits for family physicians and specialists.
   (b) Patient to Physician Limited Virtual Care Visit via Video
      (i) A single encounter with a patient who is unattached to the clinic and where neither the physician nor patient have the expectation of an ongoing care relationship.
   (c) Physician-to-Patient consultations via Telephone/Video
   (d) Physician-to-Patient certification (e.g. examination and certification of need for psychiatric examination pursuant to The Mental Health Services Act) via Telephone/Video
   (e) Physician-to-Patient counselling via Telephone/Video
      (i) family physician and specialist counselling and psychotherapy
   (f) Physician-to-Patient chronic disease management via Telephone/Video

3. At the end of the program pilot (March 31, 2022), the Ministry of Health commits to ensuring continuity and/or finalization of the services on the understanding that benefits to patients and physicians are realized and that mutually agreed upon adjustments may be needed in terms of utilization, costing assumptions, budget limitations and appropriateness.

SECTION 17: ACCESS TO DATA

1. The intent of this section is to provide a mechanism for the SMA to have access to physician information that, according to the Private Act giving authority to the SMA as a corporation and under authority of the *The Saskatchewan Medical Care Insurance Act*, section 37.

2. The parties agree that they may share data for identified purposes only where applicable legislation provides authority to do so. The parties agree that a Master Data Sharing Agreement (MDSA) will be established to govern the overarching terms and conditions under which the two parties can share data. The parties understand that sharing de-identified patient and de-identified physician information may occur in some instances without legislative requirements and sharing of identifiable data is only permitted where applicable legislation allows it. For each individual project or use, the parties will agree to develop and append a Data Sharing Schedule (DSS) to the MDSA that clearly identifies the data to be shared and intent of use, including but not limited to:
   (a) the intended purpose of the data sharing;
   (b) the legislative authority for data sharing;
   (c) details on the data elements and data flow process between the parties;
   (d) the purpose for which the data and any resulting products may be used;
   (e) any special considerations that will be taken to mitigate the risk of identification and re-identification of data subject individuals, where applicable;

(f) details on data confidentiality, access, maintenance, storage, handling and destruction;
(g) the timeframe during which the DSS will be effective and when it expires; and,
(h) any other special terms and conditions agreed between the parties.

3. The parties further agree that data covered by the MDSA and any attached DSSs will be limited to data in either party's custody or control (e.g. Physician Service File, Physician Registry File, Physician Mobility File, FPCCP, GP-Specialists, CDM-QIP, EMR Program, etc.), and does not include data from external partners such as eHealth, the Saskatchewan Cancer Agency, the Saskatchewan Health Authority, or the University of Saskatchewan College of Medicine.

4. The Ministry of Health and the SMA acknowledge the importance of either party having access to comprehensive payment data for the purposes of facilitating both the SMA's and the Ministry of Health's respective mandates under *The Saskatchewan Medical Care Insurance Act* and *The Saskatchewan Medical Association Act*.

PART IV OTHER MATTERS

SECTION 18: PREVIOUS AGREEMENTS

This Agreement, including the Appendices and Schedules and any documents to the extent incorporated herein by reference, constitutes the entire and exclusive Agreement between the parties hereto relating to the subject matter hereof and supersedes and replaces the previous agreement, and any other agreements, undertakings, representations and understandings, written or oral, between the parties or their representatives relating thereto.

SECTION 19: ENUREMENT

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns. Except as otherwise provided in this Agreement, no party may assign any of such party's rights or obligations under this Agreement to any other person without the prior written consent of the other parties hereto.

SECTION 20: AMENDMENT

By mutual agreement, the attached Schedules may be amended at any time during the period of this Agreement.

SECTION 21: EXECUTION

IN WITNESS WHEREOF the parties have set their hands and seals on the day written above.

Executed on behalf of the Minister this 20 day of October, 2021

(Signature)

Minister of Health

Minister of Health
(please print title)

Michael Elliott
(Witness Signature)

Executed on behalf of the Board this 27th day of October, 2021

(Signature)

Dr. Eben Strydom
President
Saskatchewan Medical Association

Executive Assistant to the Board of Directors
(please print title)

MBoucher
(Witness Signature)

APPENDIX "1"

LETTER OF AGREEMENT (LOA) NON-FEE-FOR-SERVICE BARAGAINING FRAMEWORK

INTENT
This Letter of Agreement (LOA) is intended to articulate the process for negotiating non-fee compensation rates, ensure consistency in compensation rates, accountability, and performance expectations across the Province related to all clinical non-fee-for service (NFFS) compensation.
It is to articulate the SMA's mandate to negotiate all NFFS compensation and contractual terms in Saskatchewan as sole and comprehensive negotiator for clinical physicians and to the greatest extent possible, ensure that physicians who do not "opt out" abide by this process.
This LOA is an amendment to the NFFS Bargaining Framework LOA signed July 9, 2020, which canceled and replaced the Letter of Understanding (Non-Fee-for-Service Bargaining Framework) dated July 3, 2012 between the Ministry of Health and the SMA.

I. SCOPE

Compensation:
This LOA encompasses and is binding upon any clinical new or existing fee or payment (including any proposed change to a fee or payment) funded by or payable by the Ministry of Health to a physician, to a group of physicians, or to the named health services entities that are responsible to pay physicians or groups of physicians for the provision of clinical physician services not paid through the Saskatchewan Physician Payment Schedule. For the purposes of this LOA, NFFS compensation includes any compensation-like benefits and/or in-kind overhead offsets provided by health services entities. This LOA excludes any and all compensation paid for academic and leadership services.
Contractual Terms and Conditions:
This LOA encompasses and is binding upon NFFS contractual terms and conditions, which include any activities, accountabilities, and obligations required of a physician or group of physicians under a NFFS compensation arrangement with a named health services entity. For further clarity, NFFS contractual terms and conditions also include termination provisions, dispute resolution provisions, and indemnification provisions within the NFFS contract.
Where workload or activity metrics/benchmarks can be reliably measured/accessed, the quantifiable accountabilities will also be considered as part of the NFFS contractual terms and conditions.
This LOA excludes any and all contract terms and conditions for academic and leadership services.
Physician Human Resource Planning:
The Ministry of Health and health services entities (e.g. Saskatchewan Health Authority, College of Medicine, and Saskatchewan Cancer Agency) are responsible for determining and funding physician resource levels. The parties will use a physician resource planning methodology as a guideline for physician resource planning. The SMA will be consulted on physician resource levels, on changes to the methodology, and informed of the results.

II. APPLICABILITY

The Ministry of Health agrees to ensure that this LOA is also binding on the following named health services entities with respect to compensation for clinical physician services and related contractual terms and conditions:

- The Saskatchewan Health Authority
- The Saskatchewan Cancer Agency
- The College of Medicine of the University of Saskatchewan, including Northern Medical Services

- Community Clinics

Exceptions:
Local issues (i.e. not provincial in nature and specific workplace and/or community) within the physician contract can be negotiated between the health services entity and physician or physician groups (with the appropriate representation/assistance from the SMA). The level of representation will be determined by the SMA and where a physician or physician group specifically wishes alternative representation ("opt out"), the SMA and the Ministry will be notified by the physician or physician groups prior to the commencement of negotiations. This does not preclude any physician or physician group from requesting SMA representation afterwards should they wish. It should be noted that, in the absence of the SMA representation, compensation rates and contractual terms and conditions which impact other similar physicians cannot be negotiated or altered and will be consistent with the provincial/central model contract(s). In addition, the contracting agency will be required to submit the contract to the SMA and to the Ministry of Health.

III. PROCESS

The intent of the following process steps is to facilitate flexible, timely, collaborative, and robust decision-making and can be amended at any time with the mutual agreement of the Ministry of Health and the SMA. The parties agree to review this process 12 months following execution of this agreement with a view to continuous improvement.
An application for NFFS compensation/contract review can be initiated by any physician, physician group, or health services entity. Applications for review must be made in writing to both the Ministry of Health and the SMA to be considered. In the event either the Ministry of Health or the SMA are the initiating party, an application made in writing to the other will suffice. The application will include, at a minimum:

- Brief overview of the request including a desired outcome
- Current state data (if available) regarding relevant benchmarks for compensation or contractual terms and conditions
- Current state data regarding relevant physician human resources
- Impacted physicians, health services entities, and patient populations

Once a completed application is received, the Ministry of Health, the SMA, and the relevant health services entity will jointly review the application within no more than 30 days and determine the process for advancement and resolution. This jointly determined process will include timelines and provide for specific actions to be undertaken by each agency and will be communicated, in writing, back to the applicant(s) within 60 days of receipt of application.
Upon completion of review/negotiations, the agreed upon rate will be established as the 'base' rate to which annual SMA increases will be applied subject to the SMA's allocation process. The associated contract will form the template for that physician group/specialty/service, unless otherwise mutually agreed. Template terms and conditions can be amended from time to time by application to this process. For further clarity, the Ministry of Health and the named health services entities will not advance, amend, or otherwise materially change any existing or future NFFS compensation/contract terms outside of this LOA

IV. PRIORITY APPLICATIONS

The parties also acknowledge that there may be physician supply matters, including market conditions, that have an impact on patient safety and in such instances, the parties commit to address these matters on a priority basis.

The parties acknowledge that review/negotiations for three specialty groups that were prioritized under the July 3, 2012 Letter of Understanding have not yet commenced. It is mutually agreed that upon execution of this LOA, the following groups will have been deemed to have applied per Section IV, as of the date of LOA execution:

- Pathologists
- Medical Health Officers/Public Health Physicians
- Psychiatrists

V. DISPUTE RESOLUTION

In the event that a dispute regarding NFFS compensation or contractual terms and conditions cannot be resolved by negotiation under this LOA, either the SMA or Ministry of Health may give written notice to the other party that they are referring the dispute to a review Board. Within 60 days, the review Board will take the form of a tribunal with equal representation from the SMA and Ministry of Health in addition to a mutually agreeable chairperson. In the event that a mutually agreeable chairperson cannot be determined within 30 days of written notice, the parties will request that the Court of Queen's Bench appoint a chairperson. The tribunal's decision will be binding on both parties, and by extension, to any relevant health services entity.

VI. FUTURE COMPENSATION ADJUSTMENTS (POST FIRST CONTRACT)

Once negotiations are completed and a first contract for the relevant physician group/service has been established, the establishment of future contract rates and adjustments will flow from the fee-for-service (FFS) Medical Compensation Review Committee (MCRC) negotiating process.
Both parties retain the right to raise specific issues within the MCRC process relating to NFFS compensation.

VII. TERM

This LOA is without term and shall continue until such time as the parties mutually agree to amend or terminate it.

If you agree to the above NFFS Bargaining Framework LOA, please sign below.

James Turner
Executive Director
Ministry of Health

Bonnie Brossart
Chief Executive Officer
Saskatchewan Medical Association

Max Hendricks
Deputy Minister
Ministry of Health

Dr. Eben Strydom
President
Saskatchewan Medical Association

APPENDIX "2"

CONNECTED CARE / PATIENT'S MEDICAL HOME

The Patient's Medial Home (PMH) is a family practice defined by its patients as the place they feel most comfortable presenting and discussing their personal and family health and medical concerns. The themes and ten pillars of the PMH vision are as follows:

FOUNDATIONS

1. **Administration and Funding.** Practices need staff and financial support, advocacy, governance, leadership, and management in order to function as part of the community and deliver exceptional care.
2. **Appropriate Infrastructure.** Physical space, staffing, electronic records and other digital supports, equipment, and virtual networks facilitate the delivery of timely, accessible, and comprehensive care.
3. **Connective Care.** Practice Integration with other care settings and services, a process enabled by integrating health information technology.

FUNCTIONS

4. **Accessible Care.** By adopting advanced and timely access, virtual access, and team-based approaches, accessible care ensures that patients can be seen quickly.
5. **Community Adaptiveness and Social Accountability.** A PMH is accountable to its community, and meets their needs through interventions at the patient, practice, community, and policy level.
6. **Comprehensive Team-Based Care with Family Physician Leadership.** A broad range of services is offered by an inter-professional team. The patient does not always see their family physician but interactions with all team members are communicated efficiently within a PHM. The team might not be co-located but the patient is always seen by a professional with relevant skills who can connect with a physician (ideally the patient's own personal physician) as necessary.
7. **Continuity of Care.** Patients live healthier, fuller lives when they receive care from a responsible provider who journeys with them and knows how their health changes over time.
8. **Patient- and Family-Partnered Care.** Family practices respond to the unique needs of patients and their families within the context of their environment.

ONGOING DEVELOPMENT

9. **Measurement, Continuous Quality Improvement, and Research.** Family practices strive for progress through performance measurement and CQI. Patient safety is always a focus, and new ideas are brought to the fore through patient engagement in QI and research activities.
10. **Training, Education, and Continuing Professional Development.** Emphasis on training and education ensures that the knowledge and expertise of family physicians can be shared with the broader health care community, and also over time by creating learning organizations where both students and fully practicing family physicians can stay at the forefront of best practice.

APPENDIX "3"

RURAL EMERGENCY ROOM PILOT SITE STABILIZATION

ISSUE

The increasing clinical demands in some rural emergency rooms (ER) has been raised as a significant concern. These concerns are most often expressed in relation to on-call workload, compensation and training supports. These issues are in-turn affecting rural physician recruitment and retention and destabilizing emergency room services in rural Saskatchewan.

PROPOSAL

Establish an interim modernized approach to providing ER and hospital coverage service that maintains the following principles:

- addresses current workload concerns;
- improves physician job satisfaction and recruitment/retention;
- provides stability of ER services in rural Saskatchewan;
- provides resources to enhance local skills and leadership for Emergency Medicine, adapted for local priorities and,
- provides an expectation for ongoing emergency support for the surrounding communities, thus improving patient outcomes.

The key parameters of the proposed model are:

- 16 hour payment model for daytime/evening hours;
- physicians would no longer work in their clinics on days/times when they are covering the ER;
- phased in the model for up to nine sites based on the weighted criteria methodology developed through the Rapid Process Improvement Workshop (RPIW) on ER stabilization held in December 2019;
- availability of the after-hours clinic premium to all Saskatchewan clinics; and
- establishment of the following key expectations, through contracts or physician compacts, for all participating physicians:
  - provide a rotation of dedicated ER coverage;
  - respond to concerns/emergencies from the inpatient hospital wards, including after hours, providing work life balance for the other physicians in the community;
  - where determined locally by the physician group (in consultation with the SHA), perform daily rounds on inpatients, freeing up time for the other physicians to focus on primary care clinic patients;
  - be responsible for providing support to smaller surrounding communities, including responding to emergency calls and virtual ER presentations, which is expected to lead to less patients being transferred into busy tertiary or regional ERs from these smaller centres; and,
  - remain current in continuing education and skills training required to work in emergency situations (e.g. advanced life support, resuscitations, trauma).

REVIEW AND FEEDBACK

- On or before March 31, 2021, feedback will be sought from participating physicians, SMA, SHA, and Ministry of Health on how the pilot model is working in terms of:
  - Recruitment and retention;
  - Stability of ER coverage and workload;
  - Pros/cons of overnight on-call/compensation model;
  - Training and skills development support;
  - Local leadership presence/support specifically for Emergency Medicine;
  - Inpatient management/daily rounds; and,
  - Feedback will be considered for potential modifications to the model.

