MEMORANDUM OF AGREEMENT

BETWEEN

NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION

AND

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Date Signed: September 2, 2025 Expires: September 30, 2027

This **AGREEMENT** made the _____ day of _____, 2025.

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF NEWFOUNDLAND AND LABRADOR, represented herein by the President of the Treasury Board and the Minister of Health and Community Services ("**Government**")

AND:

THE NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION, a body corporate organized and existing under the laws of the Province of Newfoundland and Labrador ("**NLMA**")

Together, the "Parties"

NOW THEREFORE in consideration of the terms of this Memorandum of Agreement (the "**Agreement**", the Parties agree as follows:

INDEX

Schedules

SECTION A – GENERAL CONSIDERATIONS

Article 1 Purpose of Agreement

1.01 **WHEREAS**

a) Government and physicians share responsibility for the provision of medical services to the public;

b) Both parties agree that the delivery of medical services must take into full consideration:

(i) reasonable and fair compensation and working conditions for physicians providing insured medical services;

(ii) the need for sufficient physician resources to provide adequate medical care in Newfoundland and Labrador; and

(iii) the financial circumstances of Government; and

c) Government and the NLMA, on behalf of physicians, wish to establish a working relationship based on cooperation and good faith;

The parties have negotiated this Memorandum of Agreement with respect to levels of compensation, employment-related benefits and service coverage.

Article 2 Interpretation

Under this Agreement the following definitions will apply.

"Agreement" means this Memorandum of Agreement.

"Alternate Payment Plan (APP)" means an agreement between Government, the Provincial Health Authority (PHA) acting as Newfoundland and Labrador Health Services (NLHS), and the NLMA, that provides remuneration in a format other than salary or fee-for-service (FFS) to a group of physicians in a specialty, including family medicine, in return for the provision of medical services.

"Clinical Assistant" means those licensed as such by the College of Physicians and Surgeons Newfoundland and Labrador.

"Clinical Associate" means those licensed as such by the College of Physicians and Surgeons of Newfoundland and Labrador.

"Consensus" means general agreement, characterized by the absence of sustained opposition to substantial issues by any of the voting members of a committee established under this Agreement, and by a process that involves seeking to take into account the views of all voting members and to reconcile any conflicting arguments. Consensus does not require unanimity.

"**Fee-For-Service (FFS)**" means the submission of accounts by and payment of fees to physicians for insured medical services in accordance with the MCP Payment Schedule under the Medical Care Plan, pursuant to the *Medical Care and Hospital Insurance Act,* SNL2016 C. M-5.01 (*"Medical Care and Hospital Insurance Act, 2016"*).

"Geographic Full-Time (GFT) physician" means a physician with clinical responsibilities who also has an academic teaching appointment at Memorial University. The compensation for the academic component is separate from the compensation for clinical work.

"Health and Community Services (HCS)" means the department or branch of the Government of Newfoundland and Labrador which provides leadership in health and community services programs and policy development for the Province.

"**MCP Payment Schedule**" means the schedule of fees payable, and the rules and conditions for payment of insured services provided by licensed physicians to beneficiaries under the *Medical Care and Hospital Insurance Act, 2016* and the *Regulations* made thereunder.

"Newfoundland and Labrador Medical Association (NLMA)" means the medical association representing, advocating for, and negotiating on behalf of Newfoundland and Labrador physicians pursuant to the *Medical Act, 2011,* SNL 2011, c. M.-4.02.

"**Physician**" means a person who is lawfully entitled to engage in the practice of medicine in the Province pursuant to the *Medical Act, 2011,* SNL 2011 c. M.-4.02, and includes a person who, under the regulations, is entitled to provide insured services.

"**Provincial Health Authority**" means the health authority for the province established under the *Provincial Health Authority Act*, SNL 2022, c. P-30.1 to provide for the delivery of health and community services and the establishment of a provincial health authority.

"**Province**" means the Province of Newfoundland and Labrador.

"**Salaried Physician**" means a physician who is an employee of the PHA and who provides medical services as required by the PHA.

"**Specialist**" means a physician who is recognized as a specialist by the *College of*

Physicians and Surgeons of Newfoundland and Labrador or a physician practicing outside the Province who is recognized as a specialist by the appropriate regulatory body in the jurisdiction where the physician practices.

Article 3 Term of Agreement and Interest Arbitration

3.01 Notwithstanding the date of execution hereof and except as otherwise provided herein, this Agreement shall be effective from October 1, 2023 and shall remain in full force and effect until September 30, 2027.

3.02 Either party to this Agreement may at any time within the one hundred and eighty (180) calendar day period immediately preceding the September 30, 2027 expiration date of this Agreement, give written notice to the other party to commence negotiations for a new agreement.

3.03 Within thirty (30) days following the receipt of the notice referred to in Article 3.02 or a further time that the parties may agree upon, the parties hereto shall enter into good faith negotiations and use reasonable efforts to negotiate a new Agreement.

3.04 If at the expiration date of this Agreement a new agreement has not been negotiated replacing this Agreement, this Agreement shall continue and remain in full force and effect until a new agreement has either been negotiated replacing this Agreement or the terms and conditions of a new agreement have been determined by a combination of negotiation and arbitration as provided for in this Agreement.

3.05 The parties agree to the terms of interest arbitration as articulated at Schedule N, Interest Arbitration.

Article 4 Parties to the Agreement

4.01 The parties to this Agreement are Government and the NLMA.

4.02 The parties recognize that, where applicable, the interests of Government may be represented by the President of Treasury Board and/or the Minister of Health and Community Services or any Minister as may be designated by Government from time to time.

Article 5 Operational Principles

5.01 The parties share a commitment to uphold the terms of this Agreement. The parties agree to work collaboratively to support a respectful, collaborative working relationship.

5.02 In all circumstances, the NLMA recognizes that Government retains full and exclusive authority for the management and operation of the health care system.

5.03 The NLMA recognizes that the Government may deviate from the terms of the Agreement to support the continuous and uninterrupted provision of health care services, in the circumstances set out below.

5.04 In the event that an emerging issue arises that, if unresolved, could become an urgent issue requiring immediate action, the Government and/or PHA has an obligation to notify the NLMA to discuss potential solutions.

5.05 In the event that an urgent issue arises that requires immediate action, the Government and/or PHA may make necessary deviations to the operation of the Agreement for a time-limited period which may continue as long as the matter remains urgent. The Government and/or PHA will inform the NLMA within one week of any such deviation.

5.06 Physicians shall not seek to negotiate an individual arrangement on any matter within the scope of this Agreement, including but not limited to compensation, with the Government and/or PHA. Any attempts to do so will be discussed amongst the parties to determine the course of action.

Article 6 Physicians' Negotiator

6.01 The NLMA is recognized as the sole and exclusive negotiator on behalf of physicians licensed by the College of Physicians and Surgeons of Newfoundland and Labrador to practice in this Province for matters which fall within the scope of this Agreement save and except physicians employed in the following positions:

(i) Vice President, Medical Services – PHA
(ii) Senior Medical Director – Eastern Urban, PHA
(iii) Senior Medical Director – Eastern Rural, PHA
(iv) Senior Medical Director – Central, PHA
(v) Senior Medical Director – Western, PHA

(vi) Senior Medical Director – Labrador-Grenfell, PHA
(vii) Medical Consultant – HCS
(viii) Director of Medical Services – HCS
(ix) Assistant Medical Director – HCS
(x) Chief Medical Examiner – Department of Justice and Public Safety
(xi) Chief Medical Officer of Health – HCS

Article 7 Government Negotiator

7.01 The President of Treasury Board and/or any Minister as may be designated by Government from time to time is recognized as the sole and exclusive negotiator on behalf of Government for matters that fall within the scope of this Agreement.

Article 8 Schedules of the Agreement

8.01 Schedules to the Agreement in effect between physicians, PHA, the NLMA, and Government are listed below, and shall remain in effect for the duration of this Agreement:

(i) Waterford Physicians "On-duty, on-site" Payment Policy – Schedule A
(ii) Facility Workload Disruption Payment Policy for Fee-For-Service Physicians – Schedule B
(iii) Salaried Physician Retention Bonus Categories – Schedule C
(iv) Salaried Family Physician Remoteness Bonus – Schedule D
(v) Alternate Payment Plans (APPs) – Schedule E
(vi) FFS Increases, By FFS Specialty Group – Schedule F
(vii) Approved Category A Facilities (24-Hour On-Site Emergency Department Coverage) – Schedule G
(viii) Approved Category B Facilities (24-Hour Emergency Department Coverage) – Schedule H
(ix) Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians – Schedule I
(x) Family Practice Renewal Program – Schedule J
(xi) Physician Services Liaison Committee (PSLC) Terms of Reference – Schedule K
(xii) MCP Payment Schedule Review Committee (PSRC) Terms of Reference – Schedule L
(xiii) On-Call and Internal Locum Rates – Schedule M
(xiv) Interest Arbitration – Schedule N
(xv) Cataract Surgery Fees in Non-Hospital Designated Facilities – Schedule O
(xvi) Dispute Resolution – Schedule P

(xvii) Rural Community Comprehensive Care (RCCC) Bonus – Schedule Q
(xviii) Blended Capitation Model for Primary Care – Schedule R

Article 9 Government Rights

9.01 All functions, rights, powers, and authorities, which are not specifically abridged, delegated or modified by this Agreement, are recognized by the NLMA as being retained by Government or its delegated authorities.

Article 10 Effect of Legislation

10.01 The parties acknowledge that legislation takes precedence over any provision of this Agreement. It is also acknowledged that should any legislation render null and void any provision of this Agreement, the remaining provisions shall remain in effect during the term of this Agreement.

Article 11 Agreement to Amend

11.01 It is agreed by the parties to this Agreement that any provision of this Agreement may be amended by mutual written consent of Government and the NLMA during the term of this Agreement.

Article 12 Service Coverage

12.01 Physicians commit to provide, in accordance with the negotiated MCP Payment Schedule and/or negotiated salary, insured services which have traditionally been funded through MCP and which the public might reasonably expect to be available, subject to resources and skill limitations.

12.02 The NLMA will make best efforts to encourage all practicing physicians providing clinical services in the Province to be credentialed and privileged with the PHA.

Article 13 Physician Services Liaison Committee (PSLC)

13.01 The parties agree to maintain the PSLC, through which medical issues of mutual concern may be addressed collaboratively and to act as an oversight body for the administration of this Agreement. The operation and mandate of the PSLC is described in Schedule K.

Article 14 Dispute Resolution

14.01 In the event that a disagreement arises regarding the interpretation, application, administration, or alleged violation of this Agreement:

(i) Either party may refer the matter to the Physician Services Liaison Committee (PSLC) for resolution; and/or

(ii) Either party may refer the matter to mediation in accordance with the procedure outlined in Schedule P. The mediator shall assist the parties in reaching a resolution. If resolution is not achieved the mediator will recommend a resolution for consideration by the parties. The cost of mediation shall be equally borne by the parties; and,

(iii) After completion of (i) or (ii), should the matter be unresolved, either party may refer the matter to arbitration in accordance with the *Arbitration Act, RSNL 1990 cA-14*. The arbitrator shall have the jurisdiction to determine if the matter is arbitrable. Any decision of the arbitrator is final and binding. The arbitrator shall not have any authority to alter, change, add to or detract from the Agreement or to substitute any new provision for any existing provision. The cost of arbitration shall be equally borne by the parties.

Article 15 Provincial Locum Recruitment Program

15.01 HCS will establish and resource a provincial physician locum recruitment program.

The program's mandate is to match locums with locum opportunities, including the establishment and maintenance of a provincial physician locum roster. The program objective is to bring about improved access to locums by community-based physicians and the PHA and a more equitable distribution of locum assignments.

The implementation of the program will be monitored by the PSLC and will be evaluated by the PSLC for continuation after two (2) years of operation.

SECTION B - COMPENSATION ISSUES

Article 16 Fee-For-Service Compensation

16.01 Fee-For-Service Increases

Fee-For-Service (FFS) physician groups shall receive increased remuneration as follows:

(i) FFS rates will increase by the percentages identified in Schedule F.

(ii) Family Physicians as a group will maintain access to funding under the Family Practice Renewal Program, as detailed in Schedule J, attached. This funding will be distributed effective October 1, 2023.

(iii) For the 2023-27 Agreement, an amount from the negotiated funding will be allocated to other items including, but not limited to, APP payments, FFS Intensive Care Unit (ICU) payments, surgical assisting payments, premiums for surgery fee codes, and Category B payments. This funding will be distributed effective October 1, 2024.

(iv) The $170,000 funding commitment for Psychiatry consultants from the former Clinical Stabilization Fund will continue, through the established methodology used during the term of the 2023 – 2027 Agreement.

(iv) The parties will jointly review the approach used to measure competitiveness for the purposes of the Agreement prior to the next negotiation.

16.02 Schedule of Payments

Until such time as the MCP Payment Schedule fee code allocation process is completed:

(i) FFS Physicians will continue to claim for services using MCP Payment Schedule rates in effect.

(ii) The applicable increase for each group will be paid as an adjustment in each pay period until such time as the Fee Code Allocation Process outlined below in Articles 16.03 and 16.04 is completed.

16.03 FFS Fee Code Allocation

Government and the NLMA will collaborate in the allocation of new funds to specific fee codes and rates for each specialty (the "FFS Fee Code Allocation Process").

The FFS Fee Code Allocation Process will be based on the following principles:

1. no fee code shall exceed the Ontario Health Insurance Plan rate for a comparable service unless mutually agreed;
2. there shall be no fee code allocation to offset overhead costs; and
3. there shall be no fee code allocation for currently non-insured services.

16.04 FFS Fee Code Allocation Process

The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine fee code allocation jointly and collaboratively by consensus. Any fee code allocation which has not been established through this collaborative process will be determined as outlined in steps (i) and (ii) below:

(i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

(ii) Within thirty (30) days of receipt of the information from the NLMA as referred to in 16.04 (i) HCS shall allocate the remaining 50% of the FFS increase.

16.05 MCP Payment Schedule Review Process

The parties agree to review the MCP Payment Schedule in accordance with the terms of reference of the MCP Payment Schedule Review Committee as set out in Schedule L.

16.06 Category A Designated Facilities – Emergency Department

(a) With the exception of arrangements made under the Alternate Payment Plan for Adult Emergency Department (Health Science Centre/St. Clare's Mercy Hospital) as set out in Schedule E, all FFS Physicians providing on-site coverage at Category A designated emergency facilities, which are identified in Schedule G, Approved Category A Facilities (24-Hour On-Site Emergency Department Coverage), shall be compensated at an hourly rate as follows:

	October 1, 2024	October 1, 2025	October 1, 2026
Payment Rate	$267.00	$270.20	$273.45

(b) Compensation will also include the following shift premiums, as applicable:

Monday to Friday Evening from 6pm to Midnight	+ $20 per hour
Monday to Friday Overnight from Midnight to 8am, and 24 hours on Saturday, Sunday, and Statutory Holiday Premium (as per Clause 22.01 – Statutory Holidays)	+ $30 per hour

Note: Shift premiums are fixed in value for the duration of the Agreement.

(c) Each physician providing Category A emergency services will be provided with a contract by the PHA which will reference the terms of this Agreement and may include other related requirements of NLHS in respect of the Category A emergency services.

(d) Each physician providing Category A emergency services will participate in a posted schedule for the provision of services, the process for which will be managed by PHA on a pre-determined basis (e.g., quarterly). Each physician is expected to advise PHA regarding their preferred volume of service and preferred dates when the schedule is being developed, and a final schedule will be by mutual agreement. Once a schedule is determined, the schedule will not be changed unless there is either mutual agreement between PHA and the physician, or there are extenuating circumstances (e.g., illness; bereavement).

(e) PHA will provide to the NLMA, on an annual basis, a list of physicians, by facility, who have contracts to provide Category A emergency services.

16.07 Retention Bonus – Rural FFS Specialists (excluding physicians on APPs)

FFS Specialists, who practice outside St. John's/Mount Pearl, will be eligible to receive an annual retention bonus based on accumulated service time, as follows:

After 12 Eligible Months	After 24 Eligible Months	After 36 Eligible Months
$5,000	$10,000	$15,000

Rules on eligibility have been determined by the parties and may be amended from time to time where appropriate.

16.08 Rural Community Comprehensive Care (RCCC) Bonus – Rural FFS Family Physicians

FFS Family Physicians, including physicians who transition to the Blended Capitation Model, will be eligible to receive the Rural Community Comprehensive Care (RCCC) Bonus as set out in Schedule Q.

16.09 Canadian Medical Protective Association (CMPA) reimbursement for FFS Physicians

The parties agree that, for the term of this Agreement, the HCS's calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate. All other aspects of the payment policy in effect on the date of signing of this Agreement will remain unchanged.

16.10 Obstetrical Bonus

FFS Family Physicians are eligible for the Obstetrical bonus policy as outlined in Schedule I, Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians.

16.11 Recognition of On-Call

(i) The rates for on-call billing and internal locum payments are set out in Schedule M, On-Call and Internal Locum Rates.

(ii) General Obligations

a. On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency department;

- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

b. Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

c. The on-call services will operate from designated facilities.

d. Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients and make FFS claims related to them during the period they are also on-call for unattached patients.

e. Only on-call rotations recommended by the PHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

f. Physicians on APPs who have on-call payments factored into their APP budget are not eligible to claim the on-call payment.

