

**2019 PHYSICIAN MASTER AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE  
OF BRITISH COLUMBIA**, as represented by the Minister of Health

(the “Government”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “Doctors of BC”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “MSC”)

## TABLE OF CONTENTS

<b>ARTICLE 1 - INTERPRETATION.....</b>	<b>7</b>
1.1 Definitions.....	7
1.2 Meaning of “Consensus Decision” .....	14
1.3 Successor to the MSC .....	14
1.4 Miscellaneous Interpretation.....	15
1.5 Binding Effect.....	15
1.6 Governing Law .....	15
1.7 Amendment and Waiver .....	15
1.8 Severability .....	16
<b>ARTICLE 2 - EFFECT OF AGREEMENT AND RELATED AGREEMENTS .....</b>	<b>16</b>
2.1 Ratification.....	16
2.2 Failure to Ratify .....	16
2.3 Effective Date .....	16
2.4 Further Assurances.....	16
2.5 Physician Master Subsidiary Agreements .....	17
2.6 Conflicts.....	17
2.7 Termination of Prior Agreements .....	17
<b>ARTICLE 3 - APPLICATION AND REPRESENTATION .....</b>	<b>17</b>
3.1 Application.....	17
3.2 Doctors of BC Representation of Physicians.....	17
3.3 Health Authority Compliance .....	18
<b>ARTICLE 4 - COOPERATION AND CONSULTATION TO SUPPORT QUALITY ASSURANCE AND IMPROVEMENT .....</b>	<b>18</b>
4.1 Obligation to Consult.....	18
4.2 Consultation Process .....	18
4.3 Consultation Does Not Constrain Change .....	18
<b>ARTICLE 5 - SHARING INFORMATION.....</b>	<b>19</b>
5.1 Need for Information Sharing .....	19
5.2 Agreement to Share Information .....	19
5.3 Confidentiality .....	20
<b>ARTICLE 6 - PHYSICIAN SERVICES COMMITTEE.....</b>	<b>20</b>
6.1 Physician Services Committee Composition .....	20
6.2 Costs of the Physician Services Committee.....	20
6.3 Functions of the Physician Services Committee.....	20
6.4 Conduct of the Business of the Physician Services Committee .....	24
6.5 Local Quality of Care Issues.....	24
6.6 Ad Hoc Advisory Panel .....	25

<b>ARTICLE 7 - JOINT AGREEMENT ADMINISTRATION GROUP.....</b>	<b>26</b>
7.1 Joint Agreement Administration Group Composition.....	26
7.2 Costs of the Joint Agreement Administration Group .....	26
7.3 Functions of the Joint Agreement Administration Group.....	26
7.4 Conduct of the Business of the Joint Agreement Administration Group .....	26
<b>ARTICLE 8 - JOINT CLINICAL COMMITTEES.....</b>	<b>27</b>
8.1 Joint Clinical Committees.....	27
8.2 Core Mandate of the Joint Clinical Committees.....	27
8.3 Specialist Services Committee.....	28
8.4 General Practice Services Committee.....	28
8.5 Shared Care Committee .....	28
<b>ARTICLE 9 - MEDICAL SERVICES COMMISSION.....</b>	<b>30</b>
9.1 MSC Membership.....	30
9.2 Chair of the MSC .....	31
9.3 Independence of the MSC.....	31
<b>ARTICLE 10 - ADVISORY COMMITTEES TO THE MEDICAL SERVICES COMMISSION .....</b>	<b>32</b>
10.1 Reference Committee.....	32
10.2 Audit and Inspection Committee .....	32
10.3 Patterns of Practice Committee.....	34
10.4 Guidelines and Protocols Advisory Committee.....	34
<b>ARTICLE 11 - THE AVAILABLE AMOUNT.....</b>	<b>35</b>
11.1 Establishment of the Available Amount.....	35
11.2 Monitoring and Managing the Available Amount.....	35
<b>ARTICLE 12 - REVISION AND MAINTENANCE OF THE GUIDE TO FEES.....</b>	<b>36</b>
12.1 Revisions to Guide to Fees by Doctors of BC .....	36
12.2 Revisions to Guide to Fees on Government's Recommendation .....	37
<b>ARTICLE 13 - REVISIONS TO THE PAYMENT SCHEDULE .....</b>	<b>38</b>
13.1 Revisions By Agreement .....	38
13.2 Revisions in the Absence of Agreement.....	39
13.3 Changes to Insured Medical Services .....	39
<b>ARTICLE 14 - PAYMENT OF FEE FOR SERVICE ACCOUNTS.....</b>	<b>39</b>
14.1 Payment Process .....	39
14.2 Advances.....	39
14.3 Overdue Accounts.....	40
14.4 Changes to Payment Process .....	40
<b>ARTICLE 15 - FEES, SERVICE CONTRACT RANGES, SESSIONAL CONTRACT RATES AND SALARY AGREEMENT RANGES .....</b>	<b>40</b>
15.1 Compensation Changes.....	40

15.2	Interprovincial Physician Compensation Report .....	40
15.3	WorkSafeBC Services and ICBC Services.....	40
<b>ARTICLE 16 - FUNDING NEW FEE ITEMS .....</b>		<b>41</b>
16.1	Allocation for New Fee Items.....	41
<b>ARTICLE 17 - THE MEDICAL ON-CALL/AVAILABILITY PROGRAM.....</b>		<b>41</b>
17.1	Budget for MOCAP .....	41
17.2	Provincial MOCAP Review Committee .....	41
17.3	MOCAP Terms and Conditions.....	42
17.4	Distribution of MOCAP Funds by Health Authorities .....	42
17.5	Principles of MOCAP .....	43
17.6	Review of Call Groups.....	44
17.7	Evaluation .....	45
<b>ARTICLE 18 - INFORMATION TECHNOLOGY .....</b>		<b>46</b>
18.1	Doctors of BC Participation in e-Health.....	46
<b>ARTICLE 19 - CHANGE IN FORM OF COMPENSATION FOR PHYSICIAN SERVICES .....</b>		<b>46</b>
19.1	Change in Form of Compensation .....	46
<b>ARTICLE 20 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT GENERAL PROVISIONS.....</b>		<b>46</b>
20.1	Government and Doctors of BC will Work to Prevent Withdrawals of Services.....	46
20.2	Dispute Resolution and Issue Management may not alter Agreements .....	46
20.3	Voluntary Settlements are Without Prejudice.....	47
20.4	Process, Time Limits and Procedural Requirements to be Strictly Complied With.....	47
20.5	Distinguishing Disputes from Issues .....	47
20.6	Costs of Dispute Resolution and Issue Management.....	47
<b>ARTICLE 21 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT TOOLS.....</b>		<b>48</b>
21.1	Adjudication Roster .....	48
21.2	The Adjudicator and the Adjudication Committee.....	48
21.3	Trouble Shooter .....	49
<b>ARTICLE 22 - DISPUTE RESOLUTION PROCESS .....</b>		<b>50</b>
22.1	Provincial Disputes .....	50
22.2	Local Disputes .....	51
<b>ARTICLE 23 - ISSUE MANAGEMENT PROCESS.....</b>		<b>55</b>
23.1	Local Interest Issue Resolution.....	55
<b>ARTICLE 24 - SERVICE CONTINUITY .....</b>		<b>56</b>
24.1	No Withdrawal of Services or Threat of Withdrawal of Services .....	56

24.2	Notice of Withdrawal of Services Required .....	56
24.3	No Withdrawal of Services to Pressure Government to Change Existing Agreements .....	57
24.4	Doctors of BC Will Not Condone Withdrawals of Service .....	57
<b>ARTICLE 25 - REPLACEMENT OF PROVISIONS AFFECTED BY LEGISLATION .....</b>		
<b>57</b>		
25.1	Replacement by Agreement.....	57
25.2	Replacement by Arbitration.....	57
25.3	No Conflict with Legislation .....	58
<b>ARTICLE 26 - RENEGOTIATION .....</b>		
<b>58</b>		
26.1	Renegotiation Notice .....	58
26.2	Initial Meeting.....	58
26.3	Conciliation Panel Chair .....	58
26.4	Intervention by Conciliation Panel .....	59
26.5	Report of the Conciliation Panel.....	59
26.6	Effect of Conciliation Panel's Report .....	60
<b>ARTICLE 27 - TERMINATION .....</b>		
<b>60</b>		
27.1	Termination Notice .....	60
27.2	Effect of Termination Notice .....	60
<b>APPENDIX A 2019 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT .....</b>		
<b>63</b>		
<b>APPENDIX B 2019 SPECIALISTS SUBSIDIARY AGREEMENT .....</b>		
<b>70</b>		
<b>APPENDIX C 2019 RURAL PRACTICE SUBSIDIARY AGREEMENT .....</b>		
<b>77</b>		
<b>APPENDIX D 2019 ALTERNATIVE PAYMENTS SUBSIDIARY AGREEMENT .....</b>		
<b>- 97 -</b>		
<b>APPENDIX E 2019 BENEFITS SUBSIDIARY AGREEMENT .....</b>		
<b>- 232 -</b>		
<b>APPENDIX F ADJUSTMENTS TO FEES, SERVICE CONTRACT RANGES AND SERVICE CONTRACT RATES, SALARY AGREEMENT RANGES AND SALARY AGREEMENT RATES, AND SESSIONAL CONTRACT RATES .....</b>		
<b>- 247 -</b>		
<b>APPENDIX G MEDICAL ON-CALL/AVAILABILITY PROGRAM (MOCAP).....</b>		
<b>- 255 -</b>		
<b>APPENDIX H MEMBERS OF THE ROSTER (AS OF APRIL 1, 2019).....</b>		
<b>- 274 -</b>		
<b>APPENDIX I LETTER OF AGREEMENT – TRANSFER OF JOINT COMMITTEE FEES TO THE PAYMENT SCHEDULE .....</b>		
<b>- 275 -</b>		

**2019 PHYSICIAN MASTER AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF  
BRITISH COLUMBIA**, as represented by the Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government were parties to the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement, and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed to renew and replace the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement, and the 2014 Benefits Subsidiary Agreement on the terms set out in this Agreement;

C. The parties have agreed that this agreement will constitute the 2019 Physician Master Agreement, and to enter into the General Practitioners Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement, and the Benefits Subsidiary Agreement, in the forms attached hereto as Appendices A through E respectively;

D. The parties wish to work collaboratively in the health care system and recognize their shared obligation and responsibility to meet population and patient medical needs through evidence-based, quality care provided through an integrated, sustainable, accountable, efficient and effective health care system; and

E. This Agreement:

- (a) defines a relationship between the parties built upon transparency, constructive collaboration and mutual respect;
- (b) recognizes that the Government has an obligation to maintain and improve the health status of the population; to create health legislation, regulation and policy; to determine service organization and enable that organization through Health Authorities; and to determine the allocation of provincial funding for health services;
- (c) recognizes that Health Authorities are responsible for regional service planning and operations and the allocation and management of their fiscal, human and capital resources to meet the health service needs of residents; and
- (d) recognizes the Doctors of BC's goals of maximizing physicians' professional satisfaction, achieving a high standard of healthcare, and achieving fair economic compensation for the services rendered by physicians.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

## **ARTICLE 1 - INTERPRETATION**

### **1.1 Definitions**

In this Agreement including the recitals and Appendices the following definitions shall apply:

**“this Agreement”** or **“2019 Physician Master Agreement”** means this document including the Appendices, as amended from time to time in accordance with section 1.7.

**“Ad Hoc Advisory Panel”** has the meaning given in section 6.6.

**“Adjudication Committee”** has the meaning given in section 21.2.

**“Adjudicator”** has the meaning given in section 21.2.

**“Agency”** means a Health Authority and any other public agency funded by the Government and, in the context of an Alternative Payment Arrangement where the Government is a party, includes the Government.

**“Allocation Committee”** means the committee referred to in section 5.1 of the Alternative Payments Subsidiary Agreement.

**“Alternative Payment Arrangement”** means compensation for “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) under a Salary Agreement, Service Contract or Sessional Contract.

**“Alternative Payments Committee”** means the committee referred to in section 4.1 of the Alternative Payments Subsidiary Agreement.

**“Alternative Payments Program”** means the Government program designed to fund “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) through Alternative Payment Arrangements.

**“Alternative Payments Subsidiary Agreement”** means the agreement titled “2019 Alternative Payments Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Audit and Inspection Committee”** means the panel of that name appointed by the MSC pursuant to section 6 of the *Medicare Protection Act*.

**“Available Amount”** in respect of any Fiscal Year means the amount of funding set by the MSC for allocation under section 25 of the *Medicare Protection Act* for the payment of Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, “Percentage Fee Premiums” (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, and payments made pursuant to the “Northern and Isolation Travel Assistance Program” (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

**“Benefits Committee”** has the meaning given in section 4.1 of the Benefits Subsidiary Agreement.

**“Benefits Subsidiary Agreement”** means the agreement titled “2019 Benefits Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Canadian Medical Protective Association Rebate Program”** means the program referred to in section 2.4 of the Benefits Subsidiary Agreement.

**“Central Recommendations”** has the meaning given in section 26.5(a)(i).

**“Change in form of compensation”** means a change in the type of compensation for physician services from fee for service to a Service Contract, a Salary Agreement, or any other alternate payment model.

**“Consult”** means to provide a meaningful opportunity for advice to be provided and for an exchange of views or concerns prior to the making of a decision or the finalization of a policy initiative as the context may require, and **“Consultation”** and **“Consulted”** have similar meanings.

**“CMPA Fee Schedule”** means the Canadian Medical Protective Association (CMPA) membership fees applicable to British Columbia physicians as determined by the CMPA.



**“Continuing Medical Education Fund”** means the fund referred to in section 2.5 of the Benefits Subsidiary Agreement.

**“Contributory Professional Retirement Savings Plan”** means the plan referred to in section 2.6 of the Benefits Subsidiary Agreement.

**“Dispute”** means a Provincial Dispute or a Local Dispute.

**“Doctor of the Day”** means a General Practitioner designated by a Health Authority to be available for the care of a patient who is being or has been admitted to a hospital and/or while the patient remains an inpatient of the hospital, where the patient does not have a General Practitioner or has a General Practitioner who does not have privileges at that hospital.

**“Fee for Service Accounts”** means accounts submitted by physicians to the MSP for the provision of Insured Medical Services provided on a fee for service basis.

**“Fees”** means the fees set out in the Payment Schedule.

**“Final Termination Date”** has the meaning given in section 27.2(b).

**“Fiscal Year”** means the 12 month period commencing on April 1 of a calendar year and ending on March 31 of the following calendar year.

**“Further Termination Notice”** has the meaning given in section 27.2(b).

**“Future Legislation”** has the meaning given in section 25.1.

**“General Practice Physician (non-FRCP) with a Focused Practice”** are those General Practitioners with a commitment to one or more specific clinical areas as major part-time or full-time components of their practices.

**“General Practice Services Committee”** means the committee referred to in section 4.2 of the General Practitioners Subsidiary Agreement.

**“General Practitioner”** means a physician who is not a Specialist Physician.

**“General Practitioners Subsidiary Agreement”** means the agreement titled “2019 General Practitioners Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Guide to Fees”** means the Doctors of BC Guide to Fees as published by the Doctors of BC from time to time.

**“Guidelines and Protocols Advisory Committee”** means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

**“Health Authority”** means a “board” as defined in section 1 of the *Health Authorities Act* (British Columbia), and also the Provincial Health Services Authority.

**“Insured Medical Services”** at any time means services that are benefits under the *Medicare Protection Act* at that time.

**“Issue”** means a Local Interest Issue or a Local Quality of Care Issue.

**“Joint Agreement Administration Group”** has the meaning given in section 7.1.

**“Joint Clinical Committees”** has the meaning given in section 8.1.

**“Joint Clinical Committee Administrative Agreement”** means the agreement titled “Joint Clinical Committee Administrative Agreement” between the Government and the Doctors of BC dated April 1, 2019.

**“Joint Standing Committee on Rural Issues”** or **“JSC”** means the committee referred to in section 5.1 of the Rural Practice Subsidiary Agreement.

**“Local Contract”** means:

- (a) a Salary Agreement, Service Contract, Sessional Contract, a MOCAP Contract and any other contract that the Government and Doctors of BC agree is a Local Contract; or
- (b) an agreement, existing as at May 10, 2007, made in writing by an Agency, on the one hand, and a physician or group of physicians, on the other, that was intended to create an enforceable commitment, and is sufficiently certain as to its terms and duration so as to be capable of enforcement.

**“Local Contract Dispute”** means a dispute between an Agency, on the one hand, and a physician or group of physicians, on the other, regarding the interpretation, application, operation or alleged breach of a Local Contract:

- (a) where there is no mechanism in the Local Contract to resolve the dispute; or
- (b) where the Local Contract mandates the use of any of the dispute resolution procedures in this Agreement to resolve the dispute; or
- (c) where the parties to the Local Contract otherwise agree to use the applicable dispute resolution procedures in this Agreement to resolve the dispute.

**“Local Dispute”** means a Local Contract Dispute or a Local Range Placement Dispute.

**“Local Interest Issue”** means any issue, disagreement, conflict or matter that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that is not a Dispute or a Local Quality of Care Issue.

**“Local Quality of Care Issue”** means an issue that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that relates to the quality of patient care, that is not a Dispute.

**“Local Range Placement Dispute”** has the meaning given in section 12.10 of the Alternative Payments Subsidiary Agreement.

**“Medicare Protection Act”** means the *Medicare Protection Act*, R.S.B.C. 1996, c.286.

**“Minister”** means the Minister of Health and includes the Deputy Minister or a person designated to act on the Minister’s behalf.

**“Ministry”** means the British Columbia Ministry of Health.

**“MOCAP”** means the medical on-call/availability program referred to in Article 17 and described in Appendix G.

**“MOCAP Contract”** means a contract between an Agency and a physician or group of physicians for on call availability under MOCAP.

**“MOCAP Objectives”** has the meaning given in section 17.4(a).

**“MSP”** means the division of the Ministry responsible for the administration and operation of the Medical Services Plan continued under the *Medicare Protection Act*.

**“Other Recommendations”** has the meaning given in section 26.5(a)(ii).

**“Parental Leave Program”** has the meaning given in section 2.7 of the Benefits Subsidiary Agreement.

**“Patterns of Practice Committee”** means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

**“Payment Schedule”** means the payment schedule established under section 26 of the *Medicare Protection Act*.

**“Physician Disability Insurance Program”** means the program referred to in section 2.8 of the Benefits Subsidiary Agreement.

**“Physician Health Program”** means the program referred to in section 2.9 of the Benefits Subsidiary Agreement.

**“Physician Master Subsidiary Agreements”** means, collectively, the General Practitioners Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement and the Benefits Subsidiary Agreement.

**“Physician Section”** means a group of physicians recognized by the Doctors of BC Board as a section pursuant to Bylaw 4 of the Constitution and By-Laws of the Doctors of BC.

**“Physician Services Committee”** has the meaning given in section 6.1.

**“Practice Support Program”** means the program supported by the General Practice Services Committee to improve care for patients in British Columbia and increase job satisfaction amongst physicians.

**“Provincial Dispute”** means a dispute between the Government and the Doctors of BC regarding the interpretation, application, operation or alleged breach of this Agreement and/or any of the Physician Master Subsidiary Agreements.

**“Provincial MOCAP Review Committee”** has the meaning given in section 17.2.

**“Reference Committee”** means the committee of that name established or to be established under section 5(1) (o) of the *Medicare Protection Act* as an advisory committee to the MSC.

**“Renegotiation Notice”** has the meaning given in section 26.1.

**“Roster”** has the meaning given in section 21.1.

**“Rural Practice Subsidiary Agreement”** means the agreement titled “2019 Rural Practice Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Salary Agreement”** means an employment agreement between a physician and an Agency for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement).

**“Salary Agreement Ranges”** means the annual salary rate ranges as set out in Schedule A to the Alternative Payments Subsidiary Agreement, as amended from time to time.

**“Salary Agreement Rate”** means a rate within one of the Salary Agreement Ranges and a corresponding rate in an individual Salary Agreement.

**“Service Contract”** means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a corporation, on the one hand, and an Agency, on the other hand, for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement), but does not include contracts for payment on a fee for service basis, Salary Agreements, Sessional Contracts or MOCAP Contracts.

**“Service Contract Ranges”** means the annual Service Contract rate ranges as set out in Schedule B to the Alternative Payments Subsidiary Agreement, as amended from time to time.

**“Service Contract Rate”** means a rate within one of the Service Contract Ranges and a corresponding rate in an individual Service Contract.

**“Sessional Contract”** means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a corporation, on the one hand, and an Agency, on the other, for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) provided on a sessional basis.

**“Sessional Contract Rate”** means a rate set out on Schedule C to the Alternative Payment Subsidiary Agreement, as such rates may be amended from time to time pursuant to Appendix F, and a corresponding rate in an individual Sessional Contract.

**“Shared Care Committee”** has the meaning given in section 8.5.

**“Specialist Section”** means a Physician Section for an area of Specialist Physician practice.

**“Specialist Physician”** means a physician who is a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

**“Specialist Services Committee”** means the committee referred to in section 5.1 of the Specialists Subsidiary Agreement.

**“Specialists Subsidiary Agreement”** means the agreement titled “2019 Specialists Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Tariff Committee”** means the Doctors of BC Economics Committee as described in the Constitution and By-Laws of the Doctors of BC in effect on the date of execution of this Agreement.

**“Termination Notice”** has the meaning given in section 27.1.

**“Total Claims Cost”** in respect of any Fiscal Year means the amount actually paid by the MSP for Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, all “Percentage Fee Premiums” (as defined in the Rural Practice Subsidiary Agreement) paid during that Fiscal Year, and all payments made under the “Northern and Isolation Travel Assistance Program” (as defined in the Rural Practice Subsidiary Agreement) during that Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

**“Triple Aim Principles”** means the simultaneous pursuit of positively impacting the experience of the individual receiving healthcare services and the healthcare professional providing those services, the health of populations, and healthcare spending.

**“Trouble Shooter”** has the meaning given in section 21.3.

**“withdrawal of services”** means the withdrawal of any clinical or related teaching, research or clinical administrative services, or any services related to the participation on hospital committees, the participation on the active staff of hospitals, or other administrative, educational, management or related non-clinical services.

**“2014 Alternative Payments Subsidiary Agreement”** means the agreement titled “Alternative Payments Subsidiary Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 Benefits Subsidiary Agreement”** means the agreement titled “Benefits Subsidiary Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 General Practitioners Subsidiary Agreement”** means the agreement titled “General Practitioners Subsidiary Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 PMA”** means the agreement titled “Physician Master Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 Rural Practice Subsidiary Agreement”** means the agreement titled “Rural Practice Subsidiary Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 Specialists Subsidiary Agreement”** means the agreement titled “Specialists Subsidiary Agreement” made as of April 1, 2014, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 Benefits Administration Agreement”** means the agreement referred to in section 7.1 of the Benefits Subsidiary Agreement.

## **1.2 Meaning of “Consensus Decision”**

In this Agreement, a committee shall be deemed to have made a **“consensus decision”** if:

- (a) a resolution of the committee is passed by at least a majority of the members of the committee after the committee has gone through a reasonable process to try and reach unanimous approval of the resolution by the members of the committee;
- (b) for all committees other than the Physician Services Committee, a written copy of the passed resolution is submitted to the co-chairs of the Physician Services Committee; and
- (c) either:
  - (i) the Government and the Doctors of BC both express in writing their support of the resolution by notice in writing to the other; or
  - (ii) for all committees other than the Physician Services Committee, the resolution is not objected to in writing by either the Government or the Doctors of BC by notice in writing to the other within 45 days after the date the written copy of the resolution is submitted to the co-chairs of the Physician Services Committee, and for the Physician Services Committee the resolution is not objected to in writing by either the Government or the Doctors of BC by notice in writing to the other within 45 days after the date such resolution is passed by the Physician Services Committee.

## **1.3 Successor to the MSC**

The words **“the MSC, or its successor,”** do not include a public administrator appointed pursuant to section 3(13) of the *Medicare Protection Act*, and if such a public administrator is so appointed, the parties agree to amend this Agreement to provide for an alternate process for the

determination of issues that under those sections are to be or may be referred to “**the MSC, or its successor,**” for determination.

#### **1.4 Miscellaneous Interpretation**

In this Agreement:

- (a) words in the singular include the plural and vice versa, and words in one gender include all genders;
- (b) the headings of Articles, sections and Appendices are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;
- (c) the words “**Article**” and “**section**” mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;
- (d) the words “**include**”, “**includes**” or “**including**” mean “include without limitation”, “includes without limitation” and “including without limitation” respectively, and the words following “include”, “includes” or “including” shall not be considered to set forth an exhaustive list;
- (e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;
- (f) the words “**this Agreement**”, “**herein**”, “**hereof**” and “**hereunder**” and other words of similar import refer to this Agreement as a whole and not to any particular Article, section or Appendix of this Agreement; and
- (g) unless reference is made to a statute in effect at a particular time, each reference to a statute is deemed to be a reference to that statute and any successor statute, and to any regulations and rules made under that statute and any successor statute, each as amended or re-enacted from time to time.

#### **1.5 Binding Effect**

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

#### **1.6 Governing Law**

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

#### **1.7 Amendment and Waiver**

This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act,

failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

## **1.8 Severability**

The parties:

- (a) intend that this Agreement shall comply with all applicable laws; and
- (b) agree that if any part of any Article, section, subsection, clause or provision of this Agreement shall be determined by a court or arbitrator of competent jurisdiction to be invalid or unenforceable for any reason, it shall not impair or affect or be deemed to impair or affect the validity of the remaining parts of such Article, section, subsection, clause or provision or the remaining parts of this Agreement, and such remaining parts shall continue to have full force and effect, and such invalid or unenforceable part shall be severable and severed from and deemed not to be part of this Agreement.

## **ARTICLE 2 - EFFECT OF AGREEMENT AND RELATED AGREEMENTS**

### **2.1 Ratification**

This Agreement and the Physician Master Subsidiary Agreements are not binding on the parties until this Agreement is ratified and executed by them, and the terms of this Agreement and the Physician Master Subsidiary Agreements, and all information, documents and other materials exchanged between the parties in the negotiation of this Agreement and the Physician Master Subsidiary Agreements, are without prejudice to any party if this Agreement is not ratified and executed by all of them within the time provided in section 2.2.

### **2.2 Failure to Ratify**

If this Agreement is not ratified and executed by the parties in accordance with section 2.1 on or before December 31, 2019, this Agreement and the Physician Master Subsidiary Agreements will be null and void and will not be used by any party in any proceeding or in any other way.

### **2.3 Effective Date**

This Agreement comes into force on April 1, 2019.

### **2.4 Further Assurances**

The parties agree to execute and deliver all such further documents and do all such further things as may be reasonably required to carry out the purpose and intent of this Agreement.



## **2.5 Physician Master Subsidiary Agreements**

Concurrently with execution and delivery of this Agreement, the parties shall execute and deliver the Physician Master Subsidiary Agreements in the forms attached hereto as Appendices A through E.

## **2.6 Conflicts**

If there is any conflict or inconsistency between, on the one hand, any terms of this Agreement and, on the other hand, any terms of any of the Physician Master Subsidiary Agreements, the terms of this Agreement shall govern and take precedence.

## **2.7 Termination of Prior Agreements**

If each of this Agreement and the Physician Master Subsidiary Agreements are executed, delivered and ratified as provided in sections 2.1 and 2.5, the following agreements shall terminate and be of no further force or effect:

- (a) the 2014 PMA;
- (b) the 2014 Alternative Payments Subsidiary Agreement;
- (c) the 2014 Benefits Subsidiary Agreement;
- (d) the 2014 General Practitioners Subsidiary Agreement;
- (e) the 2014 Rural Practice Subsidiary Agreement; and
- (f) the 2014 Specialists Subsidiary Agreement.

# **ARTICLE 3 - APPLICATION AND REPRESENTATION**

## **3.1 Application**

This Agreement applies to those physicians resident within the Province of British Columbia whose services are compensated by funds provided by the Government either directly or through Agencies.

## **3.2 Doctors of BC Representation of Physicians**

- (a) The Government hereby grants to the Doctors of BC the sole and exclusive right, and the Doctors of BC hereby undertakes the obligation, to represent the collective and individual interests of those physicians where the funding for their services is, in whole or in part, provided by the Government either directly or through Agencies.
- (b) The Government undertakes to include within funding contracts for physician services with Agencies, a clause requiring the Agency to advise physicians of their right to be represented by the Doctors of BC, and to negotiate in good faith when establishing Local Contracts.

- (c) The Government further undertakes that it will require Agencies to recognize the Doctors of BC's right to represent those physicians who request the assistance of the Doctors of BC in negotiating contractual arrangements with those Agencies.
- (d) The Doctors of BC undertakes that, in exercising its representation rights, it will advise physicians that all matters within the ambit of this Agreement and/or within the ambit of any of the Physician Master Subsidiary Agreements, must comply with the provisions of this Agreement and the Physician Master Subsidiary Agreements.

### **3.3 Health Authority Compliance**

The Government will ensure that Health Authorities comply with this Agreement and the Physician Master Subsidiary Agreements. If any provision in this Agreement imposes direct obligations on Health Authorities, that provision will be read to be an obligation of the Government to ensure that Health Authorities meet such obligations.

## **ARTICLE 4 - COOPERATION AND CONSULTATION TO SUPPORT QUALITY ASSURANCE AND IMPROVEMENT**

### **4.1 Obligation to Consult**

- (a) The Government and the Doctors of BC will Consult and collaborate with each other to ensure the provision of high quality medical services to the residents of British Columbia, and the Government will facilitate the participation of Health Authorities in that Consultation.
- (b) It is acknowledged and agreed that the partnership envisaged by this Agreement requires ongoing dialogue and Consultation on major issues of significance to the provision of medical care, including policy, whether such care is funded directly or indirectly by the Government.
- (c) In particular:
  - (i) the Doctors of BC shall be Consulted prior to the adoption of policy initiatives by the Government that would affect the provision of medical care by physicians; and
  - (ii) the parties will Consult on strategies and measures to ensure that total expenditures on physician services do not exceed the annual funding.

### **4.2 Consultation Process**

The primary vehicle for the Consultations referred to in this Article 4 will be the Physician Services Committee.

### **4.3 Consultation Does Not Constrain Change**

Except as explicitly identified in this Agreement, nothing in this process of Consultation and collaboration constrains the Government or the Health Authorities from implementing

change in the organization and delivery of services once the required Consultation has taken place.

## **ARTICLE 5 - SHARING INFORMATION**

### **5.1 Need for Information Sharing**

Each of the Government, the MSC and the Doctors of BC acknowledges and agrees that the sharing of relevant information and data in a timely way is critically important to the achievement of the objectives established in this Agreement and to the administration of the *Medicare Protection Act*.

### **5.2 Agreement to Share Information**

- (a) Subject to sections 5.2(c) and (d), each of the Government, the MSC and the Doctors of BC agrees to provide relevant information that is requested by the others. Relevant historical and predictive data prepared by any party will be shared.
- (b) In particular, but subject to sections 5.2(c) and (d), the Government will provide to the Doctors of BC:
  - (i) aggregate information on Total Claims Cost on a monthly basis and detailed information on fee for service claims semi-monthly, with physician and beneficiary identification encoded;
  - (ii) information including, at a minimum, the total paid amount, specialty and location for payments funded by Health Authorities and/or the Government on all Sessional Contracts, Service Contracts and Salary Agreements at the level of the individual physician, where available, on an annual basis, with physician identification encoded; and
  - (iii) information on MOCAP payments including, at a minimum, paid amount, on call level, specialty and location, at the level of the individual physician, where available, on an annual basis, with physician identification encoded.
- (c) The Government will provide information that contains the identification of physicians or beneficiaries to MSC advisory committees constituted under the *Medicare Protection Act*, but only for the purposes of the administration of the *Medicare Protection Act*.
- (d) Notwithstanding sections 5.2(a), (b) and (c), no party shall be obligated to share information with, or to disclose information to, any other party:
  - (i) unless such sharing or disclosure would be in compliance with all applicable laws; or

- (ii) if such information is subject to any solicitor and client privilege, or other privilege to which the sharing or disclosing party is entitled at law.

### **5.3 Confidentiality**

Each of the Government, the MSC and the Doctors of BC agrees that it shall, and shall cause its representatives to, keep confidential all information identified as confidential by the disclosing party that is disclosed to it pursuant to this Agreement, not disclose such information to any other person, use such information solely in connection with this Agreement, and take precautions necessary to prevent unauthorized access to or use, disclosure or reproduction of such information, provided that the foregoing restrictions shall not apply to information that is in the public domain other than through a breach of this section, or that is or was obtained from sources other than a party to this Agreement, and shall not apply to disclosure required by applicable laws or made to a professional advisor on a strictly confidential basis.

## **ARTICLE 6 - PHYSICIAN SERVICES COMMITTEE**

### **6.1 Physician Services Committee Composition**

- (a) The **Physician Services Committee** shall continue as the senior body overseeing the relationship between the Government and the Doctors of BC, and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements.
- (b) The Physician Services Committee will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the Doctors of BC, or such greater, equal number of members as agreed to by the parties and will also include the Chair of the Medical Services Commission as a non-voting member. The members appointed by the Government will consist of at least one Senior Executive from the Ministry of Health (Assistant Deputy Minister of Health or above) and at least one Senior Executive from a Health Authority (Vice-President or above). The members appointed by the Doctors of BC will include the Chief Executive Officer of the Doctors of BC.
- (c) The Government and the Doctors of BC will each name one of their respective appointees to act as co-chair of the Physician Services Committee, and the chair will alternate for successive meetings.

### **6.2 Costs of the Physician Services Committee**

The Government, the Medical Services Commission and the Doctors of BC will pay the costs of the participation in the Physician Services Committee of their respective appointees, and the Government will provide secretariat support for the Physician Services Committee.

### **6.3 Functions of the Physician Services Committee**

The Physician Services Committee, as the senior body overseeing the relationship between the Government and the Doctors of BC and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements, will, among other things:

- (a) provide direction to, and monitor the activities of, the other joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician Master Subsidiary Agreements, including, among other things, overseeing the work of the General Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee by engaging in the following process for each Fiscal Year:
  - (i) by February 1 of each year, the Physician Services Committee will convene a meeting with the co-chairs of each of the General Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee during which the Government's priorities for the health care system for the next Fiscal Year and the Strategic Plans of both the Ministry of Health and the Doctors of BC will be discussed and the possible initiatives being considered by the committee in question for the next three Fiscal Years will be identified by the co-chairs of the relevant committee, all in the context of the mandate established for the committee in question in this Agreement and/or in a Physician Master Subsidiary Agreement. After such discussion, the Physician Services Committee will provide the co-chairs with direction on the content of the written plan referenced in (ii) below which will inform priority initiatives to be addressed by the committee in the upcoming Fiscal Year, including direction on the committee's budget for the Fiscal Year;
  - (ii) following the meeting referred to in section 6.3(a)(i), and before March 1 of the same year, the committee in question shall submit to the Physician Services Committee a detailed written plan including a proposed budget by program and initiative and an administrative budget by program and initiative (which, for those committees covered by the Joint Clinical Committee Administration Agreement will be the budget for Administrative Costs approved under Article 5 of that Agreement) outlining the committee's intentions to address the initiatives within its mandate to be undertaken by the committee during the Fiscal Year commencing on April 1 of the same year. The written plan will account for the distribution of all funds which have been allocated to the committee in question, both ongoing funds and funding available for one-time allocations;
  - (iii) the Physician Services Committee will consider each plan submitted to it pursuant to section 6.3(a)(ii) by the General Practice Services Committee, the Specialist Services Committee, the Shared Care Committee, and the Joint Standing Committee on Rural Issues, and will either approve the plan or advise the committee in question of why it is unable to approve the plan in which case the committee will, within 30 days of being advised by the Physician Services Committee that it is unable to approve the plan, reconsider the plan and submit a revised plan to the Physician Services Committee for approval;

- (iv) where the Physician Services Committee receives a revised plan from a committee in accordance with section 6.3(a)(iii), the Physician Services Committee may approve the revised plan, in whole or in part, and if the Physician Services Committee does not approve the whole of the revised plan, unless agreed otherwise by the Government and Doctors of BC, either the Government or the Doctors of BC may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;
  - (v) where the Physician Services Committee is unable to approve a plan from a committee, unless agreed otherwise by the Government and Doctors of BC either the Government or the Doctors of BC may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;
  - (vi) following finalization of a committee's plan in accordance with either section 6.3(a)(iii), (iv) or (v), the Physician Services Committee will convene at least two additional meetings with the co-chairs of each committee specifically named in section 6.3(a)(iii), to take place prior to the end of the Fiscal Year in question, during which the plan of the committee in question will be reviewed, its progress assessed and any variances addressed, including directions from the Physician Services Committee on dealing with such variances;
  - (vii) if, during any Fiscal Year, any of the committees specifically named in section 6.3(a)(i) proposes to reallocate funds between its programs in a manner not specifically contemplated by its plan for that Fiscal Year, it shall first provide the Physician Services Committee a minimum of two (2) weeks of advance written notice of its intentions and the Physician Services Committee may provide direction to the committee in question on the proposed reallocation; and
  - (viii) by June 30 of each year, each committee specifically named in section 6.3(a)(i) will provide the Physician Services Committee with a report for the previous Fiscal Year on the degree to which the committee achieved the expectations outlined in the approved written plan and how funding was utilized by program and initiatives in comparison to the approved budget. The Physician Services Committee may provide direction on that report to the committees.
- (b) approve any proposal to reallocate funding between any of the joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician Master Subsidiary Agreements;
  - (c) oversee the development of and approve a joint communications protocol to be used by each of the joint committees of the Government and the Doctors of BC referred to in this Agreement or the Physician Master Subsidiary Agreements, in respect of all decisions made by such committees, that shall include the

requirement for prior approval of the co-chairs of the committee in question of any communication regarding the business and/or decisions of the committee;

- (d) on an annual basis, review the joint committee structure reflected in this Agreement and the Physician Master Subsidiary Agreements, and make any changes to that committee structure that the Physician Services Committee considers desirable;
- (e) provide a forum for Consultation on the matters specifically identified for Consultation in this Agreement;
- (f) provide a forum for the Government, the Doctors of BC and the Health Authorities to discuss and agree on a joint vision framework for medical services that is aligned with the Ministry's agenda for innovation and change;
- (g) subject to the specific processes set out elsewhere in this Agreement, discuss and where possible attempt to resolve Issues;
- (h) provide general oversight of the dispute resolution processes in this Agreement and the Physician Master Subsidiary Agreements including, among other things,
  - (i) receive, from the Joint Agreement Administration Group, regular reports of the business of the Joint Agreement Administration Group by way of copies of the minutes of the meetings of the Joint Agreement Administration Group or otherwise as directed by the Physician Services Committee; and
  - (ii) receive, from the Joint Agreement Administration Group, and consider notices of all Disputes, and upon doing so, the Physician Services Committee may require the co-chairs of the Joint Agreement Administration Group to provide the Physician Services Committee with a without prejudice briefing about any Dispute.
- (i) enable communication between the Government, the Doctors of BC and the Health Authorities;
- (j) engage in any other functions that the Government and Doctors of BC may, by written agreement, assign to it; and
- (k) in addition to fulfilling its role in relation to Disputes and Issues as specified elsewhere in this Agreement, the Physician Services Committee will attempt to resolve any other matter that arises between the Government and the Doctors of BC, and that is not a Dispute or Issue, in the following manner:
  - (i) the party raising the matter must notify the other party, in writing, with a copy of the notice to the Physician Services Committee;
  - (ii) the notice shall comprehensively outline the substance of the matter and include all data or other information relied on by the party raising the

matter as well as a statement of the proposed remedy or proposed solution;  
and

- (iii) upon receiving such a notice, the Physician Services Committee may, by consensus decision, issue recommendations with respect to the matter to the Government and the Doctors of BC or may, by consensus decision, direct that the matter be referred to the Adjudication Committee for arbitration, at which time a chair will be appointed from the Roster.

#### **6.4 Conduct of the Business of the Physician Services Committee**

- (a) The Physician Services Committee will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal agendas for its meetings, notice of meetings with agendas, formal resolutions and minutes of its meetings and decisions. Any changes to the terms of reference will be subject to adoption by consensus decision.
- (b) The Physician Services Committee will meet within one month following the signing of this Agreement, at which time the Physician Services Committee will determine its annual meeting schedule and advise the Joint Clinical Committee co-chairs of this schedule.
- (c) The Physician Services Committee will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.

#### **6.5 Local Quality of Care Issues**

- (a) The parties agree that there is benefit to discussing significant Local Quality of Care Issues that are raised by physicians, groups of physicians or Agencies, when such Local Quality of Care Issues have not been resolved at the local or regional level.
- (b) Where a physician, group of physicians or Agency has a significant concern respecting a Local Quality of Care Issue related to hospital care, the physician, physician group or Agency must first attempt to resolve the matter through the appropriate medical advisory committee.
- (c) Where a physician, group of physicians or Agency has a significant concern respecting a Local Quality of Care Issue that is not related to hospital care, the physician, group of physicians or Agency must first attempt to resolve the matter through a direct meeting.
- (d) Where a Local Quality of Care Issue is not resolved pursuant to either of sections 6.5(b) and 6.5(c), the physician, group of physicians or Agency may refer the matter to the Physician Services Committee.
- (e) Any referral of a Local Quality of Care Issue to the Physician Services Committee pursuant to section 6.5(d) must be in writing and must include full particulars



related to the matter, including relevant supporting data and any proposed solutions.

- (f) Upon receiving a referral pursuant to section 6.5(d), the Physician Services Committee may:
  - (i) appoint an Ad Hoc Advisory Panel to review the issue and provide recommendations to the Physician Services Committee;
  - (ii) refer the matter to the Trouble Shooter for recommendations to the Physician Services Committee; or
  - (iii) take any other action the Physician Services Committee considers appropriate in the circumstances.
- (g) All recommendations of an Ad Hoc Advisory Panel or the Trouble Shooter, on any Local Quality of Care Issue, will be confidential unless directed otherwise by the Physician Services Committee.
- (h) Upon receiving recommendations from any of an Ad Hoc Advisory Panel or the Trouble Shooter pursuant to section 6.5(f), the Physician Services Committee will attempt to resolve the Local Quality of Care Issue through a recommendation. Failing such a recommendation of the Physician Services Committee, there are no further steps under this Agreement to address the Local Quality of Care Issue.

## **6.6 Ad Hoc Advisory Panel**

- (a) An **Ad Hoc Advisory Panel** will be struck by the Physician Services Committee, as required, to assist in resolving Local Quality of Care Issues.
- (b) An Ad Hoc Advisory Panel will be selected by the Physician Services Committee so as to bring the necessary administrative and professional skills, experience and credentials to the examination of the Local Quality of Care Issue in question.
- (c) The Physician Services Committee will develop and maintain a roster of individuals who may be appointed to an Ad Hoc Advisory Panel, but the Physician Services Committee may appoint individuals who are not on that roster to any Ad Hoc Advisory Panel.
- (d) Recommendations of an Ad Hoc Advisory Panel will be unanimous or, failing unanimity, an Ad Hoc Advisory Panel may issue different sets of recommendations.
- (e) Upon releasing its recommendations to the Physician Services Committee, that Ad Hoc Advisory Panel will be dissolved.

## **ARTICLE 7 - JOINT AGREEMENT ADMINISTRATION GROUP**

### **7.1 Joint Agreement Administration Group Composition**

- (a) The **Joint Agreement Administration Group** shall continue under this Agreement to provide oversight of the implementation and administration of this Agreement, the Physician Master Subsidiary Agreements and the 2019 Benefits Administration Agreement, and to manage the dispute resolution provisions of this Agreement, the Physician Master Subsidiary Agreements and Local Contracts, in accordance with the provisions of this Agreement.
- (b) The Joint Agreement Administration Group will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the Doctors of BC. The members appointed by the Government will be staff members of the Government, a Health Authority, and/or the Health Employers Association of British Columbia, and the members appointed by the Doctors of BC will be staff members of the Doctors of BC.
- (c) The Government and the Doctors of BC will each name one of their respective appointees as co-chair of the Joint Agreement Administration Group, and the chair will alternate for successive meetings.

### **7.2 Costs of the Joint Agreement Administration Group**

The Government and the Doctors of BC will pay the costs of the participation in the Joint Agreement Administration Group of their respective appointees.

### **7.3 Functions of the Joint Agreement Administration Group**

The Joint Agreement Administration Group will, among other things:

- (a) report to the Physician Services Committee by:
  - (i) providing the Physician Services Committee with copies of all minutes of Joint Agreement Administration Group meetings;
  - (ii) providing the Physician Services Committee with copies of notices of all Disputes, and, if required by the Physician Services Committee, providing the Physician Services Committee with a without prejudice briefing about any Dispute; and
  - (iii) otherwise reporting as directed by the Physician Services Committee; and
- (b) oversee and manage the processes for the resolution of Disputes, in accordance with the provisions of this Agreement.

### **7.4 Conduct of the Business of the Joint Agreement Administration Group**

- (a) The Joint Agreement Administration Group will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal

agendas for its meetings, notice of its meetings with agendas, formal resolutions and minutes of meetings and decisions. Any changes to the the terms of reference will be subject to approval by consensus decision of the Physician Services Committee.

- (b) The Joint Agreement Administration Group will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.
- (c) The Joint Agreement Administration Group must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Joint Agreement Administration Group pre-approve any communication about the business and/or decisions of the Joint Agreement Administration Group.

## **ARTICLE 8 - JOINT CLINICAL COMMITTEES**

### **8.1 Joint Clinical Committees**

The Government and the Doctors of BC will continue the following joint committees (the “Joint Clinical Committees”):

- (a) the Specialist Services Committee;
- (b) the General Practice Services Committee; and
- (c) the Shared Care Committee.

### **8.2 Core Mandate of the Joint Clinical Committees**

In fulfilling each of their specific mandates, each of the Joint Clinical Committees will operate from a core mandate to:

- (a) identify changes in current physician service delivery that could result in improvements in patient care, more effective utilization of physician and other healthcare resources, and measurable savings in expenditures that could be reallocated for more optimal provision of healthcare services;
- (b) support the integration and alignment of physician services with other health service delivery;
- (c) strengthen the application of Triple Aim Principles in service design and delivery;
- (d) encourage appropriate collaborative practice with other physicians and integration of physicians with other healthcare professionals in the delivery of services;
- (e) identify gaps in care and address population health needs;
- (f) support the delivery of quality and evidence based care, including the use of quality improvement methodologies and promoting the adoption and effective

implementation of appropriate clinical practice guidelines, where appropriate in order to address unwarranted variations in care;

- (g) prior to making decisions, consider the unique issues arising from rural practice;
- (h) use total expenditure data for services as an aid to making decisions;
- (i) form temporary sub-committees (that may be allocated a specific budget) where required to address issues of patient care which engage the mandates of more than one Joint Clinical Committee;
- (j) make recommendations on appropriate shared care between physicians and other healthcare professionals;
- (k) establish measures for accountability and achievement of outcomes; and
- (l) provide input to the Guidelines and Protocols Advisory Committee and the Patterns of Practice Committee regarding the work and effectiveness of those committees.

### **8.3 Specialist Services Committee**

In addition to the core mandate outlined in section 8.2, the Specialist Services Committee will fulfill the specific mandate outlined in the Specialists Subsidiary Agreement.

### **8.4 General Practice Services Committee**

In addition to the core mandate outlined in section 8.2, the General Practice Services Committee will fulfill the specific mandate outlined in the General Practitioners Subsidiary Agreement.

### **8.5 Shared Care Committee**

- (a) The **Shared Care Committee** shall continue under this Agreement as a subcommittee of the General Practice Services Committee and the Specialist Services Committee to improve shared care between General Practitioners, Specialist Physicians and other healthcare professionals.
- (b) The Shared Care Committee will be composed of ten members, five of whom will be appointed by the Government and five of whom will be appointed by the Doctors of BC. The members appointed by the Government will include at least one of the Government appointees to each of the General Practice Services Committee and the Specialist Services Committee. The members appointed by the Doctors of BC will include at least one of the Doctors of BC appointees to each of the General Practice Services Committee, the Specialist Services Committee, and one General Practice Physician (non-FRCP) with a Focused Practice.
- (c) The Shared Care Committee will be co-chaired by one member appointed by the Government members and one member appointed by the Doctors of BC Board of Directors, and the chair will alternate for successive meetings.

