

## 2012 PHYSICIAN SERVICES AGREEMENT

**B E T W E E N:**

**ONTARIO MEDICAL ASSOCIATION**

**(“OMA”)**

**-and-**

**HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO,**

**AS REPRESENTED BY THE MINISTER OF HEALTH**

**AND LONG -TERM CARE**

**(“MOHLTC”)**

**WHEREAS** the OMA and the MOHLTC entered into a Memorandum of Agreement that recognizes the OMA as the exclusive representative of physicians practicing in Ontario (“OMA Representation and Negotiation Rights Agreement”<sup>1</sup>) and, further, that the OMA and MOHLTC shall negotiate Physician Services Agreements;

**NOW** the OMA and the MOHLTC (“Parties”) have negotiated this 2012 Physician Services Agreement (the “Agreement”).

### **1. PAYMENTS**

- 1.1 The Parties agree to a payment discount of 0.5% on all physician payments, in effect from April 1, 2013.
- 1.2 This discount will be applied to fee-for-service payments as well as primary care models, primary care specialized models, AFP/APP agreements and physician programs in the same manner as September 1, 2011 flow through payments. The discount will also apply to on-call payments.
- 1.3 The Parties agree to continue their work on evidence-based initiatives during the term of this agreement as set out in **Appendix “A”**.
- 1.4 The Parties will analyze the potential savings that arise from the Phase II and other initiatives. The amount of the payment discount in section 1.1 will be reduced effective October 1, 2013 by an amount equal to 100% of the savings in the physician services budget. The Parties agree to track the health system savings that result from these measures.

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<sup>1</sup> Also referred to as “OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement”.

## **2. REVIEW OF APRIL 1, 2012 CHANGES TO THE SCHEDULE OF BENEFITS**

- 2.1 The Parties agree that the changes to the Schedule of Benefits made as of April 1, 2012 will be amended as more particularly described in **Appendix “B”**.

## **3. APRIL 1, 2012 FLOW THROUGH**

- 3.1 The Parties agree the April 1, 2012 decreases to the Schedule of Benefits (as amended above) will be flowed through to Specialist APPs, GP Specialized APPs, GP Psychotherapists, Sleep Medicine, Nuclear Medicine and Radiation Oncology as set out in **Appendix “C”**.

## **4. PRIMARY CARE**

- 4.1 The Parties are committed to continuing the reform and renewal of primary health care in Ontario. All primary health care models are continued and amended as described in **Appendix “D”**.

## **5. VIRTUAL CARE**

- 5.1 The Parties acknowledge the importance of virtual care. The Parties agree to the initiatives set out in **Appendix “E”**.

## **6. EVIDENCE & APPROPRIATENESS**

- 6.1 The Parties recognize the need for the public health care system to fund appropriate treatments and procedures based upon current evidence.

The Parties agree on the use of evidence and best practice to ensure that the provision of healthcare is relevant to and appropriate for the clinical needs of patients. Accordingly, the Parties have agreed upon:

- (a) revisions to the Schedule of Benefits;
- (b) the inclusion of educational comments on various service fee codes in the Schedule to support the appropriate provision of such services;
- (c) the removal of various tests from the MOHLTC’s Laboratory Requisition form;
- (d) recommendations for further analysis and/or consultations.

all of which are described in more detail in **Appendix “F”**.

## **7. SYSTEM SAVINGS AND SUSTAINABILITY**

- 7.1 The Parties agree on the importance of ensuring the sustainability in the health care system and measures to promote efficiency of resources. The Parties agree to the measures described **Appendix “G”**.

## **8. BILATERAL MONITORING AND ACCOUNTABILITY PROCESS**

- 8.1 The Parties agree to,
- (a) establish a bilateral process to monitor the savings initiatives under this agreement, including efforts to monitor utilization,
  - (b) a plan to monitor the agreement's savings initiatives, and
  - (c) an agreed upon process to be negotiated if an estimated target for an initiative is not achieved.
- 8.2 The Parties agree that the performance of the investments and savings provided for in this Agreement will be managed through a process of measurement and evaluation as determined by the Parties. This process will begin upon the commencement of this Agreement and the Physician Services Committee ("PSC") will develop appropriate measurements and one or more evaluation templates by March 31, 2013. The on-going process of performance measurement and evaluation will be carried out jointly. The results of the investment and savings performance management process will be reported regularly to the PSC. The PSC will, based on the information reported, make recommendations to the Parties regarding the need for any appropriate actions
- 8.3 The PSC will develop a work plan outlining specific steps which will address:
- (a) the ongoing measurement and evaluation of the investments and savings provided for in this Agreement; and
  - (b) the ongoing measurement of utilization and advice regarding reasons for utilization changes.
- 8.4 The Parties may constitute a sub-committee of the PSC to support the PSC in monitoring, evaluation, development of options and action plans that may be required.
- 8.5 At the end of the first full year of measurement and evaluation, the Parties will assess the process and consider changes if the process is not yielding responses that are satisfactory to both Parties.
- 8.6 The Parties agree to amend the schedule to the data-sharing agreement between them to add "data on government funded programs whose administration has been, or will be, transferred to government, community/commercial laboratory payment claims data and other data as mutually agreed by the parties during the course of the PSA".
- 9. CPSO COMPLAINTS PROCESS**
- 9.1 The OMA has requested that the Ministry amend the Health Professions Procedural Code so that the CPSO does not have to conduct a full investigation into complaints about matters that are outside the jurisdiction of the CPSO and to

better manage frivolous and vexatious complaints.

The Ministry undertakes to consult with interested parties in 2013, and bring forward recommendations by March 2014 to the Government of Ontario for legislative amendments.

## **10. CMPA**

- 10.1 The Parties recognize that the base Canadian Medical Protective Association (“CMPA”) fees have not increased since 1986. The current agreement amongst the Parties and the CMPA commenced on January 1, 2009 and continues in effect until December 31, 2013 (“2009 CMPA Agreement”). The Parties agree to forthwith enter into negotiations with the CMPA with the aim to enter into a new agreement to replace the 2009 CMPA Agreement which will have a term from January 1, 2014 to December 31, 2023 and which will require physician contributions as set out in **Appendix “H”**.
- 10.2 The Parties shall review and update the tort reform measures recommended by the Medical Malpractice Coverage Committee in 2001, and report back to the PSC by June 2013 and thereafter as required by the PSC.

## **11. CONTINUANCE OF PHYSICIAN PROGRAMS**

- 11.1 The Parties agree to continue the Physician Programs set out in **Appendix “I”** or otherwise modify or discontinue the programs as set out in that Appendix.

## **12. COMMITTEES**

- 12.1 The Parties agree the Forms Committee and Primary Health Care Committee will continue with expanded mandates set out in **Appendix “J”**. The Parties agree that the PSC will decide which other bilateral committees will be continued and their ongoing mandates.

## **13. NFFS AGREEMENTS**

- 13.1 The Parties agree upon the need to standardize non-fee-for-service agreements (“NFFS”). The Parties agree to use the Specialist NFFS Agreement attached hereto as **Appendix “K”** as the boilerplate for all Specialist NFFS Agreements entered into or renewed after the date of this Agreement, with the understanding that adjustments may need to be made to the boilerplate as appropriate for particular agreements.
- 13.2 The Parties agree to negotiate a standard boilerplate for Primary Care NFFS Agreements by January 31, 2013 with recommendations to the PSC. The Parties agree that the Primary Care NFFS Agreement boilerplate will use the terms of the Specialist NFFS Agreement as appropriate.
- 13.3 The Parties will also review existing primary care agreements to standardize/update terms and make recommendations to the PSC.

## **14. INCORPORATION**

- 14.1 The Ministry acknowledges the request made by the OMA to permit non-voting shares of a Medicine Professional Corporation to be held by a family trust. The Ministry will consult with the CPSO, the Ministry of Finance and others by June 2013 and report back to the PSC with any recommendations.
- 14.2 The MOHLTC acknowledges that the OMA also requested that corporations whose voting shares are held by physicians and partnerships of physicians also be allowed to hold voting shares of Medicine Professional Corporations. The MOHLTC agrees to consult with relevant third parties in 2013. The Ministry will provide the PSC with a status report on the consultations by June 2013 and will provide any recommendations in early 2014.

## **15. STATUTORY AMENDMENTS**

- 15.1 The government undertakes to introduce and support legislation as soon as possible upon the return of the Legislature in 2013 (and effective as of the date of introduction), providing statutory immunity from action or other proceeding against the OMA's directors, officers, members, employees, agents for acts done in good faith when the OMA:
- (a) enters into agreements with the MOHLTC or the government e.g. Physician Services Agreements, or
  - (b) makes recommendations to the MOHLTC or the Government of Ontario respecting fee codes or other matters affecting physician payments.

## **16. TERM AND RENEWAL**

- 16.1 This Agreement will begin on October 1, 2012, and will terminate on March 31, 2014. Negotiations to establish the next Physician Services Agreement will begin no later than December 1, 2013. The MOHLTC recognizes the OMA as the exclusive representative of the physicians practicing in Ontario for the purposes of these negotiations. The Parties acknowledge that these negotiations will be conducted in accordance with the process set out in the OMA Representation and Negotiation Rights Agreement.<sup>2</sup>

The undersigned representatives of the Parties hereby agree to unanimously recommend acceptance of this Agreement to their respective principals.

DATED AT TORONTO, ONTARIO AS OF THIS 7th DAY OF NOVEMBER, 2012

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<sup>2</sup> See footnote 1.

FOR THE OMA

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FOR THE MOHLTC

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## APPENDIX “A”

### EVIDENCE AND APPROPRIATENESS – PHASE II

The Parties agree to the following changes to promote the use of evidence and best practices for the provision of health care that is appropriate for the clinical needs of patients:

#### A. Phase II review

1. In order to ensure appropriate use of health care resources, the PSC will establish a working group to work on Phase II recommendations to minimize:

- Overuse: the use of health care resources and procedures in the absence of evidence that they could help the patients receiving them;
- Misuse: failures to execute clinical care plans and procedures properly; and
- Underuse: failures to employ health care practices of proven benefit.

Phase II recommendations are those that require further analysis and/or consultations and will focus on tests, treatments, or services that are currently underused. Where possible, the recommendations will align with Health Quality Ontario (HQO) / Ontario Health Technology Assessment Committee (OHTAC) recommendations.