16.12 Surgical Assist - Dedicated time method Surgical Assistance

Until such time as the FFS Fee Code Allocation Process is completed:

- FFS Physicians should continue to claim for services using the rates in the MCP Payment Schedule in effect as of October 1, 2019. These payments will be increased based on the percentage increase being applied to all FFS Physicians;

- Retroactive payment to October 1, 2024 will be paid as expeditiously as possible after signing of this Agreement based on the percentage increase applicable; and,

- Following the retroactive payment, the applicable increase will be paid bi-weekly as required until such time as the FFS Fee Code Allocation Process is completed and new fees are implemented.

16.13 Compensation for Surgical Procedures Cancellation in PHA Facilities for FFS Physicians

In the event of surgical cancellation, the affected FFS Physicians (e.g.; Specialist, Family Physician, Surgical Assistant, Specialist Assistant, and Anesthesiologist) who were scheduled to perform the scheduled surgical procedure (as confirmed on the OR booking sheet or day surgery list) will be paid 100% of the fee payable, had the surgical procedure not been cancelled, on the following conditions:

a) Where a surgical procedure is cancelled within twenty-four (24) hours of the scheduled calendar day of the surgical procedure. Where a surgical procedure scheduled for a Monday is cancelled the hours of Saturday and Sunday are not included in determining the twenty-four (24) cancellation period.

b) The reasons for cancellation are outside of physicians' control (e.g., equipment is unavailable, post-operative resources are unavailable, or human resources including salaried and APP physicians, are unavailable).

c) The scheduled surgical procedure was booked on the operating room booking card (main operating room or day surgery booking card) excluding cases on the emergency board and trauma board.

d) Physicians able to perform alternate services will have the fee payable reduced by the amount billed for these alternate services.

The after-hours Surgical Procedure Premiums and Anesthesia Premiums will apply if the surgical procedure was scheduled during the after-hours period, but no other fees will be paid. This clause does not apply to Salaried and APP physicians.

Article 17 Salaried Physician Compensation

17.01 Salary Scales

(a) The salary scales for Clinical Assistants, Clinical Associates, Family Physicians, Hospitalists, and Specialists are as follows:

October 1, 2023 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3
Clinical Assistants	$163,812.00	$170,572.00	$177,333.00
Clinical Associates	$198,724.00	$206,911.00	$215,097.00
Family Physicians	$198,724.00	$206,911.00	$215,097.00

Hospitalists	$217,525.00	$226,530.00	$235,535.00
Specialists	$263,672.00	$274,637.00	$285,596.00

October 1, 2024 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3
Clinical Assistants	$179,521.57	$186,929.85	$194,339.23
Clinical Associates	$217,781.63	$226,753.76	$235,724.80
Family Physicians	$217,781.63	$226,753.76	$235,724.80
Hospitalists	$238,385.65	$248,254.23	$258,122.81
Specialists	$292,122.21	$304,270.33	$316,411.81

October 1, 2025 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3
Clinical Assistants	$185,894.59	$193,565.86	$201,238.28
Clinical Associates	$225,512.88	$234,803.52	$244,093.03
Family Physicians	$225,512.88	$234,803.52	$244,093.03
Hospitalists	$246,848.34	$257,067.25	$267,286.17
Specialists	$302,346.49	$314,919.79	$327,486.22

October 1, 2026 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3
Clinical Assistants	$192,400.90	$200,340.67	$208,281.62
Clinical Associates	$233,405.83	$243,021.65	$252,636.29
Family Physicians	$233,405.83	$243,021.65	$252,636.29
Hospitalists	$255,488.03	$266,064.61	$276,641.18
Specialists	$312,928.61	$325,941.99	$338,948.24

(b) Physicians will advance to the next step on the Salary Scale on the anniversary date of their hiring. Physicians working less than full time hours will advance to the next step on a prorated basis.

(c) In reference to Clinical Associates under this article, those Clinical Associates who hold such titles and are within the system as of the date of signing of the 2023 – 2027 Agreement, and who do not fall within the definition of "Clinical Associate" under Article 2, will become legacy at their current salary scale and will advance to the next step of their current scale on their anniversary date of hiring.

Clinical Associates working less than full time hours will advance to the next step on a prorated basis.

17.02 Per Diem Locum Rates

Locum rates paid under this Agreement shall be as follows:

	October 1, 2023	**October 1, 2024**	**October 1, 2025**	**October 1, 2026**
Family Physicians	$995.00	$1,090.42	$1,129.13	$1,168.65
Hospitalists	$1,090.00	$1,194.53	$1,236.94	$1,280.23
Specialists	$1,335.00	$1,479.05	$1,530.81	$1,584.39

17.03 Geographic Retention Bonuses

The geographic locations encompassed by the categories outlined below are set out in Schedule C, Salaried Physician Retention Bonus Categories, and are to be paid on the salaried physician's anniversary date.

a) Retention Bonuses – Salaried Family Physicians

Retention bonuses will be paid to Salaried Family Physicians including those at Category B Facilities as follows:

	Level 1 After12 Eligible Months	**Level 2 After 24 Eligible Months**	**Level 3 After 36 Eligible Months**
Category 0	$12,500	$25,000	$37,500
Category 1	$7,500	$15,000	$22,500
Category 2	$5,000	$10,000	$15,000

b) Retention Bonuses – Salaried Specialists

Retention bonuses will be paid to Salaried Specialists, including Oncologists/Pathologists, as follows:

	Level 1 After 12 Eligible Months	Level 2 After 24 Eligible Months	Level 3 After 36 Eligible Months
Category 0	$14,000	$28,000	$42,000
Category 1	$8,000	$16,000	$24,000
Category 2	$4,000	$8,000	$12,000

17.04 Obstetrical Bonus

Salaried Family Physicians are eligible for the Obstetrical Bonus Policy as outlined in Schedule I, Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians.

17.05 Oncology and Pathology Bonus

The Oncology and Pathology Bonus is paid out on the physician's anniversary dates as follows:

Step	1	2	3
Amount	$50,000	$56,250	$60,000

17.06 Recognition of On-Call

(i) The rate for on-call billing and internal locum payments for each physician group is included in Schedule M, On-Call and Internal Locum Rates.

(ii) General Obligations:

(a) On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, or treating, or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency department;
- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

(b) Approved on-call rotations must follow a defined on-call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

(c) The on-call services will be based from designated facilities.

(d) Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients during the period they are on-call for unattached patients.

(e) Physicians shall not accrue a responsibility to perform call duties for any call rotations occurring during periods of annual or other forms of leave. This provision will take effect ninety (90) days following the date of signing this Agreement.

(f) Only on-call rotations recommended by the PHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

(g) Physicians on APPs who have on-call payments factored into their APP budget are not eligible to claim the on-call payment.

17.07 Critical Escort Duty

The hourly rate for critical escort duty is:

	October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
Critical Escort Rate	$115.56	$126.64	$131.14	$135.73

17.08 University Physicians (Geographic Full-Time - "GFT")

(i) The compensation for GFT physicians working at 0.8 clinical FTE will be at 90% of the applicable salary scale. Compensation for GFT physicians working at less than 0.8 clinical FTE will be proportionate to their clinical FTE status. For example, a GFT physician working at 0.5 clinical FTE will be remunerated as follows: 0.5/0.8 x 90% of applicable salary scale.

(ii) Whereas the parties have agreed to incorporate the relative value of the After-Hours/On-Call Bonus and the Category 3 Geographic Retention Bonus into the salary scales, the parties agree that these bonuses will be incorporated into GFT compensation at 100% of their value, except where a GFT physician works at less than 0.8 clinical FTE in which case the bonus will be proportionate to their clinical FTE status as set out in 17.08(i).

17.09 Registered Retirement Savings Plan (RRSP)

(i) Government commits to maintaining an employer-sponsored salaried physician RRSP.

(ii) As a condition of employment all salaried physicians, except those participating in the Public Service Pension Plan pursuant to an election made prior to November 30, 2000, are required to participate in the employer-sponsored RRSP.

17.10 Market Adjustment Policy

The Treasury Board Secretariat, Market Adjustment Policy is applicable to Salaried Physicians and may be used by the PHA where it determines that it is unable to recruit salaried physicians in specific positions at a particular geographic site. Subject to the approval of the Treasury Board Committee of Cabinet, the PHA may approve and provide benefits to salaried physicians beyond those benefits outlined in the Agreement.

If the NLMA makes a request for the PHA to consider a position for the application of the Market Adjustment Policy, it will provide a response to the NLMA within two months indicating whether or not a proposal will be submitted to the Department of HCS.

The relevant policy and guidelines are posted on the Treasury Board website and the parties acknowledge that any policy modifications are within the sole purview of the Treasury Board Secretariat.

Article 18 Category B Facilities Compensation Model

Effective April 1, 2026, Article 18 – Category B Designated Facilities will encompass all components of compensation for physicians providing emergency department (ED) services and family medicine services working under the Category B model as described within Article 18. The compensatory rates and any remuneration listed within Article 18 shall remain for the duration of the 2023 – 2027 Agreement and shall not be subject to any additions or substitutions and are for Category B Facilities only.

Salaried physicians in Category B Designated Facilities will also qualify for additional benefits consistent with their salaried position.

18.01 Category B Facilities

(i) For the purposes of Article 18, Category B facilities are classified as follows:

a. Tier 3 are sites 200 km from the nearest Category A facility OR whose Emergency Department volume exceeded 7,000 people annually OR are an island-based facility;

b. Tier 2 are sites 100 km from the nearest Category A facility AND whose emergency Department volume has exceeded 3,500 people annually; and

c. Tier 1 are all other sites that do not qualify for Tier 2 or 3 status.

18.02 Category B Facilities – Emergency Department Coverage

(i) Physicians providing emergency department (ED) services coverage under the Category B Facilities Compensation Model at Category B designated facilities, as more particularly set out in Schedule H, shall be compensated as follows:

Modality and Shift Type	**Category B Designated Site Tier**		
	Tier 1	**Tier 2**	**Tier 3**
Salaried Family Physician (Steps 1 to 3) On-site and in-person Monday to Friday daytime (8am to 6pm)	Included in bi-weekly salary (Family Physician salary scale)		
Weekday After-Hours Contract Rate (Salaried Family Physicians Only) Offsite and on-call: Monday to Friday after-hours (6pm to 8am)	$776.54	$1,076.54	$1,376.54
Weekend/Statutory Holiday After-Hours Contract Rate (Salaried Family Physicians Only) Offsite and on-call: all-day Saturday, Sunday, and statutory holidays (as per Clause 24.01 – Statutory Holidays)	$1,807.24	$2,107.24	$2,407.24

Contract Rate (24-hour period) On-site and in-person: Monday to Friday daytime (8am to 6pm) Offsite and on-call: Monday to Friday after-hours (6pm to 8am), and all-day Saturday, Sunday, and Statutory Holidays (as per Clause 22.01 – Statutory Holidays)	$1,900	$2,200	$2,500
Call Back Rate Available to physicians, salaried and sessional, providing Category B emergency department coverage while offsite and on-call from Monday to Friday (6pm to 8am), and all-day Saturday, Sunday, and statutory holidays (as per Clause 22.01 – Statutory Holidays). The call back rate is only payable when the physician is required to appear in-person at the request of the health care provider responsible serving as the 'first line of care' for patients presenting in-person at the facility and inpatients at the facility. A physician can bill a maximum of one call back per 3-hour period. The call back shall not be contiguous to a physician's scheduled working hours. Should the total time a physician is onsite for a single call back exceed three (3) hours, the physician cannot bill an additional call back. For a subsequent call back to be billed, the physician must have left the site and be called back to the site.	$175 per call back The Call Back Rate is fixed for the duration of the Agreement.		

The Category B Emergency Department Coverage contract rates, excluding the Call Back Rate, will increase by the same percentages as the family medicine increases (year 3 – 3.55% effective October 1, 2025 and year 4 – 3.5% effective October 1, 2026).

(ii) Each physician providing Category B emergency services will be provided with a contract by NLHS which makes reference to the terms of this Memorandum of Agreement and may include other related requirements of NLHS in respect of the Category B emergency services. Where the physicians will also be providing services described in 18.03, the contract will incorporate the terms of these services.

(iii) Each physician providing Category B emergency services will participate in a written schedule for the provision of services. The scheduling process will be managed by NLHS on a pre-determined basis. Each physician is expected to advise NLHS regarding their preferred volume of service and preferred dates when the schedule is being developed, and a final schedule will be by mutual agreement. Once a schedule is determined, the schedule will not be changed unless there is either mutual agreement between NLHS and the physician, or there are extenuating circumstances (e.g., illness; bereavement).

(iv) NLHS will provide to the NLMA, semi-annually, a list of physicians, by facility, who have contracts to provide Category B emergency services.

18.03 Category B Facilities – Family Medicine Services

(i) Physicians providing family medicine services (on-site and in-person services only) under the Category B Facilities Compensation Model at Category B designated facilities, as more particularly set out in Schedule H, shall be compensated as follows:

Modality and Shift Type	**Category B Designated Site Tier**		
	Tier 1	**Tier 2**	**Tier 3**
Salaried Family Physician (Steps 1 to 3) On-site and in-person	Included in bi-weekly salary (Family Physician salary scale)		
Contract Rate On-site and in-person: Monday to Friday Note: No FFS billings will be allowed for Category B Family Medicine coverage.	$1,500	$1,800	$2,100

The Category B Family Medicine Services rates will increase by the same percentages as the family medicine increases (year 3 – 3.55% effective October 1, 2025 and year 4 – 3.5% effective October 1, 2026).

(ii) Each physician providing family medicine services by way of contract rate

payment, from a Category B facility will be provided with a contract by NLHS which makes reference to the terms of this Memorandum of Agreement and may include other related requirements of NLHS in respect of the Category B services. Where physicians also provide services described in 18.01 and 18.02, the contract will incorporate the terms of these services.

(iii) Each physician providing family medicine services from a Category B will participate in a written schedule for the provision of services. The scheduling process will be managed by NLHS on a pre-determined basis. Each physician is expected to advise NLHS regarding their preferred volume of service and preferred dates when the schedule is being developed, and a final schedule will be by mutual agreement. Once a schedule is determined, the schedule will not be changed unless there is either mutual agreement between NLHS and the physician, or there are extenuating circumstances (e.g., illness; bereavement).

(iv) NLHS will provide to the NLMA, semi-annually, a list of physicians, by facility, who have contracts to provide Category B family medicine services.

18.04 Category B Retention Bonus

(i) Eligible physicians providing family medicine and emergency department services (on-site and in-person services only) under the Category B Facilities Compensation Model at Category B designated facilities as more particularly set out in Schedule H, may receive a Category B Retention Bonus as follows:

Number of Days Worked Per Year	**Annual Bonus**
<75	$0
75 – 104	$30,000
105 – 146	$40,000
147 – 219	Maximum of $75,000 pro-rated on days worked per year
220 and over	$75,000 Year 1 $80,000 Year 2 $85,000 Year 3 $90,000 Year 4 Maximum of $95,000 after 4 years

Note: Physicians must work 220+ days per year to remain at the "220 and over" bonus tier and progress toward the maximum amount.

(ii) For the purposes of the Category B Retention Bonus, a day is defined as one family medicine clinic or one on-site ER shift. A physician cannot claim more than one day in a 24-hour period.

18.05 Category B Emergency Departments – Virtual Coverage

(i) Physicians providing Category B Virtual ED coverage while also providing "home site" coverage under the Category B Facilities Compensation Model at Category B designated facilities, as more particularly set out in Schedule H, shall be compensated as follows:

a. Daytime Virtual ED Rate, Monday to Friday (8am to 6pm): $124.38 per hour
b. After-Hours Virtual ED Rate, Monday to Friday (6pm to 8am), all-day Saturday, Sunday, and Statutory Holidays (as per Clause 24.01 – Statutory Holidays): $39.29 per hour.

(ii) Physicians providing Category B Virtual ED coverage while not also providing "home site" coverage under the Category B Facilities Compensation Model at Category B designated facilities, as more particularly set out in Schedule H, shall be compensated as follows:

a. Virtual ED Hourly Rate: $124.38 per hour

(iii) The Virtual Care ED coverage rates as specified in 18.05 (i) and 18.05 (ii) are fixed for the duration of the Agreement.

(iv) For the purposes of clause 18.05, "home site" is defined as the Category B facility location from which a physician is providing on-site emergency department coverage.

Article 19 Other Compensation Issues

19.01 Transitioning of Hospital Services

(i) The parties agree to establish a committee (consisting of two members appointed by the NLMA and two members appointed by HCS) to consider the options available for the potential to have FFS Physicians perform in private medical offices, surgical, diagnostic or therapeutic procedures that at present are non-insured services unless they are provided in facilities listed in the *Hospital Insurance Regulations* Schedule under the *Hospital Insurance Agreement Act*. The following issues will be

reviewed:

a) Timeliness of care and follow-up;
b) Appropriateness of the service;
c) Cost-effectiveness of the service;
d) Identification of a quality assurance program for the service; and
e) Monitoring of the service.

(ii) The Committee's sole responsibility will be to make recommendations to the Minister of HCS related to the issues stated above, once per annum. Decisions regarding recommendations made to the Minister will be made by consensus. Such recommendations will not impact the Minister's discretion in determining which, if any, hospital-based services may be insured when provided within private offices by FFS Physicians.

19.02 Sessional Hospitalist Daily Rate

The Sessional Hospitalist Daily Rate per 8-hour shift is:

October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
$1,236	$1.354.53	$1,402.62	$1,451.71

The requirements for a Family Physician working under a Sessional Hospitalist Daily Rate arrangement are:

(i) Enter into a contractual arrangement with the PHA in order to be rostered and/or assigned a schedule.

(ii) Participate in the hospitalist on-call service at the respective site which will be compensated by the Family Physician on-call per diem and FFS billing for services provided after-hours.

