THIS AGREEMENT is effective this 1st day of April, 2013

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, 2013;

(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 May 6, 2011.

SECTION 2: TERM

1. The term of this Agreement is April 1, 2013 to March 31, 2017. Subject to Subsection 2, in the event that the parties have not agreed to a new Agreement prior to March 31, 2017, 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 10.

PART I INSURED SERVICES AND PAYMENT SCHEDULE

SECTION 3: PAYMENT SCHEDULE ADJUSTMENTS

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

   (a) from April 1, 2013 to March 31, 2014, is 0% greater than the aggregate annualized payment on the basis of the base payment schedule;

   (b) from April 1, 2014 to March 31, 2015 is 0% greater than the amount referred to in clause (a);

   (c) from April 1, 2015 to September 30, 2015 is 0% greater than the amount referred to in clause (b);

   (d) from October 1, 2015 to March 31 2016 is 1.95% greater than the amount referred to in clause (c); and

   (e) from April 1, 2016 to March 31 2017 is 2.95% greater than the amount referred to in clause (d).

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 section 3.

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.

SECTION 4: NEW ITEMS AND MODERNIZATION OF THE PAYMENT SCHEDULE

1. In addition to the funds to be made available pursuant to section 3, the minister shall cause to be made available a sum of $500,000 (annualized) 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, 2016;

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, or recovered from other Programs under Part II.

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 and the parties will work to finalize the Project Charter and commence the Project by January 1, 2016. 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: ON-CALL COVERAGE PROGRAMS

1. The rates of payment in effect on March 31, 2013 for the Specialist Emergency Coverage Program and the Rural Emergency On-Call Program (as outlined in Schedules "D" and "E") will be maintained as identified in subsections (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.

(b) Fees for the Rural Emergency Coverage rotations:

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

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

2. For the purpose of adding additional rotas to the Specialist Emergency Coverage Program as set out in Schedule "D" the Minister shall cause to be made available:

(i) a one time payment of $900,000 to be made on October 1, 2015; and

(ii) an additional $1,900,000 annualized for the period beginning April 1, 2016, and for each succeeding fiscal period.

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

4. 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 6: PAYMENT FOR PAST SERVICES

1. As a one-time lump sum payment in lieu of a retroactive amendment to the payment schedule for April 1, 2013 to March 31, 2014, the minister will pay to physicians, or physician professional corporations who have a direct billing agreement with the minister for insured services provided to beneficiaries under the Saskatchewan Medical Care Insurance Act, a one time lump sum payment in an amount equal to:

(a) the amount the physician or physician professional corporation billed the minister under the Act for insured services during the period of April 1, 2013 to March 31, 2014, less any amount that has been reassessed for that period under the Act;

(b) multiplied by 1.5%

2. As a one-time lump sum payment in lieu of a retroactive amendment to the payment schedule for April 1, 2014 to March 31, 2015, the minister will pay to physicians, or physician professional corporations who have a direct billing agreement with the minister for insured services provided to beneficiaries under the Saskatchewan Medical Care Insurance Act, a one time lump sum payment in an amount equal to:

(a) the amount the physician or physician professional corporation billed the minister under the Act for insured services during the period of April 1, 2014 to March 31, 2015, less any amount that has been reassessed for that period under the Act;

(b) multiplied by 1.5%

3. The amounts referred to in sub-sections 1 and 2 will be paid not later than November 30, 2015.

SECTION 7: 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 8: 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 PROGRAMS AND EDUCATION

SECTION 9: OTHER PROGRAMS AND EDUCATION

1. Subject to section 10, in addition to the amounts of money to be made available pursuant to Part I of this Agreement, the minister shall cause to be made available:

   (a) For the purpose of providing programs and incentives to be agreed to by the parties to enhance the recruitment and retention of physicians in rural and regional areas of Saskatchewan:

      (i) $3,140,000 for the fiscal period beginning April 1, 2013;

      (ii) $3,140,000 for each succeeding fiscal period;

      (iii) the parties agree to develop and monitor such programs and incentives through the Committee on Rural and Regional Practice, established pursuant to the Agreement dated April 24, 1997, and in accordance with the terms outlined in Schedule "A";

