Rural Retention Program (RRP)
Policy

Ministry of Health

Effective August 2023

1.1 Description:

The Rural Retention Program (RRP) is a provincial program established by the Rural Practice Subsidiary Agreement (RSA). The RRP was implemented on January 1, 2003.

The RSA sets out the eligibility criteria, as determined from time to time by the Government of BC (Government), Doctors of BC (DoBC) and Medical Services Commission (MSC), by which a practicing physician may receive the RRP incentive.

1.2 Purpose:

The purpose of the RRP is to provide a provincial rural incentive program to enhance the supply and stability of physician services in eligible RSA communities (see Appendix 1). Communities are assessed annually for RRP eligibility, which may change from one year to the next.

2.1 Policy:
Physicians *practicing* in eligible RSA communities will receive the RRP Fee Premium on claims paid by the Medical Services Plan (MSP); the maximum RRP Fee Premium is 30 percent. A physician *residing and practicing* in an eligible RSA community for at least 9 months of the year may also receive the RRP Flat Fee (inclusive of the Rural Business Cost Modifier (RBCM)) payment allocated to the community.

2.2 A physician in an eligible RSA community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the RRP Fee Premium.

2.3 The RRP Fee Premium and Flat Fee (inclusive of RBCM) are based on the Medical Isolation Point Assessment (see Appendix 3) and are set annually by the Joint Standing Committee on Rural Issues (JSC).

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Section:	3: Definitions	**Effective:**	August 2023

Term	Definition
Alternative Payments	• Methods of payment, other than FFS, for physician services. Includes New to Practice contracts, Longitudinal Family Practice (LFP) payment model, Population Based Funding (PBF) and the Northern Model
APP	• Alternative Payments Program: A Ministry program, administered from within the Health Human Resources and Labour Relations Division that promotes, provides funding for, and offers payment options to agencies employing or contracting physician services.
Designated Specialties	• Designated specialties include General Surgery, Orthopedics, Pediatrics, Internal Medicine, Obstetrics/Gynecology, Anesthesia, Psychiatry, and Radiology.
DoBC	• Doctors of BC
Eligible RSA Community	• An RSA community which meets all the criteria for the RRP.
FFS	• Fee-for-Service is a method of physician compensation based on direct patient services. Applicable fees are established by the Medical Services Commission.
FTE (for medical isolation points calculation)	• The Full Time Equivalent income figure is based on the 40th percentile of MSP earnings for FPs and for each specialty in the previous calendar year as defined by MSP.
FPSC	• Family Practice Services Committee is a Joint Collaborative Committee of the Ministry of Health and Doctors of BC.
Health Authority (HA)	• Governing bodies defined under the Health Authorities Act (RSBC, 1996) with responsibility for the planning, coordination, and delivery of regional and/or provincial health services, including hospital, long term care, primary and community services and designated specialized services.
Itinerant Physician	• A physician who travels from his/her home community to an eligible RSA community to provide outreach/direct patient services.
Job Share	• Health Authorities may formally deem, in writing to the MOH, that a practice position as being shared by two or more physicians to fulfill medical services in the community.
Locum Tenens	• A physician with appropriate medical staff privileges (locum tenens) who substitutes on a temporary basis for another physician.
MOH	• Ministry of Health

Permanent Residence	• A permanent residence is defined as the permanent home address of a physician; listed on their federal and provincial income tax returns, BC Driver's License, and claim their Homeowners Grant (if applicable). This does not include a secondary residence owned/rented by a physician.
Resident Physician(s)	• For the purposes of this program, a physician who permanently resides and practices for at least 9 months of every year in an RRP community.
RSA	• The Rural Practice Subsidiary Agreement (RSA) is an agreement negotiated by the BC Government, Doctors of BC and Medical Services Commission and administered by the JSC.
Service Clarification Code (SCC)	• Code (Appendix 1) for the RSA community in which the service has been provided which must be indicated on all billings submitted by the physician to receive the RRP *Fee* Premium.

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Section:	4: Joint Standing Committee on Rural Issues (JSC)	**Effective:**	August July 2023

4.1 The JSC is responsible for the application and administration of the RRP, and reports to the MSC for those programs directly related to the Available Amount (AA). The JSC may periodically review and change the factors and their weighting.

4.2 The JSC is comprised of 5 members appointed by DoBC, 5 members appointed by the Government, up to 3 alternates for each party, and invited guests. Government appointees may include representatives from rural Health Authorities (HA's). The JSC meets a minimum of 6 times a year and is Co-Chaired by a member chosen by the Government and a member chosen by DoBC.

4.3 Where a community has been recommended for inclusion in the RSA, the JSC must evaluate the community using the Medical Isolation Points Assessment criteria to determine eligibility for RRP. If the evaluation results in a rating for the community of at least the minimum number of points, as determined by the JSC, the JSC must add the community to the RSA.