2. Phase II recommendations shall include:

- i. Limit self-monitoring (blood glucose test strips) and blood glucose tests and A1C tests
- ii. Investigations in the work-up of dementia
- iii. Appropriate sleep lab testing
- iv. Anaesthesia requirements for vasectomies, cataracts and endoscopy
- v. Lipid testing
- vi. Serum protein electrophoresis
- vii. Appropriate ultrasound imaging
- viii. Vitamin B12 (part 2) - Remove vitamin B12 from the Ontario laboratory requisition form (align with HQO/OHTAC recommendation)

- ix. Cease funding of routine pre-operative cardiac testing for asymptomatic patients undergoing low or moderate risk non-cardiac surgeries (part 2) - Pending the outcome of discussions with experts about defining moderate / intermediate and exposing these patient categories to pre-operative cardiac testing, align Schedule of Benefits with moderate / intermediate risk accordingly.
- x. Genetics Strategy
- xi. Companion Diagnostics – Recommend Cobas EGFR Mutation Test be required for Erlotinib (a drug for treatment of lung cancer funded under the Exceptional Access Program)
- xii. Review of Physician Schedule of Benefits for Bone Mineral Density Testing by DXA (Dual Energy x-Ray Absorptiometry) with most current Osteoporosis Canada Guideline
- xiii. Review relevancy of Pre-dental/Pre-operative Assessments with the services provided by hospital-based pre-operative assessment clinics.
- xiv. Review the utilization and relevancy of Pre-operative Consultations.
- xv. Review changes in practice patterns for the provision of cardiac services and the impact on utilization arising from changes in this agreement.

## **B. Effective April 1, 2013**

### **1. Appropriate Prescribing**

Identify areas for quick wins (narcotics and controlled substances) and longer-term savings opportunities from improved prescribing among physicians and implement targeted educational strategies and tracking mechanisms to harness savings. This would be a voluntary program, confidential to the physician, with PSC oversight on the program. Physician data used in this program that identifies a physician will be kept confidential to the physician and the Physician Services Committee.



**APPENDIX “B”**  
**REVIEW OF APRIL 1, 2012 CHANGES**  
**TO THE SCHEDULE OF BENEFITS**

The Parties agree to:

(a) amend the Schedule of Benefits, effective April 1, 2013, and

(b) develop new billing codes and payment rules,

as described below:

**1. Optical Coherence Tomography**

- Increase G818 and G820 from \$25 to \$35, with current maximums remaining as is.
- Create new code Gxxx at \$35 for patients receiving active treatment (injections or laser). Maximum of 4 in any combination of G820, G818 or Gxxx.
- Create new code Gyyy at \$25 for active management of retinal disease. After the G818/G820/Gxxx limit is reached, Gyyy may be billed for following active retinal disease.
  - Limits and treatment regimen for Gyyy to be reviewed by OHTAC with direct involvement by the Section on Ophthalmology.
- Create new code for Gzzz for OCT related to treatment of children at \$35.
  - OHTAC and the Section on Ophthalmology should review the use of OCT in this age group to determine appropriate annual limit.

**2. After-hours Procedure Premiums**

- Add-on to surgical codes, payable when a case commences in the evening (after 5pm) or at night (after midnight) fully restored.

**3. Anaesthesia Flat Fee for Procedural Sedation**

- Increase flat fee from \$60 to \$75 when anaesthesiologist is providing one on one care.
- Additional recommendations:
  1. Consider solution for supervisory code for anaesthesiology.
  2. Consider a separate solution for providing anaesthesia for cataracts, colonoscopy, cystoscopy and sigmoidoscopy in low volume settings, particularly rural settings.

3. Continue efforts to move some procedures out of hospitals and into out of hospital facilities or alternate care settings within hospitals that lend themselves to care delivered by Anaesthetic Care Teams.
  - Schedule of Benefits Amendment, including creation of new fee code effective April 1, 2013.
  - Consider a supervisory code ;PSC or similar committee shall review low volume services.

#### **4. Laparoscopic premiums**

- Restore laparoscopic surgical fee premiums E792A, E793A, E862A and E863A from 10% to 25%.
- Procedures eligible for the laparoscopic premium should be reviewed to determine both the time differential between the laparoscopic and open approaches and the proportion of the procedures performed laparoscopically.
- Based on that data analysis, an appropriate premium (which may be greater or less than 25%) should be restored on a procedure by procedure basis.

#### **5. Intensive and Coronary Care Premium (C101)**

- Complete restoration of Premium applied for each patient seen on a visit to ICU or CCU, in addition to fees payable for services, claimed by a physician who was not the MRP.

#### **6. Lumbar Spine**

- For X-ray or CT studies of the lumbar spine; April 1, 2012 OHIP Schedule of benefits change required physicians to repay for the diagnostic service if subsequently found not to be medically necessary.
- Delete Commentary Section 1 in paragraph 28, page D4 of the Diagnostic Radiology Preamble.

28. X-ray or CT studies of the lumbar spine should not be routinely ordered or rendered for low back pain without suspected or known pathology.

[Commentary:

~~1. The physician requesting the diagnostic services subsequently found not to be medically necessary in accordance with s. 18.2 (1) and 18.2 (2) of the Health Insurance Act will be responsible for repayment.~~

2. Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

## **7. Cataracts**

Enlist OHTAC to do a full evidence-based review in order to determine clear and objective criteria describing indications for cataract extractions, i.e. when is the patient's vision sufficiently impaired that extraction becomes medically necessary and therefore should be insured. The Section on Ophthalmology should be directly involved in the discussion.

## **8. Review of Payment for assessment with surgical procedures (manual review)**

- Put in place to restrict billing of higher paying assessment/consultation fees on the day of a surgical procedure when a previous assessment/consultation had already been billed.
- Physicians can submit rejected codes for manual review.
- The ministry will review these claims and the medical rule.

## **9. Review of Pediatric Consults**

- The ministry has set up an exemption process for the changes to pediatric consults and it is believed that this has resolved all of the issues. The Section on Pediatrics will be solicited to determine whether the revision is still creating problems in providing pediatric specific services to adult patients and whether there are any problems with the exemption process.

## **10. Self Referral regulation (effective April 1, 2012)**

The MOHLTC agrees to remove the Section entitled “Diagnostic Services Rendered by the Referring Physician” (and the accompanying Note and Commentary) under the heading “GENERAL PAYMENT RULES” on page GP12 of the General Preamble.

The Expert Panel on Appropriate Utilization of Diagnostic and Imaging Studies shall continue its work.

## **APPENDIX “C”**

**APRIL 2012 FLOW THROUGH**

**EFFECTIVE JANUARY 1, 2013**

### **Reverse Flow Through**

#### **1. Specialist APPs and Physician Programs**

The Parties agree to a methodology whereby specialty changes arising from the April 2012 Schedule of Benefits changes are applied to specialist AFP/APP agreements and physician programs in the same manner as the September 1, 2011 flow through under the 2008 PSA.

#### **2. Primary Care Specialty Models**

The Parties agree that the family physician average change will be applied against the primary care specialized models outlined below in the same manner as the September 1, 2011 flow through under the 2008 PSA.

- (a) Rural and Northern Physician Group Agreement (RNPGA 1 and 2)
- (b) Weeneebayko Health Authority (WHA)
- (c) GP Focus – Palliative APP
- (d) GP Focus – HIV APP
- (e) GP Focus – Care for the Elderly
- (f) Toronto Palliative Care
- (g) Algonquin FHT
- (h) St. Joseph’s Health Centre
- (i) Community Health Centres
- (j) Aboriginal Health Access Centres (AHAC)

- (k) Blended Salary Model (cFHT)
- (l) Sherbourne
- (m) Shelter Health Network
- (n) Inner City Health (ICHA)
- (o) Sioux Lookout
- (p) Group Health Centre (GHC)

### **Equivalent Flow Through**

#### **3. GP Psychotherapy**

The GP Psychotherapy premium will be reduced from 15% to 12%.

#### **4. Nuclear Medicine**

Nuclear Medicine professional fees shall be reduced by 5%.

#### **5. Sleep Studies**

The professional fees for sleep studies shall be reduced by 5%.

#### **6. Radiation Oncology Fee Codes**

The professional fees for treatment planning for radiotherapy shall be reduced by 5% (X310, X311, X312, X313).

## **APPENDIX “D”**

### **PRIMARY CARE INITIATIVES**

#### **1. PRIMARY HEALTH CARE COMMITTEE**

The Parties have agreed upon many key initiatives to be implemented as part of this Physician Services Agreement, and the implementation details will require significant work. There are also several items that require review/evaluation prior to the end of this agreement. Accordingly, the Parties agree that a reconstituted Primary Health Care Committee (PHCC) is required for the duration of this agreement. The PSC shall develop and agree upon the terms of reference and mandate of the PHCC.

#### **2. Personalized Health Visit (January 1, 2013)**

The Parties agree that the annual health exam shall be replaced by a personalized health visit for adult patients 18 to 64 years. A new fee code will be established for this personalized health visit and it will be valued at \$50. For patients in other age groups, the billing for the annual health exam will remain the same.

#### **3. SUPPORT FOR QUALITY –EXCELLENT CARE FOR ALL ACT (April 1, 2013)**

The Parties recognize that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe. The Parties agree to expand the government's Primary Health Care quality agenda to Family Health Teams, Aboriginal Health Access Centres and Community Health Centres. Other primary health care providers shall be welcome to participate on a voluntarily basis.

The Parties will collaborate in developing the plan, rollout and implementation of the Primary Health Care quality agenda. This collaboration will include; the development of annual quality improvement plans, indicator development, development of patient experience surveys and public reporting. The PHCC will be the primary vehicle for discussions between both Parties regarding rollout and implementation. No data will be published at an individual physician level, a third party (eg. HQO) will be responsible for publishing the results.

#### **4. ACCESS IMPROVEMENTS**

##### **4.1 DAYTIME ACCESS (April 1, 2013)**

The PHCC shall study the issue of daytime access to primary care physicians who participate in Patient Enrollment Model (“PEM”) primary care agreements (“PEM Physicians”). The PHCC shall make recommendations on possible guidelines to inform PEM Physicians on operating during daytime hours, including possible standards for group size, and strategies and support for advanced access.

#### **4.2 ENHANCED AFTER-HOURS ACCESS (April 1, 2013)**

The Parties agree that larger sized PEM groups should offer an additional number of after-hours blocks of coverage to accommodate for larger total group roster. The Parties agree on the following:

(a) to amend the Family Health Network (“FHN”), Family Health Organization (“FHO”) and Family Health Group (“FHG”) to create an enhanced after-hours service requirement for groups with 10 or more physicians. The revised number of after-hours service blocks required would be:

<b>NUMBER OF PHYSICIANS IN GROUP</b>	<b>TOTAL NUMBER OF AFTER-HOURS SERVICE BLOCKS</b>
10 – 19	7
20 – 29	8
30 – 74	10
75 – 100	15
100 – 199	20
200 +	25

(b) that northern FHN and FHO groups who require 50% of its physicians to maintain active in-patient hospital privileges, shall be exempt from the enhanced after-hours service requirements set out in subsection (a).

(c) to amend the FHO and FHN agreements to ensure the staffing of additional physicians after-hours may be necessary if the group determines that the volume and needs of their patients make such additional staffing necessary.