(iii) Provide comprehensive medical care to hospitalized patients. The Physician will normally be responsible for 15-20 patients, but the workload may vary periodically, up or down, within a site based on the health status and complexity of the patients presenting, and after consultation with the physician about the ratio of "medically active" versus "alternate level of care" patients.

Physicians who receive the Sessional Hospitalist Daily Rate are eligible to receive payments under the Internal Locum Policy.

19.03 Virtual Care

The PSRC will consider data with respect to the trends and patterns in the utilization of virtual care. Best efforts will be made by the PSRC to complete a final set of virtual care fee codes within six (6) months of the date of signing the Agreement.

19.04 Continuing Professional Development

19.04 (a) A funding program for Continuing Professional Development will be established that will entitle physicians to $4,500 per annum effective starting the date of signing of the 2023 – 2027 Agreement.

19.04 (b) All physicians, as per the eligibility thresholds listed in 19.04 (c), shall receive the $4,500 at the end of each Government fiscal year.

19.04 (c) Regarding eligibility, the thresholds will be:

1. Practicing physicians, including locums, who have a Newfoundland and Labrador practicing license and a Newfoundland and Labrador permanent address.
2. Other physicians who provide a minimum of seventy-five (75) days of service within Newfoundland and Labrador through an application process. The parties will develop guidelines for this program.

19.04 (d) The $4,500 per annum shall be prorated, based upon the months worked, should a physician, commencing or ending their practice, not work the full year.

SECTION C - SALARIED PHYSICIANS - TERMS AND CONDITIONS OF EMPLOYMENT

The terms and conditions of employment for salaried physicians under this Agreement supersede all other conflicting terms and conditions within employer human resource policies.

Article 20 Definitions

20.01 (a) Probationary Period

All newly hired salaried physicians shall be required to serve a twelve (12) month probationary period during which time the performance of the salaried physician shall be reviewed by PHA designate and, if unsatisfactory, the employment of the salaried physician shall be terminated. If successful, the salaried physician shall be given a letter by the PHA confirming the completion of the probationary period.

(b) Month of Service

Means a calendar month in which the salaried physician is in receipt of full salary for that month and includes any month in which the salaried physician is on approved leave of absence without pay, which leave shall not be in excess of twenty (20) days.

(c) Scale Definitions

The scale definitions contained in the Terms and Conditions of Employment for Salaried Physicians shall continue to apply until such time as amended by the mutual consent of the parties to this Agreement.

Article 21 Termination

21.01 A salaried physician is required to give the Employer three (3) months written notice of resignation and the Employer is required to give a salaried physician three (3) months written notice of termination of employment, except for just cause where no notice is required.

Article 22 Advertising of Vacancies

22.01 Physicians may apply for vacant publicly-funded salaried physician positions within Newfoundland and Labrador, as advertised by the Employers.

Article 23 Part-Time Salaried Physicians

23.01 Salaried physicians working less than a full schedule are considered part-time and are covered by this Agreement for the purpose of benefits outlined in this Agreement, which they shall receive on a prorated basis based on the work week and the specific arrangements they have with their Employer. The method of prorating will be defined in the letter of appointment from the Employer.

Article 24 Statutory Holidays

24.01 There shall be a total of nine (9) paid statutory holidays for salaried physicians. The Employer shall define the days on which those nine (9) paid statutory holidays will be observed. Whether or not a salaried physician is required to work on a paid statutory holiday shall be determined in consultation with the Vice President of Medical Services or designate where the salaried physician works.

24.02 If a salaried physician is required to work and works on a paid statutory holiday, they shall be scheduled to take another day off with pay in lieu of that holiday within ninety (90) days of the holiday. If the day off is not scheduled by the Employer within ninety (90) days, the day off with pay in lieu of the holiday will be taken at a time before the end of the fiscal year, as mutually agreed upon between the salaried physician and authorized in writing by the Vice President of Medical Services or designate. The day off with pay in lieu of the holiday will not be carried forward more than one fiscal year. It is the responsibility of the Employer to schedule this leave. If leave is carried over to the next fiscal year and is not taken in that fiscal year, it will be paid out in April of the following fiscal year.

24.03 A salaried physician required to provide on-call for a portion of the paid statutory holiday shall be deemed to have worked during the holiday. A paid statutory holiday shall be the twenty-four (24) hour period commencing at 00:01 on the day designated by the Employer as the paid statutory holiday.

Article 25 Annual Leave

25.01 Salaried physicians shall be entitled to annual leave as follows:

(a) Twenty (20) days per year for salaried physicians with one (1) year to ten (10) years of service as a salaried physician.

(b) Twenty-five (25) days per year for salaried physicians with more than ten (10) years of service but less than twenty-five (25) years of service as a salaried physician.

(c) Thirty (30) days per year for salaried physicians with twenty-five (25) years of service or more as a salaried physician.

(d) A year of service is equivalent to twelve (12) months of service as a salaried physician.

(e) Annual leave is an accumulative benefit and any unused annual leave is payable on termination of employment.

(f) A physician may carry forward to another year any portion of annual leave not taken by them in previous years until, by doing so they have accumulated a maximum of:

(i) twenty (20) days annual leave, if the physician is eligible to receive twenty (20) days in any year;

(ii) twenty-five (25) days annual leave, if the physician is eligible to receive twenty-five days in any year; and

(iii) thirty (30) days annual leave, if the physician is eligible to receive thirty (30) days in any year.

Each of the above accumulations is in addition to the physician's current annual leave entitlement. Physicians with additional accumulated time as of May 15, 2003 will have that time "legacied". However, these physicians will be subject to this policy for any future year's accumulated annual leave.

Article 26 Approval for Leaves of Absence

26.01 All leaves of absence, paid or unpaid, require the prior approval of the Vice President of Medical Services or designate. Salaried physicians shall submit requests for leave in writing and give as much notice as possible.

Article 27 Bereavement or Compassionate Leave

27.01 A salaried physician shall be entitled up to three (3) days paid compassionate leave upon the death of the salaried physician's mother, father, brother, sister, child, spouse, common-law spouse, grandmother, grandfather, grandchild, father-in-law, mother-in-law. If the salaried physician is required to travel outside the Province, one (1) additional day with pay shall be granted. In extraordinary circumstances, the Employer may grant additional unpaid leave. This leave is not cumulative and is not payable on termination or resignation.

Article 28 Compensatory Leave

28.01 All salaried physicians (excluding Casualty Officers) employed by the Employer will be entitled to one (1) week (five (5) working days) of compensatory leave once the salaried physician completes one (1) year

of service with that Employer. Salaried physicians maintain eligibility for compensatory leave if their area of employment changes, (i.e. Zone). Such leave is cumulative and payable on termination of employment.

Article 29 Deferred Salary Plan

29.01 With the approval of the Employer, salaried physicians shall be eligible to access the deferred salary plan with those Employers who have made the arrangements with Canada Revenue Agency.

Article 30 Family Leave

30.01 A salaried physician who is required to attend to the temporary care of a family member living in the same household, or to attend to needs relating to the birth of the salaried physician's child, or to attend to matters relating to a home or family emergency, shall be allowed up to three (3) days paid family leave in any calendar year provided that no other person was available to attend to these needs and provided that the salaried physician gave the Employer as much notice as possible. This leave is non-cumulative and is not payable on termination of employment.

Article 31 Maternity Leave, Adoption Leave and Parental Leave

31.01 A salaried physician is entitled to a maximum of seventy-eight (78) weeks unpaid maternity, adoption or parental leave.

31.02 A salaried physician may request maternity leave without pay which may commence prior to the expected date of delivery.

31.03 Adoption leave shall be granted to a salaried physician who legally adopts a child and upon presentation of proof of adoption.

31.04 A salaried physician may return to duty after two (2) weeks' notice of their intent to do so.

31.05 A salaried physician shall resume their former salary upon return from leave, with no loss of accrued benefits.

31.06 Periods of leave of up to seventy-eight (78) weeks without pay for maternity, adoption, or parental leave(s) shall be counted for accumulation of annual or paid leave entitlement, sick leave, severance pay, and step progression.

31.07 Salaried physicians on maternity, adoption or parental leave will

continue to pay their portion of group insurance premiums to a maximum of seventy-eight (78) weeks, unless they provide proof of alternative coverage and sign a waiver declining continued coverage. When a salaried physician opts to continue to pay their portion of group insurance premiums, the Employer shall also pay its share of the group insurance premiums.

31.08 Neither the salaried physician nor the Employer will be required to contribute to the Employer group RRSP plan during the period of maternity, adoption or parental leave.

31.09 A salaried physician may be awarded sick leave for illness that is a result of or may be associated with pregnancy.

31.10 The Employer may grant a leave of absence without pay when a salaried physician is unable to return to duty after the expiration of this leave.

Article 32 Education Leave

32.01 (a) After applying in writing, and upon receiving approval from the Employer, each salaried physician is entitled to take up to five (5) days paid leave per calendar year to attend educational sessions such as conventions or refresher courses.

(b) The five (5) days paid education leave, which are non-cumulative, are in addition to Study Leave benefits.

(c) Education leave is not payable on termination of employment.

(d) A salaried physician is to apply to their Employer for education leave as far in advance as possible.

Article 33 Paid Leave Program

33.01 Physicians who have been participating in the paid leave program since September 1, 2002 will remain eligible for the program under the same conditions as all other entrants; however, no further entrant will be permitted. A list of the current physicians participating under this program has been provided to the NLMA.

33.02 Salaried physicians who are under the paid leave program will continue to receive the benefit of the paid leave program as long as the program stays in place with that Employer, or until the salaried physician leaves that Employer. Salaried physicians who are on a paid leave program

will not be entitled to annual leave or sick leave under this Agreement.

Article 34 Sick Leave

34.01 (a) The total amount of sick leave which may be awarded to a salaried physician is calculated by multiplying the number of months of service by two (2) to a maximum of four hundred and eighty (480) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

(b) Notwithstanding Article 34.01(a), the total amount of sick leave which may be awarded to a salaried physician hired after October 1, 2005 is calculated by multiplying the number of months of service by one (1) to a maximum of two hundred and forty (240) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

34.02 At any occasion if the Employer feels the salaried physician is either excessively using sick leave or misusing sick leave, the Employer may request a medical certificate.

34.03 Sick leave is an accumulative benefit, but it is not payable on termination of employment.

Article 35 Unpaid Leaves of Absence

35.01 With the approval of the Employer, a salaried physician may be granted leaves of absence without pay provided that the salaried physician has no annual or paid leave available.

Article 36 Study Leave

36.01 Salaried physicians are entitled to study leave provisions as follows:

(a) Study leave is available to prepare for and write the licensing and certification exams.

(b) Study leave may also be used for select courses that enhance a particular physician skill set. The skills required and corresponding courses must be based on patient needs in a particular region, as deemed appropriate and approved by the Employer.

(c) Study leave may not be used for any other purpose than described above. Excluded purposes include Maintenance of Certification (Royal College) and Maintenance of Proficiency Program (College of Family

Physicians) requirements, conferences, research, reading reports and publications, and activities for which education leave is applicable.

(d) A salaried physician taking study leave is entitled to ten (10) days paid study leave per year. A salaried physician who does not take study leave in year one (1) and year two (2), but who wishes to take accumulative study leave in year three (3), would be entitled to take up to sixty (60) days paid study leave.

(e) A salaried physician who does not take study leave in years one (1) to three (3), but who wishes to take accumulative study leave in year four (4), would be entitled to take up to eighty (80) days paid study leave.

(f) A salaried physician who does not take study leave in years one (1) to four (4), but who wishes to take accumulative study leave in year five (5), would be entitled to take up to one hundred twenty (120) days paid study leave.

(g) Accumulative study leave may be taken in respect to any three (3) year, four (4) year, or five (5) year period in accordance with the above.

(h) A salaried physician's study leave entitlement is reduced by the actual number of days of study leave that are taken in a particular year.

E.g., In the case of a salaried physician who has accumulated three (3) years of entitlement, this physician may use the sixty (60) days during year three (3) as a single block or on separate occasions. Once the physician uses all or a portion of their entitlement in a particular year, no balance can be carried to the following year. In the year following, the physician's entitlement will reset to ten (10) days. If the entitlement is not used, accumulation may continue, and the entitlement will be available, until the year in which all or a portion of the entitlement is used.

(i) Study leave must be requested in writing at least three (3) months prior to the beginning of such leave and must be approved by the Employer.

(j) A salaried physician will be paid full salary during study leave, assuming that the salaried physician is receiving no additional remuneration. The salaried physician is required to declare any additional remuneration received. Salary while on study leave will be reduced proportionately to any additional remuneration received, unless otherwise approved by the Employer.

(k) A salaried physician taking study leave must agree that following the

conclusion of the study leave they will provide salaried service with the same Employer for a period that is twice the length of the study leave.

(l) Study leave is not payable on termination of employment.

Article 37 Additional Billings

37.01 Billing for Non-Insured Services

Salaried physicians may direct bill for any services not insured under provincial legislation. Salaried physicians are entitled to bill WorkplaceNL for services provided to persons covered by the WorkplaceNL plan, insurance companies for routine medical examinations of insured people, and other provincial medical care plans in respect of services provided to non-residents covered by such plans. Salaried physicians may submit bills to individual residents of the Province who are not covered by the Province's Medical Care Plan, including those covered by legislation of the Government of Canada, such as, war veterans with disabilities, and members of the Canadian Armed Forces.

37.02 Billing for Insured Services

Salaried physicians can bill Fee-For-Service when they are on an approved leave of absence from the Employer. This arrangement requires the approval, in writing, of the Medical Services Division of the Department of HCS.

Article 38 Canadian Medical Protective Association

38.01 Before commencing practice, every salaried physician must obtain Canadian Medical Protective Association coverage. Salaried physicians are responsible for paying their own Canadian Medical Protective Association coverage.

38.02 Notwithstanding Article 38.01, the parties agree that, for the term of this Agreement, the PHA's calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate.

Article 39 Meal Rates and Kilometre Rates for Use of Own Vehicle

39.01 Salaried physicians who are authorized by the Employer to travel on employer business shall be reimbursed the appropriate meal and

mileage rates in accordance with Government's Treasury Board approved Meal Rates and Transportation policies, which policies may be amended from time to time.

Article 40 Relocation Expenses

40.01 A salaried physician who is required by the Employer to relocate from one geographical location to another shall be compensated by the Employer for expenses that are legitimately and directly associated with this move. Such compensation shall be in accordance with Government's Treasury Board approved relocation expense policy, which may be amended from time to time.

Article 41 Damage or Loss of Personal Property

41.01 Where a salaried physician in the performance of their duties suffers a loss of any personal property, and it can be determined that the salaried physician would reasonably be expected to have such property in their possession during the performance of their duties, such loss shall be reported in writing by the salaried physician to the Employer within two (2) days of the loss, and if such loss was not due to the salaried physician's negligence, the Employer may compensate for such loss up to a maximum of three hundred dollars ($300.00) per incident.

Article 42 Workers' Compensation

42.01 The *Workplace Health, Safety and Compensation Act* applies to all salaried physicians.

Article 43 Health Benefits

43.01 Salaried physicians are eligible for the group insurance benefits as outlined in Government of Newfoundland Group Insurance Plan, which may be amended from time to time. A summary of the Plan in effect at the date of signing will be attached as an Appendix to the Terms and Conditions of Employment for Salaried Physicians.

IN WITNESS WHEREOF the parties hereto have executed this Agreement the day and year first before written.

SIGNED on behalf of Treasury Board representing His Majesty the King in Right of Newfoundland by the Honourable Siobhan Coady President of Treasury Board, and the Honourable Krista Lynn Howell, Minister of Health and Community Services, in the presence of the witness hereto subscribing:

Melissa Nippard
Witness

Minister of Finance
President of Treasury Board

September 2, 2025
Date

September 2, 2025
Date

Witness

Minister, Health and Community Services

SEP 1, 2025
Date

Sept 1 25
Date

SIGNED on behalf of the Newfoundland and Labrador Medical Association by its proper officers in the presence of the witness hereto subscribing:

Witness

President, NLMA

Sept 2, 2025
Date

Sept 2, 2025.
Date

Schedule A

Waterford Physicians "On-duty, on-site" Payment Policy

Salaried Family Physicians employed at the Waterford Hospital are required to remain on-site when designated to provide On-duty services, including emergent In-patient services and Emergency Department Coverage. In general, the GP designated as being "On-duty" provides 24 hours of coverage.

The GP designated as being "On-duty, on-site" will be eligible to receive this payment in addition to the provincial On-call per diem fee in effect at the time. The On-duty, on-site per diem rates are:

Weekdays – Monday to Friday

October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
$676	$740.83	$767.13	$793.98

Weekends – Saturday and Sunday (includes statutory holidays)

October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
$1,287	$1,410.42	$1,460.49	$1,511.61

In addition to the payment rates noted above, after a physician provides three (3) weekday shifts and one (1) weekend or statutory holiday shift in a month, the per diem rates will be $1,436 and $2,160 for weekdays and weekends/statutory holidays respectively.

This payment model may be changed, by mutual agreement of the parties, upon redesign of the service, after moving to the new Mental Health and Addictions facility.

Schedule B

Facility Workload Disruption Payment Policy for Fee-For-Service Physicians

Definitions:

"Facility" means a publicly funded, PHA-operated hospital/site.

"Group" means any specialty or subspecialty working in a "Facility" that maintains a distinct on-call rota as per the Department of HCS *On-Call Payment Program* or a group that is unable to work due to the Emergencies Only Status.

"Daily salary rate of pay" (DSRP) means the top of the appropriate salary scale divided by 240.

