HIS MAJESTY THE KING IN RIGHT
OF THE PROVINCE OF NEW BRUNSWICK,
as represented by the MINISTER OF HEALTH

- and -

THE NEW BRUNSWICK MEDICAL SOCIETY

PHYSICIAN SERVICES AGREEMENT

Effective April 1, 2025

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Schedules:

PHYSICIAN SERVICES AGREEMENT

THIS AGREEMENT is made effective the 1st day of April, 2025

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK, as represented by the **MINISTER OF HEALTH**, (the "**Minister**")

- and -

THE NEW BRUNSWICK MEDICAL SOCIETY, a body corporate existing pursuant to the *Medical Act*, SNB 1981, c. 87 as amended (the "**Society**")

WHEREAS:

A. the Minister is the provincial authority under the *Medical Services Payment Act,* RSNB 1973, c. M-7 (the "**Act**");

B. under subsection 4.1(1) of the Act, the Minister, with the approval of the Lieutenant-Governor in Council, is authorized to enter into an agreement with the Society respecting the payment for furnishing entitled services on a fee for service basis in accordance with a tariff or a system of payment that provides reasonable compensation to medical practitioners;

C. the Society is the professional association of medical practitioners in New Brunswick and is authorized to negotiate on their behalf and enter into an agreement with the Minister pursuant to subsection 4.1(1) of the Act respecting payment for furnishing entitled services on a fee for service basis;

D. the Parties have negotiated an agreement for payments to and for the benefit of Physicians furnishing entitled services on a fee for service basis for the period April 1, 2025 to March 31, 2029, including changes to the Tariff;

E. the Minister, pursuant to his authority under the Act and the *Financial Administration Act*, RSNB 2011, c. 160 (the "**FAA**"), and the Society, on behalf of Physicians remunerated pursuant to the Medical Pay Plan, (i) have agreed upon a process for negotiating certain elements of remuneration and other terms of service for those Physicians and for resolving related disputes, and (ii) pursuant to such process, have negotiated an agreement for payments to and for the benefit of those Physicians; and

F. the Lieutenant-Governor in Council has granted approval to the Minister to enter into this Agreement;

THIS AGREEMENT WITNESSES that the Parties have agreed as follows:

PART A - GENERAL PROVISIONS

1.0 INTERPRETATION

1.1 Definitions

In this Agreement, terms defined in the Act and not otherwise defined herein have the meanings assigned to them in the Act, and:

"**Academic Funding Plan**" means a contractual agreement between the Minister, Physicians, and organizations such as Regional Health Authorities and universities, under which the Physician is remunerated through a fixed funding formula in exchange for meeting agreed upon deliverables for patient care, clinical coverage, and research and academic work;

"**Act**" has the meaning assigned in the recitals to this Agreement;

"**Agreement**" means this agreement, including all Schedules referenced in **Section 1.4**, as it may be modified, amended, supplemented or restated by written agreement between the Parties;

"**AFP**" refers to a contractual agreement between the Minister and Physicians, including Academic Funding Plans and Alternate Funding Plans, and any other alternative funding plans agreed to by the Parties pursuant to **section 8.0**, under which Physicians are remunerated on an alternative funding basis in exchange for meeting agreed upon deliverables.

"**Alternate Funding Plan"** means a contractual agreement between the Minister, Physicians, and Regional Health Authorities, under which Physicians are remunerated on a funding pool basis in exchange for meeting agreed-upon deliverables for patient care and clinical coverage;

"**Board of Management**" means the Board of Management or any successor as established under the FAA;

"**Capitation**" means fixed per-patient payments to FFS Physicians, calculated using the approved age/gender ratio under a primary-care compensation model, for each rostered patient.

"**CPD**" means continuing professional development as described in **Schedule A**;

"**CMPA**" means the Canadian Medical Protective Association **Schedule B**;

"**Contract Year**" means a year during the Term commencing on April 1 of a calendar year and ending on March 31 of the next calendar year;

"**Dedicated Funding Pool**" means a funding pool for a specific program in respect of which any surpluses are maintained by the Society within that program and are not available for alternate use or reallocation;

"**Distribution**" means the allocation of the FFS GEI Amount for each Contract Year in accordance with the process described in **Section 4.0**;

"**Effective Date**" means April 1, 2025;

"**FAA**" has the meaning assigned in the recitals to this Agreement;

"**FFS Claims**" means accounts submitted by Physicians in accordance with the Tariff;

"**FFS Physician**" means a Physician who furnishes entitled services on a fee for service basis;

"**FFS**" means the basis of remuneration of Physicians, including all payments, reimbursements and benefits, in accordance with (i) the Tariff, (ii) Sessional Rates, (iii) Academic Funding Plans, (iv) Alternate Funding Plans, and (v) other funding programs, as provided in **Part B** and the corresponding Schedules to this Agreement;

"FFS Retention Fund means the fund established in accordance with **Schedule H**;

"**General Economic Increase**" or "**GEI**" means the annual percentage increase in funding to be applied in each Contract Year as set out in **Section 3.6** for funding for FFS Physicians and in **Section 10.3.2** for funding for MPP Physicians;

"**MPP Physician**" means a Physician who is remunerated according to the Medical Pay Plan on a non-fee for service basis, including:

(a) new salaried Physicians;

(b) established salaried Physicians;

(c) established Physicians who have personal service contracts;

(d) established Physicians who have professional service contracts; and

(e) any other Physicians as may be agreed in writing between the Parties;

"**Medical Pay Plan**" or "**MPP**" means the New Brunswick Medical Pay Plan and the Addendum to the Medical Pay Plan that set out the remuneration arrangements for MPP Physicians, as set out in **Schedule W**;

"**Negotiation DRP**" means the dispute resolution process established and defined in the *Negotiation and Dispute Resolution Regulation - Medical Services Payment Act*, New Brunswick Regulation 2002-53;

"**New Service Item**" means a proposed fee code for a new procedure, technology or technique, proposed by the Minister or the Society, to be included in the Tariff;

"**Non-Resident Claim**" means a claim for payment of amounts in respect of the cost of entitled services furnished to a non-resident of the Province, as contemplated under the Act;

"**Parties**" means the parties to this Agreement, and "**Party**" means one of them;

"**Physician**" means a participating medical practitioner, as defined in Regulation 84-20 under the Act, including a FFS Physician and a MPP Physician;

"**Predecessor Agreement**" means the Physician Services Master Agreement between the Parties made effective April 1, 2020;

"**Protected Funding Pool**" means a funding pool in respect of which Residuals are available for Redistribution in accordance with **Section 6.4**;

"**Redistribution**" means the alternate use or reallocation of Residuals available to the Society from Protected Funding Pools, in accordance with **Section 6.4**;

"**Regional Health Authority" or "RHA**"" means a regional health authority established under the RHAA;

"**Residual**" means any surplus funds from a Protected Funding Pool available for alternate use or reallocation by the Society following the annual reconciliation by the Minister;

"**RHAA**" means the *Regional Health Authorities Act*, RSNB 2011, c. 217;

"**Sessional Rates**" means payment rates set on an hourly basis for Physicians rendering entitled services, as may be approved by the Minister;

"**Tariff**" has the meaning assigned in **Section 5.1**;

"**Term**" has the meaning assigned in **Section 2.2**; and

other capitalized terms have the meanings given to them in the body of this Agreement.

1.2 Certain Rules of Interpretation

In this Agreement, (i) words importing the singular include the plural and vice versa, and words importing a particular gender include all genders, (ii) the word "including" means "including without limitation", (iii) where a term is defined herein, a capitalized derivative of such term has a corresponding meaning unless the context otherwise requires, (v) headings are for convenience of reference only and shall not affect the construction or interpretation of this Agreement, and (vi) unless otherwise indicated, references to a Part, Section or Schedule followed by a number or letter refer to the specified Part, Section or Schedule of this Agreement.

1.3 No Drafting Presumption

The Parties acknowledge that their respective legal advisors have reviewed and participated in settling the terms of this Agreement and agree that any rule of construction to the effect that any ambiguity is to be resolved against the drafting party shall not apply to the interpretation of this Agreement.

1.4 Schedules

The following are the Schedules attached to and incorporated by reference in this Agreement, which are deemed to be part hereof:

Schedule A	-	Continuing Professional Development
Schedule B	-	Canadian Medical Protective Association
Schedule C	-	Mandated On-Call Programs
Schedule D	-	Parental Leave Program
Schedule E	-	Supplementary Honoraria Program
Schedule F	-	Medicare Assessment Framework
Schedule G	-	New Brunswick Primary Care Models
Schedule H	-	FFS Retention Fund
Schedule I	-	Joint Oversight Committee
Schedule J	-	Specific Funding Items
Schedule K	-	Distribution Document
Schedule L	-	Electronic Medical Records Program
Schedule M	-	Principles of Consultation Billings
Schedule N	-	Closed Intensive Care Unit Alternate Funding Options
Schedule O	-	FFS and MPP Base Amounts
Schedule P	-	Practice Support Program
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Schedule V	-	Family Medicine New Brunswick Program – Transitional
Schedule W	-	Medical Pay Plan and Addendum to Medical Pay Plan
Schedule X	-	Other Items
Schedule Y	-	New Brunswick Primary Care Network
Schedule Z	-	Hospitalist Program
Schedule AA	-	Virtual Care
Schedule BB	-	New Brunswick Emergency Care Funding

2.0 SCOPE OF AGREEMENT

2.1 Purpose of Agreement

This Agreement:

2.1.1 with respect to FFS Physicians under **Part B**, is an agreement pursuant to subsection 4.1(1) of the Act respecting the payment in accordance with the Tariff and other systems of payment which the Parties agree will provide reasonable compensation to FFS Physicians for furnishing entitled services on a fee for service basis; and

2.1.2 with respect to MPP Physicians under **Part C**, sets out the agreement of the Minister, pursuant to his authority under the Act and the FAA, and the Society, as authorized representative of and negotiating agent for Physicians remunerated pursuant to the Medical Pay Plan on other than a fee for service basis:

2.1.2.1 as to a process for negotiating specified elements of reasonable compensation and other terms of service for MPP Physicians with a view to reaching an agreement on those elements of compensation and terms of service, and for resolving disputes which may arise during the course of such negotiations, as set out in **Part C**; and

2.1.2.2 in respect of those elements of compensation and other terms of service during the Term, as set out in **Part C**.

