

AMENDING AGREEMENT #2
(made effective April 1, 2008)

AMONG:

Her Majesty The Queen
In Right of Alberta
as represented by the
Minister of Health and Wellness
(the "Department")

and

The Alberta Medical Association
(C.M.A. Alberta Division)
(the "Association")

And

Those Regional Health Authorities
(the "Authorities")
Identified In the Master Agreement
Regarding the Tri-Lateral
Relationship And Budget Management
Process For Strategic Physician Agreements
made effective April 1, 2003,
as amended pursuant to the
amending agreement made effective April 1, 2006
("Amending Agreement #1")
(collectively, the "TMA")

RECITALS:

- A. According to "Article 11 – Reopening This Agreement" of the TMA and specifically Article 11.1 thereof, the Department, the Association and the Authorities have since the fall of 2007 conducted an informal and a formal process to renegotiate financial matters and other matters, if any, agreed to by the Master Committee.
- B. After significant discussion, communication and collaboration the Parties have reached an agreement, as to the financial funding parameters for the Fiscal Years 2008/09, 2009/10 and 2010/11 together with certain guiding principles which relate to and support other aspects of the financial agreement.
- C. The Parties, as represented by their respective members of the Master Committee (Article 3.1(a) of the TMA), acknowledge that additional agreements or modifications, amendments, variations, changes, adjustments, reallocations or redistributions to the TMA or its component Schedules as may be deemed necessary in the future may be made, by Consensus decision of the Master Committee in order to more fully describe or implement this Amending Agreement ("Amending Agreement #2").

D. This Amending Agreement #2 confirms and incorporates the decisions taken by the Department pursuant to the following letters dated:

- November 16, 2007, regarding continuance of funding for the Medical Liability Reimbursement Program;
- January 25, 2008, regarding continuance of funding for: the Benefits Program including Practice Management Program ("PMP"), Physician Locum Services, and Physician and Family Support Program to levels provided in 2007/08; TOP; Primary Care Initiative program management office to June 30, 2008 to levels approved for 2007/08; and Alternate Relationship Plan ("ARP") program management office to June 30, 2008 to levels approved for 2007/08; and
- March 19, 2008, regarding continuance of funding for: Primary Care Initiative, POSP and Physician On Call to September 30, 2008; and Primary Care Initiative, POSP and ARP program management offices to September 30, 2008.
- October 14, 2008, regarding extension of all previously granted continuance provisions that are set to expire on December 31, 2008 to January 31, 2009.

E. This Amending Agreement #2 confirms and incorporates the decisions taken by Master Committee of June 6, 2008, pursuant to which the Parties agreed:

- To an extension of current continuance provisions that are set to expire on September 30, 2008 to December 31, 2008.
- To an interim rate increase for the Fee for Service Element and ARP Element of 2.5% effective April 1, 2008.
- To an interim budget for the Primary Care Initiative Element of \$112 million (\$92 million base and \$20 million for growth).
- To an interim budget for the ARP Element of \$267 million (\$237 million for base and \$30 million for growth)
- That the above items are credited to and form part of the Master Physician Budgets and are not in addition to the Master Physician Budgets.

THEREFORE, the Department, the Association and the Authorities, each by their respective duly authorized member of the Master Committee, agree each with the other as follows:

1. The Recital clauses and all attachments form part of this Amending Agreement #2.
2. Capitalized terms in this Amending Agreement #2 have the meaning described in the TMA (including applicable Schedules thereto) unless otherwise expressly stated.

For the purposes of this renegotiation (Article 11.1(b) of the TMA), Attachment 1 to this Amending Agreement #2 is appended to the original Schedule "C" to the TMA effective April 1st, 2008 and applies for the period April 1, 2008 until March 31, 2011 and describes the Master Physician Budgets for the three Fiscal Years (2008/09, 2009/10 and 2010/11).

PHYSICIAN SERVICES

Agreement to Study

3. The Parties agree to study:
 - (a) The issue of physician incremental cost of compliance with any infection, prevention and control standards imposed by law after January 1, 2008. On completion of the study, if there is a net cost of compliance, the Parties may consider these net costs under Article 8.11 and 8.12 of the TMA.
 - (b) The impact that payment rules within urgent care centres (“UCCs”) and advanced ambulatory care centres (“AACCs”) can have on practice in private community offices. On completion of the study, if there is a cost impact for private community office practice relative to practice in UCCs and AACCs, the Parties may consider this cost impact under Article 8.11 and 8.12 of the TMA.
 - (c) Issues arising under 3 (a) or (b) shall not be subject to arbitration under the TMA.