- (d) The Shared Care Committee will make all recommendations and decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement. Failing a consensus decision the Shared Care Committee may make more than one set of recommendations on a particular topic or, in the case of a decision that is required of the Shared Care Committee, the Government and/or the Doctors of BC may make recommendations to the MSC and the MSC, or its successor, will determine the matter.
- (e) In addition to the core mandate outlined in section 8.2, the Shared Care Committee will fulfill the specific mandate to:
  - (i) develop recommendations for the General Practice Services Committee and the Specialist Services Committee including the creation of new fees (that is, fees to be added to the Payment Schedule) to enable shared care and appropriate scopes of practice between General Practitioners, Specialist Physicians and other healthcare professionals and, specifically, will develop recommendations regarding:
    - (A) changes to, or full use of, scopes of practice of General Practitioners to free up Specialist Physician time;
    - (B) refining and supporting the appropriate allocation of services between General Practitioners and Specialist Physicians to meet patients' medical needs;
    - (C) collaboration between General Practitioners, Specialist Physicians and other healthcare professionals to meet the medical needs of patients; and
    - (D) facilitating access to advice from Specialist Physicians by General Practitioners; and
  - (ii) allocate the funding identified in sections 8.5(f) and 8.5(g) in accordance with sections 8.5(f),(g) and (j).
- (f) As at March 31, 2019, the annual funding level for the Shared Care Committee to support and increase collaboration between General Practitioners and Specialist Physicians in providing high quality, integrated medical care to British Columbians is \$13.5 million, \$4 million of which is to be used to support the participation of General Practice Physicians (Non-FRCP) with Focused Practices in system improvement initiatives.
- (g) The Government will add the following new annual funding for the Shared Care Committee:
  - (i) Effective April 1, 2019: an additional \$0.75 million;
  - (ii) Effective April 1, 2020: an additional \$0.5 million;

- (iii) Effective April 1, 2021: an additional \$0.5 million.
- (h) The Shared Care Committee will establish a process to review, potentially modify and transfer to the Payment Schedule the Shared Care Committee fee items identified in section 1(a)(iii) of Appendix I to this Agreement in accordance with the processes described in Appendix I.
- (i) Upon the transfer to the Payment Schedule of the Shared Care Committee fee items identified in section 1(a)(iii) of Appendix I, those amounts determined in accordance with Appendix I will be taken out of the Shared Care Committee ongoing annual budget set out in sections 8.5 (f) and (g) and transferred into the Available Amount.
- (j) Any funds identified in sections 8.5(f) and (g) that remain unexpended at the end of any Fiscal Year will be available to the Shared Care Committee for use as one time allocations to improve the quality of care.
- (k) The costs of administrative and clerical support required for the work of the Shared Care Committee will be provided in accordance with the Joint Clinical Committee Administration Agreement and will be paid from the funds referred to in sections 8.5(f) and (g) including the cost of physician participation other than physicians who are employees of the Doctors of BC, the Government and the Health Authorities, unless such Health Authority employed physicians are participating on behalf of Doctors of BC.
- (l) On an annual basis, the Shared Care Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a).
- (m) The Shared Care Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Shared Care Committee pre-approve any communication about the business and/or decisions of the Shared Care Committee.

## **ARTICLE 9 - MEDICAL SERVICES COMMISSION**

### **9.1 MSC Membership**

Subject to applicable laws:

- (a) the following process will be used to appoint the members to the MSC:
  - (i) the Minister will advise the Doctors of BC of three individuals who will be recommended to the Lieutenant Governor in Council for appointment under the *Medicare Protection Act* as representatives of the Government;
  - (ii) the Doctors of BC will advise the Minister of three individuals the Doctors of BC nominates for membership on the MSC, and the Minister will

recommend to the Lieutenant Governor in Council the appointment of those three individuals under the *Medicare Protection Act*;

- (iii) the Minister and the Doctors of BC will consult as to the names of three individuals who will be appointed under the *Medicare Protection Act* as representatives of beneficiaries under that Act, and the Minister and the Doctors of BC must agree on a joint recommendation of the three individuals who will be recommended to the Lieutenant Governor in Council for appointment, provided that if the parties are unable to agree, either the Minister or the Doctors of BC may request the Chief Justice of the Supreme Court of British Columbia to name the three individuals who will be jointly recommended by the Minister and the Doctors of BC to be appointed as representatives of the beneficiaries;
- (b) members of the MSC will be appointed for a term of three years and may be re-appointed;
- (c) upon the expiry of the term of any member of the MSC or, in the event of death, disability, incapacity, or resignation during the term of appointment, the process outlined in section 9.1(a) that was applicable to the appointment of such member will be utilized to the extent necessary to replace such member;
- (d) the Ministry and the Doctors of BC each retain the right to remove any member of the MSC appointed as its representative and the Government will pass any necessary order-in-council; and
- (e) an alternate member may be appointed to serve in the absence of a member as permitted by section 23 of the *Interpretation Act*.

## **9.2 Chair of the MSC**

- (a) It is acknowledged that subsection 3(4) of the *Medicare Protection Act* requires the Lieutenant Governor in Council to designate a member of the MSC appointed to represent the Government as the Chair of the MSC. The Minister will Consult with the Doctors of BC prior to the appointment or reappointment of the Chair of the MSC.
- (b) The Chair of the MSC must act in a manner that is consistent with the purpose of the *Medicare Protection Act* and in the spirit of this Agreement and shall not execute or initiate matters or changes not previously authorized or agreed to by the MSC in the period between meetings of the MSC.

## **9.3 Independence of the MSC**

The parties agree that it is in the best interests of all parties and in the public interest for the MSC to exercise its full legal authority in an independent manner under the management of its members.

## **ARTICLE 10 - ADVISORY COMMITTEES TO THE MEDICAL SERVICES COMMISSION**

### **10.1 Reference Committee**

- (a) The Reference Committee may, as contemplated in this Agreement, make recommendations to the MSC.
- (b) The MSP shall inform physicians of their right to refer matters relating to their medical accounts to the Reference Committee where:
  - (i) there is a disagreement between the physician and the MSP with respect to an account or accounts, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP; or
  - (ii) there is a disagreement between the physician and the MSP over payment for services or procedures for which no fee has been established and approved by the MSC, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP.
- (c) The Reference Committee shall promptly review all matters referred to it and shall forward its recommendations to the MSC within one month of its meeting or to the Tariff Committee or MSP as appropriate.
- (d) When the MSC accepts the recommendation of the Reference Committee to pay a Fee for Service Account as submitted by a physician, the MSP shall pay the account with interest at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act*.
- (e) The Reference Committee shall meet to review matters referred to it at least three times per calendar year and the period between successive meetings is not to exceed six months. A recommendation by the Reference Committee is not binding on the MSC. However, the MSC will endeavour to follow the recommendations of the Reference Committee. This does not in any way circumscribe or fetter the duties, rights and discretions of the MSC under the *Medicare Protection Act*.
- (f) The approved costs of the Reference Committee will be shared equally by the MSP and the Doctors of BC.

### **10.2 Audit and Inspection Committee**

- (a) In this section 10.2 and section 10.3, “medical practitioner” has the meaning given to that expression in section 1 of the *Medicare Protection Act*, as further defined by section 36(1) therein, and “panel” has the meaning given to that expression in section 6 of the *Medicare Protection Act*, as further described in this section 10.2.



- (b) The MSC has the right and responsibility to appoint inspectors to audit claims for payment by medical practitioners and the patterns of practice or billing followed by medical practitioners under the *Medicare Protection Act*.
- (c) The Audit and Inspection Committee is a panel appointed by the MSC pursuant to section 6 of the *Medicare Protection Act*.
- (d) The parties agree that the Audit and Inspection Committee shall be delegated the powers of the MSC under section 36(2) of the *Medicare Protection Act* to appoint inspectors to audit and inspect practitioners.
- (e) The Audit and Inspection Committee's responsibilities include oversight of random audits, other audits and inspections referred to it by the MSC, MSP or any practitioner review committee, including the Patterns of Practice Committee, and the submission of its recommendations to the MSC.
- (f) Inspectors are to be appointed from a list maintained by the Audit and Inspection Committee and proposed jointly by the Doctors of BC and the Government after consultation with the College of Physicians and Surgeons of British Columbia.
- (g) Notice of inspection must be provided to the medical practitioner(s) in question. Except in extraordinary circumstances, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.
- (h) Inspection guidelines are to be clearly laid out and communicated to the medical practitioner(s) prior to inspection.
- (i) The confidential nature of medical records will be protected. The identity of patients shall be protected except to the extent necessary for verification or as evidence for a hearing.
- (j) Prior to any decision being made by the MSC resulting from a recommendation of the Audit and Inspection Committee, it is understood that the medical practitioner(s) subject to the audit and inspection shall be entitled to be heard by the MSC and to have legal counsel present and may have one or more colleagues present to comment on the practice of the medical practitioner(s).
- (k) Prior to a hearing before the MSC, the MSC will communicate in writing to the medical practitioner(s) its concerns and provide copies of all relevant documents (except those over which a claim of privilege is advanced and, if challenged, upheld) to the medical practitioner(s) at least 21 days prior to the hearing.
- (l) The approved costs of the Audit and Inspection Committee shall be funded by the MSP.

### **10.3 Patterns of Practice Committee**

- (a) The MSC has the right and responsibility to appoint inspectors to audit the patterns of practice of medical practitioners as part of a random review or in response to service verification irregularities.
- (b) The Patterns of Practice Committee shall continue to act as an advisory committee to the MSC under section 5(1)(o) of the *Medicare Protection Act*.
- (c) The approved costs of the Patterns of Practice Committee will be shared equally by the MSP and the Doctors of BC.
- (d) The Patterns of Practice Committee will:
  - (i) inform medical practitioners of their billing patterns and provide education to the medical practitioners as necessary;
  - (ii) prioritize a review of selected new guidelines of the Guidelines and Protocols Advisory Committee to determine their expected impact on Fee utilization and provide related education material and information to medical practitioners;
  - (iii) work with the Guidelines and Protocols Advisory Committee to jointly review a set number of guidelines per year, evaluate their impact on utilization management, and report back to the MSC as to their effectiveness; and
  - (iv) meet with the Guidelines and Protocols Advisory Committee regularly to propose ideas for new guidelines, based on the Patterns of Practice Committee's work and analysis of new areas for which guidelines could be developed.

### **10.4 Guidelines and Protocols Advisory Committee**

- (a) The Guidelines and Protocols Advisory Committee is an advisory committee to the MSC.
- (b) The Guidelines and Protocols Advisory Committee will be composed of members appointed by the MSC on the advice of the Government and the Doctors of BC.
- (c) The Guidelines and Protocols Advisory Committee will be co-chaired by a Government representative and a Doctors of BC representative, and the chair will alternate for successive meetings.
- (d) The Government will provide administrative and clerical support required for the work of the Guidelines and Protocols Advisory Committee. The Government will provide up to \$460,000 annually to support the work of the Guidelines and Protocols Advisory Committee. The costs of physician participation in the Guidelines and Protocols Committee, other than physicians who are employed by

the Doctors of BC, Government or Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC, will be paid from the \$460,000 referred to in this section.

- (e) The Guidelines and Protocols Advisory Committee will, at the request of any of the Joint Clinical Committees or the Physician Services Committee from time to time, develop guidelines and protocols to support the effective utilization of medical services.
- (f) The Guidelines and Protocols Advisory Committee will develop strategies for the rapid adoption by all affected parties of guidelines and protocols once they are approved.
- (g) The Guidelines and Protocols Advisory Committee will:
  - (i) work with the Patterns of Practice Committee to jointly review a set number of guidelines per year, evaluate their impact on utilization management, and report back to the MSC as to their effectiveness; and
  - (ii) meet with the Patterns of Practice Committee regularly to propose ideas for new guidelines, based on the Guidelines and Protocols Advisory Committee's work and analysis of new areas for which guidelines could be developed.

## **ARTICLE 11 - THE AVAILABLE AMOUNT**

### **11.1 Establishment of the Available Amount**

- (a) There will be one centrally administered Available Amount. This does not preclude segmenting components of the Available Amount for analysis of expenditures of the Available Amount for purposes of planning, evaluation and management.
- (b) The Government will Consult with the MSC and the Doctors of BC prior to the tabling of the Ministry's spending estimates on the amount of annual funding for the provision of physician services to the residents of British Columbia in each year.
- (c) For each Fiscal Year, the Government will advise the Doctors of BC through the MSC of the budget for the Available Amount within 15 days of the approval of the Ministry's spending estimates by the Legislature. Adjustments as a result of the negotiation of agreements will be disclosed following the resolution of those agreements.

### **11.2 Monitoring and Managing the Available Amount**

- (a) The MSP will track Total Claims Cost against the Available Amount at the conclusion of each month and will make a forecast concerning the adequacy of

the Available Amount. The results will be forwarded to the MSC, at or before the next meeting of the MSC.

- (b) If the MSC concludes on the basis of a reasonable forecast that the Total Claims Cost for a Fiscal Year is likely to exceed the Available Amount, the MSC will Consult with the Doctors of BC and the Ministry on developing strategies and measures to prevent the overrun of the Available Amount. While the parties agree that there will be no pro-rationing of Fees for the term of this Agreement, the parties recognize that the MSC must exercise its statutory responsibility through the use of reasonable methods within its jurisdiction, subject to the specific provisions agreed to in this Agreement. An integral part of the exercise of that responsibility will be the development of protocols and billing guidelines by the MSC. The Doctors of BC will participate in the development of those protocols and billing guidelines and the medical profession will make every effort to adhere to such protocols and billing guidelines once implemented by the MSC.
- (c) In recognition of the need for all parties to this Agreement to be satisfied that the MSC continues to be effective in managing the Available Amount, the Chair of the MSC will be a non-voting member of the Physician Services Committee and will advise the Physician Services Committee at regular intervals to assess the management process. The Physician Services Committee will report the results of these meetings to the Minister, the MSC and the Board of Directors of the Doctors of BC on a timely basis.
- (d) Reconciliation of the Total Claims Cost with the Available Amount for each Fiscal Year shall take place and be concluded by October 31 of the following Fiscal Year.

## **ARTICLE 12 - REVISION AND MAINTENANCE OF THE GUIDE TO FEES**

### **12.1 Revisions to Guide to Fees by Doctors of BC**

- (a) Funds made available in Appendix F for revisions to the Payment Schedule, will be allocated by the Doctors of BC to fee items in the Guide to Fees in a manner consistent with this Agreement including Appendix F.
- (b) Except where otherwise expressly agreed in writing, revisions to the Guide to Fees allocating funds made available under Appendix F for any Fiscal Year will be effective April 1 of that Fiscal Year.
- (c) Subject to section 12.1(d), when the Tariff Committee has prepared recommendations for revisions to the Guide to Fees for consideration by the Board of Directors of the Doctors of BC, prior to transmission of its recommendations to the Board of Directors of the Doctors of BC the Tariff Committee will:
  - (i) inform the MSC and the Physician Services Committee of the recommendations in writing;

- (ii) consult with the MSC and the Physician Services Committee to identify any comments or concerns they may have respecting such recommendations in order that the Tariff Committee may have such comments or concerns before them at the time of finally recommending a revision of the Guide to Fees to the Doctors of BC's Board of Directors; and
  - (iii) attempt to achieve agreement in writing between the Doctors of BC and the Government on the recommended changes, and if such agreement is reached, section 13.1 shall apply.
- (d) When the Tariff Committee is considering revisions to the Fees transferred to the Payment Schedule pursuant to Appendix I, the Tariff Committee will, prior to the process set out in sections 12.1(c) (i) – (iii), consult with the applicable Joint Clinical Committee(s) to identify any comments or concerns it may have respecting such recommendations.
- (e) If agreement is not reached between the Doctors of BC and the Government pursuant to section 12.1(c)(iii) within 90 days, or such additional time as may be agreed, of written notification from the Doctors of BC to the Government of a proposed revision pursuant to this section 12.1, the Doctors of BC may refer the matter to the MSC for a decision under section 13.2.
- (f) No change to the Payment Schedule shall result from a change to the Guide to Fees under this section 12.1, except in accordance with Article 13.

## **12.2 Revisions to Guide to Fees on Government's Recommendation**

- (a) When the Government wishes to recommend the creation of a new fee item or any revisions to existing fee items in the Guide to Fees, it will:
- (i) consult with the Tariff Committee and with the Health Authorities to identify any comments or concerns they may have respecting such recommendations;
  - (ii) subject to (iii) below, attempt to achieve agreement in writing with the Doctors of BC through the Tariff Committee on the recommended changes, and if such agreement is reached, section 13.1 shall apply; and
  - (iii) with respect to the Fees transferred to the Payment Schedule pursuant to Appendix I, the Tariff Committee will, prior to reaching an agreement with the Government on the recommended changes, consult with the applicable Joint Clinical Committee(s) to identify any comments or concerns it may have respecting the recommended changes.
- (b) If agreement is not reached between the Government and the Doctors of BC pursuant to section 12.2(a)(ii) within 90 days of written notification from the Government to the Doctors of BC of a proposed revision pursuant to this section 12.2, or such additional time as may be agreed, the Government may advise the

Doctors of BC that it intends to refer the matter to an ad hoc joint review panel as provided in section 12.2(c).

- (c) The joint review panel must be appointed within 60 days of the Government advising the Doctors of BC that it intends to refer the matter to an ad hoc joint review panel. The composition of the joint review panel shall be three members, with one member appointed by the Doctors of BC, one member appointed by the Government, and the third member who shall be the Chair, selected from a roster of individuals agreed upon by the Government and the Doctors of BC. The members appointed shall be chosen so as to avoid conflicts of interest. If the Government and the Doctors of BC have not agreed upon the roster, the MSC will appoint the Chair.
- (d) The joint review panel must render a majority recommendation to the parties and the MSC within three months of its appointment.
- (e) If the Government and the Doctors of BC support in writing the recommendation of the joint review panel, the Doctors of BC shall change the Guide to Fees accordingly and section 13.1 shall apply.
- (f) If either the Government or the Doctors of BC does not support in writing the recommendation of the joint review panel, the MSC will decide the matter in accordance with section 13.2, and if the MSC decides that a change to the Guide to Fees should be made, the Doctors of BC will implement the change to the Guide to Fees.

## **ARTICLE 13 - REVISIONS TO THE PAYMENT SCHEDULE**

### **13.1 Revisions By Agreement**

The MSC shall adopt as part of the Payment Schedule additions to, deletions from or other modifications of the Guide to Fees, provided that:

- (a) either:
  - (i) the Doctors of BC and the Government agree in writing to the additions, deletions or other modifications; or
  - (ii) the Government and the Doctors of BC support in writing the recommendations of the joint review panel as contemplated by section 12.2(e);
- (b) the MSC agrees that such modifications are consistent with the requirements of the *Medicare Protection Act* and Regulations;
- (c) the MSC agrees that the services covered by a given fee item are medically necessary; and

- (d) the MSC agrees to the estimated projected net cost effect on the Total Claims Cost which would result from such recommended changes.

### **13.2 Revisions in the Absence of Agreement**

Where there is no agreement between the Doctors of BC and the Government on recommended changes to the Payment Schedule, the Doctors of BC and the Government may make separate recommendations to the MSC and the MSC will determine the changes, if any, to the Payment Schedule.

### **13.3 Changes to Insured Medical Services**

If the MSC introduces any change to the medical services that are benefits under the *Medicare Protection Act*, it will provide at least 30 days' notice of such change to all physicians enrolled in the MSP.

## **ARTICLE 14 - PAYMENT OF FEE FOR SERVICE ACCOUNTS**

### **14.1 Payment Process**

- (a) It is acknowledged and agreed that there exists a common interest in ensuring that Fee for Service Accounts are processed and paid promptly.
- (b) On behalf of beneficiaries, the MSP will pay Fee for Service Accounts promptly, in accordance with the Payment Schedule, subject to the provisions of the *Medicare Protection Act* and this Agreement.
- (c) Normally, the MSC makes general remittances for Fee for Service Accounts on a regular cycle that is at least semi-monthly. If the MSC is unable to make a general remittance within five working days of the end of a payment cycle, an advance against Fee for Service Accounts payable will be paid. This will be limited to the physician's average regular cycle payment, measured over the previous 12 months or over the length of time the physician has participated in the MSP, whichever is the lesser period of time.

### **14.2 Advances**

The MSP may, on an individual physician basis, provide an advance to a physician encountering temporary difficulty submitting his or her Fee for Service Accounts or having those Fee for Service Accounts processed by the MSP. Requests for advances will be submitted to the MSP, which will determine whether or not the advance will be granted. If the MSP denies a request for an advance, the requesting physician may refer the matter to the Physician Services Committee for a final decision on the matter. Such advances will be set off against subsequent remittances to the physician by the MSP until the advance is fully repaid. Interest at the rate provided for in and in accordance with Regulation 214/83 of the *Financial Administration Act* (British Columbia) shall apply to and be paid by the physician on all such advances.

### **14.3 Overdue Accounts**

Interest shall apply to and be paid by the MSP on overdue Fee for Service Accounts at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act* (British Columbia). Interest will only apply on the amount of the outstanding Fee for Service Account that exceeds the amount of any outstanding advance.

### **14.4 Changes to Payment Process**

- (a) Should a need arise to review the routine data requirements, submission formats and/or transmission protocols for processing Fee for Service Accounts, the review must consider, among other things, the efficacy of the modification and the cost to physicians of implementing such a change.
- (b) When there are modifications to the routine data requirements, submission formats and/or transmission protocols for processing Fee for Service Accounts, the parties will attempt to reach agreement on the net average cost of implementing these modifications and, if they fail to do so, then the matter shall be determined by the Adjudication Committee and appropriate compensation (including retroactivity) if any, will be provided to the affected physicians.

## **ARTICLE 15 - FEES, SERVICE CONTRACT RANGES, SESSIONAL CONTRACT RATES AND SALARY AGREEMENT RANGES**

### **15.1 Compensation Changes**

Changes to Fees, Service Contract Ranges, Sessional Contract Rates, Salary Agreement Ranges and other fees over the term of this Agreement are set out or provided for in Appendix F.

### **15.2 Interprovincial Physician Compensation Report**

- (a) The parties recognize that the compensation of physicians and physician groups in British Columbia should, at least in part, be based upon the need to be competitive with other provinces for the recruitment and retention of physicians.
- (b) Pursuant to the 2007 Physician Master Agreement, a panel was assembled to produce a report on interprovincial comparisons and the panel produced such a report dated December 31, 2010.

### **15.3 WorkSafeBC Services and ICBC Services**

Effective April 1, 2011, an in office assessment of an unrelated condition in association with a WorkSafeBC service and/or an ICBC service shall be compensated in accordance with the Payment Schedule.



## **ARTICLE 16 - FUNDING NEW FEE ITEMS**

### **16.1 Allocation for New Fee Items**

- (a) The Government will provide the following funding to be allocated to Specialist Sections and to Physician Sections that are not Specialist Sections for adding new fees to the Payment Schedule:
  - (i) effective April 1, 2019, \$1 million per year to Specialist Sections and \$1 million per year to Physician Sections that are not Specialist Sections;
  - (ii) effective April 1, 2020, an additional \$1 million per year to Specialist Sections and an additional \$1 million per year to Physician Sections that are not Specialist Sections; and
  - (iii) effective April 1, 2021, an additional \$1 million per year to Specialist Sections and an additional \$1 million per year to Physician Sections that are not Specialist Sections.
- (b) The funds in section 16.1(a) will be allocated to new fee items pursuant to Articles 12 and 13. Any new fee item funds described in this section 16.1 and in the 2019 Physician Master Agreement that are unused in one Fiscal Year (including the Fiscal Year ending on March 31, 2022) shall be carried forward to the next Fiscal Year.

## **ARTICLE 17 - THE MEDICAL ON-CALL/AVAILABILITY PROGRAM**

### **17.1 Budget for MOCAP**

Funding for Doctor of the Day is allocated from the annual MOCAP budget.

### **17.2 Provincial MOCAP Review Committee**

- (a) The Government and the Doctors of BC have created the Provincial MOCAP Review Committee (“**PMRC**”). The PMRC is composed of three representatives appointed by the Government (including any representatives of Health Authorities) and three physician representatives appointed by the Doctors of BC. The Government and the Doctors of BC have selected an independent Chair for the PMRC. In the event that the Chair resigns or becomes unable to fulfill his role, a replacement will be appointed by agreement of the Doctors of BC and the Government.
- (b) The PMRC makes decisions by majority vote. In this case, a majority vote must consist of all of the representatives of either party and the Chair of the PMRC.
- (c) The PMRC is responsible for overseeing and guiding the transition to and implementation of the redesigned MOCAP program in accordance with the Report of the MOCAP Redesign Panel dated May 14, 2013. The PMRC issued a final report dated December 5, 2018 (“**Final MOCAP Report**”).

- (d) The PMRC has determined that the implementation date for the redesigned MOCAP is April 1, 2019.
- (e) In order to assist in the orderly implementation of the Final MOCAP Report by the implementation date of April 1, 2019, the parties agree to the following:
  - (i) every Health Authority will implement the results of the Final MOCAP Report in order to maintain consistency. Any variation will be made only with the agreement of the PMRC;
  - (ii) should a call group disagree with the initial call level allocated by the PMRC under the Final MOCAP Report, all such disagreements will be brought to the PMRC for review and decision in accordance with the process set out in the Final MOCAP Report. Any changes in the payment level for call groups arising from such a review will be effective after 90 days' written notice is provided to physicians in accordance with the terms of existing MOCAP contracts;
  - (iii) if a Health Authority can demonstrate to the PMRC that it is necessary to maintain a particular call group or an assigned level of call in a manner inconsistent with the application of those factors identified in Attachment C of the Final MOCAP Report, they may seek approval from the PMRC that an exception may be created for the call group. The PMRC will only review requests based on the issue of providing a necessary service where the application of Attachment C of the Final MOCAP Report does not justify the assigned level of call on a normal basis.

### **17.3 MOCAP Terms and Conditions**

- (a) The MOCAP shall be operated in accordance with the terms of the Final MOCAP Report and those terms outlined below in 17.4 to 17.7 and attached hereto as Appendix G.
- (b) Physicians who provide MOCAP coverage will do so in accordance with the provisions of the MOCAP Contract attached hereto as Schedule 1 to Appendix G.

### **17.4 Distribution of MOCAP Funds by Health Authorities**

- (a) The Health Authorities will distribute MOCAP funds that have been allocated to them by the Government (“**MOCAP Budget**”) in a manner that supports the following objectives (the “**MOCAP Objectives**”), in the following order of priority:
  - (i) first, to provide life and limb support in acute care hospitals, diagnostic and treatment centres, and specified emergency rooms;
  - (ii) second, where required for the operational efficiency of hospitals; and

- (iii) third, to support General Practitioner care of complex patients in the community.
- (b) Pursuant to the 2007 Physician Master Agreement, the Doctors of BC was Consulted on the development of evaluation criteria that support the MOCAP Objectives and their prioritization as required by section 17.4(a).
- (c) By July 1 of each year, each Health Authority will form a MOCAP Contract Review Committee (the "**MCRC**"). The MCRC of each Health Authority will include representatives of the Health Authority, health authority medical advisory committee (HAMAC) (or equivalent), physicians receiving MOCAP and emergency medicine physicians in the Health Authority.
- (d) Each Health Authority will determine the call groups that should exist within its MOCAP Budget and, apply the levels of payment for the call groups in the Health Authority determined by the PMRC. This will form the basis of the Health Authority's annual distribution plan for MOCAP.
- (e) In determining annual distribution plans for MOCAP, the Health Authorities will review call-back expenditures to determine whether groups should be provided with an on-call agreement.
- (f) The annual distribution plan for MOCAP in each Health Authority will be reviewed with the MCRC.
- (g) Each Health Authority will then review this distribution plan with the Ministry through the PMRC which will determine if the MOCAP funding to each Health Authority is appropriate within the provincial budget for MOCAP.
- (h) Each Health Authority will then finalize its annual distribution plan for MOCAP. Any physician or physician group may challenge a Health Authority's distribution plan for MOCAP with the Health Authority pursuant to Section 17.6 below.
- (i) It is imperative that the time frame to complete this process is limited so that necessary decisions are not delayed.
- (j) The process set out in (c) to (i) above was suspended until March 31, 2019.

## **17.5 Principles of MOCAP**

The Government and Doctors of BC adopt the following principles for MOCAP:

- (a) MOCAP is designed to meet the medical needs of new or unattached patients requiring emergency care. By definition, a new or unattached patient is not a patient of any physician participating in a call group. For clarity, in rural communities where a physician or a call group are providing additional services such as emergency, obstetrics/gynecology, anesthesia or general surgery, then patients of the physician or call group presenting for such additional services will be considered as a new patient of that additional service.

- (b) The Health Authorities are responsible for managing within their MOCAP allocation and decisions as to the specific nature and quantity of on-call availability services required rests ultimately with the Health Authorities. A Health Authority's decision to establish a MOCAP arrangement is made following consultation with physicians.
- (c) MOCAP arrangements may require availability to attend more than one site where clinically appropriate and may permit the availability to be provided in a manner consistent with advancements in technology.
- (d) MOCAP provides compensation for physician availability according to the relative burden of providing such availability. MOCAP is not meant to compensate physicians for actual services to patients.
- (e) Physicians who are on-call must respond to telephone calls in a timely way to determine clinical urgency and attend to the emergent needs of patients.
- (f) Physicians who are on-call must respond to telephone calls not just from the location(s) where they are on-call, but from other locations and physicians.
- (g) Decisions on MOCAP should reflect a consistent rationale across all Health Authorities and payments for being on-call should be based on objective data and information that reflect the burden of providing on-call services.
- (h) MOCAP arrangements must be sustainable and must not contribute to physician burnout. In some circumstances, physicians may provide partial on-call availability to meet this principle.
- (i) Health Authorities must appropriately fund the call groups that are established under MOCAP. Health Authorities should not prorate MOCAP payments (i.e. pay a lesser amount for the coverage required than is appropriate) in order to try to extend their MOCAP budget.
- (j) There are separate and independent obligations through Health Authority by-laws and rules and the College of Physicians and Surgeons of BC's professional standards that require physicians to provide call, including call for new and unattached patients. When a Health Authority requires physicians to provide call for new and unattached patients, the Health Authority will provide payment under MOCAP in accordance with this Agreement.

## **17.6 Review of Call Groups**

- (a) If, after April 1, 2019, a Health Authority or a physician group considers that, based on those factors identified in Attachment C of the Final MOCAP Report, things have changed in a manner requiring a review of the assigned level of call, a Health Authority or a physician group can bring an application to the PMRC (which will determine its procedures to consider such applications) to initiate such a review, following which:

- (i) The PMRC will consider such applications.
  - (ii) Any changes in the payment level for call groups arising from such a review will be effective after 90 days' written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.
  - (iii) This process for review of call levels will continue until March 31, 2022.
- (b) If after April 1, 2019, a physician group wishes to dispute either the nature of the call or a Health Authority decision that certain physicians do not need to provide on-call services under MOCAP, they must first provide notice to the Health Authority. Such notice must be in writing and include the facts, upon which the physician or physician group relies, an outline of argument supporting the physician(s)'s position and the remedy sought. In the event that the physician group and Health Authority are unable to reach agreement, the physician group may refer the dispute to the PMRC (which will determine its procedures to consider such applications) for binding adjudication, following which:
- (i) The PMRC will consider such applications.
  - (ii) In considering the dispute, the PMRC must only determine only whether the process of establishing the call group, and establishing the nature of call were consistent with the MOCAP principles listed at Section 17.5 above and the applicable provisions of the PMA.
  - (iii) The PMRC will not be entitled to disturb a final decision of a Health Authority that certain physicians do not need to provide on-call services under MOCAP unless MOCAP principles referenced in paragraph (ii) above are breached..
  - (iv) In the event the PMRC disturbs a final decision of a Health Authority under (iii) above, such financial consequences will be effective in the subsequent fiscal year but will, at the discretion of the PMRC, have a retroactive effect that that time back to the date of the adjudication.
  - (v) Any changes in the nature of call for call groups arising from such a PMRC adjudication process will be effective 90 days' after written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.

## **17.7 Evaluation**

The Government and the Doctors of BC will conduct an evaluation of the redesigned MOCAP in the fiscal year commencing April 1, 2021. Such evaluation will consider:

- (a) whether the changes to MOCAP have improved or reduced the ability to determine call levels;

- (b) the number of disagreements arising between Health Authorities and call groups and the reasons for those disagreements; and
- (c) if there are further changes which should be made to MOCAP.

## **ARTICLE 18 - INFORMATION TECHNOLOGY**

### **18.1 Doctors of BC Participation in e-Health**

The Doctors of BC will participate in the leadership of e-Health in British Columbia through the appointment of one senior executive representative to the senior Government committee responsible for developing and overseeing the implementation of the Government's IT strategy and relevant subcommittees.

## **ARTICLE 19 - CHANGE IN FORM OF COMPENSATION FOR PHYSICIAN SERVICES**

### **19.1 Change in Form of Compensation**

- (a) No change in form of compensation for physician services will be required of any physician.
- (b) An Agency has the right to determine the form of compensation for physician services for any new service model it introduces.

## **ARTICLE 20 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT GENERAL PROVISIONS**

### **20.1 Government and Doctors of BC will Work to Prevent Withdrawals of Services**

It is agreed that the Government and the Doctors of BC will work together through the Physician Services Committee to prevent withdrawals of services as a result of Disputes and Issues arising between physicians and/or the Doctors of BC, on the one hand, and the Government and/or Agencies, on the other.

### **20.2 Dispute Resolution and Issue Management may not alter Agreements**

- (a) Any resolution of a Dispute or Issue must be consistent with the terms of this Agreement and the Physician Master Subsidiary Agreements unless otherwise recommended by the Physician Services Committee and agreed to by the parties to this Agreement.
- (b) No term or provision of this Agreement or any Physician Master Subsidiary Agreement may be amended except by agreement of the parties to this Agreement in accordance with section 1.7.
- (c) An Adjudicator or the Adjudication Committee does not have the authority to alter, modify or enlarge upon any provisions of this Agreement, the Physician Master Subsidiary Agreements, or any other agreement.

### **20.3 Voluntary Settlements are Without Prejudice**

Any voluntary resolution of a Dispute or Issue achieved outside of any binding resolution process under this Agreement is without prejudice or precedent in any other Dispute or Issue and is inadmissible in any other proceeding relating to any other Dispute or Issue unless the Joint Agreement Administration Group decides otherwise.

### **20.4 Process, Time Limits and Procedural Requirements to be Strictly Complied With**

- (a) Subject to a decision of the Joint Agreement Administration Group, or a direction of the Adjudicator or the Adjudication Committee, in either case to relieve against breaches of time limits for equitable reasons, and subject to the right of a party to elect to proceed to the next step in a process despite the other party's non-compliance with the time limits or procedural requirements, the time limits and procedural requirements established in this Agreement are mandatory, and where a Dispute or Issue is not advanced within these time limits or procedural requirements, the Dispute or Issue will be barred for all purposes and may not be reasserted in any proceeding or any forum.
- (b) Disputes and Issues will be resolved in accordance with the processes set out in this Agreement and only in accordance with the processes set out in this Agreement.

### **20.5 Distinguishing Disputes from Issues**

- (a) The Joint Agreement Administration Group will resolve any disagreement as to whether:
  - (i) a matter is a Dispute, an Issue, or neither;
  - (ii) a Dispute is a Provincial Dispute or a Local Dispute;
  - (iii) a Local Dispute is a Local Contract Dispute or Local Range Placement Dispute; and
  - (iv) an Issue is a Local Interest Issue or a Local Quality of Care Issue.
- (b) If the Joint Agreement Administration Group cannot resolve a disagreement referred to in section 20.5(a), the Government or the Doctors of BC may refer the question to the Adjudicator or, at one party's election, the Adjudication Committee for a final and binding decision.

### **20.6 Costs of Dispute Resolution and Issue Management**

The Government and the Doctors of BC will bear the costs of their own respective participation in any of the Dispute and Issue management processes set out in this Agreement and will share the costs of the Trouble Shooter, any Adjudicator and any third party appointed to the Adjudication Committee or an Ad Hoc Advisory Panel, other than representatives of the Doctors of BC or the Government, and employees of the Health Authorities or parties.

## ARTICLE 21 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT TOOLS

### 21.1 Adjudication Roster

- (a) An Adjudication Roster (the “**Roster**”) will be maintained from which the Adjudicator or the chair for the Adjudication Committee will be appointed, on an as needed basis. The Roster will be composed of at least three individuals agreed upon in writing by the Government and the Doctors of BC.
- (b) Individuals named to the Roster will have experience in conflict resolution, mediation and adjudication.
- (c) Members of the Roster may be removed or replaced at any time by written agreement of the Doctors of BC and the Government.
- (d) The current members of the Roster are listed in Appendix H.

### 21.2 The Adjudicator and the Adjudication Committee

- (a) The Government and the Doctors of BC will refer Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement to a single arbitrator, appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing) at the time a reference is made to adjudication (the “**Adjudicator**”). If any member of the Roster to be appointed as the Adjudicator is not able to hear the matter within a reasonable time the next named member who is able to do so will be appointed, and the rotation will continue from the member actually appointed. Either the Government or the Doctors of BC may elect to have Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement heard by an Adjudication Committee as described in section 21.2(b).
- (b) Notwithstanding section 21.2(a), the Government and the Doctors of BC will maintain an adjudication committee (the “**Adjudication Committee**”) to resolve, Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement if either the Government or the Doctors of BC so elect to use the Adjudication Committee as an alternative to a single Adjudicator as provided in this Agreement. The Adjudication Committee will be composed of one Doctors of BC representative and one Government representative. In addition, a chair will be appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing), at the time a reference is made to adjudication. If any member of the Roster to be appointed to the Adjudication Committee is not able to hear the matter within a reasonable time the next named member who is able to do so will be appointed, and the rotation will continue from the member actually appointed. The Government and the Doctors of BC will each be entitled to appoint one alternate representative to the Adjudication Committee.



- (c) All arbitrations conducted by the Adjudicator or by the Adjudication Committee will be conducted pursuant to the *Arbitration Act*. The Rules of the British Columbia International Arbitration Centre for the Conduct of Domestic Commercial Arbitrations will apply unless modified by this Agreement or any other agreement between the Government and the Doctors of BC from time to time.
- (d) In resolving any matter referred to it, the chair of the Adjudication Committee will work with the other members of the Adjudication Committee in an attempt to achieve a unanimous decision, which will be binding. If, after a reasonable time, a unanimous decision is not achieved, the majority decision of the Adjudication Committee will be binding. If there is no majority decision of the Adjudication Committee, the chair of the Adjudication Committee will not decide the matter and the arbitration will terminate.

### 21.3 Trouble Shooter

- (a) A Trouble Shooter (the “**Trouble Shooter**”) will be appointed by agreement of the Doctors of BC and the Government to facilitate the early and voluntary settlement of certain Disputes and Issues in accordance with this Agreement, without withdrawals of services, and to facilitate agreement between a physician or group of physicians and an Agency on matters of workload pursuant to the terms of a Service Contract or a Salary Agreement between them.
- (b) Subject to section 21.3(c), the Trouble Shooter will be appointed for a three year term and may only be reappointed by agreement of the Doctors of BC and the Government.
- (c) The Trouble Shooter may be removed and replaced at any time by agreement of the Doctors of BC and the Government. In the event that the Trouble Shooter resigns or becomes unable to fulfill his or her role during the term of his or her appointment, a replacement will be appointed by agreement of the Doctors of BC and the Government.
- (d) In the event that a matter referred to the Trouble Shooter raises an aspect of quality of care, the Joint Agreement Administration Group may request one or more additional people with relevant expertise to provide informed advice to the Trouble Shooter. Such additional people will not directly contribute to the Trouble Shooter’s findings or recommendations.
- (e) The Trouble Shooter will consider only those matters referred to him or her in accordance with this Agreement and will at all times act in a manner consistent with this Agreement.
- (f) The Trouble Shooter may:
  - (i) assist in attempting to effect a voluntary resolution of the matter referred to it;

- (ii) conduct fact finding in relation to the matter referred to it; and
- (iii) issue recommendations regarding the matter referred to it.
- (g) Any facts found and/or recommendations made by the Trouble Shooter will be treated as confidential by the parties unless otherwise agreed by the Joint Agreement Administration Group.

## **ARTICLE 22 - DISPUTE RESOLUTION PROCESS**

### **22.1 Provincial Disputes**

- (a) In the event that a Provincial Dispute is initially raised by an Agency, the Agency will refer the matter in writing to the Government, with a copy of the reference to the Joint Agreement Administration Group. In the event that a Provincial Dispute is initially raised by a physician or group of physicians, the physician or group of physicians will refer the matter in writing to the Doctors of BC, with a copy of the reference to the Joint Agreement Administration Group.
- (b) If the Government or the Doctors of BC raises a Provincial Dispute or has a Provincial Dispute referred to it as contemplated by section 22.1(a), that party must notify the designated representative of the other party. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:
  - (i) the provisions of the agreement(s) in issue;
  - (ii) the facts upon which the complaining party relies;
  - (iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and
  - (iv) the remedy sought by the complaining party.
- (c) Within 15 days of the receipt of the notice referred to in section 22.1(b) by the other party, the designated representatives of the parties will meet informally in an attempt to resolve the matter or to narrow the issues.
- (d) If there is no resolution of the matter within 15 days of the meeting referred to in section 22.1(c), or longer period as agreed by the parties, either the Government or the Doctors of BC may refer the matter to the Adjudicator, or to the Adjudication Committee with notice to the Joint Agreement Administration Group.
- (e) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.1(d), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter

referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

- (f) Upon receipt of the notice in section 22.1(d), the Joint Agreement Administration Group will appoint the Adjudicator or a chair of the Adjudication Committee, as the case may be, from the Roster in accordance with sections 21.2(a) and (b). The Adjudicator or the Adjudication Committee will attempt to assist the parties to resolve the matter on a voluntary basis through a mediation process which will be conducted by the Adjudicator or the chair of the Adjudication Committee, or, if either the Doctors of BC or the Government stipulates so in writing within five business days of the referral to the Adjudication Committee, by the full Adjudication Committee.
- (g) Where no voluntary resolution is achieved pursuant to section 22.1(f) within 45 days of the first date the parties meet to mediate the matter as contemplated in section 22.1(f), or such longer period as may be directed by the Joint Agreement Administration Group upon the recommendation of the mediator, the Adjudicator or the Adjudication Committee will arbitrate the matter in accordance with section 21.2.

## **22.2 Local Disputes**

- (a) A party to a Local Dispute must notify the designated representative of the other party to the Local Dispute. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:
  - (i) the provisions of any Local Contract in issue;
  - (ii) the facts upon which the complaining party relies;
  - (iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and
  - (iv) the remedy sought by the complaining party.
- (b) Within 15 days of receipt of the notice referred to in section 22.2(a) by the other party to the Local Dispute, the designated representatives of the parties to the Local Dispute will meet informally in an attempt to resolve the matter or to narrow the issues.
- (c) In the event that the meeting referred to in section 22.2(b) results in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute, they will jointly submit the proposed agreement to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Joint Agreement Administration Group advises that:

- (i) the proposed agreement is so consistent, the proposed agreement will be binding on the parties to the Local Dispute;
  - (ii) the proposed agreement is not so consistent, the proposed agreement will not be implemented and section 22.2(e) will apply;
  - (iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the proposed agreement with this Agreement and the Physician Master Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the Doctors of BC may refer the question of the consistency of the proposed agreement with this Agreement and the Physician Master Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;
  - (iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(c)(iii), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.
  - (v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or the Adjudication Committee decides that the proposed agreement is so consistent, it will be binding on the parties to the Local Dispute; and if the Adjudicator or the Adjudication Committee decides that the proposed agreement is not so consistent, the proposed agreement will not be implemented and section 22.2(e) will apply.
- (d) If the Joint Agreement Administration Group does not provide a response within the time limit referred to in section 22.2(c), the proposed agreement will be deemed to be consistent with this Agreement and the Physician Master Subsidiary Agreements.
- (e) If the meeting referred to in section 22.2(b) does not result in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute within 15 days of the meeting or a longer period agreed to by the local parties; or if the Joint Agreement Administration Group advises, in accordance with section 22.2(c)(ii), that the proposed agreement is not consistent with this Agreement and/or the Physician Master Subsidiary Agreements; or if the Adjudicator or the Adjudication Committee decides, in accordance with section 22.2(c)(v), that the proposed agreement is not consistent with this Agreement and/or the Physician Master Subsidiary Agreements, then:

- (i) the parties to the Local Dispute will submit the Local Dispute to the Government and the Doctors of BC, and will agree to be bound by the resolution of the Local Dispute pursuant to this Agreement;
  - (ii) either the Government or the Doctors of BC may refer the Local Dispute in writing to the Joint Agreement Administration Group; and
  - (iii) the parties to the Local Dispute may agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute in the event that the Joint Agreement Administration Group refers the Local Dispute to the Trouble Shooter.
- (f) In the event that the Government or the Doctors of BC refers the Local Dispute to the Joint Agreement Administration Group under section 22.2(e), the Government and the Doctors of BC will thereafter have exclusive carriage of the Local Dispute.
- (g) Upon a Local Dispute being referred to the Joint Agreement Administration Group under section 22.2(e), the Joint Agreement Administration Group may direct the Trouble Shooter to attempt to facilitate a settlement of the Local Dispute.
- (h) If the parties to the Local Dispute agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute, the Trouble Shooter will make recommendations and will provide a copy of such recommendations to the Joint Agreement Administration Group. Within 15 days of receiving such recommendations, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the recommendations are consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Joint Agreement Administration Group advises that:
  - (i) the recommendations are so consistent, they will be binding on the parties to the Local Dispute;
  - (ii) the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply; and
  - (iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the recommendations with this Agreement and the Physician Master Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the Doctors of BC may refer the question of the consistency of the recommendations with this Agreement and the Physician Master Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;
  - (iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(h)(iii), the opposing party may, at their

election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

- (v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the recommendations are consistent with this Agreement and the Physician Master Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or the Adjudication Committee decides that the recommendations are so consistent, they will be binding on the parties to the Local Dispute; and if the Adjudicator or the Adjudication Committee decides that the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply.
- (i) If the parties to the Local Dispute do not agree to be bound by recommendations from the Trouble Shooter, the Trouble Shooter will attempt to facilitate a voluntary settlement of the matter. Failing settlement within 30 days of the Trouble Shooter being directed to attempt to facilitate a settlement, the Trouble Shooter will make recommendations with respect to the Local Dispute to the Joint Agreement Administration Group. If the Trouble Shooter's efforts result in a proposed agreement between the parties to the Local Dispute, the proposed agreement must be submitted to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements and the procedure outlined in section 22.2(h)(i) through (v) will apply.
- (j) If resolution of the Local Dispute is not achieved under one of sections 22.2(c), (h) or (i), the Joint Agreement Administration Group will notify the parties to the Local Dispute that the Joint Agreement Administration Group is proceeding under this section, will consider the recommendations of the Trouble Shooter, if any, and will attempt to resolve the Local Dispute. If the Local Dispute is not resolved within 30 days of the issuance of the notification to the parties under this section (or any longer period agreed to by the Government and the Doctors of BC), either the Government or the Doctors of BC may, within a further 30 days, refer the Local Dispute to the Adjudicator or to the Adjudication Committee with notice to the Joint Agreement Administration Group.
- (k) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(j), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.

- (l) Upon a referral of a Local Dispute to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j) the Adjudicator or a chair for the Adjudication Committee will be appointed from the Roster.
- (m) Where a Local Contract Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), the Adjudicator or the Adjudication Committee will arbitrate the matter in accordance with section 21.2.
- (n) Where a Local Range Placement Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), their jurisdiction will be restricted to deciding the placement of the specific physician or physician group in issue on the applicable “Service Contract Range” (as defined in the Alternative Payments Subsidiary Agreement).

## **ARTICLE 23 - ISSUE MANAGEMENT PROCESS**

### **23.1 Local Interest Issue Resolution**

- (a) A physician, group of physicians or Agency raising a Local Interest Issue must notify, in writing, all other interested parties of the Local Interest Issue, with a copy of the notice to the Physician Services Committee.
- (b) The notice shall comprehensively outline the substance of the Local Interest Issue and include all data or other information relied on by the person raising the Local Interest Issue as well as a statement of the proposed remedy or proposed solution.
- (c) Upon receipt of the notice referred to in section 23.1(b), parties interested in the Local Interest Issue will meet to discuss the Local Interest Issue and attempt to achieve a voluntary resolution of it.
- (d) If, as a result of the meeting referred to in section 23.1(c), the parties interested in the Local Interest Issue achieve a proposed resolution of the Local Interest Issue, they shall submit the proposed resolution, in writing, to the Physician Services Committee. Within 15 days of receiving a proposed resolution, the Physician Services Committee will advise the parties to the Local Interest Issue of whether or not the proposed resolution is consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Physician Services Committee advises that:
  - (i) the proposed resolution is so consistent, it may be implemented; and
  - (ii) the proposed resolution is not so consistent, or the Physician Services Committee cannot reach a consensus decision with respect to the consistency of the proposed resolution with this Agreement and the Physician Master Subsidiary Agreements, it may not be implemented.
- (e) If the Physician Services Committee does not provide a response within the time limit referred to in section 23.1(d), the proposed resolution will be deemed to be consistent with this Agreement and the Physician Master Subsidiary Agreements.