MODEL

Pilot an hourly rate model at $185/hr with a physician dedicated to the hospital (ER/inpatient outreach services) during daytime and evening hours;

- The Emergency Room Coverage Program (ERCP) stipend would be in addition to the hourly rate
  - $16.80/hour on weeknights (M-Th)
  - $41.80/hour on weekends/stats
- 16-hour payment model for daytime/evening hours
  - Physicians in community would still cover the ERs 24/7 or work collaboratively with the SHA to arrange for continuous coverage (e.g. locums).
  - 8am to midnight (for example) – hourly rate in effect (plus ERCP during ERCP billable hours).
  - Midnight to 8am (for example) – home-based on-call at regular compensation (FFS or contract) plus Emergency Room Coverage Program (ERCP) rates in effect (to cover low volume of patients).
- Under this model, physicians would no longer work in their clinics on days/times when they are covering the ER.
- Physicians covering ER, rounding on inpatients (where determined locally) and responding to inpatient emergencies will not be permitted to bill FFS or be paid under their Primary Health Care (PHC) contract during the hours they are receiving the hourly rate.
- The after-hours clinic premium would be made available to all Saskatchewan clinics.
- Supports for skills development for pilot sites (further ER training and support) to be covered largely through existing programs, such as the Committee on Rural and Regional Practice (CORRP) and the Quality & Access Fund. The design and model for skills maintenance/development will be collaboratively determined and supported by the SHA/SMA/Ministry and participating physicians;

PILOT SITES

Pilot up to nine sites based on the weighted criteria methodology developed through the Rapid Process Improvement Work (RPIW) on ER Stabilization (December 2019).

Based on the methodology, the following communities would be prioritized for **Phase 1**:

Community	Facility Designation	Current Comp Models	Funded NFFS and Typical # of FFS Physicians
Estevan	District	Mix	6 NFFS, 5 FFS (11 total)
Humboldt	District	FFS	12-15 FFS
Weyburn	District	Mix	4 NFFS, 10 FFS (14 total)
Melfort	District	FFS	12-14 FFS
Moosomin*	Community	Mix	3 NFFS, 6-7 FFS (9.5 total)
Nipawin	District	NFFS	11 NFFS

*Moosomin FFS docs have raised interest in moving to NFFS

Three communities included, based on the methodology, may need further consideration for **Phase 2**: (La Ronge and Meadow Lake based on their current compensation models; Kindersley based on lower volumes and physician numbers)

Community	Facility Designation	Current Comp Models	Funded NFFS and Typical # of FFS
La Ronge	Northern Community	Salaried physicians funded by NMS	13 employees (plus rotation of locums)
Meadow Lake	District	Similar NFFS comp model as proposed	12 NFFS
Kindersley	District	FFS	5 FFS

EXPANSION OF SITES ELIGIBLE FOR AFTER-HOURS PREMIUMS

- Currently fee-for-service physicians are limited in billing after-hours clinic premiums for office based practice. Only tertiary, regional, and bedroom communities are currently eligible in the payment schedule.
- The amount paid provides 10% premiums on services performed after 7pm and on weekends and stats.
- Expanding the eligibility to sites identified in the pilot could incentivize physicians to provide extended hours clinics, to help redirect patients from going to the ER for low acuity illnesses.
- Physicians who work nights while on-call could benefit from the option of an extended hours clinic, as it would allow them to start their clinic day later.

COST OF PROPOSAL

The annual cost of the proposal is estimated at $1M/site and takes into account:

- The hourly rate cost of $185/hr;
- FFS offsets;
- Incremental physician capacity that may be needed within the community with GPs in the hospital instead of their clinics;
- Support for skills development and leadership; and,
- Expansion of the availability of after-hours FFS clinic premiums.

BACKGROUND

- There are 65 designated facilities in Saskatchewan (59 with ERs or CECs):
  - 5 Provincial hospitals;
  - 6 Regional hospitals;
  - 9 District hospitals;
  - 4 Northern hospitals; and
  - 41 Community hospitals.
- The ERCP stipends are broken out in the payment schedule as hourly rates. ERCP rates are:
  - Category A (35 sites) - $16.80/hour on weekdays from 5pm to 8am and $41.80/hour on weekends/stats.
  - Category B (19 sites) - $8.50/hour on weekdays from 5pm to 8 am and $33.95/hour on weekends/statutory holidays.
- ERCP stipends are the same as the SECP (specialist) stipend on an annual basis ($200K for Tier 1/Category A and $150K for Tier 2/Category B), although ERCP stipends only cover after hours and weekends/stats, whereas SECP is spread across 24/7 coverage.

RPIW Background

- Through the Rapid Process Improvement Workshop (RPIW) on stabilization of ER services (December 17-19, 2019), weighted criteria was developed to help define "district hubs", or those sites with that would be "shored up" to address the service needs of that community and to support services for their surrounding area. This criteria included:
  - Acuity of care based on CTAS 1-3 ER presentations;
  - Inpatient volumes;
  - Primary care seeking patterns;
  - Number of physicians typically per community;
  - Distance to closest regional or tertiary site;
  - Provision of GP specialty services in the community (i.e., obs/surgery, anesthesia); and
  - Number of transfers to regional or tertiary centers by both air and ground.
- The RPIW also focused on minimum training standards for staff and physicians in district hubs (advanced trauma and cardiac life support, airways, etc.) and provider-to-provider virtual care support.

APPENDIX "4"

PAYMENT SCHEDULE MODERNIZATION

Pursuant to section 4(6) of the Agreement:

PHYSICIAN PAYMENT SCHEDULE MODERNIZATION PROJECT CHARTER (*DRAFT*)

1. Introduction

1.1 Purpose

The Saskatchewan Physician Payment Schedule lists payment codes that fee-for-service physicians use to bill the Medical Services Branch (MSB) for the provision of insured health services in Saskatchewan. It is a legacy document built upon a period spanning 30 years. There has never been a comprehensive review of the Payment Schedule to ensure it accurately reflects modern medical practice and supports appropriate service delivery.

With the rapid development of medicine, rising cost and demand for health services, the Ministry of Health (MoH) and the Saskatchewan Medical Association (SMA) [hereafter referred to as "the parties"] have a joint interest to modernize and improve the Physician Payment Schedule to support our physicians in maximizing health outcomes for patients through the best possible distribution of public resources.

1.2 Mandate and Objectives

The mandate of the project is to collaboratively develop and thereby consistently apply a principled methodical process to review, improve and modernize medically insured service codes in accordance with the strategic direction and goals of our health system. Expectations for the methodical process are that it be governed by a principled-based framework with the objective of achieving an improved payment schedule that supports the goal of patient first heath care and high quality, effective physician services, while balancing our commitment to a publicly funded and administered healthcare system.

Therefore, both parties agree that Modernization will be guided by a principled-based framework and consistently applied to support the achievement of the following four overarching goals and objectives:

- Aligning with the fundamental principles that underpin and advance the strategic direction and goals of our health system (i.e., better health, better care, better value and better teams);
- Outlining a principled fee code review process that is responsive to changes in technology, accurately reflects standards of care, and supports modern service delivery;
- Ensuring the best possible distribution of public resources, with a focus on patient-centered care, appropriateness, fairness and equity among and between physician groups; and
- Adding clarity and precision to billing and reporting services, allowing physicians to bill with confidence and support fair and effective audits.

1.3 Methodical Process

To achieve the above goals and objectives, both parties agree that three principles of accountability are to underpin and drive the modernization of the Physician Payment Schedule. The principles are to be

consistently applied; they are to be judged and weighed against each other, with attention given to the stipulation of "medically required".[1] The following three principles that govern Modernization are:

Principles	Performance Measures
Patient-centered Care	The individual payment code descriptors reflect current standards in the practice of medicine and best patient care (e.g., reflects new technologies; accepted medical section recommendations of Choose Wisely Campaign) to support our physicians in maximizing health outcomes.
Appropriateness (two dimensions): • Medically Required • Value for Money	Payment Schedule ensures "value for money" by appropriately compensating services or procedures (e.g., based on complexity; time involved; market comparisons) which, in the opinion of the profession, are medically required based on evidence-based clinical standard of care.
Fairness	Payment descriptors and fee amounts accurately reflects the actual service provided, are equitable among and between different physician groups, and clearly written in unambiguous language that supports fair and effective audits.

**See Lines of Enquiry to illustrate how the principles could guide the modernization of the Physician Payment Schedule.

** See Relativity of Fees for detailed examples of individual payment descriptor and fee codes which could be reviewed during the project and allocation process.

1.3 Scope

The scope of the project includes the review of all fee codes in the Payment Schedule as of April 1, 2015. In addition, the methodical process of modernization (i.e., three principles) would be used to assess any new or changes to existing few codes being considered through the regular process (i.e., PSRC, Tariff, and allocation).

Both parties agree that the scope will be constrained by the limitations of the current claims system. As such, improvements that are identified as having substantial IT implementation limitations (e.g., when extensive hardcoding by eHealth would be required because of many layers of rules and modifiers are necessary to claim each health service; adding another section; unbundling of surgical procedures; changing to ICD10; etc.,) will fall outside the scope of this project until such time as system limitations are overcome.

1.4 Key Project Linkages – Allocation Increases

Context

In July 2015, Saskatchewan physicians ratified a new four year contract (April 1, 2013 to March 31, 2017) between the Government and the SMA. The contract agreement includes two 1.5% lump sum retroactive payments (based on 2013-14 & 2014-15 gross billings) and a 1.95% and 2.95% Payment Schedule increase effective October 1, 2015, and April 1, 2016, respectively.

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[1] Importantly, both the *Canada Health Act* (Section 2) and the *Saskatchewan Medical Care Insurance Act* (Section 14(1)) stipulate that insured health services are "medically required" services.

The Ministry and the SMA agree upon the base fee-for-service payments to calculate the dollar amount to be allocated to the payment schedule that represents the negotiated percentage increase. The SMA, in consultation with their specialty sections, assigns percentage increases that will be allocated to each section, the sum of which represents the negotiated increase. The dollar amounts are then calculated with the section's specific percentage increase and made available to each section for allocation to their own fee section in the payment schedule. Historically, increases are not applied to all fee codes and each section largely decides which of their fee codes will receive allocation increases.

Both parties agree that the allocation process has a direct bearing on the Modernization Project scope of work, the ability to meet expectations and achieve the results intended of the project objectives. It is necessary to that the allocation process support and advance the current agreement's commitment to modernizing the payment schedule within the agreed-upon principles.

To that end, both parties agree to work collaboratively, to share information in a timely manner, and to consistently apply the methodical process of Modernization (i.e., the principles of patient-centered care, appropriateness, and fairness) within the existing allocation processes of both stakeholders.

1.5 Stakeholders

Project stakeholders include the following organizations:

- Saskatchewan Ministry of Health (MoH)
- Saskatchewan Medical Association (SMA)

1.6 Risk Management

The primary areas of project risk management and mitigation where identified pre-project:

Risk	*Impact*	*Mitigating Strategy*
(1) Project unable to meet deadlines &/or deliverables	(1) Sponsor and Stakeholder expectations are not met to the detriment of achieving the results intended of the project deliverables.	(1) *Milestone meetings* of Project Leads will be held with the Project Sponsors for the duration of the project. (2) *A quality project plan* (i.e., resourced, realistic, detailed, accurate) of tasks and deliverables will be established at project inception and reviewed at regular intervals. Timely notification of information requirements. (3) *Externalities* outside Project control (e.g. system &/or resource limitations) will be brought to the timely attention of the Project Sponsors.
(2) Project unable to consistently and effectively apply the methodology to the allocation process (e.g., IT and/or human resources limitations).	(1) Sponsor and Stakeholder expectations are not met to the detriment of achieving the results intended of the project deliverables. (2) Misses a valuable opportunity to modernize fee codes via the allocation process and further perpetuates the need to modernize fee codes.	(1) *Milestone meetings* of Project Leads will be held with the Project Sponsors for the duration of the project. (2) *A quality allocation plan* (i.e., resourced, realistic, detailed, accurate) of *prioritized* tasks and deliverables will be established at inception of allocation process and reviewed at regular intervals. Timely notification of information requirements. (3) *Externalities* outside Project control (e.g. system &/or resource limitations) will be brought to the timely attention of the Project Sponsors.

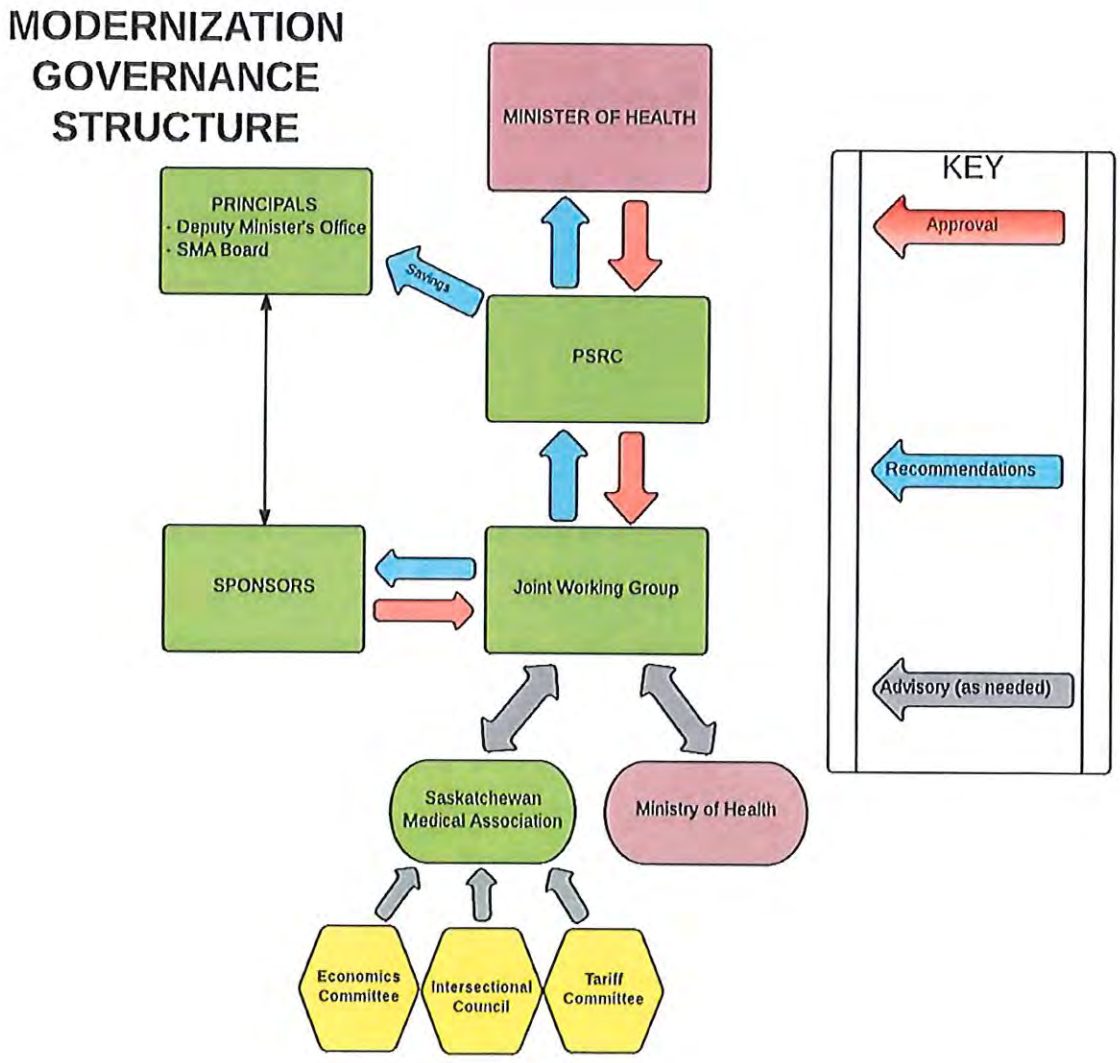
2. Project Management

The parties will establish a Committee to oversee the Modernization Working Group (the "Working Group").

The Project Sponsor on behalf of the Ministry of Health is the Executive Director, Medical Services Branch, Saskatchewan Ministry of Health.

The Chief Executive Officer, Saskatchewan Medical Association is the project sponsor on behalf of the Saskatchewan Medical Association.

2.1 Governance Structure



Principals

- The Minister of Health through the Deputy Minister.
- The SMA Board of Directors.

Payment Schedule Review Committee

The existing role of the Payment Schedule Review Committee (PSRC) established by regulations under *The Medical Care Insurance Act* will continue (i.e., to provide recommendations to the Minister on changes to the Physician Payment Schedule) and the membership of the PSRC will meet as required and with a separate modernization agenda as needed.