#### **4.3 HOUSE CALLS (April 1, 2013)**

The Parties agree that primary care physicians should be encouraged to provide more house calls with a focus on homebound and frail elderly patients. Accordingly, the Parties agree to enhance the current premium for house calls and to implement new house call incentives for homebound and frail elderly patients as follows:

(a) A new fee code, at the same value as the A901, will be developed for house calls to homebound and frail elderly patients. The definition of “homebound and frail elderly patient” for the purposes of this fee code shall be developed by the PHCC.

(b) The current premiums for house calls shall be revised as follows:

Bonus Level	Home Visits			
	A	B	C	D
Necessary annual criteria	3 or more patients served <u>and</u>	6 or more patients served <u>and</u>	17 or more patients served <u>and</u>	32 or more patients served <u>and</u>
Annual Bonus	12 or more encounters \$1,500	24 or more encounters \$3,000	68 or more encounters \$5,000	128 or more encounters \$8,000

- All family physicians are eligible for level A & B
- Only PEM Physicians are eligible for level C & D

(c) When a CCM, FHG or FHN physician provides more than 68 house calls per year to more than 17 patients (Level C), physicians will receive a 20% premium on the additional house call services if at least 75% of the house calls were provided to their enrolled and non-enrolled homebound and frail elderly patients during the fiscal year. This will be made as an annual payment after year end.

(d) When a FHO physician provides more than 68 house calls per year to more than 17 patients (Level C), all subsequent house calls to home bound and frail elderly patients will be paid out of basket. Further, FHO physicians will also receive a 20% premium on the additional house call services if at least 75% of the house calls provided to their enrolled and non-enrolled homebound and frail elderly patients during the fiscal year. This will be made as an annual payment after year end.

(e) The payment of all A901 fee codes billed by a physician for services provided to patients enrolled to a physician in a different PEM group will be reduced by 50%. The Parties agree to review the impact of this reduction 6 months following its effective date.

## 5. TERMINATION OF THAS OBLIGATION (January 1, 2013)

The Parties agree to amend all PEM primary care agreements to delete the service requirements and payment terms for the provision of Telephone Health Advisory Services (“THAS”). PEM groups may continue to provide THAS on a voluntary basis. The THAS service provider will continue to provide encounter information to all PEM physicians for their patients via fax. PEM groups will also continue to be required to report after-hours clinic schedules to the THAS service provider in order to provide information about such services to the group’s patients.

## 6. ACCESS BONUS

### 6.1 Termination of the Access Bonus Rebate for Focused Practice GP Services (Immediate)



The Parties agree to cancel the access bonus rebate (\$237.91 per eligible physician) established in the 2008 Physician Services Agreement that recompensed capitation based PEM Physicians for enrolled patient use of focused practice GPs.

## **6.2 Review of Access Bonus**

The PHCC will conduct a policy review of the access bonus payment in capitation based PEMs to review the intent and current application of outside use and the access bonus. The review will consider: (a) the value of negative access bonuses throughout the province; (b) the impact on emergency departments; (c) exemptions for Urgent Care Centres and GP focused practices; and (d) the impact from walk-in clinics. The PHCC will make recommendations to the Parties on possible amendments to capitation based PEM agreements and/or alternatives to the access bonus payment. The review shall be completed by the end of the term of this Agreement.

## **7. PREMIUM AND PAYMENT CHANGES**

### **7.1 Premium Changes – Elimination**

The Parties agree on eliminating the following service premiums in PEM agreements and the savings may be allocated to offset the implementation costs of the Acuity Modifier described in section 7.5 of this Appendix:

- In Office Service Bonus (section 5.2 in the 2008 PSA) (immediate);
- Out of Office Service Bonus (section 3.1 of Appendix “E” of the 2008 PSA) (April 1, 2013); and
- Preventative Care Management Services Enhancement Fee (section 2.1 of Appendix “I” of the FHO/FHN Agreement) (April 1, 2013).

### **7.2 Capitation and Long Term Care Patients (Immediate)**

Capitation based PEM agreements allow for the enrollment of long term care (“LTC”) patients as a distinct category of enrolled patients with a higher base rate capitation value than non-LTC enrolled patients. The basket of services for enrolled LTC patients includes the W010 LTC monthly management fee code. The Parties agree that when an enrolled patient moves to an LTC facility, the physician shall not be permitted to bill both the W010 and base capitation rate for that patient.

The Ministry shall also revise the LTC patient enrollment process to make it administratively easier for physicians to enroll such patients.

### **7.3 Payment Change – CCM Fee Reduction for Large Rosters (April 2013)**

The Parties agree to amend PEM primary care agreements to reduce the comprehensive care capitation payment (ie. CCM fee) by 50% for each patient a physician enrolls above 2,400. The PHCC shall develop methodology to determine how this reduction shall be applied.

#### **7.4 Payment Change- Diabetic Management Fee**

The Parties agree that the Q040 diabetes management fee shall be reduced from \$75 to \$60 effective April 1, 2013.

#### **7.5 Payment Change –Acuity Modifier**

The Parties agree to set aside \$40 million to develop and implement a premium for PEM agreements for the acuity of patients enrolled to a physician (“Acuity Modifier”). The PHCC will advise/support the systems implementation of the Acuity Modifier in two phases over two years:

- Year 1 – selecting of an acuity adjustment tool, testing it against OHIP data, and designing the payment system.
- Year 2 – conducting systems testing, adjusting the tool to Ministry payment systems, providing physician education, and developing a communications plan.

The PHCC shall report back to the Parties by January 2014 with recommendations for the acuity adjustment tool that will be selected as the Acuity Modifier.

Until the Acuity Modifier is implemented, the Parties agree to implement an interim modifier (“Interim Modifier”). The Interim Modifier will be developed by the Parties through the PHCC based on information provided by OHIP, Canadian Institute for Health Information, and Ontario Drug Benefits program claims data. The Interim Modifier shall be recommended to the Parties for approval March 1, 2013, for implementation in fiscal 2012/13, and will be replaced by the Acuity Modifier once that has been approved and implemented.

#### **8. MANAGED ENTRY INTO FHN, FHO, AND FHG AGREEMENTS (Immediate for FHG and April 2013 for FHN/FHO)**

The Parties agree to the following managed entry process to allow physicians to join existing or start new FHN, FHO, and FHG groups effective immediately:

- There shall be no limit for physicians wishing to join existing or create a new FHG.
- Registration of 40 new physicians into FHN and FHO models each month in two streams:
  - 20 physicians in a prioritized stream for new graduate physicians and physicians seeking to practice in an area of high need;
  - 20 physicians in the regular stream (all applications not prioritized) which will be processed on a first come, first served basis;
  - Any unused spots from one stream will shift to the other stream;
  - Any unused spots can be rolled over to subsequent months; and
  - Replacement physicians will be processed outside the Managed Entry process.

This process will be evaluated at the end of the term of this agreement.

#### **9. INTERPROFESSIONAL HEALTH PROVIDER FUNDING (April 1, 2013)**

The Parties agree to expand the availability of Interprofessional Health Providers (“IHPs”) for patients in the community with primary care needs. Full salary funding will be made available to support the integration of IHPs, including PAs, into non-Family Health Team affiliated PEM groups of three or more physicians. . The PHCC will work through the implementation details, which may include the following criteria: (a) the basis of community need; (b) roster size; (c) involvement in quality improvement initiatives; and (d) integration with other healthcare providers in the region to support population based planning and service provision.

#### **10. FHG GOVERNANCE AGREEMENTS (April 2013)**

The Parties agree to amend the FHG agreement to require each group to establish and maintain a written governance agreement between the physician members to formally set out the terms of their relationship. The governance agreement shall include terms to address:

- the nature of the relationship between the physicians,
- roles, responsibilities and obligations of the Group Physicians,
- a process for:
  - decision-making;
  - the admission of new physicians;
  - the withdrawal of physicians;
  - the expulsion of physicians;
  - approving contracted physicians; and
  - dispute resolution mechanism for disputes that may arise between physicians.
- the election of a “Lead Group Physician” and an “Associate Lead Group Physician” who are able to sign contracts, including amendments, extensions or renewals, on behalf of all physicians.

**APPENDIX “E”**  
**VIRTUAL CARE**  
**EFFECTIVE APRIL 1, 2013**

In recognition of the importance of virtual care, the parties agree to the following initiatives:

**1. Northern Health Travel Grant (NHTG)**

The NHTG program will encourage the replacement of face-to-face visits with virtual equivalents where clinically appropriate.

**2. Specialist to Primary Care Virtual Follow-up**

Establish a Working Group to evaluate existing pilots and programs and will use this data to develop recommendations for a comprehensive, provincial business and technology model for hospital to primary care communications.

**3. Patient eConsults**

An evaluation project will be developed to enable standards-based, patient-initiated patient to primary care provider eConsultations, including initial evaluations in capitated sites followed by an evaluation in a Fee for Service setting.

**4. Primary Care to Specialist eReferral**

eReferral fee codes will be established for dermatology and ophthalmology, with subsequent expansion to other specialties.

**5. Realignment of Telemedicine Premium – OTN working group**

Establish a Working Group to evaluate Personal Video Conferencing (PVC) deployment progress, utilization, volume and workflow trends. In the short term, the Working Group will develop:

- PVC utilization or deployment targets that signal a diminishing need for full telemedicine premium; and
- New premiums for northern and non-northern telemedicine consultations based on utilization patterns and adoption requirements.

## **APPENDIX “F”**

### **EVIDENCE AND APPROPRIATENESS – PHASE I**

The Parties agree to the following changes to promote the use evidence and best practices for the provision of health care to and appropriate for the clinical needs of patients:

#### **A. Reduce Unnecessary Testing –Effective November 1, 2012**

##### **1. Revised Laboratory Requisition Form**

The Parties agree that there is overuse/misuse of certain laboratory tests. As such, it was recommended that these laboratory tests be removed from the Ontario laboratory requisition form but still available to patients with appropriate indications. They were removed effective November 1, 2012:

- Removal of Ferritin;
- Thyroid stimulating hormone; and
- Vitamin B12.

#### **B. Reduce Unnecessary Testing - Effective January 1, 2013**

##### **1. AST**

Based on expert consultations conducted by Health Quality Ontario, AST is a less specific test for liver disorders than ALT, and so has limited utility in the community setting. Therefore, OHTAC recommended that AST testing in community laboratories should be restricted to patients under the care of a specialist at a hospital.

##### **2. Chloride**

Based on expert consultations conducted by Health Quality Ontario, chloride testing in the community setting has limited utility. Therefore, OHTAC recommended that chloride testing in the community should be reduced by removing chloride from the Ontario laboratory requisition form.

##### **3. Creatine Kinase**

Creatine kinase in community laboratories is being frequently ordered in patients on statin therapy, often as a screening test. Based on a rapid review conducted by Health Quality Ontario, OHTAC recommended that creatine kinase be removed from the laboratory requisition form.