- (f) If the Local Interest Issue is not resolved in accordance with section 23.1(d) within 45 days of the first meeting contemplated by section 23.1 (c), or any longer period agreed to by the parties to the Local Interest Issue, either the affected Health Authority or the affected physician(s) may, within a further 30 days, request the Government or the Doctors of BC respectively, to refer the Local Interest Issue to the Physician Services Committee. If, during the 45 days, or longer period if agreed, either party to the Local Interest Issue concludes that the process to resolve the Local Interest Issue has failed, it may so advise the other party in writing and the time limits for referral to the Physician Services Committee will commence from the date of that notice.
- (g) Upon a Local Interest Issue being referred to the Physician Services Committee in accordance with section 23.1(f), the Government and the Doctors of BC shall assume exclusive carriage of it.
- (h) Upon receiving a referral of a Local Interest Issue in accordance with section 23.1(f), the Physician Services Committee may, by consensus decision:
  - (i) issue recommendations with respect to the Local Interest Issue to the parties interested in the Local Interest Issue; or
  - (ii) direct that the Local Interest Issue be referred to an Adjudicator or, if one party so elects, to the Adjudication Committee for arbitration, at which time the Adjudicator or a chair of the Adjudication Committee will be appointed from the Roster.
- (i) Failing acceptance by the parties interested in the Local Interest Issue of recommendations from the Physician Services Committee in accordance with section 23.1(h)(i) or failing a decision of the Adjudicator or the Adjudication Committee pursuant to section 23.1(h)(ii), there are no further steps under this Agreement to address the Local Interest Issue.

## **ARTICLE 24 - SERVICE CONTINUITY**

### **24.1 No Withdrawal of Services or Threat of Withdrawal of Services**

All Disputes and Issues will be resolved or addressed through the processes set out in this Agreement. Without limiting obligations of any party or person under any law, agreement or contract, where a process exists, in this Agreement or otherwise, for binding resolution of a Dispute or Issue between physicians and/or the Doctors of BC, on the one hand, and the Government and/or Agencies, on the other, there shall be no withdrawal of services or threat of withdrawal of services by any physician or group of physicians in connection with such Dispute or Issue.

### **24.2 Notice of Withdrawal of Services Required**

- (a) Without limiting obligations of any party or person under any law, agreement or contract, where there is no binding resolution of any Dispute or Issue, or any matter between physicians and/or the Doctors of BC, on the one hand, and the



Government and/or Agencies, on the other, after any applicable process has been utilized, a physician or group of physicians may carry out a withdrawal of services but must first provide a minimum of 90 days written notice of the withdrawal of clinical and related services to the applicable Health Authority, the College of Physicians and Surgeons of British Columbia, and the Physician Services Committee. In the event that notice of a withdrawal of services is given, the matter will be referred by the Physician Services Committee to the Trouble Shooter. The Trouble Shooter will define the issues in dispute and make recommendations to the Physician Services Committee to facilitate a resolution consistent with the provisions of this Agreement.

- (b) Any withdrawal of clinical and related services during a notice period or without providing notice is contrary to this Agreement and the Doctors of BC will so advise physicians.

#### **24.3 No Withdrawal of Services to Pressure Government to Change Existing Agreements**

The Doctors of BC agrees that once an agreement is entered into, physicians who are covered by it should not carry out a withdrawal of services for the purpose of pressuring the Government or an Agency to change the terms and conditions of the agreement. The Doctors of BC will take all appropriate measures to encourage physicians to comply with existing agreements.

#### **24.4 Doctors of BC Will Not Condone Withdrawals of Service**

As long as there is no pro-rationing in effect the Doctors of BC will not sponsor, support or condone withdrawals of services by physicians and shall take the necessary steps that are available to prevent such initiatives.

### **ARTICLE 25 - REPLACEMENT OF PROVISIONS AFFECTED BY LEGISLATION**

#### **25.1 Replacement by Agreement**

Subject to section 25.3, in the event that any future legislation (the “**Future Legislation**”) renders null and void or materially alters any provision of this Agreement, the remaining provisions will remain in force and effect during the currency of this Agreement and the parties will negotiate a mutually agreeable provision to be substituted for the provision that has been rendered null and void or materially altered by the Future Legislation.

#### **25.2 Replacement by Arbitration**

- (a) If the parties are unable to reach agreement on replacement provisions pursuant to section 25.1, any of them may refer the issues in dispute to arbitration in accordance with this section 25.2.
- (b) If any party makes a referral to arbitration under this section 25.2, the parties will agree upon a single arbitrator within fifteen days of the date of the referral. If such agreement is not reached any of them may ask the Chief Justice of the Supreme

Court of British Columbia to make the appointment and the person so appointed will be the arbitrator.

- (c) The arbitration will be conducted in accordance with the *Arbitration Act*, using the Rules of the British Columbia International Arbitration Centre for the Conduct of Domestic Commercial Arbitrations, except to the extent such rules are modified by this Agreement or any other agreement between the Government and the Doctors of BC.
- (d) Subject to section 25.3, the arbitrator will issue a final and binding award on all of the outstanding issues.

### **25.3 No Conflict with Legislation**

No replacement provision, whether the subject of agreement pursuant to section 25.1 or arbitration pursuant to section 25.2, may conflict with the provisions of the Future Legislation or any other applicable laws. Specifically, an arbitrator acting pursuant to section 25.2 does not have the jurisdiction to order any replacement provision which is inconsistent with or in conflict with or would cause any reading down of the Future Legislation or any other applicable laws.

## **ARTICLE 26 - RENEGOTIATION**

### **26.1 Renegotiation Notice**

On or after April 1, 2021, but no later than April 30, 2021, either the Government or the Doctors of BC may give notice to the other (the “**Renegotiation Notice**”) of its wish to renegotiate and amend all or any of the provisions of this Agreement and the Physician Master Subsidiary Agreements.

### **26.2 Initial Meeting**

If a Renegotiation Notice is given, the Doctors of BC and the Government will meet, no later than June 1, 2021, and commence negotiations to renegotiate all or any of the provisions of this Agreement and the Physician Master Subsidiary Agreements.

### **26.3 Conciliation Panel Chair**

- (a) If a Renegotiation Notice is given, the Government and the Doctors of BC will appoint, by no later than June 1, 2021, an individual to act as chair of a conciliation panel for the negotiations. If the Government and the Doctors of BC are unable to agree upon the chair of the conciliation panel either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the chair of the conciliation panel.
- (b) If the Government and the Doctors of BC do not reach agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements, by September 30, 2021, either the Government or the Doctors of BC may request the intervention of the chair of the conciliation panel.

- (c) Once either the Government or the Doctors of BC has requested the intervention of the chair of the conciliation panel, he or she will work with the Doctors of BC and Government negotiators in an attempt to mediate an agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements.

#### **26.4 Intervention by Conciliation Panel**

- (a) After December 31, 2021, either the Government or the Doctors of BC may request the chair of the conciliation panel to discontinue the mediation and to assemble a conciliation panel. The Government and the Doctors of BC will each name one representative to the conciliation panel, and those two representatives plus the chair appointed pursuant to section 26.3(a) will comprise the conciliation panel.
- (b) The conciliation panel will conduct a conciliation in accordance with procedures agreed to by the Government and the Doctors of BC, which may include formal hearings, to review the issues in dispute.
- (c) The conciliation panel must retain an independent expert to assist it in determining costing issues and verifying comparators.
- (d) The terms of reference of the conciliation panel will include:
  - (i) the need to be consistent with the law;
  - (ii) reflecting the Government's fiscal situation, including its ability to pay;
  - (iii) the need to provide reasonable compensation to physicians for the services rendered; and
  - (iv) the operational and medical resource needs of the Health Authorities.

#### **26.5 Report of the Conciliation Panel**

- (a) The conciliation panel will publish a report containing the recommended terms of settlement on all of the outstanding issues, such report to be in two parts:
  - (i) the first part to contain the recommended terms of settlement on those issues of compensation, on-call payment issues, physician benefit plans consisting of the Continuing Medical Education Fund, Physician Disability Insurance Program, Physician Health Program, Canadian Medical Protective Association Rebate Program, Contributory Professional Retirement Savings Plan, and Parental Leave Program, and any other matters the parties have agreed in writing to submit to binding conciliation for the purpose of this section 26.5(a)(i) (collectively, the "**Central Recommendations**"); and

- (ii) the second part to contain all recommended terms of settlement other than the Central Recommendations (collectively, the “**Other Recommendations**”).
- (b) The report of the conciliation panel must also set out reasons and the estimated costs of implementing both the Central Recommendations and the Other Recommendations.

## **26.6 Effect of Conciliation Panel’s Report**

- (a) The Central Recommendations will be binding on the parties unless, within 10 days of its receipt of the conciliation panel’s report, the Government rejects the Central Recommendations in their entirety and, upon such rejection, the Central Recommendations will not be binding upon the parties. All Other Recommendations will not be binding on the parties unless agreed to by the parties in writing.
- (b) If the Government rejects the Central Recommendations, the Government and the Doctors of BC will resume negotiations on the areas in dispute with respect to the Central Recommendations and the Doctors of BC will be relieved of its obligations under sections 24.3 and 24.4 of this Agreement, subject to section 26.6(c) below, until all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements are agreed upon by the Doctors of BC and the Government.
- (c) Prior to the commencement of any service disruptions by physicians following any rejection of the Central Recommendations by the Government, the Government and the Doctors of BC will seek guidance from the College of Physicians and Surgeons of British Columbia with respect to the services that should be maintained to ensure that the safety of British Columbians is protected. The Doctors of BC will not condone or support a withdrawal of services contrary to the guidance provided by the College of Physicians and Surgeons of British Columbia.

## **ARTICLE 27 - TERMINATION**

### **27.1 Termination Notice**

- (a) Notwithstanding Article 26, either the Government or the Doctors of BC may give notice (the “**Termination Notice**”) to the other, on or after January 1, 2022, of termination of this Agreement and the Physician Master Subsidiary Agreements, in which case this Agreement and Physician Master Subsidiary Agreements will terminate on March 31, 2022, subject to section 27.2.

### **27.2 Effect of Termination Notice**

- (a) If one of the parties gives the Termination Notice in accordance with section 27.1, then the provisions of this Agreement and the Physician Master Subsidiary Agreements providing for those matters referred to in section 26.5(a)(i) and for

those matters related to the Joint Clinical Committees and the Joint Standing Committee on Rural Issues will continue in effect notwithstanding the termination of this Agreement and the Physician Master Subsidiary Agreements pursuant to section 27.1, subject however to the further rights to terminate those continuing provisions under section 27.2(b).

- (b) If a Termination Notice is given in accordance with section 27.1, either the Government or the Doctors of BC may give notice (the “**Further Termination Notice**”) to the other, on or after April 1, 2022, of termination of those provisions of this Agreement and the Physician Master Subsidiary Agreements that have continued in effect pursuant to section 27.2(a), such termination to be effective on the date (the “**Final Termination Date**”) that is one year after the date the Further Termination Notice is given, and on the Final Termination Date all such continuing provisions shall terminate and be of no further force or effect.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1<sup>st</sup> day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN IN )  
RIGHT OF THE PROVINCE OF BRITISH )  
COLUMBIA, by the Minister of Health or )  
his/her duly authorized representative, in the )  
presence of: )

Jania Marsh )  
Signature of Witness )

Jania Marsh )  
Name )

3-1, 1515 Blanshard Street )  
Address )

Victoria, BC )  
)



THE CORPORATE SEAL of the BRITISH )  
COLUMBIA MEDICAL ASSOCIATION )  
was hereunto affixed in the presence of: )

Dr Eric Cadesky )  
Signature of Authorized Signatory )

Dr Eric Cadesky )  
Name )

President )  
Position )  
)



MEDICAL SERVICES COMMISSION

Per: M. Mahum )  
Authorized Signatory )

Dr. Robert Halpenny )  
Name )

Chair )  
Position )

**APPENDIX A**

**2019 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the  
Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new General Practitioners Subsidiary Agreement, to take effect as of April 1, 2019; and

C. The parties intend this Agreement to address those matters of unique interest and applicability to General Practitioners.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

**ARTICLE 1 - RELATIONSHIP TO THE 2019 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2019 Physician Master Agreement and is subject to its terms and conditions.

## ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement have the same meaning as in the 2019 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document, as amended from time to time as provided herein.

2.3 “**Divisions of Family Practice**” means the initiative created and supported by the General Practice Services Committee to organize physicians at the local or regional level in order to address common health care goals in their communities.

2.4 “**2019 Physician Master Agreement**” means the agreement titled “2019 Physician Master Agreement” among the Government, the Doctors of BC and the MSC, dated April 1, 2019.

2.5 The provisions of sections 1.2 to 1.8 inclusive of the 2019 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

## ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2019.

3.2 This Agreement shall be for the same term as the 2019 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the 2019 Physician Master Agreement.

## ARTICLE 4 - GENERAL PRACTICE SERVICES COMMITTEE

4.1 The parties agree that full service family practice must be encouraged and supported.

4.2 The **General Practice Services Committee** shall continue under this Agreement as a vehicle for representatives of the Government, the Doctors of BC and the Society of General Practitioners to work together on matters affecting the provision of services by General Practitioners in British Columbia, including ways of providing incentives for General Practitioners to provide full service family practice and benefit patients. In addition to the core mandate outlined in section 8.2 of the 2019 Physician Master Agreement, the General Practice Services Committee will fulfill the specific mandate set out in this Agreement.

4.3 The General Practice Services Committee shall be composed of six members appointed by the Government and six members appointed by the Doctors of BC.

4.4 The General Practice Services Committee shall be co-chaired by a member chosen by the Government members and a member chosen by the Doctors of BC Board of Directors and shall appoint two of its members as vice chairs, one who shall be chosen by the Government from among the Government members and one who shall be chosen by the Doctors of BC from among the Doctors of BC members.

4.5 Decisions of the General Practice Services Committee shall be by consensus decision.



4.6 If the General Practice Services Committee cannot reach a consensus decision on any matter it is required to determine, the Government and/or the Doctors of BC may make recommendations to the MSC and the MSC, or its successor, will determine the matter.

4.7 On an annual basis, the General Practice Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2019 Physician Master Agreement.

4.8 The General Practice Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the General Practice Services Committee pre-approve any communication about the business and/or decisions of the General Practice Services Committee.

4.9 The costs of administrative and clerical support required for the work of the General Practice Services Committee will be paid from the funds to be allocated by the General Practice Services Committee pursuant to this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

## **ARTICLE 5 - FULL SERVICE FAMILY PRACTICE FUNDING**

5.1 The General Practice Services Committee will be used to further collaborate with General Practitioners to encourage and enhance full service family practice and benefit patients through increases to the existing \$ 275.9 million annual funding level for full service family practitioners, as follows:

- (a) an additional \$0.85 million per year effective April 1, 2019.

The funds identified in this section 5.1 are to be allocated by the General Practice Services Committee to support its work in maintaining, enhancing and expanding the programs that support the delivery of primary care services to British Columbians by, among other things, offsetting utilization pressures on its programs, supporting integrated and collaborative initiatives including change management, identifying and treating patients and communities with unmet needs, providing incentives for General Practitioners to provide full service family practice, enhancing risk assessment and reduction, improving capacity in primary care, enhancing comprehensive and continuous care and improving coordination and quality of care to family practice patients in British Columbia, with allocations to include, but not be limited to, the areas identified in section 5.2.

5.2 The General Practice Services Committee will use the funds available to it pursuant to section 5.1 for the following purposes, among others:

- (a) to fund financial incentive programs for the support of full service family practice, including:
  - (i) improved identification and management of:
    - (A) mental health conditions;
    - (B) chronic disease;

- (C) complex co-morbidities;
  - (D) maternity care;
  - (E) the frail elderly;
  - (F) the co-ordination of care of patients in hospital or residential care; and
  - (G) patients requiring end of life care; and
- (ii) increased multi-disciplinary care between General Practitioners and other healthcare providers;
- (b) to fund, in whole or in part, full service family practice support programs such as Divisions of Family Practice and the Practice Support Program; and
  - (c) to improve disease prevention.

5.3 In addition to the funds identified in section 5.1, the Government will provide the following funding to be allocated by the General Practice Services Committee to the development of new fees or compensation to support full service family practice:

- (a) an additional \$12.75 million per year effective April 1, 2019;
- (b) an additional \$18.00 million per year effective April 1, 2020; and
- (c) an additional \$18.00 million per year effective April 1, 2021.

5.4 The General Practice Services Committee will design all new fees funded under section 5.3 in such a way that will allow their transfer to the Payment Schedule in accordance with Appendix I to the 2019 Physician Master Agreement (hereinafter referred to as Appendix I), and the Government and the Doctors of BC confirm their intent to transfer any fee developed and funded under section 5.3 to the Payment Schedule as soon as it is feasible to do so. The Government and the Doctors of BC will meet before December 31, 2021 to review and assess the readiness of transferring to the Payment Schedule fees developed and funded under section 5.3.

5.5 The General Practice Services Committee will establish a process to review, potentially modify and transfer to the Payment Schedule the GPSC fee items identified in section 1(a)(i) of Appendix I in accordance with the processes described in Appendix I. Upon the transfer to the Payment Schedule of the fees developed and funded under section 5.3 and the GPSC fee items identified in section 1(a)(i) of Appendix I, those amounts determined in accordance with Appendix I will be taken out of the appropriate General Practice Services Committee ongoing annual budget and transferred into the Available Amount.

5.6 On an ongoing basis, the General Practice Services Committee will review and propose amendments to those GPSC fee items that have been transferred to the Available Amount.

5.7 In addition to the funds identified in sections 5.1 and 5.3, the Government will provide the following funding to be allocated by the General Practice Services Committee to:

- (a) support other non-fee enhancements to full service family practice including physician practice support, physician engagement and change management with respect to the implementation of Patient Medical Homes/Primary Care Networks:
  - (i) an additional \$3.1 million per year effective April 1, 2019; and
  - (ii) an additional \$2.0 million per year effective April 1, 2020.
- (b) fund the Pathways initiative:
  - (i) an additional \$1.4 million per year effective April 1, 2019.

5.8 In addition to the funds identified in sections 5.1, 5.3, and 5.7, the Government will provide an additional \$12.0 million per year effective April 1, 2019 to the General Practice Services Committee to support its Residential Care Initiative.

5.9 The following funding will be made available on a one-time basis for the purposes set out in the Memorandum of Understanding on Physical/Psychological Safety between the Government, the Doctors of BC and the Health Authorities from existing unexpended General Practice Services Committee funds from the 2014 General Practitioners Subsidiary Agreement or those funds set out at section 5.11:

- (a) \$150,000 effective April 1, 2019;
- (b) \$150,000 effective April 1, 2020; and
- (c) \$150,000 effective April 1, 2021.

5.10 \$25 million will be made available on a one-time basis to fund a portion of the one-time lump sum payment to eligible physicians in accordance with section 1.1 of Appendix F to the 2019 Physician Master Agreement from existing unexpended General Practice Services Committee funds from the 2014 General Practitioners Subsidiary Agreement.

5.11 Any funds described in sections 5.1, 5.3, 5.7, and 5.8 that remain unexpended at the end of any Fiscal Year will be available to the General Practice Services Committee for use as one time allocations to improve the quality of care.

5.12 If the General Practice Services Committee needs to reduce expenditures in order to meet its budget targets, the General Practice Service Committee will first address such budget pressures through a reduction of expenditures on its programs that do not have accompanying fees before considering adjustments to any of its established fees. Any such fee adjustments will be by mutual agreement. For clarity, this section 5.12 does not restrict the General Practice Service Committee from adjusting its fees in order to meet its mandate.

5.13 The General Practice Services Committee will continue to review and recommend approaches that support General Practitioners' continued role in providing hospital care, including the relationship between that role and the role of hospitalists. The General Practice Services Committee will determine the key elements or models of care with indicators that demonstrate and support optimum patient outcomes. The recommendations will propose how best to utilize existing allocations for primary care support of hospitalized patients.

## **ARTICLE 6 – PRIMARY CARE NETWORK/PATIENT MEDICAL HOME**

6.1 If the General Practice Services Committee agrees, the Government may, at its discretion, make funds available to the General Practice Services Committee to be used to support non-physician costs related to the design and implementation of the Primary Care Network and Patient Medical Home programs. Any such additional funds will be identified specifically for this purpose and any such funds not so expended by the General Practice Services Committee will be returned to the Government.

## **ARTICLE 7 - DOCTOR OF THE DAY**

7.1 The need for a Doctor of the Day will be determined by the Health Authorities.

7.2 A Doctor of the Day will be compensated at the rate of \$400 per twenty-four hours of coverage.

7.3 Where there is a requirement for less than twenty-four hours of coverage, an appropriate rate based upon the twenty-four hour rate shall be determined at the local level.

7.4 Funding for Doctor of the Day will be allocated from the annual MOCAP budget.

## **ARTICLE 8 - DISPUTE RESOLUTION**

8.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Provincial Disputes.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness )  
\_\_\_\_\_  
Name )  
\_\_\_\_\_  
Address )  
\_\_\_\_\_  
\_\_\_\_\_ )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

C/S

\_\_\_\_\_  
Signature of Authorized Signatory )  
\_\_\_\_\_  
Name )  
\_\_\_\_\_  
Position )

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

**APPENDIX B**

**2019 SPECIALISTS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the  
Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2014 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Specialists Subsidiary Agreement, to take effect as of April 1, 2019; and

C. The parties intend this Agreement to address those matters of unique interest and applicability to Specialist Physicians.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

**ARTICLE 1 - RELATIONSHIP TO THE 2019 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2019 Physician Master Agreement and is subject to its terms and conditions.

## ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement have the same meaning as in the 2019 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 **“this Agreement”** means this document as amended from time to time as provided herein.

2.3 **“2019 Physician Master Agreement”** means the agreement titled “Physician Master Agreement” among the Government, the Doctors of BC and the MSC, dated April 1, 2019.

2.4 **“2019 Regional and Local Engagement Memorandum of Understanding”** means the memorandum of understanding titled “2019 Regional and Local Engagement Memorandum of Understanding” between the Government and the Doctors of BC.

2.5 The provisions of sections 1.2 to 1.8 inclusive of the 2019 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

## ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2019.

3.2 This Agreement shall be for the same term as the 2019 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the 2019 Physician Master Agreement.

## ARTICLE 4 - COLLABORATION WITH SPECIALIST PHYSICIANS

4.1 The Government and the Doctors of BC agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients’ medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options and health human resource options.

## ARTICLE 5 - SPECIALIST SERVICES COMMITTEE

5.1 A **Specialist Services Committee** shall continue under this Agreement to facilitate collaboration between the Government, the Doctors of BC and the Health Authorities on the delivery of the services of Specialist Physicians to British Columbians and to support the improvement of the specialist care system. In addition to the core mandate outlined in section 8.2 of the 2019 Physician Master Agreement, the Specialist Services Committee will fulfill the specific mandate as set out in this Agreement.

5.2 The Government and the Doctors of BC shall each appoint an equal number (not to exceed four each) of members to the Specialist Services Committee.

5.3 The Specialist Services Committee will be co-chaired by a member chosen by the Government members and a member chosen by the Doctors of BC Board of Directors.

5.4 Decisions of the Specialist Services Committee shall be by consensus decision.

5.5 If the Specialist Services Committee cannot reach a consensus decision on any matter that it is required to determine under section 5.6(a), the Doctors of BC and/or the Government may make recommendations to the MSC and the MSC, or its successor, will determine the matter. If the Specialist Services Committee cannot reach a consensus decision with respect to any matter that is referred to it under section 5.6(d) and that requires a determination, the Physician Services Committee will determine a process for resolving the dispute, which may include referral to the Adjudicator or the Adjudication Committee or to the MSC.

5.6 The Specialist Services Committee will have the following responsibilities:

- (a) allocating funds referred to in Article 6;
- (b) identifying possible time limited projects that have measurable patient-centred goals focused on the following areas:
  - (i) system redesign; and
  - (ii) expediting access;
- (c) consulting with representatives of allied health professionals as necessary in the completion of its mandate; and
- (d) other matters that may be referred to it by the Physician Services Committee.

5.7 On an annual basis, the Specialist Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2019 Physician Master Agreement.

5.8 The Specialist Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Specialist Services Committee pre-approve any communication about the business and/or decisions of the Specialist Services Committee.

5.9 The costs of administrative and clerical support required for the work of the Specialist Services Committee will be paid from the funds referred to in Article 6 of this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

## **ARTICLE 6 - FUNDING TO IMPROVE ACCESS TO SPECIALTY SERVICES BY BRITISH COLUMBIANS**

6.1 The Government will continue to provide \$50,640,628 in annual funding to the Specialist Services Committee to be allocated by the Specialist Services Committee to support the work of the Specialist Services Committee in enhancing and expanding the programs that support the delivery of high quality specialty services to British Columbians.



6.2 The Government will provide the following additional annual funding to be allocated by the Specialist Services Committee to, amongst other things, fund new initiatives and offset utilization pressures on its programs:

- (a) an additional \$1.275 million per year effective April 1, 2019;
- (b) an additional \$3.0 million per year effective April 1, 2020; and
- (c) an additional \$1.0 million per year effective April 1, 2021.

6.3 The Specialist Services Committee will establish a process to review, potentially modify and transfer to the Payment Schedule the SSC fee items identified in section 1(a)(ii) of Appendix I to the 2019 Physician Master Agreement (hereinafter referred to as Appendix I) in accordance with the processes described in Appendix I.

6.4 Upon the transfer to the Payment Schedule of the SSC fee items identified in section 1(a)(ii) of Appendix I, those amounts determined in accordance with Appendix I will be taken out of the Specialist Services Committee ongoing annual budget set out in sections 6.1 and 6.2 and transferred into the Available Amount.

6.5 On an ongoing basis, the Specialist Services Committee will review and propose amendments to those SSC fee items that have been transferred to the Available Amount.

6.6 The following funding will be made available on a one time basis to fund a portion of the one-time lump sum payment to eligible physicians in accordance with section 1.1 of Appendix F to the 2019 Physician Master Agreement from existing unexpended Specialist Services Committee funds from the 2014 Specialists Subsidiary Agreement:

- (a) \$12.5 million from the one-time funding under section 6.5 of the 2014 Specialist Subsidiary Agreement; and
- (b) \$12.5 million from the one-time funding under section 8.5 of the 2014 Specialist Subsidiary Agreement.

6.7 The following funding will be made available on a one-time basis for the purposes set out in the Memorandum of Understanding on Physical/Psychological Safety between the Government, the Doctors of BC and the Health Authorities from existing unexpended Specialist Services Committee funds from the 2014 Specialists Subsidiary Agreement and from those funds set out at section 6.9:

- (a) \$250,000 effective April 1, 2019;
- (b) \$250,000 effective April 1, 2020; and
- (c) \$250,000 effective April 1, 2021.

6.8 Up to \$200,000 will be made available on a one-time basis over the term of the 2019 Physician Master Agreement from existing unexpended Specialist Services Committee funds from the 2014 Specialists Subsidiary Agreement and from those funds set out at section 6.9 to support Doctors of BC representatives' participation on the Workload Advisory Committee, the Provincial Workload Measures Working Group, and the Provincial Laboratory Physician

Workload Model Committee, all of which are described in Article 5 of the Alternative Payments Subsidiary Agreement.

6.9 Any funds described in sections 6.1 and 6.2 that remain unexpended at the end of any Fiscal Year will be available to the Specialist Services Committee for use as one-time allocations to improve the quality of care.

#### **ARTICLE 7 – SPECIALIST SERVICES COMMITTEE REPORTING**

7.1 The Government shall provide the Doctors of BC with any information in its control that is required by Doctors of BC in order for Doctors of BC to meet its reporting requirements described in the Joint Clinical Committee Administration Agreement.

#### **ARTICLE 8 – FACILITY-BASED PHYSICIAN ENGAGEMENT**

8.1 The Specialist Services Committee will allocate the funds described in section 8.2 of this Agreement to support the engagement of facility-based physicians with Health Authorities in accordance with the objectives described in the 2019 Regional and Local Engagement Memorandum of Agreement. In particular, the funding is intended to be used for the following purposes:

- a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and
- (b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.2 The Government shall provide the following additional annual funding to the Specialist Services Committee:

- (a) \$3 million to support all facility-based General Practitioners who are paid on a fee-for-service basis or under an Alternative Payment Arrangement; and
- (b) \$15.375 million to support all facility-based Specialist Physicians who are paid on a fee-for-service basis or under an Alternative Payment Arrangement.

8.3 Upon termination of the 2019 Regional and Local Engagement Memorandum of Agreement, the Specialist Services Committee will decide to either reallocate the funding described in section 8.2 or to continue to allocate this funding to support facility based physician engagement with Health Authorities, and in particular for the following purposes:

- (a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and
- (b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.4 Subject to the termination provision at section 8.3, any funds described in section 8.2 that remain unexpended at the end of any Fiscal Year will be available to the Specialist Services Committee for use as one-time allocations to improve facility based engagement.

## **ARTICLE 9 - DISPUTE RESOLUTION**

9.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Provincial Disputes.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1<sup>st</sup> day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness )  
\_\_\_\_\_  
Name )  
\_\_\_\_\_  
Address )  
\_\_\_\_\_  
 )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

C/S

\_\_\_\_\_  
Signature of Authorized Signatory )  
\_\_\_\_\_  
Name )  
\_\_\_\_\_  
Position )

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

## **APPENDIX C**

### **2019 RURAL PRACTICE SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1st day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the  
Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

#### **WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Rural Practice Subsidiary Agreement, to take effect as of April 1, 2019; and

C. The parties intend this Agreement to enhance the availability and stability of services provided by physicians in smaller urban, rural and remote areas of British Columbia by addressing some of the uniquely demanding and difficult circumstances attendant upon the provision of those services by physicians.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

#### **ARTICLE 1 - RELATIONSHIP TO THE 2019 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2019 Physician Master Agreement and is subject to its terms and conditions.

## ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement have the same meaning as in the 2019 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 **“this Agreement”** means this document including the Appendices, as amended from time to time as provided herein.

2.3 **“Flat Premium”** means an annual payment in an amount determined by the JSC from time to time and paid in one or more instalments that is available through the RRP to eligible physicians in RRP Communities.

2.4 **“Isolation Points”** means points allocated by the JSC to a community in accordance with Appendix “C”.

2.5 **“IAF”** means the Isolation Allowance Fund referred to in section 14.1.

2.6 **“NITAOP”** means the two-component Northern and Isolation Travel Assistance Outreach Program consisting of the Physician Outreach Program and the Northern and Isolation Travel Assistance Program, and referred to in section 11.1.

2.7 **“Northern and Isolation Travel Assistance Program”** means the component of the NITAOP that is funded through the Available Amount, and that provides funding for travel expenses incurred by approved Specialist Physicians for travel to the communities listed in Appendix B for the purpose of such Specialist Physicians providing medical services to residents of such communities.

2.8 **“Percentage Fee Premium”** means a premium, expressed as a percentage, in an amount determined by the JSC from time to time for each RRP Community in accordance with this Agreement, that is added to Fees, Service Contract, Salary Agreement and Sessional Contract payments and made available through the RRP to eligible Physicians in RRP Communities.

2.9 **“2019 Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” among the Government, the MSC and the Doctors of BC, dated April 1, 2019.

2.10 **“Physician Outreach Program”** means the component of the NITAOP that provides funding for travel honorariums for Specialist Physicians and General Practitioners, and travel expenses for General Practitioners, for approved travel to the communities listed in Appendix B for the purpose of such Specialist Physicians and General Practitioners providing medical services to residents of such communities.

2.11 **“Physician Supply Plan”** has the meaning given in Appendix “D”.

2.12 **“RCF”** means the Recruitment Contingency Fund referred to in section 10.5.

2.13 **“RCME”** means the Rural Continuing Medical Education program referred to in section 8.1.

2.14 **“REAP”** means the Rural Education Action Plan referred to in section 9.1.

2.15 **“RGPALP”** means the Rural General Practitioner Anaesthesia Locum Program referred to in section 7.2.

2.16 **“RGPLP”** means the Rural General Practitioner Locum Program referred to in section 7.1.

2.17 **“RIF”** means the Recruitment Incentive Fund referred to in section 10.1.

2.18 **“RRP”** means the Rural Retention Program referred to in section 6.1.

2.19 **“Rural Community”** means a community listed on Appendix A.

2.20 **“RRP Community”** means a Rural Community which has at least 6 Isolation Points.

2.21 **“RSLP”** means the Rural Specialist Locum Program referred to in section 7.6.

2.22 **“Rural Programs”** means the RRP, the RGPLP, the RGPALP, the RSLP, the RCME, the REAP, the RIF, the RCF, the NITAOP, and the IAF.

2.23 Subject to section 2.24, this Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

2.24 Notwithstanding section 2.23, Appendix A, Appendix B and Appendix C of this Agreement may be amended by the JSC, by consensus decision, as provided herein.

2.25 The provisions of sections 1.2 to 1.6 and 1.8 of the 2019 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

### **ARTICLE 3 - TERM**

3.1 This Agreement comes into force on April 1, 2019.

3.2 This Agreement shall be for the same term as the 2019 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the 2019 Physician Master Agreement.

### **ARTICLE 4 - SCOPE**

4.1 Subject to section 4.2, this Agreement applies to physicians practising in British Columbia except those whose practice is in Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake.

4.2 This Agreement applies to all physicians who practice in Rural Communities and are required by a Physician Supply Plan, subject to the specific terms, conditions, rules and eligibility criteria approved or established by the JSC for each of the Rural Programs from time to time.

4.3 For purposes of the NITAOP, this Agreement applies to the communities listed in Appendix B, subject to the specific terms, conditions, rules and eligibility criteria established by the JSC for the NITAOP from time to time.

4.4 A Health Authority, the Government, or the Doctors of BC may apply to the JSC to add a community, except those referred to in section 4.1, to Appendix A if a physician is (or physicians are) needed in the community as agreed upon by a consensus decision of the JSC or as reflected in a Physician Supply Plan. The criteria for including any community in Appendix A are set out in Appendix C. To be included in Appendix A, a community must receive at least 0.5 Isolation Points as a result of the application of Appendix C. The JSC will review and amend Appendix A at least annually in accordance with sections 5.7 and 5.8.

4.5 A Health Authority, the Government or the Doctors of BC may apply to the JSC to add a community to Appendix B if the community is listed in Appendix A, and the community will be added to Appendix B if the JSC agrees, by consensus decision, that the community requires itinerant services.

## **ARTICLE 5 - THE JOINT STANDING COMMITTEE ON RURAL ISSUES**

5.1 The **Joint Standing Committee on Rural Issues** (the “JSC”) will continue under this Agreement and will continue to work to enhance the delivery of rural healthcare in accordance with the duties imposed and the powers conferred by this Agreement. In addition to administering the Rural Programs as described in this Agreement, the JSC may consider and make recommendations on matters that support the following objectives:

- (a) increasing relativities between Rural Communities;
- (b) supporting hospital based core services;
- (c) supporting new physicians moving into Rural Communities;
- (d) enhancing support for rural emergency departments;
- (e) developing a response to Rural Communities in crisis; and
- (f) supporting the use of physician extenders in Rural Communities.

5.2 The JSC is composed of five members appointed by the Doctors of BC and five members appointed by the Government. In addition, each party may designate up to three alternates. Each party pays for the expenses of its own members.

5.3 The JSC must meet a minimum of six days per year and will be co-chaired by a member chosen by the Government members and a member chosen by the Doctors of BC Board of Directors. The JSC must establish, before March 31 each year, a schedule of meetings for the next 12 months.

5.4 The time for any JSC meeting may be changed but only by mutual agreement of the co-chairs. Either co-chair may call additional meetings. Any such additional meetings must take place within two weeks of the call, unless otherwise agreed.



5.5 The JSC must adopt appropriate procedural rules to ensure the fair and timely resolution of matters before it. The JSC will make all decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provisions of this Agreement.

5.6 The JSC may make recommendations to the Physician Services Committee on the use of innovative and emerging technologies.

5.7 The JSC must review Appendix A annually in accordance with section 5.8. In addition to amendments made to Appendix A as a result of that annual review, Appendix A may be amended periodically to reflect any changes determined by the JSC to be appropriate and consistent with this Agreement, provided however that any community listed on Appendix A must have at least 0.5 Isolation Points.

5.8 Commencing in December of each year, the JSC must review the Isolation Points assigned to each community in Appendix A by applying Appendix C to each such community. This annual review must be completed by the end of February of the subsequent calendar year. By no later than April 1 of the same year, the JSC must amend the Isolation Points assigned to each of the communities in Appendix A, to reflect the results of the annual review.

5.9 Where, as a result of a review pursuant to section 5.7 or section 5.8, the JSC assigns a community:

- (a) less than 6 Isolation Points then, in the year to which that assignment applies,
  - (i) eligible physicians, who received a Flat Premium the immediately preceding year, will be entitled to receive a Flat Premium in the amount of 50% of their Flat Premium entitlement from the immediately preceding year.
  - (ii) eligible physicians who received a Percentage Fee Premium for medical services performed in such community in the immediately preceding year will be entitled to receive a Percentage Fee Premium on medical services performed in such community in the amount of 50% of their Percentage Fee Premium for such community from the immediately preceding year.
- (b) between 0.5 and 5.99 Isolation Points, it will be deemed to be a “D” community and physicians residing and practising in such community will only be eligible for the RCME, the RGPLP, the RSLP, the RGPALP, the RIF, the RCF and the REAP, all in accordance with the specific terms, conditions, rules and eligibility criteria applicable to each of those programs as established by the JSC from time to time; and
- (c) less than 0.5 Isolation Points, it will be deleted from Appendix “A” and, if prior to such review it was listed in Appendix B, it will be deleted from Appendix B and physicians residing and/or providing services in such community will be ineligible for Rural Programs.

5.10 Where a community has been recommended for inclusion in Appendix A in accordance with section 4.4, the JSC must evaluate the community by application of Appendix C. If the evaluation results in a rating for the community of at least 0.5 Isolation Points, the JSC must add the community to Appendix A.

5.11 The JSC will periodically review Appendix B and may, by consensus decision, add or delete communities to it if the JSC determines such changes are required to reflect the criteria set out in section 4.5.

5.12 The JSC will periodically review Appendix C and may, by consensus decision, make any changes determined by the JSC to be appropriate.

5.13 In the event the JSC is unable to reach a consensus decision with regard to any matter that it is required by this Agreement to decide, the Government and/or the Doctors of BC may refer the matter in dispute for in accordance with section 21.2 of the 2019 Physician Master Agreement.

5.14 The JSC must establish practices and procedures appropriate to decisions with respect to the disbursement of public funds, including conflict of interest guidelines. The practices and procedures adopted by the JSC must include provisions that promote accountability, transparency and, consistent with section 5.3 of the 2019 Physician Master Agreement, confidentiality.

5.15 On an annual basis, the JSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2019 Physician Master Agreement.

5.16 The JSC must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the JSC pre-approve any communication about the business and/or affairs of the JSC.

## **ARTICLE 6 - RURAL RETENTION PROGRAM**

6.1 The Rural Retention Program (the “**RRP**”) is a program that makes available, to eligible physicians in RRP Communities, a Percentage Fee Premium and an annual Flat Premium, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

6.2 Responsibility for the governance and oversight of the RRP resides with the JSC, with day to day administration of the RRP provided by the Ministry.

6.3 To be eligible for a Percentage Fee Premium, a physician must meet all eligibility criteria approved or established by the JSC from time to time and must provide medical services in an RRP Community.

6.4 To be eligible for a Flat Premium, a physician must meet all eligibility criteria approved or established by the JSC from time to time.

6.5 The value of the Percentage Fee Premium and the value of the Flat Premium, each as applicable to each RRP Community, will be based on the Isolation Points allocated by the JSC to such community at least annually in accordance with sections 5.7 and 5.8, and the value of the Percentage Fee Premium and Flat Premium resulting therefrom shall be determined by the JSC.

6.6 Percentage Fee Premiums apply to the professional component of radiologists’ and pathologists’ in-patient and emergency services.

6.7 The Government will continue to fund the RRP at a level sufficient to maintain Percentage Fee Premium and Flat Premium values that reflect the implementation of the at least annual application of Appendix C and the amendments to the Isolation Points for each RRP Community that result therefrom, on the following basis;

- (a) for RRP Communities without a resident physician and without a vacancy, a Percentage Fee Premium will be available in an amount equal to the total Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;
- (b) for RRP Communities with at least one resident physician or at least one vacancy, a Percentage Fee Premium will be available in an amount equal to 70% of the Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;
- (c) for RRP Communities with at least one resident physician, a Flat Premium will be available in an amount equal to 30% of the Isolation Points for the RRP Community in question multiplied by \$2,040;
- (d) if the JSC chooses not to implement reductions in Isolation Points for RRP Communities as a result of the application of Appendix C, the cost of maintaining the Percentage Fee Premium and Flat Premium values will be paid out of funds provided in Article 12; and
- (e) if the JSC changes the application of the terms, conditions, rules and eligibility criteria for the RRP, any increased cost associated with such changes will be paid out of funds provided in Article 12.

## **ARTICLE 7 - RURAL LOCUM PROGRAMS**

7.1 The Rural General Practice Locum Program (the “**RGPLP**”) is a program that provides support to enable eligible General Practitioners to have reasonable periods of leave from their practices for such purposes as continuing medical education, maternity leave, vacation and health needs, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

7.2 The Rural GP Anaesthesia Locum Program (the “**RGPALP**”) is a program that provides support to General Practitioners with enhanced anesthesia skills to have reasonable periods of leave from their practices for such purposes as continuing medical education, maternity leave, vacation, and health needs, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

7.3 Responsibility for the governance and oversight of the RGPLP and the RGPALP resides with the JSC, with day to day administration of the RGPLP and the RGPALP provided by the Ministry, or as determined by the JSC.

7.4 Preference for locum support through the RGPLP and the RGPALP will be given to the most isolated/vulnerable communities.

7.5 The Government will provide annual funding of \$1,850,000 for the RGPLP.

7.6 The Rural Specialist Locum Program (the “**RSLP**”) is a program that provides support to enable eligible Specialist Physicians practising in certain designated specialities and in certain

rural communities to have reasonable periods of leave from their practices for such purposes as continuing medical education, parental leave, vacation, health needs and to assist in the provision of continuous specialist coverage as designated by the applicable Health Authority, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

7.7 Responsibility for the governance and oversight of the RSLP resides with the JSC, with day to day administration of the RSLP provided by the Ministry, or as determined by the JSC.

7.8 The Government will provide annual funding of \$600,000 for the RSLP.

7.9 Effective April 1, 2019, the JSC shall allocate up to a maximum of \$700,000 per year from its existing funding to improve the services offered by the RGPLP, RSLP, and RGPALP. This funding is to be allocated in accordance with the agreed recommendations provided in the Working Report of the Sub Committee on Rural Locum Programs dated March 10, 2014, or as determined by the JSC.

7.10 The funding described in section 7.9 is in addition to the current funding of approximately \$300,000 annually provided by the Government for four (4) full time equivalent personnel who provide the day to day administration of the RGPLP, RSLP and the RGPALP.

## ARTICLE 8 - RURAL CONTINUING MEDICAL EDUCATION

8.1 The Rural Continuing Medical Education program (the “RCME”) is a program that makes funds available to eligible physicians, to assist them with eligible educational expenses, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

8.2 Responsibility for the governance and oversight of the RCME resides with the JSC, with day to day administration of the RCME provided by the Ministry.

8.3 When a physician has practised in a Rural Community for the number of years set out below, the physician is eligible for reimbursement of eligible educational expenses up to the annual amounts set out below, according to the degree of isolation of his or her community:

### General Practitioners

	Up to 2 years	in the 3rd & 4th year	Over 4 yrs
“A” communities	\$1,320	\$3,520	\$5,720
“B” communities	\$440	\$2,640	\$4,840
“C” communities	\$0	\$2,200	\$4,400
“D” communities	\$0	\$1,100	\$2,200

### Specialists

	Up to 2 years	in the 3rd & 4th year	Over 4 yrs
“A” communities	\$1,800	\$4,800	\$7,800
“B” communities	\$600	\$3,600	\$6,600

“C” communities	\$0	\$3,000	\$6,000
“D” communities	\$0	\$1,500	\$3,000

where:

- (a) an “A” community is a Rural Community that received 20 or more Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;
- (b) a “B” community is a Rural Community that received between 15 and 19.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;
- (c) a “C” community is a Rural Community that received between 6 and 14.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community; and
- (d) a “D” community is a Rural Community that received between 0.5 and 5.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community.

8.4 RCME is provided in addition to CME. Physicians who are eligible for RCME are also eligible for CME (as defined in the Benefits Subsidiary Agreement) so long as they meet the terms, conditions, rules and eligibility criteria applicable to the CME as approved and published by the Benefits Committee (as defined in the Benefits Subsidiary Agreement) from time to time.

8.5 A physician who is eligible for RCME in accordance with section 8.3 and moves to another Rural Community, continues to get credit for the time in the previous Rural Community but is eligible to receive the RCME amount applicable to the new community.

8.6 A physician who is eligible for RCME in accordance with section 8.3 and who does not practice in a Rural Community for the entire 12 months in any given calendar year is eligible for a proportionate amount of the RCME amount set out in section 8.3, for that calendar year. If the physician uses the entire annual entitlement and subsequently ceases practising in a Rural Community before the end of the 12-month period, the physician is only eligible for a proportionate amount of the amount set out in section 8.3 for that calendar year and must reimburse the appropriate Health Authority for any amount that was received by him or her in excess of that proportionate amount.

8.7 A physician may “bank” RCME entitlements, except that the eligibility for RCME for any calendar year expires at the end of two subsequent calendar years. For greater clarity, a physician’s RCME “bank” can contain up to three calendar years of RCME entitlement. Upon expiry of eligibility, or upon the physician ceasing to practice in a Rural Community, any sum remaining from that set aside for that physician transfers to the appropriate Health Authority, to be used for that Rural Community RCME fund..

8.8 Health Authorities must, in agreement with the Health Authority medical advisory committee, use any RCME amounts transferred to them pursuant to section 8.6 or section 8.7, for continuing medical education purposes within one or more of the Rural Communities, in addition to the payment of amounts set out in section 8.3.

8.9 The eligibility of particular educational expenses for reimbursement pursuant to the RCME will be as determined by the JSC provided however that expenses related to the acquisition of new technology or to support technology upgrades which are reasonably necessary for a physician to participate in distance continuing medical education will be eligible expenses.

## **ARTICLE 9 - RURAL EDUCATION ACTION PLAN**

9.1 The Rural Education Action Plan (the “**REAP**”) is a program that provides funds to support and facilitate the training of physicians in rural practice including the enhanced skills program for rural physicians; a re-entry program, and increasing the rural training programs for physicians, in accordance with the specific terms, conditions, rules and eligibility criteria as approved or established by the JSC from time to time.

9.2 Responsibility for the governance and oversight of the REAP resides with the JSC, with day to day administration of the REAP provided by the Ministry, or as determined by the JSC.

9.3 The JSC may provide advice and recommendations to the Government and the Doctors of BC respecting rural undergraduate, post graduate and specialty training programs.

9.4 The Government will provide annual funding of \$2,250,000 for the REAP. This funding obligation is in addition to the obligation to fund training programs existing as of November 4, 2002.

9.5 The JSC must determine how to allocate the REAP budget, ensure that expenditures for any program are independently evaluated for their cost effectiveness, and make further allocation decisions taking into account the results of the evaluation.

## **ARTICLE 10 - RECRUITMENT INCENTIVES**

10.1 The Recruitment Incentive Fund (the “**RIF**”) is a program that, subject to section 10.3, makes financial benefits available to eligible physicians recruited to fill:

- (a) vacancies identified in a Physician Supply Plan; or
- (b) pending vacancies identified in a Physician Supply Plan,

in any Rural Community, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

10.2 Responsibility for the governance and oversight of the RIF resides with the JSC, with day to day administration of the RIF provided by the Ministry.

10.3 Physicians recruited from any community (other than those listed as exceptions in section 4.1) where a recruitment and retention initiative funded by the Government is in place, are not eligible for RIF. In exceptional circumstances the JSC may waive this restriction.

10.4 The maximum benefit available under the RIF is \$20,000, which is pro-rated in the case of physicians who are recruited to work less than full-time. Payment of the benefit is subject to the physician's agreement to repay the benefit in full if he/she leaves the community to which he or she was recruited within one year from the date of commencement of practice in that community.

10.5 The Recruitment Contingency Fund (the “RCF”) is a program that makes payments available to Health Authorities to assist in the recruitment of physicians to Rural Communities, where the difficulty in filling a vacancy is, or is expected to be, especially severe and where the failure to fill the vacancy in a timely manner would have a significant impact on the delivery of medical care as required by the applicable Health Authority’s Physician Supply Plan; such payments are to be used to pay expenses associated with recruiting activities or to supplement the benefit available to a recruited physician under the RIF, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

10.6 Responsibility for the governance and oversight of the RCF resides with the JSC, with day to day administration of the RCF provided by the Ministry.

10.7 Health Authorities may apply to the JSC for a grant from the RCF and must include with such application an explanation of why RCF funds are needed and how they are proposed to be spent.

10.8 The Government will provide annual funding of \$300,000 for the RCF.

#### **ARTICLE 11 - NORTHERN AND ISOLATION TRAVEL ASSISTANCE OUTREACH PROGRAM**

11.1 The Northern and Isolation Travel Assistance Outreach Program (the “NITAOP”) is a two-component program consisting of the Northern and Isolation Travel Assistance Program and the Physician Outreach Program, that makes funding available to provide approved physicians with a travel time honorarium and reimbursement of travel expenses, for approved travel to the communities listed in Appendix B for the purpose of providing medical services to the residents of such communities, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

11.2 Responsibility for the governance and oversight of the NITAOP resides with the JSC, with day to day administration of the NITAOP provided by the Ministry.