Policy:

In the event that a Facility is forced to:

a) adopt an Emergencies Only Status, which is any mandatory closure that results in the delivery of only essential and emergency service; or

b) unexpectedly close all or a portion of a Facility (e.g., weather event, non-physician labour disruption, maintenance issue, etc.),

the following arrangement can be invoked which will provide an optional payment arrangement based on the DSRP for groups of facility-based, Fee-For-Service (FFS) physicians.

General:

1. To receive payment under this policy a physician must:
   i. be part of a Group which has opted to invoke the DSRP in lieu of FFS payment; and
   ii. be available to work as required by the VP Medical Services (or designate) during the Emergencies Only Status; and
   iii. be willing to provide those services, as reasonably requested by the VP Medical Services (or designate), that may be outside of their normal scope of practice but within their competency.

2. Physicians may remain FFS at a facility where the remainder of the Group have invoked the DSRP, and to do so shall require the written authorization of the VP Medical Services (or designate).

3. Physicians who do not meet the requirements of this policy are not

eligible for payment under this policy.

Principles:

1. Any Group of physicians can invoke the DSRP in lieu of FFS. Specialties that provide city-wide on-call can be divided into groups by facility, provided the normal on-call rotation is maintained. To invoke the DSRP, it is necessary that all members of the Group who remain during either the Emergencies Only Status or "facility closure" period, accept the DSRP with the exception noted in Principle #2 below.

2. A physician who is part of a Group affected by b) above may apply to remain FFS in situations where the facility closure is partial, and some routine services are maintained or when start up is partial. When choosing to do so, it is for the duration of the partial or complete facility closure (see rules related to this outlined in Implementation #3 below).

3. It is understood that physician groups who accept DSRP will be on site during normal working hours. A physician who is receiving DSRP will not be eligible for education leave or vacation time.

4. Notwithstanding the requirement that a physician is required to be "physically present", the VP Medical Services may authorize work off site via virtual care when appropriate and safe to do so.

5. Normal on-call coverage must continue to be provided during the Emergencies Only Status or the "facility closure" period.

Application:

Physician groups who invoke the DSRP will receive payments directly from MCP.

1. Payments will be bi-weekly, based on current MCP FFS payment dates, prorated for the applicable time period.

2. For those physicians who accept the agreement above, no FFS or sessional claims will be accepted for services rendered while this arrangement is in effect (except as permitted under Principles #4 above). Following termination of this arrangement, billings will be monitored to ensure that stockpiling of claims has not occurred.

3. If the work disruption event allows for the gradual restarting of services FFS and sessional claims may be permitted, at the discretion of the VP of Medical Services, in consultation with the Department of HCS. The DSRP amount paid will be adjusted to reflect billings received in such

cases. If a physician bills MCP an amount above the DSRP then no work disruption payment is necessary.

Implementation:

1. To initiate this policy, it is required that written notice be sent by the VP of Medical Services of the PHA to the HCS Director of Medical Services, stating the date the Emergencies Only Status or "facility closure" status was activated. Such notice is to normally be provided within 24-hours of the start of the event.

2. Written acceptance of the payment arrangement for the duration of the Emergencies Only Status or "facility closure" period must be received in writing from every member of any eligible physician group. The Chief of Staff/designate at the Facility will coordinate the collection of signatures and submit them to the VP of Medical Services of the PHA.

3. For a physician or physicians who apply to remain FFS but is/are part of a group that has chosen to accept the DSRP, such approval will only be granted when there is conclusive evidence that the work/on-call schedules have been maintained as would have occurred prior to the work disruption. The PHA's VP of Medical Services will request such information and provide it to the HCS Director of Medical Services. The HCS Director of Medical Services will review the information and decide whether approval will be granted.

4. This arrangement will stay in effect for physicians who accept DSRP until written notice of the earlier of:

    a. discontinuation of the Emergencies Only Status or "facility closure" by the administration of the Facility to the HCS Director of Medical Services; or

    b. written agreement by all Group physicians to discontinue the arrangement.

Schedule C

Salaried Physician Retention Bonus Categories

The categories for retention bonuses shall be as listed below, or as modified according to the mutual agreement of the parties. If additional communities are identified, they shall be assigned to Category 2 unless otherwise agreed to by all the parties.

Salaried Family Physician Retention Bonus Table:

Category 0
Labrador

Category 1

Baie Verte	Buchans	Burgeo	Cow Head
Flowers Cove	Fogo	Hampden	Harbour Breton
Hermitage	Jackson's Arm	La Scie	Mose Ambrose
Norris Point	Port Saunders	Ramea	Roddickton
St. Alban's	Trepassey	Woody Point	

Category 2

Bay L'Argent	Bell Island	Bonavista	Botwood
Brookfield	Burin	Cape St. George	Carmanville
Centreville	Codroy Valley	Ferryland	Gambo
Glovertown	Grand Bank	Hare Bay	Lewisporte
Lourdes	Marystown	Musgrave Harbour	Musgravetown
Old Perlican	Placentia	Port aux Basques	Springdale
St. Anthony	St. George's	Stephenville Crossing	St. Lawrence
Terrenceville	Trinity	Twillingate	Virgin Arm
Western Bay	Whitbourne	Jefferies	

Salaried Specialist Retention Bonus Table:

Category 0
Labrador

Category 1

Burin	St. Anthony

Category 2

Carbonear	Clarenville	Corner Brook	Gander
Grand Falls-Windsor	Stephenville		

Schedule D

Salaried Family Physician Remoteness Bonus

The intended aim of this program is to address recruitment challenges for Salaried Family Physicians in remote sites.

Isolation Index

The Department and NLMA developed a Health Care Facility Isolation Index that includes the following variables:

- Located on the Trans Canada Highway
- Population of the community
- Travel time to nearest category A emergency room
- Travel time to nearest tertiary care center (St. John's)

It is important to note that travel time was used in place of travel distance to account for communities that are connected to the Island of Newfoundland by ferry and for those that are located away from the Trans Canada Highway.

Table 1. Isolation Index criteria and scoring.

Category	Criteria	Coded Value
Commuting time to TCH	>3 hrs	5
	2-3 hrs	4
	1-2 hrs	3
	0.5-1 hrs	2
	0 hrs	1
Category A ER within 30 minutes travel time	No	4
	Yes	1
Commuting time to St. John's	>8 hrs	5
	6-8 hrs	4
	4-6 hrs	3
	2-4 hrs	2
	0-2 hrs	1
Population of the community	<1,000	5
	1,000-3,000	4
	3,000-6,000	3
	6,000-10,000	2
	>10,000	1

Table 2. Isolation Index Classifications.

Remoteness	Score	Number of

Classification		facilities
Tier 1	13-18	17
Tier 2	10-12	11
Not Remote	5-9	6

Salaried Family Physician Remoteness Bonus

Salaried Family Physicians are exclusively employed by the Provincial Health Authority (PHA), where they provide primary care services in both inpatient (i.e. hospital) and outpatient (i.e. clinic) settings. The position description for these types of physicians is General Practice. PHA facilities with salaried family physician positions are as listed in tables 3-5. Note that salaried family physician positions within the St. John's metro area were excluded from this analysis, as these are the most urban positions in the province.

Table 3. Salaried family physician positions (Eastern Rural Zone).

Location	Facility Name	Number of Positions	Remoteness Classification
Bell Island	Dr. Walter Templeman Health Centre	2	Tier 2
Bonavista	Bonavista Peninsula Health Centre	4	Tier 1
Burin	Burin Peninsula Health Care Centre	1	Tier 2
Carbonear	Carbonear General Hospital	2	Not Remote
Clarenville	Dr. G.B. Cross Memorial Hospital	3	Not Remote
Grand Bank	Grand Bank Community Health Centre	4	Tier 2
Holyrood	Holyrood Medical Clinic	3	Not Remote
Old Perlican	Dr. A.A. Wilkinson Memorial Health Centre	3	Tier 1
Placentia	Placentia Health Centre	3	Tier 2
St. Lawrence	U.S. Memorial Community Health Centre	3	Tier 2
Whitbourne	Dr. William H. Newhook Community	3	Tier 2

Health Centre

Table 4. Salaried family physician positions (Central Zone).

Location	Facility Name	Number of Positions	Remoteness Classification
Bay D'Espoir	Bay D'Espoir Clinic	2	Tier 1
Fogo Island	Fogo Island Health Centre	1	Tier 1
Gander	James Paton Memorial Hospital	1	Not Remote
Grand Falls-Windsor	Central Newfoundland Regional Health Centre	3	Not Remote
Glovertown	Glovertown Clinic	2	Tier 2
Twillingate	Notre Dame Bay Memorial Health Centre	1	Tier 1

Table 5. Salaried family physician positions (Western Zone).

Location	Facility Name	Number of Positions	Remoteness Classification
Burgeo	Calder Health Centre	2	Tier 1
Corner Brook	Western Memorial Regional Hospital	7	Not Remote
Deer Lake	Humber/Deer Lake Medical Clinic	2	Tier 2
Jackson's Arm	Jackson's Arm Medical Clinic	1	Tier 1
Lourdes	Lourdes Medical Clinic	1	Tier 1
Norris Point	Bonne Bay Health Centre	3	Tier 1
Port aux Basques	Dr. Charles L. LeGrow Health Centre	3	Tier 1
Port Saunders	Rufus Guinchard Health Centre	1	Tier 1
Stephenville	Sir Thomas Roddick Hospital, Stephenville Clinic	6	Tier 2
Stephenville Crossing	Stephenville Crossing Clinic	1	Tier 2

Table 6. Salaried family physician positions (Labrador-Grenfell Zone).

Location	Facility Name	Number of Positions	Remoteness Classification
St. Anthony	Charles S. Curtis Memorial Hospital	8	Tier 1
Churchill Falls	Churchill Falls Clinic	1	Tier 1
Happy Valley-Goose Bay	Labrador Health Centre	16	Tier 1
Forteau	Labrador South Health Centre	3	Tier 1
Flower's Cove	Straits Of Belle Isle Health Centre	3	Tier 1
Roddickton	White Bay Central Health Centre	3	Tier 1

Remoteness Bonus Funding Categories

The Department will allocate $1 million per annum in funding for salaried family physicians practicing in the most remote locations of the province. The Salaried Family Physician Remoteness Bonus will be provided to physicians annually on the anniversary of their official start date with the PHA. Bonus amounts will be pro-rated based on the length of time that a physician has been in the position; physicians who have spent less than 12 months in their salaried position will receive a bonus that is pro-rated to their time in the position. Physicians who leave a position prior to completing 12 months of service will be eligible to receive a pro-rated bonus amount. Both provisional and fully licensed salaried family physicians will be eligible for this bonus.

The number of salaried family physician positions throughout the province is fluid, as new positions are added or inactivated each year through the Salaried Physician Approval Committee. Additionally, the number of actively filled positions will vary throughout the year, as physicians are hired into vacant positions, go on leave, retire, or move onto different positions. Therefore, there may be additional funds available in the Salaried Family Physician Remoteness Bonus from year to year. Additional funds that remain in the budget at the end of the fiscal year will be redistributed to the most remote locations and/or those with the highest vacancy rates as decided by the Department and the NLMA.

The funding tiers for the Salaried Family Physician Remoteness Bonus are as follows:

Table 7. Funding tiers for Salaried Family Physician Remoteness Bonus.

Remoteness Classification	Bonus Amount	Number of Positions	Total Funding
Tier 1	$17,000	55 funded 44 filled (20% vacancy)	$748,000
Tier 2	$11,000	27 funded 22 filled (20% vacancy)	$242,000
Not Remote	$0	19	$0

Schedule E

Alternate Payment Plans (APPs)

The following is a list of APPs in effect as of the date of signing of this Agreement:

Eastern Urban and Rural Zones

a) Adult Critical Care
b) Adult Emergency Department (Health Sciences Centre/St. Clare's Mercy Hospital)
c) Adult Haematology/Oncology
d) Anaesthesia (Carbonear General Hospital)
e) Anaesthesia Neurocoiling
f) Cardiac Surgery Anesthesia
g) Cardiac Surgery
h) Medical Oncology Services
i) Maternal Fetal Medicine
j) Neonatology Services
k) Obstetrical Anaesthesia Services
l) Obstetrical/Gynaecology (Non-elective) Services
m) Otolaryngology Services (Dr. H. Bliss Murphy Cancer Centre)
n) Paediatric Anaesthesia Services
o) Paediatric Critical Care Medicine
p) Paediatric Ophthalmology
q) Paediatric Ophthalmology (Premature Infant) Services
r) Paediatric Orthopaedic Services
s) Paediatric Surgery and Urology Services
t) Thoracic Surgery Services
u) Vascular Surgery

Central Zone

a) Anaesthesia Services – (James Paton Memorial Regional Health Centre)
b) Anaesthesia Services (Central Newfoundland Regional Health Centre)
c) General Surgery – (Central Newfoundland Regional Health Centre)
d) Orthopedic Surgery Services (James Paton Memorial Regional Health Centre)

Western Zone

a) Anesthesia (Western Memorial Regional Health Centre)
b) ICU Adult Critical Care (Western Memorial Regional Health Centre)
c) Acute Care Surgery (Western Memorial Regional Health Centre)

During the term of this Agreement, both parties agree to continue a review of the

general principles and current issues being experienced with APPs, based on the experiences in this Province and other provinces. Of particular note, productivity, accountability, reporting, termination dates, funding, and the impact on recruitment are some of the issues to be reviewed. As part of the review, a document will be produced detailing the new principles and practices.

All existing APPs will be reviewed, and for those where agreement by all parties exists to continue, the APPs must be rewritten to conform to the new principles and policies. For those where agreement to continue is not received, appropriate notification to the signatories of the APP will occur and the proper processes, as outlined in the APP agreement(s), will be followed for the termination of same.

Schedule F

FFS Increases by FFS Specialty Group

The total dollar value for each year will be allocated to disciplines using the following FFS Allocation Table.

FFS Allocation Table: Fee for Service Percentage Increases, 2024/25 to 2026/27, as of October 1st each year (base year of 2023/24)			
Specialty	2024/25	2025/26	2026/27
Family Medicine	9.59%	3.55%	3.50%
Internal Medicine	10.10%	3.50%	3.50%
Neurology	11.08%	3.50%	3.50%
Psychiatry	11.75%	3.50%	3.50%
Pediatrics	4.86%	3.50%	3.50%
Dermatology	6.09%	3.50%	3.50%
General Surgery	15.27%	3.50%	3.50%
Urology	2.00%	3.50%	3.50%
Orthopedic Surgery	2.00%	3.50%	3.50%
Plastic Surgery	6.97%	3.50%	3.50%
Neurosurgery	2.00%	3.50%	3.50%
Ophthalmology	2.00%	3.50%	3.50%
Otolaryngology	12.71%	3.50%	3.50%
Obstetrics/Gynecology	21.94%	3.50%	3.50%
Radiology	16.61%	3.50%	3.50%
Anesthesiology	9.67%	3.50%	3.50%
Weighted Average – Specialists	*10.79%*	*3.50%*	*3.50%*

Schedule G

Approved Category A Facilities
24-Hour On-Site Emergency Department Coverage

This schedule is provided for information only.

Hospital Number	Hospital Name
0302	Burin Peninsula Health Care Centre, Burin
0230	Carbonear General Hospital, Carbonear
0213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0205	James Paton Memorial Hospital, Gander
0175	Western Memorial Regional Hospital, Corner Brook
0256	General Hospital, Health Sciences Centre, St. John's
0281	Janeway Children's Health and Rehabilitation Centre, St. John's
0264	St. Clare's Mercy Hospital, St. John's
0159	Labrador West Health Centre, Labrador City
0183	Sir Thomas Roddick Hospital, Stephenville
0167	Labrador Health Centre, Happy Valley-Goose Bay
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony

Schedule H

Approved Category B Facilities
24-Hour Emergency Department Coverage

This schedule is provided for information only.

Facility Number	Facility Name
0051	Baie Verte Peninsula Health Centre, Baie Verte
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0345	Bonavista Community Health Centre, Bonavista
0442	Bonne Bay Health Centre, Bonne Bay
0451	Dr. Hugh Twomey Health Care Centre, Botwood [1]
0299	Brookfield/Bonnews Health Care Centre, Brookfield
0434	A.M. Guy Memorial Health Centre, Buchans
0388	Calder Health Care Centre, Burgeo
0329	Fogo Island Hospital, Fogo
0016	Grand Bank Community Centre, Grand Bank
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0200	North Haven Emergency Centre, Lewisporte
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0418	Placentia Health Centre, Placentia
0191	Dr. C.L. LeGrow Health Centre, Port aux Basques
0396	Rufus Guinchard Health Care Centre, Port Saunders
0426	Green Bay Community Health Centre, Springdale
0022	U.S. Memorial Health Centre, St. Lawrence
0221	Notre Dame Bay Memorial Health Centre, Twillingate
0400	Dr. William Newhook Community Health Centre, Whitbourne [2]

1 Dr. Hugh Twomey Health Care Centre, Botwood has 12-Hour Emergency Department Coverage.
2 Dr. William Newhook Community Health Centre, Whitbourne does not have Emergency Department Coverage.

Schedule I

Obstetrical Bonus Policy for Salaried and Fee-for-service Family Physicians

Under this policy, there is dedicated funding for a bonus payable to Salaried Family Physicians (FPs) and FFS FPs that provide labour and delivery obstetrical services.

Eligibility

Fee-For-Service

FFS FPs who provide obstetrical services billable as either fee code 80004 (*Delivery)* or 80014 (*Attendance at labour)* are eligible to receive a bonus payment after the end of each fiscal year. The bonus is paid in addition to the MCP Payment Schedule obstetrical fees 80004 and 80014.

