Rural Retention Program (RRP)
Policy

Ministry of Health

Revised June 2025

1.1 Description:

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

1.2 Objectives

The objectives of this policy are to outline the criteria and eligibility of the RRP.

1.3 Scope

This policy applies to physicians, health authorities and other key partners administering the RRP.

1.4 Oversight:

The RRP is a rural physician program under the Rural Practice Subsidiary Agreement (RSA), which is a subsidiary agreement of the Physician Master Agreement between the BC Government, Doctors of BC (DoBC), and the Medical Services Commission (MSC).

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.

The Joint Standing Committee on Rural Issues (JSC), established under the RSA, is comprised of representatives from DoBC, the Ministry of Health (the Ministry) and the health authorities (HAs). The JSC advises the BC Government and DoBC on matters pertaining to rural medical practice and is responsible for the overall governance of the rural programs for physicians.

The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of BC by addressing some of the unique and difficult circumstances faced by physicians in these areas.

1.5 Administration

The Ministry, in collaboration with the HAs, provide the day-to-day administration of the RRP in accordance with the policies and procedures established by the JSC.

1.6 Policy

Physicians who practice in eligible RSA communities may be eligible to receive the RRP Fee Premium on claims paid by the Medical Services Plan (MSP) (including both Fee-For-Service (FFS) and Longitudinal Family Practice (LFP) payment models); the maximum RRP Fee Premium is 30 percent.

Physicians who practice in eligible RSA communities that are funded by an alternative payment arrangement may be eligible to receive the RRP Fee Premium Equivalent (FPE), a retention payment equivalent to the RRP Fee Premium.

Physicians who permanently reside in an RSA community year-round, and practice for at least 9 months of each year in an eligible RSA community may also be eligible for the RRP Flat Fee (inclusive of the Rural Business Cost Modifier (RBCM)) payment allocated to the RSA community.

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

Term	***Definition***
Alternative Payments Program (APP)	A MoH program that works with and funds health authorities or similar agencies to improve service delivery and patient access to services through alternative physician compensation models to fee-for-service and the Longitudinal Family Physician payment model. Alternative payment models include service contracts, sessional contracts, and salary agreements.
Designated Specialties	Designated specialties include General Surgery, Orthopedics, Pediatrics, Internal Medicine, Obstetrics/Gynecology, Anesthesia, Psychiatry, and Radiology. These specialties are used as part of the Medical Isolation Point Assessment (see Appendix 3).
Fee-for-Service (FFS)	Method of payment whereby physicians bill for services provided on a FFS basis
Family Practice Services Committee (FPSC)	FPSC is a Joint Collaborative Committee of the Ministry of Health and Doctors of BC.
Full Time Equivalent (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.
Health Authority (HA)	Governing bodies, as per *Health Authority Act*, with responsibility for the planning, coordination, and delivery of regional health services, including hospital, long term care and community services.
Itinerant Physician	A physician who travels from their home community to an eligible RSA community to provide outreach/direct patient services.
Job Share	Health Authorities may formally deem, in writing to the Ministry of Health, a practice position as being shared by two or more physicians to fulfill medical services in the community.
Locum Physician	A physician with appropriate medical staff privileges who substitutes on a temporary basis for another physician (host physician) and who works as an independent contractor with the program.
Longitudinal Family Physician (LFP) Payment Model	A blended payment model to support physicians in family practice who provide longitudinal family medicine care. It supports FPs by compensating for time, patient interactions, and the number and complexity of patients in their practice.
Permanent Residence	The permanent home address of a physician; listed on their federal and provincial income tax returns, BC Driver's License, and their BC Home Owners 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 in an RSA community for at least 9 months of every year.
Rural Business Cost Modifier (RBCM)	The RBCM is an enhancement to the RRP Flat Premium to support the business costs of physicians who reside and practice in RSA Communities, subject to the same terms, conditions, rules, and eligibility criteria as the RRP.
Rural Practice Subsidiary Agreement (RSA) Community	A rural community that meets all the criteria of the RRP, included in Appendix A of the RSA.
Rural Retention Program (RRP) Fee Premium	Physicians providing services in eligible RSA communities may receive a premium on their MSP FFS/LFP billings and/or APP income.
Rural Retention Program (RRP) Flat Fee	Physicians who maintain their Permanent Residence and practice in an eligible RSA community for at least 9 months of the year, and earn at least $75,000 in eligible income, may qualify for an additional block incentive based on their community's Medical Isolation Points Assessment.
Service Clarification Code (SCC)	MSP Code for the community in which the physician services have been provided, which must be indicated on all MSP billings submitted by the physician in order to receive the RRP fee premium.
Supplemental Physician	A physician who does not have a permanent position in the community, who is providing additional support required to maintain services in the community, is not substituting for another physician, and is filling a vacancy in the physician supply plan.