11.3 The Government will provide annual funding of \$1.5 million for the Physician Outreach Program.

#### **ARTICLE 12 - ADDITIONAL FUNDING**

12.1 The Government will continue to provide \$3.2 million in annual funding identified in the 2007 Rural Subsidiary Agreement which was and continues to be allocated by the JSC among the REAP, the RGPLP, the Physician Outreach Program, the RSLP, and the RCME programs.

12.2 The Government will continue to provide \$20 million in annual funding identified in the 2007 Rural Subsidiary Agreement for allocation by the JSC to support its work enhancing and expanding the programs that support the delivery of physician services to British Columbians who reside in rural areas by, among other things, stabilizing the payments resulting from the application of isolation points, supporting the provision of physician services during periods of manpower transition and strengthening the emergency care system in the rural communities.

12.3 The Government will continue to provide \$10 million in annual funding identified in the 2012 Rural Subsidiary Agreement to be allocated by the JSC to, amongst other things, offset utilization pressures on the Rural Programs excluding the RIF, RCME and RRP.

12.4 The Government will continue to provide \$12 million in annual funding identified in the 2014 Rural Subsidiary Agreement to be allocated by the JSC to, amongst other things, offset utilization pressures impacting Rural Programs excluding the RIF, RCME and RRP, and to address issues impacting Rural Programs and physicians practicing in rural communities in a manner aligned with the Government's rural strategy.

12.5 The Government will provide the following additional funding to be allocated by the JSC:

- (a) an additional \$3.05 million per year effective April 1, 2019;
- (b) an additional \$3.20 million per year effective April 1, 2020; and
- (c) an additional \$2.25 million per year effective April 1, 2021.

12.6 The JSC will direct a portion of the additional funding in section 12.5 to the following:

- (a) improving premiums under the RRP to compensate physicians for increases to the cost of providing services;
- (b) providing ongoing funding for increased CMPA rates currently funded through one-time funds; and
- (c) extending the application of the Rural Emergency Enhancement Fund to qualified AP physicians, as determined by the JSC.

12.7 As set out in section 3(b) of Appendix I to the 2019 Physician Master Agreement, the amount of fee premiums currently funded by the JSC on Joint Clinical Committee fees will be transferred from the funding identified in sections 12.2, 12.3, 12.4 and 12.5 to the Available Amount.

12.8 Any funds identified in sections 12.2, 12.3, 12.4 and 12.5 that remain unexpended at the end of any Fiscal Year will be available to the JSC for use as one time allocations to improve the quality of care.

12.9 The following funding will be made available on a one-time basis for the purposes set out in the Memorandum of Understanding on Physical/Psychological Safety between the Government, the Doctors of BC and the Health Authorities from existing unexpended JSC funds from the 2014 Rural Practice Subsidiary Agreement or the funds set out at section 12.8::

- (a) \$100,000 effective April 1, 2019;
- (b) \$100,000 effective April 1, 2020; and
- (c) \$100,000 effective April 1, 2021.

### **ARTICLE 13 - EXPENSES WHILE ACCOMPANYING A PATIENT**

13.1 Physicians who accompany a patient who is being transferred from a Rural Community will, upon application to the Health Authority, be reimbursed for expenses reasonably incurred during, and necessitated by, the transfer.



#### **ARTICLE 14 - ISOLATION ALLOWANCE FUND**

14.1 The Isolation Allowance Fund (the “**IAF**”) is a program that makes payments available to physicians providing necessary medical services in Rural Communities with fewer than four physicians and no hospital, who are not receiving benefits under MOCAP (including call back and/or Doctor of the Day payments), for services provided in that Community, subject to the specific terms, conditions, rules and eligibility criteria as approved or established by the JSC from time to time.

14.2 Responsibility for the governance and oversight of the IAF resides with the JSC, with day to day administration of the IAF provided by the Ministry.

14.3 The Government will provide annual funding of \$600,000 for the IAF.

#### **ARTICLE 15 - DISPUTE RESOLUTION**

15.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Provincial Disputes.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2019.

SIGNED, SEALED & DELIVERED on  
behalf of HER MAJESTY THE QUEEN  
IN RIGHT OF THE PROVINCE OF  
BRITISH COLUMBIA, by the Minister  
of Health or his/her duly authorized  
representative, in the presence of:

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address  
\_\_\_\_\_

THE CORPORATE SEAL of the  
BRITISH COLUMBIA MEDICAL  
ASSOCIATION was hereunto affixed in  
the presence of:

\_\_\_\_\_  
Signature of Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

C/S

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

## Appendix A

### COMMUNITIES WITH AT LEAST 0.5 ISOLATION POINTS (As of April 1, 2019)

Physicians in communities listed in this Appendix may be entitled to receive RRP, RCME, REAP, RGPLP, RGPALP, RSLP, IAF, RCF and RIF subject to the community meeting the applicable Isolation Point requirements and the physician meeting the applicable eligibility criteria.

100 Mile House	Denman Island	Kitimat
	Doig River	Kitkatla
Agassiz/Harrison	Duncan/N. Cowichan	Kitsault
Ahousat		Kitwanga
Alert Bay	Edgewood	Klemtu
Alexis Creek	Elkford	Kootenay Bay/Riondel
Anahim Lake	Enderby	Kyuquot
Armstrong/Spallumcheen		
Ashcroft	Fernie	Ladysmith
Atlin		Lake Cowichan
	Fort Babine	Lillooet
Balfour	Fort Nelson	Logan Lake
	Fort St. James	Lower Post
	Fort St. John/Taylor	Lumby
Bamfield	Fort Ware	Lytton
Barriere	Fraser Lake	
Bella Bella		Mackenzie
Bella Coola	Gabriola Island	Madeira Park
Big White	Galiano Island	
Blind Bay	Gold Bridge/Bralorne	Mayne Island
Blue River	Gold River	McBride
Blueberry River	Golden	Merritt
Bowen Island	Granisle	Mill Bay
Bridge Lake	Greenwood/Midway/Rock Creek	Miocene
Burns Lake		Moricetown
		Mount Currie
Campbell River	Haida Gwaii	
Canal Flats		Nakusp
Canoe Creek	Halfway River	
Castlegar	Hartley Bay	
Chase/Scotch Creek	Hazelton	Nedlah
Cheslatta	Holberg	
Chemainus	Hope	Nee Tahi Buhn
Chetwynd	Hornby Island	Nelson
Christina Lk/Grand Forks	Hot Springs Cove	Nemaiah Valley
Clearwater	Houston	New Aiyansh
Clinton	Hudson's Hope	New Denver
Cobble Hill		Nitinat
Cortes Island		
Courtenay/Comox/Cumberland	Invermere	
Cranbrook		Ocean Falls
Crescent Valley	Kaslo	Osoyoos/Oliver
Creston	Keremeos	
	Kimberley	Parksville/Qualicum
Dawson Creek	Kincolith	Pemberton
Dease Lake	Kingcome	Pender Island

Port Alberni  
Port Alice  
Port Clements  
Port Hardy  
Port McNeill  
Port Renfrew  
Port Simpson  
Powell River  
Prince George  
Prince Rupert  
Princeton  
  
Quadra Island  
Quatsino  
  
Quesnel  
  
Revelstoke  
Rivers Inlet  
  
Saik'uz  
  
Salmo  
Salmon Arm/Sicamous  
Saltspring Island  
Samahquam  
Saturna Island  
Savary Island  
Sayward  
Sechelt/Gibsons

Seton Portage  
Shawnigan Lake  
Sirdar  
Skatin  
Skin Tyee  
Slocan Park  
Smithers  
Sointula  
Sooke  
Sorrento  
Sparwood  
Spences Bridge  
Squamish  
Stellat'en  
Stewart  
  
Tachet  
  
Tahsis  
Takla Landing  
Tatla Lake  
Tatlayoko Lake  
Telegraph Creek  
Tepella  
Terrace  
Texada Island

Tofino  
Trail/Rossland/Fruitvale  
Tsay Keh Dene  
Ts'il Kaz Koh  
Tumbler Ridge  
  
Ucluelet  
  
Valemount  
Vanderhoof  
Wardner  
Wet'suwet'en  
Whistler  
Williams Lake  
Winlaw  
Woss  
Woyenne  
  
Yekooche  
  
Zeballos

## Appendix B

### NITAOP COMMUNITIES (As of April 1, 2019)

*Subject to meeting eligibility criteria per specialty*

100 Mile House

Ahousat	Galiano Island	Ocean Falls
Alert Bay	Gold Bridge/Bralorne	
Alexis Creek	Gold River	Oliver/Osoyoos
Anahim Lake	Golden	
Atlin	Grand Forks/Midway/ Rock Creek	Parksville/Qualicum
	Granisle	
Bamfield	Haida Gwaii	Pender Island
	Halfway River	Port Alberni
Bella Bella		Port Alice
Bella Coola	Hartley Bay	Port Hardy
Blueberry River	Hazelton	Port McNeill
Burns Lake	Holberg	Port Renfrew
	Hot Springs Cove	Port Simpson
Campbell River	Houston	Powell River
		Prince George
Canoe Creek	Invermere	Prince Rupert
		Princeton
Castlegar	Kaslo	Quatsino
		Quesnel
	Keremeos	
Cheslatta		Revelstoke
Chetwynd	Kingcome	Riondel
Clearwater	Kitimat	Rivers Inlet
Clinton	Kitkatla	
Cortes Island	Klemtu	Saik'uz
Courtenay/Comox	Kwadacha	Salmo
Cranbrook	Kyuquot	
Crawford Bay	Lillooet	Salmon Arm
Creston		Saltspring Island
		Samaqham
Dawson Creek	Mackenzie	Saturna Island
Dease Lake	McBride	Sechelt/Gibsons
Doig River	Merritt	Seton Portage
Duncan/N. Cowichan		Skatin
	Nadleh	Skin Tyee
Edgewood		Smithers
		Sointula
Fernie	Nakusp/New Denver	Sparwood
		Stellat'en
		Stewart
Fort Babine	Nee Tahi Buhn	Tachet
Fort Nelson	Nelson	Takla Landing
Fort St. James	Nemaiah Valley	Tatla LakeTepella
Fort St. John	New Aiyansh	Terrace
Fraser Lake	Nitinat	Tofino
		Trail

Tsay Keh Dene  
Ts'il Kaz Koh  
Tumbler Ridge

Ucluelet

Valemount  
Vanderhoof

Wet'suwet'en

Whistler  
Williams Lake  
Woss  
Woyenne

Yekooche

Zeballos

## Appendix C

### ISOLATION POINT CRITERIA

<b>Medical Isolation and Living Factors</b>	<b>Points</b>	<b>Max Points</b>
<b>Number of Designated Specialties within 70 km</b>		
0 Specialties within 70 km	60	
1 Specialty within 70 km	50	
2 Specialties within 70 km	40	
3 Specialties within 70 km	20	
4 Specialties within 70 km	0	60
<b>Number of General Practitioners within 35 km</b>		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
<b>Community Size (If larger community within 35 km then larger population is considered)</b>		
30,000+	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
<b>Distance from Major Medical Community (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)</b>		
first 70 km road distance	4	
for each 35 km over 70 km	2	
to a maximum of	30	30
Note: ferry dependent communities will have a multiplier added to sea distance		
<b>Degree of Latitude</b>		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
<b>Specialist Centre</b>		
- 3 or 4 Designated Specialties in Health Authority Physician Supply Plans	30	
- 5 to 7 Designated Specialties in Health Authority Physician Supply Plans	50	
- 8 Designated Specialties and more than one specialist in each specialty in Health Authority Physician Supply Plans	60	60
<b>Location Arc</b>		
- communities in Arc A (within 100 km air distance from Vancouver)	0.10	
- communities in Arc B (between 100 and 300 km air distance from Vancouver)	0.15	
- communities in Arc C (between 300 and 750 km air distance from Vancouver)	0.20	
- communities in Arc D (over 750 km air distance from Vancouver)	0.25	

## **Appendix D**

### **PHYSICIAN SUPPLY PLANS**

- 1.1 A Physician Supply Plan is a plan created by a Health Authority further to the Ministry's Health Human Resource Strategy, in consultation with the Health Authority's medical advisory committee, and approved by the Ministry, which addresses issues related to access to physician services within the geographic jurisdiction of the Health Authority.
- 1.2 For purposes of this Agreement, the key elements of a Physician Supply Plan are:
  - The number of General Practitioners and Specialists required to provide the physician services identified in the Physician Supply Plan; and
  - The on-call requirements necessary to ensure coverage.
- 1.3 In some cases, Health Authorities do not yet have approved Physician Supply Plans. Pending development and approval of a Physician Supply Plan covering a community within the jurisdiction of a Health Authority without a Physician Supply Plan, a reference to "Physician Supply Plan" in this Agreement means, with respect to that community:
  - The number of General Practitioners and Specialists in the community as of December 31, 2018, plus any vacancies identified by the Health Authority as of that date where active recruitment was underway; and
  - On-call requirements as determined by the Health Authority.
- 1.4 Despite any provision to the contrary, all physicians working in any Rural Community as of December 31, 2018 are deemed to be included in the Physician Supply Plan for the term of this Agreement.



**APPENDIX D**

**2019 ALTERNATIVE PAYMENTS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1st day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the  
Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement, and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Alternative Payments Subsidiary Agreement, to take effect as of April 1, 2019; and

C. The parties intend this Agreement to define compensation and the general terms and conditions that will apply to all Salary Agreements, Service Contracts and Sessional Contracts between Physicians and Agencies for Physician Services.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

## **PART 1 - GENERAL MATTERS**

### **ARTICLE 1 - RELATIONSHIP TO THE 2019 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2019 Physician Master Agreement and is subject to its terms and conditions.

### **ARTICLE 2 - DEFINITIONS AND INTERPRETATION**

2.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement have the same meaning as in the 2019 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 **“this Agreement”** means this document including the Schedules, as amended from time to time as provided herein.

2.3 **“General Practice Services”** means Physician Services generally recognized as being within the practice scope of a General Practitioner.

2.4 **“Physician”** means a medical practitioner who is and remains a member in good standing of the College of Physicians and Surgeons of British Columbia, whose services require him or her to have a medical degree and who is not providing exclusively administrative services, but does not include any member who is an undergraduate or an intern, resident, clinical fellow or clinical trainee in a postgraduate training program.

2.5 **“2014 Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” among the Government, the Doctors of BC, and the MSC, dated April 1, 2019.

2.6 **“Physician Placement System”** has the meaning given in section 12.6.

2.7 **“Physician Services”** means clinical and related teaching, research and clinical administrative services provided by Physicians.

2.8 **“Salary Agreement Full Time Equivalent”** means 1957.5 paid hours of employment per year for a Physician employed under a Salary Agreement.

2.9 **“Specialist Services”** means Physician Services generally recognized as requiring Specialist Physician expertise.

2.10 **“Template Service Contract”** means a Service Contract in the form(s) attached as Schedule E to this Agreement.

2.11 **“Template Sessional Contract”** means a Sessional Contract in the form(s) attached as Schedule F to this Agreement.

2.12 The provisions of sections 1.2 to 1.8 inclusive of the 2019 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this

Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

### **ARTICLE 3 - TERM**

3.1 This Agreement comes into force on April 1, 2019.

3.2 This Agreement shall be for the same term as the 2019 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the 2019 Physician Master Agreement.

### **ARTICLE 4 - ALLOCATION COMMITTEE AND AFTER HOURS ADJUDICATION PANEL**

4.1 By June 1, 2019 the Government and the Doctors of BC shall appoint a temporary committee (“**Allocation Committee**”) and a temporary adjudication panel (“**After Hours Adjudication Panel**”) in accordance with the provisions of this Article 4, whose roles it will be to increase the Salary Agreement Ranges and the Service Contract Ranges by allocating the funding identified in sections 1.2(e), 1.3(b) and 1.4(b) of Appendix F to the 2019 Physician Master Agreement effective April 1, 2019, April 1, 2020 and April 1, 2021, respectively.

4.2 The Allocation Committee will be composed of an equal number of members appointed by each of the Government and the Doctors of BC, and will have a third party Chair jointly selected by the Government and the Doctors of BC. Decisions of the Allocation Committee will be by consensus decision of the Doctors of BC and Government members of the Allocation Committee and must be consistent with the provisions of this Agreement and the 2019 Physician Master Agreement. The Chair will mediate the discussions between the Doctors of BC and Government members of the Allocation Committee. If the Allocation Committee is unable to reach a decision on the distribution of the funding identified in sections 1.2(e)(i), 1.3(b)(i) and 1.4(b)(i) of Appendix F to the 2019 Physician Master Agreement by March 31, 2020, the Chair will make a binding decision on the outstanding issues. A binding decision of the Chair cannot result in adjustments to a practice category that has no Physicians who are paid within either the Service Contract Range or the Salary Agreement Range for that practice category (i.e. no salaried Physician and no contracted Physician in that practice category is paid within the range).

4.3 The After Hours Adjudication Panel will be composed of a third party Chair jointly selected by the Government and the Doctors of BC, a nominee appointed by the Doctors of BC, and a nominee appointed by the Government. The role of the nominees will be limited to providing support and advice to the Chair. A binding decision of the After Hours Adjudication Panel will be made by the Chair after considering the perspectives of the nominees. Such decision will be independent of any allocation decision made by the Allocation Committee in accordance with section 4.2 and must be consistent with the provisions of this Agreement and the 2019 Physician Master Agreement.

4.4 Should the Government and the Doctors of BC be unable to agree on the selection of the Chair of the Allocation Committee or the Chair of the After Hours Adjudication Panel, either of

them may make a request to the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the Chair.

4.5 The Government and the Doctors of BC will each bear the costs of their own respective participation on the Allocation Committee and the After Hours Adjudication Panel and will share the costs of the Chairs.

4.6 The Allocation Committee and the After Hours Adjudication Panel will each make a single decision that will apply to the 2019/20, 2020/21, and 2021/22 Fiscal Years.

4.7 The cost of the increases to the Salary Agreement Ranges and Rates and Service Contract Ranges and Rates for each of the 2019/20, 2020/21, and 2021/22 Fiscal Years will be based on the FTE distribution of Physicians on Service Contracts and Salary Agreements in Fiscal Year 2018/19 and will include the associated incremental RRP cost increases and the associated incremental benefit cost increases for salaried Physicians in Fiscal Year 2018/19.

4.8 The Government will provide the Allocation Committee and the After Hours Adjudication Panel with the 2018/19 FTE distribution information by October 31, 2019.

4.9 The Allocation Committee will consider the following when allocating the funding in sections 1.2(e)(i), 1.3(b)(i) and 1.4(b)(i) of Appendix F to the 2019 Physician Master Agreement among the Service Contract Ranges and among the Salary Agreement Ranges:

- (a) Inter-practice category equity issues; and
- (b) Inter-provincial disparity between the Service Contract and Salary Agreement Ranges with non-fee for service compensation rates in other provinces.

Any allocation to address inter-provincial disparity in 4.9(b) must not significantly exacerbate inequity amongst the Service Contract Ranges and amongst the Salary Agreement Ranges.

4.10 The After Hours Adjudication Panel will determine its own procedures, with those procedures to include:

- (a) an opportunity for Physicians, Sections, the Government, and the Doctors of BC to make submissions to the After Hours Adjudication Panel on the allocation of funding for all three Fiscal Years; and
- (b) an opportunity for Physicians, Sections, the Government, and the Doctors of BC to review all submissions made to the After Hours Adjudication Panel and provide a response to the After Hours Adjudication Panel.

4.11 When allocating the funding in sections 1.2(e)(ii), 1.3(b)(ii) and 1.4(b)(ii) of Appendix F to the 2019 Physician Master Agreement among the Service Contract Ranges and among the Salary Agreement Ranges, the After Hours Adjudication Panel will consider the extent of services provided by Physicians on evenings, nights, weekends, and holidays as defined below:

- (a) Evenings: 1800 to 2300 hours;
- (b) Nights: 2300 to 0800 hours; and
- (c) Weekends/Holidays: 0800 to 2300 hours.

4.12 Schedule A and Schedule B of this Agreement will be revised to reflect the increased Salary Agreement Ranges and the increased Service Contract Ranges for the applicable Fiscal Years upon being confirmed as final by the Allocation Committee and then again upon being confirmed as final by the After Hours Adjudication Panel. In each case, affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

## **ARTICLE 5 –PHYSICIAN WORKLOAD**

5.1 In order to fund additional full time equivalents of Physician Services (the “FTEs”) to address workload pressures of Physicians on Service Contracts or Salary Agreements, the Government will, for each Fiscal Year of this Agreement, increase the provincial budget for Service Contracts and Salary Agreements in effect at the end of the preceding Fiscal Year by a rate that is not less than the growth rate of the Available Amount, exclusive of price increases. If, in any Fiscal Year of this Agreement, the total funding request in the combined proposals submitted to Government under the process set out in section 5.3 is less than the growth in the provincial budget for that Fiscal Year pursuant to this section 5.1, the Government may use the difference to establish, at its discretion, new Alternative Payment Arrangements.

5.2 At the start of each Fiscal Year of this Agreement, the Government will report to the Doctors of BC the projected provincial budget increase for Service Contracts and Salary Agreements for that Fiscal Year, calculated in accordance with section 5.1. At the end of each Fiscal Year of this Agreement, the Government will report to the Doctors of BC expenditures for additional FTEs allocated in that Fiscal Year at the level of individual or group Service Contracts and Salary Agreements.

5.3 The funding process for additional FTEs will be as follows:

- (c) Physician(s) providing services under Service Contracts or Salary Agreements who experience significant and sustained growth in workload may submit a proposal to the relevant Agency to request new funding for additional FTEs (in whole or in part) prior to May 31, 2019 for funding in Fiscal Year 2019/20, and prior to November 30, 2019 and November 30, 2020 for funding in Fiscal Years 2020/21 and 2021/22, respectively.
- (d) Physician proposals will be in a standardized template developed by Government, which, among other things, will require Physician(s) to submit objective, reliable data regarding physician workload.

- (e) Following receipt of a proposal from Physician(s) for additional funding, the Agency and Physician(s) will meet to review the proposal. The Agency may provide any other relevant data not contained in the Physician(s)' proposal and may identify solutions other than additional FTEs to address growth in physician workload. The Agency and Physician(s) will attempt to reach agreement on whether there is a physician workload problem that should be addressed by additional FTEs.
- (f) By June 30, 2019, and, in subsequent years, by January 31, 2020 and January 31, 2021, the Agency will submit to Government the Physician(s)' proposal(s) for funding for additional FTEs, indicating whether or not the Agency supports the proposal and, if it does not support the proposal, the reasons why.
- (g) Within four weeks of the deadline for submission to the Government of all proposals for funding for additional FTEs, Government will consult with a Workload Advisory Committee comprised of four physicians appointed by the Doctors of BC to review and assess the proposals. Government will also advise the Workload Advisory Committee and the Doctors of BC of the estimated dollar amount of new funding available for the Fiscal Year pursuant to paragraph 5.1.
- (h) In assessing the proposals for funding for additional FTEs, the Government will consider the growth in hours, volume, complexity of services and/or other measures of workload and will not deny any proposals on the basis that hours of services have not exceeded the FTE.
- (i) Within six weeks of the first meeting between the Government and the Workload Advisory Committee, the Government will report to the Doctors of BC the budget commitments/allocations at the level of individual or group Service Contract and Salary Agreements.
- (j) Pursuant to section 5.2, the Government will report to the Doctors of BC at the end of each Fiscal Year the expenditures for additional FTEs provided under this Article 5 in that Fiscal Year at the level of individual or group Service Contract and Salary Agreements.
- (k) Where the allocation is to support additional FTEs under a group Service Contract, funding for the additional FTEs will be made available under the same terms and conditions as the existing group Service Contract. Any renewal negotiations will occur independently of and subsequent to the allocation of the additional FTEs.

5.4 Within three (3) months of the execution of the 2019 Physician Master Agreement, the Government and Doctors of BC will establish a working group composed of four members appointed by the Government/Health Authorities and four members appointed by the Doctors of BC to collaboratively develop a non-exhaustive list of standardized provincial workload measures by Practice Category/Clinical Service Area ("**Provincial Workload Measures**"). In this regard, a

“**workload measure**” is defined as a tool to identify relevant information for the review of physician workload.

5.5 Effective April 1, 2020, the Government and the Doctors of BC will add a new Appendix to the Template Service Contracts and the Standard Terms and Conditions of Employment Under Salary Agreements set out in Schedules D and E, respectively, to this Agreement titled “Workload Measures” (the “**WL Appendix**”), and the Government and the Doctors of BC agree that:

- (l) At the request of either party, an Agency and Physician(s) must expressly include relevant workload measure(s), including Provincial Workload Measures in the WL Appendix by agreement at the outset or during the re-negotiation of a Service Contract or a Salary Agreement. In the event that the parties are unable to reach agreement on such workload measures, the Provincial Workload Measures will be added to the WL Appendix.
- (b) The WL Appendix will provide that workload measure(s) included in the WL Appendix:
  - (i) provide the Agency and the Physician(s) with a tool through which to inform discussion and identify relevant information for the review of physician workload;
  - (ii) may, and are expected to, change over time;
  - (iii) do not preclude an Agency and/or the Physician(s) from considering or discussing any other workload data or workload measure(s) in the assessment of physician workload;
  - (iv) do not preclude or supersede the use of any existing or future workload models used for staffing or resource allocation; and
  - (v) do not create any contractual obligations on the Agency or the Physician(s).
- (c) To support consistency in the identification of workload measure(s) in the WL Appendix, the Government and Doctors of BC agree that Physicians will be encouraged to work together in circumstances where there are multiple individual Service Contracts or Salary Agreements for similar Physician Services with the same Health Authority.
- (d) For greater clarity, nothing in this section 5.5 precludes local parties from agreeing to workload measure(s) in Service Contracts and/or Salary Agreements prior to the addition of the WL Appendix.

5.6 By June 30, 2019, the Government and the Doctors of BC shall appoint a temporary committee called the “Provincial Laboratory Physician Workload Model Committee” (the

“LPWMC”). The LPWMC shall be composed of four members appointed by the Government and four members appointed by the Doctors of BC. The LPWMC shall be co-chaired by one committee member chosen by the Government members and one committee member chosen by the Doctors of BC members.

5.7 Decisions of the LPWMC shall be by consensus decision.

5.8 The LPWMC will have the following mandate:

- (a) reviewing the current anatomic pathology workload model and making advisable modifications;
- (b) continuing development and validation of a clinical pathology workload model; and
- (c) determining how both the anatomic and clinical pathology workload models will be used in or related to local laboratory physician compensation contracts.

5.9 The LPWMC shall determine its own procedures and timelines.

#### **ARTICLE 6 - COMPENSATION ENTITLEMENT**

6.1 Subject to sections 6.2 and 6.3 of this Agreement, Physicians providing Physician Services under the terms of a Salary Agreement or Service Contract or during the time for which they are paid in accordance with a Sessional Contract, are not entitled to any additional compensation for those Physician Services and may not be paid Fees or any other fees for those Physician Services.

6.2 Physicians paid pursuant to a Salary Agreement, a Service Contract or a Sessional Contract will be entitled to receive:

- (a) additional compensation under the Rural Practice Subsidiary Agreement; and
- (b) additional compensation under the 2019 Physician Master Agreement, the General Practitioners Subsidiary Agreement or the Specialists Subsidiary Agreement;

where eligible under those agreements and all applicable eligibility criteria.

6.3 Physicians on Service Contracts or Sessional Contracts are entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, subject to the terms of the Benefits Subsidiary Agreement and the Benefit Plans.

#### **ARTICLE 7 - COMPENSATION ADMINISTRATION**

7.1 Physicians providing Specialist Services who are registered to provide Specialist Services with the College of Physicians and Surgeons of British Columbia but who do not hold certification or fellowship with the Royal College of Physicians and Surgeons of Canada, will,



subject to agreement of the Physician Services Committee, be paid at the appropriate Sessional Contract Rate or on the appropriate Salary Agreement Range or Service Contract Range for the practice category for such Specialist Services. Pending that agreement of the Physician Services Committee, the Physician may be so paid for a period of up to six months. A Physician being paid under a Service Contract or a Salary Agreement pursuant to this section 7.1 will normally be placed at the minimum rate on the appropriate range unless the Physician Services Committee approves placement elsewhere on the range.

7.2 The Community Medicine/Public Health Areas A-D practice categories in Schedules A and B include Physicians who practice Community Medicine and are not classified in another medical group, including Medical Health Officers, Community Medicine Consultants and First Nations Medical/Public Health Advisors. Physicians will be assigned to one of the Community Medicine/Public Health Areas A-D practice categories on Schedule A and Schedule B in accordance with Schedule G.

7.3 Physicians who are currently being paid under a Salary Agreement or a Service Contract at an annual rate that is above the range maximum on the Salary Agreement Range or Service Contract Range for their practice category will receive the applicable compensation increases described at sections 1.1 (a), 1.2(a)(iii), 1.3(a)(iii), and 1.4(a)(iii) of Appendix F to the 2019 Physician Master Agreement. Physicians who are currently being paid under a Salary Agreement or a Service Contract at an annual rate that is above the range maximum on the Salary Agreement Range or Service Contract Range for their practice category will not have their annual rate decreased as a result of the application of Schedule A or Schedule B, whichever is applicable, and will only receive compensation increases that are identified in Sections 1.2(e) 1.3(b), and 1.4(b) of Appendix F to the 2019 Physician Master Agreement to the extent that their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.

7.4 Where Schedule A or Schedule B does not list a Salary Agreement Range or a Service Contract Range for a particular practice category, the Physician Services Committee will determine an appropriate range.

## **ARTICLE 8 - RELATIONSHIP WITH CONTRACTING AGENCIES**

8.1 All Salary Agreements, Service Contracts and Sessional Contracts must be signed by the Physician or group of Physicians and the Agency, and the parties to such contracts shall exchange executed copies.

8.2 Subject to this Agreement, the Agency retains authority to negotiate with Physicians how Physician Services are to be delivered and what compensation is to be provided under a Salary Agreement, a Service Contract or Sessional Contract.

8.3 Except for the indemnity at section 4.6 of the Individual Template Service Contract and Individual Template Sessional Contract and section 4.7 of the Group Template Service Contract and the Group Template Sessional Contract, Alternative Payment Arrangements must not contain provisions requiring either the Physician or the Agency to indemnify the other in the event of a claim by a third party. For greater clarity, this clause is not intended to abrogate the common law

rights of parties to an Alternative Payment Arrangement to claim indemnification from any other party.

8.4 Subject to sections 8.5 and 8.6, all Service Contracts and Sessional Contracts must be in the forms for each set out in Schedules E and F to this Agreement.

8.5 The parties to a Service Contract or a Sessional Contract may agree to contractual provisions that are in addition to those found in Schedules E and F to this Agreement provided that these additional provisions are not inconsistent with the spirit and intent of this Agreement.

8.6 The Template Service Contract and the Template Sessional Contract may be amended to reflect the legal status of the parties to the contract and the number of parties to the contract.

## **PART 2- PHYSICIANS EMPLOYED UNDER SALARY AGREEMENTS**

### **ARTICLE 9 - COMPENSATION AND HOURS OF WORK**

9.1 Physicians employed under Salary Agreements will be compensated within the Salary Agreement Range for the applicable practice category.

9.2 Physicians working less than a Salary Agreement Full Time Equivalent will receive a proportionate amount of compensation.

9.3 Annual salaries of Physicians under Salary Agreements include payment for time spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

9.4 When a Physician is initially employed by an Agency under a Salary Agreement, the Physician's annual salary on the Salary Agreement Range for the applicable practice category will be the subject of an agreement between the Agency and the Physician and reflected in the offer of employment. Thereafter, annual in-range movement on the Salary Agreement Range will be on the same basis as senior management employees of the Agency, provided that no such movement shall result in any Physician's annual salary exceeding the range maximum on the Salary Agreement Range for the applicable practice category.

### **ARTICLE 10 - STANDARD TERMS AND CONDITIONS OF EMPLOYMENT UNDER SALARY AGREEMENTS**

10.1 All Salary Agreements include and shall be deemed to include the standard terms and conditions of employment set out in Schedule D except in the case of Salary Agreements entered into before November 4, 2002 that reflect comparable practices. The Agency must provide the Physician with a copy of the applicable terms and conditions of employment.

10.2 The Agency retains full authority to direct the operations of its services, subject to this Agreement and the Physician's right to professional autonomy.

10.3 Notwithstanding section 10.1, terms regarding severance and current levels of support, office space, supplies and professional development entitlement and support in agreements

between Physicians and Agencies in place on November 4, 2002 shall be maintained for twelve months from the date of written notice of a change to such term(s) being provided to the Physician.

10.4 Severance entitlements under all Salary Agreements must conform to the Employment Termination Standards established for the purposes of section 14.4 of the *Public Sector Employers Act* and amendments thereto.

## **ARTICLE 11 - BENEFITS, VACATION AND EXPENSES**

11.1 Physicians employed under Salary Agreements will receive their benefits through the Agency that is their employer and, with the exception of the Physician Health Program, are not entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, unless otherwise specified in the Benefits Subsidiary Agreement.

11.2 Physicians employed under Salary Agreements are entitled to benefits and vacation at the same level and under the same terms as those provided to the senior management employees of the Agency that is their employer. In addition, the following will apply to Physicians employed under Salary Agreements:

- (a) reimbursement for the cost of annual dues of the College of Physicians and Surgeons of British Columbia and, where such membership is a requirement of employment, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada;
- (b) reimbursement for other approved professional fees to the maximum permitted by existing employer policies;
- (c) reimbursement for the annual dues or premiums, as applicable, for membership in the Canadian Medical Protective Association or coverage under a comparable professional/malpractice liability insurance plan;
- (d) a minimum of five days each year with pay for participation in Continuing Medical Education; and
- (e) reimbursement for Continuing Medical Education expenditures which, at a minimum, will be equivalent to that available under the Benefits Subsidiary Agreement.

11.3 In no case will a Physician's vacation, benefits, Continuing Medical Education, professional costs and fees, under an existing Salary Agreement be diminished as result of this Agreement.

11.4 Notwithstanding the employer's vacation policy, if a Physician employed under a Salary Agreement is not permitted by his or her employer to take any or all of his/her vacation entitlement, then the Physician may:

- (a) be paid out for the unused vacation days in the form of a lump sum cash payment in the employment year immediately following the employment year to which the unused vacation days are attributable;
- (b) carry forward the unused vacation days and use them for vacation leave in the employment year immediately following the employment year to which the unused vacation days are attributable; or
- (c) in the employment year immediately following the employment year to which the unused vacation leave is attributable, choose in part, to be paid out under section 11.4(a) and, in part, to use them for vacation leave under section 11.4(b).

### **PART 3 – PHYSICIAN SERVICES PROVIDED UNDER A SERVICE CONTRACT**

#### **ARTICLE 12 - COMPENSATION AND HOURS OF SERVICE**

12.1 Physicians providing Physician Services under Service Contracts will be compensated within the Service Contract Range for the applicable practice category.

12.2 Subject to section 12.7, Physicians shall provide a minimum of 1680 hours to a maximum of 2400 hours of Physician Services per year in order to receive an annual rate on the Service Contract Range, and such number of hours will constitute one full time equivalent for the purposes of this Article 12. The parties recognize that many Physicians must work hours in addition to their contract hours, providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

12.3 Parties to intended Service Contracts must attempt to reach agreement on the number of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contracts, and the following shall apply:

- (a) if the parties are unable to reach agreement on the number of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contract to meet the deliverables required by the Agency, the parties may request, through the Doctors of BC and the Government, the use of the Trouble Shooter;
- (b) where either the Doctors of BC or the Government requests the Trouble Shooter to assist in resolving the disagreement, the Trouble Shooter will conduct a fact finding review and issue recommendations, consistent with section 12.2, to the Joint Agreement Administration Group and the local parties, and such recommendations will be treated by the Doctors of BC, the Government, and the local parties as confidential unless otherwise agreed by the Joint Agreement Administrative Group;
- (c) in arriving at a recommendation, the Trouble Shooter will consider the annual hours of work reported in the 2004 National Physician Survey, the conditions under which the Physician Services have been provided previously, and the hours

of work for Physician Services under Service Contracts, Sessional Contracts and fee for service arrangements in British Columbia and other jurisdictions; and

- (d) the local parties may agree at any time to be bound by recommendations made by the Trouble Shooter, subject to section 20.2 of the 2019 Physician Master Agreement.

12.4 Physicians providing less than the hours of service per year required for a full time equivalent under any Service Contract will receive a proportionate amount of the compensation required for a full time equivalent under such Service Contract.

12.5 The Service Contract Range for emergency medicine is based on a maximum of 1680 hours of emergency medicine Physician Services per year including time spent providing indirect patient care at the beginning and end of each scheduled shift.

12.6 The Doctors of BC and the Government have developed criteria for range placement (the “**Physician Placement System**”), to be applied in determining Service Contract Range placement for Physicians providing Physician Services under Service Contracts.

12.7 Subject to section 12.9, in the case of a Service Contract for a group of Physicians, the rate for determining the financial value of the Service Contract shall be either:

- (a) the composite rate on the Service Contract Range for the applicable practice category derived from the application of the Physician Placement System to each Physician in the group; or
- (b) the rate equal to 95% of the maximum rate on the Service Contract Range for the applicable practice category;

as selected by the Physician group. The Physician group is bound by the option it selects.

12.8 In the case of any Service Contract for a group of Physicians, the Physician group will, within the total financial value of the Service Contract, determine rates of compensation for the individual Physicians in the group that the group deems appropriate (e.g. time of day, weekends, amount of time worked by an individual Physician).

12.9 A Physician or Physician group providing Physician Services under a Service Contract in existence as at March 31, 2019 may, upon renewals of that Service Contract, for the purposes of establishing a rate for determining the financial value of a renewal of the Service Contract, instead of selecting a rate as provided in section 12.7, select a rate equal to the lesser of:

- (a) the maximum rate on the Service Contract Range for the applicable practice category; and
- (b) the rate determined according to the following formula:

$$x = [(A \div B) \div C] \times D$$

where:

x = the rate;

A = the financial value of the expiring Service Contract;

B = the number of full time equivalents for the expiring Service Contract;

C = the maximum rate on the Service Contract Range for the applicable practice category at the time the expiry of the Service Contract; and

D = the maximum rate on the Service Contract Range for the applicable practice category at the time of renewal of the Service Contract.

12.10 Any dispute between an Agency and a Physician or group of Physicians as to the proper application of the Physician Placement System to the Physician or group of Physicians (a “**Local Range Placement Dispute**”) will be resolved pursuant to the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Local Range Placement Disputes.

12.11 All Service Contracts must include clear and specific provisions that identify the respective responsibilities of the Agency and the Physician or Physician group regarding the provision of support, technology, materials and supplies.

12.12 All Service Contracts must contain a comprehensive description of the Physician Services to be provided to the Agency.

#### **PART 4- PHYSICIAN SERVICES PROVIDED UNDER A SESSIONAL CONTRACT**

##### **ARTICLE 13 - COMPENSATION**

13.1 Compensation for Physicians (including forensic practitioners) providing Physician Services under Sessional Contracts will be based on the applicable rate set out in Schedule C.

13.2 A session, for the purposes of a Sessional Contract, is 3.5 hours of Physician Services. A session may be an accumulation of lesser time intervals adding up to 3.5 hours. Smaller amounts of time not adding up to a full session will be recognized provided, however, that payment will not be made until such smaller amounts of time have accumulated to at least a quarter of an hour.

13.3 The hourly rate of payment for sessional time will be determined by dividing the appropriate sessional rate set out in Schedule C by 3.5 hours.

13.4 A Physician who is a party to a Sessional Contract with an Agency and who is called in by the Agency to provide a Physician Service will be compensated for the Physician Service provided at the Physician's hourly rate under the Sessional Contract, which payment will be for a minimum of one hour; such payment to be in addition to any payment the Physician is entitled to under a MOCAP Contract.

13.5 Travel expenses related to Physician Services performed by forensic practitioners under a Sessional Contract will be in accordance with the rates established for “Group 2” (public service) employees.

13.6 Required travel rates and related billing guidelines for forensic practitioners will be in accordance with the Medical Expert Witness Billing Fees and Guidelines, as amended from time to time.

#### **ARTICLE 14 - DISPUTE RESOLUTION**

14.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Provincial Disputes.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1<sup>st</sup> day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness )

\_\_\_\_\_  
Name )

\_\_\_\_\_  
Address )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

C/S

\_\_\_\_\_  
Signature of Authorized Signatory )

\_\_\_\_\_  
Name )

\_\_\_\_\_  
Position )

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position



### Schedule “A” to the Alternative Payments Subsidiary Agreement

2019/20 Salary Agreement Ranges based on the February 25, 2019 Consensus Decision of the Allocation Committee, as increased by 0.5% in accordance with section 1.2(a)(iii) of Appendix F to the 2019 Physician Master Agreement and subject to change as contemplated in Appendix F to the 2019 Physician Master Agreement.

PRACTICE CATEGORY	Minimum	Maximum
General Practice - Defined Scope B	171,110	213,888
General Practice - Defined Scope A	191,340	239,175
General Practice - Full Scope (Non-JSC Community)	202,135	252,669
General Practice - Full Scope (Rural) – Area A	224,393	280,491
General Practice - Full Scope (Rural) – Area B	217,311	271,639
General Practice - Full Scope (Rural) – Area C	211,082	263,853
Hospitalists	191,340	239,175
Community Medicine/Public Health Area A	165,581	206,976
Community Medicine/Public Health Area B	180,389	225,486
Community Medicine/Public Health Area C	213,347	266,684
Community Medicine/Public Health Area D	226,650	283,313
General Paediatrics (Defined Scope)	208,317	260,396
General Paediatrics	231,625	289,531
Psychiatry	231,625	289,531
Forensic Psychiatry	239,173	298,966
Physical Medicine	226,779	283,474
Neurology	245,022	306,278
Dermatology	245,022	306,278
Internal Medicine	231,625	289,531
Medical Genetics	245,022	306,278
Sub-specialty Paediatrics	245,022	306,278
Sub-specialty Internal Medicine	245,022	306,278
Anaesthesia	266,082	332,603
Critical Care	268,150	335,187
Critical Care (Pediatrics) at BCCH/BCWH	305,953	382,441
Haematology/Oncology	288,483	360,604
Medical Oncology	288,483	360,604
Radiation Oncology	288,483	360,604
Laboratory Medicine	271,901	339,876
Radiology	288,483	360,604
Pediatric Radiology	324,872	406,090
Nuclear Medicine	298,166	372,708
Otolaryngology	266,082	332,603
Orthopaedic Surgery	266,082	332,603
Urology	266,082	332,603
Ophthalmology	266,082	332,603
Plastic Surgery	266,082	332,603
Plastic Surgery at VGH/SPH	385,372	481,716

Obstetrics/Gynecology	270,487	338,109
General Surgery	266,082	332,603
Gynecological Oncology	296,698	370,872
Maternal Fetal Medicine	296,698	370,872
General Surgical Oncology	296,698	370,872
Orthopaedic Surgery (Enhanced Scope)	351,642	439,553
Neurosurgery	351,642	439,553
Vascular Surgery	351,642	439,553
Cardiac Surgery	351,642	439,553
Thoracic Surgery	467,511	584,389
Emergency Medicine (Non-Hospital Based)	184,746	230,933
Emergency Medicine Area A	237,495	264,346
Emergency Medicine Area B	264,346	296,869

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated May 22, 2014, and any subsequent Consensus Decision of the Alternative Payments Committee or the Allocation Committee related to the assignment to Practice Categories.

### **Schedule “B” to the Alternative Payments Subsidiary Agreement**

2019/20 Service Contract Ranges based on the February 25, 2019 Consensus Decision of the Allocation Committee, as increased by 0.5% in accordance with section 1.2(a)(iii) of Appendix F to the 2019 Physician Master Agreement and subject to change as contemplated in Appendix F to the 2019 Physician Master Agreement.

These ranges include 12% for benefits. These rates may also be increased by reasonable overhead expenses projected to be incurred by the Physician.

PRACTICE CATEGORY	Minimum	Maximum
General Practice - Defined Scope B	191,644	239,555
General Practice - Defined Scope A	214,301	267,876
General Practice - Full Scope (Non-JSC Community)	226,391	282,989
General Practice - Full Scope (Rural) – Area A	251,320	314,150
General Practice - Full Scope (Rural) – Area B	243,389	304,236
General Practice - Full Scope (Rural) – Area C	236,412	295,515
Hospitalists	214,301	267,876
Community Medicine/Public Health Area A	185,450	231,813
Community Medicine/Public Health Area B	202,035	252,544
Community Medicine/Public Health Area C	238,949	298,686
Community Medicine/Public Health Area D	253,849	317,311
General Paediatrics (Defined Scope)	233,315	291,644
General Paediatrics	259,420	324,275
Psychiatry	259,420	324,275
Forensic Psychiatry	267,874	334,842
Physical Medicine	253,993	317,491
Neurology	274,424	343,031
Dermatology	274,425	343,031
Internal Medicine	259,420	324,275
Medical Genetics	274,425	343,031
Sub-specialty Paediatrics	274,425	343,031
Sub-specialty Internal Medicine	274,425	343,031
Anaesthesia	298,012	372,515
Critical Care	300,327	375,409
Critical Care (Pediatrics) at BCCH/BCWH	342,667	428,334
Haematology/Oncology	323,102	403,877
Medical Oncology	323,102	403,877
Radiation Oncology	323,102	403,877
Laboratory Medicine	304,529	380,661
Radiology	323,102	403,877
Pediatric Radiology	363,857	454,821
Nuclear Medicine	333,946	417,433
Otolaryngology	298,012	372,515
Orthopaedic Surgery	298,012	372,515

Urology	298,012	372,515
Ophthalmology	298,012	372,515
Plastic Surgery	298,012	372,515
Plastic Surgery at VGH/SPH	431,617	539,521
Obstetrics/Gynecology	302,946	378,682
General Surgery	298,012	372,515
Gynecological Oncology	332,302	415,377
Maternal Fetal Medicine	332,302	415,377
General Surgical Oncology	332,302	415,377
Orthopaedic Surgery (Enhanced Scope)	393,839	492,299
Neurosurgery	393,839	492,299
Vascular Surgery	393,839	492,299
Cardiac Surgery	393,839	492,299
Thoracic Surgery	523,613	654,516
Emergency Medicine (Non-Hospital Based)	206,916	258,645
Emergency Medicine Area A	265,994	296,068
Emergency Medicine Area B	296,068	332,493

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated May 22, 2014, and any subsequent Consensus Decision of the Alternative Payments Committee or the Allocation Committee related to the assignment to Practice Categories.

**Schedule “C” to the Alternative Payments Subsidiary Agreement**

**PROVINCIAL SESSIONAL RATES, EFFECTIVE APRIL 1, 2019**

The sessional rates effective April 1, 2019 are as follows:

<b>General Practitioners</b>	<b>Specialists</b>
\$507.23	\$598.32

The sessional rates for practitioners providing services to the Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development) are as follows:

<b>General Practitioners</b>	<b>Specialists</b>
\$550.17	\$792.98

**Schedule “D” to the Alternative Payments Subsidiary Agreement**

**STANDARD TERMS AND CONDITIONS OF EMPLOYMENT  
UNDER SALARY AGREEMENTS**

**1. British Columbia Medical Association**

- (a) The Physician is entitled, at his or her option, to representation by the British Columbia Medical Association (the “Doctors of BC”) in the discussion or resolution of any issue arising under this Salary Agreement, including without limitation the re-negotiation or termination of this Salary Agreement.

**2. Responsibilities and Workload**

- (a) The Physician’s responsibilities will be defined and communicated to him/her by his/her supervisor. There will be ongoing communication between the Physician and his/her supervisors regarding the performance of the services, including issues relating to workload and distribution of clinical, academic and administrative responsibilities. If they are unable to reach agreement on an approach to resolve the concerns in these areas, either party may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact finding review and issue recommendations. If they are unable to reach agreement following the use of a Trouble Shooter, either the Government or the Doctors of BC may refer the matter to the Physician Services Committee as a Local Interest Issue.
- (b) The nature of the Physician’s position requires him/her to be flexible about hours of work. The Physician is required to be adaptable to a work situation, which may result in working hours other than those considered to be the normal hours of work. The annual salary of the Physician includes payment for additional hours spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

**3. Probation and Termination**

- (a) The Physician shall be subject to the Employer’s probation policy applicable to senior management employees, unless the Employer and Physician agree otherwise.
- (b) The Employer may, at any time, terminate the Physician’s employment without notice or pay in lieu of notice if the Employer has just cause for termination.
- (c) The Employer may, at any time, terminate the Physician’s employment on notice or by making payment in lieu of notice. The amount of notice or payment in lieu of notice afforded by the Employer to the Physician terminated under this provision shall be calculated in accordance with common law and statutory

standards, including the Public Sector Employers Act and any applicable regulations.