For ease of process and to provide continuity, the appointed membership of the PSRC will provide oversight to and decisions requested from the Modernization Working Group.

The following is how the PSRC will govern Payment Schedule Modernization:

The PSRC provides oversight and issue resolution to the Project Leads and the Working Group. The PSRC will meet as required to address emergent issues that require the PSRC's consideration, and at significant milestones. The mandate of the PSRC as it relates to Modernization is to:

- Approve project plan and provide advice and guidance on scope, timelines or project priorities that arise during all phases of the project;
- Provide recommendations on proposed changes to the Payment Schedule;
- Provide recommendations to the Principals regarding savings over $x (amount to be determined by the parties);
- Provide issue resolution on other matters referred to the PSRC by the Project Sponsors or Project Leads;
- Ensure the Project Leads are provided with all resources necessary to ensure the satisfactory and timely completion of the deliverables, including the assignment of staff resources to the Working Group; and,
- Ensure that all decisions are recorded and communicated to stakeholders.

All changes (i.e., additions, deletions, or amendments) to items in the Payment Schedule recommended by the PSRC are subject to the final approval/denial by the Minister of Health and Cabinet as per legislation.

All changes (i.e., additions, deletions, or amendments) to items in the Payment Schedule recommended by the Working Group are subject to the PSRC's approval/denial.

Working Group

Mandate

The mandate of the working group is to modernize the payment schedule according to the principles, goals and objectives listed in the Project Charter with the understanding that the PSRC will make the final decision.

The Working Group is a joint group that is structured to support a collaborative approach that includes members of the MoH and SMA. The Working Group is accountable to the Project Sponsors and the PSRC, and shall provide information as requested.

All new items or changes to existing items in the Payment Schedule are subject to Modernization analysis by the Working Group.

Meetings

The Working Group will meet at approximately monthly intervals (but may vary according to need) with an agenda that will include monitoring progress against achievement of project objectives, any problems or issues encountered and instances of fee codes modernized via the methodical process.

The Working Group, through the Project Leads, is expected to engage in on-going discussions between meetings as required.

The Project Leads will consult the membership to determine venues of meetings and teleconference will be made available. Minutes will be kept of each meeting and will be distributed in a timely manner

The Project Leads may invite other organizational representatives or other stakeholders to attend meetings, as required.
The membership of the Working Group, meeting frequency, reporting arrangements, etc., can be varied on the instructions of, or with the approval of, the Project Sponsors.

2.2 Terms of Reference

The roles and responsibilities of the Working Group will include:

- Project Leads
  - To facilitate Working Group communication and accomplishment of the project mandate and deliverables.
  - To work in a collaborative manner, consistent with the mandate and objectives of the Project Charter and with the advice of the Project Sponsors.
  - To identify and bring to the attention of the Project Sponsors any additional tasks that may be necessary in order to achieve a specific outcome.
  - Bring to the attention of the Project Sponsors any problems and issues that may adversely affect the timely accomplishment of allocated tasks, such as a lack of resources to meet deadlines, skill shortage in particular areas, etc.
  - Serve as the conduit through which information about the project is communicated to colleagues or other stakeholders.
  - To arrange and co-chair meetings of the Working Group.
  - To arrange appropriate communication and consultation strategies.
  - To prepare meeting agendas and prepare and distribute relevant materials.
  - To consult with and feedback to the organization represented by the Project Lead.
- Members
  - To actively participate in Working Group meetings.
  - To assist in the identification and collection of relevant data, analysis, and methodical assessment.
  - To identify and bring to the attention of the Project Leads any additional tasks that may be necessary in order to achieve a specific outcome.
  - Bring to the attention of the Project Leads any problems and issues that may adversely affect the timely accomplishment of allocated tasks, such as a lack of resources to meet deadlines, skill shortage in particular areas, etc.
  - To complete assignments as delegated by the Project Leads in a timely manner.
  - To work in a collaborative manner, consistent with the mandate and objectives of the Project Charter and with the advice of the Project Leads.

2.3 Time Table

The broad project deliverables and targeted completion dates are:

1. Phase 1 Guiding Principles – Now Completed.
2. Phase 2 Project Scope, Governance and Resourcing – by October 31, 2015.
3. Phase 3 Initial Fee Code Review & Allocation Implementation – by December 31, 2015.
4. Future Phases - The ongoing work and timelines of future phases have yet to be determined.

Each of the above phases will be managed as sub-projects, with an agreed set of deliverables and timescales. They will comprise a number of discrete tasks and activities with the aim of ensuring satisfactory and timely completion of the deliverables. The specific deliverables are:

- Phase I: Guiding Principles
  - Development of overarching goals and objectives of Modernization of the Physician Payment Schedule.
  - Development of the guiding principles that are to underpin and drive Modernization.
  - Share the guiding principles for feedback.
  - Reach formal agreement on the overarching goals and objectives of Modernization of the Physician Payment Schedule.
  - Reach formal agreement on the guiding principles of Modernization.

This phase is now complete.

- Phase II: Project Scope, Governance and Resourcing
  - Development of project scope and timelines.
  - Development of staff resource allocation.
  - Development of options for overall governance and approval mechanism.
  - Reach agreement on scope, timelines, governance and resourcing.

This phase is ongoing with an end date of October 31, 2015.

- Phase III: Initial Fee Code Review and Implement Allocation Increases
  - The aims of the initial review of fee codes will be to apply the methodical process and thereby identify:
    - JMPRC-flagged codes: codes that are unclear, ambiguous or difficult to support fair and effective audits;
    - Outdated codes: do not reflect new technologies, accepted standard of care or modern service delivery;
    - Inequitable codes: do not accurately reflect time required or complexity;
    - Codes with zero 2014-15 utilization rates: no longer necessary or in accordance with the standard of care; and,
    - Review of Hospital Care Codes
  - Engage physicians to review the diagnoses and service descriptions they use now and to identify the additional descriptions required to reflect the work they do.
  - Apply the agreed-upon allocation process for negotiated increases to be implemented into April 1, 2016 Payment Schedule.
  - Process changes will be defined and a plan developed for the next phase.

This phase is ongoing with an end date of December 31, 2015 for allocation implementation into April, 2016 Payment Schedule.

- Future phases
  - Begin consultation around billing education.
  - The work and timelines of future phases have yet to be determined.

2.5 Project Resources

To Be Determined.

Last Revised: November 19, 2015

Lines of Enquiry

- To achieve the project's objectives, the following lines of enquiry are being considered:
  1. Patient-Centered payment codes
     - Assess whether there is a gap in service coverage for patients and/or payment for physicians? And if so, does the gap in service of coverage cause an unreasonable financial and/or medical hardship for the patient or family?
     - Assess whether coverage for the service is provided in other jurisdictions.
     - Assess whether coverage been requested by other patients, patient advocacy groups, healthcare professional groups, or medical and nursing societies.
     - Assess whether the individual payment code descriptor reflects actual clinical practice and best patient care (e.g., reflects new technologies; section recommendations of Choose Wisely Campaign) and uses clear language not prone to varying interpretations (i.e., supports a fair and effective audit).
  2. Appropriateness of individual payment codes

     (I) Medically Required:
     - Assess whether the individual payment code descriptor reflects the accepted medical practice/standard of care.*
     - Review and validate that the payment code descriptor has not been superseded in clinical practice by more effective and professionally accepted techniques and thus no longer considered the best treatment in the opinion of the profession (i.e., that it's not considered outdated).
     - Review and validate that the service or procedure is not solely to satisfy cosmetic concerns.
     - Review and validate that there is credible, scientific evidence to support the fee code.

     (II) Value for Money:
     - Review and validate that the individual payment descriptor and fee amount reflects the service actually being provided (i.e. what is done, complexity, and how long it takes).
     - Assess whether the utilization of the code and fee amount reflects the accepted medical practice/ standard of care*.
     - Assess whether the individual payment code descriptor and fee amount reflect the technology currently being used to deliver the service.
     - Assess whether the individual payment code fee amount is in line with the relative value of other fee code payments.

3. Fairness: compensation and utilization of individual payment codes
   - Review and validate that the fee amount for the service actually being provided (i.e. what is done, complexity, and how long it takes) aligns with the relative value of other fee code payments across sections.
   - Assess whether the individual payment code descriptor uses clear language not prone to varying interpretations, which leaves physicians vulnerable during routine audits (i.e., supports a fair and effective audit).
   - Assess whether providing the service has undergone substantial changes (up or down) in practice expenses (e.g., important to consider relative impact on the code where time is reduced but overhead is increased).
   - Assess whether the utilization of the code reflects the accepted medical practice/ standard of care*.
   - Assess whether the utilization of the payment code is in accordance with the intent of the code.

   * Accepted medical practice/standard of care is defined as a diagnostic and treatment process/ guideline that a clinician should follow which specifies appropriate treatment (including the timing of treatment) for a certain type of patient, illness or clinical circumstance, based on scientific evidence and collaboration between medical professionals involved in the treatment.

Relativity of Fee

Some example of fee codes/principles to consider:

RELATIVITY OF FEE		
Payment Code	**Principle**	**Description of Issue**
Orthopedic Partial Assessment (7M) Orthopedic Initial Assessment (5M)	• Appropriateness • Fairness	• Currently, the 7M pays more than the 5M; however, it requires less payment criteria be provided. • Referred rate and non-referred rate are the same. • The standard is that referred rates are paid at a higher rate than non-referred services. • 7M fee was raised because the SMA identified that the utilization was higher; however, you have to look at related codes within the same context and the reasons for the higher utilization.
Internal Medicine Complete Assessment (3D) Internal Medicine Partial Assessment (5D)		• Currently, both the 3D and the 5D pay the same rate.
Plastic Surgery Follow up Assessment (7N)		• Both the non-referred and referred rate for 7N are the same
OBGYN Follow up Assessment (7P)		• Both the non-referred and referred rate for 7P are the same Consideration should be given when reviewing increases to fee codes requiring less payment criteria (i.e. initial assessments versus follow up assessments) Consideration should be given when reviewing increases to un-referred and referred rates, as referred rates should be higher.
Obstetrical scan for singleton pregnancy (40W) Obstetrical scan for twins (47W)	• Appropriateness • Fairness	• The single pregnancy ultrasound (40w) pays more than the twin pregnancy ultrasound (47W). • Consideration should be given when reviewing increases to fee codes requiring less criteria for the service

Payment Code	Principle	Description of Issue - Fee Code Application
Psychiatric Care (40E/41E)	• Appropriateness • Fairness	• Psychiatric care is not defined in the payment schedule and currently there is no descriptor listed for this service. • This results in varying interpretations and questions regarding appropriate application. • Without a clearly defined descriptor, the code cannot be audited or adjudicated.
Laparoscopy & arthroscopy (34P, 259M)	• Appropriateness • Fairness	• Laparoscopy and arthroscopy are both diagnostic tools used to view the inside of your body to diagnose a medical condition. • In the Gynecology Section laparoscopy (34P; tool used to view the inside of a woman's pelvis/abdomen) is not paid with laparoscopic surgery unless it precedes the surgery as a diagnostic procedure, which usually means it is not payable in conjunction with other surgeries when being done laparoscopically. • In the Orthopedic Section an arthroscopy (359M; tool used to view the inside of a person's joint) is payable in addition to other surgeries performed at the same time. • These diagnostic tools are essentially used for the same purpose; however, it is payable in one section and not payable in the other.

APPENDIX "5"

LETTER OF AGREEMENT OF VIRTUAL CARE

The SMA and Ministry of Health reserve the right to mutually agree to reduce, suspend or cancel these fee items, and/or make changes to the fees to ensure financial accountability and effectiveness.

INTENT

- The Ministry of Health and the SMA have a joint interest in improving patient access and health outcomes through technology for the provision of care with and on behalf of patients.

- The SMA and Ministry of Health agree to a Virtual Care Pilot Program, with the following considerations:
    - Service codes funded first via existing Whites of the Eyes surplus and then SMA Accumulated Programs Fund for the life of the agreement, estimated at $6M annually;
    - Commitment to implement temporary fee codes by January 1, 2021 or earlier via a staggered approach;
    - Commitment to monitor utilization of the temporary fee codes and negotiate adjustments/changes should expenditures trend over/under budget; and,
    - At the end of the program pilot (March 2022), the Ministry of Health commits to ensuring continuity and/or finalization of the services on the understanding that benefits to patients and physicians are realized and that mutually agreed upon adjustments may be needed in terms of utilization, costing assumptions, budget limitations and appropriateness.

- A Virtual Care Pilot allows for a higher degree of nimbleness to implement new or amend existing program service codes, monitor utilization, use trends, patient outcomes, and track costs, in order to adjust the program, if required.

OVERARCHING PRINCIPLES

- In developing the proposed virtual care fee codes, the SMA and Ministry of Health agree to the following broad considerations/principles:
    - Virtual care fee codes should support patient care close to home.
    - Virtual care fee codes should support physicians offering adjunct care to their own attached or referred patients.
    - Unattached patients should have access to virtual care services.
    - Telephone visit services are not equal or equivalent to an in-person visit. A physician is not expected to provide the same service as an in-person.
    - Telephone service code cannot be billed with any additional service codes.
    - Virtual Care visits require a synchronous clinical telephone/video discussion between the patient or the patient's medical representative and the physician.
    - Virtual Care visits may not be claimed for booking/notification of appointments or referrals.
    - Virtual Care visits may not be claimed when the physician leaves a message for the patient.

- Virtual Care visits are payable to a maximum of 3,000 services per physician per year, unless otherwise agreed to.
- Surcharges, out-of-hours premiums and age premiums not applicable, unless otherwise agreed to.
- It is the physician's responsibility to ensure that the service can be safely and appropriately delivered via video technology.
- Physicians will use these services to deliver a medically required service to enhance value-added patient care and their pattern of practice.
- Existing "visit services" assessment rules apply.
- Not payable in addition to another service on the same day for the same patient by same practitioner.
- Virtual Service codes are to be EMR eligible where applicable (i.e. consistent with existing "visit services" eligibility).

Note – The intent is to have a 'Virtual Care Pilot Payment Schedule' with a Preamble, overarching billing rules and each specific service code listed with additional principles/restrictions/considerations.

VIRTUAL CARE SERVICES

- The Ministry of Health and the SMA have agreed to implement the following services via temporary fee codes (further details in Appendix D.1: Virtual Care Pilot - List of Service Codes):
  - Physician-to-Patient visits via Telephone/Video - Assessments and follow-up visits for family physicians and specialists.
  - Patient-to-Physician Limited Virtual Care Visit via Video - A single encounter with a patient who is unattached to the clinic and where neither the physician nor patient have the expectation of an ongoing care relationship.
  - Physician-to-Patient consultations via Telephone/Video
  - Physician-to-Patient certification via Telephone/Video (e.g. Examination and certification of need for psychiatric examination pursuant to *The Mental Health Services Act*)
  - Physician-to-Patient counselling via Telephone/Video - family physician and specialist counselling and psychotherapy
  - Physician-to-Patient chronic disease management via Telephone/Video

- **This list of services prioritized Physician-to-Patient virtual care services and would add approximately 83 new virtual care service codes.**

FORECASTED RANGE OF COSTING & ASSUMPTIONS

- The Ministry and SMA agree the list of services is estimated to cost $6M annually.
- Utilization assumptions are required and were used with the understanding that the actual cost will vary based on patient and physician uptake, as well as the level at which virtual care visits replace existing in-person visits and timing of service code implementation. Utilization assumptions used to determine risk indicated that on the high end of the forecasted range, the basket of services could cost up to $8.5M annually.

