2014 Physician Master Agreement Negotiations
Tentative Settlement

Highlight Sheet

The terms and conditions outlined in the 2012 Physician Master Agreement will continue with the exception of the changes as outlined below.

1. **Term and Limited Re-opener**
    a. Five year term (April 1, 2014 to March 31, 2019)

    b. Either party may give notice to the other to consider mutually agreeable amendments to the PMA between February 1 2016 and December 1 2016.
        i. Such negotiations are not subject to conciliation or any other dispute resolution mechanism. Should no agreement be reached, the PMA will continue for the remainder of the term.

2. **Funding to Cover Rising Physician Costs**
    a. One-time payment as reimbursement for the increased cost of delivering services
        i. 0.5% for Fiscal Year 2014/15

    b. General increase as reimbursement for the increased cost of delivering services
        i. 0.5%, April 1, 2015, and an additional
        ii. 0.5%, April 1, 2016, and an additional
        iii. 0.5%, April 1, 2017, and an additional
        iv. 0.5%, April 1, 2018

            - One-time payment and general increases apply to fees (excluding laboratory, GPSC, SSC and SCC fees), service contract ranges and rates, salary ranges and rates, sessional rates, MRI fees and Screening Mammography fees.

    c. Economic Stability Dividend
        i. Should the Provincial real GDP increase faster than expected, fees (excluding laboratory, GPSC, SSC and SCC fees), service contract ranges and rates, salary ranges and rates and sessional rates will increase by 50% of the difference between the planned and actual growth in Provincial GDP

d. CME, PDI, CPRSP, Parental Leave Program, Physician Health Program (PHP)
    i. Current level of these benefits to be maintained over the life of the PMA. Anticipated cost increases to be covered through:
        1. One-time funds to be allocated from GPSC and SSC to cover all of the anticipated growth in costs of these benefit programs in fiscal year 2014/15

        2. New annual funding:
            - $10.6M April 1, 2015, and an additional
            - $2.9M April 1, 2016, and an additional
            - $1.9M April 1, 2017, and an additional
            - $1.9M April 1, 2018

    ii. Commitment to maintain PHP annual funding on an ongoing basis

e. CMPA
    i. Joint CMPA Cost Containment Committee to seek to reduce the cost of CMPA dues increases

    ii. One time funds to be reallocated from GPSC and SSC to cover the majority of the anticipated growth in costs of CMPA in fiscal years 2014/15 and 2015/16

    iii. New annual funding of $35.7M by the 5th year of the PMA to cover approximately 70% of the anticipated growth of CMPA fees

3. Funding Targeted to Physician Priorities

a. <u>General Practice Physicians</u>
    i. New annual funding for the General Practice Services Committee:
        1. $20.8M April 1, 2016, and an additional
        2. $23.1M April 1, 2017, and an additional
        3. $23.5M April 1, 2018

    ii. Residential Care Initiative
        1. GPSC to fund the Residential Care Initiative through existing unallocated one-time funds in each of fiscal years 2016/17, 2017/18 and 2018/19

2. Beginning April 1, 2019, government to increase annual funding to the GPSC to maintain ongoing funding for the Residential Care Initiative

iii. Should the GPSC need to reduce expenditures in any fiscal year, it will first address such budget pressure through a reduction of non-fee GPSC programs except by explicit agreement of the parties

iv. New annual funding for facility-based GP engagement (see section 4 b) for details):
    1. $2M April 1, 2017

v. <u>General Practice Physicians with Focused Practices</u>
    1. Shared Care Committee membership to include a GP with Focused Practice
        - GPs with Focused Practice are those General Practitioners with a commitment to one or more specific clinical areas as major part-time or full time components of their practice

    2. New annual funding for Shared Care Committee to support the participation of GP's with Focused Practice in system improvement initiatives:
        - $2M April 1, 2017, and an additional
        - $2M April 1, 2018

b. <u>Specialist Physicians</u>
    i. New annual funding to address Specialist fee disparity:
        1. $15M April 1, 2016, and an additional
        2. $16M April 1, 2017, and an additional
        3. $24M April 1, 2018

            - 50% of disparity funding to be allocated to address inter-sectional disparities and 50% to be allocated to address inter-provincial disparity
            - Allocated through a binding third-party adjudication process based on submissions by Sections, Doctors of BC and Government

    ii. New annual funding for the Specialist Services Committee
        1. $1.6M April 1, 2017, and an additional
        2. $1.8M April 1, 2018

iii. New annual funding for the Specialist New Fee Fund:
    1. $1M April 1, 2016, and an additional
    2. $1M April 1, 2017, and an additional
    3. $1M April 1, 2018

iv. New annual funding for facility-based Specialist Physician engagement (see section 4 b) for details):
    1. $12M April 1, 2017

c. Alternative Payment Physicians (APP)

i. New annual funding to adjust Service Contract and Salary Agreement rates and ranges:
    1. $9M April 1, 2016, and an additional
    2. $8M April 1, 2017, and an additional
    3. $11M April 1, 2018

- To be allocated each year by a joint committee with equal representation of parties to address recruitment, retention and equity issues prior to the year for which increases apply
- If committee cannot reach agreement prior to deadline, funding is distributed equally among APP FTE's

ii. New annual funding to relieve workload pressures by increasing physician FTE's providing services under existing APP arrangements:
    1. $10M April 1, 2015, and an additional
    2. $10M April 1, 2016, and an additional
    3. $8M April 1, 2017, and an additional
    4. $6M April 1, 2018