- (d) Termination of employment by the Physician will require three months' notice, or a shorter period as may be agreed to by the parties.
- (e) On termination of the Physician's employment, the Employer must provide the Physician with the necessary support to abide by all applicable patient notification requirements of the College of Physicians and Surgeons of BC.

#### **4. Fee for Service and Third Party Billings**

- (a) Unless specified otherwise, the Physician will not retain fee-for-service billings or receive any other form of remuneration for the services or procedures provided under the terms of this Salary Agreement.
- (b) Where the Available Amount is not a source of funding for this Salary Agreement, the Physician will sign:
  - (i) a waiver in the form attached hereto as Appendix 1A and such other documentation in connection with such waiver as may be reasonably required; or
  - (ii) if the Physician is required to assign to the Employer any and all rights the Physician has to receive third party billings for any of the services or procedures provided under the terms of this Salary Agreement, a waiver and assignment in the form attached hereto as Appendix 1B and such other documentation in connection with such waiver and assignment as may be reasonably required.
- (c) Where the Available Amount is a source of funding for this Salary Agreement, the Physician assigns to the Employer any and all rights he or she may have to receive fee-for-service payments from the Available Amount for any of the services or procedures provided under the terms of this Salary Agreement, and will sign an assignment in the form attached hereto as Appendix 2.
- (d) The Physician shall retain one hundred per cent (100%) of third party billings provided they are not included within the services or procedures provided under the terms of, and do not conflict with the Physician's obligations under, this Salary Agreement. For the purposes of this clause, third party billings include but are not limited to:
  - (i) billings for services associated with WorkSafeBC, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
  - (ii) billings for non-insured services, excluding medical/legal services, and

- (iii) billings for services provided to persons who are not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

## **5. Autonomy**

- (a) The Physician will provide the services under this Salary Agreement in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws or rules and regulations that are not inconsistent with, and do not represent a material change to, the terms of this Salary Agreement.
- (b) Subject to section (5)(a), the Physician is entitled to professional autonomy in the provision of the services covered by this Salary Agreement.

## **6. Locum Coverage**

- (a) The Employer, at its sole discretion, shall be responsible for securing the services of a locum in consultation with the Physician.

## **7. Dispute Resolution**

- (a) This Salary Agreement shall be governed by and construed in accordance with the laws of British Columbia.
- (b) All disputes arising out of or in connection with this Salary Agreement that the parties are unable to resolve at the local level, may be referred to mediation on notice by either party to the other, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the Arbitration Act.
- (c) Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- (d) Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- (e) The Employer and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC shall have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.



- (f) Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

## **8. Licenses & Qualifications**

- (a) The Physician is and shall remain a registered member in good standing with the College of Physicians and Surgeons of British Columbia and conduct his/her practice of medicine consistent with the conditions of such registration.
- (b) The Physician is and shall remain enrolled in the Medical Services Plan.
- (c) If all or some of the services provided under this Agreement are Specialists Services, then the Physician must be and remain registered by the College of Physicians and Surgeons of British Columbia to provide these Specialist Services.
- (d) Where the Employer is subject to the Hospital Act, all Physicians performing Services on behalf of the Employer must first be credentialed and granted privileges by the Employer, and no physician who has not been credentialed or obtained and maintained such privileges, shall be permitted by the Employer to perform the Services.
- (e) All medical services under this Agreement will be provided either directly by the Physician, by a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

## **9. Third Party Claims**

- (a) Each party will provide the other with prompt notice of any action against either or both of them arising out of this Salary Agreement.

## **10. Medical Liability Protection**

- (a) The Physician will obtain and maintain professional malpractice liability protection, at the expense of the Employer, through membership with the Canadian Medical Protective Association or an alternative professional/malpractice protection plan and will be required to provide the Employer with evidence of the required protection on request.

## **11. Confidentiality**

- (a) The Physician and the Employer shall maintain as confidential and not disclose any patient information, except as required or permitted by law.
- (b) The Physician must not, without the prior written consent of the Employer, publish, release or disclose or permit to be published, released, or disclosed before, during the term of this Salary Agreement, or otherwise, any other

confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Salary Agreement unless the publication, release or disclosure is required or permitted by law and is:

- (i) necessary for the Physician to fulfill his/her obligations under this Salary Agreement;
- (ii) made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of B.C.; or
- (iii) in reference to the Physician's Salary Agreement.

The Physician will notify the employer prior to the publication, release, or disclosure of information under (i) and (ii) above.

- (c) For the purposes of section 11(b), information shall be deemed to be confidential where all of the following criteria are met:
  - (i) the information is not found in the public domain;
  - (ii) the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgment to be confidential; and
  - (iii) the Employer has maintained adequate internal control to ensure information remained confidential.

## **12. Conflict of Interest**

- (a) During the term of this Salary Agreement, absent the written consent of the Employer, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.
- (b) The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach section 12(a). Should they not be able to resolve the issue, the matter will be dealt with in accordance with section 7 above.

## **13. Notices**

- (a) Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
  - if mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

- if delivered by hand to the addressee's address listed below on the date of such personal delivery.
- if delivered by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address listed below.

Either party may give notice to the other of a change of address.

Address of the Employer

- 
- 
- 

Address of the Physician

- 
- 
- 

#### **14. Headings**

- (a) The headings in this Salary Agreement have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Salary Agreement.

#### **15. Enforceability and Severability**

- (a) If any provision of this Salary Agreement is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, avoidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

#### **16. 2019 Physician Master Agreement and Physician Master Subsidiary Agreements**

- (a) This Salary Agreement is subject to the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements (as defined in the Physician Master Agreement), and amendments thereto.
- (b) In the event that during the Physician's employment a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other, to re-negotiate and amend the terms of this Salary Agreement to ensure it complies with the new

Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

**17. Work Environment:**

- (a) The Employer, at its discretion, shall provide the Physician with the facilities, equipment, support and supplies that are reasonably required for the Physician to provide the services covered by this Salary Agreement. If the Physician disagrees with the Employer's decision on these matters he/she may address them with the Physician Services Committee as a Local Interest Issue.

**APPENDIX 1A**

**FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER**

Physician Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

I acknowledge that the payments paid to me by \_\_\_\_\_ (the Agency) for the services provided under the terms of the Salary Agreement between us dated \_\_\_\_\_ (the “**Services**”) are payments in full for those Services, and I will make no other claim for those Services.

I will not retain and hereby waive any and all rights I have to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here.*

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Date

## APPENDIX 1B

### FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

I acknowledge that the payments paid to me by \_\_\_\_\_ (the Agency) for the services provided under the terms of the Salary Agreement between us dated \_\_\_\_\_ (the “**Services**”) are payments in full for those Services, and I will make no other claim for those Services.

I will not retain and hereby waive any and all rights I have to receive any fee for service payments from the Medical Services Plan with respect to such Services.

I will not retain and hereby assign to the Agency any and all rights I have to receive any payments for any such Services from any third party including but not limited to:

- (a) billings associated with WCB, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
- (b) billings for all non-insured Services, excluding medical-legal services, and
- (c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

I will execute all documents and provide all information and paperwork not already in the Agency’s possession relating to the Services provided under the terms of the Salary Agreement that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, I will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

## APPENDIX 2

### FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

I acknowledge that the payments paid to me by \_\_\_\_\_ (the Agency) for the services provided under the terms of the Salary Agreement between us dated \_\_\_\_\_ are payments in full for those Services and I will make no other claim for those Services.

I will not retain and hereby assign to the Agency any and all rights I have to receive fee for service payments from the Medical Services Plan and third parties with respect to such Services.

I will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Salary Agreement that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, I will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Schedule “E” to the Alternative Payments Subsidiary Agreement**  
**INDIVIDUAL TEMPLATE SERVICE CONTRACT**

**BETWEEN:**

*<name of physician/corporation>*

(the “Physician”)

**AND:**

(the “Agency”)

**WHEREAS** the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Service Contract;

**THEREFORE** in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

**Article 1: Definitions**

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2019 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2019 Physician Master Agreement or the Physician Master Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (a) “**Contract**” or “**Service Contract**” means this document including the Appendices, as amended from time to time in accordance with Article 23.
- (b) “**2019 Physician Master Agreement**” means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government, the Medical Services Commission and the British Columbia Medical Association (“**Doctors of BC**”), as subsequently amended from time to time.
- (c) “**Services**” means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.



## **Article 2: Term & Renewal**

- 2.1 This Contract will be in effect from <insert date> to <insert date> notwithstanding the date of its execution, unless terminated earlier as provided herein (the “Term”).
- 2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 2.3 Subject to clause 2.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 2.4 In the event that notice is given by either party in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

## **Article 3: Termination**

- 3.1 Subject to clause 3.2, either party may terminate the Contract without cause upon six (6) months’ written notice to the other party.
- 3.2 Either party may terminate this Contract immediately upon written notice if the other party breaches a fundamental term of this Contract. For clarity, loss of privileges related to the Services provided under this Contract by the Physician is a breach of a fundamental term of this Contract.

## **Article 4: Relationship of Parties**

- 4.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician.
- 4.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 4.3 If the Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:
  - (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of

whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a “worker”, advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

- 4.4 If the Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician’s Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.
- 4.5 The Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers’ compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.
- 4.6 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician’s failure to make any payments referred to in clause 4.5.
- 4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

#### **Article 5: Waiver/Assignment**

- 5.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:
- (a) billings for Services associated with WorkSafeBC, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
  - (b) billings for non-insured Services, excluding medical/legal services, and
  - (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act*, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

- 5.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign:
- (a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required; or
  - (b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.
- 5.3 Where the Available Amount is a source of funding for this Contract, the Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such other documentation in connection with such assignment as may be reasonably required.

#### **Article 6: Autonomy**

- 6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.
- 6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

#### **Article 7: Doctors of BC**

- 7.1 The Physician is entitled, at the Physician's option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

#### **Article 8: Dispute Resolution**

- 8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 8.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the

parties in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.

- 8.3 Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 8.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- 8.5 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- 8.6 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

#### **Article 9: Service Requirements**

- 9.1 The Physician will provide the Services as described in Appendix 1 and will schedule the Physician's availability, as set out in Appendix 1, to reasonably ensure the provision of the Services.
- 9.2 Hours are as agreed upon by the parties at Appendix 1. It is understood that many circumstances require flexibility of hours and the Physician will respond to these needs.
- 9.3 If the Physician is unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the parties will meet to discuss and develop an approach to attempt to resolve the concern. If they are unable to reach an agreement, either party may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact finding review and issue recommendations. If they are unable to reach agreement following the use of a Trouble Shooter, either the Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

#### **Article 10: Licenses & Qualifications**

- 10.1 During the Term, the Physician will maintain:

- (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration;
  - (b) enrolment in the Medical Services Plan; and
  - (c) all other licences, qualifications, privileges and credentials required to deliver the Services.
- 10.2 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physician will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.
- 10.3 All medical Services under this Contract will be provided either directly by the Physician, or a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

#### **Article 11: Locum Coverage**

- 11.1 The Physician and the Agency will work together in recruiting and retaining qualified locum physicians when necessary. Locum physicians are subject to the approval of the Agency, whose approval will not be unreasonably withheld
- 11.2 In the event a locum is not available, the Agency and the Physician may agree that the Physician will provide hours of service in excess of the annual hours of service specified at Appendix 1. In this event the parties must agree upon appropriate compensation for the additional hours of service.

#### **Article 12: Subcontracting**

- 12.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld. The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

#### **Article 13: Compensation**

- 13.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.
- 13.2 The Agency will pay the Physician pursuant to Appendix 2.
- 13.3 The Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).

- 13.4 The Agency must forward the necessary information with respect to the Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

Benefits Manager  
Doctors of BC  
115 – 1665 West Broadway  
Vancouver, BC V6J 5A4

- 13.5 The Physician is not entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime or statutory holidays.

#### **Article 14: Reporting**

- 14.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health, the same as required for physicians billing fee-for-service, including:
- 14.1.1 the name and identity number of the patient;
  - 14.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;
  - 14.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 14.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 14.1, by providing the information listed at Appendix 4.
- 14.3 The Physician will also:
- (a) report to the Agency all work done by the Physician in connection with the provision of the Services;
  - (b) comply with the reporting obligations set out in Appendix 4 of this Contract; and
  - (c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.

- 14.4 The Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

#### **Article 15: Records**

- 15.1 Where the Physician is providing Services in an Agency facility and the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.
- 15.2 Where the Physician is providing Services in an Agency facility, and the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.
- 15.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.
- 15.4 For the purposes of this Article 15, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.
- 15.5 If requested to do so by the Agency the Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in the Physician's possession or control.

#### **Article 16: Third Party Claims**

- 16.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

#### **Article 17: Liability Protection**

- 17.1 The Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:
- 17.1.1 Where the Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

17.1.2 Membership with the Canadian Medical Protective Association or alternative professional/malpractice protection plan.

- 17.2 All of the insurance required under Article 17.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.
- 17.3 The Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 17 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

#### **Article 18: Confidentiality**

- 18.1 The Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 18.2 The Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:
- 18.2.1 necessary to fulfill the Physician's obligations under this Contract; or
  - 18.2.2 made in accordance with professional obligations as identified by the College of Physicians and Surgeons of BC; or
  - 18.2.3 in reference to this Contract.
- 18.3 For the purposes of this Article 18, information will be deemed to be confidential where all of the following criteria are met:
- 18.3.1 the information is not found in the public domain;
  - 18.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and
  - 18.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

#### **Article 19: Conflict of Interest**

- 19.1 During the Term, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the



performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.

- 19.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 19.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 8 of this Contract.

## **Article 20: Ownership**

- 20.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

## **Article 21: Audit, Evaluation and Assessment**

- 21.1 The Physician acknowledges the auditing authority of the Medical Services Commission under the *Medicare Protection Act*.

## **Article 22: Notices**

- 22.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

22.1.1 If mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

22.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or

22.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 22.

- 22.2 Either party must give notice to the other of a change of address.

- 22.3 Address and e-mail address of Agency:

Address and e-mail address of Physician:

### **Article 23: Amendments**

23.1 This Contract must not be amended except by written agreement of both parties.

### **Article 24: Entire Contract**

24.1 This Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements.

### **Article 25: No Waiver Unless in Writing**

25.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

### **Article 26: Headings**

26.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

### **Article 27: Enforceability and Severability**

27.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

### **Article 28: Physician Master Agreement and Physician Master Subsidiary Agreements**

28.1 This Contract is subject to the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.

28.2 In the event that during the Term, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

## **Article 29: Execution of the Contract**

- 29.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.
- 29.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.
- 29.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

## **Article 30: Physicians as Professional Medical Corporations**

- 30.1 Where the Physician is a professional medical corporation:
- (a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;
  - (b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and
  - (c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this Contract have duly executed this Contract as of the date written above.

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered by the Physician:**

**[Sign here if you are a Physician who is not incorporated]**

\_\_\_\_\_  
Dr.

**[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]**

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## APPENDIX 1

### SERVICES/DELIVERABLES

1. The Physician agrees to provide \_\_\_\_\_ hours of service per year.
2. The Physician will provide the following Services:

- 
- 
- 

*It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physician and the Agency, but must include the following:*

- (a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.
- (b) Those activities that are necessary to satisfy the Physician's obligations under Article 14 and Appendix 3 of this Contract.

3. The Physician will supply the following support, technology, material and supplies:
4. The Agency will provide the following support, technology, material and supplies:

## **APPENDIX 2**

### **PAYMENT**

The Agency will pay the Physician [*bi-weekly/monthly/other*] at the rate of \$\_\_\_\_\_ per day/month/year that the Physician provides Services under the terms of this Contract.

*It is understood and agreed that a more detailed description of the payment processes will be included in this Appendix 2 as negotiated at the local level, and will include either payment on receipt of an invoice for the Services provided or payment on installment with reconciliation where hours worked and reported are less than the minimum contracted hours set out in Appendix 1.*

**APPENDIX 2A**

**INVOICE**

*Insert form of invoice used by Agency.*

**APPENDIX 3A**

**FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Date



### APPENDIX 3B

#### FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

- (a) billings associated with, WCB, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
- (b) billings for all non-insured Services, excluding medical-legal services , and
- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

---

Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date

**APPENDIX 3C**

**FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date

## **APPENDIX 4**

### **REPORTING**

The Physician will comply with the reporting requirements set out below. It is the Physician's responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

*It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physician and the Agency.*

**Schedule “E” to the Alternative Payments Subsidiary Agreement**  
**GROUP TEMPLATE SERVICE CONTRACT**

**BETWEEN:**

**THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED  
ON THE SIGNATURE PAGE OF THIS CONTRACT**

(each is individually a “**Physician**” and collectively all  
are referred to as the “**Physicians**”)

*OR*

*[PARTNERSHIP NAME]*

(the “**Partnership**”)

*OR*

*[CORPORATION NAME]*

(the “**Corporation**”)

*If this Contract is between the Agency and a partnership or a corporation, the Contract requires amendments that reflect the legal status of the parties.*

**AND:**

(the “**Agency**”)

**WHEREAS** the Physicians wish to contract with the Agency and the Agency wishes to contract with the Physicians to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Service Contract;

**THEREFORE** in consideration of the mutual promises contained in this Contract, the Physicians and the Agency agree as follows:

**Article 1: Definitions**

- 1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2019 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2019 Physician Master Agreement or the Physician

Master Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (d) **“Contract”** or **“Service Contract”** means this document including the Appendices, as amended from time to time in accordance with Article 24.
- (e) **“2019 Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government, the Medical Services Commission and the British Columbia Medical Association (**“Doctors of BC”**), as subsequently amended from time to time.
- (f) **“Services”** means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

## **Article 2: Term & Renewal**

- 2.1 This Contract will be in effect from **<insert date>** to **<insert date>** notwithstanding the date of its execution, unless terminated earlier as provided herein (the **“Term”**).
- 2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing:
  - (a) If the Physicians wish to renew this Contract, the Physicians must provide written notice to the Agency no later than ninety (90) days prior to the end of the Term.
  - (b) If the Agency wishes to renew this Contract, it must provide written notice to the Physicians no later than ninety (90) days prior to the end of the Term.

As soon as practical after either the Physicians or the Agency has provided notice in accordance with this clause 2.2, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

- 2.3 Subject to clause 2.4, if both the Physicians and the Agency agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 2.4 In the event that notice is given by either the Physicians or the Agency in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

### **Article 3: Termination**

- 3.1 The Physicians (collectively) or the Agency may terminate the Contract without cause upon six (6) months' written notice to the other, or immediately upon written notice if the other breaches a fundamental term of this Contract.
- 3.2 Subject to clause 3.3 and without affecting the rights and obligations of the remaining Physicians:
  - (a) each Physician has the separate and distinct right to terminate the Contract as between that Physician and the Agency without cause upon six (6) months' written notice to the Agency, with an information copy of such notice to the remaining Physicians; and
  - (b) the Agency may terminate the Contract as between the Agency and any individual Physician without cause upon six (6) months' written notice to that Physician, with an information copy of such notice to the remaining Physicians.
- 3.3 Each Physician or the Agency may terminate the Contract as between that Physician and the Agency immediately upon written notice if the other breaches a fundamental term of this Contract. For clarity, loss of privileges by a Physician related to the Services provided under this Contract is a breach of a fundamental term of this Contract.
- 3.4 No Physician will be required to resign privileges as a result of a termination of the Contract except in accordance with a fully executed and attached Appendix 7 (Resignation of Privileges Under Exclusive Contracts), if applicable. If Appendix 7 is not attached to this Contract or fully executed by the Physicians (collectively) and the Agency, it does not apply or form part of this Contract.

### **Article 4: Relationship of Parties**

- 4.1 Each Physician is an independent contractor to the Agency and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician. No partnership relationship between the Physicians is created by this Contract or by the provision of the Services to the Agency by the Physicians. None of the Physicians intends to carry on a business with a view to profit with the other Physicians in respect of the Services.
- 4.2 None of the Physicians nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 4.3 If a Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:



- (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or
  - (b) if advised by WorkSafeBC that the Physician is a “worker”, advise the Agency and provide the Agency with any related documentation from WorkSafeBC.
- 4.4 If a Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician’s Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.
- 4.5 Each Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers’ compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.
- 4.6 The liability of the Physicians for payments referred to in clause 4.5 is several and not joint.
- 4.7 Each Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from that Physician’s failure to make any payments referred to in clause 4.5.
- 4.8 The indemnity in clause 4.7 survives the expiry or earlier termination of this Contract.

## **Article 5: Unincorporated Groups**

- 5.1 As the Services are provided under this Contract by multiple Physicians, each Physician will be party to, and bound by, this Contract.

*Parties to select one of three options for clause 5.2 in negotiations.*

- 5.2 The Physicians will develop a process or agreement to govern their intra-group relationship.

OR

- 5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the

Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. If the Physicians are failing to provide the Services pursuant to the terms of this Contract on a persistent basis and the Agency reasonably believes that such failure is related to the Physicians' intra-physician group governance agreement, the Agency may request a copy of the intra-physician group governance agreement from the Physicians, and the Physicians will not unreasonably deny the Agency's request.

OR

- 5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. The Physicians will provide the Agency with a copy of the intra-physician group governance agreement within two months of the first day of the Term. Any amendments to the intra-physician group governance agreement made during the Term will be promptly disclosed to the Agency.
- 5.3 Subject to sub-clause 3.2(b), the Physicians may designate a representative from among the Physicians to represent the Physicians with respect to notices, the proposed addition of new physicians to the Contract and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Agency of the identity of the Representative. If the Representative changes during the Term, the Physicians will notify the Agency of the new Representative.
- 5.4 Where a notice under any term of this Contract is to be given to all of the Physicians, the Physicians agree that a single notice to the Representative sent to the address provided in Article 23 will constitute notice to all of the Physicians. Where notice is to be given to less than all of the Physicians, it must be given to those individual Physicians at the address(es) provided at Appendix 5.
- 5.5 In the event of the departure of a Physician pursuant to clauses 3.2 or 3.3, the parties will meet to discuss whether amendments to any Appendices are required and to make agreed changes.
- 5.6 The Physicians must use reasonable efforts to replace departing Physicians.
- 5.7 Any replacement or new physicians that the Physicians propose to add are subject to approval by the Agency in accordance with its normal policies, by-laws, and rules. Such approval will not be unreasonably withheld.
- 5.8 Subject to clause 5.7, for any new physician added to this Contract who is not an initial signatory to this Contract, the Physicians (collectively) or their Representative, the Agency, and the new physician will sign and deliver to the others an acknowledgement and agreement in the form set out in Appendix 6 ("**New Physician – Agreement to**

**Join”**), agreeing that the new physician will become party to and bound by the terms of this Contract.

## **Article 6: Waiver/Assignment**

- 6.1 Unless specified otherwise, each Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. Physicians may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:
- (a) billings for Services associated with WorkSafeBC, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
  - (b) billings for non-insured Services, excluding medical/legal services, and
  - (c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.
- 6.2 Where the Available Amount is not a source of funding for this Contract, each Physician will sign:
- (a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required;
  - (b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.
- 6.3 Where the Available Amount is a source of funding for this Contract, each Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such documentation in connection with such assignment as may be reasonably required.

## **Article 7: Autonomy**

- 7.1 Each Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

- 7.2 Subject to clause 7.1, each Physician is entitled to professional autonomy in the provision of the Services.

### **Article 8: Doctors of BC**

- 8.1 Each Physician separately and the Physicians collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

### **Article 9: Dispute Resolution**

- 9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 9.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Physician(s) and the Agency (the Physician(s) or the Agency, each a **“Party to the Dispute”** or collectively **“Parties to the Dispute”**) are unable to resolve informally at the local level, may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the Parties to the Dispute.. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 9.3 Should the Parties to the Dispute be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any Party to the Dispute seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 9.4 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration.
- 9.5 The Parties to the Dispute must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- 9.6 Any dispute settlement achieved by the Parties to the Dispute, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

## **Article 10: Service Requirements**

- 10.1 The Physicians will provide the Services as described in Appendix 1 and will schedule their availability, as set out in Appendix 1, to reasonably ensure the provision of the Services.
- 10.2 Hours are as agreed upon by the parties at Appendix 1. It is understood that many circumstances require flexibility of hours and the Physicians will respond to these needs.
- 10.3 If the Physicians are unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the Agency and the Physicians will meet to discuss and develop an approach to attempt to resolve the concern. If they are unable to reach an agreement, either the Physicians or the Agency may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact finding review and issue recommendations. If they are unable to reach an agreement following the use of a Trouble Shooter, either the Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

## **Article 11: Licenses & Qualifications**

- 11.1 During the Term, each Physician will maintain:
  - (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration;
  - (b) enrolment in the Medical Services Plan; and
  - (c) all other licences, qualifications, privileges and credentials required to deliver the Services.
- 11.2 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physicians providing the Specialist Services will be and remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.
- 11.3 All medical Services under this Contract will be provided either directly by a Physician, or a resident under the supervision and responsibility of a Physician, or by a clinical fellow under the supervision and responsibility of a Physician.

## **Article 12: Locum Coverage**

- 12.1 The Physicians and the Agency will work together in recruiting and retaining qualified locum physicians when necessary. Locum physicians are subject to the approval of the Agency, whose approval will not be unreasonably withheld
- 12.2 In the event a locum is not available, the Agency and the Physicians may agree that the Physicians will provide hours of service in excess of the annual hours of service specified at Appendix 1. In this event the parties must agree upon appropriate compensation for the additional hours of service.

## **Article 13: Subcontracting**

- 13.1 Each Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld. Each Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

## **Article 14: Compensation**

- 14.1 The Physicians will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.
- 14.2 The Agency will pay the Physicians pursuant to Appendix 2.
- 14.3 Each Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).
- 14.4 The Agency must forward the necessary information with respect to each Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physicians will provide the Agency with any information necessary for the Physicians to access the Benefit Plans not in the possession of the Agency.

Benefits Manager  
Doctors of BC  
115 – 1665 West Broadway  
Vancouver, BC V6J 5A4

- 14.5 No Physician is entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for the Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime or statutory holidays.

## **Article 15: Reporting**

- 15.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:
- 15.1.1 the name and identity number of the patient;
  - 15.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;
  - 15.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 15.2 Each Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 15.1, by providing the information listed at Appendix 4.
- 15.3 Each Physician will also:
- (a) report to the Agency all work done by the Physician in connection with the provision of the Services;
  - (b) comply with the reporting obligations set out in Appendix 4 of this Contract; and
  - (c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.
- 15.4 Each Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

## **Article 16: Records**

- 16.1 Where a Physician is providing Services in an Agency facility and the Agency has procedures in place, each Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.
- 16.2 Where a Physician is providing Services in an Agency facility and the Agency does not have procedures in place, each Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.
- 16.3 The Physicians will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.

- 16.4 For the purposes of this Article 16, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.
- 16.5 If requested to do so by the Agency each Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in that Physician's possession or control.

#### **Article 17: Third Party Claims**

- 17.1 The Physicians and the Agency will provide the others with prompt notice of any action against any of them arising out of this Contract.

#### **Article 18: Liability Protection**

- 18.1 Each Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:
- 18.1.1 Where a Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.
- 18.1.2 Membership with the Canadian Medical Protective Association or an alternative professional/malpractice protection plan.
- 18.2 All of the insurance required under Article 18.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.
- 18.3 Each Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 18 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

#### **Article 19: Confidentiality**

- 19.1 Each Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 19.2 Each Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or



otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:

- 19.2.1 necessary for the Physician to fulfill the Physician's obligations under this Contract; or
  - 19.2.2 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or
  - 19.2.3 in reference to this Contract.
- 19.3 For the purposes of this Article 19, information will be deemed to be confidential where all of the following criteria are met:
- 19.3.1 the information is not found in the public domain;
  - 19.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and
  - 19.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

#### **Article 20: Conflict of Interest**

- 20.1 During the Term, absent the written consent of the Agency, each Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.
- 20.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 20.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

#### **Article 21: Ownership**

- 21.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. Each Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, each Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

#### **Article 22: Audit, Evaluation and Assessment**

- 22.1 Each Physician acknowledges the auditing authority of the Medical Services Commission under the *Medicare Protection Act*.

### **Article 23: Notices**

- 23.1 Any notice, report, or any or all of the documents that either the Physicians or the Agency may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

23.1.1 If mailed by prepaid double registered mail to the addressee's address listed below or in Appendix 5 (as applicable), on date of confirmation of delivery; or

23.1.2 If delivered by hand to the addressee's address listed below or in Appendix 5 (as applicable), on the date of such personal delivery; or

23.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 23 or in Appendix 5 (as applicable).

- 23.2 Each Physician and the Agency must give notice to the other of a change of address.

- 23.3 Address and e-mail address of Agency:

Address and e-mail address of the individual Physicians – see Appendix 5:

*If the Physicians have selected a Representative as per Article 5:*

Address and e-mail address of the Representative:

### **Article 24: Amendments**

- 24.1 This Contract must not be amended except by written agreement of both parties.

### **Article 25: Entire Contract**

- 25.1 This Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements.

### **Article 26: No Waiver Unless in Writing**

- 26.1 No provision of this Contract and no breach by either a Physician or the Agency of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other. The written waiver of a Physician or the Agency of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

#### **Article 27: Headings**

- 27.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

#### **Article 28: Enforceability and Severability**

- 28.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

#### **Article 29: Physician Master Agreement and Physician Master Subsidiary Agreements**

- 29.1 This Contract is subject to the Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.
- 29.2 In the event that during the Term, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the Physicians and the Agency agree to meet on notice by one to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

#### **Article 30: Execution of the Contract**

- 30.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.
- 30.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.
- 30.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

### **Article 31: Physicians as Professional Medical Corporations**

31.1 Where a Physician in this Contract is a professional medical corporation:

- (a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;
- (b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and
- (c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this Contract have duly executed this Contract as of the date written above.

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered by the Physicians:**

**[Sign here if you are a Physician who is not incorporated]**

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Dr.

**[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]**

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## **APPENDIX 1**

### **SERVICES/DELIVERABLES**

1. The Physicians agree to provide \_\_\_\_\_ hours of service per year.
2. The Physicians will provide the following Services:
  - 
  - 
  -

*It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physicians and the Agency, but must include the following:*

- (a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.
  - (b) Those activities that are necessary to satisfy the Physicians' obligations under Article 15 and Appendix 3 of this Contract.
3. The Physicians will supply the following support, technology, material and supplies:
4. The Agency will provide the following support, technology, material and supplies:

## **APPENDIX 2**

### **PAYMENT**

The Agency will pay the Physicians [*bi-weekly/monthly/other*] at the rate of \$\_\_\_\_\_ per day/month/year that the Physicians provide Services under the terms of this Contract.

*If the Agency is paying the individual Physicians, replace “Physicians” above with “each Physician”.*

*If payment is being made to the group via a Representative, additional language should be added to Appendix 2 as follows:*

*Payments will be made to the Representative. It is the responsibility of the Physicians and the Representative to allocate payments among the Physicians providing the Services in accordance with this Contract and their intra-physician process or agreement. Each Physician hereby acknowledges that the Agency is not and will not be responsible for such allocation and for any disagreements between the Physicians over such allocation of payments from the Agency.*

*It is understood and agreed that a more detailed description of the payment processes will be included in this Appendix 2 as negotiated at the local level, and will include either payment on receipt of an invoice for the Services provided or payment on installment with reconciliation where hours worked and reported are less than the minimum contracted hours set out in Appendix 1.*

**APPENDIX 2A**

**INVOICE**

*Insert form of invoice used by Agency.*



**APPENDIX 3A**

**FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [name of Agency] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services covered by and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[   ] Inc.

\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Date

### APPENDIX 3B

#### FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

- (a) billings associated with, WCB, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
- (b) billings for all non-insured Services, excluding medical-legal services , and
- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

---

Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date

**APPENDIX 3C**

**FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Service Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date

## **APPENDIX 4**

### **REPORTING**

Each Physician will comply with the reporting requirements set out below. It is the Physicians' responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

*It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix as negotiated at the local level between the Physicians and the Agency.*

## APPENDIX 5

## PHYSICIAN NAMES AND CONTACT INFORMATION

[illegible]

## APPENDIX 6

### NEW PHYSICIAN - AGREEMENT TO JOIN

#### ("New Physician-Agreement to Join")

Re: **Service Contract effective <insert date> (the "Contract") between the Agency and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Physician - Agreement to Join.**

*[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Physicians" and make other consequential amendments]*

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Physicians, confirms that the Physicians wish to add Dr. \_\_\_\_\_ (the "New Physician") as a "Physician" under the Contract to provide Services to the Agency under the terms of the Contract.
2. The New Physician acknowledges having received a copy of the Contract and hereby agrees with the Agency and the other Physicians that the New Physician will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Physician". The New Physician acknowledges that all payments for Services under the Contract will be made by the Agency to the Physicians as provided in the Contract and that the Representative, currently Dr. \_\_\_\_\_, has been granted certain authority to act as the representative of the Physicians, including the New Physician, under the Contract. [The New Physician confirms that Dr. \_\_\_\_\_ is the "Physician Owner" for the New Physician]
3. The New Physician will become party to any intra-group governance agreement between the Physicians.
4. The New Physician confirms that notices to the Physicians will be delivered as set out in clause 23.3 of the Contract. Where a notice is to be given to less than all of the Physicians, the address for notice for the New Physician is:

▼ ▼

▼ ▼



5. The Agency's agreement to the New Physician joining is subject to the New Physician meeting all credentialing, licensing and other qualifications set out in the Contract (if not already met).
6. All capitalized terms used in this New Physician – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Physician – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this New Physician – Agreement to Join have duly executed this New Physician – Agreement to Join as of the date written above.

\_\_\_\_\_  
**Dr. \_\_\_\_\_ as the Representative**

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered on behalf of the New Physician:**

\_\_\_\_\_  
New Physician's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## APPENDIX 7

### RESIGNATION OF PRIVILEGES UNDER EXCLUSIVE CONTRACTS

1. By executing this Appendix 7, the Physicians (collectively) and the Agency agree that the services provided under the terms of this Contract (in effect from <insert date> to <insert date>) are exclusive to the Contract, such that no such services may be provided to the Agency by any physician that is not a party to the Contract except as provided under Articles 12 and 13 of this Contract.
2. Accordingly, each Physician acknowledges and agrees that an individual Physician who voluntarily terminates this Contract with the Agency pursuant to sub-clause 3.2(a) of the Contract will resign that Physician's privileges related to the Services provided under this Contract. For clarity, this clause does not apply to any other termination under Article 3 of the Contract.

DATED: \_\_\_\_\_

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and delivered by the Physicians:**

[Sign here if you are a Physician who is not incorporated]

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

**Schedule “F” to the Alternative Payments Subsidiary Agreement**

**INDIVIDUAL TEMPLATE SESSIONAL CONTRACT**

**BETWEEN:**

*<name of physician/corporation>*

(the “Physician”)

**AND:**

(the “Agency”)

**WHEREAS** the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Sessional Contract;

**THEREFORE** in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

**Article 1: Definitions**

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2019 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2019 Physician Master Agreement or the Physician Master Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (a) “**Contract**” or “**Sessional Contract**” means this document including the Appendices, as amended from time to time in accordance with Article 22.
- (b) “**Fiscal Quarter**” means a three month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.
- (c) “**2019 Physician Master Agreement**” means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government, the Medical Services Commission and the British Columbia Medical Association (“**Doctors of BC**”), as subsequently amended from time to time.
- (d) “**Services**” means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in

Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

- (e) “**Session**” means 3.5 hours of Services and may be an accumulation of lesser time intervals adding up to 3.5 hours.

## **Article 2: Term & Renewal**

- 2.1 This Contract will be in effect from <insert date> to <insert date> notwithstanding the date of its execution, unless terminated earlier as provided herein (the “**Term**”).
- 2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 2.3 Subject to clause 2.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 2.4 In the event that notice is given by either party in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

## **Article 3: Termination**

- 3.1 Subject to clause 3.2, either party may terminate the Contract without cause upon six (6) months’ written notice to the other party.
- 3.2 Either party may terminate this Contract immediately upon written notice if the other party breaches a fundamental term of this Contract. For clarity, loss of privileges related to the Services provided under this Contract by the Physician is a breach of a fundamental term of this Contract.

## **Article 4: Relationship of Parties**

- 4.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician.
- 4.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.

- 4.3 If the Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:
- (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or
  - (b) if advised by WorkSafeBC that the Physician is a “worker”, advise the Agency and provide the Agency with any related documentation from WorkSafeBC.
- 4.4 If the Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician’s Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.
- 4.5 The Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers’ compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.
- 4.6 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician’s failure to make any payments referred to in clause 4.5.
- 4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

#### **Article 5: Waiver/Assignment**

- 5.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:
- (a) billings for Services associated with WorkSafeBC, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
  - (b) billings for non-insured Services, excluding medical/legal services, and

- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act*, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.
- 5.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign:
- (a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required; or
  - (b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.
- 5.3 Where the Available Amount is a source of funding for this Contract, the Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such other documentation in connection with such assignment as may be reasonably required.

#### **Article 6: Autonomy**

- 6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.
- 6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

#### **Article 7: Doctors of BC**

- 7.1 The Physician is entitled, at the Physician's option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

#### **Article 8: Dispute Resolution**

- 8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

- 8.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 8.3 Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 8.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- 8.5 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- 8.6 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

#### **Article 9: Service Requirements**

- 9.1 The Physician will provide the Services and the number of Sessions as described in Appendix 1.

#### **Article 10: Licenses & Qualifications**

- 10.1 During the Term, the Physician will maintain:
- (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration;
  - (b) enrolment in the Medical Services Plan; and
  - (c) all other licences, qualifications, privileges and credentials required to deliver the Services.

- 10.3 All medical Services under this Contract will be provided either directly by the Physician, or a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

#### **Article 11: Subcontracting**

- 11.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld. The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

#### **Article 12: Compensation**

- 12.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.
- 12.2 The Agency will pay the Physician pursuant to Appendix 2.
- 12.3 The Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).
- 12.4 The Agency must forward the necessary information with respect to the Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

Benefits Manager  
Doctors of BC  
115 – 1665 West Broadway  
Vancouver, BC V6J 5A4

- 12.5 The Physician is not entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime or statutory holidays.

#### **Article 13: Reporting**

- 13.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health, the same as required for physicians billing fee-for-service, including:
- 13.1.1 the name and identity number of the patient;



- 13.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;
- 13.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 13.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 13.1, by providing the information listed at Appendix 4.
- 13.3 The Physician will also:
  - (a) report to the Agency all work done by the Physician in connection with the provision of the Services;
  - (b) comply with the reporting obligations set out in Appendix 4 of this Contract; and
  - (c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.
- 13.4 The Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

#### **Article 14: Records**

- 14.1 Where the Physician is providing Services in an Agency facility and the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.
- 14.2 Where the Physician is providing Services in an Agency facility, and the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.
- 14.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.
- 14.4 For the purposes of this Article 14, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

- 14.5 If requested to do so by the Agency the Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in the Physician's possession or control.

#### **Article 15: Third Party Claims**

- 15.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

#### **Article 16: Liability Protection**

- 16.1 The Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:

16.1.1 Where the Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

16.1.2 Membership with the Canadian Medical Protective Association or alternative professional/malpractice protection plan.

- 16.2 All of the insurance required under Article 16.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.
- 16.3 The Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 16 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

#### **Article 17: Confidentiality**

- 17.1 The Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 17.2 The Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:

- 17.2.1 necessary to fulfill the Physician's obligations under this Contract; or
  - 17.2.2 made in accordance with professional obligations as identified by the College of Physicians and Surgeons of BC; or
  - 17.2.3 in reference to this Contract.
- 17.3 For the purposes of this Article 17, information will be deemed to be confidential where all of the following criteria are met:
- 17.3.1 the information is not found in the public domain;
  - 17.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and
  - 17.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

#### **Article 18: Conflict of Interest**

- 18.1 During the Term, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.
- 18.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 18.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 8 of this Contract.

#### **Article 19: Ownership**

- 19.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

#### **Article 20: Audit, Evaluation and Assessment**

- 20.1 The Physician acknowledges the auditing authority of the Medical Services Commission under the *Medicare Protection Act*.

## **Article 21: Notices**

- 21.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
- 21.1.1 If mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or
- 21.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or
- 21.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 21.
- 21.2 Either party must give notice to the other of a change of address.
- 21.3 Address and e-mail address of Agency:
- Address and e-mail address of Physician:

## **Article 22: Amendments**

- 22.1 This Contract must not be amended except by written agreement of both parties.

## **Article 23: Entire Contract**

- 23.1 This Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements.

## **Article 24: No Waiver Unless in Writing**

- 24.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

## **Article 25: Headings**

- 25.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

## **Article 26: Enforceability and Severability**

- 26.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

## **Article 27: Physician Master Agreement and Physician Master Subsidiary Agreements**

- 27.1 This Contract is subject to the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.
- 27.2 In the event that during the Term, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

## **Article 28: Execution of the Contract**

- 28.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts will be construed together and will constitute one and the same original agreement.
- 28.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.
- 28.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

## **Article 29: Physicians as Professional Medical Corporations**

- 29.1 Where the Physician is a professional medical corporation:
- (a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills,

in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;

- (b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and
- (c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this Contract have duly executed this Contract as of the date written above.

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered by the Physician:**

**[Sign here if you are a Physician who is not incorporated]**

\_\_\_\_\_  
Dr.

**[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]**

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## APPENDIX 1

### SERVICES/DELIVERABLES

1. Subject to paragraph 2 of this Appendix 1, the Physician shall provide \_\_\_\_\_ Sessions per fiscal year during the Term in the \_\_\_\_\_ [*insert Program/Department*], at \_\_\_\_\_ [*insert site or sites*].
2. If during any Fiscal Quarter during the Term, the Physician provides fewer than \_\_\_\_\_ Sessions [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] then the Agency may reallocate from this Contract a number of sessions up to the number that is equal to the difference between \_\_\_\_\_ [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] and the number of Sessions provided by the Physician during the Fiscal Quarter in question, in which case the total number of Sessions to be provided by the Physician under this Contract will be automatically reduced by the number of Sessions reallocated.
3.
  - (a) Subject to paragraph 3 (b) of this Appendix 1, the Physician will provide the Sessions in accordance with a schedule established by the parties, in advance for each Fiscal Quarter.
  - (b) It is understood that the schedule established in accordance with paragraph 3 (a) of this Appendix 1 will be the expected and typical schedule but that variations may occur to it from time to time due to planned time off for the Physician, and client needs and care commitments of greater urgency. Unless impracticable, such variations will be discussed between the Physician and the \_\_\_\_\_ in advance.
4. In the event that in order to meet operational requirements, the Agency and the Physician agree that the Physician will provide Services beyond the Sessions agreed to in paragraph 1 above, the Agency will ensure that the Physician receives payment for such Services at the appropriate sessional rate.
5. The Physician will provide the following Services:

*It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physician and the Agency, but must include the following:*

- (a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.
- (b) Those activities that are necessary to satisfy the Physician's obligations under Article 13 and Appendix 3 of this Contract.



5. The Physician will supply the following support, technology, material and supplies:
6. The Agency will provide the following support, technology, material and supplies:

## **APPENDIX 2**

### **PAYMENT**

1. The Agency will pay the Physician at the rate of \$\_\_\_\_\_ per Session that the Physician provides under the terms of this Contract upon receipt of the invoice for the Services provided.
2. Subject to section 4 of Appendix 1, the total amount paid by the Agency to the Physician under this Contract will not exceed \$\_\_\_\_\_.
3. All invoices for Services provided under this Contract must:
  - (a) identify by date and hours the Sessions or partial Sessions for which payment is claimed;
  - (b) be accompanied by an identification of the specific Service(s) provided during each such Session or partial Session using the Agency's sessional coding system; and
  - (c) be submitted to the Agency within 30 days following the end of the month during which the Services were provided.

**APPENDIX 2A**

**INVOICE**

*Insert form of invoice used by Agency.*

**APPENDIX 3A**

**FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Date

## APPENDIX 3B

### FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

- (a) billings associated with, WCB, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
- (b) billings for all non-insured Services, excluding medical-legal services , and
- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

---

Physician's Signature (unincorporated)

or

[     ] Inc.

---

Authorized Signatory

---

Date

### APPENDIX 3C

#### FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [name of Agency] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date



## **APPENDIX 4**

### **REPORTING**

The Physician will comply with the reporting requirements set out below. It is the Physician's responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

*It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physician and the Agency.*

**Schedule “F” to the Alternative Payments Subsidiary Agreement**

**GROUP TEMPLATE SESSIONAL CONTRACT**

**BETWEEN:**

**THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED  
ON THE SIGNATURE PAGE OF THIS CONTRACT**

(each is individually a “**Physician**” and collectively all  
are referred to as the “**Physicians**”)

*OR*

*[PARTNERSHIP NAME]*

(the “**Partnership**”)

*OR*

*[CORPORATION NAME]*

(the “**Corporation**”)

*If this Contract is between the Agency and a partnership or a corporation, the Contract requires  
amendments that reflect the legal status of the parties.*

**AND:**

(the “**Agency**”)

**WHEREAS** the Physicians wish to contract with the Agency and the Agency wishes to contract with the Physicians to provide clinical and related teaching, research and clinical administrative services on the terms, conditions and understandings set out in this Sessional Contract;

**THEREFORE** in consideration of the mutual promises contained in this Contract, the Physicians and the Agency agree as follows:

**Article 1: Definitions**

- 1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2019 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2019 Physician Master Agreement or the Physician

Master Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (a) “**Contract**” or “**Sessional Contract**” means this document including the Appendices, as amended from time to time in accordance with Article 23.
- (b) “**Fiscal Quarter**” means a three month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.
- (c) “**2019 Physician Master Agreement**” means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government, the Medical Services Commission and the British Columbia Medical Association (“**Doctors of BC**”), as subsequently amended from time to time.
- (d) “**Services**” means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.
- (e) “**Session**” means 3.5 hours of Services and may be an accumulation of lesser time intervals adding up to 3.5 hours.

## **Article 2: Term & Renewal**

- 2.1 This Contract will be in effect from <insert date> to <insert date> notwithstanding the date of its execution, unless terminated earlier as provided herein (the “**Term**”).
- 2.2 This Contract may be renewed for such period of time and on the terms as the parties may mutually agree to in writing:
  - (a) If the Physicians wish to renew this Contract, the Physicians must provide written notice to the Agency no later than ninety (90) days prior to the end of the Term.
  - (b) If the Agency wishes to renew this Contract, it must provide written notice to the Physicians no later than ninety (90) days prior to the end of the Term.

As soon as practical after either the Physicians or the Agency has provided notice in accordance with this clause 2.2, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.

- 2.3 Subject to clause 2.4, if both the Physicians and the Agency agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 2.4 In the event that notice is given by either the Physicians or the Agency in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following

the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

### **Article 3: Termination**

- 3.1 The Physicians (collectively) or the Agency may terminate the Contract without cause upon six (6) months' written notice to the other, or immediately upon written notice if the other breaches a fundamental term of this Contract.
- 3.2 Subject to clause 3.3 and without affecting the rights and obligations of the remaining Physicians:
  - (a) each Physician has the separate and distinct right to terminate the Contract as between that Physician and the Agency without cause upon six (6) months' written notice to the Agency, with an information copy of such notice to the remaining Physicians; and
  - (b) the Agency may terminate the Contract as between the Agency and any individual Physician without cause upon six (6) months' written notice to that Physician, with an information copy of such notice to the remaining Physicians.
- 3.3 Each Physician or the Agency may terminate the Contract as between that Physician and the Agency immediately upon written notice if the other breaches a fundamental term of this Contract. For clarity, loss of privileges by a Physician related to the Services provided under this Contract is a breach of a fundamental term of this Contract.

### **Article 4: Relationship of Parties**

- 4.1 Each Physician is an independent contractor to the Agency and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract or by the provision of the Services to the Agency by the Physician. No partnership relationship between the Physicians is created by this Contract or by the provision of the Services to the Agency by the Physicians. None of the Physicians intends to carry on a business with a view to profit with the other Physicians in respect of the Services.
- 4.2 None of the Physicians nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 4.3 If a Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:
  - (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of

whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or

(b) if advised by WorkSafeBC that the Physician is a “worker”, advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

- 4.4 If a Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician’s Option), the Physician will provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible.
- 4.5 Each Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers’ compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.
- 4.6 The liability of the Physicians for payments referred to in clause 4.5 is several and not joint.
- 4.7 Each Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from that Physician’s failure to make any payments referred to in clause 4.5.
- 4.8 The indemnity in clause 4.7 survives the expiry or earlier termination of this Contract.

## **Article 5: Unincorporated Groups**

- 5.1 As the Services are provided under this Contract by multiple Physicians, each Physician will be party to, and bound by, this Contract.

*Parties to select one of three options for clause 5.2 in negotiations.*

- 5.2 The Physicians will develop a process or agreement to govern their intra-group relationship.

OR

- 5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. If the Physicians are

failing to provide the Services pursuant to the terms of this Contract on a persistent basis and the Agency reasonably believes that such failure is related to the Physicians' intra-physician group governance agreement, the Agency may request a copy of the intra-physician group governance agreement from the Physicians, and the Physicians will not unreasonably deny the Agency's request.