2.2 Term of Agreement

2.2.1 This Agreement is effective as of the Effective Date and will remain in force until the date on which it is replaced by another agreement (the "**Term**").

2.2.2 For the purposes of the Negotiation DRP only, the "termination date" of this Agreement is March 31, 2029.

PART B - FFS PHYSICIANS

3.0 BASIS OF COMPENSATION

3.1 Additional Definitions

In this **Section 3.0**:

"**Applicable Agreement**", where such term appears in **Section 3.2**, means (i) the Predecessor Agreement, when determining the FFS Base Amount in respect of the 2025-2026 and 2026-2027 Contract Years, and (ii) this Agreement, when determining the FFS Base Amount in respect of each of the remaining Contract Years;

"**Applicable Reference Year**" means, for a Contract Year, the period associated with that Contract Year in the following table:

Contract Year	Applicable Reference Year
2027-2028	April 1, 2025 – March 31, 2026
2028-2029	April 1, 2026 – March 31, 2027

The Parties acknowledge that the Applicable Reference Year fiscal information shall provide a reference point to assist in estimating the FFS Base Amount for each Contract Year, in accordance with Section 3.2. All estimates shall be inclusive of negotiated resource adjustments and GEI (as set out below in **sections 3.3, 3.4 and 3.6**), and increased services provided.

"**Cash Payments**" means actual payments made by the Minister in a fiscal year;

"**FFS Base Amount**" means the amount in respect of a Contract Year determined in accordance with **Section 3.2**;

"**FFS Funding Base**" means, for each Contract Year, the total amount of the funding the Minister will make available during that Contract Year for payments under this **Part B**, calculated in accordance with **Section 3.7.2**;

"**FFS GEI**" means, with respect to a Contract Year, the GEI for that Contract Year set out in **Section 3.6**;

"**FFS GEI Amount**" means the amount for a Contract Year calculated in accordance with **Section 3.7.1**; and

"FFS Payments" means Cash Payments to Physicians at Applicable Reference Year Tariff Rates excluding payments for Non-Resident Claims, and excluding payment of claims under **Sections 3.2.2** to **3.2.17**.

3.2 FFS Base Amount

The FFS Base Amount in respect of a Contract Year is the aggregate of the following Cash Payments made or funding allocated by the Minister during or in respect of the Applicable Reference Year for that Contract Year:

3.2.1 FFS Payments;

3.2.2 manual payments to Physicians including:

3.2.2.1 payments at agreed Sessional Rates;
3.2.2.2 any other manual payments; and
3.2.2.3 payments to FFS Physicians related to the Access Initiative (Collaborative Practice) Program;

3.2.3 fund for Alternate Funding Plans, including annualization of changes made during the Applicable Reference Year;

3.2.4 fund for Academic Funding Plans, including annualization of changes made during the Applicable Reference Year;

3.2.5 upward or downward adjustments to budgeted funds resulting from transfers of Physicians from one type of remuneration to another during the Applicable Reference Year (including annualization for the Applicable Reference Year);

3.2.6 payments for CPD expenses as described in **Schedule A** to the Applicable Agreement;

3.2.7 fund for reimbursement of CMPA medical liability protection premiums for FFS practice as described in **Schedule B** to the Applicable Agreement;

3.2.8 funding for Mandated On-Call Programs as described in **Schedule C** to the Applicable Agreement;

3.2.9 fund for the Parental Leave Program as described in **Schedule D** to the Applicable Agreement;

3.2.10 fund for Supplementary Honoraria as described in **Schedule E** to the Applicable Agreement;

3.2.11 funding for Collaborative Care Clinic Interdisciplinary Care Coordination Fee as described in **Schedule G** to the Applicable Agreement;

3.2.12 fund for the FFS Retention Fund as described in **Schedule H** to the Applicable Agreement;

3.2.13 fund for the Electronic Medical Records program as described in **Schedule L**;

3.2.14 fund for the Practice Support Program, as described in **Schedule P**;

3.2.15 fund for the Physician Wellness Program as described in **Schedule S**;

3.2.16 payments for Capitation under the Family Medicine New Brunswick Program or any other primary care compensation model listed in **Schedule G**, or panel payments made to Physicians for rostered patients, introduced November 1, 2024, and discontinued under this Agreement; and

3.2.17 any other funding as agreed to in writing by the Parties.

3.3 <u>Resource Adjustment – FFS Medical and Surgical Specialists</u>

Effective April 1, 2025, the Minister shall increase the FFS Funding Base for the 2025-2026 Contract Year with a one-time resource adjustment of 12%, targeted to medical and surgical

specialties which shall then become part of the recurring FFS Base Amounts in subsequent years, as set out in **Schedule J**.

3.4 Resource Adjustment – FFS Family Medicine Specialists

Effective April 1, 2025, the Minister shall increase the FFS Funding Base for the 2025-2026 Contract Year with a one-time resource adjustment of 18%, targeted to the family medicine specialty which shall then become part of the recurring FFS Base Amounts in subsequent years, as set out in **Schedule J**.

3.5 FFS Base Amounts

The Parties agree that the FFS Base Amount for the purposes of calculating the FFS Funding Base for the **2025-2026 Contract Year** will be **$756,050,578.00** based on the estimated amounts set out and agreed upon in **Schedule O,** and estimated funding allocated by the Minister for the 2025-2026 Contract Year, as summarized in **Schedule J**.

The Parties agree that the FFS Base Amount for the purposes of calculating the FFS Funding Base for the **2026-2027 Contract Year** will be **$900,293,661.00** based on the estimated amounts set out and agreed upon in **Schedule O,** and estimated funding allocated by the Minister for the 2026-2027 Contract Year, as summarized in **Schedule J**.

The Parties Agree that the FFS Base Amount for the purposes of calculating the FFS Funding Base for the **2027-2028 Contract Year** and the **2028-2029 Contract Year** will be agreed upon by the Parties for each respective Contract Year, including estimated funding allocated by the Minister as summarized in **Schedule J.**

The Parties agree to use diligent efforts to calculate the FFS Funding Base for the 2027-2028 and 2028-2029 Contract Years within a reasonable timeframe, to support timely payment to Physicians through the Distribution process set out under section 4.0, herein.

3.6 FFS General Economic Increase

The FFS GEI for each Contract Year is as follows:

Contract Year	GEI
2025-2026	2.5 %
2026-2027	3.5 %
2027-2028	2.5 %
2028-2029	4.0 %

3.7 FFS GEI Amount and FFS Funding Base

For each Contract Year:

3.7.1 the FFS GEI Amount is the amount calculated by multiplying the FFS Base Amount in respect of that Contract Year by the FFS GEI for that Contract Year; and

3.7.2 the FFS Funding Base is the FFS Base Amount in respect of that Contract Year plus the FFS GEI Amount for that Contract Year.

3.8 Funding by the Minister

The Minister will provide the FFS Funding Base for each Contract Year for payment of FFS Physician accounts for entitled services furnished on a fee for service basis, and for payment in respect of the other services and programs described in this **Part B** and the associated Schedules.

3.9 Agreed Funding Items

The Parties acknowledge that **Schedule J** sets out specific funding items as agreed to by the Parties and the amount of the funding as agreed or estimated for those items. The Parties further acknowledge that **Schedule J** contains estimates based on information available and circumstances which exist at the time of execution of this Agreement and are subject to changes based on the information available, for the applicable fiscal years.

4.0 DISTRIBUTION OF FFS GEI AMOUNT

4.1 Basis of Distribution

The Distribution of the FFS GEI Amount for each Contract Year to the budgeted amounts for FFS payments pursuant to particular items of the Tariff and to other programs and expenses funded by the Minister under this **Part B** will be as mutually agreed in writing by the Parties or as otherwise determined pursuant to this **Section 4.0**.

4.2 GEI Targeted Funding Initiatives under Predecessor Agreement

Under the Predecessor Agreement, several targeted funding initiatives were established. Under this Agreement, the Parties agree to utilize specific recurring funding associated with these GEI targeted funding initiatives as follows:

4.2.1 *Primary care task force* – $250,000 per year allocated to this initiative shall be transitioned and utilized under the newly established *Practice Support Program*, described in **Schedule P**;

4.2.2 *Coronary Intensive Care Unit (CICU)* - $1,750,000.00 per year allocated to this initiative shall be continued for the purposes of establishing a CICU AFP. If the

CICU AFP is not yet established, the Society shall notify the Minister in writing of the intended use of this funding.

4.3 Distributions

4.3.1 *Distribution Proposals* - As soon as practicable after the Applicable Reference Year data pursuant to **Section 3.2** is available for a Contract Year (each an "**Applicable Contract Year**"):

4.3.1.1 the Minister will notify the Society of the FFS Base Amount and the GEI Amount for the Applicable Contract Year; and

4.3.1.2 the Parties shall exchange written proposals setting out their respective priorities with respect to the Distribution of the FFS GEI Amount (each a "**Distribution Proposal**") for the Applicable Contract Year.

4.3.2 *Negotiation of Distribution* - Following the exchange of Distribution Proposals pursuant to **Section 4.3.1** and any amendments thereto, the Parties shall negotiate in good faith to reach agreement upon the Distribution for the Applicable Contract Year.

4.3.3 *Dispute Resolution* - If the Parties fail to agree in writing on the Distribution for the Applicable Contract Year by no later than December 31 of the Applicable Contract Year, either Party may submit the outstanding issues for determination pursuant to the Negotiation DRP.

4.4 Incorporation and Application of Distributions

4.4.1 *Incorporation of Distribution* - When the Distribution for a Contract Year is (i) mutually agreed in writing by the Parties, or (ii) finally determined pursuant to the Negotiation DRP, as the case may be, the Distribution for that Contract Year as so agreed or determined will thereupon be incorporated in and form part of this Agreement. The Parties will promptly cause the terms of the Distribution to be set forth in and appended as **Schedule K**, or an amended **Schedule K**, to this Agreement.