- Health Authorities to determine distribution of funding considering submissions by AP physicians
- Government to monitor to ensure compliance and to provide data as proof that funding is allocated to address workload issues
- Government to conduct a comprehensive review of AP Program in 2014/15, following which the parties will meet to consider changes to more effectively address AP service demand growth

iii. New annual funding for facility-based alternative payment physician engagement (see section 4 b) for details):
    1. $4M April 1, 2017

iv. Sessional Physicians
    1. New annual funding to increase sessional rates over and above the general increases by:
        - Approximately 4.8% April 1, 2015, and an additional
        - Approximately 5.4% April 1, 2017

    2. The sessional rate for all specialists providing services to the Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services) will increase to $729.17 on April 1, 2015.

d. Rural Physicians
    i. New annual funding for the Rural Joint Standing Committee
        1. $3M April 1, 2015, and an additional
        2. $4M April 1, 2016, and an additional
        3. $5M April 1, 2017

    ii. Ongoing commitment to fund the Rural Retention Program to maintain current level of RRP payments subject to the implementation of the annual points assessment.

    iii. Rural Locum Program:
        1. The parties to explore the opportunity of transferring operations of the Rural Locum Program from the Ministry of Health to HealthMatch BC

        2. The RJSC to allocate $700,000/yr of its existing funding to supplement current government funding to improve services offered by the Rural Locum Programs

e. Shared Care Committee
    i. New annual funding for the Shared Care Committee:
        1. $1M April 1, 2016, and an additional
        2. $1M April 1, 2017, and an additional
        3. $1M April 1, 2018

4. Funding and Support for Physician Influence and Engagement

a. Provincial Influence and Engagement
    i. Memorandum of Understanding outlining how Doctors of BC, Government and Health Authorities will work together to ensure effective and timely engagement on strategy and provincial issues affecting physicians and the delivery of physician services

b. Facility-Based Physician Influence and Engagement with Health Authorities

    i. New funding to Medical Staff Associations (MSA's) to be allocated through the Specialist Services Committee for the following purposes:

        1. To fund Medical Staff Associations for administrative costs and to reimburse facility-based physicians for their time participating in meetings
        2. To fund SSC staff to support MSA's and Health Authorities to develop local structures to facilitate effective collaboration

    ii. Commitment that Health Authorities will engage with MSA's to create appropriate collaborative structures and will consult with MSA's on a wide range of issues of importance to both parties, including:

        1. Health Authority planning, budgeting and resource allocation
        2. Medical staff bylaws and rules
        3. The working environment of physicians

    iii. Funding commitments:

        1. Fiscal Year 2014/15:
            - $4M for Fiscal Year 2014/15 from accumulated SSC one-time funds

        2. Fiscal year 2015/16
            - $8M from accumulated SSC one-time funds

        3. Fiscal year 2016/17:
            - $15M to be funded from accumulated SSC one-time funds
            - $3M to be funded from accumulated GPSC one-time funds

4. April 1, 2017, government to provide ongoing annual funding to the Specialist Services Committee of:
    - $15M for facility-based specialists (to include both FFS and AP Specialists)
    - $3M for facility-based GP's (to include both FFS and AP GP's)

5. Other Provisions

a. Payment Schedule Review and Utilization Management Initiatives

i. Government will conduct an internal review of fee codes prior to Fiscal Years 2016/17, 2017/18 and 2018/19. Should it identify fee codes to be adjusted or eliminated, Government will pursue these through the existing processes outlined in the PMA.

ii. Consistent with the goal of high quality of patient care and effective utilization of physician services, Doctors of BC will work collaboratively with government through the Guidelines and Protocols Committee and the Patterns of Practice Committee to seek annual savings of $25M over the course of the agreement.

b. Joint Committee Structure, Roles and Administration

i. Joint Clinical Committee Administration Agreement (JCCA)
    1. A new agreement which more clearly sets out the reporting relationship and governance of Doctors of BC staff who provide support to the GPSC, the SSC and the SCC in order to streamline the implementation decisions made by those committees.

ii. The role of the Physician Services Committee (PSC) as the senior oversight committee is strengthened

iii. The Chair of the Medical Services Commission will participate on the PSC as a non-voting member

iv. Joint committees will be required to submit 3 year work plans to the PSC by February 1 of each Fiscal Year

v. Prior to reallocating funds between programs in a manner not contemplated in its approved plan, joint committees are required to provide the PSC with a minimum of 2 weeks' advance written notice

vi. Joint Committees are required to provide a report to the PSC by June 30 on the degree to which the Committee achieve the expectations outlined in the previous fiscal year.

vii. The Clinical Support Services Committee is eliminated

viii. The core mandate of the Joint Clinical Committees to be expanded to include the consideration of quality improvement methodologies as a means of supporting the delivery of quality and evidence based care

c. Miscellaneous Amendments

i. MOCAP provisions are amended to reflect the interim recommendations of the MOCAP Redesign Panel Report. Should the Provincial MOCAP Review Committee determine that the objectives of the Report can be met through a redesigned MOCAP Program, the parties will make the appropriate amendments to the MOCAP provisions of the PMA. If the parties are unable to agree on changes to the PMA, Eric Harris QC will make a final and binding determination on the outstanding issues.

ii. A senior executive representative of Doctors of BC to be appointed to the senior government committee responsible for developing and overseeing the implementation of the Ministry of Health's IT strategy and relevant subcommittees.

iii. A single adjudicator to replace the tri-partite Adjudication Committee for the resolution of disputes under the PMA except upon the request of either party.