4.4 All case reviews/appeals concerning point allocations and eligibility must be submitted in writing to the JSC. The JSC may choose to hear this appeal in- person. If the JSC chooses not to alter its decision, the physician and/or HA may request a review through the JSC, in writing, to the MSC. At the MSC's discretion, it may review the issue/case and make recommendations to the JSC. Should you wish to request a review, e-mail a request ***within 30 days*** from the date of the response from the JSC to:

Co-Chairs
Joint Standing Committee on Rural Issues
Email: Hlth.ruralprograms@gov.bc.ca

5.1 RRP Fee Premium

Practitioners eligible for the RRP Fee Premiums include resident physicians, itinerant physicians and locum tenens that provide medical services *directly in* eligible rural communities as outlined in the RSA (see Appendix 1, RSA communities).

5.2 Payment of Fee Premium

Eligible physicians will receive the RRP Fee Premium on their FFS and LFP billings submitted for services in eligible RSA communities.

To receive the RRP Fee Premium, the Service Clarification Code (SCC) for the community in which the service has been provided must be indicated on all billings submitted by the physician. No retroactive payments will be made. Any premiums paid in error on claims submitted with the incorrect SCC will be recovered.

Eligible physicians funded by an alternative payment arrangement will receive the RRP Fee Premium Equivalent (FPE), calculated on contract payments for eligible services.

5.3 Payment of RRP Fee Premiums on Telehealth/Virtual Care Services

Any physician who provides telehealth/virtual care services while present in an RSA community to a patient who is located in a different RSA community, will be eligible for the RRP Fee Premium based on the physician's location. Physicians must indicate the SCC of the RSA community where they are physically located at the time of service.

Physicians who provide telehealth/virtual care services from an RSA community to a patient located in a non-RSA community are *not* eligible for the RRP Fee Premium. Physicians who provide any telehealth services from a non-RSA community, regardless of patient's location, are not eligible for the RRP Fee Premium.

5.4 Payment of RRP Fee Premiums for Itinerant Physicians

If a physician provides itinerant services to a rural community eligible for the RRP Fee Premium, they may indicate the SCC of the RSA community where they provide the service on their billings. The RRP Fee Premium is based on where the physician is physically located, not the patient. If a physician provides follow-up services to the patient upon returning home they would only receive the RRP Fee Premium of their home location if applicable; no RRP Fee Premium would be paid if the physician resides in a non-RSA community. This applies to all payment modalities including FFS, APP, sessions, etc.

5.5 Application of RRP for Diagnostic Services

A physician who practices in an eligible RSA community and provides radiology or pathology services to an approved hospital or facility may be eligible to receive the RRP on the professional component of outpatient radiology and category I, II, and III laboratory medicine services. A listing of the professional component, provided by the DoBC, is used in the RRP calculation process.

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Section:	6: Eligibility: Flat Fee Payment (including Rural Business Cost Modifier (RBCM))	**Effective:**	August 2023

6.1 General application of RRP Flat Fee (includes RBCM)

6.1.1 A physician who permanently resides and practices at least 9 months per year and bills $75,000 or greater for eligible services in the previous calendar year in an eligible RSA community may receive the RRP Flat Fee (includes RBCM) payment.

6.1.2 Eligible billings to achieve the $75,000 threshold include FFS (MSP) and/or APP (service, session, or salary contract) payments. This also includes the RRP Fee Premium, tray fees, visit and procedural premiums, retroactive payments, FPSC fees and reciprocal payments.

6.2 Eligibility to Receive the Flat Fee (includes RBCM) payment:

6.2.1 If a physician permanently resides and practices solely in a community that qualifies for the RRP, the physician will receive the RRP Flat Fee of the community in which they permanently reside and practice.

6.2.2 If a physician permanently resides in an eligible RSA community but practices in a different eligible RSA community (for at least 9 months of the year), they will receive the RRP Flat Fee for the community where they practice.

6.2.3 If a physician permanently resides and practices in an eligible RSA community and also practices in a different RSA community (for at least 9 months of the year) they will receive the RRP Flat Fee for the community where they permanently reside and practice.

6.3 If a physician moves from the community following the 9 months of the year requirement, they will receive the RRP Flat Fee prorated to the date they leave the community. If the physician bills less than $75,000 during that period, they receive no RRP Flat Fee.

6.4 New physicians are entitled to the RRP Flat Fee, retroactively, upon successful completion of the 9 months of the year requirement in an eligible RSA community. HA's are required to report new physicians, start dates, status and permanent residence to the MoH on a quarterly basis. Reconciliation and payment of the retroactive RRP Flat Fee will be made on a quarterly basis.