3.1 The JSC is responsible for the application and administration of the RRP and may periodically review and change the factors and their weighting.

3.2 The JSC is comprised of 5 members appointed by the 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 (HAs). 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.

3.3 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.

3.4 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.JSCSecretariat@gov.bc.ca

4.1 RRP Fee Premium

Physicians eligible for the RRP Fee Premium include resident physicians, itinerant physicians and locum tenens who provide medical services directly in eligible RSA communities as outlined in Appendix 1, RSA communities.

4.2 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 RSA community in which the service has been provided must be indicated on all billings submitted by the physician. Retroactive payments will follow MSP rules. 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. This funding is paid by the regional Health Authorities to eligible physicians.

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

Any physician who provides telehealth/virtual care services while physically present in an RSA community, to a patient who is located in the same RSA community or 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 while physically present in an RSA community to a patient located in a community that is not included in the RSA are not eligible for the RRP Fee Premium.

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

4.4 Payment of RRP Fee Premiums for Itinerant Physicians

Physicians who provide itinerant services to a rural community are eligible to receive the RRP Fee Premium. Eligibility for the 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 designated as an RSA community; no RRP Fee Premium would be paid if the physician resides in a community that is not included in the RSA. This applies to all payment modalities.

4.5 Application of RRP for Diagnostic Services

Physicians who practice in an eligible RSA community and provide radiology or pathology services to an approved hospital or facility may be eligible to receive the RRP Fee Premium Equivalent (FPE) 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: 5	Eligibility: Flat Fee Payment (including Rural Business Cost Modifier (RBCM))	**Effective:**	April 2025

5.1 Physician eligibility to receive the RRP Flat Fee (includes RBCM):

5.1.1 Physicians must maintain their Permanent Residence (home address) in an eligible RSA community year-round and provide clinical services for at least 9 months of the year (considering time off for vacation, CME; see Section 2, Permanent Residence).

5.1.2 Physicians must bill $75,000 or greater for eligible clinical services provided in the previous calendar year in an eligible RSA community. This also includes the RRP Fee Premium, tray fees, visit and procedural premiums, retroactive payments, FPSC fees. Note: Reciprocal payments, ICBC and WCB income are excluded from the eligible income. Medical Administration contracts (e.g. Medical Directors) are not considered eligible income as it is not clinical income.

5.2 Application of the RRP Flat Fee (includes RBCM):

5.2.1 If a physician maintains their Permanent Residence and practices in the same RSA community that qualifies for the RRP, the physician will receive the RRP Flat Fee for the RSA community where they permanently reside and practice.

5.2.2 If a physician maintains a Permanent Residence in an RSA community but permanently practices in a different eligible RSA community, they will receive the RRP Flat Fee for the RSA community where they practice.

5.2.3 If a physician maintains a Permanent Residence and practices in the same eligible RSA community, but also practices in a different RSA community, they will receive the RRP Flat Fee for the RSA community where they both permanently reside and practice.

5.3 If a physician moves from the RSA community following the completion of 9 months of clinical services, they will receive the RRP Flat Fee pro-rated to the date they leave the RSA community. If the physician bills less than $75,000 during that period, they receive no RRP Flat Fee.

5.4 New physicians are entitled to the RRP Flat Fee, retroactively, upon successful completion of the one-year permanent residency and 9-month clinical practice requirement in an eligible RSA community. HAs are required to report new physicians, start dates, status and Permanent Residence to the Ministry on a quarterly basis. Reconciliation and payment of the retroactive RRP Flat Fee will be made on a quarterly basis.