OR

- 5.2 The Physicians will develop an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes a party to the intra-physician group governance agreement. The Physicians will provide the Agency with a copy of the intra-physician group governance agreement within two months of the first day of the Term. Any amendments to the intra-physician group governance agreement made during the Term will be promptly disclosed to the Agency.
- 5.3 Subject to sub-clause 3.2(b), the Physicians may designate a representative from among the Physicians to represent the Physicians with respect to notices, the proposed addition of new physicians to the Contract and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Agency of the identity of the Representative. If the Representative changes during the Term, the Physicians will notify the Agency of the new Representative.
- 5.4 Where a notice under any term of this Contract is to be given to all of the Physicians, the Physicians agree that a single notice to the Representative sent to the address provided in Article 22 will constitute notice to all of the Physicians. Where notice is to be given to less than all of the Physicians, it must be given to those individual Physicians at the address(es) provided at Appendix 5.
- 5.5 In the event of the departure of a Physician pursuant to clauses 3.2 or 3.3, the parties will meet to discuss whether amendments to any Appendices are required and to make agreed changes.
- 5.6 The Physicians must use reasonable efforts to replace departing Physicians.
- 5.7 Any replacement or new physicians that the Physicians propose to add are subject to approval by the Agency in accordance with its normal policies, by-laws, and rules. Such approval will not be unreasonably withheld.
- 5.8 Subject to clause 5.7, for any new physician added to this Contract who is not an initial signatory to this Contract, the Physicians (collectively) or their Representative, the Agency, and the new physician will sign and deliver to the others an acknowledgement and agreement in the form set out in Appendix 6 ("**New Physician – Agreement to Join**"), agreeing that the new physician will become party to and bound by the terms of this Contract.

## **Article 6: Waiver/Assignment**

- 6.1 Unless specified otherwise, each Physician must not retain fee-for-service billings, including third party billings, for the Services provided under the terms of this Contract. Physicians may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract. For the purposes of this Article, third party billings include but are not limited to:
- (a) billings for Services associated with WorkSafeBC, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
  - (b) billings for non-insured Services, excluding medical/legal services, and
  - (c) billings for Services provided to persons who are not beneficiaries under the Medicare Protection Act, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.
- 6.2 Where the Available Amount is not a source of funding for this Contract, each Physician will sign:
- (a) a waiver in the form attached hereto as Appendix 3A and such other documentation in connection with such waiver as may be reasonably required;
  - (b) if the Physician is required to assign to the Agency any and all rights the Physician has to receive third party billings for any of the Services provided under the terms of this Contract, a waiver and assignment in the form attached hereto as Appendix 3B and such other documentation in connection with such waiver and assignment as may be reasonably required.
- 6.3 Where the Available Amount is a source of funding for this Contract, each Physician will assign to the Agency any and all rights the Physician has to receive fee-for-service payments from the Available Amount for any of the Services provided under the terms of this Contract and will sign an assignment in the form attached hereto as Appendix 3C and such documentation in connection with such assignment as may be reasonably required.

## **Article 7: Autonomy**

- 7.1 Each Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws, rules, and regulations that are not inconsistent with or represent a material change to the terms of this Contract.
- 7.2 Subject to clause 7.1, each Physician is entitled to professional autonomy in the provision of the Services.

## **Article 8: Doctors of BC**

- 8.1 Each Physician separately and the Physicians collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

## **Article 9: Dispute Resolution**

- 9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 9.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Physician(s) and the Agency (the Physician(s) or the Agency, each a “**Party to the Dispute**” or collectively “**Parties to the Dispute**”) are unable to resolve informally at the local level, may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the Parties to the Dispute. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 9.3 Should the Parties to the Dispute be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any Party to the Dispute seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 9.4 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration.
- 9.5 The Parties to the Dispute must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC will have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- 9.6 Any dispute settlement achieved by the Parties to the Dispute, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

## **Article 10: Service Requirements**

- 10.1 The Physicians will provide the Services and the number of Sessions as described in Appendix 1.



## **Article 11: Licenses & Qualifications**

11.1 During the Term, each Physician will maintain:

- (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration;
- (b) enrolment in the Medical Services Plan; and
- (c) all other licences, qualifications, privileges and credentials required to deliver the Services.

11.3 All medical Services under this Contract will be provided either directly by a Physician, or a resident under the supervision and responsibility of a Physician, or by a clinical fellow under the supervision and responsibility of a Physician.

## **Article 12: Subcontracting**

12.1 Each Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld. Each Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

## **Article 13: Compensation**

13.1 The Physicians will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 2A.

13.2 The Agency will pay the Physicians pursuant to Appendix 2.

13.3 Each Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).

13.4 The Agency must forward the necessary information with respect to each Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physicians will provide the Agency with any information necessary for the Physicians to access the Benefit Plans not in the possession of the Agency.

Benefits Manager  
Doctors of BC  
115 – 1665 West Broadway  
Vancouver, BC V6J 5A4

- 13.5 No Physician is entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for the Physicians or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime or statutory holidays.

#### **Article 14: Reporting**

- 14.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:
- 14.1.1 the name and identity number of the patient;
  - 14.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service;
  - 14.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 14.2 Each Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 14.1, by providing the information listed at Appendix 4.
- 14.3 Each Physician will also:
- (a) report to the Agency all work done by the Physician in connection with the provision of the Services;
  - (b) comply with the reporting obligations set out in Appendix 4 of this Contract; and
  - (c) complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 4) of the Agency's written request.
- 14.4 Each Physician is responsible for the accuracy of all information and reports submitted by the Physician to the Agency.

#### **Article 15: Records**

- 15.1 Where a Physician is providing Services in an Agency facility and the Agency has procedures in place, each Physician will create Clinical Records in the clinical charts that are established by and owned by the Agency and used by the facility where the Services are provided.

- 15.2 Where a Physician is providing Services in an Agency facility and the Agency does not have procedures in place, each Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.
- 15.3 The Physicians will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.
- 15.4 For the purposes of this Article 15, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.
- 15.5 If requested to do so by the Agency each Physician will promptly return to the Agency all materials, including all findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician or provided to the Physician by the Agency in connection with the Services, that are in that Physician's possession or control.

#### **Article 16: Third Party Claims**

- 16.1 The Physicians and the Agency will provide the others with prompt notice of any action against any of them arising out of this Contract.

#### **Article 17: Liability Protection**

- 17.1 Each Physician will, without limiting the Physician's obligations or liabilities herein, purchase, maintain, and cause any sub-contractors to maintain, throughout the Term:
  - 17.1.1 Where a Physician owns or rents the premises where the Services are provided, comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.
  - 17.1.2 Membership with the Canadian Medical Protective Association or an alternative professional/malpractice protection plan.
- 17.2 All of the insurance required under Article 17.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.
- 17.3 Each Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 17 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

## **Article 18: Confidentiality**

- 18.1 Each Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 18.2 Each Physician must not, without the prior written consent of the Agency, publish, release, or disclose or permit to be published, released, or disclosed before, during the Term or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is required or permitted by law and is:
- 18.2.1 necessary for the Physician to fulfill the Physician's obligations under this Contract; or
  - 18.2.2 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or
  - 18.2.3 in reference to this Contract.
- 18.3 For the purposes of this Article 18, information will be deemed to be confidential where all of the following criteria are met:
- 18.3.1 the information is not found in the public domain;
  - 18.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and
  - 18.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

## **Article 19: Conflict of Interest**

- 19.1 During the Term, absent the written consent of the Agency, each Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest under this Contract.
- 19.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 19.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

## **Article 20: Ownership**

- 20.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. Each Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, each Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

## **Article 21: Audit, Evaluation and Assessment**

- 21.1 Each Physician acknowledges the auditing authority of the Medical Services Commission under the *Medicare Protection Act*.

## **Article 22: Notices**

- 22.1 Any notice, report, or any or all of the documents that either the Physicians or the Agency may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

22.1.1 If mailed by prepaid double registered mail to the addressee's address listed below or in Appendix 5 (as applicable), on date of confirmation of delivery; or

22.1.2 If delivered by hand to the addressee's address listed below or in Appendix 5 (as applicable), on the date of such personal delivery; or

22.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 22 or in Appendix 5 (as applicable).

- 22.2 Each Physician and the Agency must give notice to the other of a change of address.

- 22.3 Address and e-mail address of Agency:

Address and e-mail address of the individual Physicians – see Appendix 5:

*If the Physicians have selected a Representative as per Article 5:*

Address and e-mail address of the Representative:

## **Article 23: Amendments**

- 23.1 This Contract must not be amended except by written agreement of both parties.

#### **Article 24: Entire Contract**

- 24.1 This Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements.

#### **Article 25: No Waiver Unless in Writing**

- 25.1 No provision of this Contract and no breach by either a Physician or the Agency of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other. The written waiver of a Physician or the Agency of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

#### **Article 26: Headings**

- 26.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

#### **Article 27: Enforceability and Severability**

- 27.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

#### **Article 28: Physician Master Agreement and Physician Master Subsidiary Agreements**

- 28.1 This Contract is subject to the Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.
- 28.2 In the event that during the Term, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the Physicians and the Agency agree to meet on notice by one to the other to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

#### **Article 29: Execution of the Contract**

- 29.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document.

All counterparts will be construed together and will constitute one and the same original agreement.

- 29.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.
- 29.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form will be the equivalent of an original written paper agreement between the parties.

### **Article 30: Physicians as Professional Medical Corporations**

- 30.1 Where a Physician in this Contract is a professional medical corporation:
- (a) the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a professional medical corporation;
  - (b) the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a professional medical corporation; and
  - (c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this Contract have duly executed this Contract as of the date written above.

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered by the Physicians:**

**[Sign here if you are a Physician who is not incorporated]**

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Dr.

**[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]**

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory



## APPENDIX 1

### SERVICES/DELIVERABLES

1. Subject to paragraph 2 of this Appendix 1, the Physicians shall provide \_\_\_\_\_ Sessions per fiscal year during the Term in the \_\_\_\_\_ [*insert Program/Department*], at \_\_\_\_\_ [*insert site or sites*].
2. If during any Fiscal Quarter during the Term, the Physicians provide fewer than \_\_\_\_\_ Sessions [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] then the Agency may reallocate from this Contract a number of sessions up to the number that is equal to the difference between \_\_\_\_\_ [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] and the number of Sessions provided by the Physicians during the Fiscal Quarter in question, in which case the total number of Sessions to be provided by the Physicians under this Contract will be automatically reduced by the number of Sessions reallocated.
3.
  - (a) Subject to paragraph 3 (b) of this Appendix 1, the Physicians will provide the Sessions in accordance with a schedule established by the Physicians and the Agency, in advance for each Fiscal Quarter.
  - (b) It is understood that the schedule established in accordance with paragraph 3 (a) of this Appendix 1 will be the expected and typical schedule but that variations may occur to it from time to time due to planned time off for the Physician, and client needs and care commitments of greater urgency. Unless impracticable, such variations will be discussed between the Physician and the \_\_\_\_\_ in advance.
4. In the event that in order to meet operational requirements, the Agency and the Physicians agree that the Physicians will provide Services beyond the Sessions agreed to in paragraph 1 above, the Agency will ensure that the Physician receives payment for such Services at the appropriate sessional rate.
5. The Physicians will provide the following Services:

*It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix as negotiated at the local level between the Physicians and the Agency, but must include the following:*

- (a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.

- (b) Those activities that are necessary to satisfy the Physicians' obligations under Article 14 and Appendix 3 of this Contract.
- 6. The Physicians will supply the following support, technology, material and supplies:
- 7. The Agency will provide the following support, technology, material and supplies:

## APPENDIX 2

### PAYMENT

1. The Agency will pay the Physicians at the rate of \$\_\_\_\_\_ per Session that the Physicians provide under the terms of this Contract upon receipt of the invoice for the Services provided.
2. Subject to section 4 of Appendix 1, the total amount paid by the Agency to the Physicians under this Contract will not exceed \$\_\_\_\_\_.
3. All invoices for Services provided under this Contract must:
  - (a) identify by date and hours the Sessions or partial Sessions for which payment is claimed;
  - (b) be accompanied by an identification of the specific Service(s) provided during each such Session or partial Session using the Agency's sessional coding system; and
  - (c) be submitted to the Agency within 30 days following the end of the month during which the Services were provided.

*If the Agency is paying the individual Physicians, replace "Physicians" above with "each Physician".*

*If payment is being made to the group via a Representative, additional language should be added to Appendix 2 as follows:*

*Payments will be made to the Representative. It is the responsibility of the Physicians and the Representative to allocate payments among the Physicians providing the Services in accordance with this Contract and their intra-physician process or agreement. Each Physician hereby acknowledges that the Agency is not and will not be responsible for such allocation and for any disagreements between the Physicians over such allocation of payments from the Agency.*

**APPENDIX 2A**

**INVOICE**

*Insert form of invoice used by Agency.*

**APPENDIX 3A**

**FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER**

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services covered by and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan or third parties with respect to such Services.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Date

### APPENDIX 3B

#### FEE FOR SERVICE WAIVER AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician has to receive any fee for service payments from the Medical Services Plan with respect to such Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive any payments for any such Services from any third party including but not limited to:

- (a) billings associated with, WCB, ICBC, Armed Forces, Corrections (provincial and federal), Interim Federal Health Programs for Refugee Claimants and disability insurers,
- (b) billings for all non-insured Services, excluding medical-legal services , and
- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the

Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

---

Physician's Signature (unincorporated)

or

[    ] Inc.

---

Authorized Signatory

---

Date

### APPENDIX 3C

#### FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician/Corporation Name \_\_\_\_\_

MSP Practitioner Number \_\_\_\_\_

All capitalized terms herein have the meaning given to them in the Sessional Contract between the undersigned and [*name of Agency*] dated \_\_\_\_\_.

The Physician acknowledges that the payments paid to the Physician (or to the Representative on the Physician's behalf) by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby assigns to the Agency any and all rights the Physician has to receive fee for service payments from the Medical Service Plan and third parties with respect to such Services.

The Physician will execute all documents and provide all information and paperwork not already in the Agency's possession relating to the Services provided under the terms of the Contract that are necessary for the Agency to bill, and/or to permit and assist the Agency to bill, the Medical Services Plan according to the Medical Services Commission Payment Schedule for all third party billings with respect to those third parties for whom MSP acts as a processing agent, (including but not limited to ICBC and those Canadian provinces that have reciprocal payment arrangements with the province of British Columbia). For all other third party billings, the Physician will, as reasonably required, assist the Agency to submit claims directly to, or otherwise as required by, the relevant third party.

*Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.*

\_\_\_\_\_  
Physician's Signature (unincorporated)



or

[    ] Inc.

---

Authorized Signatory

---

Date

## **APPENDIX 4**

### **REPORTING**

Each Physician will comply with the reporting requirements set out below. It is the Physicians' responsibility to ensure that all reports/forms are completed and submitted as set out below, and in particular:

*It is understood and agreed that more detailed descriptions of the reporting requirements will be included in this Appendix 4 as negotiated at the local level between the Physicians and the Agency.*



## APPENDIX 6

### NEW PHYSICIAN - AGREEMENT TO JOIN

#### ("New Physician-Agreement to Join")

Re: **Sessional Contract effective <insert date> (the "Contract") between the Agency and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Physician - Agreement to Join.**

*[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Physicians" and make other consequential amendments]*

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Physicians, confirms that the Physicians wish to add Dr. \_\_\_\_\_ (the "New Physician") as a "Physician" under the Contract to provide Services to the Agency under the terms of the Contract.
2. The New Physician acknowledges having received a copy of the Contract and hereby agrees with the Agency and the other Physicians that the New Physician will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Physician". The New Physician acknowledges that all payments for Services under the Contract will be made by the Agency to the Physicians as provided in the Contract and that the Representative, currently Dr. \_\_\_\_\_, has been granted certain authority to act as the representative of the Physicians, including the New Physician, under the Contract. [The New Physician confirms that Dr. \_\_\_\_\_ is the "Physician Owner" for the New Physician]
3. The New Physician will become party to any intra-group governance agreement between the Physicians.
4. The New Physician confirms that notices to the Physicians will be delivered as set out in clause 22.3 of the Contract. Where a notice is to be given to less than all of the Physicians, the address for notice for the New Physician is:

▼▼

▼▼

5. The Agency's agreement to the New Physician joining is subject to the New Physician meeting all credentialing, licensing and other qualifications set out in the Contract (if not already met).
6. All capitalized terms used in this New Physician – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Physician – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this New Physician – Agreement to Join have duly executed this New Physician – Agreement to Join as of the date written above.

\_\_\_\_\_  
**Dr. \_\_\_\_\_ as the Representative**

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered on behalf of the New Physician:**

\_\_\_\_\_  
New Physician's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

**Schedule “G” to the Alternative Payments Subsidiary Agreement**

**CLASSIFICATION CRITERIA FOR COMMUNITY MEDICINE/PUBLIC HEALTH  
AREAS A-D PRACTICE CATEGORIES –  
Salary Agreements and Service Contracts**

**Subject to amendment by the Allocation Committee under Article 4.**

**General Principles**

*Community Medicine/Public Health (CMPH) Physician* shall be the title of the job group used to classify physician positions that require the practice of Public Health or Community Medicine. This includes, for example, Medical Health Officers (MHOs), Public Health Epidemiologists, Community Medicine Consultants, and First Nations Medical/Public Health Advisors.

Physician positions that are matched to the CMPH classification require graduation from a medical school of recognized standing with a degree of Doctor of Medicine and membership in good standing with the College of Physicians and Surgeons of British Columbia.

Physician positions that are matched to the CMPH classification and are compensated through a Salary Agreement or Service Contract shall be paid in accordance with the Salary Agreement Range or Service Contract Range, as applicable, for the Community Medicine/Public Health Areas A-D in accordance with the Application section below.

**Application**

1. Area A is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is not certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty and does not have a Master’s degree in Public Health (e.g., a GP working in the job of MHO) or where such specialty or degree is not relevant to the duties of the job.
2. Area B is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician has the additional training of a Master’s degree in Public Health or the equivalent Master’s degree, provided that the degree is relevant to the duties of the job.
3. Area C is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job.

4. Physician positions that include the administrative roles of supervising other physicians and establishing program policy (e.g., Chief Medical Health Officer, Director Epidemiology) move to the next higher Area (e.g., a Chief MHO who is a GP would fall within Area B; a Chief MHO who has a relevant Master's degree would fall within Area C; a Chief MHO who has a relevant Specialist certification would fall within Area D).
5. Area D is reserved for physician positions that include the administrative roles of supervising other physicians and establishing program policy AND where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job (i.e., all criteria must be met).

**APPENDIX E**

**2019 BENEFITS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1st day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the  
Minister of Health

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2014 PMA, the 2014 General Practitioners Subsidiary Agreement, the 2014 Specialists Subsidiary Agreement, the 2014 Rural Practice Subsidiary Agreement, the 2014 Alternative Payments Subsidiary Agreement and the 2014 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Benefits Subsidiary Agreement, to take effect as of April 1, 2019; and

C. The parties intend this Agreement to:

- (a) identify the benefits that are available to physicians through agreements between the parties;
- (b) describe threshold eligibility for participation in the Benefit Plans, subject to the specific terms, conditions, rules and eligibility criteria applicable to each Benefit Plan;
- (c) assign responsibility for the oversight and administration of the Benefit Plans; and
- (d) identify the funding for the Benefit Plans.



**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

## **ARTICLE 1 - RELATIONSHIP TO THE 2019 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2019 Physician Master Agreement and is subject to its terms and conditions.

## **ARTICLE 2 – DEFINITIONS AND INTERPRETATION**

2.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement have the same meaning as in the 2019 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 **“this Agreement”** means this document including the Schedules, as amended from time to time as provided herein.

2.3 **“Benefit Plans”** means the CME, the PDI, the CMPA Rebate Program, the CPRSP, the PHP, and the Parental Leave Program.

2.4 **“CMPA Rebate Program”** means the Canadian Medical Protective Association Rebate Program referred to in Schedule “C” to this Agreement.

2.5 **“CME”** means the Continuing Medical Education Fund referred to in Schedule “B” to this Agreement.

2.6 **“CPRSP”** means the Contributory Professional Retirement Savings Plan referred to in Schedule “D” to this Agreement.

2.7 **“Parental Leave Program”** means the program referred to in Schedule “E” to this Agreement.

2.8 **“PDI”** means the Physician Disability Insurance Program referred to in Schedule “A” to this Agreement.

2.9 **“PHP”** means the Physician Health Program operated by the Doctors of BC to provide advocacy and support for physicians, including those in training, and their families, who are experiencing problems related to personal and family emotional health issues, the inappropriate use of alcohol and/or drugs or coping with physical illness.

2.10 **“2019 Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” among the Government, the Doctors of BC, and the MSC, dated April 1, 2019.

2.11 The provisions of sections 1.2 to 1.8 inclusive of the 2019 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

### ARTICLE 3 - TERM

- 3.1 This Agreement comes into force on April 1, 2019.
- 3.2 This Agreement shall be for the same term as the 2019 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 26 and 27 of the 2019 Physician Master Agreement.

### ARTICLE 4 - PHYSICIAN BENEFITS COMMITTEE

- 4.1 The Government and the Doctors of BC will continue the **Benefits Committee** which provides oversight of the Benefit Plans and the administration of them.
- 4.2 The Benefits Committee will be composed of up to three members appointed by the Doctors of BC and up to three members appointed by the Government, and will be co-chaired by one member chosen by the Doctors of BC Board of Directors and one member chosen by the Government appointees.
- 4.3 The Benefits Committee must meet a minimum of two times per year, unless the members of the Benefits Committee agree to additional meetings or the Physician Services Committee directs additional meetings, in which case the Benefits Committee must hold such additional meetings.
- 4.4 The terms of reference of the Benefits Committee will include:
- (a) providing general oversight of the Benefit Plans within the available funding, consistent with the terms of this Agreement and the 2019 Benefits Administration Agreement;
  - (b) determining when there is a surplus in funding for any of the Benefit Plans and allocating any such surplus in accordance with this Agreement;
  - (c) identifying and making changes to the specific terms, conditions, rules, eligibility criteria and benefits associated with each of the Benefit Plans, except the PHP, to maximize the benefits realized within the budget for each Benefit Plan; and
  - (d) discovering whether or not physicians who are compensated by Salary Agreements are entitled to make any contribution to an RRSP and, if so, considering whether to provide a partial CPRSP benefit to such physicians.
- 4.5 The Benefits Committee will make decisions by consensus decision.
- 4.6 If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to sections 4.4(a) or (b), the Government and/or the Doctors of BC may make recommendations to the Adjudicator regarding such matter. If the Government or the Doctors of BC initially refers the matter to the Adjudicator, the opposing party may, at their election and within 10 days of the receipt of the notice advise that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter

will be dealt with by the Adjudication Committee. The Adjudicator or the Adjudication Committee, as the case may be, shall then determine the matter. If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to section 4.4(c) or section 4.4(d), the Government and/or the Doctors of BC may refer the matter to the Physician Services Committee and the Physician Services Committee will attempt to resolve the matter, failing which there will be no change to the Benefit Plan(s) in issue.

4.7 On an annual basis, the Benefits Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2019 Physician Master Agreement.

4.8 The Benefits Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Benefits Committee pre-approve any communication about the business and/or decisions of the Benefits Committee.

## **ARTICLE 5 – IDENTIFICATION OF BENEFIT PLANS**

5.1 Subject to section 5.2, the following Benefit Plans will be available to physicians who have not made an election under Section 14 of the *Medicare Protection Act* and who are not subject to an order made under Section 15(2)(a) or (b) of the *Medicare Protection Act*, under the terms and conditions that are described in the 2019 Physician Master Agreement, this Agreement and any of the other Physician Master Subsidiary Agreements:

- (a) the CME;
- (b) the PDI;
- (c) the CMPA Rebate Program;
- (d) the CPRSP;
- (e) the PHP; and
- (f) the Parental Leave Program.

5.2 The Benefit Plans, other than the PHP, are generally described in Schedules A through E. The specific terms, conditions, rules, eligibility criteria and benefits associated with each Benefit Plan, other than the PHP, are as approved and published by the Benefits Committee from time to time.

## **ARTICLE 6 - FUNDING**

6.1 The annual base funding for the PDI, CME, CPRSP and Parental Leave Program is as follows:

- (a) \$11,700,000 for the PDI;

- (b) \$9,725,000 for the CME;
- (c) \$52,370,000 for the CPRSP;
- (d) \$4,300,000 for the Parental Leave Program; and
- (e) \$4,690,000 to be allocated on annual basis by the Benefits Committee among the PDI, CME, CPRSP, and Parental Leave Program.

6.2 The Government will continue to provide the following funds \$17.3 million on an annual basis to be allocated by the Benefits Committee to increase the base funding of the PDI, CME, CPRSP, and Parental Leave Program.

6.3 The Government will provide the following funds on an annual basis to be allocated by the Benefits Committee to increase the base funding of the PDI, CME, CPRSP and Parental Leave Program:

- (a) an additional \$3.8 million will be made available effective April 1, 2019;
- (b) an additional \$4.3 million will be made available effective April 1, 2020; and
- (c) an additional \$4.5 million will be made available effective April 1, 2021;

6.4 In addition to those funds set out at sections 6.2 and 6.3, the Government will provide the following funds on an annual basis to increase the base funding of the CPRSP to improve the CPRSP Basic and Length of Service benefits available to physicians:

- (a) an additional \$19.5 million will be made available effective April 1, 2020; and
- (b) an additional \$20.5 million will be made available effective April 1, 2021.

6.5 Subject to section 6.6, the Benefits Committee will modify or include in the terms of the CPRSP program effective April 1, 2020 as follows (the “**CPRSP Program Changes**”):

- (a) eliminate the matching requirement for physicians so that CPRSP funds cover the full CPRSP benefit regardless of physician contribution (no requirement for physicians to match funding);
- (b) allow CPRSP Basic and Length of Service (LOS) benefits to be paid into a Tax Free Savings Account; and
- (c) permit withdrawals from an RRSP funded by CPRSP Basic or LOS benefits for the first time buyers’ home plan and the lifelong learning plan in accordance with CRA rules.

6.6 The CPRSP Program Changes will apply to the extent that they and their administration by the Benefits Committee are permissible under applicable laws, including without limitation, federal and provincial taxation laws and rules. In the event that one or more CPRSP Program Changes or their administration by the Benefits Committee is not permissible under applicable

laws, then such CPRSP Program Change or CPRSP Program Changes, as the case may be, will cease to be in effect. Neither the Government nor the MSC make any representation or warranty as to whether any of the CPRSP Program Changes or their administration by the Benefits Committee is permissible under applicable laws.

6.7 The annual base funding of \$40,700,000 for the CMPA Rebate Program shall continue and will be increased on an annual basis as follows:

- (a) an additional \$3.2 million will be made available effective April 1, 2020;
- (b) an additional \$9.0 million will be made available effective April 1, 2021;

6.8 The Government and physicians will share ongoing cost increases to the CMPA Fee Schedule in Fiscal Year 2019/20 and for each Fiscal Year thereafter for the term of this Agreement. On the basis of CMPA costs data for the Fiscal Year 2019/20, the parties will determine the amount by which CMPA costs are expected to exceed the funding provided by Government pursuant to section 6.7 of this Agreement ("Extraordinary Amount"). The Government will contribute 70% of the Extraordinary Amount to the CMPA Rebate Program up to a maximum of \$17 million in each such Fiscal Year and physicians will absorb the balance of the cost increase.

6.9 For each of the Fiscal Years 2019/2020 through to 2021/2022 inclusive, the Benefit Committee will support the level of the Benefit Plans (excluding the CMPA Rebate Program) in existence as of March 31, 2019 by:

- (a) allocating the funding described in sections 6.2, 6.3 and 6.4 of the Agreement;
- (b) use of surplus funds in any of the Benefit Plans, other than the CMPA Rebate Program; and
- (c) if the funds referred to in section 6.9(a) and (b) are inadequate to maintain the level of the Benefit Plans as described in this section 6.9, use of surplus from the CMPA Rebate Program;

subject to the terms, conditions, rules and eligibility criteria applicable to each of the Benefit Plans.

6.10 If in any Fiscal Year during the term of this Agreement, after any surplus funds in the Benefit Plans are applied to maintaining the level of the Benefit Plans as described in section 6.9, there remain surplus funds in any of the Benefit Plans, other than CMPA Rebate Program, such surplus funds will be allocated by the Benefits Committee.

6.11 The Government will provide annual funding to the PHP in order to fully fund the program and support the increasing demand for its services among physicians as follows:

- (a) \$1.9 million per year will be made available effective April 1, 2019;

- (b) an additional \$0.1 million per year will be made available effective April 1, 2020; and
- (c) an additional \$0.1 million per year will be made available effective April 1, 2021.

#### **ARTICLE 7 - ADMINISTRATION OF THE BENEFITS PLANS**

7.1 Concurrently with the execution and delivery of this Agreement, the Government and the Doctors of BC will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the “**2019 Benefits Administration Agreement**”). The 2019 Benefits Administration Agreement shall include the following:

- (a) The responsibilities of the Doctors of BC include the verification that public funds have been properly used for the purposes intended, including such audit and inspection procedures as may be necessary and required.
- (b) The Doctors of BC acknowledges and accepts its responsibility to administer the Benefit Plans available to all eligible physicians who have not made an election under Section 14 of the *Medicare Protection Act* and who are not subject to an order made under Section 15(2)(a) or (b) of the *Medicare Protection Act*, and acknowledges and accepts its responsibility to provide the same standard of administration to both members and non-members of the Doctors of BC.
- (c) It is understood and agreed that the Doctors of BC may charge physicians who are not members of the Doctors of BC an administrative fee when such non-members apply for any benefits available to them under the Benefit Plans. It is further understood and agreed that non-members will not be charged administrative fees that exceed the equivalent of dues and levies charged to Doctors of BC members in the calendar year in which the non-member applies for a benefit or benefits.
- (d) To facilitate the Government and the MSC in meeting their statutory obligations to account for the use of public money, the Doctors of BC will report annually to the Government on its expenditures related to the administration of the Benefit Plans, such report to also include audited financial statements for each Benefit Plan.
- (e) A clause permitting either party to terminate without cause upon 6 months written notice to the other party, such clause not to be operable prior to April 1, 2021.

7.2 The costs associated with administering the Benefit Plans that are the subject of the 2019 Benefits Administration Agreement will be paid from the annual funding made available for those Benefit Plans.

7.3 During the term of this Agreement, either the Government or the Doctors of BC may, at its own expense, initiate a review of the Benefit Plans. The other party will be fully reimbursed for the costs of its participation in the review. Where one party initiates a review under this section the other party will fully cooperate.

7.4 Information that contains the identification of physicians will be provided to the Doctors of BC Benefits Department for the administration of the Benefits Plans only. Such information will be kept confidential in compliance with relevant legislation.

7.5 The Benefits Committee will review the current information needs of the Doctors of BC Benefits Department with the aims of improving the quality of the information collected and reducing the administrative burden on the Health Authorities, the Government, and the Doctors of BC associated with collecting the information.

7.6 The Doctors of BC Benefits Department will report to the MSC the value of the benefits (excluding PDI and PHP) at the level of the individual physician on an annual basis. This information will be treated as confidential by the MSC and, subject to any statutory requirements to the contrary, will not be published or otherwise publicly reported.

7.7 The Doctors of BC Benefits Department will report to the Benefits Committee the value of administrative fees charged to non-members for each Benefit Plan on an annual basis.

## **ARTICLE 8 - ELIGIBILITY TO PARTICIPATE IN THE BENEFIT PLANS**

8.1 Subject to any specific provision of the 2019 Physician Master Agreement and any of the Physician Master Subsidiary Agreements, including this Agreement, and subject to the specific terms, conditions, rules and eligibility criteria applicable to each of the Benefit Plans, physicians who are compensated by Fees, Sessional Contracts, Service Contracts or contracts for the provision of provincially funded clinical services under an alternative payment model (excluding Salary Agreements) are eligible to participate in all of the Benefit Plans. Income from each compensation source shall be totalled and combined in determining eligibility/coverage.

8.2 Physicians who are compensated by Salary Agreements are not eligible to participate in the Benefit Plans (except for the PHP), with the exception of:

- (a) certain physicians who are compensated under part-time Salary Agreements and are entitled to participate in Benefit Plans as per current policy;
- (b) any physicians who the Benefits Committee determines, in accordance with section 4.4(d), will be provided with a partial CPRSP benefit,

provided however that no physician, as a result of working under more than one mode of compensation, may receive more than the full annual value of the benefits available under any of the Benefit Plans. Should a physician transfer to or from a Salary Agreement position during a year, the benefits available under each compensation arrangement will be pro-rated to match the time served by the physician under each compensation arrangement during that year.

8.3 A physician who elects to be paid directly by a beneficiary pursuant to Section 14 of the *Medicare Protection Act* is not entitled to participate in the Benefit Plans.

8.4 Where the MSC has, for cause, made an order under Section 15 (2) (a) or (b) of the *Medicare Protection Act* that physician is no longer entitled to participate in the Benefit Plans.

## **ARTICLE 9 - QUARANTINE INCOME REPLACEMENT**

9.1 The Government will compensate physicians required by the Provincial Health Officer to undergo a period of quarantine as a result of exposure to a communicable disease while providing Insured Medical Services in British Columbia. Such compensation will be paid at a rate equal to the maximum benefit available under the PDI, for a period of up to two weeks.

## **ARTICLE 10 DISPUTE RESOLUTION**

10.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2019 Physician Master Agreement applicable to Provincial Disputes.



**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness )

\_\_\_\_\_  
Name )

\_\_\_\_\_  
Address )  
\_\_\_\_\_  
\_\_\_\_\_ )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

C/S

\_\_\_\_\_  
Signature of Authorized Signatory )

\_\_\_\_\_  
Name )

\_\_\_\_\_  
Position )

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

## **SCHEDULE A**

### **PHYSICIAN DISABILITY INSURANCE PROGRAM**

Funding for the PDI will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The PDI funds will be payable by the MSC to, and on the date required by, the insurance company which is providing the PDI coverage.

The PDI provides income replacement to eligible physicians who become totally disabled. Coverage is not automatic and each physician must apply for coverage and provide medical evidence of insurability. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the PDI are as approved and published by the Benefits Committee from time to time.

## **SCHEDULE B**

### **CONTINUING MEDICAL EDUCATION FUND**

Funding for the CME will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The annual funds will be payable to the Doctors of BC on May 1st of each Fiscal Year.

The CME fund is a yearly allotment of monies used to assist physicians with eligible educational expenses. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the CME are as approved and published by the Benefits Committee from time to time.

## **SCHEDULE C**

### **CANADIAN MEDICAL PROTECTIVE ASSOCIATION REBATE PROGRAM**

The maximum funding available for the CMPA Rebate Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The funding for the CMPA Rebate Program as set out in Article 6 of the Benefits Subsidiary Agreement will be allocated among physician type of work categorizations so that the net proportional contribution to CMPA dues by physicians as set out in the 1985 CMPA fee structure is maintained unless otherwise determined by a consensus decision of the Benefits Committee.

The CMPA Rebate Program provides eligible physicians with partial reimbursement of their CMPA dues. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the CMPA Rebate Program are as approved and published by the Benefits Committee from time to time.

## **SCHEDULE D**

### **CONTRIBUTORY PROFESSIONAL RETIREMENT SAVINGS PLAN**

Funding for the CPRSP will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The CPRSP is a retirement savings program that provides funds for eligible physicians to contribute to their retirement savings plan, subject to the available CPRSP funding, and subject to the specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee, which terms will include those set out in section 6.5 of the Benefits Subsidiary Agreement.

## **SCHEDULE E**

### **PARENTAL LEAVE PROGRAM**

Funding for the Parental Leave Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The Parental Leave Program will provide up to \$1,000 per week for up to 17 weeks within one year of the date an eligible male or female physician becomes a parent of a newborn or newly adopted child or of a newborn through a surrogate mother. The 17 weeks need not be consecutive if it is necessary for the physician to return to work for one or more periods within the qualifying year.

The specific terms, conditions, rules and eligibility criteria applicable to the Parental Leave Program will be as approved and published by the Benefits Committee from time to time.

## **APPENDIX F**

### **ADJUSTMENTS TO FEES, SERVICE CONTRACT RANGES AND SERVICE CONTRACT RATES, SALARY AGREEMENT RANGES AND SALARY AGREEMENT RATES, AND SESSIONAL CONTRACT RATES**

#### **1.1 One-Time Payment in 2019/20**

- (a) Prior to October 1, 2019, \$85 million less the cost of Health Insurance BC's implementation of the Business Cost Premium (as defined in section 1.5) will be paid in an equal dollar amount to each physician who practiced in 2018 and who earned above \$75,000 in income from the following sources in any of the calendar years 2016, 2017, or 2018:
  - (i) Fees;
  - (ii) Joint Clinical Committee fees;
  - (iii) Sessional Contracts;
  - (iv) Service Contracts and Salary Agreements;
  - (v) reading fees for screening mammography;
  - (vi) MRI fees;
  - (vii) Rural Retention Percentage Premiums; and
  - (viii) Population-Based Funding and Value-Based Compensation contracts.
- (b) For the purposes of section 1.1(a):
  - (i) the Government will provide \$35 million less the cost of Health Insurance BC's implementation of the Business Cost Premium;
  - (ii) \$25 million will be made available from existing unexpended funds available to the General Practice Services Committee under section 5.7 of the 2014 General Practitioners Subsidiary Agreement;
  - (iii) \$12.5 million will be made available from existing unexpended funds available to the Specialist Services Committee under section 6.5 of the 2014 Specialists Subsidiary Agreement; and
  - (iv) \$12.5 million will be made available from existing unexpended funds available to the Specialist Services Committee under section 8.5 of the 2014 Specialists Subsidiary Agreement.

1.2 Compensation Changes in 2019/20

- (a) Effective April 1, 2019,
  - (i) Fees will be increased by an average of 0.5% to fund the increases in the cost of providing services, with such increase to be allocated pursuant to Articles 12 and 13 of the 2019 Physician Master Agreement.
  - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2019 to fund the increases in the cost of providing services;
  - (iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 0.5% over those in effect on March 31, 2019 to fund the increases in the cost of providing services;
  - (iv) the reading fee for a screening mammogram will be increased by 0.5% over that in effect on March 31, 2019 to fund the increases in the cost of providing services; and
  - (v) the MRI fee will be increased by 0.5% over that in effect on March 31, 2019 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2019, Sessional Contract Rates will be increased by 7.0% over those in effect upon application of section 1.2(a)(ii) above, except for the Sessional Contract Rate for Specialist Physicians providing services to the Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development).
- (c) Effective April 1, 2019, all Out-of-Office-Hours Premiums (i.e. Fees 01200 to 01217) in the Payment Schedule will be increased by an additional 17.0%.
- (d) Effective April 1, 2019, the Government will fund an additional increase of 0.5% to Emergency Medicine Fees 01811 to 01843 and Critical Care Fees 01411 to 01443 in the Payment Schedule with such increase to be allocated pursuant to Articles 12 and 13 of the 2019 Physician Master Agreement.
- (e) Effective April 1, 2019,
  - (i) \$6.5 million will be made available to fund increases to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address issues of equity and inter-provincial disparity among physicians providing services under a Service Contractor a Salary Agreement. ; and



- (ii) \$3.25 million will be made available to fund increases to be made by the After Hours Adjudication Panel to the Salary Agreement Ranges and the Service Contract Ranges to compensate physicians who provide on-site clinical services after regular office hours.

Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

### 1.3 Compensation Changes in 2020/21

#### (a) Effective April 1, 2020,

- (i) Fees will be increased by an average of 0.5% to fund the increases in the cost of providing services, with such increase to be allocated pursuant to Articles 12 and 13 of the 2019 Physician Master Agreement.
- (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2020 to fund the increases in the cost of providing services;
- (iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 0.5% over those in effect on March 31, 2020 to fund the increases in the cost of providing services;
- (iv) the reading fee for a screening mammogram will be increased by 0.5% over that in effect on March 31, 2020 to fund the increases in the cost of providing services; and
- (v) the MRI fee will be increased by 0.5% over that in effect on March 31, 2020 to fund the increases in the cost of providing services.

#### (b) Effective April 1, 2020,

- (i) \$7.5 million will be made available to fund increases to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address issues of equity and inter-provincial disparity among physicians providing services under a Service Contractor a Salary Agreement; and
- (ii) \$3.25 million will be made available to fund increases to be made by the After Hours Adjudication Panel to the Salary Agreement Ranges and the Service Contract Ranges to compensate physicians who provide on-site clinical services after regular office hours.

Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

#### 1.4 Compensation Changes in 2021/22

(a) Effective April 1, 2021,

- (i) Fees will be increased by an average of 0.5% to fund the increases in the cost of providing services, with such increase to be allocated pursuant to Articles 12 and 13 of the 2019 Physician Master Agreement.
- (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2021 to fund the increases in the cost of providing services;
- (iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 0.5% over those in effect on March 31, 2021 to fund the increases in the cost of providing services;
- (iv) the reading fee for a screening mammogram will be increased by 0.5% over that in effect on March 31, 2021 to fund the increases in the cost of providing services; and
- (v) the MRI fee will be increased by 0.5% over that in effect on March 31, 2021 to fund the increases in the cost of providing services.

(b) Effective April 1, 2021,

- (i) \$6 million will be made available to fund increases to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges to address issues of equity and inter-provincial disparity among physicians providing services under a Service Contractor a Salary Agreement; and
- (ii) \$3 million will be made available to fund increases to be made by the After Hours Adjudication Panel to the Salary Agreement Ranges and the Service Contract Ranges to compensate physicians who provide on-site clinical services after regular office hours.

Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum).

1.5 Business Cost Premium

- (a) Subject to this section 1.5, the Government will fund a percentage premium (the “**Business Cost Premium**”) on Eligible Fees (as defined in section 1.5(b)), as follows:
  - (i) \$34.8 million will be made available for Fiscal Year 2020/21 effective April 1, 2020; and
  - (ii) \$35.7 million will be made available for Fiscal Year 2021/22 effective April 1, 2021.
- (b) As of April 1, 2020, the Business Cost Premium will apply to Fees for the following services (“**Eligible Fees**”) where those services are provided in a community-based office by a physician who is responsible for the lease, rental, or other overhead costs of that office and who is entitled to receive and retain payment for the Eligible Fees directly from MSP (“**Eligible Physician**”):
  - (i) Examinations;
  - (ii) Visits and Consultations; and
  - (iii) Counselling.
- (c) Subject to sections 1.5(d) and 1.5(e), the percentage values and the daily maximum amounts of the Business Cost Premium that Eligible Physicians will be paid on Eligible Fees are based on the location of the community-based office in which the services are provided as follows:
  - (i) City of Vancouver:  
5% to a daily maximum of \$60;
  - (ii) Greater Vancouver (except the City of Vancouver) and Greater Victoria:  
4% to a daily maximum of \$48;
  - (iii) Other communities outside of Greater Vancouver and Greater Victoria, excluding those communities where the Rural Retention Premiums are applicable:  
3% to a daily maximum of \$36.
- (d) If the expenditures in Fiscal Year 2020/21 are less than \$34.8 million, a proportional retroactive payment will be provided to Eligible Physicians to bring the expenditures in Fiscal Year 2020/21 to \$34.8 million, and the percentage values of the Business Cost Premium will be adjusted upward proportionally for Fiscal Year 2021/22. If the expenditures in Fiscal Year 2020/21 exceed \$34.8

million, the percentage values of the Business Cost Premium for Fiscal Year 2021/2022 will be adjusted downward to allow for the recovery of the amount paid out in excess of \$34.8 million in Fiscal Year 2020/21 (e.g. if excess expenditures in Fiscal Year 2020/21 are \$1 million, percentage values will be adjusted downward in Fiscal Year 2021/22 so that projected expenditures are \$34.7 million).

- (e) No later than July 1, 2019, the Government and the Doctors of BC will form a working group composed of Tariff Committee representatives and Ministry of Health staff to:
  - (i) confirm the percentage values and corresponding daily maximums of the Business Cost Premium for Fiscal Year 2020/21; and
  - (ii) determine the process to implement and administer the Business Cost Premium for Eligible Physicians, including the introduction of mandatory facility codes for all MSP billings.

#### 1.6 Specialist Disparity Funding

- (a) The Government will provide the following funding to be allocated to new or existing Fees and paid to Specialist Sections in order to address interprovincial and intersectional disparity among fee-for-service specialists:
  - (i) \$9.73 million per year made available effective April 1, 2019;
  - (ii) an additional \$16.5 million per year made available effective April 1, 2020; and
  - (iii) an additional \$16.5 million per year made available effective April 1, 2021.
- (b) The gross allocation of the funds described in this section 1.6 among Specialist Sections for Fiscal Years 2019/20, 2020/21, and 2021/22 will be adjudicated by a third-party adjudicator who will:
  - (i) consider the effect of both intersectional and interprovincial disparities in compensation;
  - (ii) ensure that allocations to address interprovincial disparities do not significantly exacerbate intersectional disparities; and
  - (iii) allocate 80% of the funds in each Fiscal Year toward addressing intersectional disparities in compensation and 20% of the funds in each Fiscal Year toward addressing interprovincial disparities in compensation.

- (c) Once the gross allocation of funds for all three Fiscal Years is determined by the adjudicator, the resulting changes to the Payment Schedule will be determined in accordance with Articles 12 and 13 of the 2019 Physician Master Agreement, and will be effective as of April 1<sup>st</sup> of the Fiscal Year for which the funding is allocated. Specialist Sections who are awarded disparity funding under this section 1.6 may pursue changes to the Payment Schedule by directing the funds toward increasing the value of Fees or creating new Fees, including Fees that address increased complexity of services and the impact of after-hours service delivery. Any financial impact to any Physician Section resulting from the allocation of funding under this section 1.6 to a specific Specialist Section will be paid out of the Specialist Section allocation that produces such a cross-sectional impact.
- (d) The adjudication described in this section 1.6 will be conducted in accordance with procedures as determined by the adjudicator and will include an opportunity for the Specialist Sections, the Government and the Doctors of BC to make submissions on the allocation of the funds over all three Fiscal Years. The adjudication process will commence no later than October 1, 2019 and will conclude by March 31, 2020, unless otherwise agreed to by the parties.

## 1.7 General

- (a) Consistent with section 7.3 of the Alternative Payments Subsidiary Agreement, a physician who is compensated through a Salary Agreement or Service Contract and who is paid an annual rate that is above the range maximum for the applicable practice category on Schedule A or Schedule B to the Alternative Payments Subsidiary Agreement will, insofar as this Appendix F is concerned, only be entitled to:
  - (i) the applicable lump sum payment and compensation increases described in sections 1.1(a), 1.2(a) (iii), 1.3(a) (iii), and 1.4(a) (iii); and
  - (ii) to the funding described in sections 1.2(e), 1.3(b), and 1.4(b) of this Appendix F to the extent their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.
- (b) The increases identified in sections 1.2(a), 1.3(a), and 1.4(a) do not apply to targeted funds including, but not limited to, new targeted funds which have been reflected in sections 1.2(b), 1.2(c), 1.2(d), 1.2(e), 1.3(b), 1.4(b), 1.5(a), and 1.6(a) of this Appendix F and in Article 5 of the General Practitioners Subsidiary Agreement, Article 6 of the Specialists Subsidiary Agreement, and Article 12 of the Rural Practice Subsidiary Agreement in the year in which those targeted funds are introduced. In particular, and without limiting the generality of the foregoing, in the event that any targeted funds are used for increases to Fees, Service Contract Ranges, Service Contract Rates, Salary Agreement Ranges, Salary Agreement Rates, Sessional Contract Rates, the reading fee for a screening mammogram and/or the MRI fee (collectively “**Targeted Increase**”):

- (i) the base years for any Targeted Increase that is applied on base years that vary from Fiscal Year to Fiscal Year (i.e. section 1.6(a) of this Appendix F) will be the Fiscal Year commencing April 1, 2018 for any Targeted Increase made effective April 1, 2019, Fiscal Year commencing April 1, 2019 for any Targeted Increase made effective April 1, 2020, and Fiscal Year commencing April 1, 2020 for any Targeted Increase made effective April 1, 2021; and
- (ii) the increases identified in sections 1.2(a), 1.3(a), and 1.4(a) will be applied prior to the application of any Targeted Increase.

In other words, no Targeted Increase will attract any increase identified in sections 1.2(a), 1.3(a), and 1.4(a) in the year in which such Targeted Increase is introduced.

- (c) The lump sum payment and increases to Fees set out in sections 1.1(a)(i), 1.2(a)(i), 1.3(a)(i), and 1.4(a)(i) of this Appendix F do not apply to Laboratory fees, General Practice Services Committee fees, Specialist Services Committee fees and Shared Care Committee fees. For clarity, this section 1.7(c) does not apply to any General Practice Services Committee fees, Specialist Services Committee fees, and Shared Care Committee fees that have been transferred to the Payment Schedule pursuant to Appendix I to the 2019 Physician Master Agreement (as such fees are, upon their transfer to the Payment Schedule, Fees to which sections 1.1(a)(i), 1.2(a)(i), 1.3(a)(i), and 1.4(a)(i) of this Appendix F apply).