4.4.2 *Application of Distribution* - The final Distribution for a Contract Year, as agreed or determined pursuant to **Section 4.3**, will be applied retroactively, if and as applicable, to all transactions affected by the Distribution that occurred on and after the first day of the Contract Year, and all resulting supplementary payments to FFS Physicians and other financial adjustments will be promptly made.

5.0 TARIFF

5.1 Adoption of Tariff

The *New Brunswick Physicians' Manual* in the form mutually agreed in writing by the Parties, or otherwise determined pursuant to this Agreement, to be in effect from time to time (the "**Tariff**"):

5.1.1 is incorporated in and forms an integral part of this Agreement;

5.1.2 will contain the schedule of fees, amended as outlined in **Schedule K**, including the terms and conditions applicable to the schedule of fees, to be used by Physicians to guide their submission of FFS Claims to the Minister; and

5.1.3 is intended to provide reasonable compensation to Physicians for the entitled services furnished by them on a FFS basis.

The Tariff will be revised and re-published periodically by the Minister whenever changes to FFS items resulting from a Distribution pursuant to **Section 4.0** or other negotiated amendments to the Tariff come into effect.

5.2 Payments under the Tariff

The Minister agrees to assess FFS Claims submitted by and to make payments to Physicians in accordance with the Tariff for services on a Fee for service basis.

5.3 Joint Oversight Committee

The NBMS/DH Joint Oversight Committee shall be continued under **Schedule I.**

5.4 New Service Items Negotiation Process

The New Service Items negotiation process is as defined in **Schedule Q**.

5.5 Fee Code Review

The Parties agree that the work of the **Fee Code Review Committee** (previously referred to as the "Oversight Committee" established under the *2014-2016 Physician Services Master Agreement* and continued under section 5.4 of the Predecessor Agreement, to oversee the review of the Tariff and associated fees) shall be referred to the **Joint Oversight Committee** (as continued under **Schedule I**) to recommend how that work might be most efficiently completed.

6.0 NON-TARIFF ITEMS

6.1 Program Funding

General - The following programs and other non-Tariff items under this Agreement and the Predecessor Agreement, as amended if applicable, are continued during the Term of this Agreement upon and subject to the terms and conditions contained in the respective Schedules:

6.1.1 Continuing Professional Development for Private Practice Physicians as set out in **Schedule A**;

6.1.2 CMPA Program of Compensation for Medical Liability Protection Premiums Fee for Service/Private Practice as set out in **Schedule B**;

6.1.3 Mandated On-Call Programs as set out in **Schedule C**;

6.1.4 Parental Leave Program for FFS Physicians as set out in **Schedule D**;

6.1.5 Supplementary Honoraria Program as set out in **Schedule E**;

6.1.6 FFS Retention Fund Program as set out in **Schedule H**;

6.1.7 The Electronic Medical Records Program, as set out in **Schedule L**;

6.1.8 The Practice Support Program, as set out in **Schedule P**;

6.1.9 Remuneration for Surgical Cancellations, as set out in **Schedule R**;

6.1.10 Physician Wellness Program, as set out in **Schedule S**;

6.1.11 Family Medicine New Brunswick – Transitional, as set out in **Schedule V**;

6.1.12 The New Brunswick Primary Care Network shall be implemented as set out in **Schedule Y**; and

6.1.13 The New Brunswick Hospitalist Program shall be amended and continued as set out in **Schedule Z**.

6.2 Business Continuity Plan

In the event a Physician is unable to work due to a mandatory isolation requirement imposed by either the RHA or a government authority, they will be eligible to apply for compensation.

Compensation will be based on the average of the physician's Medicare FFS earnings for the same period of the previous year.

This measure would only apply during a pandemic, global health emergency or a similar provincial or national public health crisis deemed to meet this threshold by both Parties to this Agreement.

6.3 Virtual Care

The Parties agree to permanently enable virtual care in New Brunswick as set out within **Schedule AA.** The Parties further agree to expand the provincial eConsult program as set out within **Schedule AA.**

6.4 Residual Program Funding

Protected Funding Pools - Protected Funding Pool balances shall be reconciled annually by the Minister and any surplus in a Protected Funding Pool shall be available to the Society as agreed by the Parties for alternate use or reallocation. Any over-expenditure of a Protected Funding Pool shall be funded with the existing surplus from other Protected Funding Pools, or shall be recovered from the following year's Distribution if no funding is available in the current year. As of the Effective Date, the Protected Funding Pools are as follows:

6.4.1 Mandated On-Call;
6.4.2 Second Call;
6.4.3 Province Wide Call;
6.4.4 Supplementary Honoraria; and
6.4.5 Physician Wellness Program.

Effective April 1, 2026, the Minister shall continue to manage the funding associated with On-Call Programs as set out in **Schedule C**, and the current annual reconciliation process and calculation of any residual payments for the Mandated, Second and Province Wide On-Call programs will be discontinued.

Dedicated Funding Pools - As of the Effective Date, the Dedicated Funding Pools where surpluses are maintained by the Society within those individual programs and are not available for alternate use or reallocation are as follows:

6.4.6 Parental Leave;
6.4.7 Practice Support Program;
6.4.8 CMPA; and
6.4.9 EMR Program.

6.5 Other Funding

The Parties agree that Emergency Department funding shall be set out in **Schedule BB**.

7.0 OTHER FFS PROVISIONS

7.1 Costing of New Initiatives

7.1.1 *New Initiatives/Fees* - Any funding shortfall resulting from a variance between actual and estimated costs of a new initiative or fee negotiated during the term of this Agreement shall be recovered through the following Contract Year's Distribution unless it is a new initiative or service introduced by the Minister, and any surplus will be available for alternate use or reallocation in the following Contract Year.

7.1.2 *Distribution* - Any funding shortfall resulting from new service codes introduced through Distribution shall be recovered through the following Contract Years' Distribution, and any surplus will be available for alternate use or reallocation in the following Contract Year. This does not apply to increases in existing fee codes through the fee Distribution process.

7.1.3 *Protected Funding Pools* - Any funding shortfall in the total amount available for Protected Funding Pools shall be recovered through the following Contract Year's Distribution, and any surplus will be available for alternate use or reallocation in the following Contract Year.

7.2 Physicians Providing Locum Services after Payout from FFS Retention Fund

The following guidelines apply to Physicians who wish to provide locum services after collecting their payout from the FFS Retention Fund:

7.2.1 Physicians may bill Medicare for locum services for a maximum of five years after payout from the FFS Retention Fund;

7.2.2 Physicians who have accepted their payout from the FFS Retention Fund will not be eligible for a minimum guarantee as per the relevant Medicare Locum Policy;

7.2.3 Physicians must provide Medicare with an acceptable transition plan for patients or their practice; and

7.2.4 Locums may earn a maximum of $75,000 annually. The only exception to the $75,000 annual income is if the locum is covering a parental leave, in which case no maximum annual earnings apply.

7.3 Sole Payment

The Parties agree to co-operate to ensure that their agreement with respect to the amounts to be paid to any FFS Physician (for services provided to beneficiaries on an opted-in basis), both under the Tariff pursuant to **Section 5.0** and for non-Tariff payments pursuant to **Section**

6.0, will be the sole payment by the Minister or any other provincial authority for or in respect to such Tariff and non-Tariff items.

7.4 Reciprocal Agreement with Quebec

The Parties acknowledge and recognize that (i) New Brunswick and Quebec share patients and medical services, yet there is no medical reciprocal agreement addressing how these services are remunerated, and (ii) the Department of Health has no ability to bind the Province of Quebec to any agreement, and that there are other jurisdictional and legal issues requiring consideration relative to this item. The Minister agrees to cause the Department of Health to endeavor to explore the potential for negotiating a medical reciprocal agreement with the Province of Quebec.

7.5 Other FFS and MPP Items

The Parties agree to the other items set forth in **Schedule X**.

8.0 ALTERNATE MODELS OF REMUNERATION

8.1 New Alternative Funding Plans

The Parties agree to follow the process set out in **Schedule T** for negotiating and establishing AFPs as alternate models of remuneration.

8.2 Closed Intensive Care Unit – Alternate Funding Plans

The Parties agree to eliminate the terms and conditions in Schedule N of the Predecessor Agreement. The Parties agree that all Closed ICU AFPs shall continue in force and effect subject only to each hospital's individual respective AFP agreement, and the new rates of funding set out within **Schedule N** to this Agreement.

8.3 Saint John Regional Hospital Intermediate Medical Care Unit – Alternate Funding Plan

The Parties agree to eliminate the terms and conditions in Schedule P of the Predecessor Agreement. The Parties agree that the Saint John Regional Hospital Intermediate Medical Care Unit AFP shall continue in force and effect subject only to the existing AFP agreement as amended from time to time in accordance with the process set out in **Schedule T**.

8.4 No Arbitration

All newly proposed AFPs requested during the Term shall require consultation between the Parties. Where the Parties fail to reach agreement on a newly proposed AFP, it will be deferred to the following round of negotiations. Failure to reach agreement on a newly proposed AFP will not be subject to any form of arbitration outside FFS negotiations.

8.5 New Funding

Any additional requests for alternate models of remuneration may be funded through Distribution. New funding may also be approved through mutual agreement of the Parties.

PART C - MPP PHYSICIANS

9.0 NEGOTIATION PROCESS FOR MPP PHYSICIANS

9.1 General

The Minister and the Society will negotiate the matters that are subject to negotiation pursuant to **Section 9.2**, and if applicable will resolve any dispute arising from such negotiations, following a process substantially the same as the process for negotiating and resolving disputes with respect to an agreement under subsection 4.1 of the Act, as set out in the Negotiation DRP. This **Section 9.0** will apply to the negotiation of, and if applicable the dispute resolution process for, the extension or renewal of, or successor agreement to, this **Part C**.