Virtual Care Program - Additional Annual FFS Payments (estimated high range)

Service	Service Details	Rate	Incremental Cost
PHYSICIAN-to-PATIENT SERVICES			
Assessments and Follow-up Visits (telephone/video) - Family Physician	5B, 55B (no premiums)	90%	$ 4,100,000
Assessments and Follow-up Visits (telephone/video) - Specialist	Specialist Visits	90%	$ 940,000
Patient to Physician Limited Virtual Care Visit (unattached patients) - Virtual Clinic	30 Phys @ 1,500 services	70%	$ 1,102,500
Specialist Consultations (telephone/video)	(no premiums, surcharges, etc)	90%	$ (177,000)
Specialist Certification (telephone/video)		90%	$ 40,000
Family Physician Counselling		90%	$ 639,000
Specialist Counselling and Psychotherapy		90%	$ 1,229,000
Chronic Disease Management	DM, CAD, COPD, HF	90%	$ 654,000
TOTAL RECOMMENDED OPTIONS			$ 8,527,500

- The Ministry of Health and SMA recognize the complexity of creating and costing a potential basket of virtual care services. Therefore, the following assumptions were used to forecast the costing range:
  - Telephone/Video visits were costed using a rate of 90% of the April 1, 2020 payment schedule in-person rates (e.g. $31.85 for a virtual 5B), with some exceptions.
  - Utilization assumptions built in (20%-27.5% incremental virtual service growth depending on the service; 5-7.5% incremental in-person growth depending on the service; and offsets depending on the service provided).
    - There will be 'failed' virtual care visits that result in an in-person visit or a referral.
    - A proportion of virtual visits will be incremental to a physician's practice (new patients who did not want or could not access in person care).
    - A proportion of virtual visits will be for minor ailments that patients generally would have ignored.
    - A proportion of virtual visits will be for services that generally do not qualify as a full 5B (e.g. prescription renewal) but will still be billed.
  - There is a desire for enabling a new service for Virtual Care Clinic Visits (unattached patients) (e.g. a Virtual Clinic that provides service at a lower rate; 70% $24.50).
    - Allowing virtual visits creates a market for virtual clinics that did not exist previously and is largely incremental.
- Note: Other services such as Physician-to-Physician codes were discussed during negotiations. While these codes are not part of this initial package, the Ministry is willing to continue to review cost neutral opportunities with the SMA and implement additional temporary service codes outside of MCRC as appropriate.

Other Services Considered - Not Recommended		
ADD "Complex" Consult & Video Code to Specialist Visits	$	288,000
ADD Time of Day Premium to Specialist Consults	$	977,000
ADD 10% to Assessment and Follow-up Visits Rate (SMA original request)	$	4,700,000
ADD Physician-to-Physician Services		TBD
TOTAL NOT RECOMMENDED	$	5,677,000

PILOT REVIEW

- Evaluation of the virtual care pilot program will be done with the intention of reviewing/confirming costing assumptions, ensuring quality improvement, and appropriate utilization of service codes.
- The Ministry of Health and SMA commit to review utilization quarterly, which allows for a higher degree of nimbleness to implement new or amend existing program service codes, monitor utilization, use trends, patient outcomes, and track costs, in order to adjust the program, if required.

IMPLEMENTATION PLAN

- Commitment to implement temporary fee codes by January 1, 2021 or earlier via a staggered approach to be determined.

If you agree to the above Virtual Care LOA, please sign below.

James Turner
Executive Director
Ministry of Health

Bonnie Brossart
Chief Executive Officer
Saskatchewan Medical Association

Max Hendricks
Deputy Minister
Ministry of Health

Dr. Eben Strydom
President
Saskatchewan Medical Association

APPENDIX 5.1: Virtual Care Pilot - List of Service Codes

APPLICABLE CODES:

Virtual care services are only applicable to the existing payment schedule services listed in the table "Virtual Care Pilot – List of Service Codes". Titles, descriptors, service requirements, and assessment rules of existing service codes all apply to virtual services unless otherwise stated in the table below.

Virtual Care Pilot - List of Service Codes						
Section	Code	Description	Virtual Care Service does not include:	Rate (referred)	Rate (Non-referred	Approved for the following modalities:
Existing Applicable Codes						
B	5B	Partial Assessment of subsequent visit	d) examination of affected	$ 31.85		Telephone, Video
B	9B	Consultation	b) ... examination	$ 67.50		Telephone, Video
B	11B	Repeat Consultation	Physical examination	$ 32.75		Telephone, Video
B	40B	40B Counselling -- first 15 minutes	N/A	$ 33.75		Telephone, Video
B	41B	Counselling -- next 15 minutes or major portion thereof	N/A	$ 33.75		Telephone, Video
B	55B	Partial Assessment of subsequent visit involving a specialist referral	d) examination of affected	$ 31.85		Telephone, Video
C	5C	Partial assessment or subsequent visit	d) examination of affected	$ 58.25	$ 52.40	Telephone, Video
C	9C	Consultation	b) ... examination	$ 121.50		Telephone, Video
C	11C	Repeat consultation	Physical examination	$ 49.50		Telephone, Video
C	15C	Pediatric counselling - per first complete 15-minute time period	N/A	$ 43.20	$ 43.20	Telephone, Video
C	16C	Pediatric counselling - for each additional 15-minute time period, or major portion the	N/A	$ 43.20	$ 43.20	Telephone, Video
D	5D	Partial assessment or subsequent visit	d) examination of affected	$ 62.10	$ 42.90	Telephone, Video
D	9D	Consultation	b) ... examination	$ 131.60		Telephone, Video
D	11D	Repeat consultation	b) ... examination	$ 66.15		Telephone, Video
E	7E	Follow-up assessment	c) examination	$ 46.80	$ 39.30	Telephone, Video
E	9E	Adult consultation	b) ... examination	$ 219.80		Telephone, Video
E	10E	Child Consultation – 17 years of age and under	Physical examination	$ 241.55		Telephone, Video
E	11E	Repeat consultation	Physical examination	$ 96.30		Telephone, Video
E	31E	Psychiatric social interview	N/A	$ 45.90	$ 41.30	Telephone, Video
E	35E	Family Psychotherapy -- first 45 minutes	N/A	$ 145.90	$ 131.30	Telephone, Video
E	37E	Family Psychotherapy -- each subsequent 15 minutes or major part thereof -- bill units	N/A	$ 48.60	$ 43.75	Telephone, Video
E	38E	Individual Psychotherapy or psychiatric counselling -- minimum period of 30 minutes	N/A	$ 101.00	$ 90.90	Telephone, Video
E	39E	Individual Psychotherapy or psychiatric counselling -- each subsequent 15 minutes or	N/A	$ 50.50	$ 45.45	Telephone, Video
E	62E	Examination and certification of need for psychiatric examination pursuant to The Mental Health Services Act		$94.50		Telephone, Video
E	63E	Consultation, examination, patient history, admission to hospital and certification of mental ill health		$214.20	$192.85	Telephone, Video
E	64E	Consultation, examination and certification of mental ill health - second phychiatrist		$214.20	$192.85	Telephone, Video
E	66E	Repeat examination and recertification of mental ill health		$95.40	$85.85	Telephone, Video
E	67E	Repeat examination and recertification of mental ill health - second psychiatrist		$95.40	$85.85	Telephone, Video
E	68E	Consultation, examination and recertification of mental ill health when previous certifying psychiatrist is unavailable		$214.20	$192.85	Telephone, Video
E	70E	Completion of certification of mental ill health		$38.25	$34.45	Telephone, Video
E	73E	Necessary examination and certification for ECT on an involuntary patient		$38.25	$34.45	Telephone, Video
E	74E	Examination and certification for ECT on an involuntary patient - second psychiatrist		$38.25	$34.45	Telephone, Video
E	75E	Consultation, examination and certification for ECT on an involuntary patient who has not been seen by the psychiatrist in the preceding 42 days		$211.50	$190.40	Telephone, Video
E	100E	Psychiatric Care – Admitted Patient to a hospital or health care centre -- minimum of 1	N/A	$ 50.50	$ 45.45	Telephone, Video
E	101E	Psychiatric Care – Admitted Patient to a hospital or health care centre -- each subsequ	N/A	$ 50.50	$ 45.45	Telephone, Video
E	110E	Psychiatric Care – Patient not admitted to a hospital or health care centre -- minimum	N/A	$ 50.50	$ 45.45	Telephone, Video
E	111E	Psychiatric Care – Patient not admitted to a hospital or health care centre -- each subs	N/A	$ 50.50	$ 45.45	Telephone, Video

Virtual Care Pilot - List of Service Codes						
Section	Code	Description	Virtual Care Service does not include:	Rate (referred)	Rate (Non-referred	Approved for the following modalities:
Existing Applicable Codes						
F	7F	Follow-up assessment	d) examination of affected	$ 29.15	$ 28.05	Telephone, Video
F	9F	Consultation	b) ... examination	$ 75.50		Telephone, Video
F	11F	Repeat consultation	Physical examination	$ 40.80		Telephone, Video
G	7G	Follow-up assessment	b) necessary examination	$ 53.40	$ 48.05	Telephone, Video
G	9G	Consultation	a) ...examination	$ 153.00		Telephone, Video
G	11G	Repeat consultation	Physical examination	$ 73.70		Telephone, Video
H	9H	Major Consultation	Physical examination	$102.80		Telephone, Video
I	5I	Partial assessment or subsequent visit	d) examination of affected	$ 66.60	$ 45.85	Telephone, Video
I	9I	Consultation	b) ... examination	$ 134.75		Telephone, Video
I	11I	Repeat consultation	Physical examination	$ 64.70		Telephone, Video
K	7K	Follow-up assessment	d) examination	$ 46.80	$ 43.00	Telephone, Video
K	9K	Consultation	b) ... examination	$ 139.50		Telephone, Video
K	10K	Consultation -- spinal, routine	b) ... examination	$96.30		Telephone, Video
K	11K	Repeat consultation	Physical examination	$ 47.50		Telephone, Video
K	15K	Follow-up visit, spinal, routine	Physical examination	$ 42.05	$ 37.85	Telephone, Video
L	7L	Follow-up assessment	c) examination	$ 32.15	$ 32.15	Telephone, Video
L	9L	General, thoracic and vascular surgery consultation	b) ... examination	$ 103.50		Telephone, Video
L	11L	Repeat Consultation	Physical examination	$ 49.60		Telephone, Video
M	7M	Follow-up assessment	c) examination	$ 39.35	$ 39.35	Telephone, Video
M	9M	Consultation	b) ... examination	$ 86.95		Telephone, Video
M	11M	Repeat consultation	Physical examination	$ 33.50		Telephone, Video
N	7N	Follow-up assessment	c) examination	$ 35.65	$ 35.65	Telephone, Video
N	9N	Consultation	b) ... examination	$ 80.75		Telephone, Video
N	11N	Repeat consultation	Physical examination	$ 41.30		Telephone, Video
O	5O	Partial assessment or subsequent visit	d) examination of affected	$ 73.80	$ 59.05	Telephone, Video
O	9O	Consultation	b) ... examination	$ 176.20		Telephone, Video
O	11O	Repeat consultation	Physical examination	$ 96.30		Telephone, Video
P	7P	Follow-up assessment	c) examination	$ 28.60	$ 28.60	Telephone, Video
P	8P	Pre-natal visit subsequent to a first visit under 5P for maternity care or post-natal offi	Physical examination	$ 28.60		Telephone, Video
P	9P	Consultation	b) ... examination	$ 77.40		Telephone, Video
P	11P	Repeat consultation	Physical examination	$ 37.70		Telephone, Video
Q	5Q	Partial assessment or subsequent visit	d) examination of affected	$ 69.60	$ 48.00	Telephone, Video
Q	9Q	Consultation	b) ... examination	$ 144.65		Telephone, Video
Q	11Q	Repeat consultation	Physical examination	$ 77.05		Telephone, Video
R	7R	Follow-up assessment	c) examination	$ 31.80	$ 28.55	Telephone, Video
R	9R	Consultation	b) ... examination	$ 74.60		Telephone, Video
R	11R	Repeat consultation	Physical examination	$ 38.10		Telephone, Video
S	7S	Follow-up assessment	c) examination	$ 36.90	$ 31.80	Telephone, Video
S	8S	Neuro-ophthalmology follow-up assessment	c) examination	$ 42.30	$ 38.10	Telephone, Video
S	9S	Consultation	b) ... examination	$ 75.95		Telephone, Video
S	11S	Repeat consultation	Physical examination	$ 40.40		Telephone, Video
T	7T	Follow-up assessment	c) clinical examination	$ 45.45	$ 42.65	Telephone, Video
T	9T	Consultation	b) ... examination	$ 78.30		Telephone, Video
T	11T	Repeat consultation	Physical examination	$ 45.90		Telephone, Video
New Temporary Codes						
A	XXX	Limited Virutal Care Visit	Physical examination	$ 24.50		Video
B	XXX	Virtual Chronic Disease Management	Physical examination	$ 41.30		Telephone, Video

APPENDIX "6"

List of codes excluded from fee increases starting April 1, 2020:

1. On-Call Coverage: Payments to physicians who provide on-call coverage services to Provincial and Regional hospitals to assist in managing patient care. Service plans are developed by the SHA in conjunction with the physician coverage group and must be approved by the Emergency Room Coverage Committee (ERCP). These rates are traditionally negotiated separately. As with the surcharges and premiums, rates remain the same.
   (a) 717A-718A Family Physician On-Call Coverage

   (b) 708A-716A ERCP codes

2. Premiums and Supplements: Payment for age and time of day are considered percentage-based payments and are excluded from fee increases.

3. Percentage-based and Assist Codes: These surgical assist codes pay out at a percentage of the first surgeon's claim. While the first-surgeon claims are eligible to receive an increase, the percentage rates for these codes are not eligible for an adjustment. Applicable codes exempted from the fee increase are as follows:
   (a) 332J Surgical Assist (1/3)
   (b) 333J Surgical Assist (30%)
   (c) 334J Surgical Assist – Second assistant (30%)
   (d) 130I Electrophysiological study/ablation team fee (50%)
   (e) 616K Major decompression add-on (30%)
   (f) 618K Posterior decompression add-on (30%)
   (g) 677K Acute spinal cord injury (15%)
   (h) 331K Team spinal surgery (45%)
   (i) 681K Revision surgery add-on – decompression (30%)
   (j) 682K Revision surgery add-on – fusion (30%)

4. Cataract Fees: Due to improvements in technology, rates for these codes have been frozen. These codes should not receive an increase and the Ophthalmology Section should allocate any increase towards other services.
   (a) 135S, 136S Cataract Surgery
   (b) Ophthalmology diagnostic testing

5. Recently Modernized Items: These items are being tracked for cost neutrality and have been modernized at a rate both parties deemed fair and appropriate. The parties agree to restrict fee increases for recently modernized items for the October 2020 allocation. Other consideration/details include:

   (a) Psychiatry - 9E, 10E, 38E, 39E, 50E, 100E, 101E, 110E, & 111E
      (i) 9E, 10E - the SMA agrees with these restrictions for October 1, 2020 allocation only (i.e., not restricted for April 1, 2021 allocation)

(ii) 38E, 39E, 100E, 101E, 110E, & 111E – price increases restricted to maintaining existing price relativity between these specific codes (i.e. these codes may receive an equal proportional increase)

(iii) 50E – the SMA agrees that no price increase may be applied to this code; further price decreases may be applied.

(b) Orthopedics – 379M, 437M, 449M, 460M, 462M, & 467M

(i) Restrict allocation for October 1, 2020 allocation only (i.e. not restricted for April 1, 2021 allocation)

(c) General Practice – Special Care Home Management (627A, 628A, 629A)

(i) Restrict allocation for October 1, 2020 allocation only (i.e. not restricted for April 1, 2021 allocation)

(d) Neurosurgery – 331K, 9K, 25K, 26K, 27K & 28K

(i) Restrict allocation for October 1, 2020 allocation only (i.e., not restricted for April 1, 2021 allocation)

(e) Internal Medicine – 601D, 603D, 611D, 613D

(i) Restrict allocation for October 1, 2020 allocation only (i.e., not restricted for April 1, 2021 allocation)

6. Technical Fees: exclude from fee increases.

SCHEDULE "A"

RURAL AND REGIONAL PROGRAMS AND INCENTIVES

Programs and incentives developed pursuant to section 12(6)(a) of the Agreement; shall:

1. Be developed and monitored through a committee of the Board, entitled the "Committee on Rural and Regional Practice" established pursuant to the agreement dated April 24, 1997;

2. Be administered through program agreements which shall be approved by the Board and the Minister;

3. Further the Board agrees:

   (a) that any funds recovered by the Minister through enforcement of obligations under any program agreements shall be the property of the Minister.