Salaried

Salaried FPs who provide obstetrical services where they either: (i) perform the delivery; or (ii) attend the patient during labour but transfer the patient to a Specialist because of complications during labour and/or delivery, are eligible to receive a bonus payment after the end of each fiscal year.

Calculation of the Bonus

Fee-For-Service

The bonus amount for an individual FFS FP will be calculated after the end of the fiscal year by multiplying the total number of delivery and attendance at labour events (codes 80004 and 80014) times $100, and adding the result to the applicable figure from the following table:

Total Units 80004 + 80014	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Salaried

The bonus amount for an individual salaried FP will be calculated after the end of the fiscal year by adding the total number of eligible services and multiplying it by $100 and adding the result to the applicable figure from the following table:

Total Units	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Example:

A FP provided 24 eligible labour and delivery services in the one-year period. The bonus payment will be 24 x $100 plus $7500 = $9900.

Applying for the Bonus

Fee-For-Service

FFS FPs must submit an application for the bonus within ninety (90) days of the end of each fiscal year (March 31st). The application form can be printed from the MCP website.

Salaried

Salaried FPs who wish to apply for the bonus for the first time must complete the *Application for Salaried General Practitioner Obstetrics Bonus* form. The Department of HCS will open an Obstetrics Bonus file for each salaried FP who completes and returns the form. If an application was submitted in a previous year, a secondary application is not required.

On an ongoing basis, each salaried FP who has a file opened must submit copies of their patient records for the eligible services. Copies of actual patient labour and delivery record should be submitted as soon as possible after the eligible service has been provided.

Schedule J

Family Practice Renewal Program

This Schedule to the Agreement outlines the principles, structure, physician and broad program areas for a Family Practice Renewal Program. This Schedule addresses matters of unique interest and applicability to Family Physicians.

GUIDING PRINCIPLES FOR PRIMARY CARE RENEWAL

The parties agree that improved population health and health system sustainability in Newfoundland and Labrador will require a renewed focus on primary health care reform. The parties acknowledge that Family Physicians have an important role to play in the improvement and full integration of primary care and primary health care services and supports.

In alignment with the Province's new Primary Health Care Framework/Action Plan, the Family Practice Renewal Program shall incorporate the following principles, which the Family Practice Renewal Committee will convert into priorities and targets as specific programs and initiatives are designed and implemented.

Patient-Centered Services and Supports

Primary health care services should be provided in the manner that works best for patients and their families. Family Physicians and other primary health care providers should partner with patients, their families, and the local community to meet a range of health care needs and preferences.

Collaborative Multi-Disciplinary Teams

Processes must be developed to enable inter-professional communication and decision making that brings together the separate and shared knowledge of various providers to achieve the best possible patient outcomes.

Multi-Disciplinary Teams should include each patient's Family Physician or family practice group and a variety of other primary health care professionals all working together and at their full scope of practice to improve patient outcomes. This should include providers collaborating to increase continuity of care and improve the integration of community-based services and supports with secondary, tertiary, home, and long-term care services.

Increased collaboration among physicians, and between physicians, the PHA, and other health professionals to solve health system and population health issues,

to improve health outcomes, and to increase patient and provider satisfaction must be encouraged.

Coordination of Care

Highly coordinated services and supports at the primary health care level are essential to effective treatment plans that maximize the health and wellness of individual patients. Coordination of care requires awareness of available supports and clear communication between patients, providers, community stakeholders, and across the spectrum of primary, secondary, long-term, and tertiary health care.

Comprehensiveness of Care

Comprehensive care encompasses the provision and organization of a full range of services and supports across the spectrum of the patient's health and wellness needs. It is a patient-centered approach to care that acknowledges an individual's physical and mental health needs throughout their entire life and does not focus on the episodic treatment of specific diseases or illnesses. Comprehensive care includes the provision of a range of primary care services within the Family Physician's scope of practice or the organization of services provided by other physicians and primary health care providers.

Access to Appropriate Services and Supports

Appropriate access centres on the patient's ability to receive the right care, from the right provider, at the right time, and in the right place. It includes an approach to service delivery that aligns with the patient's needs for health care services and supports available in her or his local area or within a reasonable distance. It includes improved access to primary care physicians and increased availability of physicians outside of traditional business hours and on weekends.

Attachment and Longitudinal Relationships

Primary health care providers should be supported to build long-term patient-provider relationships that foster the development of trust and respect between the patient, the Family Physician or practice, and other health care professionals providing services and supports to the patient. Physicians should be encouraged to act as the most responsible provider for their patients and ensure that care is coordinated, consistent, and the patient's long-term needs are considered.

Communities of Practice

Communities of practice should include Family Physicians coming together in a physical or virtual way to share information and experiences and learn from each

other and the other health care professionals they work with. Communities of practice support the identification of local primary health care solutions, recognize the need for each provider to participate in ongoing personal and professional development, and encourage innovative means to improving patient care. They enable faster response to emerging health issues at both the community and regional levels.

Continuous Evaluation and Evidence-Based Decision Making

Ongoing monitoring and evaluation of primary care services is essential to the process of continuous quality improvement. Greater use of evidence-based and cost-effective approaches to management of the common conditions encountered in primary care must be encouraged. Improving the effectiveness of primary health care services and supports, the satisfaction of providers, and the health outcomes of the population requires ongoing evaluation and continuous improvement of service delivery models. Public investments in primary health care must help to achieve better care, better health, and better value.

Community Engagement and a Local Focus

Local communities have an important role to play in working with Family Physicians, other primary health care providers, and the PHA to improve the health of their residents. No community is the same, and improving population health and wellness may require solutions tailored to individual communities and regions.

ARTICLE 1 - DEFINITIONS AND INTERPRETATION

1.1 "**Schedule**" means this document, as amended from time to time as provided within the Agreement.

1.2 "**Attachment**" means ensuring citizens of Newfoundland and Labrador have access to a Family Physician with whom they develop a long-term relationship.

1.3 **"Family Practice Renewal Program (FPRP)"** is the renewal program including governance, funding, and evaluation structures described within this Schedule.

1.4 **"Family Practice Renewal Committee (FPRC)"** means the governance committee for the Family Practice Renewal Program and the Blended Capitation Model of physician payment as established in accordance with Schedule R.

1.5 **"Practice Improvement Program"** means a jointly sponsored program of the Department of Health and Community Services (HCS) and the NLMA through the FPRC. The program offers continuing professional development for physicians and

their staff, as appropriate, to help them improve practice efficiency, support change management, and to enable enhanced delivery of patient care.

1.6 "**Family Practice Networks (FPN)**" means the initiative created and supported by the FPRC to organize physicians at the sub-regional or regional level in order to address common health care goals in their communities. Each FPN will participate in a Collaborative Services Committee (CSC) with the PHA. Each FPN will be a not-for-profit corporation constituted by the physicians within their sub-region or region.

1.7 **"Collaborative Services Committee (CSC)"** means the joint committee of the FPN and the PHA, with membership shared equally between FPN representatives and PHA representatives with decision-making authority. The CSC may also choose to invite patients and local community representatives to participate as ex-officio members. The mandate of the CSC is to identify and respond to primary health care needs of the community. The partners work to co-design programs to improve local primary health care. Decisions of the CSC are made by consensus and both FPN and PHA participation is mandated.

1.8 **"Comprehensive care"** is the delivery of a full range of primary health care services including the following:

(a) Health and health risk assessments
(b) Coordination of patient care across the spectrum of primary, secondary, and tertiary care, including making referrals, and acting upon consultative advice
(c) Longitudinal care of patients across the spectrum of their medical needs
(d) Diagnosis and management of acute ailments
(e) Guidelines-based chronic disease management
(f) Primary reproductive care including the organization of appropriate screening
(g) The provision of or the arrangement with another provider for the provision of prenatal, obstetrical, postnatal, and newborn care
(h) Mental health care and counselling
(i) End of life planning / advanced care directives
(j) Palliative and end of life care
(k) Care and support of the frail elderly
(l) Support for hospital, home, rehabilitation, and long-term care facilities
(m) Patient education and preventative care, including support and education for ongoing patient self-management
(n) The maintenance of a longitudinal patient record

ARTICLE 2 – Family Practice Renewal Committee

2.1 The FPRC is hereby established under this Agreement as a mechanism for representatives of HCS, the NLMA, and PHA to work together on matters affecting

the provision of insured primary care services by Family Physicians in Newfoundland and Labrador.

2.2The mandate of the FPRC is to:

(a) Within available funding, design program initiatives that seek to improve primary care in the Province consistent with the principles outlined in the preamble of this Schedule and the goals identified in Article 3 of this Schedule.
(b) Build a culture of collaboration and innovation between HCS, the NLMA, PHA, and other stakeholders as appropriate.
(c) Identify gaps in care and address population health needs.
(d) Work with stakeholders to identify changes in primary health care delivery, including physician services, which could result in improvements in patient care and health outcomes.
(e) Work to identify and implement initiatives that will result in more effective utilization of physician and other health care resources, and a more fiscally sustainable health care system.
(f) Establish clear metrics for the evaluation of primary care and primary health care services as per Article 5 of this Schedule.
(g) Administration and oversight of the Blended Capitation Model in accordance with Schedule R.

2.3 The FPRC shall be composed of three (3) members appointed by HCS and three (3) members appointed by the NLMA.

(a) Committee members are to be appointed on staggered terms of two (2) and three (3) years to ensure continuity.
(b) Representatives of the PHA may be HCS appointees and/or participate in the FPRC as ex-officio members.
(c) A patient or citizen representative will be jointly selected by the appointed members to participate as non-voting ex-officio member.
(d) From time to time appointed committee members may agree to invite relevant stakeholders, including physicians, allied health care professionals, government representatives, citizens, and PHA employees to participate in FPRC meetings and discussions.
(e) Quorum for all FPRC meetings will require at least two (2) appointed members from HCS and two (2) appointed members from the NLMA.
(f) Within its mandate, the FPRC has authority to establish rules and procedures for the orderly conduct of business.

2.4The FPRC shall be co-chaired by a member chosen by the HCS members and a member chosen by the NLMA members.

2.5 The FPRC will develop annual work plans and ensure that evaluations to measure outputs and outcomes are an integral part of the plan.

2.6The FPRC will establish communication protocols to allow the co-chairs to communicate information about the business and/or decisions of the FPRC to physicians, Government, and other stakeholders including the public.

2.7The cost of evaluation and administrative and clerical support required for the work of the FPRC will be paid from the funds to be allocated to the PCRP pursuant to this Schedule.

(a) Spending on auditing or evaluation activities is not to exceed $275,000 of total FPRP funding allocated during the fiscal year in which the evaluation activities occur.
(b) Spending on administrative and clerical support is not to exceed $825,000 of total FPRP funding allocated during the fiscal year in which it is spent.
(c) Program development, implementation, and operating costs will not be included in the spending limits described in Articles 2.7 (a) and (b) of this Schedule.
(d) Physician participation in the FPRC will be compensated at a rate to be determined by the FPRC.

2.8Decisions of the FPRC shall be by consensus.

ARTICLE 3 – GOALS OF FAMILY PRACTICE RENEWAL PROGRAM

3.1Improved health outcomes, particularly among high-needs populations and those living with chronic disease(s).

3.2Improved coordination of patient care across the continuum of care, and between providers and community-based services and supports.

3.3Increased collaboration between local Family Physicians, and between Family Physicians and other primary health care providers.

3.4The establishment of collaborative, community-based multidisciplinary teams.

3.5Greater collaboration between Family Physicians and the PHA leading to improved alignment on priority issues.

3.6 Improved recruitment and retention of Family Physicians, particularly in rural and underserviced communities.

3.7 Enhanced access to primary care services, such as through the provision of more flexible and conveniently scheduled after-hours clinics and improved access to same-day or next-day urgent appointments.

3.8Improved patient-physician longitudinal attachment, particularly for those living

with chronic disease(s).

3.9 Improved patient and provider satisfaction including greater work-life balance for Family Physicians.

3.10 Measurable improvements in system sustainability including reduced demand on secondary and tertiary emergency departments and other acute care services.

3.11 Effective governance of the Blended Capitation Model in accordance with Schedule R.

ARTICLE 4 – FAMILY PRACTICE RENEWAL PROGRAM FUNDING

4.1 The Government will allocate funding for FPRP initiatives at an annual rate of $5.5M, as of October 1, 2023. The annual rate of $5.5M will be fixed and will not be affected by annual surpluses that may arise in the operation of the program, recognizing that any decision with respect to the use of surplus funds must be jointly agreed by the FPRC.

4.2 The FPRC will use the FPRP funds available pursuant to section 4.1 for the following purposes:

(a) To design and fund new condition-based fee code initiatives for the support of comprehensive care delivery, including:
   (i) Increased coordination and collaboration with other primary health care providers.
   (ii) Improved patient access.
   (iii) Improved identification and management of a full range of Comprehensive Care services.

(b) To fund the development and implementation of FPNs as a means to organize Family Physicians at the sub-regional or regional level in order to address common health care goals in their communities.

   (i) FPNs will participate in a Collaborative Services Committee (CSC) with the PHA, as well as other committees or projects that result from the work of the CSC.
   (ii) FPNs will organize and promote the participation of physicians in their region in activities that improve the delivery of Primary Health Care services.
   (iii) FPNs will be supported and funded within a program framework and funding formula, to be developed by the FPRC, with funds to be used for management, honoraria, administrative expenses and other expenses relevant to the mandate of the program. The program

framework will also specify accountability requirements of the FPNs.

(iv) FPNs will not engage in labour relations or advocacy activities regarding compensation and benefits of salaried, FFS, and blended capitation physicians.

(v) The establishment of a CSC does not preclude or limit the PHA's right to consult or work collaboratively with physicians outside of the formal CSC structure.

(c) To fund the development and operation of a Practice Improvement Program designed to support evidence-based change management aligned with initiatives described in Articles 4.2(a) and (b) of this Schedule and the following target areas:

(i) Primary care best practices and guidelines-based care
(ii) Clinical and practice efficiency
(iii) Adoption of new technology (exclusive of electronic medical records program)
(iv) Practice reorganization
(v) Multi/interdisciplinary collaboration and coordination
(vi) Health prevention and promotion
(vii) Mental health and addictions
(viii) Other target areas as agreed by the FPRC.

4.3 Any funds identified in Article 4.1 of this Schedule that remain unexpended at the end of any fiscal year will be available to the FPRC for use as one-time allocations to improve the quality of primary health care. One-time allocations will require FPRC consensus.

ARTICLE 5 – Accountability and Evaluation

5.1 The FPRC will regularly monitor, review, and evaluate all initiatives implemented and/or funded under the FPRP.

5.2 The FPRP goals identified in Article 3 of this Schedule will serve as the basis for developing all FPRP evaluation metrics. Specific indicators and output and outcome targets will be defined by the FPRC for each individual initiative.

5.3 Funding for newly approved FPRP initiatives, including one-time allocations, will not be released prior to the FPRC approving an evaluation plan that will include the following elements:

(a) defined evaluation objectives;
(b) defined and measurable output and outcome indicators;
(c) ongoing and continuous collection of relevant data;
(d) dissemination of relevant data or monitoring results to stakeholders involved in the initiative;

(e) regular progress reports to the FPRC;
(f) explicit reporting deadlines with a minimum of one formal written status report per fiscal year;
(g) an evaluation budget and work plan describing evaluation activities, deliverables, timeframes, and responsible parties; and
(h) a clear communications plan that describes how evaluation findings will be reported to physicians, government, and relevant stakeholders, including the public.

5.4 The FPRC may employ evaluation staff or enter into agreements with third parties, including academics, research organizations, and evaluation professionals to ensure proper and timely evaluation of all initiatives.

5.5 The results of all formal written status reports will be public records, accessible under the *Access to Information and Protection of Privacy Act*, SNL2015 c. A-1.2, and will be communicated publicly. This will include the public release of annual evaluation summaries and, when appropriate, publication of evaluation findings in academic journals.

5.6 The FPRC will review evaluation results on an annual basis. In cases where the FPRC deems a PCRP initiative has underperformed or was unsuccessful, the FPRC will be responsible for amending or ending the initiative.

5.7 All FPRP initiatives that do not demonstrate progress in reaching the goals identified in Article 3 of this Schedule within 3 (three) years will be discontinued unless otherwise agreed by FPRC consensus.

(a) Funding previously allocated to unsuccessful or cancelled initiatives will be returned to the FPRP budget and re-administered by the FPRC.

(b) Article 5.7(a) of this Schedule applies to all FPRP initiatives, including all physician payments and remuneration initiatives within the FPRP.

Schedule K

Physician Services Liaison Committee (PSLC) Terms of Reference

Purpose of PSLC

To maintain an ongoing mechanism through which medical issues of mutual concern may be addressed collaboratively between the NLMA and HCS, and to act as an oversight body for the administration of the Agreement.

Membership of PSLC

The membership shall consist of four (4) members selected by the NLMA and four (4) members selected by HCS. The Chair shall be appointed for a one-year term and shall alternate between the NLMA and the HCS representatives. The Deputy Minister of the HCS and the NLMA Executive Director shall agree on the Chair.

Frequency of Meetings

Meetings shall be held at least quarterly, or at the call of the Chair for urgent issues that may arise between regular meetings.

Quorum

Two members from the NLMA and two members from the HCS shall constitute a quorum. Decisions will be made by consensus.

Record of Discussions and Action Items

A record of discussions and action items shall be kept for all meetings. All discussions at the meetings shall be confidential. These records shall be available to the Minister, Deputy Minister, and the Executive of HCS, and the Executive and Board of Directors for the NLMA. These records shall also be made available to the CEO of the PHA where appropriate.

Location

The time and location of the meetings shall be at the call of the Chair.