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

   (b) In recognition of the costs related to Canadian Medical Protective Association (CMPA) 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 insured clinical services in Saskatchewan for the years 2013, 2014 and 2015 (based on the calendar year beginning January 1, 2013);

(ii) effective January 1, 2016, and for each calendar year thereafter, the amount for each calendar year calculated in accordance with the formula set out in Schedule B;

(iii) 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;

(iv) the minister will make a payment to the board for the 2015 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

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

(c) For the purpose of supporting the Continuing Medical Education Fund:

(i) $4,400,000 for each fiscal period beginning April 1, 2013 and ending March 31, 2016;

(ii) $4,650,000 for each succeeding fiscal period beginning April 1, 2016;

(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".

(d) For the purposes of providing a Physician Retention Fund:

(i) $7,200,000 for each fiscal period beginning April 1, 2013 and ending March 31, 2016;

(ii) $8,000,000 for each succeeding fiscal period beginning April 1, 2016;

(iii) $2,400,000 for a one-time payment in 2016-17;

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

(v) 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.

(e) For the purpose of providing programs and incentives to be agreed to by the parties to enhance the recruitment and retention of specialists:

(i) $2,000,000 for the fiscal period beginning April 1, 2013;

(ii) $2,000,000 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; and

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

(f) For the purpose of providing Parental Leave Benefits:

(i) $700,000 for each fiscal period beginning April 1, 2013 and ending March 31, 2016;

(ii) $1,000,000 for each succeeding fiscal period beginning April 1, 2016 ;

(iii) $300,000 for a one-time payment in 2016-17 to maintain sustainability of the program.

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

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

(g) For the purpose of providing enhanced management of patients with chronic diseases:

(i) $3,000,000 for each fiscal period beginning April 1, 2013. This funding will be utilized as follows:

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

- Annualized program maintenance funding, and future development costs.

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

(ii) provisions under Part I, Section 4, sub-sections 2 to 6 inclusive will apply to sub-clause (i) above.

(h) For the purpose of providing Information Technology development in physician practices:

(i) $2,000,000 for the fiscal periods of April 1, 2013 to March 31, 2014, April 1, 2014 to March 31, 2015, and April 1, 2015 to March 31, 2016;

(ii) $2,800,000 beginning April 1, 2016 and 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; and

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

(i) For the purpose for improving quality and access for Saskatchewan residents:

(i) $3,000,000 for the the fiscal period beginning April 1, 2013;

(ii) $3,000,000 for each succeeding fiscal period;

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

(iv) provisions under Part I, Section 4, sub-sections 2 to 6 inclusive will apply to sub-clauses (i) and (ii) above.

(j) For the purpose of recognizing Full-Service Family Physicians and the Metro On-Call Program, in accordance with Schedule "L":

(i) $9,830,000 for the fiscal periods of April 1, 2013 to March 31, 2014 and April 1, 2014 to March 31, 2015 in accordance with the terms and definitions outlined in Appendix 1 of the previous agreement and the Letter of Understanding applicable to the previous agreement;

(ii) $13,300,000 for the fiscal period beginning April 1, 2015 and ending March 31, 2016;

(iii) $14,300,000 for the fiscal period beginning April 1, 2016; and

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

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

(i) $1,400,000 for the fiscal periods of April 1, 2013 to March 31, 2014 and April 1, 2014 to March 31, 2015 in accordance with the terms and definitions outlined in Appendix 2 of the previous agreement and the Letter of Understanding applicable to the previous agreement;

(ii) $1,000,000 for the fiscal period beginning April 1, 2015 and for each succeeding fiscal period; and

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

(l) an additional $3,500,000 in one-time funding to support options to improve patient access and health outcomes through collaborative care and technology. These funds will be made available on April 1, 2016 in accordance with the terms outlined in Appendix 1.

(m) an additional $1,100,000 in one-time funding to support physician participation and initiatives aimed at improving appropriateness of care. These funds will be made available on April 1, 2016 in accordance with the terms outlined in Appendix 2.