   (b) the Board and Minister may, by exchange of mutual correspondence, agree that any future programs or incentives developed between them to enhance the provision of physician services in Saskatchewan will be governed by the terms of this Agreement.

Rural and regional incentives in existence at the onset of this Agreement:

- Family Medicine Residency Bursary Program
- Rural Practice Enhancement Training
- Rural Emergency Care - Continuing Medical Education
- Locum Service (Rural Relief/Weekend Relief Program)
- Rural Travel Fund
- Rural Extended Leave Program
- Special Needs Loan Program
- PREP
- Clinical Skills Program
- Roadmap
- High School Outreach program (proposed)
- Lifestyle Benefit Program (proposed and pending)
- Rural and Regional Practice Establishment Program (suspended)

SCHEDULE "B"

CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) REIMBURSEMENT FUND ELIGIBILITY

Pursuant to section 12(4)(a) of the Agreement:

Eligible Physicians:

Eligible physicians must:

- Reside and practise in the province of Saskatchewan during the period in which reimbursement is being claimed;
- Hold regular, provisional, or Ministerial licensure with the College of Physicians and Surgeons of Saskatchewan under section 28 of the Medical Profession Act;
- Receive the majority of their income through fee-for-service payments from the Saskatchewan Medical Services Plan and meet the minimum billing thresholds (see below), **or** receive a majority of their income providing clinical/insured services in Saskatchewan under a salary, contract or blended funding arrangement and meet the minimum practice activity thresholds (see below), **or** are working under a salary or self-employment contract as a physician leader at either the Saskatchewan Health Authority, Saskatchewan Cancer Agency, or College of Medicine and have some expectations of providing clinical/insured services either as part of the contracted FTE or as a condition of hire;
- Meet the criteria for full or Part-time pro-rated entitlement set out below; and
- Not receive reimbursement of CMPA dues from an employer or any other third party.

Minimum Payment Requirements for CMPA Reimbursement

A. Fee-For-Service Physicians:

Full entitlement

The threshold of Medical Services Plan (MSP) payments required to qualify for full entitlements is $60,000 per year. Eligible physicians who meet the full-time billing threshold will be reimbursed to a maximum of 100 percent of the actual costs of their dues less $1,000 during the period in which they resided and practiced in Saskatchewan.

Part-time pro-rated entitlement

The minimum threshold of MSP payments to qualify for a part-time pro-rated entitlement is $30,000 per year. For physicians who receive payments between $30,000 and $60,000, the pro-rated entitlement is calculated using the following formula:

(Physician's total payments/$60,000) multiplied by the cost of CMPA coverage less $1,000 for the period in which the physician was otherwise eligible for the program.

B. Salaried, Contracted or Blended (fee-for-service and contract/salary) Physicians:

Full entitlement

The minimum threshold required to qualify for full entitlements is $60,000 per year. Eligible physicians who meet the full-time threshold will be reimbursed to a maximum of 100 percent of the actual costs of their dues less $1,000 during the period in which they resided and practised in Saskatchewan.

Part-time pro-rated entitlement

The minimum threshold required to qualify for a part-time pro-rated entitlement is $30,000 per year. For physicians earning between $30,000 and $60,000, the pro-rated entitlement is calculated using the following formula:

> (Physician's annual clinical income/$60,000) multiplied by the cost of CMPA coverage less $1,000 for the period in which the physician was otherwise eligible for the program.

For the 2020 calendar year and for each calendar year thereafter that the Agreement is in force, the amount to be made available by the Minister will be the actual cost for that calendar year of CMPA re-imbursement eligibility under this Schedule for all eligible physicians in the year less an amount derived by multiplying the number of such physicians by:

(a) in the case of eligible physicians that qualify for full entitlement, $1000 per physician; and,

(b) in the case of eligible physicians that qualify for part-time pro-rated eligibility, $1000 per physician multiplied by:

   a. the same percentage of income or hours which is applied to that physician to calculate his/her CMPA reimbursement eligibility under this Schedule; or;

   b. the same portion of a year that the physician has resided and practiced in Saskatchewan and which applies to calculate the physician's CMPA reimbursement eligibility under this Schedule.

SCHEDULE "C"

SASKATCHEWAN MEDICL ASSOCIATION (SMA)
CONTINUING MEDICAL EDUCATION FUND

Pursuant to section 12(4)(b) of the Agreement:

Purpose

The purpose of the Continuing Medical Education Fund is to promote quality patient care by maintaining and advancing the skills of Saskatchewan physicians.

Eligible Physicians

In order to apply for monies from the CME Fund a physician must:

1. Be licensed and reside in Saskatchewan; and

2. Provide insured clinical services in Saskatchewan that meet the thresholds for eligibility (see below) or be in an approved medical administrative position.

Benefits

Full-time benefits apply when:

- The Physician has an employment or other alternate remuneration arrangement during the fiscal year and has earned a minimum of $60,000 per year; or

- The Physician is engaged as a fee-for-service physician during the fiscal year and received a minimum of $60,000 per year in gross revenues from the practice of medicine.

Part-time (half) benefits apply when:

- The Physician has an employment or other alternate remuneration arrangement during the fiscal year and earns a minimum of $30,000 per year; or

- The Physician is engaged as a fee-for-service physician during the fiscal year and received a minimum of $30,000 per year in gross revenues from the practice of medicine; or

Advisory Committee

1. The CME Fund shall be administered by the Board through an Advisory Committee which shall be comprised of:

   (a) two members appointed by the Board; and
   (b) two members appointed by the Minister.

2. The Advisory Committee shall have the following responsibilities:

   (a) to supervise the administration of the CME Fund;
   (b) to determine eligibility of physicians who apply for benefits;
   (c) to rule on the appropriateness of specific proposals for use of funds by eligible physicians;
   (d) to suggest new methods by which continuing medical education of physicians may be improved and facilitated in the future;
   (e) to submit an annual report to the Board and Minister; and
   (f) such other matters pertinent to the operation of the Fund as may be agreed upon from time to time in consultation with the Board.

Administration

The SMA secretariat will be responsible to the Advisory Committee for the administration of the CME Fund.

1. The SMA shall receive and process applications from eligible physicians for medical education benefits and the SMA shall pay to eligible physicians an amount up to but not more than that eligible physician's maximum entitlement in accordance with the approvals granted by the Advisory Committee.

2. An eligible physician may accumulate part or all of the annual entitlements but at no time shall the amount accumulated exceed the current year's entitlement and the entitlement from the previous year as defined in 3 below.

3. (a) Each year's eligible physician entitlement is discrete and accumulated separately;
   (b) The entitlement not used in the current year may be accumulated for one year;
   (c) The entitlement accumulated for more than one year expires; and
   (d) The maximum an individual can have available for use would be the current year's entitlement plus the previous year's entitlement.

4. All monies remaining in the CME Fund at the end of a calendar year shall remain in and be administered as part of, the CME Fund pursuant to the provisions herein set out, unless otherwise agreed by the Minister and the Board.

5. Administration Costs:

The SMA may use the lesser of 4 percent of the aggregate maximum eligible physician entitlements (as may be increased from time to time in respect of that calendar year), or the actual amount of the administration costs incurred in that calendar year subject to the direction of the Advisory Committee.

Distribution of the Fund

1. Annual entitlements to individual qualifying physicians will be as follow:
    a. Full-time - $3,000 per year
    b. Part-time - $1,500 per year

2. Use of the CME Fund for continuing medical education encompasses such learning situations as recognized conventions, courses in hospital clinical programs, libraries, tapes, CME software and data services, audio visual aids, etc. Funds obtained for accepted courses will cover such costs as travel, registration, living expenses and consideration of the applicants' on-going practice overhead costs. It is recognized that such continuing education resources that an eligible physician utilized must be appropriate to the physician's particular practice or specialty.

SCHEDULE "D"

SPECIALIST EMERGENCY COVERAGE PROGRAM (SECP)

Pursuant to Section 8(1)(a) of the Agreement:

Program Description

1. The primary objective of the program is to meet the emergency medical needs of new or unassigned patients requiring specialty care and to ensure that specialists providing coverage as part of an established call rotation are fairly compensated for being available to provide this service.

2. The program is jointly managed by a tripartite Implementation Committee with representation from the Saskatchewan Medical Association, the SHA and the Ministry of Health. The Committee is accountable to and provides advice to the Minister and the Board.

3. Final decisions regarding service locations (services, rotas, facilities, regions) will be made by the Ministry of Health.

Coverage

1. Subject to recommendation and advice of the Implementation Committee, two categories are identified:

    a) Tier I – Physicians participating in a Tier I call rotation are expected to provide continuous coverage (365 days, 24 hours per day) and must be available to respond by telephone within 15 minutes and be able to be on-site within 30 minutes.

    b) Tier II – Tier II call coverage can be either continuous or non-continuous in nature. A physician(s) participating on a Tier II rotation must be available to respond by telephone within 15 minutes and be on site within a reasonable time. (The appropriate on-site response time will be dependent on the clinical judgment of the physician on-call and will vary between specialties and with the specific requirements of each case.)

Program Parameters and Policies

1. The Implementation Committee shall advise on and recommend policies and procedures for administration of the program including, but not restricted to, policies and procedures regarding:

    a) new or unassigned patients
    b) frequency of call
    c) participation on multiple call rotations and in multiple emergency coverage programs
    d) audit and accountability
    e) claims assessment and adjudication
    f) eligibility of physicians
    g) program payments and administration
    h) interruptions in coverage

SCHEDULE "E"

EMERGENCY ROOM COVERAGE PROGRAM (ERCP)

Pursuant to Section 8(1)(b) of the Agreement:

Program Principle

The Minister and Board wish to maintain a program to improve and stabilize the provision of emergency room coverage in rural Saskatchewan.

The Minister and the Board agree to work collaboratively to ensure the integrity of an emergency coverage program that will efficiently and effectively address the emergency care needs of Saskatchewan residents.

Emergency Coverage Committee

1. The Minister and the Board agree to maintain a committee with representation from the Ministry of Health, the Saskatchewan Medical Association and the SHA for the purposes of developing and refining the criteria related to the categorization of health facilities, including the criteria and operation of any supportive program such as the weekend rural relief program announced in February of 1997.

Levels of Emergency Room Coverage

1. The requirements for emergency room coverage will vary by community and will depend upon the size of the catchment area and population served, geographic location, the ability to respond to and provide a comprehensive range of emergency services, the availability of physicians and other health professionals, resources, and the emergency room coverage plan of the SHA.

2. Rural health facilities shall be designated by category with varying emergency room coverage requirements:

   Category A -- these are acute care facilities serving a large catchment area and with high volume emergency departments. They provide a broad range of emergency and other acute care services and generally have three or more physicians. Generally, these facilities serve as primary emergency centres within a geographic region or the SHA.

   Category B -- these are smaller acute care facilities or health centres that the SHASHA has designated as requiring 24 hour physician coverage. These facilities serve a smaller population and have low to medium emergency volumes. Generally, these facilities have fewer than three physicians providing a limited range of emergency and acute care services.

3. The criteria for categorization will be determined through a collaborative process involving the SHA, the Ministry of Health and the Saskatchewan Medical Association and administered by the Committee.

Emergency Coverage Expectations

1. **CATEGORY A** - Physicians who participate in the emergency coverage rota are eligible for payment. It is expected that the rota will be configured so as to ensure that an on-call physician will:

   (a) remain on-call at all times and will be available to respond in person to all emergency or emergent cases within 15-30 minutes, 24 hours a day, 7 days per week; and

   (b) provide telephone/triage consultation to nursing units, ambulance attendants, health centres and other hospitals as required.

2. **CATEGORY B** - to be eligible for payment the physicians agree, where possible, to participate in a shared call arrangement of 1 in 3 and to provide coverage for the designated sites. In the event that the call rotation exceeds 1 in 3, regions/physicians may wish to explore alternative coverage plans, access the weekend on-call relief program or may receive additional payment within the parameters of the weekend on-call relief program. Further, it is expected that the region plan will ensure:

   (a) one physician will remain on-call and will be available to respond in person to all emergency or emergent cases within *30-45 minutes, 24 hours a day, 7 days per week.* This may include more than one facility if two communities are within 30-45 minutes and is subject to advice from the College of Physicians and Surgeons of Saskatchewan; and

   (b) provide telephone/triage consultation to nursing units, ambulance attendants, health centres and other hospitals as required.

Administration

1. The SHA, in consultation with other stakeholders, will be asked to provide plans for emergency room coverage that utilize physician and other resources effectively to meet the emergency needs of the population served. Plans will include the facilities designated as requiring 24 hour physician coverage and shall be based on an emergency coverage plan developed and implemented by the authorities in collaboration with local physicians and the Ministry of Health. These plans may change over time and adjustments will be made accordingly. Collaboration within and between regions is encouraged. It is also expected that physicians will participate in region planning and protocols related to the efficient delivery of emergency services within the region(s).

2. Pursuant to Section 88 of the Agreement, rates of payment for emergency coverage are as follows. Funding provided pursuant to this program is in addition to the normal payments for services rendered:

(a) In **CATEGORY A** centres, one physician will be designated as the roster physician for emergency coverage. For each hour covered below the designated physician will be eligible to bill the Medical Services Plan for the following:

	April 1, 2013
Weekdays (evenings and nights from 5 p.m. to 8 a.m., Monday through Thursday, including from midnight to 8 a.m. Friday morning) per complete hour.....	$16.75
Weekends (Friday 5 p.m. to Monday 8 a.m.) per complete hour.....	$41.75
Statutory Holidays (or designated days in lieu) (5 p.m. on the day prior to the Statutory Holiday or designated day in lieu, to 8 a.m. the day following the statutory holiday or designated day in lieu) per complete hour	$41.75

(b) In **CATEGORY B** centres, one physician will be designated as the roster physician for emergency coverage. For each hour covered below the designated physician will be eligible to bill the Medical Services Plan for the following:

	April 1, 2013
Weekdays (evenings and nights from 5 p.m. to 8 a.m., Monday through Thursday, including from midnight to 8 a.m. Friday morning) per complete hour.....	$ 8.50
Weekends (Friday 5 p.m. to Monday 8 a.m.) per complete hour.....	$33.90
Statutory Holidays (or designated days in lieu) (5 p.m. on the day prior to the Statutory Holiday or designated day in lieu, to 8 a.m. the day following the statutory holiday or designated day in lieu) per complete hour	$33.90

3. Claims submitted pursuant to sections 2(a) and 2(b) will be subject to assessment and verification procedures applied by the Medical Services Plan.

Weekend Relief Program

1. **CATEGORY A** centres will generally have 3 or more physicians providing emergency coverage would not qualify for assistance under the Weekend Relief Program. CATEGORY A centres eligible for financial assistance under this Program will be determined by mutual agreement of the Minister and the Board.

2. **CATEGORY B** designated centres with fewer than 3 physicians will continue to qualify for assistance under the parameters outlined in the Weekend Relief Program. However, the establishment of rural practice arrangements with neighbouring communities that reduce the need to access the Weekend Relief Program are encouraged.

SCHEDULE "F"

PARENTAL LEAVE BENEFITS

Pursuant to Section 12(4)(d) of the Agreement:

Purpose

To assist in the recruitment and retention of Saskatchewan physicians by providing parental leave benefits to physicians who do not currently have access to parental leave benefits.