6.5 Payment of the RRP Flat Fee will not be released if reported to the MoH after one year from the physician's date of eligibility.

6.6 Locum tenens are not generally eligible for the RRP Flat Fee (includes RBCM).

6.7 Supplemental physicians, who are identified as filling a vacancy in the HA Physician Supply Plan, or equivalent, who permanently reside in the community and meet the remaining eligibility criteria may be eligible for the RRP Flat Fee. Note: supplemental physicians do not fill in for other physicians.

In cases where a HA does not have an approved Physician Supply Plan, it is permissible to calculate physician vacancies using the method set out in the Rural Practice Subsidiary Agreement (RSA).

6.8 If the HA deems in writing to the MoH a position is a formalized job-share position, the physicians sharing the position may be eligible to share the RRP Flat Fee provided they meet the eligibility requirements outlined above.

6.9 A physician who is on a HA approved leave of longer than 92 days, consistent with the criteria and time limits set out within the Medical Staff By-laws (e.g., for illness, skills enhancement, sabbatical, leave of absence) will not be eligible for the RRP Flat Fee after the 92 day period.

Physicians on maternity/parental leave are eligible for up to 1 year of continued RRP Flat Fee.

6.10 Physicians on a medical leave of absence may be eligible for up to 1 year of continued RRP Flat Fee. A signed medical note with the dates of the leave must be provided to the Ministry and HA.

6.11 A physician who returns to an RSA community, after a period of absence of less than two years, and who has previously qualified for the RRP Flat Fee, will recommence eligibility, providing that they permanently reside and practice in an eligible RSA community and bills $75,000 or greater.

7.1 The Medical Isolation Point assessment and the determination of the value of the RRP retention payments resulting from those points shall be determined by the JSC.

7.2 For a new community to be assessed and considered for inclusion in Appendix A of the RSA, a letter of application must be submitted by the HA by e-mail to the JSC, to:

Co-Chairs
Joint Standing Committee on Rural Issues
Email: Hlth.ruralprograms@gov.bc.ca

7.3 The JSC may also recommend inclusion of communities for assessment as appropriate.

7.4 The total Medical Isolation Points result must be at least 1.5 for a community to be eligible for the RRP Fee Premium and/or Flat Fee. D communities which have less than 1.5 total Medical Isolation Points are not eligible for the RRP Fee Premium or Flat Fee (including RBCM). An RSA community's total Medical Isolation Points determine the RRP Fee Premium and Flat Fee as follows:

70% of the total Medical Isolation Points are awarded as the RRP Fee Premium (to a maximum of 30% for communities with a minimum of one resident physician or vacant position as indicated in the HA Physician Supply Plan. For eligible RSA communities with no resident physician or vacancy, 100% of the total Medical Isolation Points are applied as the RRP Fee Premium, to a maximum Fee Premium of 30%.

The remaining 30% of the total Medical Isolation Points multiplied by a per point dollar figure determined by the JSC, are applied as the RRP Flat Fee when a community has a minimum of one resident physician or vacant position as indicated in the HA Physician Supply Plan.

7.5 If the annual Medical Isolation Points review results in a community falling below the minimum isolation points required to qualify, the community will be removed from Appendix A of the RSA. The JSC, as its sole discretion, may seek to ensure eligible physicians in that community receive 50 percent of the previous year's retention allowance (RRP Fee Premium and Flat Fee – if received previously) for a one-year period.

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Section:	8: Monitoring, Reporting, Evaluation	**Effective:**	August 2023

8.1 The MoH will monitor RRP expenditures on a regular basis and perform an annual reconciliation of program expenditures.

8.2 For the purpose of determining isolation points, HA's will report physician numbers and vacancies on a quarterly basis, as per the MoH's request. That information will be integral to the development of the HA's regional Physician Supply Plans or equivalent.

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Section:	APPENDIX 1: Communities Covered by RSA Subject to Meeting the Minimum Point Requirement	**Effective:**	August 2023

For the full list of eligible RSA Communities, including their designation and SCC codes, see RRP Points: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/rrp_points.pdf

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Section:	APPENDIX 2: Medical Isolation Point Rating System	**Effective:**	August 2023

RRP Medical Isolation Point Rating System

Factor	Points	Max Points
Number of Designated Specialties within 70km		
0 Specialties within 70km	60	
1 Specialty within 70km	50	
2 Specialties within 70km	40	
3 Specialties within 70km	20	
4+ Specialties within 70km	0	60
Number of Family Practitioners within 35km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
Community Size (If larger community within 35km then larger pop is considered)		
30,000 +	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
Distance from Major Medical Community (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)		
first 70 km road distance (70km-104km)	4	
for each 35km over 70km	2	
to a maximum of	30	30
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
Location Arc		
Communities in Arc A (within 100km air distance from Vancouver)	0.10	
Communities in Arc B (between 100-300km air distance from Vancouver)	0.15	
Communities in Arc C (between 300-750km air distance from Vancouver)	0.20	
Communities in Arc D (over 750km air distance from Vancouver)	0.25	
RSA Specialist Centre		
3 designated specialties in physician supply plan	30	
4 designated specialties in physician supply plan	40	
5 to 7 designated specialties in physician supply plan	50	
8 designated specialties and more than one specialist in each specialty as set out in the physician supply plan	60	60