#### **4. Folate**

Based on expert consultations conducted by Health Quality Ontario, it was identified that folate deficiency is rare in Canada and there is unnecessary testing occurring in Ontario. OHTAC recommends that folate testing be restricted to red blood cell folate, except when ordered by or on the advice of physicians with expertise in hematological, inflammatory or gastrointestinal disorders.

#### **5. Reflexive testing**

There are a number of conditions for which reflexive testing could be used to increase the efficiency of test ordering. Instead of ordering a sequence of tests one clinical visit at a time, or ordering multiple tests (some unnecessary) at the same time, reflexive testing allows the clinician to indicate the clinical situation or condition in question, and the laboratory to run the necessary tests using a diagnostic algorithm.

#### **6. Thyroid scans**

Language is to be added to the OHIP Schedule of Benefits clarifying that thyroid scans should only be ordered for hyperthyroidism (inc. nodules associated with hyperthyroidism), congenital hypothyroidism, masses in neck or mediastinum suspected to be thyroid in origin and that scans are not generally indicated for investigation of thyroid nodules (except if associated with hyperthyroidism) and adult hypothyroidism.

#### **7. Diagnostics by other practitioners (requirement of referring field for tracking)**

Review and evaluate appropriateness of diagnostic studies (e.g., x-rays) ordered by non-physicians (e.g., chiropractors). For tracking and evaluative purposes, require referring provider number be provided for OHIP payment purposes.

## **C. Schedule of Benefits Alignment with Recommendations Screening & Routine Tests ( Effective January 1, 2013)**

### **1. Colon cancer screening intervals**

To align with Cancer Care Ontario's screening program, increase colorectal cancer follow-up screening intervals. For asymptomatic patients whose colonoscopy has either no polyps or small (<1 cm) hyperplastic polyps present, the recommended interval for follow up colonoscopy is to be set at 1 every 5 years or 1 every 10 years based on individual patient indications.

### **2. Cervical cancer screening**

Revise the Schedule of Benefits and PEM cervical cancer screening bonuses accordingly to reflect CCO's new guidelines on cervical cancer screening, including increasing the interval of screening from a 2-year interval to a 3-year interval, and defining when to start (21 years of age) and stop (after the age of 70) screening.

### **3. Annual stress tests**

As identified by the American College of Cardiology and the American College of Physicians in the Choosing Wisely Campaign, language is to be added to the OHIP Schedule of Benefits clarifying that annual stress tests to asymptomatic patients at low risk for coronary heart disease should not be billed to OHIP.

### **4. Pre-Operative Cardiac Testing**

As identified by the American College of Cardiology and the American College of Physicians in the Choosing Wisely Campaign, language is to be added to the OHIP Schedule of Benefits clarifying that pre-operative testing including cardiac testing (echo, ECG, and nuclear imaging), pulmonary function testing, routine chest x-rays, and laboratory testing is not necessary for patients undergoing low/moderate-risk non-cardiac surgery and should not be billed to OHIP.

### **5. Chest x-rays**

Language is to be added to the OHIP Schedule of Benefits clarifying that routine chest x-rays for screening and routine pre-admission for ambulatory and in-patients with

unremarkable history/physical exam is not medically necessary and should not be billed to OHIP.

**D. Reducing Procedures Not Supported By Evidence (Effective January 1, 2013)**

**1. Arthroscopic Lavage**

Based on Ontario Health Technology Advisory Committee (“OHTAC”) recommendations, language is to be added to the OHIP Schedule of Benefits clarifying that arthroscopic lavage for osteoarthritis of knee should not be billed to OHIP.

**2. Injection of Hyaluronic acid**

Based on OHTAC recommendation, Hyaluronic acid is not insured, however the injection of hyaluronic acid is insured (G370). Since the substance being injected is not recommended, OHIP should consider no longer paying for the injection of hyaluronic acid.



## APPENDIX "G"

### SYSTEM SAVING AND SUSTAINABILITY

The Parties agree on the following measures to promote the efficient use of resources to ensure the sustainability in the health care system:

#### **Effective April 1, 2013**

#### **1. Annual Consecutive Consultations**

Reduce the fee for annual consecutive consultations by the same specialist on the same patient for the same clinical diagnosis to a limited / repeat consult fee or a specific assessment fee.

#### **2. Multiple consultations**

Clarify the language within the OHIP Schedule of Benefits to limit patient benefit to one second opinion consultation (where a second opinion consultation is one requested by the patient).

#### **3. Group appointments**

Shared appointments or group care for chronic diseases and some mental health issues enhance or preserve patient care and result in cost savings. The diseases where shared appointments or care can be employed include:

- Diabetes
- Congestive Heart Failure
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Hypercholesterolemia
- Fibromyalgia

The Parties shall create group care codes for the disorders outlined above similar to existing, per patient GP group psychotherapy codes.

#### **4. Hospital supplies and equipment**

The Ministry and OMA shall establish a province-wide product/supplies standard for specific procedures, resulting in a reduction in the number of vendors and reduced cost, without impacting patient care. The OMA shall encourage physicians to standardize their use of hospital supplies and equipment. Areas of initial focus include the equipment, technology and prosthetics used for the following: Hip, Knee replacements, Spine, Cataract/Cataract lenses, vascular stents and cardiac stents.

**Effective October 1, 2013**

**5. Medically Complex Patients**

In order develop proposals for medically complex patients, both post-discharge and on-going, the Parties agree to develop demonstration projects to measure results, to be evaluated after one year. To that end, the Ministry agrees to reserve \$10M for the period October 2013 to October 2014 for this initiative.

## APPENDIX "H"

### CANADIAN MEDICAL PROTECTIVE ASSOCIATION FEES

**EFFECTIVE JANUARY 1, 2014**

The Parties agree to the following physician contribution schedule for Canadian Medical Protective Association (CMPA) fees. Should Ontario CPI exceed 4%, the physician contribution schedule below may be revised as agreed to by the Parties.

Current Rate	Type of Work	New Rate - Physician Contribution										
		Year 2014	Year 2015	Year 2016	Year 2017	Year 2018	Year 2019	Year 2020	Year 2021	Year 2022	Year 2023	
\$300	Interns and Residents; Clinical Fellows	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300
\$400	Administrative Medicine; Pathology (Anatomic, General, Haematological); Medical Biochemistry; Medical Microbiology; Pathology (Neurological); Physical Medicine and Rehabilitation; Community Medicine (Public Health)	\$600	\$615	\$625	\$640	\$650	\$665	\$680	\$695	\$710	\$725	
\$650	Clinical Associates (Medical, Surgical); Assistance at surgery - no other professional work; Family Med or Geeral Practice (excl emergency shifts, incl emergency shifts); Psychiatry; Surgical practice - without operative treatment.	\$850	\$870	\$885	\$905	\$925	\$945	\$965	\$985	\$1,005	\$1,025	
\$900	Chronic Pain Management-without general or spinal anesthesia; Obstetrical Practice - without labour and delivery; Allergy; Clinical Immunology; Dermatology; Diagnostic Imaging; Endocrinology; Gastroenterology; Genetics; Haematology; Occupational Medicine; Infectious Diseases; Intensive Care - full time; Internal Medicine and its specialties not elsewhere noted; Nephrology; Neurology; Nuclear Medicine; Medical Oncology; Ophthalmology; Paediatric - may include shift in Emergency Department; Respiratory Medicine; Rheumatology; Sports Medicine; Therapeutic Radiology/Radiation Oncology; Neonatology.	\$1,100	\$1,125	\$1,145	\$1,170	\$1,195	\$1,220	\$1,245	\$1,270	\$1,300	\$1,325	
\$1,200	Family/General Practice with Obstetrics; Fam/Gen Practice with Anaesthesia/Surgery/Emerg Dept Work.	\$1,464	\$1,495	\$1,525	\$1,560	\$1,590	\$1,625	\$1,660	\$1,695	\$1,730	\$1,765	
\$1,500	Cardiology; Otolaryngology; Emergency Medicine/Emergentology.	\$1,830	\$1,870	\$1,910	\$1,950	\$1,990	\$2,030	\$2,075	\$2,115	\$2,160	\$2,205	
\$3,500	General Surgery; Gynaecologic Surgery - without labour and delivery; Paediatric Surgery; Plastic Surgery; Thoracic Surgery; Urology; Vascular Surgery.	\$4,270	\$4,360	\$4,450	\$4,545	\$4,640	\$4,740	\$4,835	\$4,940	\$5,040	\$5,150	
\$4,900	Anesthesia; Cardiovascular Surgery; Neurosurgery; Obstetrics; Orthopedic Surgery	\$5,978	\$6,105	\$6,230	\$6,365	\$6,495	\$6,635	\$6,770	\$6,915	\$7,060	\$7,210	
Notes												
1. 2014 rate is the current rate plus the larger of \$200 or 22% for all types of work, except interns, residents, and clinical fellows, which remains the same as the current rate over the entire period.												
2. The rates for 2015-2023 are increased annually by 2.1% (the historical average of CPI over the past 10 years -- 2001-2011).												

**APPENDIX “I”**  
**PHYSICIAN PROGRAMS**

**1. CONTINUED PROGRAMS**

The Parties agree to continue the following programs previously developed by the Parties:

- (a) Clerkship Stipend Program (Final Year Medical Student Bursary Program);
- (b) Continuing Medical Education (CME);
- (c) Rural Family Medicine Locum Program;
- (d) Northern Physician Retention Initiative (NPRI) & NPRI CME;
- (e) Pregnancy and Parental Leave Benefit Program (PPLBP);
- (f) Northern and Rural Recruitment and Retention Initiative and the Postgraduate Return of Service Program (Formerly UAP);
- (g) Northern Specialist Locum Programs;
- (h) Emergency Department Coverage Demonstration Project;
- (i) Rural Medicine Investment Program;
- (j) Physician Health Benefits Program (PHBP);
- (k) Hospital Pediatric Stabilization Program;
- (l) Hospital On-Call Coverage Program;
- (m) Resident Loan Interest Relief Program;
- (n) Mental Health Stipends;
- (o) Mental Health Sessional Payments and Sessional Fee Supplements;
- (p) Divested Psychiatric Physician Hospital funding;
- (q) Assertive Community Treatment Program;
- (s) Ontario Psychiatric Outreach Program;
- (t) Enhanced Care for the Frail and Elderly Funding Initiative;

- (u) Funding for Infectious Disease Specialists;
- (v) Funding for Geneticists;
- (w) Clinical Decision Units; and
- (x) any other programs not listed above that the parties have agreed to continue.

## **2. MODIFIED PROGRAM**

The Parties agree to modify the ED Summer Incentive to focus funding on specific needs. HFO will restrict access to the Summer Incentive to the highest need hospitals (i.e. some 30 or more EDs). These could include:

- Rural Northern Physician Group Arrangement (RNPGA) hospitals with 2 physicians and 24-hour emergency coverage;
- Emergency Department Coverage Demonstration Project (EDCDP), participating hospitals;
- EDCDP Regional Referral Centres; and
- If necessary, other hospitals based on a timely assessment of need.