9.2 Matters Subject to Negotiation

Subject to **Section 9.3**, the matters subject to negotiation and dispute resolution under this **Part C** generally include the Medical Pay Plan, including general increases, certification increases, changes and Addendums thereon, and the provisions of the related New Brunswick Policy for Physicians on the Medical Pay Plan, including the following:

9.2.1 Remuneration matters limited to the following:

9.2.1.1 salary;

9.2.1.2 remuneration levels;

9.2.1.3 compensation for:

9.2.1.3.1 On-call stipend

9.2.1.3.2 mandated On-call services;

9.2.1.3.3 mandated second call;

9.2.1.3.4 called in when not participating in On-call;

9.2.1.3.5 on-site coverage in psychiatric facilities of Centracare and Restigouche;

9.2.1.3.6 autopsy fees (type 1 and 2); and

9.2.1.3.7 Provincial-Wide On-call;

9.2.2 Non-Clinical Funding

9.2.2.1 CMPA; and

9.2.2.2 CPD programs;

9.2.3 Patient Rounds;

9.2.4 Working on Statutory Holidays;

9.2.5 Working excessive hours;

9.2.6 FFS Program Threshold;

9.2.7 FFS Program Guidelines;

9.2.8 Accountability Benchmarks;

9.2.9 Locums; and

9.2.10 Office Overhead and Personnel.

9.3 Matters not Subject to Negotiation

The matters not subject to negotiation and dispute resolution under this **Part C** are as follows:

9.3.1 Clinical Department Heads;

9.3.2 Supervisory Allowance;

9.3.3 Part Time Positions;

9.3.4 Other Physician Responsibilities;

9.3.5 Subject to **Section 9.4.5**, vacation and other leaves (including sick leave);

9.3.6 Insured Benefits (Health and Dental benefits);

9.3.7 Long Term Disability Benefits;

9.3.8 Shadow Billing;

9.3.9 Research;

9.3.10 Statutory Deductions;

9.3.11 Ownership of Materials;

9.3.12 Medicare Funded Positions;

9.3.13 Return of Service on Incentives;

9.3.14 Relocation Expenses;

9.3.15 Monitoring and Compliance / Practitioner Audits; and

9.3.16 The New Brunswick Shared-Risk Pension Plan.

9.4 Agreed Upon Matters

The Parties acknowledge and agree the following principles govern negotiations and the resulting agreement under this **Part C**:

9.4.1 The current Medical Pay Plan in place for MPP Physicians will remain in effect until revised, renewed or amended in accordance with this Agreement, or by mutual written agreement between the Parties.

9.4.2 The starting point for the negotiation of the remuneration and compensation for MPP Physicians will be the current Medical Pay Plan and the then-existing levels of remuneration and compensation.

9.4.3 The MPP GEI will include any negotiated adjustments to existing programs and any funding for new initiatives negotiated by the Parties.

9.4.4 The criteria for Physician reimbursement under the CME and CMPA programs will be standardized and consistent for both MPP Physicians and FFS Physicians.

9.4.5 Vacation Leave credits for MPP Physicians are accumulated as outlined in the current Addendum to the Medical Pay Plan. There shall be no changes to the existing Vacation Leave benefits without the express written agreement of both Parties.

9.4.6 MPP Physicians who are full-time (i.e., 1.0 full-time equivalent), are expected to work 37.5 hours per week. The hours of work shall normally be provided between 0800 and 1800 hours, Monday to Friday, unless otherwise agreed to between the MPP Physician and the applicable Regional Health Authority. There shall be no changes to existing Normal Hours of Work without the express written agreement of both Parties.

9.5 Approvals and Ratification

The Parties acknowledge and agree that any agreement reached under the process outlined in this **Section 9.0** will be subject to approval by the Board of Management, and ratification and approval by the Society's members and Board of Directors.

9.6 Limit to Negotiations

The Parties acknowledge and agree that the basis of remuneration for MPP Physicians on matters outlined in **Section 9.2** have been agreed upon and reflected in **Section 10.0** and will not be subject to re-negotiation under this **Section 9.0** during the Term.

10.0 BASIS OF REMUNERATION

10.1 General

The Parties acknowledge and agree that the basis of remuneration and other terms of service for MPP Physicians set out in this **Section 10.0** have been negotiated and agreed to by the Parties in accordance with the provisions of **Section 9.0**.

10.2 Additional Definition

In this **Section 10.0,** "**MPP GEI**" means, with respect to a Contract Year, the GEI for that Contract Year as set out in **Section 10.3.2**.

10.3 Basis of Remuneration - MPP Physicians

10.3.1 MPP Resource Adjustment:

Effective April 1, 2025, the Minister shall increase the Medical Pay Plan with a one-time resource adjustment for MPP physicians, as set out below, and as reflected in **Schedule W**:

MPP Category	Resource Adjustment
Family Medicine Specialist	17%
Certified/Non-Certified Specialists	12%
Medical Officers of Health	12%
Clinical Assistants	7.5%

10.3.2 MPP General Economic Increase:

The MPP GEI for each Contract Year is as follows:

Contract Year	GEI
2025-2026	2.5%
2026-2027	3.5%
2027-2028	2.5%
2028-2029	4.0%

10.3.3 MPP Physician Remuneration:

MPP Physicians will be remunerated in accordance with the Medical Pay Plan as adjusted annually as of the first day of each Contract Year by the applicable Contract Year's MPP GEI, as set out in **Schedule W**.

10.4 Funding by the Minister

The Minister will provide funding to the Regional Health Authorities pursuant to the RHAA to pay the MPP Physicians in accordance with the Medical Pay Plan utilizing the adjusted rates for the applicable Contract Year.

11.0 DISPUTES

11.1 Definition

In this **Section 11.0**, "**Dispute**" means any difference, controversy or dispute between the Parties as to any matter arising out of or related to this Agreement, including without limitation, the validity, interpretation, application, administration, enforcement or termination of this Agreement, the rights or liabilities of the Parties hereunder, any failure to agree where agreement between the Parties is called for, or any claim whatsoever arising out of any alleged failure to perform or breach of obligations under this Agreement, but excluding any matter or dispute that is required by this Agreement to be resolved pursuant to the Negotiation DRP.

11.2 Notice of Dispute

If a Party considers that there is a Dispute, that Party may give notice of the Dispute to the other Party and such notice shall provide all relevant particulars of the Dispute. The Parties shall attempt in good faith to resolve the Dispute, but if it is not resolved by written agreement of the Parties within 30 days after delivery of the notice, the Dispute shall be resolved pursuant to **Section 11.3**.

11.3 Arbitration

If a Dispute is not resolved pursuant to **Section 11.2**, either Party may by notice to the other Party refer the Dispute to final and binding arbitration in accordance with the *Arbitration Act*, SNB 2014, c 100 (the "**Arbitration Act**"). Neither Party shall commence any proceedings relating to a Dispute in any jurisdiction, other than in accordance with the terms of this Agreement and this Agreement shall constitute a complete bar to any such proceedings. The arbitration shall be conducted by a single arbitrator agreed upon by the Parties. If the single arbitrator cannot be agreed upon within 10 Business Days of referral of a Dispute, either Party may apply under the Arbitration Act for judicial appointment of the single arbitrator. In respect of any arbitration to be conducted pursuant to this **Section 11.3**, the following rules shall apply:

11.3.1 the arbitration shall be conducted in English or French, as mutually agreed in writing by the Parties or as determined by the Arbitrator;

11.3.2 the arbitration shall be conducted in the City of Fredericton, New Brunswick;

11.3.3 no such arbitrator shall have previously been employed by either Party and shall not have a direct or indirect interest in either Party or the subject matter of the arbitration;

11.3.4 the costs of the arbitration, excluding a Party's legal fees and disbursements shall, unless otherwise ordered by the arbitrator, be borne equally by the Parties;

11.3.5 The arbitration hearing shall be completed within 120 days after the selection or appointment of the arbitrator. In order to facilitate the arbitration hearing in an expedited manner and in the absence of an agreement of the Parties to the contrary, the following procedures shall be followed by the arbitrator and the Parties:

11.3.5.1 Within 10 Business Days after the selection or appointment of the arbitrator, the claimant shall send a written statement to the respondent and the arbitrator outlining the facts supporting the claimant's claim, the points at issue and the relief or remedy sought;

11.3.5.2 Within 10 Business Days after the respondent receives the claimant's statement, the respondent shall send a written statement to the claimant and the arbitrator outlining the respondent's defence, and a written statement of the respondent's counterclaim, if any, outlining the facts supporting the counterclaim, the points at issue, and the relief or remedy sought;

11.3.5.3 The claimant may respond to a counterclaim by sending a written statement to the respondent and the arbitrator outlining the claimant's defence to the counterclaim within 10 Business Days after the claimant receives the counterclaim; and

11.3.5.4 Each Party shall submit with the Party's statements a list of the documents upon which the Party intends to rely, which shall specify the document type, date, author, recipient and subject-matter;

11.3.6 The arbitrator shall deliver his or her award within 30 days after completion of the hearing or within such other time as the Parties may agree; and

11.3.7 Subject to subsection 45(1) of the Arbitration Act, the award of the arbitrator shall be final and binding upon the Parties with no right of appeal, whether as to fact, law, or mixed fact and law, and shall be enforceable by them in any court of competent jurisdiction.

Notwithstanding any provision contained herein to the contrary, the Parties agree that the arbitration procedure set forth in this **Section 11.3** shall not apply in circumstances where (i) the claimant is seeking a temporary restraining order or other immediate injunctive relief, (ii)

a third party has brought a claim, except with the consent of such third party, or (iii) the Dispute relates to claims in respect of intellectual property rights, whether initiated by third parties or by a Party.

PART D - OTHER PROVISIONS

12.0 APPLICATION OF AGREEMENT

This Agreement applies to and is binding on the Minister and the Society and on any Physician receiving payment hereunder whether or not they have made themselves aware of the terms of this Agreement.

13.0 NOTICES

13.1.1 Any notice required or permitted to be given to the Minister by the Society shall be sufficiently given if personally delivered to the office of the Minister or if sent by the registered mail to the office of the Minister.