5.5 Physicians on maternity/parental or medical leave may be eligible for up to 1-year of continued RRP Flat Fee (includes RBCM) payments.

5.6 For medical leaves, a signed medical note from their treating physician with the dates of the leave may be requested by the Ministry and/or the HA.

5.7 Effective April 1, 2025, if a physician begins a maternity/parental or medical leave before meeting the initial 9 month eligibility requirement, they will be eligible for the RRP Flat Fee for the period of their leave, if they return to work and complete the remaining month(s) of their 9-month eligibility requirement or a period equal to their leave, whichever is longer, to be eligible for the benefit.

5.8 Effective April 1, 2025, if a physician who is already eligible for the RRP Flat Fee begins a maternity/parental or medical leave, they are required to return to work for the same duration of the leave taken to be eligible for the benefit.

5.9 The RRP Flat Fee will be repayable to the Ministry by the Physician (via the health authority) if the physician does not carry on practice for the required duration outlined in 5.7 or 5.8.

5.10 Physicians who are reported late to the Ministry may be eligible for up to 1-year of retroactive RRP Flat Fee (includes RBCM) payments, from the physician's date of eligibility.

5.11 Locum physicians are not eligible for the RRP Flat Fee (includes RBCM).

5.12 Supplemental physicians, who are identified as filling a vacancy in the HA Physician Supply Plan (or equivalent), who permanently reside in the community year-round 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 Appendix C to the Rural Practice Subsidiary Agreement (RSA).

5.13 If the HA deems in writing to the Ministry a position is a formalized job-share position, the physicians sharing the position may be eligible to share the RRP Flat Fee (includes RBCM) provided they meet the eligibility requirements outlined above. Job-share physicians share all rural benefits except for the Rural Continuing Medical Education (RCME) Individual Fund.

5.14 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., skills enhancement, sabbatical, leave of absence) will not be eligible for the RRP Flat Fee after the 92-day period.

5.15 A physician who returns to an RSA community, after a period of absence of less than 2 years, and who has previously qualified for the RRP Flat Fee, will recommence eligibility, providing that they meet the Permanent Residence and clinical service guidelines set out in section 5.1.

6.1 The Medical Isolation Points Assessment and the determination of the value of the RRP retention payments resulting from those points is determined annually by the JSC.

6.2 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.JSCSecreatriat@gov.bc.ca

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

6.4 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.

6.5 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% of the previous year's retention allowance (RRP Fee Premium and Flat Fee – if received previously) for a 1-year period.

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

7.2 For the purpose of determining isolation points, HA's will report physician numbers and vacancies on a quarterly basis, at the Ministry'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:**	April 2025

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:**	April 2025

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	60
4+ Specialties within 70km	0	
Number of Family Practitioners within 35km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	60
0 to 3 Practitioners	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	25
Up to 5,000	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	30
to a maximum of	30	
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	30
Communities above 53 degrees latitude	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 HA Physician Supply Plans	30	
4 designated specialties in HA Physician Supply Plans	40	
5 to 7 designated specialties in HA Physician Supply Plans	50	
8 designated specialties and more than one specialist in each specialty in HA Physician Supply Plans	60	60

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.

   Designated specialties include General Surgery, Orthopaedics, Paediatrics, Internal Medicine, Obstetrics/Gynecology, Anaesthesia, Psychiatry, and Radiology.

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.

   FP and Designated SP Count: Physician FTE count: At the beginning of each calendar year, the number of physicians practicing in each community is verified by the RRP physician count as at December 31 of the previous year as submitted by each HA.

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

   Income includes all fee payments types. It also includes the RRP Fee Premium, tray fees, visit and procedural premiums, retroactive payments, FPSC fees and reciprocal payments. **Non-clinical income, including Medical Administration contracts, is not considered.**

   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.

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 Citizens' Services.

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

8. ROAD DISTANCES

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

- For communities accessible only by ferry, the distance is calculated by multiplying the water distance x 8; the ferry distance (based on data from the BC Ferry Corporation and the Ministry of Transportation) is then added to the applicable road distance.
- Where communities are combined, the distance from the furthest community is used.