Mandate

1) To provide information and advice to the HCS on medical issues from a policy, systemic, and strategic perspective.

2) To oversee the administration of the Agreement.

3) To generally explore options that would contribute to a sustainable health care system that maintains and/or enhances quality of service that is reasonably accessible to all.

4) To create sub-committees and establish, where necessary, terms of reference for these committees, to address issues such as:

    a) Improving efficiency;
    b) Developing clinical practice guidelines;
    c) Exploring standards related to such issues as wait times and hospital lengths of stay;
    d) Physician recruitment and retention;
    e) Interdisciplinary primary care delivery models;
    f) Primary health care;
    g) Clinical stabilization;
    h) MCP Payment Schedule review;
    i) Others, at the discretion of the PSLC.

5) To liaise with other professional groups, the PHA, or other organizations when both parties consider it necessary or useful;

6) Upon the request of the Minister of HCS, to review and provide timely advice on issues that may be directed to the Committee by the Minister of HCS.

Costs

The costs of participation in the PSLC will be borne by the parties separately.

Schedule L

MCP Payment Schedule Review Committee Terms of Reference

The MCP Payment Schedule Review Committee (PSRC) will be responsible for the ongoing review, editing, and drafting associated with maintaining the integrity of the MCP Payment Schedule.

Scope:

The PSRC will consider and make recommendations to the Minister of HCS regarding:

I. MCP Payment Schedule Review Process
II. MCP Payment Schedule Fee Code Allocation Process
III. MCP Payment Schedule Fee Code Addition Process

Composition of the Committee:

The PSRC will consist of four members:

- Two (2) HCS representatives, and,
- Two (2) NLMA representatives.

Alternate and/or additional members may attend PSRC meetings.

Frequency of Meetings:

The PSRC will meet a minimum of four (4) times a year, otherwise on an as-needed basis. Meetings shall be held at least quarterly or by mutual agreement for urgent issues that may arise between regular meetings.

Work of the Committee:

I. MCP Payment Schedule Review Process

The PSRC is responsible for reviewing the MCP Payment Schedule in order to identify areas for change to ensure that public expenditure on insured medical services yields high quality patient care and high value for money. In this regard the PSRC will:

1. Develop a methodology to analyze physicians' FFS billings in order to identify fee codes or groups of fee codes, and billing rules for review.
2. Establish a process to review and adjust fee codes and billing rules to reflect changes in time, technology, direct cost, market comparison, and other such factors as may be determined by the parties from time to time, for the purpose of adjusting such fees and rules appropriately.

3. Identify fees that are no longer necessary, for elimination.
4. Fee codes may have funding increased or decreased, via valuation change or via rule modification, but in any event, no new fee codes will be introduced via the review.
5. In cases where fee codes are reduced, ensure that no discipline will have its overall funding adjusted to less than the amount achieved under the terms of the Agreement.
6. Fee codes and billing rules will be adjusted on an overall cost-neutral basis only. No new funding will be allocated to support the MCP Payment Schedule Review process.
7. Consult with affected discipline(s) on any recommended adjustments to fees.
8. Provide ninety (90) days' notice of any adjustments to affected discipline(s).
9. Re-allocate any savings as a result of adjustments to fee codes firstly within the discipline and secondly in another discipline to respond to unmet needs.
10. After the process is complete, HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
11. Promote the initiatives of *Choosing Wisely Canada* to optimize value and minimize waste in medical care.
12. Decisions of the PSRC shall be made by consensus and shall be subject to the approval of the Minister of HCS.

II. MCP Payment Schedule Fee Code Allocation Process

Increases awarded by agreement between HCS and the NLMA shall be allocated to individual fee codes in the MCP Payment Schedule by the PSRC in accordance with the following FFS fee code allocation process:

1. The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine funding allocation jointly and collaboratively by consensus. The PSRC will incorporate a gender equity lens into the fee code allocation process. This will include inviting submissions that address gender equity, assessing whether all proposals for allocation of funding increase or reduce gender equity, and allocating available funding to lessen or close any inequity identified.

2. Fee code funding not allocated by consensus via this collaborative process will be determined as outlined in i) and ii) below:

    i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

    ii) HCS will then allocate the remaining 50% during the next thirty (30) day period.

3. Following allocation in accordance with (1) and/or (2), above, HCS

representatives will seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.

III. MCP Payment Schedule Fee Code Addition Process

The PSRC is responsible for receiving applications for new fee codes in order to ensure that the MCP Payment Schedule includes appropriate fee codes for new physician services that become available in the Province, and for the overall maintenance of the integrity of the MCP Payment Schedule, in accordance with the following:

1. The PSRC will receive applications for new fee codes from physicians or from HCS and will review them jointly and collaboratively and work toward a consensus-based response.
2. The PSRC will develop and use a MCP Payment Schedule Request form that must be completed by HCS or the physician (or discipline) making the proposal. From time to time the PSRC may review and revise the form to ensure suitability.
3. The PSRC will consider such things as insurability, the site of the proposed service, the degree to which the proposed fee code or rate may affect gender equity, and the rate and terms and conditions of payment with reference to the Atlantic provinces. Where reference to Atlantic Canada is not possible, by consensus, the PSRC may make reference to the rates and/or terms and conditions established by another province/territory outside of Atlantic Canada.
4. After the process is complete HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
5. In the absence of consensus, HCS representatives will make a recommendation to the Minister of HCS and the NLMA may also advise the Minister of HCS regarding their separate recommendation.
6. Revisions to the MCP Payment Schedule that have been approved by the Minister of HCS will take effect ninety (90) days following the date of approval by the Minister of HCS.

Schedule M

On-Call and Internal Locum Rates

On-call service shall be remunerated according to the following four-tiers, and the rules as published from time to time in the MCP On-Call Payment Information Manual:

	October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
Tier 1	$326.16	$366.09	$444.00	$476.93
Tier 2	$289.92	$326.69	$394.19	$425.38
Tier 3	$253.68	$287.30	$344.39	$373.83
Tier 4	$217.44	$247.91	$294.59	$322.29

Note: Rates listed in the table are daily rates, based on 24-hours (paid hourly).

Internal Locum payments shall be remunerated according to the following rates:

	October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
Salaried Specialist	$43.55	$48.37	$47.81	$48.76
FFS Specialist	$18.73	$20.81	$20.56	$20.97
Salaried Family Physician	$30.13	$32.64	$31.66	$32.04
FFS Family Physician	$12.92	$13.99	$13.57	$13.74
Salaried Hospitalist	$34.09	$36.98	$36.15	$36.69

Multi-site call:

Compensation for each additional site added to a physician's responsibility during a call shift shall be set at 50% of the rate for the site(s) from which calls are received up to a maximum of an additional 100% Tier 1 rate. This shall be in addition to the full rate for their home site for which they are originally on-call. For greater clarity, physicians covering a province-wide call plus a home site will be remunerated at Tier 1 plus the level for their home site.

Schedule N

Interest Arbitration

1. (a) This amendment replaces the Schedule N originally included in the 2013-2017 Agreement. This Schedule N shall come into force upon signing by the Parties of the 2017-2023 Agreement. To clarify, the Parties agree that Schedule N shall not give rise to any retroactive entitlements arising from actions by either party which occurred prior to the date of signing the 2017-2023 Agreement.

   (b) Should the parties fail to enter into a new Agreement to replace this Agreement within twelve (12) months following the date of the receipt by any party of the written notice referred to in Article 3.03 of this Agreement, any party may give written notice to the other party of its intention to invoke the arbitration provisions set forth in this Schedule.

2. Where a party has given notice under section 1 of its intention to invoke the arbitration provisions, the parties agree to submit all matters in dispute to a three (3) member Arbitration Board, which shall be constituted and shall proceed as follows:

   (a) Within ten (10) days following the receipt by any party of the notice referred to in section 1, each of the parties shall nominate an arbitrator to be its nominee on the Arbitration Board and shall give written notice to the other party of the name and address of the person so nominated.

   (b) Within seven (7) days following the nomination of the persons to the Arbitration Board referred to in section 2(a), the two persons so nominated shall together select a third person who shall be the Chairperson of the Arbitration Board, and the three persons so nominated and selected shall together constitute the Arbitration Board for the purpose herein set forth.

   (c) Within thirty (30) days following the selection of the Chairperson of the Arbitration Board as provided in section 2(b), or within such other period as may be mutually agreed by the parties, the Arbitration Board shall convene a hearing to arbitrate the matters in dispute.

   (d) Not later than ten (10) days prior to the day set for the commencement of the hearing referred to in section 2(c), each party shall submit to the Arbitration Board, in writing, a statement of its respective positions on the matters in dispute together with all relevant documentation in support thereof, and shall serve a copy on the other party. Subject to section 2(e), no matter may be submitted to the Arbitration Board as a matter in dispute unless:

(i) within one hundred and eighty (180) days following the date of the receipt by any party of the written notice referred to in Article 3.03 that matter has been the subject of a written proposal by one party towards settlement of the matter and which written proposal has been delivered to the other party within that 180 day period; or

(ii) both parties consent in writing to that matter being submitted to the Arbitration Board as a matter in dispute.

(e) Unless both parties explicitly consent in writing, no matter may be submitted to the Arbitration Board that involves a decision or decisions by Government as to: (i) the allocation of human resources, including without limitation, the number and allocation of salaried positions and the location of services; (ii) the allocation of fee codes (i.e. fee code allocations); (iii) new services to be compensated; (iv) new programs, new benefits, new bonuses and new incentives; and (v) determination of what are insured services. Other than the foregoing, the Arbitration Board shall be able to determine any matter in dispute concerning compensation and benefits, including the rules and terms that define the entitlement of physicians to such compensation and benefits, that are contained in the Agreement under which the referral to arbitration has been made, including, subject to section 2(f), the duration of the Agreement.

(f) The arbitration referred to section 2(c) shall be governed by the provisions of the *Arbitration Act, RSNL 1990, c. A-14*. In conducting the arbitration and making its decision or award, the Arbitration Board shall give due consideration to the purposes of the Agreement set out in Article 1.0l(b). The Arbitration Board shall not have jurisdiction to make a decision or award for a period covering more than three (3) years unless the parties agree otherwise. The Arbitration Board shall give full opportunity to the parties to present evidence and make submissions.

(g) The Arbitration Board shall use conventional arbitration principles and, in making its decision, shall consider and take into account any matter(s) or factor(s) which it judges to be relevant, including the following factors:

(i) Evidence relating to comparable groups in Atlantic Canada;

(ii) Reasonable and fair compensation and working conditions for physicians in rendering professional services;

(iii) The ability of Government to pay in light of its current and projected fiscal position, including levels of taxation, expenditures and debt levels; and

(iv) Recent general economic increases provided to the provincial public sector unions in Newfoundland and Labrador.

(h) The Arbitration Board shall, should it determine that either party has

failed to bargain in good faith to conclude a new agreement, refer the parties back to bargaining for a period of sixty (60) days with a view to resolving, clarifying, or otherwise addressing one or more matters in dispute.

(i) The Arbitration Board shall deliver its decision or award by majority decision in writing within forty-five (45) days from the conclusion of the hearing referred to in section 2(c), and the decision or award of the majority shall be the decision of the Arbitration Board and shall be final and binding on the parties with respect to the matters in dispute and shall not be subject to any appeal. Should there be no majority decision or award, the decision or award of the Chairperson of the Arbitration Board shall be the decision or award of the Arbitration Board. The decision or award of the Arbitration Board shall be implemented in the manner provided in the decision or award. The Arbitration Board shall have jurisdiction to provide clarification to the parties concerning the decision or award, provided, however, that the Arbitration Board shall not change its decision or award in any substantive way.

(j) Each party shall bear its own costs and expenses of the arbitration, including the costs and expenses of its nominee to the Arbitration Board, and shall share equally the costs and expenses of the arbitration including those of the Chairperson of the Arbitration Board.

(k) The Arbitration Board shall not have jurisdiction to amend or vary the terms of any part of Article 1.0l(b), Article 3.03 or this Schedule N of the Agreement.

(l) Judgment upon the decision or award of the Arbitration Board may with leave of the Court be entered in the Supreme Court of Newfoundland and Labrador and, if so registered, be enforced subject to those restrictions, if any, ordered by the Court.

(m) Nothing in this Agreement prohibits, limits or restricts the right of either party to seek judicial review of the award or decision of the Arbitration Board or of a component thereof on a matter of law or jurisdiction.

3. During the life of this Agreement the parties agree that:

(a) The NLMA shall not declare, organize, authorize, encourage, support, participate in, or sanction in any way action by a physician acting alone or in concert with other physicians that would breach the obligations imposed in subsection 3(b); and

(b) A physician, acting alone or in concert with other physicians, shall not

engage in a cessation or refusal to work or to continue to work, including, without limitation, a resignation, slow-down of work or other such concerted activity, or threat thereof, in respect of the provision of an insured service, for the purpose of exerting economic influence on either Government or the NLMA to achieve personal economic gain or to achieve a benefit in excess of those determined pursuant to the terms of this Agreement.

4. (a) (i) Where the Government reasonably believes that there has been a breach of the obligations imposed by subsection 3(a), the Government may provide written notice to the NLMA stating the sources and grounds for its belief and may declare this Schedule to be of no force or effect.

(ii) Where the Government reasonably believes that there has been a breach of the obligations imposed by subsections 3(b), the Government may provide written notice to the NLMA stating the sources and grounds for its belief and require the NLMA to remedy the breach within two (2) working days of such notice. If the breach is not remedied to the reasonable satisfaction of Government within two (2) working days of such notice, the Government may declare this Schedule to be of no force or effect.

(b) If the NLMA disputes that there has been a breach as identified in any notice provided by Government under subsection 4(a) the NLMA may, within fifteen (15) calendar days of receiving such notice, refer the matter to arbitration in accordance with Article 13(iii) of this Agreement. Such referral will be deemed by the parties as mutual agreement to engage the services of an arbitrator in accordance with Article 13 (iii).

(c) Where an arbitrator appointed pursuant to subsection 4(b) determines, on a balance of probabilities, that there has not been a breach of the obligations imposed by subsections 3(a) or 3(b) or that any such breach of 3(b) was remedied by the NLMA to a level that should reasonably have satisfied Government within two (2) working days, this Schedule shall continue in full force and effect as though the declaration issued by Government under subsection 4(a) had not occurred. The findings of an arbitrator, as to whether a breach occurred or whether the NLMA failed to remedy the breach to a level that should reasonably have satisfied Government shall be final and binding.

(d) Following the referral to arbitration in accordance with subsection 4(b), no notice shall be given pursuant to section 1 and, where any such notice was given prior to such reference and the proceedings have not concluded, such proceedings shall be suspended unless and until an arbitrator has made a determination in accordance with subsection 4(c).

(e) Where a declaration by Government has been issued in accordance with

subsection 4(a) and there has been no referral to arbitration in accordance with subsection 4(b), any proceeding initiated pursuant to section 1 shall cease.

5. The parties hereby agree that:

   (a) Any judicial or quasi-judicial determination, including, without limitation, a determination by an arbitrator appointed pursuant to Article 13 of this Agreement, which has the effect, directly or indirectly, of bringing within the scope of this Agreement any matter, compensatory or otherwise, that was not explicitly contained in this Agreement prior to such determination, that matter shall be specifically excluded from the jurisdiction of an interest arbitration board, unless agreed between both parties.

6. This Schedule shall cease to be of any force or effect on the earlier of either:

   (a) The parties' written agreement;

   (b) A determination made pursuant to section 4 that there has been a breach of the obligations imposed by subsections 3(a) or 3(b).

7. Notwithstanding any other provision of this Agreement, and for further clarity, if this Schedule ceases to be of any force or effect in accordance with sections 4 or 6 of this Schedule, the parties hereby agree and confirm that this Schedule shall not form part of any subsequent agreement unless the parties explicitly agree otherwise in writing.

8. The following Schedules are not subject to interest arbitration:

   1. Schedule B Facility Workload Disruption Payment Policy for Fee-For-Service Physicians
   2. Schedule C Salaried Physician Retention Bonus Categories
   3. Schedule D Salaried Family Physician Remoteness Bonus
   4. Schedule E Alternate Payment Plans (APPs)
   5. Schedule G Approved Category A Facilities: 24-Hour on-site Emergency Department coverage
   6. Schedule H Approved Category B Facilities: 24-Hour Emergency Department coverage
   7. Schedule K Physician Services Liaison Committee Terms of Reference
   8. Schedule L MCP Payment Schedule Review Committee Terms of Reference
   9. Schedule N Interest Arbitration
   10. Schedule O Cataract Surgery Service Fees in Non-Hospital Designated Facilities

11. Schedule P Dispute Resolution

The following Schedules are subject to interest arbitration:

1. Schedule F FFS Increases, By FFS Specialty Group
2. Schedule M On-call and Internal Locum Rates
3. Schedule Q Rural Community Comprehensive Care (RCCC) Bonus
4. Schedule R Blended Capitation Model for Primary Care

The following Schedules are subject to interest arbitration in part, as indicated:

1. Schedule A Waterford Physicians On-Duty, on-site Payment Policy: rates only
2. Schedule I Obstetrical Bonus Policy for Salaried and FFS Family Physicians: rates only
3. Schedule J Primary Care Renewal Program: clause 4.1 ("Funding") only

Schedule O

Cataract Surgery Service Fees in Non-Hospital Designated Facilities

1. The purpose of this Schedule is to outline the agreement reached between the Department of Health and Community Services (HCS) and the Newfoundland and Labrador Medical Association (NLMA) with respect to service fees for cataract surgeries carried out in a facility designated by the Lieutenant-Governor in Council. Service fees do not include professional fees for insured services as specified in the Medical Care Plan (MCP) Medical Payment Schedule.