13.1.2 Any notice required or permitted to be given to the Society by the Minister shall be sufficiently given if personally delivered to the office of the President of the Society or if sent by registered mail to the office of the President.

13.1.3 Any notice given by registered mail shall be deemed to have been given 48 hours after the time it is posted.

14.0 MISCELLANEOUS

14.1.1 *Amendment* - No modification of this Agreement is valid unless set out in writing and signed by an authorized representative of each of the Parties.

14.1.2 *Invalidity* - If any provision in this agreement shall be deemed void or invalid by a court of competent jurisdiction, the remaining provisions shall be and remain in full force and effect.

14.1.3 *Waivers* - The waiver by either party of any breach or violation of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach or violation of it.

14.1.4 *Language* - The Parties have required that this Agreement and all documents relating thereto be drawn up in the English language. Les Parties ont demandés que cette convention et ci que tous les documents qui s'y rattachent soient rédigés en anglais.

14.1.5 *Severability* - If any part of this Agreement is held to be unenforceable or invalid, it will be severed from the rest of this Agreement which shall continue in full force and effect.

14.1.6 *Entire Agreement* - This Agreement constitutes the entire agreement between the Parties and supersedes all prior agreements and negotiations with respect to the subject matter hereof.

14.1.7 *Further Assurances* - Each party shall do such acts and shall execute such further documents as are within its power as the other party may at any time reasonably request to give full effect to the provisions of this Agreement.

[*Intentionally left blank – Signature page follows*]

IN WITNESSES WHEREOF the Parties have executed this Agreement, to take effect as of the Effective Date.

SIGNED AND DELIVERED in the presence of:

Witness

Witness

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK, as represented by the **MINISTER OF HEALTH**

Hon. John Dornan
Minister of Health

Date Signed: March 12, 2026

THE NEW BRUNSWICK MEDICAL SOCIETY

Dr. Lise Babin
President

Date Signed: March 12, 2026

Schedule A

Continuing Professional Development

1.0 Annual CPD Funding Allocation

Funding will be allocated to physicians on an annual basis for Continuing Professional Development (CPD), based on the following criteria:

To be eligible for the annual allocated CPD funding, physicians (including locums) must meet the following criteria:

For Fee-for-service (FFS) Physicians:

- Must be licensed in New Brunswick
- Medicare income must be equal to or greater than the Medicare income threshold established for the allocation year
- For the purposes of this program, physicians not meeting the salaried physician criteria noted below, are assessed under the FFS program, this includes Family Medicine New Brunswick (FMNB), Sessional, Alternate Funding Plan (AFP), Academic Payment Plan (APP) as well as regular fee-for-service

For Salaried Physicians:

- Must be licensed in New Brunswick
- Must have been employed under Part I or Part III of the *Public Service Labour Relations Act* and
- Must be remunerated under the Medical Pay Plan for more than six (6) months; and must be employed, as a minimum, in a half-time position (0.5 FTE).

1.1.1 Active FFS Physicians with annual Medicare income less than the income threshold will be allocated annual CPD funding once in any two-year period subject to established program criteria, provided their cumulative Medicare Income over that two-year period is equal to or greater than the income threshold for the second year. The annual allocation will be assigned once the physician's cumulative Medicare income over the two-year period reaches the income threshold for the second year. This provision does not apply to locums or salaried physicians.

1.1.2 Both FFS and Salaried Physicians on parental leave, will be eligible for full CPD funding allocation in that fiscal year.

Physicians who become disabled or ill will be eligible for CPD funding allocation for that fiscal year. These applications will be assessed on an individual basis.

1.1.3 In a fiscal year, a physician can only be allocated CPD funding in either the FFS or the salaried program. Physicians who switch remuneration models during a fiscal year, who meet the eligibility criteria for both programs, will be assigned funding based on the Program they qualified for first (FFS or Salary).

2.0 Value of Funding Allocation

2.1 By March 31st of each year, the Society will provide the value of CPD reimbursement to the Department of Health.

2.2 There will be two levels of CPD funding, urban and rural. Physicians who have practice locations beyond and not falling between Moncton, Dieppe and Riverview; or Saint John, Rothesay, Hampton, Quispamsis and Grand Bay/Westfield; or Fredericton, Oromocto and New Maryland, will be eligible to receive rural CPD funding.

2.2.1 In the event of a dispute, the Parties will resolve the matter using the following as a benchmark: In order to be deemed "rural" for the purpose of this Program, at least 75% of the income must be generated in a community or communities that meet the definition of rural. If less than 75% of the income is generated in rural communities then the urban CPD funding allocation would apply.

2.3 If within a fiscal year, a physician relocates their practice from an urban location to a rural location or from a rural location to an urban location, then for that year, and subject to all other qualifying requirements, the physician would be awarded CPD funding based on which location they first qualified, rural or urban.

3.0 Accumulated CPD Funding

Allocated CPD funding must be claimed within three (3) years.

4.0 Eligibility for CPD Course Reimbursement

4.1 The physician must be in active practice in New Brunswick at the time of the CPD event.

4.2 As a general guide, courses must be accredited by the Royal College of Physicians and Surgeons of Canada, Canadian College of Family Physicians or their delegated accredited providers. The final determination for CPD eligibility will be the responsibility of the Department of Health and the Society.

4.3 Any hardware expenses such as computers, TVs, etc. or other expenses such as books, journal subscriptions or other similar materials that may be required to undertake the home centered CPD are ineligible expenditures.

5.0 Application Procedure

5.1 Physicians must complete and submit their claim for CPD course reimbursement through "MyAccount" on the NBMS website, accompanied by the following documentation:

- Certificate of attendance (Includes Course Name, Dates, Location and CPD Learning Credits earned)
- Receipt of registration fees (if claiming registration expense – note receipt of registration does not constitute proof of attendance)

6.0 Reimbursement Criteria

6.1 Tuition/Registration

Tuition/Registration fees will be reimbursed at 100% in addition to the per diems. Receipt is required for tuition or registration fee. Annual dues and social fees will not be reimbursed.

6.2 Per Diem

Travel expenses (including accommodation, meals and transportation) are reimbursed on a per diem basis, using the following table:

Type	Per Diem
NB	$300.00
PEI/NS/QC/NL/ON/Maine	$500.00
Rest of Canada	$600.00
International excluding Maine	$700.00

6.2.1 Travel Days

The following formula/scale will be used to determine the total number of travel days eligible for reimbursement:

Travel Days	Claim Days
<100 kms	0 Days
Between 101 kms – 400 kms	½ day
Between 401 kms – 800 kms	1 day
> 800 kms	2 days

6.2.2 Program Days

The maximum number of CPD Programs days will be determined by the number of actual days of attendance or the number of CPD hours determined by the formula/scale below, whichever is less.

Total Number of CPD Hours for the Program	Maximum Number of Days Eligible for Reimbursement
Up to 3.5	1
3.5+ to 7	2

7+ to 10.5	3
10.5+ to 14	4
14+ to 17.5	5
17.5+ to 21	6
21+ to 24.5	7
24.5+ to 28	8

6.2.3 Office Overhead / Income Replacement

FFS Physicians will be eligible for Office Overhead/Income Replacement as follows:

Maximum of $300/day

In general, the office overhead allowance will be paid 100% for each CPD program day and travel day assigned according to the Travel Days formula under section 6.2.

6.3 Online/virtual CPD programs

Claims for Online/Virtual CPD programs will be eligible for the following reimbursement:

- Registration Fee (Receipt Required)
- Office overhead/Income Replacement (FFS physicians only)

Note:

-Eligible CPD expenses will be reimbursed based on the CPD funding available at the time of processing.

-In cases where a balance remains on the CPD Claim, the balance of the claim will be automatically paid out once the physician is allocated more CPD funding within the program.

7.0 CPD Reimbursement

The Society will submit to the Department of Health, on a monthly basis, physician accounts that qualify for reimbursement. The Society is responsible for verifying the eligibility of physicians applying for CPD reimbursement and for the processing of applications. The Department of Health will process invoices and issue payment to the Society. The Society is responsible for distribution of individual CPD reimbursement payments to physicians.

8.0 Maintenance of Documents

8.1 It will be the responsibility of the Society to maintain all documents required to support invoices submitted to the Department of Health for payment.

8.2 The Society will maintain a complete listing of CPD funding allocated and reimbursed to each physician.

8.3 The Department of Health will provide to the Society, on request, information regarding a physician's income relevant to the CPD earnings requirements, or in the case of Salaried Physicians, a list of Salaried Physicians.

8.4 For the purpose of administering the rural CPD reimbursement, the Department of Health shall provide to the Society on a semi-annual basis an electronic listing of eligible physicians. The list shall be produced using Medicare's Standard Geographical Location Code.

When the Society adds new physicians to its database an "urban" or "rural" notation will be assigned on the basis of the description in Paragraphs 2.2 and 2.3. The new assignments will be verified with the Department at the end of each month.

9.0 Program Funding

9.1 The annual physician funding allocation and the income threshold for eligible physicians will be adjusted annually through the negotiation and distribution processes.

9.2 NBMS will submit an invoice on or before April 10th of the fiscal year for the "Initial program funding" of $350,000. NBMS will be required to continue to submit monthly invoices with appropriate details. The initial funding program will be reconciled at the end of the fiscal year on the March invoice for CPD.

9.3 Changes agreed upon, effective April 1, 2025, will be reevaluated annually.

10.0 CPD Audits

In addition to any audit the Auditor General might want to conduct, the Department of Health reserves the right to audit all documents pertinent to individual CPD accounts held by the Society.

11.0 Program Administration Fee

The Society will apply an administration fee of 1.5%. The amount will be added to each batch of claims submitted.

Schedule B

CANADIAN MEDICAL PROTECTIVE ASSOCIATION

The New Brunswick Medical Society (the **Society**) has negotiated an annual fund with the Department of Health to reimburse FFS and MPP Physicians for a portion of their medical liability protection premiums.