## **APPENDIX G**

### **MEDICAL ON-CALL/AVAILABILITY PROGRAM (MOCAP)**

- 1.1 MOCAP will provide payment to physician(s) and physician groups who are available to provide emergency care to new or unattached patients, other than their own or their call groups', as required and approved by Health Authorities.
- 1.2 The MOCAP funding described in section 17.1 of the 2019 Physician Master Agreement includes funding for Doctor of the Day payments. This provides greater flexibility for Health Authorities in purchasing MOCAP coverage and Doctor of the Day services.
- 1.3 Where MOCAP availability coverage is required it is in the best interests of the population served that it be provided on a 24/7/52 basis. It is recognized that, in some circumstances, a Health Authority may decide to provide MOCAP availability coverage on some other basis.
- 1.4 Physicians will provide MOCAP availability coverage in accordance with the provisions of the template MOCAP Contract attached as Schedule 1 to this Appendix.
- 1.5 MOCAP availability payments will be determined on the basis of annual rates.
- 1.6 The annual rates for the MOCAP availability will be as follows:
  - (a) Level 1- The annual rate for 24/7/52 Level 1 is \$225,000 per call group.
  - (b) Level 2 - The annual rate for 24/7/52 Level 2 is \$165,000 per call group.
  - (c) Level 3 -. The annual rate for 24/7/52 Level 3 is \$70,000 per call group.
  - (d) On Site On-Call - Where a physician is designated to be on-call on site. Physician groups in this category predominately include tertiary obstetrics, anesthesia, and neonatology. The annual rate for 24/7/52 on site on-call is \$325,000 per call group.
- 1.7 Where a physician is not on-call but is called in by the Health Authority to provide a service, the physician will be compensated at the rate of \$250 per call back provided the Call Back Criteria attached as Schedule 2 are met.
- 1.8 MOCAP arrangements should be sustainable and therefore must not contribute to physician burnout.

**SCHEDULE 1 TO APPENDIX G**  
**TEMPLATE MOCAP CONTRACT**

**BETWEEN: THOSE PHYSICIANS AND PROFESSIONAL MEDICAL  
CORPORATIONS LISTED ON THE SIGNATURE PAGE OF THIS  
CONTRACT**

(collectively called the “Call Group” and  
individually referred to as a “Member”)

**AND:** [Insert name of Health Authority]

(the “Health Authority”)

**WHEREAS** the Call Group and its Members wish to contract with the Health Authority and the Health Authority wishes to contract with the Call Group and its Members to provide On-Call/Availability on the terms, conditions and understandings set out in this contract (the “Contract”);

**THEREFORE** in consideration of the mutual promises contained in this Contract, the Call Group, its Members and the Health Authority agree as follows:

**DEFINITIONS**

**“On-Call/Availability”** means being available to provide emergency care to new or unattached patients (i.e. patients other than a Member’s or Call Group’s own patients) and being available to provide advice to other health care providers and other professionals involved in the care of those patients.

**“Call Group”** has the meaning set out in the introductory clause of this Contract. A Call Group represents a group of physicians who have agreed to share responsibility to provide On-Call/Availability for new or unattached patients under this Contract.

**“MOCAP”** means the medical on-call/availability program referred to in Article 17 and described in Appendix G of the 2019 Physician Master Agreement.

**“new or unattached patient”** means a patient who is typically not the Member’s or Call Group’s patient. For clarity, in rural communities where a Member or Call Group are providing additional services such as emergency, obstetrics/gynecology, anesthesia or general surgery, then patients of the Member or Call Group presenting for such additional services will be considered as a new patient of that additional service.



**“Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government of British Columbia, the Medical Services Commission (MSC) and the British Columbia Medical Association (Doctors of BC), as amended from time to time.

**“Physician Master Subsidiary Agreements”** has the meaning given in the Physician Master Agreement.

**“Provincial MOCAP Review Committee”** means the committee established in accordance with Article 17.2 of the Physician Master Agreement.

## **ARTICLE 1 - TERM & RENEWAL**

- 1.1 This Contract will be in effect from \_\_\_\_\_ to \_\_\_\_\_ notwithstanding the date of its execution (the “Term”).
- 1.2 This Contract may be renewed for such period of time and on such terms as the parties may mutually agree to in writing. If either the Call Group or the Health Authority wishes to renew this Contract, it must provide written notice to the other no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 1.3 Subject to section 1.4 herein, if both the Call Group and the Health Authority agree to renew the Contract, the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 1.4 In the event that a new contract is not completed within ninety (90) days following the end of the Term, this Contract and any extensions will terminate without further obligation on either the Call Group or the Health Authority.

## **ARTICLE 2 - TERMINATION**

- 2.1 Either the Call Group or the Health Authority may terminate this Contract without cause upon ninety (90) days written notice to the other.
- 2.2 Either the Call Group or the Health Authority may terminate this Contract immediately upon written notice if the other breaches a fundamental term of the Contract.

## **ARTICLE 3 - PAYMENTS BY CALL GROUPS**

- 3.1 No employment relationship is created by this Contract or by the provision of the On-call/Availability coverage by any Member under this Contract. No partnership relationship between the Members is created by this Contract or by the provision of On-Call/Availability coverage by the Call Group. None of the Members intends to carry on a business with a view to profit with the other Members in respect of the On-Call/Availability coverage.

- 3.2 Each Member must pay any and all payments and/or deductions required to be paid by the Member, including those required for income tax, Employment Insurance premiums, Workers Compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Member is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Member pursuant to this Contract.
- 3.3 The liability of Members for payments referred to in section 3.2 herein is severable and not joint.
- 3.4 Each Member of the Call Group agrees to indemnify the Health Authority from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from any Member of the Call Group's failure to make payments referred to in section 3.2 herein.
- 3.5 The indemnity clause in section 3.4 herein survives the expiry or earlier termination of this Contract.

#### **ARTICLE 4 - UNINCORPORATED CALL GROUPS**

- 4.1 The Call Group may designate a representative from among the Members to represent the Call Group with respect to notices, the addition of new physicians to the Contract, and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Health Authority of the identity of the Representative. If the Representative changes during the Term, the Call Group will notify the Health Authority of the new Representative.
- 4.2 Where a notice is to be given to the Call Group in accordance with Article 12, the Members agree that a single notice to the Representative will constitute notice to all Members of the Call Group. Where notice is to be given to less than all of the Members of the Call Group, it must be given to those individual Members at the address(es) provided at Article 12.
- 4.3 Each Member has the right to terminate their relationship with the Health Authority without affecting the rights and obligations of the remaining Members and must do so in accordance with the termination provisions of this Contract.
- 4.4 The Health Authority may terminate the Contract with respect to an individual Member in accordance with the termination provisions herein.
- 4.5 In the event of the departure of a Member by resignation or termination, the parties will meet to discuss whether amendments are required and to make agreed changes.
- 4.6 For any new member added to this Contract who is not an initial signatory to this Contract, the Members (collectively) or their Representative, the Health Authority, and the new member will sign and deliver to the others an acknowledgement and agreement

in the form set out in Appendix 1 (“**New Member – Agreement to Join**”), agreeing that the new member will become party to and bound by the terms of this Contract.

## **ARTICLE 5 – PROFESSIONAL RESPONSIBILITY**

- 5.1 Each Member will provide the On-Call/Availability coverage under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Health Authority policies, by-laws or rules and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

## **ARTICLE 6 - DISPUTE RESOLUTION**

- 6.1 This Contract is governed by, and is to be construed in accordance with, the laws of British Columbia.
- 6.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Member(s) and the Health Authority (the Member(s) or the Health Authority, each a “**Party to the Dispute**” and collectively “**Parties to the Dispute**”) are unable to resolve at the local level may be referred to mediation on notice by either Party to the Dispute to the other. The neutral mediator shall be jointly selected by the Parties to the Dispute. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the Parties to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 6.3 If an arbitrator or mediator cannot be agreed upon within fifteen (15) working days after notice is served by either Party to the Dispute seeking appointment of an arbitrator or mediator under section 6.2 herein, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the arbitrator or mediator.

## **ARTICLE 7 - ON-CALL COMPENSATION AND REQUIREMENTS**

- 7.1 The Call Group will be compensated for On-Call Availability coverage under this Contract pursuant to the application of the MOCAP, and in accordance with the system determined by the Provincial MOCAP Review Committee, as follows:

☐

Level 1

The annual rate for 24/7/52 Level 1 is \$225,000 per call group.

- ☐ Continuous coverage
- ☐ Non-continuous coverage (Details – e.g. hours, days)

☐

Level 2

The annual rate for 24/7/52 Level 2 is \$165,000 per call group.

- ☐ Continuous coverage
- ☐ Non-continuous coverage (Details)

☐ Level 3

The annual rate for 24/7/52 Level 3 is \$70,000 per call group.

- ☐ Continuous coverage
- ☐ Non-continuous coverage (Details)

☐ On site On-call

Availability on-site. The annual rate for 24/7/52 on site on-call is \$325,000 per call group.

- ☐ Continuous coverage
- ☐ Non-continuous coverage (Details)

As per the following:

Nature of On-Call/Availability: \_\_\_\_\_ (e.g. general surgery, hours)

Location(s): \_\_\_\_\_ (e.g. St Paul's Hospital)

- 7.2 Levels 1, 2 and 3 must provide availability by telephone within 10 minutes. Attendances on-site will be dependent on patient need and the clinical circumstances.
- 7.3 The Call Group will notify the Health Authority of the call rota, which includes the Member covering each shift, in a timely fashion [*If the Health Authority has a specific format (e.g. electronic scheduling system) for submitting call schedules, this provision can be modified to detail the specific requirements*].

## **ARTICLE 8 – LICENSES AND QUALIFICATIONS**

- 8.1 During the Term, each Member will maintain:

8.1.1 registered membership in good standing with the College of Physicians and Surgeons of British Columbia and the Member will conduct their practice of medicine consistent with the conditions of such registration; and

8.1.2 enrolment in the Medical Services Plan.

## **ARTICLE 9 - SUBCONTRACTING**

- 9.1 Each Member may, with the written consent of the Health Authority, subcontract or assign any of the On-Call/Availability coverage. The consent of the Health Authority will not be unreasonably withheld.

## **ARTICLE 10 - COMPENSATION**

- 10.1 The Health Authority will pay the Call Group or individual Members monthly upon receipt of an invoice [*Health Authority may include reference to specific invoice format here*] for On-Call/Availability coverage provided based on an annual rate of \_\_\_\_\_.
- 10.2 In no event will the aggregate amount paid under this Contract exceed the sum of \_\_\_\_\_ per year.

## **ARTICLE 11 - REPORTING**

- 11.1 Each Call Group will report to the Health Authority payment received by each Member of the group for the provision of On-Call/Availability no later than thirty (30) days after the end of every quarter.
- 11.2 Where a Call Group elects to receive payments from the Health Authority to individual group Members, the Call Group will report to the Health Authority the dates and shifts worked by each Member no later than thirty (30) days after the end of each month.

## **ARTICLE 12 - NOTICES**

- 12.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
- 11.1.1 If mailed by regular mail or by prepaid registered mail to the addressee's address listed below, on date of confirmation of delivery.
- 11.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or
- 11.1.3 If delivered by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address listed below.
- 11.2 Either party may give notice to the other of a change of address or e-mail address.
- 11.3 Address of Health Authority:
- Address of Representative:
- Address of each Member of Call Group:

## **ARTICLE 13 - AMENDMENTS**

- 13.1 This Contract may be amended by written agreement of the parties.

#### **ARTICLE 14 - ENTIRE CONTRACT**

- 14.1 This Contract, the 2019 Physician Master Agreement and the 2019 Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to On-Call/Availability and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of these agreements.

#### **ARTICLE 15 - NO WAIVER UNLESS IN WRITING**

- 15.1 No provision of this Contract and no breach by either a Member or the Health Authority of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a Member or the Health Authority of any breach of any provision of this Contract by the other must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

#### **ARTICLE 16 - HEADINGS**

- 16.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

#### **ARTICLE 17 - ENFORCEABILITY AND SEVERABILITY**

- 17.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, illegality or unenforceability will attach only to such provision or part of such provision.

#### **ARTICLE 18 – EXECUTION OF THE CONTRACT**

- 18.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts shall be construed together and shall constitute one in the same original agreement.
- 18.2 This Contract may be validly executed by transmission of a signed copy thereof by e-mail.

#### **ARTICLE 19 – MEMBERS AS PROFESSIONAL MEDICAL CORPORATIONS**

- 19.1 Where a Member in this Contract is a professional medical corporation:
- (a) the Member will ensure that its physician owner, being the individual signing this Contract on the Member's behalf (the “**Member's Owner**”), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Member under this Contract that cannot be performed or fulfilled by a professional medical corporation;

- (b) the Health Authority agrees to confer on the Member's Owner, for the Member's benefit, all rights of the Member under this Contract that cannot be held by a professional medical corporation; and
- (c) for clarity, all remuneration for the On-Call/Availability will be paid to the professional medical corporation.

#### **ARTICLE 20 – DOCTORS OF BC**

20.1 Each Member separately and the Members collectively are entitled, at their option, to representation by the Doctors of BC in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Dated for reference this \_\_\_\_ day of \_\_\_\_\_ 20\_\_.

**IN WITNESS WHEREOF THE PARTIES** have duly executed this Contract as of the date written above.

\_\_\_\_\_  
Health Authority Authorized Signatory

\_\_\_\_\_  
Name of Member of Call Group (individual)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## APPENDIX 1

### NEW MEMBER - AGREEMENT TO JOIN

#### ("New Member-Agreement to Join")

Re: **MOCAP Contract effective <insert date> (the "Contract") between the Health Authority and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Member - Agreement to Join.**

*[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Member" and make other consequential amendments]*

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Members, confirms that the Members wish to add Dr. \_\_\_\_\_ (the "New Member") as a "Member" under the Contract to provide On-Call/Availability to the Health Authority under the terms of the Contract.
2. The New Member acknowledges having received a copy of the Contract and hereby agrees with the Health Authority and the other Members that the New Member will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Member". The New Physician acknowledges that all payments for On-Call/Availability under the Contract will be made by the Health Authority to the Members as provided in the Contract and that the Representative, currently Dr. \_\_\_\_\_, has been granted certain authority to act as the representative of the Members, including the New Member, under the Contract. [The New Member confirms that Dr. \_\_\_\_\_ is the "Member's Owner" for the New Member]
3. All capitalized terms used in this New Member – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Member – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.



Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

**IN WITNESS WHEREOF THE PARTIES** to this New Member – Agreement to Join have duly executed this New Member – Agreement to Join as of the date written above.

\_\_\_\_\_  
**Dr. \_\_\_\_\_ as the Representative**

**Signed and Delivered On behalf of the Health Authority:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered on behalf of the New Member:**

\_\_\_\_\_  
New Member's Signature (unincorporated)

or

[    ] Inc.

\_\_\_\_\_  
Authorized Signatory

## **SCHEDULE 2 TO APPENDIX G**

### **CALL BACK CRITERIA**

#### **Part A: Call Back Payment Eligibility**

All the following Criteria must be met for a physician to be eligible for the \$250 MOCAP call back payment.

#### **1. Criteria related to the person making the decision to call.**

The decision to initiate the call back is made by one of the following:

- a) A physician with privileges at the facility in issue who has responsibility for the care of the patient in question, including but not limited to the Most Responsible Physician.
- b) Any other member of the medical or nursing staff of the facility in issue who has been specifically authorized by the Health Authority to initiate call backs eligible under these Criteria.

#### **2. Criteria related to the person who is called.**

The call is made to a physician who meets all of the following:

- a) Has been designated for call back payments by the Health Authority in accordance with Part B below or falls within a category or group that has been so designated, and meets all the terms of such designation or, alternatively, has had the specific call back in issue approved for payment after-the-fact on an exception basis in accordance with Part C below.
- b) Is a member of the medical staff at the facility in issue with privileges to provide the required services.
- c) Is not on call or being paid to be on site, on shift, or otherwise available at the time of the call back.
- d) Is not:
  - i) at the time of the call back, on site at the facility at which the patient is present in accordance with Part A3(b) below;
  - ii) at the time of the call back, scheduled to be on site at the facility at which the patient is present in accordance with Part A3(b) below; or
  - iii) scheduled to be next on site at the facility at which the patient is present in accordance with Part A3(b) below at a time when the patient's needs could be adequately met.
- e) Is not receiving isolation allowance under the Rural Subsidiary Agreement.

### **3. Criteria related to the clinical circumstances.**

All of the following circumstances are present:

- a) The call is for an identified patient who is not a patient of the physician being called or of a colleague for whose patients the physician has accepted responsibility.
- b) The patient is present in:
  - i) an acute care hospital, or
  - ii) a diagnostic and treatment centre or specified emergency treatment room that has been approved as a call back payment eligible facility by the MOCAP Advisory Committee.
- c) The patient requires medical services on an emergency basis as assessed by the person deciding to initiate the call at the time the call is made.
- d) Reasonable steps are taken to determine that the medical services required by the patient could not be provided (due to issues of competence or availability) by a physician who has ongoing responsibility for the care of the patient (either directly or by virtue of his/her call group), by a physician who is on-call, or by a physician who is being paid to be on site, on shift, or otherwise available.
- e) The physician being called personally attends the patient at the site contemplated by Part A3(b) above within the time dictated by the patient's needs but in any event no later than within 3 hours of being called.

### **4. Administrative Criteria**

All of the following administrative rules are complied with:

- a) Only one \$250 payment is available per call back, regardless of the number of patients seen.
- b) Only one \$250 payment is available per patient per physician (i.e. for each episode of illness/injury).
- c) Within 30 days of the call back, an invoice in the form attached must be submitted to the Health Authority by the physician claiming the call back payment.
- d) Within 30 days of the call back, a verification, in the form attached must be submitted to the Health Authority by the person who made the decision to initiate the call back (that is the person referred to in Part A1 above).

### **Part B: Designation**

1. Each Health Authority may designate physicians and/or services for call back payments.

2. The Health Authorities may designate individual physicians by name, groups of individual physicians by name, or practice categories/services without naming specific physicians (in which case any physician who is a member of the medical staff of the facility in issue with the privileges and qualifications required to provide the services and who meets all other terms of the designation will be deemed to be designated).
3. The Health Authorities may specify additional terms as being applicable to any designation so long as such additional terms are not inconsistent with these Criteria. Permissible additional terms include, but are not limited to:
  - a) Specific sites;
  - b) Specific services;
  - c) Specific times (e.g. hours in a day, days in a week);
  - d) Maximum dollar amounts for call back payments in a given time period (e.g. monthly, annually); and
  - e) Maximum number of call backs in a given time period (e.g. monthly, annually).
4. If the designation is in respect of a specific physician or group of specific physicians, then each such physician or group, respectively, will be provided with a standardized Call Back Designation Letter that expresses the names of the physicians that are the subject of the designation, expresses all additional terms applicable to the designation, and encloses a copy of these Criteria and a copy of the form of invoice to be used to submit claims for payment, and in the event the designation is cancelled or altered will be provided with a letter advising of same.

**Part C: Approving Payments on an Exception Basis**

1. Approval for call back payment on an exception basis may be sought for specific call backs by physicians who are not designated in accordance with Part B above and by physicians who are designated in accordance with Part B above but in circumstances where all terms applicable to the designation have not been met (e.g. the call back was to a non-designated site, for non-designated services, and/or at a non-designated time of day; or if paid, the maximum dollar amount would be exceeded and/or the maximum number of call backs would be exceeded).
2. To seek approval on an exception basis, a physician must submit an invoice in accordance with Part A4(c) above which clearly and expressly indicates that payment is sought on an exception basis.
3. Each Health Authority will specify an individual by name or position/title with authority to approve call back payments on an exception basis.
4. The individual specified in accordance with Part C3 above will approve exceptional claims for payment if all criteria for call back payment eligibility as set out in Part A above (except that set out in Part A2(a)) have been met.

**Part D: Appeal of Denied Call Back Claims**

1. In the event that a physician's claim for call back payment is denied the physician may, within 30 days of being advised by the Health Authority of the denial of the claim, request the Doctors of BC to initiate a Call Back Dispute on his/her behalf. If the Doctors of BC agrees to do so, the Doctors of BC must provide notice of same to the applicable Health Authority and to the Joint Agreement Administration Group within 30 days of being requested by the physician to initiate a Call Back Dispute. The notice must be in writing and must include the facts upon which the physician relies including a copy of the invoice submitted in association with the claim as required by Part A4(c) above but with the name(s) and personal health number(s) of the patient(s) expunged, the identification of the ground upon which the Call Back Dispute is advanced, an outline of argument supporting the physician position, and a written consent to release information signed by the physician, in the form attached.
2. Upon receipt by the Ministry of Health Services of a consent to release information in the form attached, the Ministry will forward to the Joint Agreement Administration Group and to the applicable Health Authority a list of the information that the Ministry proposes to release. After providing the applicable Health Authority and the physician with the opportunity to comment on the list, the Joint Agreement Administration Group will request the Ministry to release some or all of the information on the list. The Ministry will then release the information as requested by the Joint Agreement Administration Group.
3. The only ground upon which a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above have been met (except where the Call Back Dispute relates to a physician not designated in accordance with Part B above or a claim that does not fall within the terms of such a designation, in which case the only ground upon which such a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above, except that in Part A2(a), have been met).
4. The Joint Agreement Administration Group will consider each Call Back Dispute referred to it and, after providing the physician and the applicable Health Authority with the opportunity to be heard, may decide the merits of the Call Back Dispute, following any further process stipulated by it, by consensus decision (as that term is defined in section 1.2 of the Physician Master Agreement), in which case the decision of the Joint Agreement Administration Group will be final and binding on the physician and the Health Authority.
5. In the event that the Joint Agreement Administration Group is unable to reach a consensus decision with respect to the resolution of any Call Back Dispute within 60 days of receipt of the associated notice, or any longer period agreed to by the Joint Agreement Administration Group, the Doctors of BC or the Government may, within a further 30 days, refer the Call Back Dispute to a member of the Roster set out at Appendix H to the

Physician Master Agreement or any other person agreed to by the Doctors of BC and the Government (the “Call Back Adjudicator”)

6. Where, within the time limits in Part D5 above, the Joint Agreement Administration Group has not reached a consensus decision with respect to the resolution of any Call Back Dispute and the Call Back Dispute is not referred to the Call Back Adjudicator, then there will be no further process under these Criteria or otherwise for the physician to advance his/her claim for call back payment, and the Health Authority’s denial of such claim will be final and binding on the physician.
7. Where a Call Back Dispute is referred to the Call Back Adjudicator pursuant to Part D5, the Call Back Adjudicator will determine whether the criteria set out in Part A above have been met, following any further process stipulated by him/her. If the Call Back Adjudicator determines that the criteria set out in Part A have not been met then he/she will render a final and binding award confirming the Health Authority’s denial of the claim for call back payment. If the Call Back Adjudicator determines that the criteria set out in Part A have been met then he/she will render a final and binding award allowing the claim for call back payment following which the applicable Health Authority will make the payment.
8. The Government and the Doctors of BC will share the costs associated with the referral of Call Back Disputes to the Call Back Adjudicator.

## Call Back Invoice

Name of physician making the claim: \_\_\_\_\_

Name of Health Authority: \_\_\_\_\_

MSP Billing # of physician making the claim: \_\_\_\_\_

Physician has been designated by the Health Authority for call back payments:

Yes ☐ No ☐

If Yes, name of designated group/category: \_\_\_\_\_

Personal information on this form is collected under the *Freedom of Information and Protection of Privacy Act*. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-3146.

If No, or if any of the call backs on this invoice do not fall within the terms of the designation, indicate, in the last column below, that approval is sought for payment on an exception basis.

Date & time call back received	Name of person initiating call back	Date & time physician physically attended the patient	Name of Patient	PHN # of Patient	Facility where patient was attended	Indicate with a ✓ if approval is sought on exception basis

With respect to each of the above noted call backs:

1. The patient was not my patient or the patient of a colleague for whose patients I had accepted responsibility; and
2. At the time of the call back I was not on site at the Facility noted in the sixth column above, or scheduled to be on site, or scheduled to be next on site at a time when the patient's needs could be adequately met; nor was I on call or being paid to be on site, on shift or otherwise available.

I am not receiving Isolation Allowance Fund payments and was not receiving such payments at the time of any of the call backs above noted.

I authorize the Ministry of Health Services to release to the Health Authority named above any information related to the claims reflected on this invoice, excluding patient personal information (i.e. the name and personal health number of the patient), that, in the reasonable opinion of the Ministry, is relevant to assessing this claim, and if necessary, resolving any dispute over this claim through arbitration or otherwise. Such information will include, but not be limited to compensation/billing information (excluding patient personal information).

I certify all the information on this form to be correct.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

## Call Back Verification Form

Name of person initiating call back: \_\_\_\_\_

Name of Health Authority: \_\_\_\_\_

Title of person initiating call back: \_\_\_\_\_

Date & time call back was initiated	Name of physician who was called back	Indicate with a ✓ if the physician was designated for this call back	Name of patient	PHN # of Patient	Facility where patient was attended	Symptoms indicating emergency care was required	Associated Call Back Invoice Number (this column to be filled in by the Health Authority)

With respect to each of the above noted call backs:

1. I assessed the patient as requiring medical services on an emergency basis; and
2. Reasonable steps were taken to determine that the emergency medical services required by the patient could not have been provided (due to issues of competence or availability) by a physician who had on-going responsibility for the care of the patient (either directly or by virtue of his or her call group); by a physician who was on-call or by a physician who was being paid to be on site, on shift or otherwise available.

I certify all the information on this form to be correct.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person initiating call back



**Consent to Release Information**  
**In Relation to a Call Back Dispute**

*Personal information on this form is collected under the Freedom of Information and Protection of Privacy Act. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-1849.*

To: The Ministry of Health Services

Attention: Hlth.MOCAPCallBack@gov.bc.ca

From: Dr. \_\_\_\_\_ [name of physician initiating a Call Back Dispute]

I have requested the Doctors of BC to initiate a Call Back Dispute on my behalf. The Doctors of BC has agreed to do so. A copy of the associated notice to the \_\_\_\_\_ Health Authority and the Joint Agreement Administration Group (the “JAAG”) is attached.

I authorize the Ministry of Health Services to disclose to the \_\_\_\_\_ Health Authority, the JAAG and/or to any arbitrator any of my information, including but not limited to compensation/billing information but excluding patient personal information (i.e. name or personal health number of the patient) which, in the reasonable opinion of the Ministry, is relevant to resolving the Call Back Dispute.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Claiming Physician

**APPENDIX H**

**MEMBERS OF THE ROSTER (AS OF APRIL 1, 2019)**

Robin McFee

Barbara Cornish

Marion Allan

**APPENDIX I**

**LETTER OF AGREEMENT – TRANSFER OF JOINT COMMITTEE FEES TO THE  
PAYMENT SCHEDULE**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health

(the “Government”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)

(the “Doctors of BC”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “MSC”)

(individually a “party” and collectively the “parties”)

The parties agree to transfer to the Payment Schedule (as defined in the 2019 Physician Master Agreement) the Joint Clinical Committee fees set out in this Letter of Agreement, in accordance with the processes set out in this Letter of Agreement and the terms of the 2019 Physician Master Agreement.

**1. Fees to be transferred**

- a. The Joint Clinical Committees (“JCCs”) will establish a process to review, potentially modify and transfer, the following JCC fee items into the MSC Payment Schedule, effective April 1, 2020.
  - i. GPSC fee items – see Appendix A
    1. The GPSC fees outlined in Appendix A.2 may require additional modifications as to their eligibility to allow them to be offered as part of a Primary Care Network.

2. The GPSC fees outlined in Appendix A.3 may require additional modifications to uncouple the planning and management fees.

ii. SSC fee items - See Appendix B

1. For Appendix B2 fees that are currently in the process of being transferred to the MSC Payment Schedule will be transferred in the Fiscal Year 2019/20 and Article 3.a.i.1 will apply to the remaining fees.

iii. SCC -Teledermatology Initiative

## **2. Process to transfer fees**

- a. In the course of reviewing the JCC fees to be transferred into the MSC Payment Schedule the appropriate Joint Clinical Committees will:
  - i. review the fee item descriptions, fee prices, and/or billing rules to ensure the fees meet the requirements of the *Medicare Protection Act*, and to ensure that, under the revised descriptions, they continue to be directed to the same purposes as when managed by the Joint Clinical Committee; and
  - ii. consult with the MSC to determine any fees that will require revisions.
- b. All JCC fee items transferred to the Payment Schedule will be designated Provisional for a period of two years, subject to Articles 3.a.iv and 3.c of this Memorandum of Understanding.
- c. If the modifications to fees as outlined above cannot be completed in advance of April 1, 2020, the Government and Doctors of BC will agree to transfer those fees in their existing form, and will determine a process by which the appropriate JCC may recommend appropriate modifications after the transfer, subject to Article 13.1 of the 2019 Physician Master Agreement.
- d. Once the Government and Doctors of BC have agreed to recommend a fee, or a modified fee, for transfer, they will notify the MSC by February 1, 2020 and Article 13.1 of the Physician Master Agreement shall apply.

## **3. Transfer of Funding**

- a. Upon the transfer into the MSC Payment Schedule, the following amounts will

be taken out of the appropriate JCC ongoing annual budgets, and transferred into the Available Amount:

- i. Starting in Fiscal Year 2020/21, an amount equal to the actual expenditure for the transferred fee items in Fiscal Year 2019/20:
    1. For Appendix B2 fees, if the budgeted amount is higher than actual net expenditure in 2019/20, the budgeted amount will be the amount transferred into the Available Amount. In the event that the transfer is based on a Section's fee items budgeted amount, the surplus funds will be transferred to that Section to apply to existing or new fees.
    2. For fees that are modified and the expenditure is anticipated to change as a result of the modification, the predicted annual expenditure will be transferred into the Available Amount.
  - ii. After June 2021, an additional amount from the 2020/21 and ongoing JCC budgets will be transferred to cover the actual cost of growth for the transferred fee items (exclusive of price increases) in excess of 2.4% for Fiscal Year 2020/21. For fees that meet the criteria in section i.2 above, there will be an amount transferred to reconcile between the predicted annual expenditure and the actual annual expenditure in Fiscal Year 2020/21.
  - iii. After June 2022, an additional amount from the 2021/22 and ongoing JCC budgets will be transferred to cover the actual cost of growth for the transferred fee items (exclusive of price increases) in excess of 2.4% for Fiscal Year 2021/22.
  - iv. After June 2023, an additional amount from the 2022/23 and ongoing JCC budgets will be transferred to cover the actual cost of growth for the transferred fee items that meet the criteria in section a.i.2 above (exclusive of price increases) in excess of 2.4% for Fiscal Year 2022/23.
  - v. The amounts calculated in sections (ii), (iii), and (iv) above will be based on the total for all fee codes for each JCC, rather than at an individual fee level.
- b. The amount of the fee premiums currently funded by the JSC on JCC fees will also be transferred from the JSC budget to the Available Amount.
  - c. Before December 31, 2021, the Government and Doctors of BC will review

actual expenditure of all transferred fees, and for any fees where growth has been significant, the parties will meet to assess the appropriateness of the growth and determine if any further steps are required.

## APPENDIX A

### GPSC Fees to be incorporated into the Payment Schedule

#### A.1 Recommended GPSC fees for transfer with minimal revision needed:

1. GPSC portal codes- 14070, (14071 for locum)- zero value
2. Incentive for Full Service General Practitioner – Annual Chronic Care Incentive (Chronic Disease Management Fees)
  - G14050 Diabetes mellitus (\$125.00)
  - G14051 Heart Failure (\$125.00)
  - G14052 Hypertension (\$50.00)
  - G14053 COPD (\$125.00)
  - G14250- APP Diabetes Mellitus (\$125.00)
  - G14251- APP Heart Failure (\$125.00)
  - G14252- APP Hypertension (\$50.00)
  - G14253- APP COPD (\$125.00)

*To support team based care Allied Care Providers working within the family physician's practice may provide one of the visits required for GPSC chronic disease management incentives.*

3. G14076 GP Patient Telephone Management Fee (\$20.00)  
*Call can be made by the physician or a college certified allied care provider. Maximum 1500/year. Consideration to be given to adding medically necessary prescription renewals to this fee, as requested by MSC.*
4. G14078 GP Email/Text/Telephone Medical Advice Relay Fee (\$7.00)  
*For 2 way communication of medical advice from the physician to patients or patient's medical representative.*
5. G14066 Personal Health Risk Assessment (\$50.00)  
*Payable once per patient per year to maximum of 100 patients per physician per year*
6. Case conferencing with specialists or other care providers:
  - G14018 General Practice Urgent Telephone Conference with a Specialist Fee (\$40.00)
  - G14077 GP Allied Care Provider Conference Fee – per 15 minutes or greater portion (\$40.00)
  - G14019 GP-Advice fee to Nurse Practitioner/Registered Midwife – Telephone or In-Person (\$40.00)

7. Low volume obstetric incentive bonuses.

- G14004 Obstetric Delivery Incentive for Full Service General Practitioner – associated with vaginal delivery and postnatal care (14104) (\$288.77)
- G14005 Obstetric Delivery Incentive for Full Service General Practitioner – associated with management of labour and transfer to a higher level of care facility for delivery (14105) (\$120.26)
- G14008 Obstetric Delivery Incentive for Full Service General Practitioner – associated with postnatal care after an elective C-section (14108) (\$59.41)
- G14009 Obstetric Delivery Incentive for Full Service General Practitioner – related to attendance at delivery and postnatal care associated with emergency caesarean section (14109) (\$240.52)

*Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.*

8. Hospital Visit Fees

- 13008 Community based GP: hospital visit (active hospital privileges) (\$53.20)
- 13109 Community based GP: Acute care hospital admission examination (\$101.25)

9. G14063 GP Palliative Care Planning Fee (\$100.00)

10. Mental Health Management Fees (14044, 14045, 14046, 14047 ad 14048)

11. Allied Care Provider Practice Code – zero value (14029)

**A. 2 GPSC fees recommended for transfer with some change in eligibility needed:**

1. GP with specialty training:

- G14021 GP with Specialty Training Telephone Advice – Initiated by a Specialist, General Practitioner or Allied Care Provider, Response within 2 hours (\$60.00)
- G14022 GP with Specialty Training Telephone Advice – Initiated by a Specialist, General Practitioner or Allied Care Provider, Response in One Week – per 15 minutes or portion thereof (\$40.00)
- G14023 GP with Specialty Training Telephone Patient Management / Follow-Up

*Current criteria is A GP who has specialty training and provides services in that specialty area through a Health Authority supported or approved program. This could be adapted to reference offering services as part of the PCN, rather than through a HA program.*

2. Palliative care patient facility visit (\$53.20) (currently fee code 00127, changing to 13127)



### **A.3 GPSC fees that would benefit from further refinement prior to transfer:**

#### **1. Complex Care/Planning Fees**

- G14075 GP Frailty Complex Care Planning and Management Fee (\$315.00)
- G14033 GP Complex Care Planning and Management Fee (2 diagnoses) (\$315.00)
- G14043 Mental Health Planning Fee (\$100.00)

*The current fee G14075 and G14033 include a planning fee as well as a management fee. The planning component has been aligned across the fees. The recommendation is to uncouple the \$100.00 planning from the management fees. This requires some further modeling and analysis and might take more than one year.*

## APPENDIX B

### SSC Fees to be incorporated into the Payment Schedule

#### B.1 Specialist Services Committee (SSC) Initiated Listing:

1. G10001 Urgent Specialist Advice – initiated by a Specialist or General Practitioner, Response within 2 hours (\$60)

*The purpose of this fee is for the specialist to provide urgent real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*

2. G10002 Specialist Advice for Patient Management – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinators of the patient's care. Response in one week – per 15 minutes or portion thereof (\$40)

*The purpose of this fee is for the specialist to provide real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*

3. G10005 Specialist Email Advice for Patient Management – Initiated by a Specialist, General Practitioner or Allied Care Provider. Response in one week (\$10.10)

*The purpose of this fee is for the specialist to provide email advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*

4. G10004 Multidisciplinary Conferencing for Complex Patients – per 15 minutes (\$46.23)

*A scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances where the patient is too complex for the specialists to deal with on his/her own. Payable only when coordination of care is required via a collaborative conference with at least two of the following: other specialists, GPs, allied health providers and/or coordinators of the patient's care*

5. G10003 Specialist Patient Management / Follow-up – per 15 minutes or portion thereof (\$24.05)

*The purpose of this fee is for the specialist to provide real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*

6. G10006 Specialist Email Patient Management / Follow-up (\$10.10)

*The purpose of this fee is for the specialist to provide email advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.*

7. G78763 to G78781 Specialist Group Medical Visits provides medical care in a group setting. \$47.16 to 13.01 per patient per half hour.

*Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction.*

8. G78717 Specialist Discharge Care Plan for Complex Patients – extra (\$75)

*For the purpose of creating and ensuring complex patients have a detailed care plan following discharge. This fee is intended to support clinical coordination leading to effective discharge and community based management of complicated patients. It is to be billed for patients who require community support upon discharge and are otherwise at risk of readmission.*

9. G78720 Specialist Advance Care Planning Discussion – (\$40)

*This fee premium is to facilitate a Specialist Physician to have a discussion with the patient about advance care planning based on the patient's beliefs, values and wishes for future health care.*

**B.2 Fee Codes Implemented and Managed by the Specialist Services Committee (Excludes fee codes that have been deleted or been transferred to the Available Amount)**

Fee Codes	Current Fee
<b>Neurology</b>	
450 - Neurology Complex Care-Extend Consult - Per 15 Min	\$58.10
460 - Neurology Ext Consult - Transfer Of Care From Peds	\$388.18
462 - Neurological Interpretation + Written Report Of X-Ray Sub	\$52.48
465 - Acute Stroke Intra-Arterial Thrombolysis	\$1,063.23
468 - Neurology Outpatient Transcranial Doppler Ultra So	\$118.86
469 - Neurology Outpatient Trans Doppler Ultra Sound -Prolon	\$29.71
<b>Obstetrics &amp; Gynaecology</b>	
4702 - Transection Or Removal Of Suburethral Mesh Sling	\$417.12
4703 - Augmented Anterior Compartment Vaginal Prolapse	\$415.99
4704 - Augmented Posterior Compartment Vaginal Prolapse	\$415.99
4705 - Removal Of Trans-Vaginal Placed Synthetic Mesh	\$499.19

4706 - Vaginal Vault Suspension-Apical Support Procedure	\$405.64
4708 - Prolonged Laparoscopic Surgery, Per 15 Min (Extra)	\$71.72
4714 - Prolonged Surgery-Open Procedure, Per 15 Min(Extra)	\$71.72
4715 - Obstetrical Surcharge Therapeutic Abortion >18 Wks	\$81.97
4716 - Obstetrical Surcharge Therapeutic Abortion,14-18wk	\$61.48
4717 - Prenatal Office Visit -Complex Obstetrical Patient	\$46.89
4718 - Care Of Complex Antepartum Patient Prior To Transfer	\$280.53
4719 - Gynecology Surgical Surcharge Patient 75yr + Older	\$64.05
<b>General Internal Medicine</b>	
32307 - Sub F/U Off Visit, Complex Pat-3 Medical Cond GIM	\$90.00
32308 - Sub Hosp Visit, Complex Pat-3 Medical Cond GIM	\$53.00
<b>Anesthesia</b>	
1195 - Minimum Anesthetic Procedural Fee, Per Case	\$105.04
<b>Geriatrics</b>	
33445 - Geriatric Care Conference (Pat 65+) Per 15 Min	\$48.68
33450 - Geriatric Family Conference (Pat 65+)-Per 15 Min	\$43.55
<b>Rheumatology</b>	
31050 - Extended Consultation - Rheumatology-Exceed 61 Min	\$270.47
31055 - Rheumatology Immunosuppressant Review	\$40.99
31060 - Multidisciplinary Conference For Community Pat	\$225.96
<b>Respirology</b>	
32011 - Complex Respiratory Medicine Assessment	\$59.92
<b>Endocrinology</b>	
33240 - Premium For Patients >75 Years -Addition To Consult	\$53.97
33241 - Premium For Patients 75+Over, Addition To Visit	\$14.47
33250 - Virtual Communication With Patient	\$10.25
33255 - Insulin Start	\$40.99
33256 - Insulin Pump Start	\$81.97
33260 - Initial Virtual Consultation, With Patient Or Rep.	\$120.95
33262 - Repeat Or Limited Virtual Consultation	\$60.48
<b>Infectious Diseases</b>	
33655 - Home Parenteral Antibiotic Management Fee	\$18.78

## **2019 BENEFITS ADMINISTRATION AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE  
PROVINCE OF BRITISH COLUMBIA**, as represented by the Minister of  
Health

(the “**Government**”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)

(the “**Doctors of BC**”)

**WITNESSES THAT WHEREAS:**

- A. The Doctors of BC, the Medical Services Commission (the “**MSC**”) and the Government have agreed to renew and replace the 2014 Physician Master Agreement and the 2014 Benefits Subsidiary Agreement with the 2019 Physician Master Agreement and the 2019 Benefits Subsidiary Agreement;
- B. The 2019 Benefits Subsidiary Agreement is to take effect as of April 1, 2019;
- C. The 2019 Benefits Subsidiary Agreement provides, among other things, that the Government and the Doctors of BC will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the “ **2019 Benefits Administration Agreement**”); and
- D. The Doctors of BC and the Government have agreed that this Agreement will constitute the 2019 Benefits Administration Agreement.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

### **ARTICLE 1– DEFINITIONS, INTERPRETATION AND TERMINATION OF PRIOR AGREEMENT**

- 1.1 Words used in this Agreement that are defined in the 2019 Physician Master Agreement or in the 2019 Benefits Subsidiary Agreement have the same meaning as in the 2019

Physician Master Agreement or 2019 Benefits Subsidiary Agreement unless otherwise defined in this Agreement.

- 1.2 “**Administrative Costs**” means costs incurred directly by the Doctors of BC to perform the services required of the Doctors of BC under this Agreement, including the following categories of costs: staff salaries and benefits, rent, equipment amortization, office supplies, audit costs and bank charges.
- 1.3 “**Administrative Fees**” means the fees paid to the Doctors of BC under this Agreement for Administrative Costs
- 1.4 “**Beneficiaries**” means physicians who are eligible to receive benefits from a Benefit Plan.
- 1.5 “**Benefit Plans**” means:
  - (a) the CMPA Rebate Program;
  - (b) the CME;
  - (c) the CPRSP;
  - (d) the Parental Leave Program; and
  - (e) the PDI.
- 1.6 In this Agreement:
  - (a) words in the singular include the plural and vice versa, and words in one gender include all genders;
  - (b) the headings of Articles and sections are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;
  - (c) the words “**Article**” and “**section**” mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;
  - (d) the words “**include**”, “**includes**” or “**including**” mean “include without limitation”, “includes without limitation” and “including without limitation” respectively, and the words following “include”, “includes” or “including” shall not be considered to set forth an exhaustive list;
  - (e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;

- (f) the words “**this Agreement**”, “**herein**”, “**hereof**”, and “**hereunder**” and other words of similar input refer to this Agreement as a whole and not to any particular article or section.

- 1.7 Upon execution of this Agreement, the 2014 Benefits Administration Agreement made as of the 1<sup>st</sup> day of April 2014 between the Government and the Doctors of BC shall terminate and be of no further force or effect.

## **ARTICLE 2- DOCTORS OF BC SERVICES**

- 2.1 The Doctors of BC will administer the Benefit Plans for all eligible physicians who have not made an election under Section 14 of the *Medicare Protection Act* and who are not subject to an order made under Section 15(2)(a) or (b) of the *Medicare Protection Act*, and will provide the same standard of administration to both members and non-members of the Doctors of BC.
- 2.2 The Doctors of BC will provide all services required to administer the Benefit Plans, including the following:
  - (a) determining physician eligibility for the Benefit Plans in accordance with the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements, including the 2019 Benefits Subsidiary Agreement and any specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee for the Benefit Plans from time to time;
  - (b) paying benefits to or on behalf of eligible physicians consistent with the requirements of each of the Benefit Plans and in accordance with the 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements, including the 2019 Benefits Subsidiary Agreement and any specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee for the Benefit Plans from time to time;
  - (c) maintaining financial and other records relating to all aspects of the Benefit Plans including records related to the receipt of funds from the Government, the payment of benefits to Beneficiaries and Administrative Costs;
  - (d) developing and implementing procedures and developing and maintaining documentation for physicians to apply for benefits under the Benefit Plans;
  - (e) producing communication materials required to provide physicians with an understanding of the Benefit Plans, including the requirements for eligibility, and the procedures for applying for benefits and subsequent communications with physicians;
  - (f) ensuring that the expenditures for benefits paid from each of the Benefit Plans do not exceed the funding provided by the Government for each Benefit Plan;

- (g) ensuring that benefits paid to physicians pursuant to the Benefit Plans do not exceed entitlements under the Benefit Plans;
- (h) collecting administrative fees from eligible physicians who are not members of the Doctors of BC in accordance with section 7.1(c) of the 2019 Benefits Subsidiary Agreement;
- (i) providing information to the Benefits Committee as required by the Benefits Committee, including information to enable the Benefits Committee to determine whether there is a surplus in funding for any of the Benefit Plans;
- (j) ensuring that interest accrued from reserves held by the Doctors of BC is used to fund the Benefit Plans or, if not needed for such purpose, is added to the surplus in funding for the Benefit Plans as determined by the Benefits Committee;
- (k) verifying to the Government annually that all funds provided for the Benefit Plans have been properly used for the purposes intended and cooperating with any audit and inspection procedures as may be required by the Government;
- (l) maintaining a detailed written record of all Administrative Costs, including appropriate supporting documents, and providing same to the Government on request; and
- (m) subject to the 2019 Benefits Subsidiary Agreement, providing other reports concerning the administration of the Benefit Plans when requested by the Government.

- 2.3 The Doctors of BC will perform the services required under this Agreement in the same manner and with the same degree of care, skill and efficiency as would be employed by a prudent and reasonable professional benefits administrator performing the same services.

### **ARTICLE 3 - ADMINISTRATIVE COSTS AND FEES**

- 3.1 The Administrative Costs for any Fiscal Year shall be reasonable and reasonably comparable to the costs that would be incurred by a prudent and reasonable professional benefits administrator performing the same services.
- 3.2 On or before March 1 of each year, the Doctors of BC will prepare a budget for Administrative Costs for each of the Benefit Plans for the subsequent Fiscal Year, for review with and approval by the Benefits Committee. If the Benefits Committee is unable to reach agreement on the budget for Administrative Costs the matter will be resolved by the Adjudicator or Adjudication Committee in the same manner as set out in Article 22.1 of the 2019 Physician Master Agreement for resolution of Provincial Disputes.
- 3.3 Upon approval of the budget for Administrative Costs for a particular Fiscal Year by the Benefits Committee or a decision of the Adjudicator or Adjudication Committee in that regard in either case as contemplated by section 3.2 above, the budgeted Administrative



Costs associated with each of the Benefit Plans will be paid to the Doctors of BC as Administrative Fees from the funding made available by the Government for each of the Benefit Plans.

#### **ARTICLE 4- ANNUAL REPORT**

- 4.1 On or before September 30 of each year, the Doctors of BC will provide to the Government through the Benefits Committee a written report for the preceding Fiscal Year including:
- 4.1.1 For each of the CME, the CMPA Rebate Program, the CPRSP, and the Parental Leave Program:
- (a) the total amount expended for benefits and the number of physicians for whom an entitlement was calculated;
  - (b) the total amount of funding received from physicians who are not members of the Doctors of BC for administrative fees
  - (c) the number of claims applications received, the number accepted and the number refused;
  - (d) the amount of any surplus, including any surplus carried forward from a previous year;
  - (e) the total amount of Administrative Costs charged by the Doctors of BC against the Benefits Plans, with details as to the amounts charged against each such plan
  - (f) the audited financial statements for each Benefit Plan; and
- 4.1.2 For the PDI:
- (a) the financial statements provided by Sun Life (or successor insurance company) to the Doctors of BC.

#### **ARTICLE 5 – INDEMNITY**

- 5.1 The Doctors of BC shall indemnify and hold harmless the Government from and against any and all claims arising from or in connection with the administration of the Benefit Plans.

#### **ARTICLE 6- AMENDMENTS**

- 6.1 This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the

specific matter waived and only in the specific instance and for the specific purpose for which it is given.

#### **ARTICLE 7 – TERM AND TERMINATION**

- 7.1 Subject to earlier termination in accordance with section 7.2 below, this Agreement shall have the same term as, and shall terminate concurrent with any termination of, the 2019 Benefits Subsidiary Agreement.
- 7.2 Notwithstanding section 7.1 above, either party may give written notice to the other, on or after April 1, 2021, of termination of this Agreement without cause, in which case this Agreement will terminate on the date that is six months after the date such written notice was given.
- 7.3 Upon termination of this Agreement, the Doctors of BC will:
- (a) continue to process benefit claims for which it has received complete information prior to termination and which were due and payable prior to termination, except where requested not to do so by the Government;
  - (b) subject to all applicable legislation, forward all records and files, including all electronic records, to any successor benefits administrator, as advised by the Government; and
  - (c) forward the balance of any funds held in or for any of the Benefit Plans to any successor benefits administrator, as advised by the Government.