2. Designated facilities will be those facilities designated by the Lieutenant-Governor in Council as meeting the established criteria as set by the Department of HCS.

3. A service fee will be payable to the operator of a designated facility on a per-procedure basis to be invoiced to the PHA of the region in which the facility is located.

4. The service fee will be $945.41.

5. The service fee may be reviewed at the request of the NLMA or HCS on a frequency no greater than annually. Upon request, both parties will undertake good faith discussions based on actual changes in the cost of insured cataract surgery services. During a review, HCS has the right to request verification of costs related to consumables, including rarely used consumables, staff compensation, and specific contracts.

6. The service fee represents the total compensation for the provision of cataract surgery in a designated facility and no additional compensation, except for the list of rarely used consumables attached hereto as Exhibit "A" and the MCP professional fee, is payable.

7. Rarely used consumables as identified in Exhibit "A" do not form part of this service fee and will be provided by the PHA.

8. This Schedule shall remain in effect for ten (10) years. The parties agree to review the Schedule at five (5) years.

9. Any designated facility may cease provision of cataract surgery at any time by providing six (6) months' written notice to the PHA.

10. Commencing in 2020/2021, and prorated for any portion of 2019/2020 in which a designated facility is in operation, there shall be an annual provincial cap of 3,500

cases to be performed in designated facilities, comprising a regional cap of 1,231 procedures within the eastern region and a regional cap of 2,269 procedures within the western region. HCS acknowledges that any procedures performed in a hospital facility at the request of HCS or the PHA will not be deducted from the regional or provincial cap.

11. Commencing in 2021/2022, the number of procedures comprising the annual provincial cap and the corresponding regional caps shall be adjusted annually. Changes shall be based on demographic projections of the Department of Finance, and a calculation of total predicted regional demand based on factors derived from relevant peer-reviewed evidence. The factors are the rate of cataract surgeries for the population 65 and over, plus the ratio of surgeries performed for people under the age of 65 to the total number of cataract surgeries.

12. This Schedule is not subject to interest arbitration.

Exhibit A

Infrequently used hospital provided items:

- Malyugin ring
- Iris hooks
- Vision blue
- Capsular tension rings
- Capsular segments
- 10-0 nylon suture
- 10-0 vicryl suture
- Centurion vitrectomy kits
- Myostat
- Myochol
- Healon
- Implantable glaucoma devices
- Kenalog/triesence
- Cartridges for rarely used lenses
- Anterior chamber lenses for rare complicated cases
- And other rarely used consumables not included in a standard cataract surgery, to be provided on an as-needed basis, for complex cases.

Schedule P

Dispute Resolution

1. The purpose of Schedule P is to establish a mediation process so as to facilitate the early and fair resolution of disputes between the parties regarding the interpretation of this Agreement, other than any dispute that is subject to Interest Arbitration.

2. In this Schedule, the following words and phrases shall have the following meanings:

   "mediation" means a process of discussion between the parties or their representatives or both the parties and their representatives under the direction of a neutral third party ("the mediator") with a view to facilitating communication among the parties to assist them in reaching a mutually acceptable resolution of some or all of the issues in dispute.

3. If within ten (10) calendar days following the delivery of a written notice of a reference to mediation the parties do not in writing agree upon and appoint a mediator, then either party may in writing request the ADR Atlantic Institute ("ADRAI") to name a mediator from the roster of arbitrators established by the Labour Management Arbitration Committee of the Labour Relations and Standards Division who is also a current member of ADRAI.

4. A mediation shall be conducted by the mediator appointed by written agreement of the parties, or by appointment in accordance with section 3.

5. The parties agree that the representatives selected to participate in the dispute resolution process will have either the authority required to settle the dispute or a ready means of obtaining the requisite authorization to do so.

6. The mediation may be conducted for a period of up to six (6) weeks after appointment of the mediator ("the mediation period"), unless the mediation period is extended by written agreement of the parties.

7. Unless otherwise agreed by the parties in writing, a mediation session shall commence within twenty (20) calendar days of the appointment of the mediator.

8. Following the appointment of a mediator, the parties shall expeditiously contact the mediator to schedule the mediation session(s).

9. Unless the parties and the mediator agree otherwise, at least seven (7)

calendar days before the first scheduled mediation session each party shall provide to the mediator and each other party a brief statement of factual and legal issues in dispute, a summary of that party's position, and copies of all documents relevant to the mediation.

10. The parties shall attend the mediation session(s) unless the mediator directs otherwise.

11. The procedure and methodology to be followed at a mediation session may vary according to the particular style and approach of the mediator who shall, after consultation with the parties, adopt an approach which in their opinion is best calculated to facilitate the purposes of the mediation and otherwise complies with the requirements of the mediation.

12. The mediator may deliver to a party a notice of non-compliance if it is not practical to conduct a mediation session because a party has failed to comply with section 9, or because a party has failed to attend at the time scheduled for the session, unless the party in attendance agrees otherwise. Where a mediator delivers a notice of non-compliance, the other party may ask the mediator to schedule a further mediation session.

13. Unless otherwise agreed by the parties and the mediator, within fifteen (15) calendar days after the date of the final mediation session, the mediator shall deliver to each of the parties a report: (i) identifying the issues on which agreement has been reached; (ii) identifying the remaining issues in dispute and the points of difference, if any; and (iii) containing recommendations that the mediator considers appropriate as to how the remaining issues in dispute and points of difference might be resolved.

14. The mediator will develop their report based on the information submitted pursuant to section 9 and any other information supplied by the parties in face-to-face mediation sessions.

15. All communications during a mediation session:

    (a) shall constitute without prejudice settlement discussions;
    (b) shall be privileged from disclosure; and
    (c) shall not be admissible as evidence in a legal proceeding.

In this context, communications include, but are not limited to, the following:

(a) the mediator's recollections of a mediation session;
(b) the mediator's notes and records relating to a mediation session; and
(c) anything said or written down during a mediation session.

16. For greater certainty, a mediator shall not be a compellable witness regarding any aspect of a mediation session relating to the issues in dispute being mediated or the results of the mediation, including any discussions relating thereto.

17. A mediator may stipulate that they are not liable for loss or damage suffered by a person by reason of an action or omission of the mediator in the discharge of their duties under this Schedule.

18. If there is an agreement by the parties resolving all or any of the issues in dispute, it shall be in writing and signed by the parties. Notwithstanding section 15 above, an agreement resolving all or any of the issues in dispute shall be admissible in evidence for the purpose of enforcing that agreement. Where a party to a signed agreement fails to comply with its terms, another party to the agreement may apply to the Supreme Court of Newfoundland and Labrador for judgment in the terms of the agreement or with those modifications as subsequent circumstances may require to ensure that the applying party receives that to which the applying party is substantially entitled under the agreement.

19. Unless the parties otherwise agree, the mediator's fees and expenses shall be borne equally by the parties.

Schedule Q

Rural Community Comprehensive Care (RCCC) Bonus

The start date for the Rural Community Comprehensive Care (RCCC) Bonus program, which replaced the FFS Rural Retention Bonus for Family Physicians, is September 30, 2022.

The RCCC Bonus amount is $10,000 per annum. This amount (and eligibility criteria) will be prorated, where necessary, in situations where the physician is on parental leave, retires, or enters practice partway through the bonus period. Other situations may be considered and are subject to approval by HCS and the NLMA.

Eligibility Criteria

1. FFS Family Physician who practices outside the Northeast Avalon (i.e., communities north of and including Holyrood and Witless Bay with the exception of Bell Island).
2. Physician has billed at least $100,000 in the year covered by the bonus period.
3. Physician has billed for services on at least 115 days in the year covered by the bonus period.
4. Physician participates in the Family Practice Renewal Program (FPRP) Fee Code Program or, physician meets the FPRP's eligibility criteria for the Fee Code Program threshold for providing comprehensive community care.

Any physician eligible for a payment under the previous program will receive a prorated bonus up to the start date of the new program.

The parties will jointly develop other transition and administrative rules as necessary.

Schedule R

Blended Capitation Model for Primary Care

This Schedule to the Agreement outlines the principles, structure, rates, rules and other related matters for a blended capitation remuneration model for primary care. The Parties agree that this Schedule shall be effective on April 1, 2023.

1.0 Program Objective

The objective of the Blended Capitation Program (Program) is to contribute to a health care system in which all citizens have timely access to excellent team-based primary care that provides comprehensive, continuous primary care to Attached patients. The Program will enable, promote, and support team-based primary care, comprehensive family medicine, greater attachment, access to and quality of care for patients, and improved recruitment, retention and professional satisfaction for physicians. The parties are committed to working cooperatively in pursuit of this objective.

1.01 Public Accountability

The parties acknowledge that, in the Blended Capitation Model (Model) of primary care, the majority of compensation is based upon patient attachment, where the physician commits to provide ongoing care and treatment to a patient throughout an entire year, and not on the episodic provision of care or treatment. The parties therefore agree that there must be appropriate accountability for the public funds so expended and that the management and administration of the Model by the Family Practice Renewal Committee (FPRC) must include, through the use of appropriate performance metrics, the continuing assessment and evaluation of the operation of the Model.

Definitions

Attached means that there is a formalized, continuous relationship between a patient and Blended Capitation family practice. Attachment is formalized through discussion and documentation in accordance with section 3.4.

Basket of Services means the set of core insured services provided by participating physicians for attached patients and reflects the typical activities of a family physician (non-specialized) in an office-based setting. The Basket of Services is set out in Appendix B. The Basket of Services may be provided in-person or virtually, as determined appropriate by the provider.

Blended Capitation Model (Model) means the payment model for physicians licensed to practice family medicine in Newfoundland and Labrador that provides a

capitation payment for providing a Basket of Services to each Attached patient, and a partial fee-for-service payment for each service provided within the MCP Medical Payment Schedule to an Attached patient, in accordance with this Schedule.

Blended Capitation Group (Group) means a group of three or more physicians who enroll in the Model and are working together to provide their patients comprehensive access to quality primary health care services.

Capitation Payment means the payment made annually to a physician for the care of an Attached patient. The capitation payment for an individual Attached patient is the base Capitation Rate set out in section 3.8 adjusted in accordance with the Complexity Modifier set out in the table in Appendix A.

Complexity Modifier means a methodology to adjust Capitation Payments to physicians based on the complexity of care required by patients as set out in the table in Appendix A.

Income Floor means a guaranteed minimum level of compensation provided to physicians participating in the Model for an initial period of up to two years, calculated pursuant to section 3.12.

Program means the rules, funding and processes that, collectively, within the Schedule, describe physician eligibility for Blended Capitation payments, and other obligations of the parties and program participants.

Provider Roster means the patients who are Attached to a physician.

2.0 Governance and Administration

2.1 Payments under this Program will be made by Government consistent with, and within the scope of, this Schedule.

2.2 The FPRC will carry out implementation of the Program consistent with, and within the scope of, this Schedule, and will consult widely with stakeholder groups. The FPRC will develop additional program objectives, rules, and processes as necessary, consistent with, and within the scope of, this Schedule.

a) The Family Practice Renewal Program (FPRP) will be responsible for Model administration, project management, physician engagement, enrolling physician practices, entering into agreements with physician practices, and practice improvement initiatives to support successful practices.

b) The FPRC will establish staffing and administrative requirements within the funding amounts set out in this Schedule.

c) The FPRC will establish an evaluation subcommittee including two patient representatives to develop an evaluation framework and complete a formal evaluation of the Program, inclusive of access, quality, and other relevant objectives, to be completed within five years of the Effective Date. The FPRC will also ensure that a formal evaluation to measure outcomes of the Program is conducted.

d) The Program will be comprehensively tested to identify risks, including those around cost escalation, and will explore solutions to mitigate those risks. The FPRC will continuously review the Program to update its rules and processes and to determine if modifications to the parameters of the Model are required. The FPRC may make recommendations to the Parties for changes to this Schedule as and when they are deemed necessary.

2.3 The administration budget for the Model will be funded through a combination of FPRP's existing budget, including the accumulated surplus available as of the Effective Date, and through additional funding from Government in accordance with the table below. These contributions may at any time be re-evaluated at the request of the Minister of Health and Community Services or the NLMA and may be modified by written agreement of the Parties. Any surplus remaining as of March 31, 2028, taking into account the opening accumulated surplus and the continuing annual funding, may be utilized for further operational funding of the Program or otherwise shall be returned to Government.

Additional funding from HCS	
Date of signing to March 31, 2024	$600,000
Fiscal 2024/2025	$500,000
Fiscal 2025/2026	$300,000
Fiscal 2026/2027	$300,000
Fiscal 2027-2028	$300,000
TOTAL	**$2,000,000**

3.0 Blended Capitation Model

3.1 Timelines.

April 1, 2023	The Program will be open for applications.

October 30, 2023	The Program will start to issue notifications of acceptance. Subsequent notifications will be made within 3 months of receipt of application. The date of acceptance into the Program will be the start date of the income guarantee period and the date that payment of all transition/incentive grants and stipends will be authorized.
April 1, 2024	The billing system for capitation claims and partial fee-for-service claims will be ready no later than this date. A test group of a maximum of 75 physicians will start billing on the new billing system no later than this date. If the billing system is ready for launch prior to April 1, 2024 the test group may start at that time.
July 1, 2024	Once the reliability and accuracy of the billing system are confirmed by Government, on or before July 1, 2024, the billing system will be open to all other applicants who have been accepted into the Program.

3.2 **Group Size.** The minimum Blended Capitation Group size will be three physicians. The FPRC will establish rules and procedures to allow Blended Capitation Groups that drop below the mandatory group size the opportunity to reach the minimum size of three.

3.3 **Eligibility.** Participation by physicians in the Blended Capitation Model will be voluntary. Physicians paid through either Fee-For-Services (FFS) or an alternate method may convert to the Model if they meet the eligibility criteria as defined below. Physicians may transition back to FFS at their discretion, in accordance with terms and conditions that will be developed under section 2.2.

All family physicians will be eligible for payment through the Model, provided they commit to the following items in a Blended Capitation Group agreement with the Program:

a) Commit to provide comprehensive continuous primary healthcare services across the life span of their patients, based on patient

needs and responsive to documented needs of the geographic community they serve;

b) Meet parameters set out in this Schedule;

c) Meet performance indicators as established in section 3.6;

d) Are part of a Group of family physicians in one practice or across multiple practices, who practice in an office-based setting in Newfoundland and Labrador and partner together in providing after-hours care for their Attached patients;

e) Are a member of a Family Practice Network, where one exists in their geographic region;

f) Maintain registration with the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) as follows:

- Full registration, or;
- Provisional Licence and are part of a Group that provides adequate opportunity for practice supervision as per CPSNL policies and guidelines;

g) Use the provincial Electronic Medical Record (EMR);

h) In regard to physicians who have a private primary care practice located in a Health Authority facility, they shall bill office codes for services provided in their private primary care practice, and facility-based codes for services provided as part of PHA services;

i) Submit data on access, quality and other matters as may be agreed by the Parties, as specified in this schedule, or as approved by the FPRC;

j) Participate in quality initiatives and activities as outlined in section 3.14; and

k) Agree to participate in Program evaluation.

3.4 **Rostering.**

a) A patient is deemed to be Attached when they are rostered within the information system designed for that purpose.

b) On a regular basis, as required by the payment system, physicians will confirm the Attachment of their current patients, new patients, and de-rostered patients.

c) Patients who enter Long-Term Care facilities will be automatically de-rostered from their physician.

d) MCP will generate reports on out-of-practice visits for the Attached patients of each family physician. These reports will be designed to assist physicians with identifying opportunities to improve patient access.

3.5 **Service Expectations.** Physicians participating in the Program will meet the following service expectations:

a) Physicians commit to using best practices in scheduling to provide timely access to appointments, including the ability for patients, where appropriate, to access their own physician or another physician in the Group or other team members on the same day.

b) Each physician will coordinate with the other physicians in the Group as required to ensure that non-emergency primary care services will be accessible during reasonable, regular hours each week of the year and meet the health needs of the patient population served by the Group.

c) **After-hours**: A Blended Capitation Group will provide after-hours clinics for Attached patients outside the hours of 9am to 5pm, Monday to Friday. The number of hours of after-hours clinics that each Group must provide per quarter (i.e., 13 week period) shall be 2.2 hours per 100 patients on the total practice roster (including the rosters of non-physician providers), provided that in any event, and regardless of roster size, there are a minimum of 3 after-hours clinic hours per week per Group.

Examples:

Number Attached Patients	Hours per Quarter (13 weeks) Formula: Roster Size/100x2.2	Average Hours per week	Minimum Hours per week
3600	79	6.1	3
4000	88	6.8	3
6000	132	10.1	3
7200	158	12.2	3

All physicians will participate in after-hours service expectations, with distribution being adjusted by taking into consideration the regular, ongoing provision of services such as hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services, or other relevant factors. FPRC will develop policies and rules regarding the foregoing after-hours service expectations.

c.1) Redistribution/Exemption – After Hours Expectations
(Effective September 1, 2023 up to August 31, 2025)

- The Group that provides regular, ongoing provision of services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services may distribute their after-hours BCM service to the Group's Nurse Practitioner (NP), where the Group has hired a NP;
- The Group that provides regular, ongoing provision of services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services, where the Group has not hired a NP, may be exempted from the BCM after-hours requirement in subsection 3.5 (c), on application to the FPRP and on decision of the FPRP in accordance with the FPRP's policies and rules;
- This subsection 3.5 (c.1) shall only be in effect for the transition period September 1, 2023 and August 31, 2025 and only so long as the physician provides at least two hours of the types of services described in the above two bullets to NLHS for every one hour of after-hours BCM service redistributed/exempted; and,
- Where a physician member of a Group does not provide the type or duration of services to the NLHS as described in the above three bullets, that member of the Group is not eligible

for redistribution/exemption of after-hours service expectations as set out in subsection 3.5 (c). The physician will provide after-hours service pursuant to the s. 3.5 (c) formula but prorated to the number of patients who are attached to them.

d) Where reasonably possible, services will be provided by the physicians in a Group rather than by locums or subcontractors.

e) Excellent availability of and access to team-based primary care is considered to include, unless circumstances dictate otherwise, each practice providing an average service level of not fewer than 88 Attached patient care encounters per 100 Attached patients each 3-month quarter (13 weeks).