Historically, nearly all eligible physicians have obtained medical liability protection through the Canadian Medical Protective Association (CMPA). Therefore, the risk categories referenced in this document refer to the CMPA Type of Work (TOW) Codes and the level of compensation is calculated using the CMPA fee structure as the frame of reference. However, eligible physicians may be reimbursed for premiums paid to other companies, provided that appropriate supporting documentation is submitted to the Society.

1.0 Definitions

1.1 **"FFS"** has the meaning assigned under the *2025 Physician Services Agreement* to which this Schedule is attached.

1.2 **"MPP Physician"** has the meaning assigned under the *2025 Physician Services Agreement* to which this Schedule is attached.

2.0 Eligibility Criteria

2.1 FFS or MPP Physicians are eligible for CMPA reimbursement if each of the following criteria are met:

2.1.1 They are a member of the New Brunswick Medical Society (locum Physicians are eligible);
2.1.2 They are practicing medicine in New Brunswick as a FFS, sessional or MPP Physician;
2.1.3 They are classified with a CMPA *Type of Work* (TOW) Code, or equivalent category with another provider, indicating their level of medical-legal risk and associated fees;
2.1.4 They are classified with a CMPA *Province of Work* (POW) Code indicating the physician worked in New Brunswick during the period which reimbursement is sought; and
2.1.5 They have paid their CMPA premiums, or alternative coverage provider premiums, in full for the period in which they are seeking reimbursement.

NOTE: *A physician shall NOT receive CMPA reimbursement from this program if they have received reimbursement for CMPA premiums or premiums for alternate liability coverage from any other organization or jurisdiction for the same period. This limitation is not intended to preclude reimbursement to Regional Health Authorities who have already paid the cost of coverage for the Physician.*

3.0 Physician Reimbursement

3.1 The physician deductible can be modified during the term of the contract subject to the mutual agreement of the parties.

3.2 Physicians will receive 47% of their premium OR the difference between the appropriate TOW code and the deductible, whichever amount is greater.

3.3 Physicians will be reimbursed on a quarterly basis for their CMPA Premiums as follows:

- 3.3.1 May for the preceding January to March period;
- 3.3.2 August for the preceding April to June period;
- 3.3.3 November for the preceding July to September period; and
- 3.3.4 February for the preceding October to December period.

3.4 Specialties with CMPA premiums ≥ $15,000 would receive payment in 6-month installments; an initial payment in February covering the period January 1 – June 30 and a second payment in July, covering the period July 1 – December 31.

- 3.4.1 Income verification for all physicians, including those with Premiums ≥ $15,000 would continue to be done quarterly.
- 3.4.2 All other specialties will continue to be reimbursed quarterly, to include quarterly income verification.
- 3.4.3 Locums will now be eligible for reimbursement on a quarterly basis rather than once per year, at the end of the year.

3.5 Compensation requests must be received by the Society within one year of the Physician incurring the expense for medical liability protection.

3.6 If a physician meets all the eligibility criteria for only a portion of the year, the physician is eligible for a pro-rated portion of the reimbursement.

- 3.6.1 The amount of reimbursement is calculated as follows: The total number of months the Physician was a member of the Society; practicing in New Brunswick based on CMPA's POW Code and in an eligible CMPA TOW code, including the month of registration (or departure), divided by 12; multiplied by the full reimbursement for that risk category. (The total is rounded up to the nearest dollar.)

- 3.6.2 If the Society's office has been informed of the exact date the Physician has left New Brunswick or began to practice in New Brunswick, the reimbursement will be prorated based on the date of departure/commencement. The amount of eligible months assumes that the Physician is in an eligible category for the months indicated.

4.0 Processing of Payments

4.1 CMPA Physician Payment Information

4.1.1 The Society will only accept the CMPA acknowledgement of fees paid, in electronic format from the CMPA. This file is posted to a secure website by CMPA for download by the New Brunswick Medical Society. CMPA has been advised that if any New Brunswick Physician requests the CMPA to fax Acknowledgements to the Society, they are to do so.

4.1.2 The data capture for the electronic file is based on the CMPA POW code. CMPA provides the Society with the information on all Physicians who are practicing in New Brunswick during the year being assessed and have not withdrawn permission for the release of information. This means locum physicians will automatically be included in the electronic CMPA file.

4.1.3 The quarterly electronic file cannot be made available until after the CMPA has processed the payment of monthly fees, which is usually around the 20th of the month.

4.2 Assessment of Eligibility for Compensation

4.2.1 Payment, TOW and POW information received from the CMPA is matched quarterly against the Society's membership database and the Department of Health billing data, to determine whether physicians meet the eligibility criteria of the funding program as outlined in paragraph 2.0.

4.2.2 Queries are applied to the data to identify FFS and MPP Physicians who were not included in the CMPA data file, who may be eligible for reimbursement.

4.2.3 Physicians may change their CMPA TOW or POW code during the year. Each of the electronic transfers that CMPA sends the Society contains membership information for the entire membership year. Prior periods for the year will be checked against previously received information to ensure that members have received the correct amount of compensation and that no prior period adjustments are needed.

5.0 Notification of Physicians

5.1 Given that the Society has direct access to an electronic CMPA file that contains physician payment information, the majority of eligible physicians will not have to do anything in order to receive reimbursement.

5.2 Physicians are informed about the CMPA Program when they become members of the Society.

5.3 "Reminder" notices may be included in the Society newsletter and other member communications.

6.0 Timeline

6.1 March of each fiscal year – Society will submit manual payment requisition to the Department of Health requesting funds for the year, as per section 7.1.

6.2 Society to confirm electronic file access dates with CMPA. CMPA data is generally available for download on the first day of work following the dates listed below:

March 20	(January – March period)
June 20	(April – June period)
September 20	(July – September period)
December 20	(October – December period)

6.3 The Society shall make best efforts to distribute payments to FFS and MPP Physicians in May, August, November and February. Follow-up letters shall be sent to physicians eligible for under-utilized claims.

6.4 The Society shall provide an annual payment report to the Department of Health no later than April 30, detailing total CMPA payments made to FFS and MPP Physicians with respect to the previous calendar year.

7.0 Program Funding Formula

7.1 The reimbursement formula described in Section 3 will be funded as follows:

7.1.1 The Department of Health shall fund the reimbursement program with annual funding of $6,802,972 ($4,869,151 FFS and $1,933,821 Salary) (the **"CMPA Funding"**).

7.1.2 The Department of Health shall transfer the CMPA Funding to the Society on or before April 1 of each year, to cover payments to FFS and MPP Physicians for the following year.

7.2 Any funding remaining in the CMPA reimbursement program at the end of March each year will be maintained by the Society to offset future liability in the program.

7.3 If the total cost of the reimbursement program exceeds $6,802,972.00 the balance of the additional funding will be taken from the reserve until such time as the reserve is depleted.

7.4 Any cost in addition to the Dedicated Funding Pool, once the residual is depleted, will be funded through negotiation of the parties or fee distribution.

8.0 Interest

8.1 Interest earned on funds received from the Department of Health for the CMPA reimbursement program, shall be retained by the Society and shall be considered as the administration fee for the operation of the program.

Schedule C

Mandated On-Call Programs

The purpose of the Mandated On-Call Program is to provide compensation for Mandated On-Call/Second On-Call in New Brunswick hospitals, nursing homes, and NB Provincial Correctional Centres for physicians to meet the emergent/urgent needs of the public.

Mandated On-Call: defined as 1st and 2nd on-call rotations that cover a single facility or service, encompassing the following:

Family Medicine Specialists	Provincial Nursing Homes
Medical and Surgical Specialists	Provincial Correctional Centres
	Medical Officers of Health

Provincial On-Call: defined as on-call rotations that cover the entire province, including all eight (8) zones at both Regional Health Authorities (RHAs).

1. **Protected Funding**

   From April 1,2025 to March 31, 2026, inclusively, except as expressly modified by this Schedule, the terms and conditions set out in the former Schedule C (*Mandated On-call Program*) and former Schedule G (*Province-Wide On-call Program*), of the 2020 Physician Services Master Agreement are incorporated into and form part of this Schedule C.

   Effective April 1, 2026, the *Mandated On-Call Program* and the *Province-Wide On-Call Program* will no longer operate as protected funding pools. The current annual reconciliation process and calculation of any residual payments will be discontinued effective April 1, 2026.

   The responsibility for the administration of the Mandated On-Call Programs and the management of on-call rotations will reside with the RHAs and the Department of Health.

2. **Responsibility for Existing Mandated On-Call Rotations**

   Existing on-call funding shall remain in place and payable to physicians providing Mandated On-Call services through existing FFS billing codes found in the *New Brunswick Physicians Manual*.

   The RHAs and the Department of Health will be responsible for managing the on-call rotations as follows:

Vitalité and Horizon Health Networks	Department of Health
Family Medicine Specialist	Nursing Homes
Medical and Surgical Specialist	Provincial Correctional Centres
Provincial On-Call	Medical Officers of Health

3. Mandated On-Call Rates

On-call rates will be negotiated between the Society and the Department of Health. Rates will not be subject to the Resourcing Adjustment or the General Economic Increase (GEI).

Effective April 1, 2025, the following rates will apply:

Regular On-Call (1st & 2nd)	Provincial Correctional Centres On-Call	Nursing Home On-Call	Medical Officer of Health On-Call	Provincial On-Call
$272.70	$272.70	$212.10	$212.10	$500

Effective April 1, 2026, the following rates will apply:

Regular On-Call (1st & 2nd)	Provincial Correctional Centres On-Call	Nursing Home On-Call	Medical Officer of Health On-Call	Provincial On-Call
$300.00	$300.00	$215.00	$215.00	$600

If a physician or physician group is required by the RHA to cover two (2) or more zones or two (2) different services, they may bill up to a maximum of two (2) Mandated On-Call rotations (Regular On-Call **only**), when the Mandated On-Call rotation is already funded and is not covered, or other exceptional circumstances as mutually agreed between the DH and the RHA.

Effective April 1, 2026, on-call coverage for the Provincial Hospitalist Program will be determined as part of each respective Provincial Hospitalist Program Alternate Funding Plan (AFP) agreement, where an AFP has been negotiated.