#### **ARTICLE 8 – RESOLUTION OF DISPUTES**

- 8.1 Where there is a dispute between the Government and the Doctors of BC regarding the interpretation, application operation or alleged breach of this Agreement, it shall be resolved in the same manner as set out in Article 22.1 of the 2019 Physician Master Agreement for resolution of Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1<sup>st</sup> day of April, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

Jania Marsh )  
Signature of Witness )  
Jania Marsh )  
Name )  
3-1, 1515 Blanshard Street )  
Address )  
Victoria, BC )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

Eric Cadesky )  
Signature of Authorized Signatory )  
Dr Eric Cadesky )  
Name )  
President )  
Position )

[Signature]



## **JOINT CLINICAL COMMITTEE ADMINISTRATION AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2019,

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Minister of Health

(the "**Government**")

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**  
doing business as Doctors of BC

(the "**Doctors of BC**")

**WITNESSES THAT WHEREAS:**

- A. The Doctors of BC, the Medical Services Commission (the "MSC") and the Government have agreed to a renewed Physician Master Agreement and Physician Master Subsidiary Agreements, including the Specialist Subsidiary Agreement and the General Practice Subsidiary Agreement to take effect as of April 1, 2019;
- B. The Doctors of BC, the MSC and the Government previously created certain joint clinical committees which will continue under the 2019 Physician Master Agreement, the 2019 Specialist Subsidiary Agreement and the 2019 General Practice Subsidiary Agreement;
- C. The Doctors of BC and the Government previously created the Joint Clinical Committee Administration Agreement to establish how the work of these joint clinical committees will be administered by the Doctors of BC; and
- D. The Doctors of BC and the Government have agreed to continue the Joint Clinical Administration Agreement.

**NOW THEREFORE** in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

## DEFINITIONS AND INTERPRETATION

1. Words used in this Agreement that are defined in the 2019 Physician Master Agreement, the 2019 Specialist Subsidiary Agreement or the 2019 General Practitioners Subsidiary Agreement have the same meaning as in the 2019 Physician Master Agreement, the 2019 Specialist Subsidiary Agreement and the 2019 General Practitioners Subsidiary Agreement, unless otherwise defined in this Agreement.
  - 1.1. **"Administrative Costs"** means costs incurred directly by the Doctors of BC to perform the Administrative Services required of the Doctors of BC under this Agreement, including the following categories of costs: staff salaries and benefits, rent, equipment amortization, office supplies, Allocated Costs and bank charges. For clarity, Administrative Costs do not include such costs incurred by Health Authorities as a result of their participation in initiatives of the Joint Clinical Committees.
  - 1.2. **"Administrative Fees"** means the funds to be paid to the Doctors of BC under this Agreement for Administrative Costs.
  - 1.3. **"Administrative Services"** means those activities that are required to implement and manage those programs of the Joint Clinical Committees as determined by an Approved Work Plan and budget (as amended by the parties from time to time based on the decisions of the Joint Clinical Committees or the Physician Services Committee).
  - 1.4. **"Allocated Costs"** means the amount of Administrative Fees paid to the Doctors of BC for Accounting, Payroll and IT Services required to manage those programs of the Joint Clinical Committees and is based on the amount of funding and the level of activity of the program.
  - 1.5. **"Approved Work Plan"** means a work plan prepared by a Joint Clinical Committee in accordance with sections 6.3(a)(i) and (ii) of the 2019 Physician Master Agreement and approved by the Physician Services Committee in accordance with sections 6.3(a)(iii) and (iv) of the 2019 Physician Master Agreement.
  - 1.6. **"Joint Clinical Committee"** means those committees listed in section 8.1 of the 2019 Physician Master Agreement.
  - 1.7. In this Agreement:
    - 1.7.1. words in the singular include the plural and vice versa, and words in one gender include all genders;
    - 1.7.2. the headings of Articles and sections are for convenience of reference only and do

not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;

1.7.3. the words "Article" and "section" mean and refer to the specified Article or section of this Agreement unless reference is made of another agreement;

1.7.4. the words "include", "includes" or "including" mean "include without limitation", "includes without limitation" and "including without limitation" respectively, and the words following "include", "includes" or "including" shall not be considered to set forth an exhaustive list;

1.7.5. all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;

1.7.6. the words "this Agreement", "herein", "hereof", and "hereunder" and other words of similar input refer to this Agreement as a whole and not to any particular article or section.

## **DOCTORS OF BC SERVICES**

2. The Doctors of BC will:

2.1. faithfully implement the directions, resolutions, programmes and decisions of the Joint Clinical Committees as determined by their respective Approved Work Plans and budgets;

2.2. independently provide all Administrative Services to the Joint Clinical Committees;

2.3. maintain financial and other records relating to all aspects of the administration of the Joint Clinical Committees, including records related to the receipt of funds from the Government; Administrative Costs; and disbursement of funds relating to the Joint Clinical Committees programs and initiatives, but not including accounting for funds expended by the Joint Clinical Committees through fees administered by or on behalf of the MSC;

2.4. produce communication materials as approved by the co-chairs of the Joint Clinical Committee in question required to provide physicians and the public with an understanding of work of the Joint Clinical Committees;

2.5. subject to applicable privacy legislation, provide all information related to the Administrative Services and the programs and initiatives of the Joint Clinical Committees as set out in the Approved Work Plan as reasonably requested by the Joint Clinical Committees, including information to advise the Joint Clinical Committees on

the financial status of the Approved Work Plan;

- 2.6. hire staff, and where necessary consultants, to undertake the Administrative Services, as set out in the Approved Work Plan and in accordance with the requirements set out in Article 3 of this Agreement;
  - 2.7. ensure that interest accrued from program funds held by the Doctors of BC is used to fund the work of each Joint Clinical Committee or, if not needed for such purpose, is added to the surplus in funding for the Joint Clinical Committee as determined by the appropriate Joint Clinical Committee;
  - 2.8. provide all reporting required by this Article and Articles 6 to 8 of this Agreement and participate in any audit that the Government may require;
  - 2.9. maintain a detailed written record of all Administrative Costs (excluding the expenses covered by the Allocated Costs) and the costs of all Joint Clinical Committee programs and initiatives, including appropriate supporting documents, and provide the same to auditors as required; and
  - 2.10 subject to applicable privacy legislation provide other reports concerning the Administrative Costs (excluding the expenses covered by the Allocated Costs) and the programs and initiatives of the Joint Clinical Committees to the Government as reasonably requested by the Government.
3. The Doctors of BC will:
- 3.1. perform the services required under this Agreement in the same manner and with the same degree of care, skill and efficiency as would be employed by a prudent and reasonable administrator performing the same services.
  - 3.2. ensure that staff providing Administrative Services:
    - 3.2.1. implement decisions of the Joint Clinical Committees;
    - 3.2.2. remain neutral as between the Government and the Doctors of BC in any disagreements between Doctors of BC and the Government and in respect of any work of the Joint Clinical Committees;
    - 3.2.3. will not provide additional services unrelated to the business of the Joint Clinical Committees to Doctors of BC, Government, Health Authorities or other parties if employed full-time providing Administrative Services under this Agreement.
  - 3.3. seek input from the co-chairs of the responsible Joint Clinical Committee, together or separately when preparing the performance reviews for Executive Leads and Initiative

Leads;

- 3.4. ensure that information related to the Administrative Services provided under the terms of this Agreement flows fairly and evenly to the Joint Clinical Committees and to stakeholders;
- 3.5. follow fair business practice and engage in an open and transparent engagement process when engaging consultants to provide Administrative Services; and
- 3.6. designate a senior employee who is responsible for answering any question or addressing concerns of the Government with respect to the application and administration of this Agreement.

#### **ADMINISTRATIVE COSTS AND FEES**

4. The Administrative Costs for any Fiscal Year shall be reasonable and reasonably comparable to the costs that would be incurred by a prudent and reasonable administrator performing the same services.
5. On or before February 1 of each year, the Doctors of BC will prepare a budget for Administrative Costs for each of the Joint Clinical Committees for the subsequent Fiscal Year, for review with and approval by the relevant Joint Clinical Committee. If such Joint Clinical Committee is unable to reach agreement on the budget for Administrative Costs the matter will be considered by the Physicians Services Committee and if it cannot be resolved by the Physician Services Committee then it shall be resolved by the Adjudicator or Adjudication Committee in the same manner as set out in Article 22 of the 2019 Physician Master Agreement for resolution of Provincial Disputes. If the budget for Administrative Costs has not been approved by April 1 of each year, the parties will utilize the approved budget from the previous Fiscal Year until the new budget is approved.

#### **REPORTING REQUIREMENTS**

6. On or before April 1 of each year, the Doctors of BC will provide to Government through each Joint Clinical Committee, a separate funding schedule which includes the estimated monthly disbursements of government funding, for both Administrative Costs (approved as per Article 5 above) and for the approved programs and initiatives of the Joint Clinical Committees to be implemented by Doctors of BC in accordance with the Approved Work Plans of the Joint Clinical Committees (as amended by the parties from time to time based on the decisions of the Joint Clinical Committees or the Physician Services Committee).
7. On or before the 28<sup>th</sup> day of each month, the Doctors of BC will provide to Government through each Joint Clinical Committee the status of expenditures under the Approved Work Plan for the preceding month. This will include the approved budget, YTD expenditures,



updated projections to the end of the Fiscal Year and variance analysis explanation for the various programs and initiatives of the Joint Clinical Committee. The Doctors of BC will provide financial reporting in the form initially required by Government or in a form subsequently agreed to by the parties.

8. On or before September 30 of each year, the Doctors of BC will provide to the Government through each Joint Clinical Committee a written report for that Joint Clinical Committee for the preceding Fiscal Year including:
  - 8.1. the total amount of Administrative Costs, itemized for the various types of expenses by program and initiative, including staff salaries and benefits, consultant costs, rent, equipment amortization, office supplies Allocated Costs, and bank charges, provided by Doctors of BC against the funding made available by the Government for the Joint Clinical Committee;
  - 8.2. the total amount expended for the various programs and initiatives of the Joint Clinical Committee;
  - 8.3. the amount of any Joint Clinical Committee funding surplus, including any surplus carried forward from a previous Fiscal Year; and
  - 8.4. the audited financial statements for the Joint Clinical Committee.

#### **TRANSFER OF FUNDING**

9. Funding for Administrative Fees, as well as the funding for the programs and initiatives approved by the Joint Clinical Committees for implementation by Doctors of BC, will be transferred by Government to Doctors of BC on the first day of each quarter in accordance with the funding schedule referenced in Article 6 above. If actual expenditures are less than the estimated expenditures in the funding schedule such that a surplus of four months' worth of expenditures accrues, the Government may adjust the transfer of funds to hold further transfers until the accrual is reduced to a surplus of less than 2 months. The Joint Clinical Committees will review the activities of each program and initiative at the end of the Fiscal Year and funding will be adjusted based on the actual expenditures.

#### **INDEMNITY**

10. The Doctors of BC shall indemnify and hold harmless the Government from and against any and all claims arising from or in connection with the administration of the Joint Clinical Committees.

#### **AMENDMENTS**

11. This Agreement may be amended at any time by written agreement of the parties. Any waiver

of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

#### **TERM AND TERMINATION**

- 12.1 Subject to earlier termination in accordance with section 12.2 below, this Agreement shall have the same term as, and shall terminate concurrent with any termination of the 2019 Physician Master Agreement.
- 12.2 Notwithstanding section 12.1 above, either party may give written notice to the other, on or after April 1, 2020, of termination of this Agreement without cause, in which case the parties will forthwith enter into discussions to reach agreement on a revised Agreement or an alternative means of providing the Administrative Services. If no agreement on a revised Agreement or alternate means of providing the Administrative Services is reached within 12 months of the date the written notice of termination was provided, this Agreement will terminate.

## RESOLUTION OF DISPUTES

13. Where there is a dispute between the Government and the Doctors of BC regarding the interpretation, application operation or alleged breach of this Agreement, it shall be resolved in the same manner as set out in Article 22 of the 2019 Physician Master Agreement for resolution of Provincial Disputes.

**IN WITNESS WHEREOF** the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the \_\_\_\_ day of \_\_\_\_\_, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister of )  
Health or his/her duly authorized )  
representative, in the presence of: )

Jania Marsh )  
Signature of Witness )

Jania Marsh )  
Name )

3-1, 1515 Blanshard Street )  
Address )

Victoria, BC )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

Eric Cadesky )  
Signature of Authorized Signatory )

Dr Eric Cadesky )  
Name )

President )  
Position )



**MEMORANDUM OF UNDERSTANDING – INTRODUCTION OF EHRs IN HEALTH  
AUTHORITY FACILITIES**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health  
(the “Ministry”)

**AND:**

**FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, ISLAND  
HEALTH, VANCOUVER COASTAL HEALTH, NORTHERN HEALTH and  
PROVINCIAL HEALTH SERVICES AUTHORITY**  
(the “Health Authorities”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)  
(the “Doctors of BC”)

**1. Engagement and Communication:**

- a) Health Authorities will actively engage with physicians before and throughout EHR implementation by seeking physicians’ feedback and input into planning, design and implementation processes. This includes:
  - meeting and working with Medical Staff Associations (MSAs), on a regional, sub-regional, or site level, on the development of an engagement and implementation plan prior to implementation; and
  - ongoing engagement of MSAs throughout implementation.
- b) Health Authorities’ EHR implementation plans will:
  - ensure that clear processes are established and outlined for physicians to identify and report issues, questions and problems;

- ensure physicians receive support should more significant problems arise; and
  - consider successful strategies and best practices proven at sites with successful EHR implementation.
- c) Health Authorities will create a comprehensive communication plan that reaches the entire medical staff (i.e. at both the departmental and individual level in each site).
- d) Where invited by MSA representatives, Doctors of BC representatives will be permitted to participate at both the regional and site level in Health Authority and MSA discussions outlined above.
- e) EHR engagement will be supported by the Specialist Services Committee and the Facility Engagement process and funding, to the exclusion of funding for required EHR training, which remains the responsibility of each Health Authority. This does not preclude MSAs from using Facility Engagement funding for activities related to the training.

## 2. **Measurement:**


- a) Health Authorities will:
- measure the impact of EHR introduction,
  - engage with local or regional MSA representatives on what is measured and the approach to measurement, and
  - share and review the results of relevant measurement with local or regional MSA representatives.

## 3. **Resolution of Disagreements:**

If any of the parties has a concern respecting this Memorandum, the parties directly impacted (e.g. Doctors of BC and a Health Authority) will meet to attempt to resolve the issues. If they cannot resolve the issues, the matter will be resolved in the same manner as set out in Article 22.1 of the 2019 Physician Master Agreement for resolution of Provincial Disputes.


This Memorandum shall terminate effective March 31, 2022, or as otherwise agreed by the Parties.

Dated this 1<sup>st</sup> day of April 2019



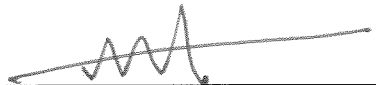
---

Dr. Eric Cadesky  
President  
Doctors of BC



---

Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC



---

Mark Armitage  
Assistant Deputy Minister  
Ministry of Health

---

Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority

---

Kathy MacNeil  
Chief Executive Officer  
Island Health

---

Cathy Ulrich  
Chief Executive Officer  
Northern Health

---

Susan Brown  
Chief Executive Officer  
Interior Health Authority

---

Carl Roy  
Chief Executive Officer

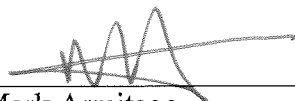
Dated this 1<sup>st</sup> day of April 2019

---

Dr. Eric Cadesky  
President  
Doctors of BC


---

Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC




---

Mark Armitage  
Assistant Deputy Minister  
Ministry of Health



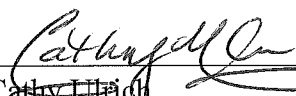
---

Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority




---

Kathy MacNeil  
Chief Executive Officer  
Island Health



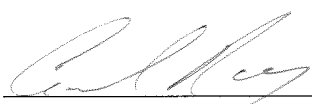
---

Cathy Ulrich  
Chief Executive Officer  
Northern Health



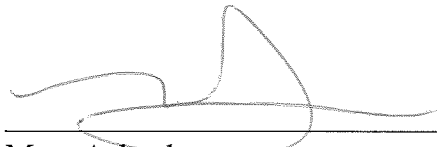
---

Susan Brown  
Chief Executive Officer  
Interior Health Authority



---

Carl Roy  
Chief Executive Officer  
Provincial Health Services Authority



---

Mary Ackenhusen  
Chief Executive Officer  
Vancouver Coastal Health Authority



**MEMORANDUM OF AGREEMENT**  
**PHYSICAL/PSYCHOLOGICAL SAFETY**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health  
(the “Ministry”)

**AND:**

**FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, ISLAND  
HEALTH, VANCOUVER COASTAL HEALTH, NORTHERN HEALTH and  
PROVINCIAL HEALTH SERVICES AUTHORITY**  
(the “Health Authorities”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)  
(the “Doctors of BC”)

(individually a “party” and collectively the “parties”)

## **Occupational Health & Safety, Psychological Health & Safety, and Violence Prevention for Physicians Working in Health Authority Facilities**

### **1. Provincial Level: Working Group for Provincial Framework/Structure**

The parties acknowledge the need for a coordinated and integrated effort to improve the health and safety of health care workers/providers and renew and rebuild a provincial framework/structure for occupational health and safety in the BC health sector (the “**Framework**”), built on the following principles:

- Broad stakeholder engagement in governance;
- Collaborative approach;
- Transparency;
- Evidence based decision making; and
- Compliance.

To this end, the parties, within 180 days of execution of the 2019 Physician Master Agreement, will develop a recommended work plan for submission to and approval by the Ministry through Leadership Council. The plan will include recommendations on an approach to governance, data sharing, objective setting, implementation, compliance, measurement and evaluation. The intention is to create proactive programs with a focus on prevention.

To create the work plan, the Doctors of BC will participate in a broad working group chaired by HEABC, and comprised of one representative from Doctors of BC, one representative from each participating employee group (bargaining association), three employer representatives (Health Authorities or health sector affiliated employers), and a representative from the Ministry (the “**Provincial Working Group**”). The Provincial Working Group may include a representative from other relevant groups as agreed by the participants. The Provincial Working Group will decide matters by consensus.

Unless otherwise agreed by the majority of representatives in the Provincial Working Group, the Provincial Working Group shall meet not less than once per calendar month until its final report is issued.

The Provincial Working Group shall develop Terms of Reference for the purpose of drafting recommendations for the Framework that will:

- Establish institutional systems for implementing the below objectives, including sharing information, data, and experience across the sector.

- Promote a safe and healthy environment and organizational safety culture through prevention of injury initiatives, safe workloads, safe work practices and healthy workforces, including pilot and demonstration programs.
- Prevent and reduce the incidence of injuries (physical and psychological) and occupational diseases.
- Support the adoption of leading (best) practices, programs or models, including the implementation of the Canadian Standards Association's Occupational Health & Safety Management, and Psychological Health and Safety Workplace standards.
- Facilitate co-operation information and data sharing between the Doctors of BC, Health Authorities and unions, on health and safety issues.
- Facilitate and provide education and training for effective functioning of local Joint Occupational Health and Safety committees.
- Improve the awareness of and compliance with, where appropriate, the *Workers Compensation Act* and the *Occupational Health and Safety Regulation*
- Discuss and consider appropriate Doctors of BC participation in the ongoing Framework.

It is understood that the Framework should serve all stakeholders in the provincial health care sector. To that end, the parties will make all reasonable efforts to promote the adoption of the Framework on a province and sector-wide basis.

## **2. Physician Violence Prevention Working Group (PVPWG)**

The work of the Physician Violence Prevention Working Group (PVPWG) will continue, and the focus will shift to implementation and evaluation.

## **3. Psychological Safety – Physician Specific Issues**

The parties will create a small working group composed of an equal number of representatives of the Doctors of BC and the Ministry/Health Authorities for addressing specific physician issues related to psychological safety (the “**Physician Specific Issues Working Group**”).

The Physician Specific Issues Working Group will decide matters by consensus.

The Physician Specific Issues Working group will make recommendations to the Provincial Working Group or Regional Committees where necessary.

## **4. Physician Training**

Health Authorities will:

- Provide appropriate violence prevention and response training for individual physicians working in high and low-risk environments. This training will include an online module for all medical staff, and Health Authorities will make reasonable efforts to ensure such modules may be credited towards continuing education.
- In addition, and for physicians in high-risk environments (Emergency/Urgent Care, Psychiatry/Mental Health Addictions, Residential/Long-term Care, Neurology/Brain Injury), there will be additional classroom training compensated at current sessional rates.
- Where appropriate, provide team-based training at a department/group level with entire teams (physicians, nurses etc.) to help those teams better prevent and respond to violent incidents in their environment.

## 5. Regional Level

In order to explore safety improvement opportunities, the parties will develop, within 180 days of execution of the 2019 Physician Master Agreement, recommendations for Regional OHS, PHS and Violence Prevention Committees.

To develop the recommendations, the parties agree to establish a broad working group to be chaired by HEABC, comprising one representative from each of Doctors of BC, the employee groups (bargaining associations), and the Health Authorities or health sector affiliated employers (the “**Regional Working Group**”). The Regional Working Group may also establish subcommittees as appropriate and include a representative from other relevant groups as agreed by the participants, and will decide matters by consensus. Unless otherwise agreed by the majority of representatives of the Regional Working Group, the Regional Working Group shall meet not less than once per month until its final recommendations are made.

The Regional Working Group shall develop Terms of Reference for the purpose of drafting recommendations for the Regional OHS, PHS and Violence Prevention Committees that will:

- provide a consistent and collaborative approach to safety related issues
- make recommendations to the Health Authorities on:
  - OHS, PHS, and Violence Prevention policies and procedures
  - OHS, PHS, and Violence Prevention training implementation
  - Risk assessment completion
  - Worksafe BC Orders (where applicable)

- Corrective action to address OHS and violent incidents and trends
- clear and consistent reporting, tracking and follow up processes across health authorities and hospitals related to violent incidents and recommendations for improvement, as well as psychological safety

In addition, the parties will ensure Doctors of BC and/or physician representatives are appointed to these Regional Committees.

## **6. Communication and Consultation**

Health Authorities will:

- create a comprehensive communication plan for Health Authority facilities encompassing violence prevention and response as well as psychological safety that ensures key information reaches the department/individual level. This includes effective reporting of critical tracking information, policy or process changes as well as progress on elements of the CSA standard regionally and for specific sites.
- share such communication plans with Doctors of BC and Medical Staff Associations.

## **7. Local Level**

Health Authorities will work:

- with both the Doctors of BC and SSC Facility Engagement to engage Medical Staff Associations (MSAs) at local sites about violence prevention and psychological safety that includes consultation about existing challenges as well as ongoing feedback regarding any changes or initiatives made at a local level; and
- with MSAs to ensure that physicians are invited from their MSAs to participate on local committees, where appropriate.

## **8. Physician Compensation**

The physician members appointed by the Doctors of BC on the Working Groups and Committees noted above will be compensated from existing Joint Collaborative Committee funding.

## **9. Project funding**

The parties agree to re-allocate one time funds from the General Practice Services Committee (GPSC), the Specialist Service Committee (SSC) and the Joint Standing Committee on Rural

Issues (JSC) as outlined below that the Doctors of BC may use in conjunction with the Health Authorities for activities contributing to the development of a provincial Framework, or to identify and address initiatives specific to physicians within any appropriate ongoing structures within the Framework:

- Effective April 1, 2019
  - i. From SSC: \$250,000
  - ii. From GPSC: \$150,000
  - iii. From JSC: \$100,000
- Effective April 1, 2020:
  - i. From SSC: \$250,000
  - ii. From GPSC: \$150,000
  - iii. From JSC: \$100,000
- Effective April 1, 2021:
  - i. From SSC: \$250,000
  - ii. From GPSC: \$150,000
  - iii. From JSC: \$100,000


## **10. Resolution of Disagreements**

If any of the parties has a concern respecting this Memorandum, the parties directly impacted (e.g. Doctors of BC and a Health Authority) will meet to attempt to resolve the issues. If they cannot resolve the issues, the matter will be resolved in the same manner as set out in Article 22.1 of the 2019 Physician Master Agreement for resolution of Provincial Disputes.

## **11. Termination**

This Memorandum shall terminate effective March 31, 2022, or as otherwise agreed by the Parties.

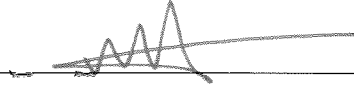
Dated this 1<sup>st</sup> day of April 2019

  
\_\_\_\_\_  
Dr. Eric Cadesky  
President  
Doctors of BC



---

Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC



---

Mark Armitage  
Assistant Deputy Minister  
Ministry of Health

---

Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority

---

Kathy MacNeil  
Chief Executive Officer  
Island Health

---

Cathy Ulrich  
Chief Executive Officer  
Northern Health

---

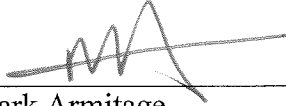
Susan Brown  
Chief Executive Officer  
Interior Health Authority

---

Carl Roy  
Chief Executive Officer  
Provincial Health Services Authority


---

Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC



---

Mark Armitage  
Assistant Deputy Minister  
Ministry of Health



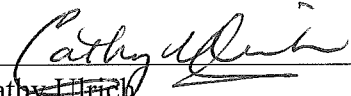
---

Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority




---

Kathy MacNeil  
Chief Executive Officer  
Island Health



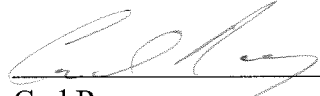
---

Cathy Ulrich  
Chief Executive Officer  
Northern Health



---

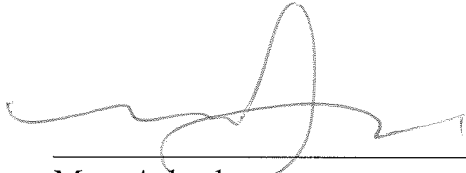
Susan Brown  
Chief Executive Officer  
Interior Health Authority



---

Carl Roy  
Chief Executive Officer  
Provincial Health Services Authority





---

Mary Ackenhusen  
Chief Executive Officer  
Vancouver Coastal Health Authority

**MEMORANDUM OF UNDERSTANDING**

**PROVINCIAL ENGAGEMENT**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health

(the “Ministry”)

**AND:**

**FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, ISLAND  
HEALTH, VANCOUVER COASTAL HEALTH, NORTHERN HEALTH and  
PROVINCIAL HEALTH SERVICES AUTHORITY**

(the “Health Authorities”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)

(the “Doctors of BC”)

(individually a “Party” and collectively the “Parties”)

## Public Sector Governance and Accountability

The Ministry of Health and Health Authorities are taking important steps to strengthen governance and accountability in the health system in British Columbia. These efforts are guided by two key government documents:

- From the Ministry of Finance, **Taxpayer Accountability Principles: Strengthening Public Sector Governance and Accountability**, which sets out principles to strengthen accountability, promote cost control and ensure public sector entities operate in the best interests of taxpayers.<sup>1</sup>
- From the Ministry of Health, **Setting Priorities for the BC Health System**, which sets out government's strategic priorities for the health system, including:
  - Hard – wiring patient-centered care into health service delivery systems, board and executive management decision making and policy development;
  - Driving health service performance management and accountability through continuous quality improvement; and,
  - Establishing a cross system focus on a number of key patient populations and service delivery areas that are critical to both quality and sustainability.<sup>2</sup>

Both documents highlight the need to strengthen and clarify relationships, both across the public sector and within the health sector, in order to promote strategic collaboration and ensure public funds are spent in a responsible manner.

## Strengthening the Relationship with Physicians

Within this context, the Ministry and Health Authorities are committed to and will be mutually accountable for strengthening and clarifying their relationship with physicians at provincial, regional and local levels. At the provincial level, this will be carried out through constructive engagement and dialogue between senior executives of the Ministry, Health Authorities and the Doctors of BC, primarily through a number of key individual points of contact as well as the senior decision making committees of the Ministry, Health Authorities and Doctors of BC. Constructive engagement and dialogue between the Parties is intended to:

- Enable effective alignment of strategic planning on issues significantly affecting physicians;
- Enable strategic level discussions on major issues/policies affecting the Parties;

---

<sup>1</sup> Available online at:

<http://www2.gov.bc.ca/gov/DownloadAsset?assetId=B613CF138959439D9A947CF3D586FE6B>

<sup>2</sup> Available online at: <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

- Support the development of effective relationships at senior decision making levels; and,
- Support the improvement of engagement and consultation and mutual accountability between physicians and Health Authorities at Regional and Local levels throughout the province.

The following are the key interactive contacts for the Parties:

**a) President Doctors of BC – Minister of Health**

On an annual basis, prior to the finalization of the Ministry's annual Service Plan, the Minister and the Deputy Minister of Health and the President and the CEO of Doctors of BC will hold a meeting to share and discuss their strategic priorities for the upcoming year.

**b) Doctors of BC Executive Committee – Leadership Council**

- (i) The President and the CEO of the Doctors of BC will be invited to make an annual presentation to the Leadership Council on the strategic plan and priorities of Doctors of BC for the year;
- (ii) Doctors of BC will be invited to add agenda items for consideration by Leadership Council on a quarterly basis, or on an ad hoc basis as determined appropriate by the Chair of Leadership Council;
- (iii) Leadership Council will be invited to make an annual presentation on health system priorities for the year to the Executive Committee of Doctors of BC;
- (iv) Leadership Council will be invited to add agenda items for consideration by the Executive Committee of Doctors of BC on a quarterly basis, or on an ad hoc basis as determined appropriate by the CEO of Doctors of BC; and,
- (v) Doctors of BC will be invited to participate in initiatives of the Leadership Council Standing Committees as determined appropriate by Leadership Council and/or the Chairs of the Standing Committees.

**c) Doctors of BC Executive Committee – Provincial Medical Services Executive Council**

- (i) The President and the CEO of the Doctors of BC will be invited to make an annual presentation to the Physician Medical Services Executive Council (PMSEC) on the strategic plan and priorities of Doctors of BC for the year;

- (ii) Doctors of BC will be invited to add agenda items for consideration by PMSEC on a quarterly basis, or on an ad hoc basis as determined appropriate by the Co-Chairs of the Committee;
  - (iii) PMSEC will be invited to make an annual presentation on its strategic plan and/or priorities for the year to the Executive Committee of Doctors of BC;
  - (iv) PMSEC will be invited to add agenda items for consideration by the Executive Committee of Doctors of BC on a quarterly basis, or on an ad hoc basis as determined appropriate by the CEO of Doctors of BC.
- d) Doctors of BC Executive Director of Communications and Public Engagement – Ministry and Health Authority Communications Directors**
- e) Doctors of BC Executive Director(s) responsible for Joint Clinical Committees – Ministry and Health Authority Senior Staff Responsible for Joint Committees**
- f) Doctors of BC Physician and External Affairs – Health Authority Medical Affairs**
- (i) Senior representatives from Doctors of BC’s Department of Physician and External Affairs will meet with senior representatives of Medical Affairs from each Health Authority at least once per year to outline key priorities and opportunities for collaboration or consultation. Guests can be included as needed and as invited by Doctors of BC and Health Authorities to assist in discussions or to provide advice or resources where appropriate.
  - (ii) The parties will meet at a location that is convenient to Health Authority representatives.
  - (iii) The parties will exchange their agenda and a list of attendees a minimum of thirty (30) days in advance of the meeting.

The Parties mutually share the goal of providing excellent health care to British Columbians. To that end they will work collaboratively to implement and continue the process outlined in this Memorandum.

It is an expectation of the Parties that they will also pursue other avenues of constructive engagement and dialogue or undertake communication on other matters including:

- (i) Provincial Programs/Provincial Policy Changes;

- (ii) Regional Programs/Regional Policy Changes; and
- (iii) Issues management.

The Parties recognize that the Doctors of BC Department of Physician and External Affairs has a key role in such engagement and dialogue.

### **Separate Agreement**

This Memorandum is a separate and distinct agreement and its construction is not to be influenced or affected by the provisions of the Physician Master Agreement (PMA). The provisions of the PMA do not apply to this Memorandum. For greater certainty, and without limiting the generality of the foregoing, the following provisions of the PMA have no application: (i) Articles 20 through 23; and (ii) Articles 26 and 27. In the event of a conflict between the terms of this Memorandum and that of the PMA, the PMA terms will take precedent.

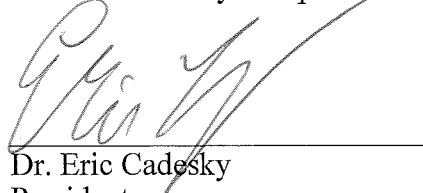
### **Resolution of Disagreements**

If any of the Parties has a concern respecting this Memorandum, the CEO of Doctors of BC, the Deputy Minister of Health and/or the Health Authority CEOs will meet to attempt to resolve these issues. Failing resolution, there are no further steps under this Memorandum to address such concerns.


### **Termination**

This Memorandum shall terminate effective March 31, 2022, or as otherwise agreed by the Parties.


Dated this 1<sup>st</sup> day of April 2019



Dr. Eric Cadesky  
President  
Doctors of BC



Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC



Mark Armitage  
Assistant Deputy Minister  
Ministry of Health



Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority



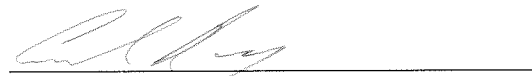
Kathy MacNeil  
Chief Executive Officer  
Island Health



Cathy Ulrich  
Chief Executive Officer  
Northern Health



Susan Brown  
Chief Executive Officer  
Interior Health Authority



Carl Roy  
Chief Executive Officer  
Provincial Health Services Authority



Mary Ackenhusen  
Chief Executive Officer  
Vancouver Coastal Health Authority

**MEMORANDUM OF UNDERSTANDING**

**2019 REGIONAL AND LOCAL ENGAGEMENT**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health  
(the “Ministry”)

**AND:**

**FRASER HEALTH AUTHORITY, INTERIOR HEALTH AUTHORITY, ISLAND  
HEALTH, VANCOUVER COASTAL HEALTH, NORTHERN HEALTH and  
PROVINCIAL HEALTH SERVICES AUTHORITY**  
(the “Health Authorities”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
(doing business as Doctors of BC)  
(the “Doctors of BC”)

(individually a “Party” and collectively the “Parties”)



## Public Sector Governance and Accountability

The Ministry of Health and Health Authorities are taking important steps to strengthen governance and accountability in the health system in British Columbia. These efforts are guided by two key government documents:

- From the Ministry of Finance, **Taxpayer Accountability Principles: Strengthening Public Sector Governance and Accountability**, which sets out principles to strengthen accountability, promote cost control and ensure public sector entities operate in the best interests of taxpayers.<sup>1</sup>
- From the Ministry of Health, **Setting Priorities for the BC Health System**, which sets out government's strategic priorities for the health system, including:
  - Hard – wiring patient-centered care into health service delivery systems, board and executive management decision making and policy development;
  - Driving health service performance management and accountability through continuous quality improvement; and,
  - Establishing a cross system focus on a number of key patient populations and service delivery areas that are critical to both quality and sustainability.<sup>2</sup>

Both documents highlight the need to strengthen and clarify relationships, both across the public sector and within the health sector, in order to promote strategic collaboration and ensure public funds are spent in a responsible manner.

### Strengthening the Relationship with Physicians

Within this context, the Ministry and Health Authorities are committed to and will be mutually accountable for clarifying and strengthening their relationship with physicians at provincial, regional and local levels.

At the provincial level, the parties have agreed to continue a Memorandum of Understanding with the aim of improving engagement and dialogue between senior executives of the Ministry, Health Authorities and the Doctors of BC through a number of key points of contact and senior level committees.

---

<sup>1</sup> BC Ministry of Finance, **Taxpayer Accountability Principles: Strengthening Public Sector Governance and Accountability**  
Available online at:

<http://www2.gov.bc.ca/gov/DownloadAsset?assetId=B613CF138959439D9A947CF3D586FE6B>

<sup>2</sup> Available online at: <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

At the regional and local levels, Health Authorities are currently working to establish and improve relationships with community-based family practice physicians through Divisions of Family Practice and Collaborative Services Committees.

With respect to physicians who have privileges to practice in Health Authority facilities and programs, the *Hospital Act*, *Hospital Act Regulation* and respective Health Authority medical staff rules and bylaws set out the framework for the governance of medical staff and the relationship between Health Authorities and physicians. Within this governance framework, Health Authorities will take the following actions to strengthen relationships with physicians practicing in their facilities and programs:

- a. Support the improvement of medical staff engagement within Health Authorities through existing local medical staff association structures, or where mutually agreed to by the parties at the local level, through new local structures (collectively, “Local Structures”) so that medical staff:
  - i. views are more effectively represented;
  - ii. contribute to the development and achievement of Health Authority plans and initiatives, with respect to matters directly affecting physicians;
  - iii. prioritize issues significantly affecting physicians and patient care; and,
  - iv. have meaningful interactions with Health Authority leaders, including physicians in formal Health Authority medical leadership roles.
- b. Improve processes locally within Health Authority programs and facilities as well as provide physicians with appropriate information to allow for more effective engagement and consultation between physicians and Health Authority operational leaders.
- c. Support physicians to acquire, with continued or expanded Joint Clinical Committee funding support, the leadership and other skills required to participate effectively in discussions regarding issues and matters directly affecting physicians and their role in the health care system.

The Parties commit that the Ministry’s Health Sector Workforce Division and Doctors of BC Department of Physician and External Affairs will play a key role in continuing to support both the Health Authorities and physicians in successfully implementing this Memorandum.

Health Authorities and physicians are mutually accountable for the quality of their relationship with the goal of providing high quality health care services. The actions to be taken by Health Authorities set out in this Memorandum will continue to be incorporated into the Ministry’s accountability letters to Health Authority Boards and Executives, and will continue to be subject to ongoing monitoring and reporting for the period of this agreement. Further, the quality of engagement and consultation and mutual accountability of the parties will be the subject of

ongoing dialogue at a senior level through the various points of interface identified in the Memorandum of Understanding on Provincial Engagement.

### **Regional and Local Engagement Initiative**

1. The Specialist Services Committee (SSC) will be responsible for developing payment and other financial support mechanisms, in line with the *Joint Clinical Committee Administration Agreement*, to enable facility-based Specialists, General Practitioners and Physicians paid under Alternative Payment Arrangements to participate in this engagement process, including:
  - a. the hiring of Physician Engagement Leads, per the terms of the Joint Clinical Committee Administrative Agreement, to support physicians, working in consultation with Health Authorities to improve Local Structures, and thereafter to provide support to physicians as required to ensure effective participation of physicians in these structures.
    - i. Physician Engagement Leads will not function as representatives in the relationship between Health Authorities and physicians.
  - b. providing funding to qualified Local Structures, for the purpose of facilitating effective engagement and consultation between physicians and Health Authority leaders.
  - c. support for EHR engagement, to the exclusion of funding for required EHR training, which remains the responsibility of each Health Authority.
2. The appropriate Joint Clinical Committee will provide funding to support facility-based Specialists, General Practitioners and Alternative Paid Physicians developing leadership and other skills necessary for effective, collaborative working relationships with health care managers, administrators and other health care workers.
3. In order to qualify for funding under paragraph one above, Local Structures, must:
  - a. demonstrate a capacity for accepting and managing funding and reporting on expenditures;
  - b. demonstrate a composition, governance and decision making structure that can effectively represent its members' interests; and
  - c. work closely with the Health Authority on the development of the representative structure(s) to facilitate effective interaction with Health Authority operational leaders.

4. At the discretion of the Local Structures the annual funding provided is to be used exclusively for the following purposes:
  - a. governance/administration costs of the Local Structure;
  - b. compensation of physicians for their time in participating in internal meetings and in meetings with Health Authority/facility representatives in relation to this specific SSC engagement initiative;
  - c. other costs contributing to the objectives of this Memorandum, including for activities related to EHR training
5. The annual funding may not be used for the following purposes:
  - a. advertising with the exception of physician recruitment ads;
  - b. compensation for clinical services;
  - c. purchase of real estate and vehicles;
  - d. purchase of clinical equipment;
  - e. donations to charities or political parties; and
  - f. meeting attendance that is presently required as part of maintaining privileges.
6. The above funding criteria may be amended and additional funding criteria may be established by the SSC in consultation with Health Authorities through the Leadership Council. The SSC may take into consideration the availability of funding, the size of Local Structures and other criteria that the parties consider relevant.
7. Funding to support the Regional and Local Engagement Initiative will be as per the renewed Physician Master Agreement.

### **Consultation**

Health Authorities will commit to consult and engage with medical staff on regional and local issues including the following:

- a. Issues of importance to the medical staff;
- b. Health Authority decisions on planning, budgeting and resource allocation directly affecting the medical staff;
- c. Significant decisions affecting physicians and the delivery of physician services;

- d. The working environment for physicians, including the physical and psychological safety of physicians working in Health Authority facilities;
- e. Matters referred by the Board of Directors, CEO or Medical Advisory Committee;
- f. Medical Staff Bylaws and Rules;
- g. Ensuring professional and collegial communications with health administrators, other physicians and members of the inter-professional health care team;
- h. Quality and cost improvement opportunities;
- i. Physician access to processes and resources that provide timely feedback on variations and the level of quality of clinical care in a way that will help to optimize patient outcomes;
- j. Quality improvement projects, including quality assurance projects, identified by the Health Authority, Local Medical Structure, Joint Clinical Committees, Physician Quality Assurance Steering Committee, BC Patient Safety and Quality Council or other; and
- k. A culture that supports appropriate and constructive physician advocacy for both patients and changes to the health care system.

### **Roles and Responsibilities**

Nothing in this Memorandum limits the authority of the Ministry or Health Authorities to make decisions with respect to any matters within their purview.

Nothing in this Memorandum limits the responsibilities of medical staff, Health Authority medical leadership and administration arising from Health Authority bylaws and rules.

Nothing in this Memorandum limits the representation rights of the Doctors of BC as provided for in the Physician Master Agreement.

### **Separate Agreement**

This Memorandum is a separate and distinct agreement and its construction is not to be influenced or affected by the provisions of the Physician Master Agreement (PMA), except as provided in this Memorandum. This Memorandum does not apply to any issues of physician compensation addressed in the PMA. The general provisions of the PMA do not apply to this Memorandum. For greater certainty, and without limiting the generality of the foregoing, the following provisions of the PMA have no application: (i) Articles 20 through 23; and (ii) Articles 26 and 27.

## Resolution of Disagreements

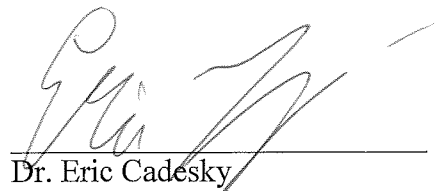


If any of the Parties has a concern respecting this Memorandum, the CEO of the Doctors of BC, the Deputy Minister of Health and/or the Health Authority CEO(s) will meet to attempt to resolve these issues. Failing resolution, there are no further steps under this Memorandum to address such concerns.

## Termination

This Memorandum shall have the same term as, and shall terminate concurrent with any termination of the 2019 Physician Master Agreement, subject to the following:

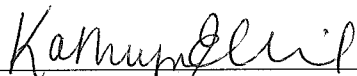
- a. The Doctors of BC will survey facility-based physicians to measure engagement under this Memorandum between January 1, 2021 and June 30, 2021.
- b. The Doctors of BC, the Ministry and the Health Authorities will meet between July 1, 2021 and December 31, 2021 to discuss the results of the Doctors of BC survey and any other issues related to engagement and the operation of this Memorandum. The parties may agree on amendments to this Memorandum.
- c. If the parties are not able to agree on amendments to this Memorandum, if any, either the Doctors of BC or the Ministry and the Health Authorities, through Leadership Council may give notice to the other parties on or after January 1, 2022 of the termination of this Memorandum, in which case this Memorandum will terminate on March 31, 2022.

Dated this 1st day of April, 2019

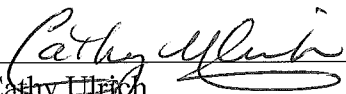
  
\_\_\_\_\_  
Dr. Eric Cadesky  
President  
Doctors of BC  
\_\_\_\_\_  
Allan Seckel Q.C.  
Chief Executive Officer  
Doctors of BC  
\_\_\_\_\_  
Mark Armitage  
Assistant Deputy Minister  
Ministry of Health



Dr. Victoria Lee  
Chief Executive Officer  
Fraser Health Authority



Kathy MacNeil  
Chief Executive Officer  
Island Health



Cathy Ulrich  
Chief Executive Officer  
Northern Health



Susan Brown  
Chief Executive Officer  
Interior Health Authority



Carl Roy  
Chief Executive Officer  
Provincial Health Services Authority



Mary Ackenhusen  
Chief Executive Officer  
Vancouver Coastal Health Authority

**MEMORANDUM OF UNDERSTANDING  
COMPENSATION MODEL CONSULTATION**

**BETWEEN:**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH  
COLUMBIA**, as represented by the Ministry of Health

(the “**Ministry**”)

**AND:**

**THE BRITISH COLUMBIA MEDICAL ASSOCIATION**  
doing business as Doctors of BC

(the “**Doctors of BC**”)

(individually a “**party**” and collectively the “**parties**”)

**Agreement to Discuss**

1. The parties agree to work together on the development of new compensation models and their application through specific physician services template contracts (“**New Compensation Models**”) that reflect the needs and interests of government, physicians and patients. Within this context, the Ministry commits to engage in discussions with Doctors of BC through the process outlined in this Memorandum of Understanding if it intends to develop a New Compensation Model for widespread implementation immediately or over time. The Ministry makes no commitments to use the process outlined in this Memorandum of Understanding to renew or alter any existing contracts.

**Discussion Process**

2. Either party may initiate a request for discussion on the development of New Compensation Models. The party requesting a discussion on a New Compensation Model must, in its request:



- a) identify to the other party the clinical environment for the application of the proposed New Compensation Model; and
  - b) provide to the other party a high level outline of the New Compensation Model to be applied.
- 3. Subject to paragraph 4, the parties will meet to discuss the proposed New Compensation Model and its application within thirty (30) days of either party receiving a request for discussion from the other in accordance with paragraph 2. Prior to meeting, each party will identify and communicate to the other those representatives that will carry out the discussions on its behalf in accordance with the following:
  - a) The Ministry's team will include representatives from the Ministry and applicable Health Authorities with relevant expertise and responsibility;
  - b) The Doctors of BC team will include physicians who work in the clinical environment to which the New Compensation Model will apply.
- 4. Meeting within thirty (30) days in accordance with paragraph 3 is conditional upon Doctors of BC's ability to identify, based on internal governance processes, appropriate physician representatives within that timeframe.
- 5. Each party will make a good faith effort to conclude an agreement on the New Compensation Model within ninety (90) days following receipt of the request for discussions, and this will include, without limitation, meeting as promptly and frequently after the first meeting as is practicable.
- 6. On the expiry of ninety (90) days following receipt of the request for discussions, the discussion process will be considered concluded unless the parties agree otherwise.

### **Principles**

- 7. The parties agree that the following principles will govern the parties' discussions and developments of New Compensation Models under this Memorandum of Understanding:
  - a) New Compensation Models are intended to present attractive options to physicians and meet the Ministry's objectives;
  - b) The parties will share in a timely fashion relevant information to assist in the costing and evaluation of New Compensation Models;
  - c) Any New Compensation Model developed by the parties will be tested by offering them to physicians to determine their effectiveness in practice;

- d) The parties will work together to seek out and enlist physicians to test any New Compensation Model based on contractual terms to be agreed to by the parties; and
- e) The income of enlisted physicians over the “test” period will be protected, and those physicians will have the option to return to their previous payment arrangement at their discretion in accordance with the terms of their “test” contract or following conclusion of the “test” period.

### **Physician Costs**

The cost of physician representatives participating in these discussions will be borne by the relevant Joint Clinical Committee.

### **Resolution of Disagreements**

If either party has a concern respecting this Memorandum of Understanding, that party may refer the matter to the Physician Services Committee for resolution. Failing resolution, there are no further steps under the 2019 Physician Master Agreement to address the concern.

## Termination

Either party may terminate this Memorandum of Understanding on thirty (30) days' written notice to the other, but no earlier than March 31, 2022.

**IN WITNESS WHEREOF** the parties have executed this Memorandum of Understanding by or in the presence of their respective duly authorized signatories as of the \_\_\_\_ day of \_\_\_\_\_, 2019.

SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN )  
IN RIGHT OF THE PROVINCE OF )  
BRITISH COLUMBIA, by the Minister )  
of Health or his/her duly authorized )  
representative, in the presence of: )

Janina Marsh )  
Signature of Witness )

Janina Marsh )  
Name )

3-1, 1515 Blanshard Street )  
Address )

Victoria, BC )

THE CORPORATE SEAL of the )  
BRITISH COLUMBIA MEDICAL )  
ASSOCIATION was hereunto affixed in )  
the presence of: )

Dr. Eric Cadesky )  
Signature of Authorized Signatory )

Dr. Eric Cadesky )  
Name )

President )  
Position )