Eligibility and Amounts Available

- To be considered for benefits, a physician must:

  (a) be licensed with the College of Physician and Surgeons of Saskatchewan under Section 28 of *The Medical Profession Act;*

  (b) be a resident in Saskatchewan and be providing insured clinical services in Saskatchewan for 26 weeks prior to the date of birth/adoption; and

  (c) be self-employed.

General Information

Timeframes

- Where the physician gives birth (maternity leave), benefits can begin as early as five weeks before the expected date of delivery.

- The leave must begin within three months of the delivery/adoption date. Application for benefits under the program must be submitted within 6 months from the delivery/adoption date.

Process

- Physicians are asked to fill out a registration form to determine initial eligibility.

- If practice requirements are met, to access weekly benefits, physicians are required to fill out a claim card declaring earnings in each week that a claim is made. Multiple weeks may be submitted on a single form.

- Physicians may be asked to provide additional information to substantiate their claims.

Benefits

- Physicians receive 50 percent of their average weekly income earned over the past six months, to a maximum of $1,300 per week.

- Physicians receiving benefits, supplements or income from another source during their claim period may have benefits reduced. Income earned from other sources must be less than $ 2,000 per week, for a combined income (from external sources plus this program) of $3,300 per week. The program benefits would be reduced dollar-for-dollar for combined income in excess of $3,300 per week.

- Physicians who qualify for the program are eligible to receive up to 20 weeks of benefits.

Advisory Committee

The Minister and the Board agree to form a committee with two representatives from the Ministry of Health and two representatives plus chairperson appointed by the Saskatchewan Medical Association for the purposes of:

- making recommendations regarding changes to program parameters;

- reviewing and approving financial statements for this program; and

- determining rules for hearing of appeals, and hearing and adjudicating appeals.

Decisions made by the advisory committee will be considered final.

SCHEDULE "G"

PHYSICIAN RETENTION FUND

Pursuant to Section 12(4)(c) of the Agreement:

1. Description

The Physician Retention Fund is a program designed to encourage the long-term retention of physicians in Saskatchewan. Physicians who practise in Saskatchewan for a defined period of time will qualify for annual entitlements that will be paid to them as outlined in Section 9.1(d).

2. Eligible Physicians

The Saskatchewan Medical Association and Government of Saskatchewan have established a Physicians' Retention Fund (the "Fund") for the purpose of providing benefits to promote and facilitate the retention of physicians in the Province of Saskatchewan.

The parties agree to the following description of eligibility criteria for benefits under the Fund:

1. DEFINITIONS

For the purposes of this document the following terms shall have the following meanings ascribed to them:

a) ***"Base Rate"*** for a Physician means such amount as the Board determines from time to time dependent upon years of service in the province of Saskatchewan.

b) ***"Board"*** means The Physician Retention Fund Board.

c) ***"Continuous Service"*** shall mean being engaged in the practice of medicine without an interruption in service as defined in this document. Temporary interruptions such as maternity leave are acceptable and are defined as "Allowable Breaks in Service" as described in further detail in section 3.1.

d) ***"First Vesting Date"*** describes the first date a Payee has a legitimate right to claim for benefits and receive payments from the Fund. The First Vesting Date for most Payees will be 10 years from their start of practice in Saskatchewan or 2011, whichever is longer, unless a Physician has become deceased, disabled or retired before their Vesting Date.

e) ***"Payee"*** refers to person entitled to receive the payout of benefits in accordance with section 2.1.

f) ***"Physician"*** refers to an individual holding a medical license with the College of Physicians and Surgeons of Saskatchewan after April 1, 2001, whether that individual is providing medical services as an individual or through a Professional Corporation.

g) ***"Professional Corporation"*** shall refer to a body corporate incorporated under The Medical Profession Act, 1981 (Saskatchewan) of which a Physician is a shareholder and director and through which the same Physician has been engaged in to practice medicine.

h) ***"Subsequent Vesting Date"*** means the day upon which a Payee's entitlement to benefits vests for a fiscal year accruing after the First Vesting Date, being the day after the end of the fifth fiscal year after the First Vesting Date, and in five year intervals thereafter.

i) ***"Vesting Date"*** refers to the date when a Payee has the legitimate right to claim benefits and receive payments from the Fund.

2. ELIGIBILITY TO ACCUMULATE BENEFITS

A Payee will be eligible to accumulate benefits when,

1) in the case of a Payee who is Physician providing medical services as an individual:

   a) the Physician resides in Saskatchewan; and

   b) the Physician:

      i) provides insured clinical services that meet the thresholds for eligibility; or

      ii) is in a medical administrative position approved by the Board.

2) in the case of a Payee that is a Professional Corporation through which a Physician is providing medical services:

   a) the Physician engaged by the Professional Corporation resides in Saskatchewan; and

   b) the Physician engaged by the Professional Corporation:

      i) provides insured clinical services that meet the thresholds for eligibility; or

      ii) is in a medical administrative position approved by the Board.

2.1 **Payment to Professional Corporation**

Where an individual has been engaged to practice medicine through a Professional Corporation of which he or she is director, the entitlement to benefits shall accrue to the benefit of the Professional Corporation as Payee in accordance with the following guidelines:

a) If the individual Physician is practicing medicine through a Professional Corporation at the Vesting Date, the Professional Corporation shall be the Payee;

b) If the individual Physician is not practicing medicine through a Professional Corporation at the Vesting Date, the individual Physician shall be the Payee.

For greater certainty, the determination of who shall receive benefits shall be made based on whether the individual Physician is or is not practicing medicine through a Professional Corporation at the Vesting Date, regardless of how the individual Physician was otherwise practicing medicine throughout the accrual period.

2.2 **Full Entitlement**

A Payee will meet the criteria for "Full Entitlement" where either:

a) the Physician has an employment or other alternate remuneration arrangement during the fiscal year and has provided an average of at least twenty (20) hours service or more per working week or have met the following criteria for the minimum in gross revenues from the practice of medicine:

    i) for fiscal years falling in the period April 1, 2001 to March 31, 2006, the Physician earns Forty Thousand ($40,000) Dollars or more in gross revenues during the fiscal year from practising medicine; or

    ii) for fiscal years after April 1, 2006, the Physician earns Sixty Thousand ($60,000) Dollars or more in gross revenues during the fiscal year from practicing medicine.

b) the Physician is engaged as a fee-for-service physician during the fiscal year and meets the following criteria for the minimum in gross revenues from the practice of medicine, as applicable:

    i) for fiscal years falling in the period April 1, 2001 to March 31, 2006, the Physician earns Forty Thousand ($40,000) Dollars or more in gross revenues during the fiscal year from practising medicine; or

    ii) for fiscal years after April 1, 2006, the Physician earns Sixty Thousand ($60,000) Dollars or more in gross revenues during the fiscal year from practicing medicine.

Commencing on April 1, 2001, on the completion of each fiscal year, a Payee who qualifies for Full Entitlement for the fiscal year shall have accrued the following applicable amount, without interest:

a) for a Physician with Continuous Service of ten (10) years or less at the beginning of a particular fiscal year, an amount equal to the Base Rate for years one through ten (10);

b) for a Physician with Continuous Service in excess of ten (10) years but less than twenty (20) years at the beginning of a particular fiscal year, an amount equal to 150% of the Base Rate of years ten (10) through twenty (20); and

c) for a Physician with Continuous Service for over twenty (20) years or more at the beginning of a particular fiscal year, an amount equal to 200% of the Base Rate for years twenty-one and thereafter.

In the event that a Payee would have qualified for Full Entitlement for the fiscal year if the Physician had maintained service in the province as a practicing Physician but did not maintain practice for reasons of retirement, disability or death, the Payee shall be entitled to a pro-rated portion of the Full Entitlement amount for the portion of the fiscal year in which the Physician had service as a practising Physician in the Province of Saskatchewan. The full-time threshold will also be pro-rated accordingly. As an example, if a Physician entered practice on October 1st, 2006 the Full Entitlement earned by this Physician would be 50 percent of the base rate of $3,500. The threshold for full time activity would be 50 percent of annual full-time threshold of $60,000.

Where a Physician completes his/her 10th year of practice mid way through a fiscal year, the Payee will receive an entitlement based upon the weighted average of the two rate categories that the Payee straddles. As an example, a full-time Physician whose 10 year anniversary falls on October 1st of 2001 would receive an entitlement based upon the following formula:

(6months/12months)*base rate + (6months/12months)*base rate* 150%

2.3 **Half Entitlement**

A Payee will meet the criteria for "Half Entitlement" where:

a) the Physician has an employment or other alternate remuneration arrangement during the fiscal year and provides an average of at least ten (10) but less than twenty (20) hours service per working week or meets the following criteria for the minimum in gross revenues from the practice of medicine, as applicable:

   i) for fiscal years following in the period April 1, 2001 to March 31, 2006, the Physician earns more than Ten Thousand ($10,000) Dollars

but less than Forty Thousand ($40,000) Dollars in gross revenues during the fiscal year from insured clinical services;

ii) for fiscal years after April 1, 2006, the Physician earns more than Thirty Thousand ($30,000) Dollars but less than Sixty Thousand ($60,000) Dollars in gross revenues during the fiscal year from insured clinical services.

b) ; or

c) the Physician is engaged as a fee-for-service physician during the fiscal year and meets the following criteria for the minimum in gross revenues from the practice of medicine, as applicable:

i) for fiscal years following in the period April 1, 2001 to March 31, 2006, the Physician earns more than Ten Thousand ($$10,000) Dollars but less than Forty Thousand ($40,000) Dollars in gross revenues during the fiscal year from insured clinical services;

ii) for fiscal years after April 1, 2006, the Physician earns more than Thirty Thousand ($30,000) Dollars but less than Sixty Thousand ($60,000) Dollars in gross revenues during the fiscal year from insured clinical services.

Commencing on April 1, 2001, on the completion of each fiscal year, a Payee who qualifies for Half Entitlement for the fiscal year shall have accrued one-half the amounts stipulated under "Full Entitlement".

In the event that the Payee would have qualified for Half Entitlement for the fiscal year if the Physician had maintained service in the province as a practicing Physician but did not maintain practice for reasons of retirement, disability or death the Payee shall be entitled to a pro-rated portion of the Half Entitlement amount for the portion of the fiscal year in which the Physician had service as a practising Physician in the Province of Saskatchewan. See example under "Full Entitlement".

Where a Physician completes his/her 10th year of practice mid way through a fiscal year, the Payee receives an entitlement based upon the weighted average of the two rate categories the Payee straddles. See example under "Full Entitlement"

3. RETENTION OF BENEFITS

A Payee's accumulated benefit will remain in the Fund provided there has been no interruption of service (section 3.2) or payout (section 4)

3.1 Allowable Breaks In Service

The following situations are deemed to be "Allowable Breaks in Service" during which a Payee may maintain eligibility benefits:

a) A Physician may take up to a maximum of one-year leave, such as a sabbatical, in a location other than Saskatchewan without incurring an interruption in service. A Physician has the ability to practice medicine during the term of his or leave without any type of restriction on their income or hours of work. No benefits will accrue to the Payee during the Physician is away from practice nor will the Payee lose benefits during the time the Physician is away from practice. The year away from practice will not count as year of service.

b) A Physician may take up to a maximum of a five-year medical education leave without incurring an interruption in service provided that the Physician provides proof of acceptance at a medical school. A Physician may also leave the Province for up to five years to accompany a spouse who is on a medical education leave. Education leave, either for self or for a spouse, will not count towards years of service.

c) Physician may opt to leave medical practice under a Special Circumstances Leave for a period of up to five consecutive years and the Payee will neither accrue nor lose benefits under the plan. Such allowable breaks include, but are not limited to:

   i) Maternity/Paternity leave;

   ii) Providing care for a terminally ill spouse/family member;

   iii) Personal disability or illness of the Physician;

   iv) Running for, or elected to public office; or

   v) Non medical education leave (e.g. to pursue an MBA).

The time spent away from practice will not count as years of service. Eligibility for Special Circumstances Leave will be determined by the Retention Fund Board.

If a Physician exceeds the timeframes for "Allowable Breaks in Service" his or her Payee will be deemed to have experienced an "Interruption of Service", with consequences outlined below.

3.2 **Interruption Of Service**

An ***"Interruption of Service"*** shall be deemed to have occurred under any circumstances that are not specifically outlined above as an "Allowable Break in Service". In particular, an "Interruption of Service" occurs:

a) if a Physician practices in a jurisdiction other than Saskatchewan for a period that exceeds one year; or

b) if a Physician ceases service, through education or other leave, for a period in excess of five consecutive years.

A Payee will automatically forfeit all benefits accrued under the Plan where a Physician has an Interruption of Service. A Payee would receive credit for prior years of service in the determination of their benefit accumulation rate where a Physician chooses to repatriate to Saskatchewan within a timeframe beyond those allowed under the "Allowable Breaks in Service", but would re-enter the plan with zero accumulated benefits.

It is the expectation of the SMA and Saskatchewan Health that a Physician will notify the Plan Administrator of the Fund if/when they change location or practice circumstances. There is an onus on the Physician to assist the Plan Administrator in maintaining an up-to-date database of his/her practice status.

4. VESTING

A Payee's entitlement to benefits shall first vest on the later of the following:

a) On the day after the Physician has completed ten (10) years of Continuous Service; and

b) April 1, 2011.

A Payee's entitlement to benefits shall subsequently vest on the day after the end of the fifth year after the First Vesting Date and in five-year intervals thereafter.

5. PAYMENT OF BENEFITS

There are four circumstances wherein a Payee would be eligible for payout under the Fund:

a) At Vesting Date;

b) Upon Permanent Disability of the Physician;

c) Upon Retirement of the Physician; and

d) Upon Death of the Physician.

It will be the responsibility of the Plan Administrator of the Fund to ensure and verify the appropriateness of claims and payments from the Fund.

5.1 Payout At Vesting Date

Prior to a Payee's Vesting Date, the Payee will be sent a confirmation form. Upon completion of the form the Payee will be paid his, her or its benefits in a lump sum as soon as reasonably possible after the Payee's Vesting Date

5.2 **Payout Upon Permanent Disability**

a) A permanently disabled Physician is an individual who is not engaged in the practice of medicine as a direct result of disabilities following a six month period of medical practice inactivity. Permanent or total disability means the inability of the Physician, due to injury or sickness, to perform the duties of his/her regular occupation. (Whether specialist or general practitioner, or a combination thereof, the regular occupation is the duties/work performed prior to the disability).

b) A Payee shall be paid all accumulated benefits in a lump sum as soon as reasonably possible following the determination of permanent disability of a Physician.

5.3 **Payout Upon Retirement**

a) A Physician is deemed retired if he/she declares retirement, and either discontinues practicing medicine or medical administrative work, or practices at an activity level less than the part-time entitlement threshold.

b) A Payee will be eligible to receive all accumulated benefits when a Physician provides a sworn statement of declaration of retirement to the Plan Administrator of the Fund, and discontinues licensure in Saskatchewan or elsewhere, following a six-month waiting period. The six-month waiting period is waived when the retiring Physician has prior service of thirty (30) or more years in Saskatchewan.

c) A Physician who declares retirement but continues to hold a medical license will be subject to a waiting period sufficient to verify his or her professional incomes. The retiring Physician is responsible for providing information sufficient to verify his or her income (e.g. income tax returns). This requirement is waived for a Physician with prior service of thirty (30) or more years in Saskatchewan.

d) A Payee who chooses to defer payment of benefits at the time of the Physician's retirement will cease to be entitled to future benefits following the date of the Physician's retirement.

   Example: Dr X retires in 2009 but opts for personal financial planning reasons to leave his benefit payment in the plan. He receives payout of benefits in 2011. He does not receive credit for years of service from 2009 onward as he was not engaged in medical practice from 2009 until 2011.

e) A Physician who has declared retirement is not permitted to re-enter the plan at a later date.

f) A Physician must have a minimum of ten (10) years of service (120 months) in Saskatchewan to qualify for a retirement payout.