Schedule D

PARENTAL LEAVE PROGRAM
PRIVATE PRACTICE PHYSICIANS

1.0 Purpose

The purpose of this document is to set out the criteria which must be met by Fee For Service (FFS) Physicians in order to be eligible for Parental Leave Program, administered by the New Brunswick Medical Society (the **Society**) which includes maternity, paternity, loss of pregnancy, adoption, and surrogacy (collectively referred to as **Parental Leave**).

2.0 Description

The Department of Health has agreed to provide Parental Leave benefits payments to FFS Physicians who meet the eligibility criteria set out in this document.

3.0 Benefits Payments

3.1 Eligible physicians are reimbursed for a maximum of 26 consecutive weeks at two thousand dollars two hundred ($2,200) per week, or alternatively, for a maximum of 52 consecutive weeks at one thousand one hundred dollars ($1,100) per week. No “top-ups” can be made from any other source.

3.2 The Department of Health provides an all-inclusive amount of $1,129,000 annually to fund the Parental Leave Program for Physicians under the Physician Services Agreement.

3.2.1 This amount provides a self-sufficient fund which will not sustain any cost overruns.

3.2.2 In the event the amount is not fully spent, the remaining funds will be retained by the Society for future years.

4.0 Eligibility Criteria

4.1 Physicians are eligible for benefits payments provided that their income meets or exceeds the income threshold either during the fiscal year or during the 12-month period prior to requesting benefits. To be eligible, the physician must be registered with the Department of Health as an active FFS physician at the time of application to the Program. The income threshold is the same as the CME income threshold and will be adjusted using the same formula as the CME threshold.

4.2 Physicians are eligible if they reside in New Brunswick, have an established practice in New Brunswick for 12-months and are full-dues paying members of the Society.

4.3 In the event a physician does not qualify under section 4.2, the physician will be eligible to access the FFS Parental Leave Program by signing a 12 month Return of Service Agreement attached at Appendix A.

4.4 This Program does not apply to locums.

4.5 In general, Parental Leave benefits payments will start the week of the date of birth or, if the baby is detained in hospital, benefit payments may be deferred until the week the baby is released from hospital. In the case of an adoptive child five years of age or under, benefit payments for Parental Leave will begin the week during which care of the adoptive child is commenced by the adopting parents.

4.6 Parental Leave benefits payments may begin sooner than the week of the birth/adoption of the child only if the parent is required for health reasons to stop working. If the applicant is required to begin Parental Leave sooner than the week of the birth, a medical certificate will be required indicating medical necessity.

Other Specific Circumstances

4.7 In the event of a two-physician family, each individual physician will be eligible to apply for up to 26 weeks of benefits**.** In these circumstances, the parents may choose to take their leave individually, concurrently, or consecutively. Leave for one physician cannot be transferred to the other.

4.8 Any individual, concurrent, or consecutive leave must be taken and completed within 52 weeks of the child's birth or adoption for both physician spouses.

4.9 Physicians who continue to bill FFS while on Parental Leave are ineligible to receive Parental Leave benefits payments during weeks where billings exceed $2,200 per week.

4.10 In the case where a locum has been hired to replace a physician on Parental Leave, the physician on Parental Leave will normally have their billing number suspended.

4.10.1 In the event the physician on Parental Leave has hired a locum but is required to perform necessary duties their billings will be limited to $2,200 per week after which Parental Leave benefits will be lost and transferred to the FFS fund.

4.11 Unless otherwise agreed by the Society and the Department of Health, physicians must normally give at least four weeks' notice in writing Parental Leave to the Society and the Service Provider Registrar at the Department of Health before commencing Parental Leave. Physicians must also provide notice of the length of the Parental Leave intended to be taken.

4.12 A medical certificate is required in the case of maternity leave. In the case of an adoption, a letter from the adopting agency indicating expected placement date is required.

4.13 **Loss of pregnancy:** Physicians that experience a loss of pregnancy at or after 20 weeks of pregnancy (stillbirth or infant loss) are eligible for up to 12 weeks of benefits payment at $2,200 per week. In a two-physician family, each individual physician will be eligible for loss of pregnancy benefit payments.

5.0 Documentation Required (Post-birth/placement)

5.1 The following documents are required to receive Parental Leave benefits under this program:

5.1.1 Birth Certificate or written verification from the attending physician confirming birth.

5.1.2 Written verification from the adoption agency or birth parent confirming date of adoption/surrogacy.

5.1.3 If the child is detained in hospital, written verification from the attending physician confirming date of hospital release.

5.2 All documentation must be retained by the Society and made available to the Department of Health upon request.

6.0 Review

6.1 The Parties agree to review payments under the Parental Leave Program annually.

6.2 Appeals/exceptions will be individually assessed by the Department of Health and the Society.

7.0 Program Management

7.1 The Program is managed by the Society.

7.2 The Department of Health provides the all-inclusive amount of $1,129,000 on Jan 1st annually.

7.3 Payment details will be submitted to the Department of Health quarterly by the Society.

7.4 The benefits payments shall be reported as physician income and will be included in the Department of Health consolidated earnings report.

7.5 Notwithstanding Section 3.2.2 of this Schedule, any interest earned on funds received by the Society for the Parental Leave Program shall be retained by the Society and shall be considered as the administration fee for the operation of the program.

8.0 Payment of Benefits

8.1 Benefits will be paid on a monthly basis.

8.2 It is the understanding of the Parties that Parental Leave benefits are considered a taxable benefit.

9.0 Scope

This document applies to all Physicians:

a) whose primary method of payment is FFS, sessional or Alternate Payment/Funding Plan, or Academic Funding Plan; and

b) who meet the eligibility criteria described in article 4 of this Schedule.

Schedule E

SUPPLEMENTARY HONORARIA PROGRAM

The Parties have agreed to renew the Supplementary Honoraria Program. The parameters of this program are as follows:

1.0 Administration

1.1 Only Fee For Service (**FFS**) physicians will be eligible under this program.

1.2 The program will be administered by the New Brunswick Medical Society (**Society**).

Process

1.3 Physicians who serve on approved departmental and joint NBMS/Department of Health committees under the *Physician Services Agreement* are entitled to receive a supplementary honoraria payment under this program.

1.4 The Department of Health will submit to the Society quarterly accounts detailing payments made by the Department.

1.5 Based on the quarterly accounts, the Society will prepare and submit an account, identifying the eligible Physicians, to the Department of Health for the honoraria amount available under this Program.

1.6 The Department of Health agrees to make payment to the Society in the amount of 3% of annual program funding as an administration fee for the operation of the Supplementary Honoraria Program. For greater clarity, the 3% administration fee is included within, and not in addition to the annual program funding.

1.7 The records and accounts to support this program will be maintained by the Society and will be available for audit purposes by the Department of Health.

2.0 Funding

2.1 The Department of Health will fund this program up to a maximum of $260,000 per year.

2.2 The Society will issue supplementary honoraria payments directly to the eligible physicians.

2.3 FFS physicians who participate in approved joint NBMS/Department of Health Committees are entitled to $500 per half day or $1000 per full day.

2.4 This program will be responsible for payment of the difference between the amounts stipulated in section 2.3, above, and the Department of Health *Policies and Procedures Manual, Policy 213, Remuneration for Departmental Committees.*

2.5 This program will cover the Supplementary Honoraria top-up portion only, excluding travel, meals and any accommodations costs.

2.6 Payment will be made by the Society to physicians on a quarterly basis during the fiscal year.

2.7 Eligible physicians must be residents of the province at the time of payment by the Society.

2.8 This is a *Protected Funding Pool* as established under section 6.4.4 of the *Physician Services Agreement*, and any surplus remaining in the fund at the end of the fiscal year shall be available for alternate distribution, as mutually agreed to.

3.0 <u>Review</u>

3.1 This Schedule may be reviewed from time to time and amendments may be adopted that are mutually agreeable to the Parties.

3.2 Increases in the funding of this Program will be dealt with through the FFS negotiation.

3.3 The Parties will review the funding during fee distribution or negotiations.

Schedule F

Medicare Assessment Framework

Pursuant to the *Medical Services Payment Act* and Regulations, the Department of Health may develop, in consultation with the Professional Review Committee (PRC), rules applicable to the assessment of accounts. In addition to those actions referred to in the Act, the Provincial Authority may also take actions to deny payment of an account, or to provide that payment be made at a rate less than that provided in the agreement for entitled services, or any other action that the provincial authority considers necessary.

The following process is intended to establish new assessment rules with respect to the assessment of accounts of physicians with patterns of billing which require review. This includes questions of:

- Whether the quality of service provided was below a minimum acceptable level;
- Whether the level of service provided was in excess of what could be considered to be medically required; and
- Whether there has been a misuse of the fee schedule under the medical services plan or under an agreement entered into under the *Medical Services Payment Act*.

Process:

1. *Quarterly Review of Data by NB Medicare*

A. Family Medicine Specialists

Medicare will generate a report at the end of each quarter which will identify physicians whose total billings for all fee types (FFS, AFP, Sessional, On-Call) are three (3) or more standard deviations greater than their specialty remuneration average over the course of a quarter, using the quarterly Consolidated Earnings Report; and a minimum annual income threshold of $190,000.00

a. If a physician's billings are three (3) or more Standard Deviations above the average for their specialty at the end of any quarter a letter will be sent from the Department of Health to the physician:
    i. Explaining the process and potential actions if billings remain greater than three (3) standard deviations
    ii. Providing an opportunity for the physician to respond to the concerns addressed in the letter

b. The quarterly list of physicians identified will be provided to PRC along with any letters of response from those physicians

If a physician exceeds three (3) standard deviations above the average for a second quarter within the same 12- month period, a letter will be sent by the Provincial Authority to the physician:

a. Advising of specific concerns related to the physician's billing patterns. And notifying the physician that the following daily payment rate for the number of office visits will be implemented.

Patients per day	Rate
0 to 55(~2 SD)	100%
56 to 65	50%
66 and above	0%

b. Inviting the physician to make representations to the PRC respecting the matter under review.