(n) an additional $1,000,000 in one-time funding to support mutually agreed upon information technology initiatives that will result in tangible benefits for the health system that support appropriate care and patient safety. These funds will be made available on April 1, 2016 in accordance with the terms outlined in Appendix 3.

2. The parties agree that any programs or incentives developed and implemented within the terms of sub-sections 1 (a), 1(e), 1(g), 1(h), 1(i), 1(j), 1(k), 1(l), 1(m) and 1(n):

   (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 1(a), 1(e), 1(g), 1(h), 1(i), 1(j), 1(k), 1(l), 1(m) and 1(n); 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.

3. The board:

   (a) will maintain separate interest bearing accounts for the funds referred to in sub-sections 1(a), 1(c), 1(d), 1(e), 1(f) and 1(h) 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 1(d), shall accrue to the benefit of the minister and notwithstanding sub-section 5 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.

4. No sums may be expended from the accounts referred to in sub-section 3 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.

5. 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.

6. The minister and the board agree to a third party review of the programs referred to in sub-sections 1(a), 1(e) and 1(h), by March 31, 2017, at the expense of the minister. A joint oversight structure will provide input into program review design, and receive recommendations from the third party.

7. The Board acknowledges and agrees that the minister's obligation with respect to the funds described in clause 1(d) 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;

   (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.

8. 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 of April 1, 2013 to March, 31, 2014 and April 1, 2014 to March 31, 2015 have been fully paid.

SECTION 10: 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 sub-section 9.1 to be made available as part of the Payment Schedule in place at that time.

4. Notwithstanding the termination of Part II of this Agreement, the provisions of this Part respecting the use of any unspent funds in the accounts referred to in sub-sections 9.1(a), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m) and (n) shall continue to apply until all funds are utilized, unless the parties agree otherwise.

PART III OTHER MATTERS

SECTION 11: 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 12: 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 13: AMENDMENT

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

SECTION 14: EXECUTION

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

Executed on behalf of the Minister this 4 **day of** February, **20**16

(Signature)

Dustin Duncan
Minister of Health

Chief of Staff
(please print title)

(Witness Signature)

Executed on behalf of the Board this 10 **day of** February, **20**16

(Signature)

Dr. Mark T. Brown
President
Saskatchewan Medical Association

Board Secretary
(please print title)

Vanessa Bauer
(Witness Signature)

APPENDIX "1"

OPTIONS TO IMPROVE PATIENT ACCESS AND HEALTH OUTCOMES THROUGH COLLABORATIVE CARE AND TECHNOLOGY

Pursuant to Section 9(1)(l) of the Agreement:

The Ministry and the SMA agree to $3.5M in one-time funding in 2016-17 to support options to improve patient access and health outcomes through collaborative care and technology.

The parties agree that this funding is to be used for innovative projects for both general practitioners and specialists, to test various approaches. Any unspent funds relating to this funding at the end of 2016-17 will be distributed among other programs (to be determined by mutual agreement of the parties) or carried forward to sustain new approaches.

APPENDIX "2"

APPROPRIATENESS

Pursuant to section 9(1)(m) of the Agreement

The Ministry and the SMA agree to $1.1M in one-time funding in 2016-17 to support physician participation and initiatives aimed at improving appropriateness of care which may include the Ministry's appropriateness hoshin, and the Choosing Wisely Canada campaign.

The parties agree that this funding is to be used for innovative projects for both general practitioners and specialists to test various approaches. Any unspent funds relating to this funding at the end of 2016-17 will be distributed among other programs (to be determined by mutual agreement of the parties) or carried forward to sustain new approaches.

APPENDIX "3"

INFORMATION TECHNOLOGY INITIATIVES

Pursuant to section 9(1)(n) of the Agreement:

The parties agree to $1.0M in one-time funding in 2016-17 for mutually agreed upon information technology initiatives that will result in tangible benefits for the health system that support appropriate care and patient safety (e.g., explore integrating private radiologist information into the provincial system). Any unspent funds relating to this funding at the end of 2016-17 will be distributed among other programs (to be determined by mutual agreement of the parties) or carried forward to sustain new approaches.