5.4 **Payout Upon Death**

a) A Payee will be eligible for immediate payout of accumulated benefits upon the death of the Physician.

b) The Payee will be required to provide the Plan Administrator notification in writing of the date of death of the Physician or Payee, and a copy of the Wills Probate.

c) In the case where the Payee is a Professional Corporation, payment upon the Physician's death will be made to the Professional Corporation. In the case where the Payee would have been the Physician, if the Physician were alive, the Payee shall be deemed to be the Physician's estate, and payment upon the Physician's death will be made to the beneficiary or the executor of the estate, as directed by the Physician's Probated Will.

5.5 **No Other Rights To Accrued Amounts**

No Payee shall have any rights unless such benefit amounts have vested, or unless the requirements for early payout are met.

6. RIGHT OF APPEAL OF PHYSICIAN

Where a Payee disagrees with a determination made by the Plan Administrator of the Fund or the SMA on any matter related to the Payee in connection with this document, the Payee shall have a right to appeal the Plan Administrator's or the SMA's determination to the Board of the Fund.

7. SMA'S RECORDS CONCLUSIVE

The SMA's records with respect to a Payee's entitlement to benefits hereunder shall be conclusive of the facts with which they are concerned, unless or until they are proven to be in error.

In development of one or more benefit plans the SMA will attempt to ensure that Physicians would receive annual statements detailing their service record for the purpose of determining eligibility for benefits. It is the responsibility of the Physician to ensure information held by the SMA is accurate and to correct any discrepancies in the information in a timely and efficient manner.

8. BENEFITS PAYABLE IN CANADIAN CURRENCY

All benefits payable under the Fund to a Payee shall be paid in the lawful currency of Canada.

9. EFFECTIVE DATE

Notwithstanding the date of execution of this Agreement, the effective date of this Agreement is April 1, 2001, excepting to the extent that the Agreement is amended subsequent to that date.

The parties agree that this eligibility document is created for the sole intention of articulating fully the terms and conditions under which eligible Payees are entitled to receive benefits from the Fund.

SCHEDULE "H"

SPECIALIST RECRUITMENT AND RETENTION

1. Programs and incentives developed pursuant to section 12(6)(a) of the Agreement shall be developed and monitored through a committee of the Board, entitled the "Specialist Recruitment and Retention Committee" which shall consist of:

   (a) the chairperson appointed by the Board;
   (b) up to six other members appointed by the Board;
   (c) up to two Saskatchewan Health representatives appointed by the Minister of Health or his or her designate;
   (d) up to three representatives from Regional Health Authorities;
   (e) one representatives appointed by the Dean, College of Medicine;
   (f) one student representatives appointed by the Student Medical Society;
   (g) one resident representative appointed by the Professional Association of Interns and Residents of Saskatchewan.

2. The Saskatchewan Medical Association appointees shall be chosen to include the perspectives of specialists in the three major centres (Regina, Saskatoon and Prince Albert).

3. The Regional Health Authority appointees shall be chosen to include the perspectives of the three major centres (Regina, Saskatoon and Prince Albert) and may include district physician recruiters.

4. The Committee shall:
   (a) identify strategies and programs which would help recruit and retain specialists in Saskatchewan,
   (b) make appropriate recommendations regarding policy issues and funding matters in regard to the recruitment and retention of specialist physicians in Saskatchewan to Board and the Minister,
   (c) manage the distribution of funds outlined in section 12.6(a126a) of the Agreement,
   (d) establish subcommittees, as required, to carry out programs and initiatives approved by the Board and the Minister.

Specialist recruitment and retention incentives in existence at the onset of this Agreement:

- Specialist Recruitment Incentive Program
- Roadmap
- PREP
- Specialist Resident Bursary Program (suspended)
- Specialist Physician Enhancement Training Program (new parameters proposed and pending approval)
- Specialist Physician Quality and Leadership Training Program (proposed and pending approval)
- Specialist Resident Elective Support (proposed)

SCHEDULE "I"

CHRONIC DISEASE MANAGEMENT

Pursuant to Section 12(4)(c) of the Agreement:

Launched in summer 2013, the Chronic Disease Management – Quality Improvement Program (CDM-QIP) is a program focused on the on-going continuous improvement of chronic disease management in Saskatchewan.

The Saskatchewan Medical Association, Ministry of Health and eHealth Saskatchewan are partnering to develop the program with assistance from clinical leaders.

PROGRAM GOALS

- Improve the continuity and quality of care for people living with chronic conditions
- Encourage and support physicians and other health care providers to implement best practices (e.g. flow sheets and clinical practice guidelines)
- Leverage Saskatchewan's health information system to better meet the needs of residents and providers (e.g. EMRs and the eHR Viewer)

The CDM-QIP will provide tools to enable enhanced follow up and quality of care for patients living with chronic diseases. Ultimately, it will advance efforts to transform primary health care services and achieve more effective patient care in Saskatchewan.

Chronic Disease Management – Quality Improvement Program Payment Policy

Purpose:

The Chronic Disease Management – Quality Improvement Program (CDM-QIP) is focused on on-going continuous improvement of chronic disease management in Saskatchewan. The program will allow health care providers to:

- access electronic and paper CDM visit flow sheets that are standardized, evidence-based and are regularly updated to reflect current best practices;
- generate clinical and administrative reports to support optimal chronic disease care;
- track patients due and overdue for follow-up and disease specific investigations; access electronic links to clinical support tools (e.g. clinical practice guidelines, resources for patients);
- graph and view historic chronic disease indicator observations related to specific patients or groups of patients within your clinical setting;
- view chronic disease indicator observations of a patient submitted to the eHR Viewer by other clinicians; and
- graph and view reports comparing practice patterns and patients' progress to those of other practices and patient groups across Saskatchewan (longer term goal of this program).

Requirements:

- All family physicians, regardless of their payment modality, will be eligible to participate in this voluntary program.

- Payment under the program is currently only available for patients who are residents of Saskatchewan and who are at least 17 years of age at the time of the first visit in which observations are submitted under the program.
- Family physicians providing continuity of care to their patients with chronic conditions will be recognized under this program.
- Family physicians using an approved Electronic Medical Record (EMR) are able to submit chronic disease indicator data electronically through their EMR, while paper-based physicians participating in the CDM-QIP will submit indicator data online through the eHR Viewer.

Program Implementation:
- CDM-QIP payments are effective as of April 1, 2013.

Compensation:
Three types of payments are available under the CDM-QIP. These payments are in addition to payments included in the Physician Payment Schedule (e.g. 64B). All family physicians, regardless of payment modality, are eligible to receive the CDM-QIP payments.

1. Early Adopter Payment:
The Early Adopter Payment is available for the first two years of the program (April 1, 2013 through March 31, 2015).

- Physicians will receive a one-time $20.00 payment for each patient with a chronic disease for which they submit chronic disease indicators.
- To support continuity of care, payments will be made after the second submission of indicators and will be made on a bi-weekly basis over the term of the payment period.
- Observation data must be submitted within a six month time period of the chronic condition visit (consistent with current legislation).
- Payments will not be issued for out-of-province patients or for patients who have elected to not participate in the program.

Payment Process
- CDM-QIP early adopter requests for payment are automatically created at midnight every second Sunday and will be based on up to-the-minute input of observations.
- Payments will be made at the same time as the regular bi-weekly provider payment run that occurs every second Tuesday.
- Payments will appear as a separate line item on the physician's return file and payment list, with a fee code of 994Y.
- Payments will be deposited (or cheques mailed) the following Monday.

2. Quality Improvement Payment:
The Quality Improvement Payment is the ongoing payment for the submission of all chronic disease specific indicators over a 12 month period.

- Physicians will be paid $75.00 per patient per year for each chronic condition in which all of the required indicator data has been submitted.

- Observation data must be submitted within a six month time period of the chronic condition visit (consistent with current legislation).
- Physicians must have billed at least one Chronic Disease Management base fee code (64B) for the patient within the 12 month period. Shadow billing is a necessary pre-requisite for physicians in Primary Health Care.
- Payments will be issued on a quarterly basis at the end of each patient's 12 month assessment period (i.e. one year after the first submission of indicator information), when indicators have been met for that condition.
- Payments will be pro-rated for care teams consisting of more than one physician based on the number of visits for which indicators have been entered by each physician. In order to qualify for a payment, a minimum of two visits must be entered for physicians not practicing in the same clinic.
- Quality improvement payments will begin to be made in 2014-15.

Payment Process

- CDM-QIP quality improvement payments are automatically calculated at the end of each fiscal quarter (March, June, September and December).
- Eligibility for payment and payment amount will be determined for all physicians participating in the care of a patient whose 12 month assessment period for a particular chronic condition ended in the fiscal quarter.
- Payments will be made at the same time as the regular bi-weekly provider payment run that occurs every second Tuesday.
- Payments will appear as a separate line item on the physician's return file and payment list, with a fee code of 996Y.
- Payments will be deposited (or cheques mailed) the Monday following the MSB payment run.

3. Active User Payment:

The Active User Payment is a one-time payment that recognizes active users since program inception to the end of the 2014-15 fiscal year (April 1, 2013 to March 31, 2015).

- Active user physicians will receive a one-time $1,000 payment.
- Active users will be defined as physicians who have made a minimum of 15 flowsheet submissions within any three month period between April 1, 2013 and March 31, 2015.

Payment Process

- Payments will be issued in January 2015 (to those who became active prior to December 31, 2014), and in April 2015 (to those who become active between January 1 and March 31, 2015).
- Payments will appear as a separate line item on the physician's return file and payment list, with a fee code of 994Y.
- Payments will be deposited (or cheques mailed) as per current physician administrative arrangements with MSB.

SCHEDULE "J"

GENERAL PRACTITIONER SPECIALIST PROGRAM

Pursuant to Section 12(4)(h) of the Agreement:

Guiding Principles:

- The Ministry of Health (Ministry) and the Saskatchewan Medical Association (SMA) agree GP Specialists need to maintain their skills in the specialized areas of their practice and that patient safety and quality need to be supported.
- A quarterly bonus payment will be provided to family physicians that provide specialty services (specifically Anesthesia, Surgery and Obstetrics) as a portion of their practice.
- This program is available to family physicians providing services outside of the Regina and Saskatoon metropolitan areas.

Program Criteria:

- The program is effective April 1, 2011.
- Participation is based on services provided outside of the Regina and Saskatoon metropolitan areas.
- Bonus payments will be available to physicians regardless of their payment modality.

Category	Requirements	Exclusions
To be eligible for GP-Anesthesia	A physician must have between 5% and 80% of their activity in anesthesia	Critical care/ Intensive care codes
To be eligible for GP-Surgery	A physician must have between 5% and 80% of their activity performing minor and major surgery (10 and 42 day surgical procedures) and including at least one major procedure (requiring medium or high complexity anesthesia)	All surgical procedures performed in an office location
To be eligible for GP-Obstetrics	A physician must have between 5% and 80% of their activity in obstetrical work, including performing at least one C-section	
Note: A GP Specialist could qualify for participation by having specialty activity ranging from 5% to 80% in a combination of anesthesia, surgery, and obstetrical work that meet the requirements above.		

Program Administration:

- GP Specialists are qualified at the end of each quarter, based on their fee-for-service and/or shadow billings for the previous four quarters. Physicians will be paid a maximum $5,000/quarter for those quarters where the GP specialist was providing eligible services.
- Physicians will be considered full time and receive the maximum payment if they earned a minimum of $60,000 in the previous four quarters. Less that full-time physicians will have their payment pro-rated.
- Payments will appear on the physician's payment list as fee code 993Y.
- Policy decisions regarding the administration of the Bonus Payments for GP Specialists will be jointly negotiated between the Ministry and the SMA and will be subject to approval from the Deputy Minister's Office.

SCHEDULE "K"

QUALITY AND ACCESS

Pursuant to Section 12(4)(f) of the Agreement:

The Quality and Access (Q&A) Fund was established in July 2012, as part of the 2009-2013 Agreement between the Province of Saskatchewan and the Saskatchewan Medical Association to encourage physicians to participate in the development and adoption of new ways of practicing to improve the quality of services and patient access to services.

Initiatives approved for expenditure within the Q&A Fund include:

- Spinal care pathway billing code (200B fee code); and
- Physician Compensation Quality Improvement Program (PCQIP). (See program parameters below).

Any change to the Quality and Access Fund requires mutual agreement by the Ministry and the SMA.

Physician Compensation Quality Improvement Program (PCQIP)

Program Parameters and Guidelines (*DRAFT*)

I. Program Summary

Introduction

The Quality and Access Fund was established in July 2012, as part of the 2009-2013 Agreement between the Province of Saskatchewan and the Saskatchewan Medical Association (SMA) with agreement that a portion of the fund is dedicated to providing financial support for physician involvement in health system change.

Established under the Quality and Access Fund, the Physician Compensation Quality Improvement Program (PCQIP) is a joint initiative between the Ministry of Health (Ministry) and the SMA to advance Saskatchewan's health system priorities by building physician capacity and involvement in quality improvement, leadership and change management across the health system.

The Program is jointly managed by a tripartite Committee with representation from the SMA, SHASHA and the Ministry. The Committee is accountable to and provides advice to the SMA Board of Directors and the Minister of Health through the Deputy Minister of Health.

As of January 1, 2016, the program will require organizations to apply for funding to support physician engagement in quality improvement (QI) work, at the rates identified.

Vision

Our vision is to improve the quality of patient care and transform health care in Saskatchewan by supporting physician involvement in QI initiatives and leadership training in quality improvement methods through an innovative program.

Objective

The goal of the Program is to support, enhance, and accelerate physician involvement in quality improvement initiatives and leadership training focused on building a high-performing health care system with the goal of providing patients and families with better health, better care, better value and better teams.

Purpose

The purpose of the PCQIP is to:

- Provide financial support for physician involvement in QI work linked to the achievement of Saskatchewan's health system transformation priorities. (See Eligibility Criteria below).
- Promote physician leadership development (i.e., training provides comprehensive knowledge and skills in QI principles, methods and tools, including adaptive leadership and change) for the role of leading QI work that engages meaningfully with physicians and supports Saskatchewan's health system transformation.

II. Program Parameters and Policies

a. Guiding Principles

The PCQIP will be guided by the following five principles:

1. Acknowledge physician involvement is a key factor for the success of health system transformation.
2. Support physician involvement in QI work/training that contributes to Saskatchewan's health system priorities and transformation.
3. The PCQIP is one provincial program, which is delivered consistently to support physician involvement in QI work/training within or across health care sectors and regions.
4. The PCQIP is a sustainable program that pays for physician involvement in QI work/training consistent with Program mandate and is provided through contractual arrangements between the Ministry and the SMA.
5. The PCQIP is transparent and accountable.

b. Eligibility

Provincial Health System Priorities

The PCQIP is expanded to compensate physicians for eligible time they spend on approved QI training and projects that support provincial health system priorities as indicated on the Provincial Leadership Team approved system matrix. These projects may be led by the following organizations:

- SHAS;
- Ministry of Health;
- Saskatchewan Medical Association;
- Physician offices;
- eHealth;
- Health Quality Council;
- 3sHealth; and,
- Saskatchewan Cancer Agency.

c. Application Process

Organizations must submit a separate application for each QI project/training initiative for assessment
by the PCQIP Oversight Committee. Generally projects should commence within three months of receiving approval for funding and should be completed within 12 months. Deadlines for applications: To be decided.

The application must detail:

- Organization Applying
- Project description
- Nature of physician involvement:
  - Education Stream (e.g., Lean Leader Certification)
  - Engagement Stream (e.g., planning meetings, value stream mapping, visioning sessions, Rapid Process Improvement Workshops, Kaizen Basics)
- Number of physicians to be engaged
- Estimate of amount of time required for each type of involvement
- Timeframe for physician engagement
- Success measures
- Describe how the application meets the following criteria (full description of criteria is in section e):
  - *Potential Impact;*
  - *Contribution to Provincial Health System Strategic Priorities;*
  - *Patient- and Family-Centered;* and,
  - *Feasibility.*

The QI Program Committee will review applications following each application date. Committee decisions will not be implemented on a retroactive basis.

d. Available Funds

The number of proposals awarded funding each year depends on the merits of the proposals received and the total funds available. The Oversight Committee has discretion over the proposals selected and the amount awarded, within the PCQIP budget allocated by the Quality and Access Fund. Funds must generally be used according to the approved QI work and timelines unless special permission is obtained from the Committee.