Insured Services

4. Articles 8.4 and 8.5 of the TMA are amended as follows:

Article 8.4 of the TMA is amended by deleting the word “and” in paragraph (d), and adding the following after paragraph (e):

 - “(f) 5% effective April 1, 2008;
 - (g) 5% effective April 1, 2009; and
 - (h) 4.5% effective April 1, 2010.”

Article 8.5 of the TMA is amended by deleting the word “and” in paragraph (d), and adding the following after paragraph (e):

- “(f) 3.2% population growth and utilization increase combined for the 2008/09 Fiscal Year;
- (g) 4% population growth and utilization increase combined for the 2009/10 Fiscal Year; and
- (h) 3.8% population growth and utilization increase combined for the 2010/11 Fiscal Year.”

Benefits

5. The Parties agree to amend Schedule “E” to the TMA, Appendix A, paragraph 2, Continuing Medical Education, by deleting “\$1,300” and replacing it with “\$2,500” effective in the 2008-09 budget year.
6. The Parties agree that the benefit rates within the retention Benefit Program will be increased by 10% in 2008-09 and a further 10% in 2010-11.

7. The Parties agree to establish one additional Benefit Plan within the Benefit Element to be known as the Learning Prescription Program (“LPP”).
- (a) The budget for the LPP is \$1.5 million in 2009-10 and \$3.5 million in 2010-11. This funding is included in the Benefits Element line item of Schedule C, Attachment 1.
 - (b) The LPP is established to support and promote continuous professional learning of physicians in Alberta. The criteria, program details and operational parameters will be established by the Association in consultation with the University of Alberta and the University of Calgary, and approved by the Department. The LPP funding may only be used for the LPP described herein. Notwithstanding the foregoing the Association shall, subject to Article 6.12 (b) of Schedule “E” of the TMA, have the authority to allocate a reasonable amount of the funding, for administration costs of the LPP. If LPP funding amounts larger than those allocated in the Master Physician Budget are found to be required for successful completion of the LPP, the Master Committee will bring forward a proposal to the Ministers of Health and Wellness and Advanced Education for consideration.
8. Other amounts which continue to be included in the Benefits Element are:
- (a) Funding for TOP of \$0.5 million per Fiscal Year. For clarification, in addition to this funding, the Department and the Association will continue to share the costs of the TOP program to a maximum of \$375,000 each as is already provided for in Articles 6.19 and 6.20 of Schedule “E” to the TMA.
 - (b) Funding for the PMP of \$1.8 million per Fiscal Year. Accordingly, Schedule “E” of the TMA shall apply to the PMP funding, however, Articles 5 and 11 of Schedule “G” to the TMA shall continue to apply to the PMP as applicable. PMP activities will include those activities originally contemplated in the TMA and other activities proposed by the Association and approved by the Department.

ARP Program Management Office

9. The Parties acknowledge and agree that funding for an ARP Program Management Office continues to be part of the Physician Services Budget but is not part of the Insured Services Element.

PRIMARY CARE INITIATIVE

10. The Parties agree that there is a need to provide further support for the provision of primary care in Alberta
- (a) Funding for primary care is intended by the Parties to increase access and accountability, improve outcomes and encourage continuous quality improvement. In particular, there is a need for innovative programs that will provide incentives to provide high quality care, promote the use of other professionals in concert with physicians, and continue to expand the availability of services through the Primary Care Networks. Primary Care Network (“PCN”)

base program funding includes PCN per capita funding, special/directed funding and change management funding.