13 week recommended access level per practice (Examples):		
Number Attached patients	Care Encounters per quarter	Average number of care encounters per week
3750	3300	254
5400	4752	365
7200	6336	487

f) The maximum roster for each physician shall be 2,400 Attached patients.

g) **Other Providers:** Where a nurse practitioner is employed by or contracted to work as part of a Blended Capitation Group, 900 patients may be rostered by the physicians in the Group in addition to the amount specified in section 3.5 (f). Where a registered nurse is employed by or contracted to work as part of a Blended Capitation Group, 600 patients may be rostered by the physicians in the Group in addition to the amount specified in section 3.5 (f). The actual roster of any provider within a Group will be as agreed between the Group and the provider, and the division of the additional rostered patients as specified in this section between the physicians for billing purposes will be as agreed by the physicians in the Group. There shall be no cap on the number of other providers that may be added to a Group but the total roster addition under this section shall be capped at 3000, unless otherwise approved by the FPRC.

3.6 **Performance Indicators.** Physicians will be accountable to the Program for reporting on performance indicators. The FPRC will be responsible for implementing the performance indicators of the Model.

a) The following indicators will be measured:
- Percentage of same day or next day appointments available to Attached patients.
- After-hours access provided to Attached patients. This indicator will be based on after-hours service expectations in section 3.5 (c).
- Relational continuity, meaning the ongoing therapeutic relationship between a family physician, including their team, and an Attached patient. This indicator will measure the proportion of visits by Attached patients to their family physician, and to their family physician's Blended Capitation Group.

b) A phased-in implementation approach to measuring performance indicators will be used. This will involve creating a baseline of data, ensuring that the metrics are reliable, and informing Blended Capitation Groups how to access and interpret the indicators.

c) Indicators will be measured at the Group level and at the individual physician level.

d) The objective of the performance indicators process is to encourage continuous improvement and/or maintenance of accessibility and high-quality care. If a Group, (or an individual physician within a Group), is not maintaining accessibility or quality of care, consistent with the above objective, based on the performance indicators, the FPRC will engage the Group or the physician in a process of information exchange and performance improvement. If, following these activities, improvement has not been achieved, the FPRC will have discretion to terminate the Group (or an individual physician within a Group) from the Program.

e) The FPRC will further develop definitions and guidelines for the Performance Indicator program. For the purposes of section 3.6 (d) above, indicators will be limited to activities and outputs over

which the practice has control and will not be linked to patient behaviour or outcomes.

f) The FPRC will monitor and adjust these indicators as required and may develop additional indicators.

g) Indicators will be based on Provincial Electronic Medical Record (EMR) data or data from hospital information systems. New data gathering requirements that create additional work for physician practices will not be introduced unless approved by FPRC.

h) Physicians will permit access to EMR data by the PHA (formerly NLCHI) for purposes of indicator requirements under this Schedule.

i) Should the FPRC be unable to reach a decision regarding termination, as described in section 3.6 (d), the FPRC will refer the matter to the Minister of Health and Community Services for a determination after consultation with Government and NLMA members of the FPRC. Within 10 days of the Minister's decision, the NLMA may refer any dispute, controversy or claim arising out of or relating to the Minister's determination, including any question regarding the Minister's interpretation and application of this Schedule, to arbitration for final resolution in accordance with the *Arbitration Act, RSNL 1990 cA-14.* The cost of arbitration shall be equally borne by the Parties.

3.7 **Payment Blend.**

a) MCP will provide remuneration to the physicians in a Blended Capitation Group for care of Attached patients in the form of a Capitation Payment, and FFS payments at a rate of 25% of the rates in the MCP Medical Payment Schedule, for in-basket services, and 100% of the rates in the MCP Medical Payment Schedule for other insured services.

b) For clarity, the Blended Capitation payments do not include payments received by physicians for services to patients outside the normal in-basket practice setting. Such excluded payments include: emergency department payments, the rural retention bonus, CMPA reimbursement, obstetrical bonus, on-call payments, surgical assist payments, academic payments, and other sessional payments and/or employment income from health

authorities or third parties. The FPRC may add other categories of excluded payments to this list.

c) Continuation of the practice of billing for insured services provided by medical learners, to support clinical teaching activities, will be at 100% FFS.

3.8 **Capitation Rate.** The base Capitation Rate in the table below is per patient per fiscal year and will change in the future according to negotiated changes for Family Medicine fee codes in the Memorandum of Agreement. The Capitation Rate will be adjusted for each Attached patient according to the table appended to this Schedule (Appendix A). The table may be adjusted from time to time on the written agreement of the parties.

October 1, 2023	October 1, 2024	October 1, 2025	October 1, 2026
$186.37	$204.24	$211.49	$218.90

3.9 **FFS Billing for Non-Rostered Patients.** After the Income Floor period, the FFS limit per physician for in-basket services provided to non-Attached patients is:

October 1, 2023	$56,000
October 1, 2024	$61,370
October 1, 2025	$63,549
October 1, 2026	$65,773

There is no limit for FFS billings for the provision of "out of basket" services for rostered and non-rostered patients.

3.10 **Locum Arrangements.** The Capitation Rate accounts for the cost of a physician hiring a locum for two weeks of practice coverage annually.

Blended Capitation Groups will hire and pay locums as needed. Payment agreements may vary based on terms decided upon by the host physician and locum and funding of such arrangements is not the responsibility of the Government.

Locum physicians will submit all billings for services rendered through the locum physician's billing number, with the payment assigned to the blended capitation physician or Group. This will generate the FFS payment

for in-basket services delivered to Attached patients, as well as the FFS payment for out-of-basket services delivered to all patients and in-basket services delivered to non-Attached patients.

3.11 **Complexity Modifier.** The Parties agree that the Blended Capitation Model must incorporate measures of patient complexity to compensate physicians fairly for the care of complex patients and to improve access for complex patients. The Parties commit to work together to ensure that the Age/Gender Complexity Modifiers matrix in Appendix A is as relevant as possible to the Newfoundland and Labrador context. The Parties agree to review Appendix A, along with other measures of patient complexity, during the term of this Schedule.

3.12 **Income Floor**. Physicians will receive a two-year guaranteed minimum income (Income Floor) starting on the date of their acceptance into the Model.

a) The Income Floor for physicians accepted into the Model, who have been in practice greater than two years, will be calculated by averaging the physician's billings from two recent, representative years of active practice in Newfoundland and Labrador prior to application to the Program, excluding periods of time when the physician was away from their practice, such as time on parental leave, plus an additional 10.9% payable in year one of the Income Floor period. The FPRC will develop a policy to apply to individual cases to account for periods of parental, sick or other appropriate types of leave.

b) The Income Floor for physicians without a two-year billing history and physicians who do not have an established patient panel, will be set at Step 1 from the Memorandum of Agreement, or for a physician transitioning from a salaried position their current Step, of the Salary Scale for Family Physicians, adjusted to the proportion of FTE of comprehensive primary care the physician commits to provide in accordance with the table below, plus an additional 30% in recognition of overhead expenses, and an additional 10.9% payable in year one of the Income Floor period. The amount of FTE of comprehensive primary care that will be required to qualify for payment under this section will be determined according to the number of three-hour community medicine blocks provided per four-week period.

FTE Adjustment Factor	Minimum number of three-hour community-based primary care blocks per week, on average over a four-week

	period
1.0	9
0.9	8
0.8	7
0.7	6
0.6	5
0.5	4

c) If the Model and billing system are not operational when a physician enters year two of the Income Floor period, the physician will continue to receive the 10.9% premium on a month to month basis until the billing system is ready, up to the end of their two-year Income Floor period.

d) During the Income Floor period, after the billing system becomes operational, physicians will bill under the Blended Capitation Model, as established in this Schedule.

e) Physicians will be eligible for a top-up payment if their Income Floor would have paid more than the Blended Capitation Model, inclusive of FFS billings for out-of-basket services and for non-rostered patients. This calculation will be completed, and top-up payments made, on a semi-annual basis.

3.13 **Transition Incentive.** A payment of $11,250 will be made by HCS to each physician upon acceptance into the Model.

3.14 **Redeployment of FPRP Funding.**

a) The FPRC will develop rules and processes as necessary, consistent with, and within the scope of, this Schedule to implement redeployment of FPRP Fee Code funding to the Program.

b) When a FFS physician starts under the Model, the two-year average FPRP fee code earnings of that physician will be removed from the FPRP Fee Code budget.

c) **Quality of Care Stipend.** Each physician, upon being accepted into the Program, will be entitled to receive an annual quality of care stipend of $7,500 in recognition of the physician's participation in FPRP or practice-initiated quality programs, practice improvement and related professional development. This

stipend will be subject to FPRP guidelines. The FPRP will draw this funding from the redeployed FPRP Fee Code budget.

d) **One-Time Start-Up Grant.** Each physician, upon being accepted into the Program, and who part of a Blended Capitation Group at the time of the Group's establishment, will receive a one-time grant of $10,000 in recognition of start-up costs under the Model related to areas such as renovations, technology, training, and legal services. For clarity, a physician joining an established Blended Capitation Group will not be eligible for this grant. The FPRP will draw this funding from the accumulated FPRP surplus.

e) **EMR Transition Grant.** Practices will be required to commit to using the provincial EMR as a condition of acceptance into the Model. Each practice who is using a different EMR at the time of their acceptance into the Model will be entitled to receive an EMR transition grant of $30,000. The FPRP will draw this funding from the accumulated FPRP surplus. Blended Capitation Model billing will commence on confirmation of successful transition to the provincial EMR. Physicians shall complete the transition to the provincial EMR within six months from the date of their acceptance into the Model. Billing under the Blended Capitation Model cannot start until the provincial EMR is in place. If the transition is not completed within six months, access to the 10.9% premium (section 3.12) will be held in abeyance until such time as the provincial EMR transition within the practice is complete.

f) **Procedures Bonus.** Each physician will be entitled to receive an annual procedures bonus as follows:

- A physician will be entitled to the bonus who bills $1,200 of in-basket Procedures fee codes (as set out in Appendix B) in a calendar year, with the $1200 measured according to 100% of MCP Medical Payment Schedule;
- Bonus payment of $2,500;
- Procedures bonus is payable when the above billing threshold is achieved during the year.

For the first five years of this agreement, the source of funds for the procedures bonus will be the FPRP surplus. Thereafter, the bonus will continue from an alternate source of funding.

Appendix A – Age/Gender Complexity Modifiers

Age/Gender Complexity Modifiers[1]

Age Group	Female	Male	Non-Binary[2]
0 – 4	0.62	0.64	0.64
5 – 9	0.45	0.44	0.45
10 – 14	0.46	0.43	0.46
15 – 19	0.64	0.46	0.64
20 – 24	0.82	0.53	0.82
25 – 29	0.92	0.64	0.92
30 – 34	1.01	0.69	1.01
35 – 39	1.01	0.70	1.01
40 – 44	1.01	0.73	1.01
45 – 49	1.05	0.77	1.05
50 – 54	1.08	0.85	1.08
55 – 59	1.08	0.92	1.08
60 – 64	1.11	1.00	1.11
65 – 69	1.32	1.22	1.32
70 – 74	1.48	1.41	1.48
75 – 79	1.67	1.65	1.67
80 – 84	1.73	1.80	1.80
85 – 89	1.73	1.80	1.80
90+	1.73	1.80	1.80

Notes:

(1) Age/gender complexity modifiers to be multiplied by the capitation rate when calculating payment for enrolled patients.

(2) Non-binary modifiers represent the higher value of female or male modifiers for each age group.

Appendix B – Basket of Services

Fee code	Description
Office	
111010	Office - Pre-Dental General Assessment
112010	Office - General Assessment
114010	Office - General Reassessment
118010	Office - Routine Post-Operative Care
121010	Office - Partial Assessment
122010	Office - Visit For Well-Baby Care
123010	Office - Partial Assessment Of A Patient Aged 65 To 74 Years Of Age
124010	Office - Partial Assessment Of A Patient Aged 75 Years Or Older
126010	Office - Partial Assessment Of A Patient Who Received A Whscc Service during the same Office Visit.
127010	Office - Chronic Disease Management of a Patient under 75 Years of Age
129010	Office - Family Medicine Counselling (Add-On to 121,123,124).....Add on
131010	Office - Psychotherapy - Individual, Per 1/2 Hr Or Major Part Thereof (I.E. In Excess Of 15 Minutes)
132010	Office - Psychotherapy - Group (4 To 8 People) Per Member, Per Hour - Or Major Part Thereof
136010	Office - Psychotherapy - Family Therapy (2 Or More Family Members) Per 1/2 Hour, Per Family
139010	Fee For Patients Seen In Scheduled After Hours Clinic.....Add on
181010	Office - Detention Per 1/4 Hr
543800	Office E.C.G. - Technical Component
543820	Office E.C.G. - Professional Component
147	Driver medical examination of a patient who is 75 years of age or older, as required by Motor Registration for age
Family Practice Renewal Program	
520010	Shared Care - Family Practice Renewal Program
521010	Patient Care Telephone Code
522010	Family Practice Renewal Program - COPD
Procedures	
546140	Speculum exam (no charge if done as part of the following: consultation, repeat consultation, general or specific assessment, routine post-natal visit, or surgical procedure requiring the use of a speculum)
540000	When A Procedure(S) Is The Sole Reason For A Visit; I.E., When No Consultation Or Visit Fees Is Being Charged, Add $4.60 Basic Fee Per Visit Regardless Of The Number Of Procedures Carried Out.
542260	Anticoagulant Supervision - Long Term - Per Month

545980	Ear Syringing - Uni Or Bilateral Note: May Be Billed For Service Rendered In Office, Home Or Hospital Settings.
546440	Bursa, Joint Or Tendon Sheath Injection - Including Pre- Liminary Aspiration
546460	Bursa, Joint Or Tendon Sheath Injection - Each Additional Site Or Area - (Maximum 8 Injections Per Visit)
546560	Intradermal, Intramuscular Or Subcutaneous Injection - Each Additional Injection
546580	Intradermal, Intramuscular Or Subcutaneous Injection - First Injection
901000	Abscess Or Haematoma - Local Anaesthetic - Subcutaneous - One (I.O.P.)
901020	Abscess Or Haematoma - Local Anaesthetic - Two (I.O.P.)
901040	Abscess Or Haematoma - Local Anaesthetic - Three Or More (I.O.P.)
901100	Abscess Or Haematoma - Local Anaesthetic - Palmar Or Plantar Spaces (I.O.P.)
901220	Comedones, Acne Pustules, Milia - Ten Or Less (I.O.P.)
901240	Comedones, Acne Pustules, Milia - Eleven Or More (I.O.P.)
901260	Foreign Body Removal - Local Anaesthetic (I.O.P.)
901560	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting And/Or Cryosurgery And/Or Laser Surgery - Single Lesions (I.O.P.)
901580	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting - And/Or Cryosurgery And/Or Laser Surgery - Two Lesions - (I.O.P.)
901600	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting - And/Or Cryosurgery And/Or Laser Surgery - Three Or More Lesions (I.O.P.)
901760	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Single Lesion - (I.O.P.)
901780	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Two Lesions (I.O.P.)
901800	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Three Or More Lesions (I.O.P.)
902240	Excision Of Pressure Sore Or Decubitus Ulcer - Minor, Less Than 1 Cm. Average Diameter (I.O.P.)
902520	Excision Of Malignant And Premalignant Lesions (Other Areas)- Single Lesion
902530	Excision Of Malignant And Premalignant Lesions (Other Areas) - Two Lesions
902540	Excision Of Malignant And Premalignant Lesions (Other Areas) - Three Or More

902580	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Single Lesion
902600	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Two Lesions
902620	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Three Or More Lesions
902640	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Single Lesion
902660	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Two Lesions
902680	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Three Or More Lesions
903040	Debridement And Dressing - Major (I.O.P.)
905600	Chemical And/Or Cryotherapy Treatment Of Minor Skin Lesions - One Or More Lesions, Per Treatment (I.O.P.)
906820	Aspiration Of Breast Cyst - One Or More (I.O.P)
933500	Knee - Incision And Drainage - Soft Tissue (I.O.P.)
971200	Bladder Catheterization, Acute Retention Or Change Of Re- Tention Catheter - Office (I.O.P.)
971220	Bladder Catheterization, Acute Retention Or Change Of Re- Tention Catheter - Home (I.O.P.)
Other	
371010	Hospital (In-Patient) - Supportive Care - Not Exceeding 1 Visit Every 2 Days In 1st. 7 Days - Per Visit
372010	Hospital (In-Patient) - Supportive Care - Not Exceeding 1 Visit Every 4 Days Thereafter - Per Visit
500000	Pandemic Virtual Care Assessment (Telephone or Video)
502010	Telemedicine - Partial Assessment
54648	Adult immunization for target populations as described in Appendix D
54649	Adult immunization for target populations as described in Appendix D add-on to office visit

END OF SCHEDULES TO THE AGREEMENT