For clarity, this $1.0M will not be subject to the 70/30 Ministry/SMA Electronic Medical Record cost-share provision.

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 Appendix A for proposed lines of enquiry to illustrate how the principles could guide the modernization of the Physician Payment Schedule.

** See Appendix B 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.

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

[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.

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.

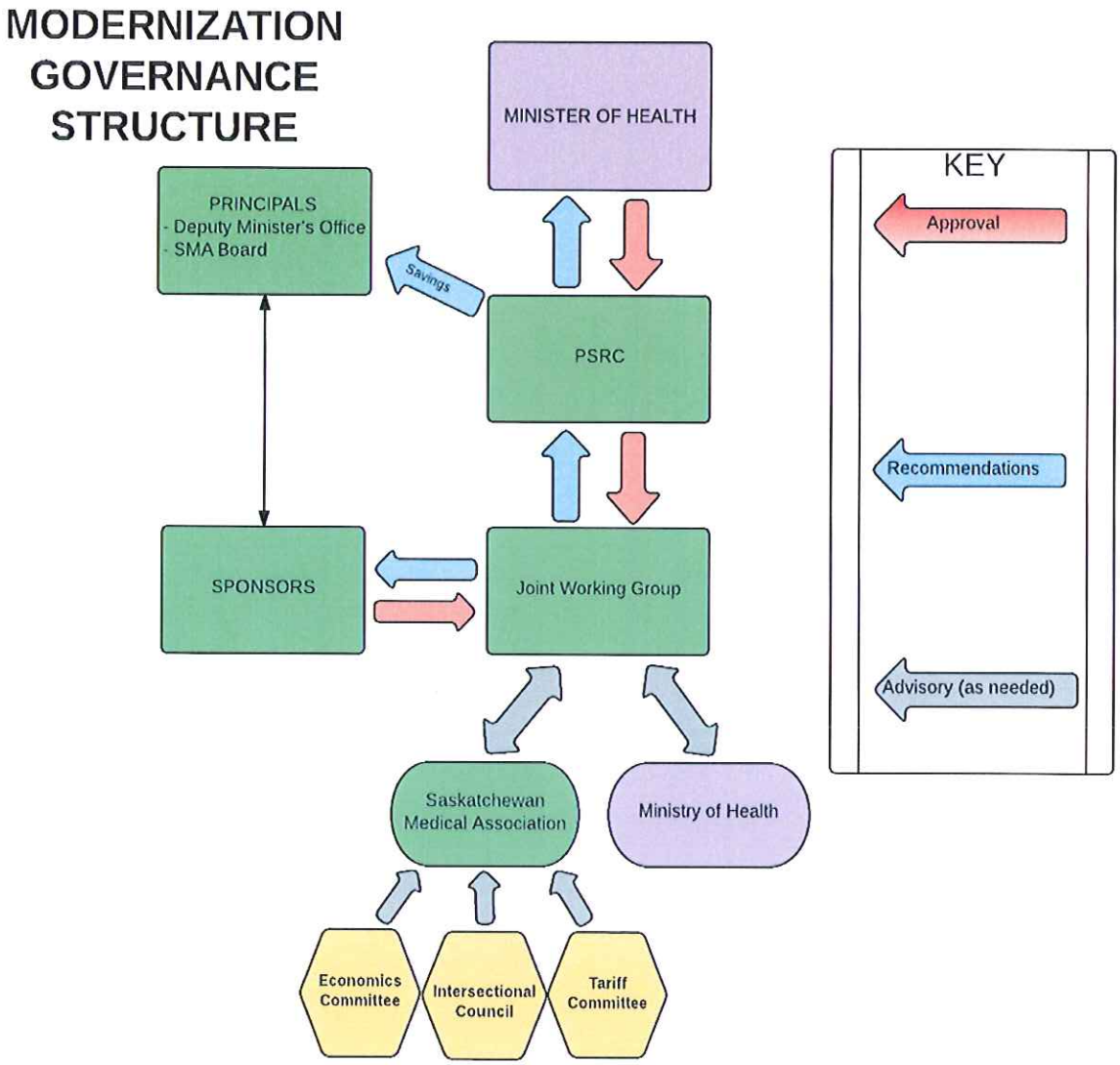
2. Project Management

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

APPENDIX A:

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.