- (b) In addition to PCN base program funding, the Parties agree to establish funding within the Primary Care Initiative Element for the family physician Performance and Diligence Indicator Fund (“PDI Fund”). The PDI Fund will be used by the Parties to establish a performance and diligence indicator program that will provide funding to individual family physicians, both within and outside of PCNs, who achieve specific performance and/or diligence indicators that deliver substantive clinical value. Recommendations on indicators, incentive levels, implementation, and other related matters will be developed by the Parties, through the Primary Care Initiative Committee (“PCIC”). The PCIC will involve, but not be limited to involving the multi-stakeholder Comprehensive Family Practice Strategy Steering Committee. The program proposal must be approved by Master Committee. Notwithstanding anything to the contrary, such funding shall not, in any event, exceed the amount specified in Attachment 1 to this Amending Agreement #2.
- (c) It is the intent of the Parties that the full amount of the PDI Fund will be expended within each of the budget years. The Secretariat will provide an assessment of the PDI Fund to the Master Committee by July 1, 2009 and July 1, 2010 as to whether the PDI Fund will be expended within the given budget year. If the available amounts cannot be expended on the performance and diligence indicator program, the Secretariat will be responsible for developing a plan for expenditure of the PDI Fund which supports primary care within the budget year. This plan for expenditure might include, for example:
1. Funding for PCNs.
 2. Pilot funding for a chronic disease management program.
 3. Special/directed funding for other health care providers and specialists within PCNs.
 4. Expansion of PCN coverage to additional Albertans.
 5. Increases in the payment rate in PCNs.
 6. Change management.
- (d) If the Secretariat cannot reach Consensus on a plan for expenditure, the matter will be referred to Master Committee. If Consensus cannot be reached at Master Committee, the matter will be referred to the Minister, who will resolve the matter using the following process:
1. Each Party will submit a proposal for the full expenditure of any amounts outstanding in the PDI Fund for that budget year.
 2. The Minister, after consultation with the President of the Association and the Chair of the Authorities, will consider the submitted proposals and will either choose one of the submitted proposals or initiate an alternate proposal for primary care support which will expend the PDI Fund within the budget year.

PHYSICIAN ON-CALL PROGRAM

11. The Parties confirm that Physician On-Call (POC) programs are continued through the term of the TMA.
 - a) Physician On-Call payment rates will be increased by 5% in 2009-2010 and by an additional 3% in 2010-2011, and
 - b) The Parties agree to continue to examine POC Program design. Should savings result from this review, the savings will be applied, within the established 2010-2011 POC budget, to program rates in 2010-2011.

CLINICAL STABILIZATION INITIATIVE

12. The Parties agree to amend and confirm the following items of the Clinical Stabilization Initiative Element, as identified in Amending Agreement #1, Article 5, Attachment 2:
 - (a) The under serviced area program portion of the Clinical Stabilization Initiative Element was renamed the Rural, Remote Northern Program effective September 2007. The program purposes and processes remained unchanged.
 - (b) The Business Costs Program ("BCP") is continued through the term of the TMA. A business costs study is currently underway in relation to the BCP and will provide information necessary to manage the BCP. Upon completion of the study, the Parties will re-examine the BCP.
 - (c) The Parties confirm that funding initially allocated for communities in crisis has been reallocated by the Master Committee, pursuant to its authority under Amending Agreement #1, Article 5(d), and paragraph 13 of Attachment 2, to the Rural, Remote Northern Program and the BCP to support those communities deemed by the Master Committee to meet communities in crisis criteria.

PHYSICIAN OFFICE SYSTEM PROGRAM

13. The Parties recognize that the evolution of health care informatics requires a comprehensive and integrated approach to governance and operation of the provincial health care IM/IT system to achieve the maximum value for patients and providers. Accordingly, the Parties have agreed as follows:
 - (a) POSP funding has been established to support physicians in starting to use or transitioning to POSP-eligible Electronic Medical Record ("EMR") products. The POSP budget includes the first three years of an anticipated five-year transition process to POSP-eligible EMR products.
 - (b) The POSP budget includes specific, direct financial support for physicians currently using an EMR who transition from their current EMR to one of the RFP-approved or Authority-sponsored EMRs. The initial allowance is

\$20,000 per physician for transition from one EMR solution to a different EMR solution, and \$5,000 for transition from one vendor's EMR to the same vendor but with an ASP platform. The initial allowance per physician may be subsequently modified by the POSP Committee based on experience and evidence concerning the impact on the physician's practice. The total of these transition costs are estimated at \$8.5 million in 2009-10 and \$8.5 million in 2010-11.