All unused funds must be returned to the PCQIP when the approved QI work is completed or if a physician recipient is, for any reason, unable to complete the approved QI work.

Applicants must notify the PCQIP of any co-funding or potential in overlap of physician compensation. Applicants must specify if an overlap of physician compensation exists and if so, the amount and source, and whether this additional funding has been secured at the time of application. PCQIP funding is conditional on disclosure to the PCQIP and the PCQIP's approval of the co-funding/overlap in physician compensation.

- For example - Where a physician is participating in this work as a direct result of an administrative position they hold and for which they have an existing contract (i.e., Senior Medical Officers), the physician would not be able to be paid both through their non-fee-for-service contract and this program.

e. <u>Assessment of Applications</u>

Applications will be adjudicated based only on the information submitted. Two-to-three pages should suffice and applications are not to exceed four pages.

<u>Eligibility Criteria</u>

Funding applications will be assessed on the following criteria:

1. *Potential Impact:* What you are trying to accomplish. Preference will be given to QI work that impacts and brings benefits across the spectrum of healthcare services with the goal of improving quality, access, continuity and efficiency, and which contributes to better patient care. Client/patient/resident population(s); potential to implement benefits/outcomes across other organizations and/or sectors within Saskatchewan, demonstrated commitment of sponsoring organizational leadership, and other impacts on the provision of care will be important review criteria. (Examples include—but are not limited to—the implementation of cross-sectoral evidence-based guidelines; shared clinical protocols, pathways and standards of care);
2. *Contribution to the achievement of Saskatchewan's Health System Strategic Priorities:*
    - *Highest priority will be given* to QI work that contributes to the achievement of health system strategic priorities articulated in the provincial strategy matrix by making improvements in quality and/or access not limited to a specific location i.e., work may be rolled-out to achieve similar improvements elsewhere in the province).
    - QI work that has been identified as a high priority/transformational by health system leaders, but that may not be explicitly identified as provincial strategy deployment matrix, will also be considered.
3. *Patient- and Family-Centered:* Preference will be given to QI work which includes the involvement of patients, families and communities (e.g., shared decision-making, patient and family advisors, and community involvement); and,
4. *Feasibility:* Preference will be given to QI work with feasible outcomes (e.g., anticipated resources, such as, human, financial, IT, equipment, in-kind resources, etc., required to achieve goals), timelines and within the project team's "scope of control".

Ineligible Projects and Support

The PCQIP does not provide funding for standard employment duties, activities required to maintain professional standing or improvement initiatives where it is not obvious that the primary goal of physician involvement is to directly support the achievement of providing Saskatchewan patients and families with better health, better care, better value, and better teams. If an event is cancelled with less than 3 weeks notification given, the physician is able to register a complaint with the Oversight Committee.

Ineligible work would include but is not limited to:

- Physician committee work related to Practitioner Staff Bylaws;
- Physician travel time;
- Physician preparation time;
- Physician work that is a Continuing Medical Education accredited activity and does not count towards Lean Leader certification (i.e., Lean Leader certification training is eligible for Program funding)
- Physician time spent backfilling another physician who is participating in approved QI work; and,
- Work that has already been completed (i.e., applications must be prospective).

<table>
<tr><th>Eligible Time</th><th>Examples of Non-Eligible Time</th></tr>
<tr><td rowspan="3">Time spent on QI projects by medical leadership (including SMOs) and administrative physicians if the time spent is in addition to the time for which they are already remunerated

(e.g. if a physician is contracted to provide 2 days (16 hours) of administrative work per week and works 2 days (16 hours) on administrative work plus 3 hours for QI work in a week, the 3 hours is eligible time; however, the 3 hours is not eligible if the QI work is done as part of the 2 days (16 hours) of administrative work)</td><td>Time spent working on a QI project when the physician is already receiving compensation (e.g. salary) for the work as part of their remuneration package (i.e. no duplicate payments)</td></tr>
<tr><td>Physicians in positions paid by Regions where QI work is already part of their position responsibilities</td></tr>
<tr><td>Medical leadership (including SMOs) and administrative physician work time involving regular or ongoing department, section head or management meetings or committee work</td></tr>
<tr><td rowspan="2">Time spent on QI projects by a non-fee-for-service physician when the time is during clinical time and the clinical time spent working on the QI project is made up after normal clinical hours</td><td>Physician travel time</td></tr>
<tr><td>Physician time spent doing preparation work, homework assignments or other work outside of QI training.</td></tr>
<tr><td rowspan="3">Time spent participating in an eligible sponsoring organization-approved project not directly linked to the achievement of the breakthrough initiatives included in the provincial strategy. Physician- identified projects will be eligible commencing in 2015; such projects must be approved by an eligible sponsoring organization</td><td>Physician time spent backfilling a physician who is taking part in QI work or training.</td></tr>
<tr><td>Physician time spent on mortality and morbidity rounds or other intra-departmental matters</td></tr>
<tr><td>Cancelled projects or meetings</td></tr>
</table>

In the event an applicant plans, but does not conduct QI work as scheduled, no payment will be made to physicians through the QI program.

Communication has been shared with health system organizations regarding the last-minute cancellation of QI work that involves physicians and the barriers this presents to

physician involvement. If cancellation of an event is necessary, best attempts will be made by the sponsoring organization to give appropriate notice to physician participants.

Clarification on eligible and non-eligible time is provided in the table below.

f. Awarding of Applications

Best attempts will be made to distribute funding across the province. The Committee will advise each applicant on the decision on their application.

Once an application has been approved, funding will be provided to the applicant that will then be responsible to provide payment to the individual physicians at the rates noted below. Half of the approved amount will be issued once a letter of agreement is signed between the Ministry and applicant; the remaining funding will be issued following reconciliation of time required and/or
provided by participating physicians.
Committee decisions regarding awarding of applications are final and binding.

g. Payment to Physicians

- Education Stream: Physicians who participate approved QI educational activities including Lean Leader Certification will be compensated at the rate of $187.50 per hour.
- Engagement Stream: Physicians who participate in projects or training (e.g., Kaizen Basics) which are approved for the QI Program will be compensated at the rate of $150 per hour.

The Education Stream's higher rate is to acknowledge that some approved QI educational activities
(e.g., Lean Leader certification training) require considerable dedication and a greater level of intensity of study to successfully complete.

Organizations cannot top-up PCQIP rates of pay. Rates are not intended to be an income replacement, but meant to acknowledge contribution to system transformation above and beyond employment duties. Negotiation of the rate of pay is outside the scope of Oversight Committee and, instead, is negotiated between the Ministry and SMA.

Funding cannot be used for other Continuing Medical Education purposes; PCQIP funding is separate from funding available in the Continuing Medical Education Fund.

Physicians eligible for payment include those who are licensed to practice medicine independently in the province of Saskatchewan.

While medical learners may be involved in QI work, their involvement does not qualify for compensation through this fund.

h. Project Reporting

Organizations must submit a brief status report of the QI initiative by email within six months of receiving the grant funds. They must also submit a final report confirming physician involvement when the project is completed in order to receive the outstanding approved funding. Successful applicants will be given a contact person from the Ministry of Health to submit reports to.

i. Monitoring and Verification of Service

The Oversight Committee or its agents reserve the right to audit the Program in any reasonable manner they see fit to ensure accountability.

The Oversight Committee or its agents may follow-up with either the organization or the physician to verify that the physician is participating in the QI work/training. Records must support the claims submitted by demonstrating that physician involvement in QI work/training was pre-approved; that the claim submitted represented the work/ training completed; and that the time claimed was eligible for payment. As such, a records review is used to verify that physician involvement occurred and the appropriate compensation was claimed.

If, in the judgment of the Committee, a claim for payment was fraudulently submitted to the Program, all funding for the involved project will be recovered.

SCHEDULE "L"

FAMILY PHYSICIAN COMPREHENSIVE CARE PROGRAM AND METRO ON CALL PROGRAM

Pursuant to Section 12(4)(g) of the Agreement, the parties agree to continue under the existing parameters for the remainder of the contract period, as outlined:

Purpose:

The Family Physician Comprehensive Care Program (FPCCP) is intended to recognize family physicians for the value and continuity of care they provide to patients when they provide a full range of services. The Program is also intended to incent more physicians in providing comprehensive care.

Requirements:

- All physicians will be required to provide on-call coverage for patients. Rural physicians must be designated to an emergency room within close proximity, and all physicians will be on-call for a minimum of their assigned patients.
- Rural physicians who practice in communities with a Collaborative Emergency Centre (CEC) are deemed to have met the on-call requirement.
- To recognize the differences in practices and service level demands, the program thresholds will vary for physicians practising in the four major community locations:
  - **Metro** - includes Regina, Saskatoon and bedroom communities (Balgonie, Clavet, Corman Park, Dalmeny, Delisle, Emerald Park, Langham, Lumsden, Martensville, Pense, Pilot Butte, Warman and White City);
  - **Regional** – includes Lloydminster, Moose Jaw, North Battleford, Prince Albert, Swift Current and Yorkton;
  - **Northern Medical Services (NMS)** – includes Stony Rapids, La Loche, Ile a la Crosse and La Ronge; and
  - **Rural** – includes all other communities.
- Practice activity is evaluated on a "per clinic" basis, under the notion that patients should be able to receive the full suite of medical services from their clinics and to recognize varying practice arrangements of individual physicians. It is recognized that within a clinic, individual physicians may not always provide all services, but may collectively organize themselves to provide patients with the full spectrum of care. Thresholds are based upon services per 100 discrete patients seen by the clinic and will consist of:

		Target Service Levels/100 Patients			
Service Group	**Fee Code(s)**	**Metro**	**Region**	**Rural**	**NMS**
1-Hospital/Supportive Care	25B-28B, 52B-53B	3	20	20	20
2-Nursing Home Care/House Calls	615A, 627A-629A, , 915A, visit services with "Home" location	n/a	1	10	n/a
3-Pre/Postnatal, Deliveries, Well Baby Care	4B, 8B, 41P, 42P	3	2	1	1

4-Complete Assessments and Pap Tests	3B, 131A	8	7	6	6
5-Chronic Disease Management	64B or 5B with CDM Diag	5	5	9	9
6-Phone Calls from Allied Health Personnel	761A, 793A 796A, 797A, , 42B, 43B	1	1	1	1
	Max. Number of Service Groups	5	6	6	5
On-call	**Various Fee Codes**	**Mandatory**			

- Service per 100 patients is defined as providing one service in the identified service group for every 100 discrete patients seen. This means that to meet the service level requirement for Hospital/Supportive Care, a metro family physician must provide three of the identified services (fee codes 25B-28B, 52B-53B) for every 100 patients in their clinic.
- Where more than one service is listed in a service group, the threshold is applied on all the component services added together. As an example, the "pre/postnatal care, deliveries and well baby" threshold can be met through any combination of fee codes 4B, 8B, 41P, 42P.

Program Premiums:

- Base earning levels will exclude Emergency Room Coverage Program (ERCP) payments, any fee code premiums, as well as on-call surcharges/premiums.
- In calculation of the premium, the maximum individual base earnings will be $400K annually.
- The program will have two tiers of payment based on the number of service groups and location of practice. The eligibility tiers and program premiums are as follows:

Program Premiums on Base Earnings

	Meets 4 out of 5	**Meets 5 out of 5**	**Meets 5 out of 6**	**Meets 6 out of 6**
Metro	4.5%	5.5%		
Regional			4.5%	5.5%
Rural			4.5%	5.5%
Northern Medical Services (NMS)	4.5%	5.5%		

- All rural practices that qualify under the program will receive an additional 5% rural index premium on their base earnings to recognize the differences in service levels, on-call requirements, relative isolation and reduced level of supports associated with rural practice.

Metro On-Call:

Metro On-call is intended to compensate comprehensive care physicians who provide after hours coverage for their own patients. To qualify and receive payment, metro family physicians must meet the following three criteria:

1. Physicians must participate in a group that is expected to provide continuous coverage (24 hours / 365 days per year) and must respond by telephone within a

reasonable time frame and in person when the family physician deems it necessary; and

2. Physicians must have admitting privileges with the Saskatoon Regional Health Authority or the Regina Qu'Appelle Regional Health Authority; and
3. Physicians must submit their actual on-call schedules to the Ministry of Health at the end of each quarter (i.e. March 31st, June 30th, September 30th, and December 30th of each calendar year), to the address below.

   Saskatchewan Ministry of Health
   Attention: Metro On-Call Program
   Medical Services Branch
   3475 Albert Street
   REGINA SK S4S 6X6
   fax: (306) 787-3761

- The threshold of Medical Services Plan (MSP) payments required to qualify for full entitlements is $60,000 per year. The minimum threshold of MSP payments to qualify for a part-time pro-rated entitlement is $30,000 per year.
- Detailed call schedules that accurately reflect the actual call provided by each physician participating in the call rotation must include the following information:
  - information, by individual physician, on who provided call for the clinic's patients. The schedule must be legible and detail the dates that each physician was on call; and
  - clinic name and Medical Services Branch (MSB) clinic number under the call rotation; and
  - list of all physicians on the call roster, including their MSB billing number; and
  - name and phone number of a person to contact in the event there are questions arising from the schedule.
- Metro family physicians who qualify under FPCCP and meet the criteria identified above, will receive an annual payment of $7,000. Physicians, who meet the on-call requirements but no not qualify under FPCCP, will receive an annual payment of $3,500.
- Physicians will be ineligible to receive the Metro On-call payment if they do not participate in a call rotation that provides coverage to their patients 24 hours, 365 days per year. Solo physicians are encouraged to partner with other clinics to ensure call is provided to all patients.

SCHEDULE "M"

CLINICAL QUALITY IMPROVEMENT PROGRAM (CQIP)

Introduction

Launched in 2017, CQIP is a 10-month course designed to build capability in leading improvement work in health care, with a focus on clinical quality improvement projects. The program includes a mix of theory and experiential learning, along with individual coaching and a community of practice. Saskatchewan's CQIP is a sister program to Intermountain Healthcare's internationally recognized mini-Advanced Training program that has been adapted for Saskatchewan's health care system. Leaders from the SMA, Health Quality Council (HQC), Saskatchewan Health Authority (SHA) and Ministry of Health work collaboratively to provide direction and guidance to the ongoing evolution of this mainstay clinical quality improvement program.

Objective

This program is designed for clinicians who are actively practicing in a clinical context or setting. This program has been designed with physicians as the primary target learning group; however, other clinicians are also welcome given the team-based nature of health care and improvement work. CQIP provides physicians and other clinicians in Saskatchewan with the training required to lead clinical improvement projects.

Purpose

The purpose of the CQIP is to:

- Provide financial support for physicians enrolled in the CQIP
- Provide financial support for CQIP physician coaches and faculty
- Promote physician leadership development and build capability in leading quality improvement work in clinical settings

Use of Funds

Funding for the CQIP is used in the following ways:

- Payment for participating in training events, coaching interactions and project work. Physician are reimbursed at a rate of $150/hr; residents at $75/hr. There are maximum allowable reimbursable hours per participant.
- Payments to coaches and faculty
- Expense/sustenance allowances
- Guest speakers, venue costs and promotional materials
- Administration of CQIP by Health Quality Council
- Software and reference materials for participants
- 50% of HQC Program Coordinator role
- Other relevant expense items

In-kind Support

- HQC support staff (e.g., improvement lead, manager, communications and program coordinator (50%))
- SHA – quality improvement support (e.g., data acquisition and data support/analysis)