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Section:	APPENDIX 3: Medical Isolation Point Assessment	**Effective:**	August 2023

MEDICAL ISOLATION POINT ASSESSMENT

Medical Isolation Factors

1. **Number of Designated Specialties within 70 km**
   All designated specialties within 70km (by road or ferry) of the community where the specialist(s) meet the FTE income figure as defined below are counted.

2. **Number of Family Practitioners (FP's)within 35 km**
   FP's practicing within 35km (by road) of the community and who meet the FTE income figure as defined below are counted. FP's practicing in a community within 35km of the community by ferry are not counted.

3. **Distance from a Major Medical Community**
   Major Medical Communities are designated as Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, and Prince George. Major Medical Community is defined as those communities with at least 3 specialists in each of the Designated Specialties.

   Maximum points are awarded for communities with no road or ferry access.

4. **RSA Specialist Centre**
   Communities will be assigned points for the RSA Specialist Centre when their regional Physician Supply Plan requires 3 or more designated specialties to provide services in a community. To be considered an RSA Specialist Centre, communities are required to be included in Appendix A of the RSA.

   An RSA community located within 35km (by road) of an RSA Specialist Centre will receive the same points as the RSA Specialist Centre for this factor.

Living Factors

5. **Community Size**
   Where a community is within 35km by road of a larger community, the points are based on the population of the larger community. Where a community is within 35km of a larger community by ferry, the population of the larger community is not counted. When two communities are combined in this Agreement, the populations will be amalgamated.

Community populations are established annually using the most recent National Census-based estimate for the preceding calendar year, which is supplied by BC STATS, Ministry of Finance and Corporate Relations. They are based on regional districts defined by the Ministry of Community, Aboriginal and Women's Services. In case of changes to regional districts from one year to the next, population assignment is determined by MSP, based on all available information (available on request).

6. **Degree of Latitude**
   Points are allocated for those communities in British Columbia located at and above the 52° of latitude.

7. **Location Arc**
   Four differential multipliers have been established for the purpose of determining the final point total for determination of retention allowances. Arcs are based on air distance from Vancouver and multiplied by the applicable factor to determine the community's final point total.

DESIGNATED SPECIALTIES:

1. Designated specialties include General Surgery, Orthopedics, Pediatrics, Internal Medicine, Obstetrics/Gynecology, Anesthesia, Psychiatry, and Radiology.

2. Physician FTE count: At the beginning of each calendar year, the number of physicians practicing in each community is verified through written confirmation by the responsible HA. This is done in collaboration with the local and/or regional Medical Advisory Committee.

3. A confirmation form must be submitted for all communities.

4. Physicians are counted as one FTE if their total income (including FFS, salary, sessional and subsidy income) exceeds the FTE income figure established by MSP for that year for their specialty.

Income includes FFS, service contract, salaried earnings, and sessional payments. It also includes the RRP Fee Premium, tray fees, visit and procedural premiums, retroactive payments, FPSC fees and reciprocal payments.

For those physicians who did not practice in the community for the full year, income will be extrapolated to produce an estimated annual income figure. For physicians whose total income (or estimated annual income) is below the FTE income figure, the incomes of all such physicians will be added and divided by the FTE income figure.

The resulting number is rounded down to the nearest whole number, which is counted in the number of physicians in the community. If there is more than one specialist in the same specialty meeting the FTE income figure, only one specialist is counted; if there is more than one specialist in the same specialty who do not meet the FTE income figure, the incomes of those specialists are combined to determine if their combined income equals an FTE. FP's practicing more than 75 percent in a specialty (based upon FFS billings) will be counted as specialists; all specialists practicing more than 75 percent as a FP (based upon fee for service billings) will be counted as a FP. The MSP FTE income figure is based on the 40th percentile of earnings for each specialty in the previous calendar year as defined by MSP.

ROAD DISTANCES:

In all cases where reference is made to road distances, these distances are determined using Google Maps:

- Road distances are converted to travel time using an assumed average speed of 70km per hour.
- For communities accessible only by ferry, a multiplier is applied to the ferry distance, based on data from the BC Ferry Corporation and the Ministry of Transportation.
- Where communities are combined in this Agreement, the distance from the furthest community is used.