- (c) The Parties will better integrate POSP into the Provincial Electronic Health Record ("EHR") system by moving POSP out of the TMA by April 1, 2009. The Parties agree to work together to create an acceptable terms of reference document to facilitate the movement of POSP from the TMA, to a program operated by the Department with support and input from the EHR Governance Committee. The Parties acknowledge that appropriate representation from organized medicine will be required to guide decision making in terms of clinical impact as a result of introducing new EMRs into provider locations. Furthermore, the Parties will work towards the effective implementation of the EMR systems in provider locations, and the sharing and integration of clinical information with province wide systems.
- (d) Notwithstanding the provisions of Article 13(c) of this Amending Agreement #2, if the Parties are unable to reach agreement on moving POSP out of the TMA by April 1, 2009, it will continue under the TMA for the balance of the TMA.
- (e) The Parties confirm that POSP is a voluntary funding program for physicians. Under the TMA, the role of the POSP Committee is to manage the funding program on behalf of the Parties.
- (f) As per Article 8 of Amending Agreement #1, the Parties acknowledge that changes to POSP will be needed as part of the integration process. Accordingly, the Parties confirm and agree that the EHR Governance Committee is responsible for the overall direction and implementation of the province wide electronic health system including establishment of provincial standards and supporting processes regarding EMR and connectivity to the EHR and other related matters.

GENERAL PROVISIONS

- 14. These amendments shall be incorporated into and form part of the TMA effective the date first noted above.
- 15. In all other respects the TMA remains unchanged and shall continue in full force and effect throughout the term of the TMA.
- 16. This Amending Agreement #2 may be executed in any number of counterparts each of which, when so executed and delivered to the Department, shall be deemed to be an original and all such counterparts shall constitute one and the same instrument and, notwithstanding the date of actual execution, shall be deemed effective as of the date first

noted above. A facsimile copy of such counterpart signature when received by the Department shall be deemed to be as valid as an originally executed counterpart.

The Association, the Authorities, and the Department have executed this Amending Agreement #2 by their respective representatives, all such executions to be effective as of the date first noted above, notwithstanding the dates of signature below.

Representing Alberta Health
and Wellness

Representing the Alberta
Medical Association

Representing the Regional
Health Authorities

Jan 30/09.
Date

Jan 30, 2009
Date

Jan 30, 2009
Date

Attachment I
AS AMENDED EFFECTIVE April 1, 2008
SCHEDULE "C"
MASTER PHYSICIAN BUDGETS
FISCAL YEARS 2008-09 TO 2010-11

	2008-09	2009-10	2010-11
	\$'000		
PHYSICIAN SERVICES BUDGET			
<u>Insured Services</u>			
Fee for Service			
Base	1,817,100	1,895,400	2,029,100
Base Transfer	(52,000)	(17,300)	-
Rate Increase	90,900	94,800	91,400
Volume Increase	39,400	56,200	56,700
<i>Sub-total</i>	1,895,400	2,029,100	2,177,200
Alternate Relationship Plans			
Base	183,700	273,400	338,500
Base Transfer	52,000	17,300	-
Rate Increase	9,200	13,800	15,400
Volume Increase	28,500	34,000	37,500
<i>Sub-total</i>	273,400	338,500	391,400
Insured Services Total	2,168,800	2,367,600	2,568,600
<u>Benefits</u>	88,900	86,500	68,700
<u>ARP Program Management Office</u>	1,800	1,800	1,800
PHYSICIAN SERVICES BUDGET TOTAL	2,259,500	2,455,900	2,639,100
PRIMARY CARE INITIATIVE			
Base Program	119,800	142,400	149,025
Performance and Diligence Indicator Fund	-	14,650	22,480
PRIMARY CARE INITIATIVE TOTAL	119,800	157,050	171,505
PHYSICIAN ON-CALL	82,000	87,150	90,795
CLINICAL STABILIZATION INITIATIVE	92,700	98,800	105,100
MASTER PHYSICIAN BUDGET (before POSP)	2,554,000	2,798,900	3,006,500
PHYSICIAN OFFICE SYSTEM PROGRAM	38,000	65,100	65,500
MASTER PHYSICIAN BUDGET (including POSP)	2,592,000	2,864,000	3,072,000