## **3. DISCONTINUED PROGRAMS**

The Parties agree to discontinue the following programs:

- (a) Service Recognition Program (Discontinuance Date - Upon final payment on October 1, 2012)

The 2007 Reassessment agreement, paragraph 6(j) states:

“Continuation of program:

The Parties may at future negotiations agree to modify, extend or discontinue the payment program. If the payment is reduced or discontinued, the funding will remain in the physician services budget and the Parties will determine the reallocation of the funding.”

- (b) HOCC Collaboration Fund (Discontinuance Date – Immediate)

The 2008 Physician Services Agreement, section 6.2.4 states:

“An On Call Coverage Collaboration Initiative fund of \$22 million will be established as set out in Section 9.3 to recognize physicians in each LHIN where following implementation of recommendations pursuant to 6.2.2, a comprehensive regional on-call coverage program is in place and aligned to the needs of that community.”

- (c) Technical Fee Payment (Discontinuance Date – Immediate)

The 2008 Physician Services Agreement, section 4.2 states:

“A fund of \$15 million for technical fees will be provided, with the method of allocation to be determined by the PSC. Any future funding increases will be determined through a separate process.”

## APPENDIX “J”

### CONTINUED BILATERAL SUBCOMMITTEES

The Parties agree for the following bilateral subcommittees to continue under their current terms of reference, subject to the following revisions:

#### 1. Joint Forms Committee

The mandate of the Joint Forms Committee shall expand to make recommendations on the following:

- fees for Forms;
- review current undervalued and unremunerated Government forms;
- Standardize hospital forms that require physician input/signature;
- Review of the document requirements for the exceptional access program process (Section 16 of the Ontario Drug Benefit Act); and
- fee for the Out of Country Forms.

#### 2. Primary Health Care Committee

As set out in Appendix “D”, the Parties have agreed upon many key initiatives to be implemented as part of this Physician Services Agreement, and the implementation details will require significant work. Accordingly the Parties agree to reconstitute the Primary Health Care Committee (PHCC) under terms of reference developed by the PSC. The PHCC’s responsibilities shall include the following initiatives specifically identified in Appendix “D”:

- Support for Quality – Excellent Care for All Act (section 3);
- Daytime Access (s. 4.1);
- House Calls (a) and (e) (s. 4.3);
- Review of Access Bonus (s.6.2); and
- Payment Change – CCM Fee Reduction for Large Rosters (s.7.3).
- Payment Change –Acuity Modifier (s.7.5); and
- Interprofessional Health Provider Funding (s.9)

**APPENDIX "K"**

**APP BOILER PLATE PROVISIONS  
FOR SPECIALIST PHYSICIANS**



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**Basic APP Boilerplate Provisions for Specialist Physicians**

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**This Agreement** effective as of the 1st day of \_\_\_\_\_, 201\_

**Among:**

**Her Majesty the Queen  
in right of Ontario  
as represented by  
the Minister of Health and Long-Term Care**

(the “**Ministry**”)

- and -

.....

(the “**Group**”)

- and -

.....

(the “**Hospital**”)

- and -

**Ontario Medical Association (the “OMA”)**

**BACKGROUND**

1. The purpose of this Agreement is **[NTD: To be determined on a case-by-case basis.]**
2. The Parties acknowledge that the Ontario Health Insurance Plan (the “Plan”) is established by the Health Insurance Act (Ontario) to provide for health care services for all insured persons of Ontario. All payments under this Agreement are made by the Government of Ontario under the Plan.

**In consideration** of the mutual covenants and agreements contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

**ARTICLE 1 – DEFINITIONS**

- 1.1 **Interpretation.** For the purposes of interpretation:

- (a) words in the singular include the plural and vice-versa;
- (b) words in one gender include all genders;
- (c) the background and the headings do not form part of the Agreement; they are for reference only and shall not affect the interpretation of the Agreement;
- (d) any reference to dollars or currency shall be to Canadian dollars and currency; and
- (e) “include”, “includes” and “including” shall not denote an exhaustive list.

1.2 **Definitions.** In the Agreement, the following terms shall have the following meanings:

**“Agreement”** means this agreement, the appendices, and any amendments entered into under this agreement as of the date of the amendments.

**“Business Day”** means any working day, Monday to Friday inclusive, excluding statutory and other holidays, namely: New Year’s Day; Family Day; Good Friday; Easter Monday; Victoria Day; Canada Day; Civic Holiday; Labour Day; Thanksgiving Day; Remembrance Day; Christmas Day; Boxing Day and any other day on which the Ministry has elected to be closed for business.

**“Clinical Services”** has the meaning ascribed to it in Appendix “A”.

**“CMPA”** means the Canadian Medical Protective Association.

**“College”** means the College of Physicians and Surgeons of Ontario.

**“Declaration and Consent”** means a declaration and consent in one of the forms attached to the Agreement as Appendix “F”.

**“Defaulting Party”** means the Group and/or the Hospital.

**“Designated Physician”** means a physician who meets the requirements for a Group Physician as set out in Appendix “B”, and who is designated by a Medicine Professional Corporation to provide Services on behalf of the Medicine Professional Corporation.

**“Effective Date”** means the date set out at the top of the Agreement.

**“Event of Default”** has the meaning ascribed to it in section 12.3.

**“Fee-For-Service”** means the submission of accounts to the Ontario Health Insurance Plan under the *Health Insurance Act*.

**“FTE Position”** means a full-time equivalent position where full-time means the provision of a minimum of [NTD: To be completed when the Agreement is drafted, such as hours, vacation and permissible leaves if applicable.]

**“Force Majeure”** has the meaning ascribed to it in section 17.2.

**“Funding Year”** means:

- (a) in the case of the first Funding Year, the period beginning on the Effective Date and ending on **[March 31, 20XX]**; and
- (b) in the case of Funding Years subsequent to the first Funding Year, the period beginning on the date that is April 1 following the end of the previous Funding Year and ending on the following March 31.

**“Funds”** means the funds as set out in Appendix “D”.

**“Governance Agreement”** means the governance agreement referred to in section 3.1.

**“Group Number”** means **[To be completed when the Agreement is drafted.]**

**“Group Physician”** means:

- (a) a physician who meets the requirements for a Group Physician as set out in Appendix “B”; or
- (b) a Medicine Professional Corporation that has identified one or more Designated Physicians.

**“Health Insurance Act”** means the *Health Insurance Act*, R.S.O. 1990, c. H.6.

**“Indemnified Parties”** means her Majesty the Queen in right of Ontario, her ministers, agents, appointees and employees.

**“Indirect Services”** has the meaning ascribed to it in Appendix “A”.

**“Insured Person”** means an insured person as defined in the *Health Insurance Act*.

**“Insured Service”** means an insured service as defined in the *Health Insurance Act*.

**“Medicine Professional Corporation”** has the same meaning ascribed to the term Physician Corporation under O. Reg. 665/05 made under the *Business Corporations Act*, R.S.O. 1990, c. B.16.

**“MNI”** means the master number index **[NTD: To be completed when the Agreement is drafted.]**

**“Notice”** means any communication given or required to be given pursuant to the Agreement.

**“Notice Period”** means the period of time within which the Defaulting Party is required to remedy an Event of Default, and includes any such period or periods of time by which the Ministry considers it reasonable to extend that time.

“**OHIP**” means the Ontario Health Insurance Plan established under the *Health Insurance Act*.

“**Party**” means the Ministry, the Group, the Hospital or the OMA.

“**Parties**” means the Ministry, the Group, the Hospital and the OMA.

“**Personal Health Information**” means personal health information as defined in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A.

“**Records**” means the records and other documents referred to in section 9.1.

“**Report**” means a report referred to in Appendix “E”.

“**Services**” has the meaning ascribed to it in Appendix “A”.

“**Service Encounter Report**” means a report prepared in a manner similar to the manner in which physicians bill Fee-For-Service.

“**Schedule of Benefits**” means the schedule of benefits for physician services under the *Health Insurance Act*.

1.3 **Physicians as Natural Persons and Medicine Professional Corporations.** Every reference in the Agreement to a Group Physician shall be understood to mean a Group Physician as a natural person or as a Medicine Professional Corporation, and the following interpretative guidelines shall apply:

- (a) where the Group Physician is a natural person, the provisions of the Agreement shall be read as drafted; and
- (b) where the Group Physician is a Medicine Professional Corporation, the provisions of the Agreement shall be read to apply to the Medicine Professional Corporation as a corporation, with the understanding that:
  - (i) a Designated Physician shall provide Services on behalf of the Medicine Professional Corporation; and
  - (ii) all remuneration for the Services of any Designated Physician shall be paid to the Medicine Professional Corporation.

1.4 **Despite Section 1.3.** Despite section 1.3, where the provision relates to an appointment, membership, privilege, qualification, obligation, activity, service or right of a Group Physician that cannot be held or performed by a corporation, the provision shall be understood to refer to the Designated Physician in her or his capacity as the agent of the Medicine Professional Corporation.

## ARTICLE 2 – TERM

2.1 **Term.** The term of the Agreement shall commence on the Effective Date and shall continue until terminated pursuant to Article 12.

## ARTICLE 3 – GOVERNANCE AGREEMENT ESTABLISHED

- 3.1 **Governance Agreement Established.** The Group represents, warrants and covenants that it has and shall maintain in writing, for the period during which the Agreement is in effect, a governance agreement among Group Physicians that:
- (a) establishes the respective and mutual obligations of the Group Physicians, and the processes to support those obligations;
  - (b) establishes the roles and responsibilities of the Group Physicians, including a process for decision-making;
  - (c) requires all officers of the Group to be elected through an open and democratic process;
  - (d) establishes a dispute resolution mechanism to resolve disputes that may arise between or among Group Physicians;
  - (e) provides that all premiums, contributions and remittances of any nature arising from any payments made under the Agreement are remitted to the proper authority;
  - (f) states the relationship among the Group Physicians;
  - (g) creates a set of governing principles and guidelines that:
    - (i) establishes the expected code of conduct and ethical responsibilities at all levels of the Group;
    - (ii) enables efficient decision-making among the Group Physicians;
    - (iii) ensures the ongoing effective functioning of the Group;
    - (iv) facilitates the delivery of Services; and
    - (v) enables the timely identification of risks to the delivery of Services, and strategies to address the identified risks;
  - (h) creates a set of policies and processes for the purposes of:
    - (i) receiving, managing, allocating and distributing the Funds;
    - (ii) managing access to personal, financial and other information;
    - (iii) ensuring that any reports or information a Group Physician provides to the Group is consistent and sufficient to enable the Group to meet its obligations under the Agreement; and
    - (iv) dealing with amendments to the Agreement; and

- (i) deals with such other matters as the Group considers necessary to ensure that all Group Physicians properly and efficiently carry out their respective and mutual obligations under the Agreement.