APPENDIX B:

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 arthoroscopy 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 procedures, 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.

SCHEDULE "A"

RURAL AND REGIONAL PROGRAMS AND INCENTIVES

Programs and incentives developed pursuant to section 9(1)(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 9.1(b) 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 licensure with the College of Physicians and Surgeons of Saskatchewan under sections 28 (full licence), 29 (provisional licence), 30 (special licence) of the Medical Profession Act, **or** hold licensure with the College of Physicians and Surgeons of Saskatchewan under section 31 (locum licence) of the Medical Profession Act and be resident and practising in the province for at least six months;
- 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 insured medical services in Saskatchewan under a salary, contract or blended funding arrangement and meet the minimum practice activity thresholds (see below),
- 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 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 (until December 31, 2015) during the period in which they resided and practised 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 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 an average of 20 paid working hours per week or $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 (until December 31, 2015) 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 an average of 10 paid working hours per week or $30,000 per year. For physicians working between 10 and 20 hours per week (or $30,000 and $60,000), the pro-rated entitlement is calculated using the following formula:

> (Physician's average weekly hours/20) multiplied by the cost of CMPA coverage for the period in which the physician was otherwise eligible for the program.
>
> OR
>
> (Physician's annual clinical income/$60,000) multiplied by the cost of CMPA coverage for the period in which the physician was otherwise eligible for the program.

Locum Eligibility/Back Payment:

Once a locum becomes eligible for benefits (resides and practises in Saskatchewan for at least six months), reimbursements will be back-paid to the first month in practice, provided all other eligibility criteria is met.

Calculation of Payment for calendar year 2016 and thereafter:

"minister's maximum contribution" is the amount derived from the following calculation:

(i) the actual cost of CMPA reimbursement paid by the minister for the calendar year 2015 plus 5% of that amount;

(ii) less the amount derived by multiplying the number of eligible physicians for the calendar year

For the 2016 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.

In no case will the amount to be paid by the minister under this section exceed the minister's maximum contribution.

In the event that the amount calculated above exceeds the minister's maximum contribution, any additional amount is the responsibility to be paid by the board or by eligible physicians.

SCHEDULE "C"

SASKATCHEWAN MEDICL ASSOCIATION (SMA)
CONTINUING MEDICAL EDUCATION FUND

Pursuant to section 9.1(c) 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 a medical administrative position approved by the Advisory Committee.

Benefits

Full-time benefits apply when:

- The Physician has an employment or other alternate remuneration arrangement during the fiscal year and has provided an average of at least 20 hours service or more per working week; or

- The Physician is engaged as a fee-for-service physician during the fiscal year and received a minimum of $60,000 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 provides an average of at least 10 but less than 20 hours service per working week; or

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

- The Physician has declared himself/herself to be in part-time practice.

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.

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 entitlement to the individual physician will be derived by dividing the total amount available for the year [Government CME Fund Contributions minus Administration Expenses] by the number of eligible physicians, adjusting for the expected level of physician uptake.

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.

Evaluation of Fund

There shall be an annual evaluation of the effectiveness of the Fund in achieving its expressed goal of facilitating continuing medical education. This evaluation shall be part of the Annual Report prepared by the Advisory Committee.

Changes to Physician Entitlements

Both parties to this Agreement recognize that individual entitlements may be altered by expanding the minister's contributions to the Fund, or making entitlements consistent with utilization. It is recognized that changing entitlements according to utilization experience and in consideration of the overall limits of the CME Fund is within the mandate of the Advisory Committee.

Changing the amount of the Fund requires a negotiated agreement between the minister and the board.

SCHEDULE "D"

SPECIALIST EMERGENCY COVERAGE PROGRAM (SECP)

Pursuant to Section 5 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, regional health authorities 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"

RURAL EMERGENCY ON-CALL PROGRAM

Pursuant to Section 5 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 Regional Health Authorities 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 regional health authority.

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 regional health authority.