**[NTD: While governance agreements will be consistent with the requirements above, the contents of the Group governance agreements will differ depending on the size and complexity of the Groups.]**

- 3.2 **Managing Disputes.** The Group acknowledges that it has the sole responsibility for resolving any disputes that may arise between or among Group Physicians, and that the Ministry has no responsibility in this regard.

#### **ARTICLE 4 – PROVISION OF SERVICES**

- 4.1 **Provision of Services.** The Group shall provide Services in every Funding Year.

#### **ARTICLE 5 – PHYSICIAN RETENTION AND QUALIFICATIONS**

- 5.1 **Retention Obligation.** The Group shall:

- (a) ensure the continued retention of such number of FTE Positions as are set out in Appendix “C”;
- (b) ensure that every Group Physician meets the criteria for Group Physicians as set out in Appendix “B”;
- (c) ensure that every Group Physician has, at the time the Group Physician begins to provide Services, malpractice protection through a commercial insurance program or through the Group Physician’s membership in the CMPA;
- (d) where a Group Physician is providing Services as a natural person, ensure that the Group Physician signs a Declaration and Consent in the form titled “Declaration and Consent for Natural Persons as Group Physicians” as set out in Appendix “F”, within 10 days of starting to provide Services in that capacity;
- (e) where a Group Physician is providing Services as a Medicine Professional Corporation, ensure that the Group Physician signs a Declaration and Consent in the form titled “Declaration and Consent for Medicine Professional Corporations as Group Physicians” as set out in Appendix “F”, within 10 days of starting to provide Services in that capacity; and
- (f) submit the signed copy of the Declaration and Consent to the Ministry as soon as a Group Physician signs the Declaration and Consent.

- 5.2 **Signing a Declaration and Consent Clarified.** A physician may, at any time, change the status under which the physician is providing Services, and shall sign a new Declaration and Consent as provided for in section 5.1(d) or (e) to reflect the change.

## ARTICLE 6 – FUNDS

- 6.1 **Funds Provided.** The Ministry shall provide the Funds directly to the Group for the provision of Services:
- (a) on a pro rata basis to reflect:
    - (i) the proportion of the Funding Year during which the Group provides Services; and
    - (ii) the number of FTE Positions the Group filled during the Funding Year;
  - (b) only for the stated Funding Year and not on a cumulative basis;
  - (c) in equal monthly instalments on the last Business Day of every month; and
  - (d) by electronic transfer directly into an account designated by the Group.
- 6.2 **Use of Funds.** The Group shall use the Funds only to remunerate Group Physicians for the provision of Services.
- 6.3 **No Fee-For-Service.** The Group shall not retain the services of any physician to provide any Clinical Service or Indirect Service on a Fee-For-Service basis, except as provided for in the Agreement.

## ARTICLE 7 – BILLINGS AND OTHER PAYMENTS

- 7.1 **No Group Physician to Claim or Accept Payment.** The Group shall ensure that no Group Physician claims or accepts payment, directly or indirectly, by any means, including through any person, the Hospital, any other entity or OHIP for any Clinical Service or Indirect Service that the Group Physician provides.
- 7.2 **Ministry's Rights of Set-Off or Deduction.** If a Group Physician accepts payment contrary to section 7.1, the amount of any such payment shall constitute a debt due and owing by the Group to the Ministry, and:
- (a) the Ministry shall provide Notice to the Group of the amount of any such payment, and the name of the Group Physician it was paid on account of; and
  - (b) the Ministry may retain an amount equal to the payment by way of deduction or set-off out of any Funds to be provided to the Group.
- 7.3 **Exceptions to section 7.1.** Despite section 7.1, all Group Physicians may claim or accept payment, directly or indirectly, by any means, including through any person, the Hospital, any other entity or OHIP:
- (a) for the Clinical Services and/or Indirect Services they provide pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16;

- (b) for the Clinical Services they provide pursuant to the following K codes under the Schedule of Benefits: K018, K021, K051, K052, K053, K061, K018, K050, K054 and K055;
- (c) for the Clinical Services and/or Indirect Services they provide in the **[service area/Hospital]** that are covered by any reciprocal medical billing arrangement between the Ministry and the provinces (including Quebec) and territories of Canada, to a total maximum of **[\$..... ]** for the Group; and
- (d) for the technical component of an Insured Service set out in the Schedule of Benefits under the *Health Insurance Act*.

7.4 **Nothing in the Agreement Shall Prohibit.** Nothing in the Agreement shall prohibit a Group Physician from:

- (a) claiming or accepting payment for any services the Group Physician provides to persons who are not Insured Persons;
- (b) applying for funds under any of the physician programs listed in Appendix “H”; or
- (c) accepting payments:
  - (i) in the form of stipends from a hospital or university for administrative activities that are not Administrative Activities;
  - (ii) including royalties or honoraria for articles written for journals (whether peer reviewed or not), newspapers or other publications;
  - (iii) from the Workplace Safety and Insurance Board for reports a Group Physician writes or other activities in which the Group Physician participates pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16; or
  - (iv) for participation in accreditation surveys, peer review examinations and external reviews of departments or programs.

## ARTICLE 8 – REPORTS

8.1 **Reports from the Group.** The Group shall submit to the Ministry the Reports as required in Appendix “E”.

8.2 **Reporting Services and Billing for Services Provided Pursuant to Section 7.3.** The Group shall:

- (a) provide every Group Physician with the Group Number and the MNI; and
- (b) ensure that every Group Physician:
  - (i) prepares Service Encounter Reports;



- (ii) uses the Group Number and the MNI when preparing Service Encounter Reports; and
- (iii) uses the MNI when preparing all Fee-For-Service claims for the services the Group Physician provides pursuant to section 7.3.

## **ARTICLE 9 – GROUP RECORDS**

- 9.1 **Record Maintenance.** The Group shall, and shall require the Group Physicians to, keep and maintain:
- (a) all financial records relating to the Funds or otherwise to the Services in a manner consistent with generally accepted accounting principles; and
  - (b) all non-financial documents and records relating to the Funds or otherwise to the Services.
- 9.2 **Audit.** The Ministry, its authorized representatives or an independent auditor identified by the Ministry may, at its own expense, upon twenty-four hours Notice to the Group and during normal business hours, enter upon the Group’s premises to:
- (a) inspect and copy the Records; and
  - (b) conduct an audit or investigation of the Group in respect of the expenditure of the Funds and/or the Services.
- 9.3 **Disclosure.** To assist in respect of the rights set out in section 9.2, the Group shall disclose any information requested by the Ministry, its authorized representatives or an independent auditor identified by the Ministry, and shall do so in a form requested by the Ministry, its authorized representatives or an independent auditor identified by the Ministry, as the case may be.
- 9.4 **Disclosure of Personal Health Information.** Nothing in the Agreement shall require the Group, except as otherwise permitted or authorized by law, to disclose any Personal Health Information contained in any of the Records to anyone.
- 9.5 **No Control of Records.** No provision of the Agreement shall be construed so as to give the Ministry any control whatsoever over the Records of the Group and/or the Group Physicians.
- 9.6 **Auditor General.** For greater certainty, the Ministry’s rights under this Article are in addition to any rights provided to the Auditor General pursuant to section 9.1 of the *Auditor General Act*, R.S.O. 1990, c. A.35.
- 9.7 **Purpose.** The Ministry may only exercise its rights under this Article for the purpose of confirming that the Group has met its obligations under the Agreement.

## **ARTICLE 10 – HOSPITAL RESPONSIBILITIES**

- 10.1 **Hospital's Rights Not Derogated From.** Nothing in the Agreement shall derogate from the Hospital's rights to determine medical staff appointments, to safeguard the quality of care provided in the Hospital or to exercise its rights and meet its responsibilities under applicable legislation and regulations.
- 10.2 **Hospital Funds and Payments.** The Hospital shall:
- (a) use best efforts to continue to provide, in every Funding Year, the overall level of funding, resources and support for the provision of Services that it provided at the time of entering in this Agreement; and
  - (b) not use any monies from its global operating budget to pay Group Physicians for the provision of Services.
- 10.3 **No Fee-For-Service.** The Hospital shall not retain the services of any physician to provide any Clinical Service or Indirect Service on a Fee-For-Service basis, except as provided for in the Agreement.

#### **ARTICLE 11 – OMA DUES**

- 11.1 **OMA Dues.** The Parties recognize that all Group Physicians receiving Funds through the Agreement, whether members of the OMA or not, are required to pay OMA dues and assessments that the OMA would charge each Group Physician as if she or he were a member of the OMA.
- 11.2 **Ensuring Payment.** To ensure the payment to the OMA of OMA dues and assessments:
- (a) the Group shall provide to the OMA the names and billing numbers of all Group Physicians;
  - (b) the OMA may advise the Group of the name of any Group Physician who has not paid their OMA dues or assessments and the amount outstanding, and request the Group to pay that amount to the OMA;
  - (c) upon receiving a request under section 11.2(b), the Group shall deduct from the Funds the amount requested by the OMA and remit such amount to the OMA.

#### **ARTICLE 12 – TERMINATION, EVENTS OF DEFAULT AND CORRECTIVE ACTION**

- 12.1 **Termination by Either Ministry or Group.** Either the Ministry or the Group may, in their sole discretion, at any time and for any reason, terminate the Agreement upon giving three months Notice to the other Parties.

**[NTD: The length of notice may need to be revised on a case-by-case basis.]**

- 12.2 **Termination by Group.** The Group may, in its sole discretion, terminate the Agreement immediately upon giving Notice to the Ministry if the Ministry fails to provide Funds in

accordance with Article 6, unless the failure was caused by a circumstance of Force Majeure as provided for in Article 17.

**12.3 Event of Default.** Each of the following events shall constitute an Event of Default:

- (a) the Group breaches any representation, warranty, covenant or other material term of the Agreement, including failing to provide Reports in accordance with Article 8;
- (b) the Hospital breaches any representation, warranty, covenant or other material term of the Agreement, including failing to provide Reports in accordance with Article 8;
- (c) the Hospital makes an assignment, proposal, compromise, or arrangement for the benefit of creditors, or is petitioned into bankruptcy, or files for the appointment of a receiver;
- (d) the Group and/or the Hospital cease to operate; and
- (e) an event of Force Majeure that continues for a period of 60 days or more.

**12.4 Consequences of Event of Default.** If an Event of Default occurs, the Ministry may, at any time, in proportion to the Event of Default, and in relation to the Defaulting Party, take one or more of the following actions:

- (a) initiate any action the Ministry considers necessary in order to facilitate the continued provision of the Services;
- (b) provide the Defaulting Party with an opportunity to remedy the Event of Default;
- (c) suspend the payment of Funds for such period as the Ministry determines appropriate;
- (d) reduce the amount of the Funds;
- (e) cancel all further instalments of Funds;
- (f) demand the repayment of any Funds remaining in the possession or under the control of the Group;
- (g) demand the repayment of an amount equal to any Funds the Group used, but did not use in accordance with the Agreement;
- (h) demand the repayment of an amount equal to any Funds the Ministry provided to the Group; and/or
- (i) terminate the Agreement at any time, including immediately, upon giving Notice to the Parties.