   Category B -- these are smaller acute care facilities or health centres that the regional health authority 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 regional health authorities, Saskatchewan 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. Regional health authorities, in consultation with regional medical associations and 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 5 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 9.1(f) 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 Sections 28 of *The Medical Profession Act;*

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

  (c) be self-employed; and

  (d) be providing insured clinical services.

- Physicians must also reside in the province while receiving benefits under the program.

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 $1,300 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. In the case where two spouses apply for benefits (ie. both are physicians eligible under the program), they would be eligible for a combined maximum of 20 weeks of benefits.

Advisory Committee

The minister and the board agree to form a committee with two representatives from the Department 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 9.1(d) 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 licence 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:

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

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/1 2months)*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

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 following in the period April 1, 2001 to March 31, 2006, the Physician earns more than Ten Thousand (S 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

a) Prior to a Payee's Vesting Date, the Payee will be sent an election form (in the appropriate form from Schedule "A"). The Payee will be requested to elect the method by which the Payee will receive benefits upon vesting. The Payee may elect as follows:

   i) A Payee may be paid his, her or its benefits in a lump sum as soon as reasonably possible after the Payee's Vesting Date; or

   ii) A Payee may elect, prior to the Vesting Date, to defer all of the benefits to a specified date selected by the Payee, which date shall be after the Payee's Vesting Date but before the date that is four (4) years after the Payee's Vesting Date ("Elected Date").

   The executed election form must be delivered to the Plan Administrator of the Fund prior to the Payee's Vesting Date.

b) Upon delivery of an executed election form described in section 5.1(a), the Payee's election shall be irreversible and irrevocable, and the Payee will be paid his, her or its benefits in accordance with that election.

c) Unless the Payee elects in the manner set forth in section 5.1(a), the Payee will be deemed to have elected to receive all benefits in a lump sum payment as soon as reasonably possible following the Payee's Vesting Date. This deemed election shall be irreversible and irrevocable as of the Payee's Vesting Date.

d) In the event that a Payee elects in accordance with this section 5.1 to defer the benefits to an Elected Date, the Payee shall only be entitled to receive payment of the benefits on the Elected Date, and not before that date. Any amounts deferred in accordance with this section 5.1 shall be paid without interest.

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 licence 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 9.1(e) 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 three 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 9.1(e) 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 9.1(g) 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 followup 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 9.1(k) 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 9.1(i) 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, Regional Health Authorities (RHAs) 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:

- RHAs;
- 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".

<u>Ineligible Projects and Support</u>
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).

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.

Eligible Time	Examples of Non-Eligible Time
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)	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)
	Physicians in positions paid by Regions where QI work is already part of their position responsibilities
	Medical leadership (including SMOs) and administrative physician work time involving regular or ongoing department, section head or management meetings or committee work
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	Physician travel time
	Physician time spent doing preparation work, homework assignments or other work outside of QI training.
Time spent participating in an eligible sponsoring organization-approved project not directly linked to the achievement of the	Physician time spent backfilling a physician who is taking part in QI work or training.

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	Physician time spent on mortality and morbidity rounds or other intra-departmental matters
	Cancelled projects or meetings

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.

Revised: November 27, 2015

SCHEDULE "L"

FAMILY PHYSICIAN COMPREHENSIVE CARE PROGRAM AND METRO ON CALL PROGRAM

Pursuant to Section 9.1(j) 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, Dalmeny, Delisle, 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, 626A, 790A, 915A, visit services with "Home" location	n/a	1	20	n/a
3-Pre/Postnatal, Deliveries, Well Baby	4B, 8B, 41P, 42P	3	2	1	1

Care					
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, 790A, 791A, 793A, 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.
- Satellite clinics are identified and services are combined as follows:
  - Services for the physicians with a "Solo" satellite practice in "Rural" communities with annual billings less than $60K will be combined to their other practice in a different community with annual billings of more than $60K (main clinic), if both practices are active simultaneously during the year. In this situation, all clinics will be assessed as a whole, with the Premium being calculated from the total earnings of all combined clinics.

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%		

* clinics that meet three out of five service groups or lower are ineligible for a premium

- 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: Lorna Billan
   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.