- 12.5 **Opportunity to Remedy.** If, in accordance with section 12.4(b), the Ministry provides the Defaulting Party with an opportunity to remedy the Event of Default, the Ministry shall provide Notice to the Defaulting Party of:
- (a) the particulars of the Event of Default; and
  - (b) the Notice Period.
- 12.6 **Not Remediating.** If the Ministry has provided the Defaulting Party with an opportunity to remedy the Event of Default pursuant to section 12.4(b), and:
- (a) the Defaulting Party does not remedy the Event of Default within the Notice Period;
  - (b) it becomes apparent to the Ministry that the Defaulting Party cannot completely remedy the Event of Default within the Notice Period; or
  - (c) the Defaulting Party is not proceeding to remedy the Event of Default in a way that is satisfactory to the Ministry,
- the Ministry may extend the Notice Period, or initiate any one or more of the actions provided for in sections 12.4(a), (c), (d), (e), (f), (g), (h) and (i).
- 12.8 **Dispute Resolution.** A Party to the Agreement may submit a disagreement regarding the interpretation and application of the Agreement to the Physician Services Committee for mediation. The PSC will make written recommendations to the Parties regarding the resolution of the disagreement.
- 12.9 If the matter remains unresolved after two weeks from the date the recommendation was provided, then either Party may submit the disagreement to expedited arbitration before an agreed upon arbitrator for final and binding determination.

**[NTD: Section numbers will need to be renumbered]**

- 12.7 **When Termination Effective.** Termination under this Article shall take effect as set out in the Notice.
- 12.8 **Funds on Termination.** If either the Ministry or the Group terminates the Agreement pursuant to section 12.1, or the Group terminates the Agreement pursuant to section 12.2, the Ministry:
- (a) shall cancel all further instalments of Funds;
  - (b) may demand the repayment of any Funds remaining in the possession or under the control of the Group; and/or
  - (c) may demand the repayment of an amount equal to any Funds the Group used, but did not use in accordance with the Agreement.

## **ARTICLE 13 – REPAYMENT**

13.1 **Repayment of Overpayment.** If the Ministry provides Funds in excess of the funds to which the Group is entitled under the Agreement, the Ministry may, at any time, request the payment of monies equal to the excess Funds.

13.2 **Debt Due.** If:

- (a) the Ministry demands pursuant to the Agreement the repayment of any Funds from the Group; or
- (b) the Group owes any Funds or any other money to the Ministry, whether or not their return or payment has been demanded by the Ministry,

such Funds or other money shall be deemed to be a debt due and owing to the Ministry by the Group, and the Group shall pay or return the amount to the Ministry immediately, unless the Ministry directs otherwise.

13.3 **Interest Rate.** The Ministry may charge the Group interest on any money owing by the Group at the then current interest rate charged by the Province of Ontario on accounts receivable.

13.4 **Payment of Money to Ministry.** The Group shall pay any money owing to the Ministry by cheque payable to the "Ontario Minister of Finance" and mailed to the Ministry at the address provided in section 14.1.

#### ARTICLE 14 – NOTICE

14.1 **Notice in Writing and Addressed.** Notice shall be in writing and shall be delivered by email, postage-prepaid mail, personal delivery or fax, and shall be addressed to the Ministry and the Parties as set out in Appendix "G", or as any of the Parties may later designate to the other Parties by Notice.

14.2 **Notice Given.** Notice shall be deemed to have been received:

- (a) in the case of postage-prepaid mail, seven days after a Party mails the Notice; or
- (b) in the case of email, personal delivery or fax, at the time the other Party receives the Notice.

14.3 **Postal Disruption.** Despite section 14.2(a), in the event of a postal disruption:

- (a) Notice by postage-prepaid mail shall not be deemed to be received; and
- (b) the Party giving Notice shall provide Notice by email, personal delivery or by fax.

#### ARTICLE 15 – RELATIONSHIPS

15.1 **Parties Independent.** The Ministry, the Group, the Group Physicians, the Hospital and the OMA are and shall remain independent and each Party shall be responsible for its,

her or his own actions and nothing in the Agreement is intended to or shall be construed so as to:

- (a) constitute the Ministry, the Group, any of the Group Physicians, the Hospital or the OMA as a partner, employee, agent or representative of the Ministry;
- (b) constitute a joint venture among any of the Ministry, the Group, the Group Physicians, the Hospital or the OMA;
- (c) permit the Group, any of the Group Physicians, the Hospital or the OMA to represent to third parties that they have any right or authority to enter into any agreement on behalf of the Ministry; or
- (d) permit the Group, any of the Group Physicians, the Hospital or the OMA to enter into any agreement with anyone on behalf of the Ministry.

## **ARTICLE 16 – LIMITATION OF LIABILITY, INDEMNIFICATION AND INSURANCE**

- 16.1 **Limitation of Liability.** The Indemnified Parties shall not be liable to the Group, any of the Group Physicians, the Hospital or the OMA for any losses, taxes, payments (of any kind), damages (whether incidental, indirect, special or consequential), injury, loss of use or loss of profit (together the “**Losses**”) of the Group, any of the Group Physicians, the Hospital or the OMA arising from or in connection with the provision of Services, except to the extent that the Losses were caused by the negligence or wilful misconduct of an Indemnified Party or the Indemnified Parties.
- 16.2 **Indemnification.** The Hospital hereby agrees to indemnify and hold harmless the Indemnified Parties from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted, in any way arising out of or in connection with its obligations under the Agreement or otherwise in connection with the Agreement, unless solely caused by the negligence or wilful misconduct of the Ministry.
- 16.3 **Hospital’s Insurance.** The Hospital represents and warrants that it has, and shall maintain for the term of the Agreement, at its own cost and expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person carrying out a program with similar obligations as provided for under the Agreement would maintain, including commercial general liability insurance on an occurrence basis for third party bodily injury, personal injury and property damage, to an inclusive limit of not less than two million dollars (\$2,000,000) per occurrence. The policy shall include the following:
- (a) the Indemnified Parties as additional insureds with respect to liability arising in the course of performance of the Hospital’s obligations under, or otherwise in connection with, the Agreement;
  - (b) a cross-liability clause;
  - (c) contractual liability coverage; and

(d) a 30 day written notice of cancellation, termination or material change.

16.4 **Proof of Insurance.** The Hospital shall provide the Ministry with certificates of insurance, or other proof as may be requested by the Ministry, that confirms the insurance coverage as provided for in section 16.3. Upon the request of the Ministry, the Hospital shall make available to the Ministry a copy of each insurance policy.

**[NTD: Sections.16.2, 16.3 and 16.4 apply to Hospitals and will not be changed to Group if there is no Hospital-party to the Agreement.]**

## ARTICLE 17 – FORCE MAJEURE

17.1 **Definition of Party.** For the purposes of section 17.1 through 17.5, “**Party**” shall mean the Ministry or the Group, and “**Parties**” shall mean the Ministry and the Group.

17.2 **Force Majeure Means.** Subject to section 17.4, “**Force Majeure**” means an event that:

- (a) is beyond the reasonable control of a Party; and
- (b) makes a Party’s performance of its obligations under the Agreement impossible or so impractical as reasonably to be considered impossible in the circumstances.

17.3 **Force Majeure Includes.** Force Majeure includes:

- (a) infectious diseases, war, riots and civil disorder;
- (b) storm, flood, earthquake and other severely adverse weather conditions;
- (c) lawful act by a public authority; and
- (d) strikes, lockouts and other labour actions,

if such events meet the test set out in section 17.2.

17.4 **Force Majeure Shall Not Include.** Force Majeure shall not include:

- (a) any event that is caused by the negligence or intentional action of a Party or such Party’s agents or employees; or
- (b) any event that a diligent Party could reasonably have been expected to:
  - (i) take into account at the time of the execution of the Agreement; and
  - (ii) avoid or overcome in the carrying out of its obligations under the Agreement.

17.5 **Failure to Fulfill Obligations.** Subject to section 12.3(e), the failure of either Party to fulfill any of its obligations under the Agreement shall not be considered to be a breach of, or Event of Default under, the Agreement to the extent that such failure to fulfill the

obligation arose from an event of Force Majeure, if the Party affected by such an event has taken all reasonable precautions, due care and reasonable alternative measures, all with the objective of carrying out the terms and conditions of the Agreement.

## ARTICLE 18 – GENERAL PROVISIONS

- 18.1 **Invalidity or Unenforceability of Any Provision.** The invalidity or unenforceability of any provision of the Agreement shall not affect the validity or enforceability of any other provision of the Agreement. Any invalid or unenforceable provision shall be deemed to be severed.
- 18.2 **Waivers in Writing.** If a Party fails to comply with any term of the Agreement, that Party may only rely on a waiver of any other Party if the other Party has provided a written waiver in accordance with the Notice provisions. Any waiver must refer to a specific failure to comply and shall not have the effect of waiving any subsequent failures to comply.
- 18.3 **Governing Law.** The Agreement and the rights, obligations and relations of the Parties shall be governed by and construed in accordance with the laws of the Province of Ontario and the applicable federal laws of Canada. Any actions or proceedings arising in connection with the Agreement shall be conducted in Ontario.
- 18.4 **Agreement into Effect.** The Parties shall do or cause to be done all acts or things necessary to implement and carry into effect the terms and conditions of the Agreement to their full extent.
- 18.5 **Approval and Consent in Writing.** Any approval or consent granted pursuant to this Agreement shall not be valid unless given in writing by the Party giving the approval or consent.
- 18.6 **Reference to Statute.** Any reference in the Agreement to any statute or any section thereof shall, unless otherwise expressly stated, be deemed to be a reference to such statute or section as amended, restated or re-enacted from time to time.
- 18.7 **Survival.** The following shall survive termination of the Agreement for a period of 7 years as provided below:
- (a) the interpretation provisions and definitions as set out in Article 1 and such other definitions that may be referred to in any other provisions that survive;
  - (b) the provisions respecting billing and the rights of set-off in Article 7;
  - (c) the Group's obligation to submit Reports and use numbers as set out in Article 8, if any Report remains outstanding upon termination of the Agreement;
  - (d) the Group's obligations respecting the maintenance and disclosure of Records as set out in Article 9, subject to the provisions contained in that Article;
  - (e) the Ministry's rights as set out in section 9.2, subject to the provisions contained in that Article 9;



- (f) the provisions respecting Event of Default as set out in Article 12;
- (g) the Ministry's rights regarding Funds, and/or an amount equal to Funds, on termination as set out in sections 12.8(a), (b) and (c);
- (h) the Ministry's right relating to the provision of excess Funds as set out in section 13.1;
- (i) the Group's obligations respecting the repayment to the Ministry as set out in sections 13.2 and 13.4;
- (j) the Ministry's right to charge interest on money owing as set out in section 13.3;
- (k) the method of repaying money as set out in section 13.4;
- (l) the provisions relating to Notice as set out in Article 14;
- (m) the limitation of liability provision as set out in section 16.1;
- (n) the indemnification by the Hospital provision as set out in section 16.2; and
- (o) the general provisions in Article 18.

18.7 **Appendices.** The Agreement includes the following Appendices:

- (a) Appendix "A" – Services;
- (b) Appendix "B" – Physician Categories and Definitions;
- (c) Appendix "C" – Retention;
- (d) Appendix "D" – Funds;
- (e) Appendix "E" – Reports;
- (f) Appendix "F" – Declaration and Consent Forms;
- (g) Appendix "G" – Contact Information; and
- (h) Appendix "H" – Physician Programs.

**[NTD: The order of the appendices may need to be revised in light of other changes made to the boilerplate.]**

18.8 **Counterparts.** The Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

18.9 **Rights and Remedies Cumulative.** The rights and remedies of the Parties under the Agreement are cumulative and are in addition to, and not in substitution for, any of their

rights and remedies provided by law or in equity.

- 18.10 **No Assignment.** No Party shall assign any part of the Agreement without the prior written consent of the other Parties.
- 18.11 **Agreement to Extend.** All rights and obligations contained in the Agreement shall extend to and be binding on the Parties' respective heirs, executors, administrators, successors and permitted assigns.
- 18.12 **Entire Agreement.** The Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in the Agreement and supersedes all prior oral or written representations and agreements.
- 18.13 **Agreement Amended.** The Agreement may only be amended by a written agreement duly executed by the Parties.

The Parties have made the Agreement by their duly authorized signing officers as of the last date written below.

**Her Majesty the Queen in right of Ontario  
as represented by the Minister of Health and Long-Term Care**

\_\_\_\_\_  
**Name Date**  
Minister

**Group**

\_\_\_\_\_  
**Name Date**  
I have the authority to bind the Physician Organization.

**Hospital**

\_\_\_\_\_  
**Name Date**  
I have the authority to bind the Hospital.

**Ontario Medical Association**

\_\_\_\_\_  
**Name Date**  
I have the authority to bind the OMA.

## **APPENDIX “A” – SERVICES**

Services will be set out here, including a description of Clinical Services and Indirect Services.

## APPENDIX “B” – PHYSICIAN CATEGORIES AND DEFINITIONS

All physician categories (e.g., Group Physicians, Group Contracted Physicians, Service Extenders, Fellows, etc.) and qualifications will be set out here based on the particular circumstances and specialty of the physicians.

For example, for Group Physicians, the following may be provided:

1. Every Group Physician who is a natural person, and every Designated Physician where the Group Physician is a Medicine Professional Corporation, shall:
  - (a) be a member of the Group;
  - (b) be a member of the College and hold a certificate of registration to practise medicine issued by the College under the *Medicine Act*;
  - (c) hold a certification in **[specialty]** from the Royal College of Physicians and Surgeons of Canada;
  - (d) have malpractice protection through a commercial insurance program or membership in the CMPA or its equivalent; and
  - (e) have a medical staff appointment at the Hospital.

## **APPENDIX “C” – RETENTION**

Retention requirements will be set out here.

## **APPENDIX “D” – FUNDS**

The Funds will be set out here.

## **APPENDIX “E” – REPORTS**

Reports and report requirements will be set out here – dates for the submissions of Reports, particulars about the content of Reports, and the manner of submitting Reports (if required).

## **APPENDIX “F” – DECLARATION AND CONSENT FORMS**

See attached.



**Declaration and Consent for Natural Persons as Group Physicians**

**To: Ministry of Health and Long-Term Care (the “Ministry”)**

**And To: [Enter Name of Group] (the “Group”)**

**And To: [Enter Name of Hospital] (the “Hospital”)**

**And To: Ontario Medical Association (the “OMA”)**

1. I am a Group Physician as that term is defined in the agreement entered into between the Ministry, the Group, the Hospital and the OMA effective as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, including all appendices and any amendments to the agreement (the “**Agreement**”).
2. Capitalized terms used, but not defined, in this Declaration and Consent have the same meanings as those terms have in the Agreement.
3. I have read and understand the Agreement.
4. I authorize the lead physician for the Group, as may be specified from time to time in Appendix “G” of the Agreement (or as may be designated in writing to all Parties in accordance with the Agreement), to sign the Agreement on my behalf.
5. In consideration of the remuneration I will receive from the Group:
  - (a) I shall continue to be a Group Physician for as long as I provide Services;
  - (b) as a Group Physician, I am a member of the Group and shall continue to be a member of the Group for as long as I provide Services, and agree that the obligations of the Group under the Agreement are the obligations of the Group Physicians collectively;
  - (c) I shall be bound by the terms and conditions of the Agreement as a Group Physician;
  - (d) I authorize the Ministry to disclose to the OMA my name and the fact that I am a Group Physician under the Agreement; and
  - (e) I authorize the Ministry to disclose to the Group the following data in Ministry records relating to the Clinical Services and Indirect Services I provide as part of the Services:
    - (i) my name;
    - (ii) the fee code for the Clinical Service and/or Indirect Service;
    - (iii) the date on which I provided the Clinical Service and/or Indirect Service;
    - (iv) the monetary value of the Clinical Service and/or Indirect Service;
    - (v) the MNI and/or name of the facility where I provided the Clinical Service and/or Indirect Service;

- (vi) my OHIP billing number; and
- (vii) the number of Clinical Services and/or Indirect Services I provided.

6. I agree that sections 5(d) and 5(e) of this Declaration and Consent shall survive the termination of the Agreement.

Date: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Signature of physician: \_\_\_\_\_

Name of witness: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

OHIP Number  
(billing number): \_\_\_\_\_

College Registration Number: \_\_\_\_\_

## Declaration and Consent for Medicine Professional Corporations as Group Physicians

To: Ministry of Health and Long-Term Care (the “Ministry”)

And To: [Enter Name of Group] (the “Group”)

And To: [Enter Name of Hospital] (the “Hospital”)

And To: Ontario Medical Association (the “OMA”)

1. \_\_\_\_\_ [Enter name of Medicine Professional Corporation] (the “MPC”) is a Group Physician as that term is defined in the agreement entered into between the Ministry, the Group, the Hospital and the OMA effective as of the \_\_\_ day of \_\_\_\_\_, 20\_\_\_, including all appendices and any amendments to the agreement (the “Agreement”).
2. Capitalized terms used, but not defined, in this Declaration and Consent have the same meanings as those terms have in the Agreement.
3. On behalf of and with the authority of the MPC, I declare that:
  - (a) The MPC has read and understands the Agreement;
  - (b) The MPC is duly incorporated and validly subsisting pursuant to the laws of Ontario;
  - (c) The MPC has full power and authority to enter into the Agreement and to observe, perform and comply with the terms and conditions of the Agreement, and all necessary action has been taken in order to enter into and authorize the Agreement;
  - (d) The MPC holds, and shall continue to hold for as long as it provides Services, all registrations and certificates necessary to carry on business in Ontario and to perform its obligations under the Agreement; and
  - (e) The MPC authorizes the lead physician for the Group, as may be specified from time to time in Appendix “G” of the Agreement (or as may be designated in writing to all Parties in accordance with the Agreement), to sign the Agreement on behalf of the MPC.
4. In consideration of the remuneration the MPC will receive from the Group:
  - (a) the MPC shall continue to be a Group Physician for as long as it provides Services;
  - (b) as a Group Physician, the MPC is a member of the Group and shall continue to be a member of the Group for as long as it provides Services, and agrees that the obligations of the Group under the Agreement are the obligations of the Group Physicians collectively;

- (c) the MPC shall be bound by the terms and conditions of the Agreement as a Group Physician, and acknowledges that any reference in the Agreement to an appointment, membership, privilege, qualification, obligation, activity, service or right of the Group Physician that cannot be held or performed by a corporation, shall be understood to refer to the Designated Physician in her or his capacity as the agent of the MPC;
- (d) the MPC authorizes the Ministry to disclose to the OMA the name of the MPC and the fact that the MPC is a Group Physician under the Agreement; and
- (e) the MPC authorizes the Ministry to disclose to the Group the following data in Ministry records relating to the Clinical Services and Indirect Services the Designated Physician provides as part of the Services:
  - (i) the Designated Physician's name;
  - (ii) the fee code for the Clinical Service and/or Indirect Service;
  - (iii) the date on which the Designated Physician provided the Clinical Service and/or Indirect Service;
  - (iv) the monetary value of the Clinical Service and/or Indirect Service;
  - (v) the MNI and/or name of the facility where the Designated Physician provided the Clinical Service and/or Indirect Service;
  - (vi) the Designated Physician's OHIP billing number; and
  - (vii) the number of Clinical Services and/or Indirect Services the Designated Physician provided.

5. The MPC agrees that sections 4(d) and 4(e) of this Declaration and Consent shall survive the termination of the Agreement.

\_\_\_\_\_  
Name of Medicine Professional Corporation

\_\_\_\_\_  
Name and Title of Authorized Signing Officer

\_\_\_\_\_  
Signature of Authorized Signing Officer

\_\_\_\_\_  
Date

I, the undersigned Designated Physician, of \_\_\_\_\_ **[enter name of Medicine Professional Corporation]:**

- (a) agree to be bound by the terms and conditions of the Agreement as a Designated Physician; and
- (b) authorize the Ministry to make disclosures in accordance with section 4(e) of this Declaration and Consent, and agree that section 4(e) of this Declaration and Consent shall survive the termination of the Agreement.

Date: \_\_\_\_\_

---

Name of physician: \_\_\_\_\_

Signature of physician: \_\_\_\_\_

Name of witness: \_\_\_\_\_

Signature of witness: \_\_\_\_\_

OHIP Number  
(billing number): \_\_\_\_\_

College Registration Number: \_\_\_\_\_

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## APPENDIX “G” – CONTACT INFORMATION

### **Ministry:**

Ministry of Health and Long-Term Care  
Specialist Physician Contracts Unit  
Negotiations Branch  
3<sup>rd</sup> Floor, 1075 Bay Street  
Toronto, ON M5S 2B1

Attention:

Fax:

E-mail:

### **The Group:**

Group name:

Address:

Attention:

Fax:

E-mail:

### **The Hospital:**

Hospital name:

Address:

Attention:

Fax:

E-mail:

### **Ontario Medical Association:**

Ontario Medical Association  
150 Bloor Street West  
Suite 900  
Toronto, ON M5S 3C1

Attention:

Fax:

E-mail:

## **APPENDIX “H” – PHYSICIAN PROGRAMS**

The physician programs will be set out here.