Upon review of any representations made by the physician, the physician will be notified if:

i. No further action is to be taken and the limit on the number of patients per day be removed and that withheld funds be reimbursed; or

ii. A Medicare audit and/or assessment is to be completed; or

iii. An amount of overpayment to be recovered from the physician; or

iv. An external review is to be completed as set out below.

PRC will notify the physician in writing of the results of its review of any representations executed by the Provincial Authority as noted above.

B. Medical and Surgical Specialists

Medicare will generate a report at the end of each quarter which will identify physicians whose total billings for all fee types (FFS, AFP, Sessional, On-Call) are three (3) or more standard deviations greater than their specialty remuneration average over the course of a quarter, using the quarterly Consolidated Earnings Report; and a minimum annual income threshold of $250,000.00.

a. If a physician's billings are three (3) or more Standard Deviations above the average for their specialty at the end of any quarter a letter will be sent from the Department of Health to the physician:

i. Explaining the process and potential actions if billings remain greater than three (3) standard deviations

ii. Providing an opportunity for the physician to respond to the concerns addressed in the letter

b. The quarterly list of physicians identified will be provided to PRC along with any letters of response from those physicians

If a physician exceeds three (3) standard deviations above the average for a second quarter within the same 12-month period, a letter will be sent by the Provincial Authority to the physician:

i. Advising of specific concerns related to the physician's billing patterns and inviting the physician to make representations to the PRC respecting the matter under review.

ii. Advising that all future bi-weekly billings in excess of two (2) standard deviations above the average for that specialty section shall be withheld by NB Medicare pending review by the PRC.

Upon review of any representations made by the physician, the physician will be notified if:

i. No further action be taken and the amounts withheld be returned to the physician;

ii. A Medicare audit and/or assessment be completed;

iii. An amount of overpayment be recovered from the physician; and/or

iv. An external review be completed as set out below.

PRC will notify the physician in writing of the results of its review of any representations executed by the Provincial Authority as noted above.

2. *<u>Order for External Review</u>*

a. The physician may request (at their cost), a comprehensive physician-assisted external review from a Consultant or Firm with relevant expertise as recommended and approved by the Provincial Authority to provide further determination of whether

i. the quality of service provided was below a minimum acceptable level; and/or

ii. the level of service provided was in excess of what could be considered to be medically required; and/or

iii. there has been misuse of the fee schedule under the medical services plan or under an agreement entered into under the *Medical Services Payment Act.*

Once an external review is requested, it must be completed within 90 days.

The PRC shall consider the results of any external review and make recommendations, as needed to the Minister within 6 weeks of receipt of a report.

b. Upon implementation of above-noted capped payment rates, physicians may continue to see and bill for patients beyond the prescribed levels, and any payments reduced or withheld shall be held in trust with the Department of Health until the conclusion of any external review.

3. *PRC Recommendations*

a. If, following a Medicare audit or assessment there is a determination that an overpayment has been made; regular Medicare audit and recovery processes will be followed.

b. If, following an external review, the PRC determines that:

   i. the quality of service provided was acceptable; and/or

   ii. the level of service provided was considered to be medically required; and/or

   iii. there was no misuse of the fee schedule under the medical services plan;

   any physician payments reduced or withheld shall be released to the physician, and any costs for external review services incurred by the physician to perform the external review will be reimbursed to the physician upon provision of proof of payment. No further actions pursuant to this assessment rules framework will be taken against that physician for at least 2 fiscal years.

c. If, following the review, the PRC determines that:

   i. the quality of service provided was below a minimum acceptable level; and/or

   ii. the level of service provided was in excess of what could be considered to be medically required; and/or

   iii. there has been misuse of the fee schedule under the medical services plan or under an agreement entered into under the *Medical Services Payment Act:*

   Any physician payments reduced or withheld shall be released to the Department of Health, and the PRC may make additional recommendations to the Provincial Authority regarding recovery for any identified overpayments.

   Furthermore, the PRC may make any recommendations they may deem appropriate, up to and including, suspension as per section 5.5 (6) of the *Medical Payments Service Act*.

Schedule G

New Brunswick Primary Care Compensation Models

The Primary Care Compensation Models below are initial adjustments which shall not be funded through the Physician Services Agreement (PSA) GEI.

Primary Care Compensation Models:

The New Brunswick Medical Society (**NBMS**) is committed to the Government of New Brunswick's goal of increasing the provincial attachment rate from 77% to 85% by 2028 (per the New Brunswick Health Council). The NBMS and the Department of Health (**DH**) agree to offer the following models of compensation and support to incentivize accessible, efficient, and high-quality collaborative practice and longitudinal family medicine in New Brunswick.

Family medicine specialists may choose from the following models of compensation to be effective on April 1, 2026.

1. Solo Practice Compensation Model;
2. Group-based Practice Compensation Model (GBP); and
3. Collaborative Care Clinic Compensation Model (CCC).

It is expected that when physicians onboard additional patients they take them primarily from the official Provincial Waitlist. All Family Medicine specialists operating under the Provincial *Family Medicine New Brunswick (FMNB)* program or practicing under a collaborative/integrated care agreement with an RHA, shall be eligible to transition to a compensation model herein.

Collaborative Care Clinic – Additional Supports

Family Medicine specialists that choose to practice within the *Collaborative Care Clinic Compensation Model* are eligible for additional supports and must sign a *Collaborative Care Clinic Accountability Agreement* with the DH or the Regional Health Authorities (**RHA**) which indicate attachment and access requirements.

The Parties agree that any funding associated with the additional supports for the Collaborative Care Clinic compensation model is not and shall not be included as a component of the costing in *Schedule O* of the PSA or considered physician remuneration for provincial or national reporting purposes, i.e. CIHI.

1.0 <u>Solo Practice Compensation Model</u>

1.1 Eligibility: Family Medicine specialists may choose to practice longitudinal family medicine independently, without penalty.

1.2 Compensation: Family Medicine specialists in a solo practice shall receive compensation as follows:

1.2.1 FFS claims paid at 100%, + 5% increase to Family Medicine (FM) Fee Schedule;

1.2.2 FFS age/gender Capitation* Base Rate: $62 avg. applied to age/gender ratios;

1.2.3 After-hours Premium: +25% (weekdays - 18:00 – 06:59, weekends & holidays); and

1.2.4 Continue delegated billing per November 1, 2024, Medicare Memo.

2.0 Group-Based Practice Compensation Model

2.1 Eligibility: Family Medicine Specialists may choose to practice longitudinal family medicine within a *GBP Compensation Model* if they agree to the following:

2.1.1 Practice as part of a team which consists of, at minimum, two (2) Family Medicine specialists or one (1) Family Medicine specialist and one (1) nurse practitioner;

2.1.2 Cross coverage of patients during short-term absences (up to 14 calendar days) in accordance with the College of Physician and Surgeons Professional Standards;

2.1.3 Use an Electronic Medical Record;

2.1.4 Mandatory Monthly Reporting on:

2.1.4.1 Timely access as measured by 3rd next available appointment;

2.1.4.2 monthly individual performance reports; and

2.1.5 Family Medicine Specialists that choose to practice within the *GBP* shall submit an Attestation Agreement confirming they will practice in accordance with the eligibility requirements set forth in section 2.1 in the form attached hereto as **Appendix 1**.

Note: If at any point the eligibility criteria outlined above (2.1.1 – 2.1.4) are not met, the Family Medicine specialist will return to the solo practice compensation model.

2.2 Compensation: Family Medicine specialists choosing to practice within the *GBP Compensation Model* shall be eligible for the following compensation:

2.2.1 FFS claims paid at 100% + 5% increase to FM Fee Schedule

2.2.2 GBP Age/Gender Capitation* Base Rate: $80 avg. applied to age/gender ratios

2.2.3 After-hours Premium: +25% (weekdays - 18:00 – 06:59, weekends & holidays)

2.2.4 Continue delegated billing per November 1, 2024, Medicare Memo.

3.0 Collaborative Care Clinic Compensation Model & Additional Support Options

3.1 Eligibility: Family Medicine specialists may choose to practice longitudinal family medicine within a CCC compensation model if they agree to the following:

3.1.1 Practice as part of a team, which consists of a minimum of two (2) family medicine specialists or one (1) family medicine specialist and one (1) nurse practitioner and the integration of an interdisciplinary team inclusive of nursing and allied health professionals;

3.1.2 Cross coverage of patients during short-term absences (up to 14 calendar days) in accordance with the College of Physician and Surgeons Professional Standards;

3.1.2 Sign a *Collaborative Care Clinic Accountability Agreement* with the RHA or DH; and

3.1.3 Use an Electronic Medical Record (EMR)

3.2 Compensation: Physicians choosing to practice within the CCC compensation model shall be eligible for the following compensation:

3.2.1 FFS claims paid at 100% + 5% increase to FM fee schedule
3.2.2 CCC Age/Gender Capitation* Base Rate: $80 avg. applied to age/gender ratios
3.2.3 CCC Interdisciplinary Care Coordination Fee: $15 per rostered patient (capped at 3000 patients)
3.2.4 After hours premium: +25% (weekdays - 18:00 – 06:59, weekends & holidays)
3.2.5 Continue delegated billing per November 1, 2024, Medicare Memo.

***Capitation:** Capitation payments under all compensation models will be capped at 3,000 patients. Capitation rates will remain fixed for the duration of the PSA.

Physicians choosing a *CCC Compensation Model* may receive additional financial supports in exchange for partnering with the DH or the RHAs under a *Collaborative Care Clinic Accountability Agreement*, as follows:

A. Physicians choosing to partner with the RHA shall execute an *RHA CCC Accountability Agreement*. Each *RHA CCC Accountability Agreement* shall include, at a minimum, the financial and administrative supports attached hereto as **Appendix 2**.

B. Physicians choosing to partner with the DH shall execute a *DH CCC Accountability Agreement* attached hereto as **Appendix 3**.

Primary Care Compensation Model & CCC Additional Support Options: Retroactive Payments

Family Medicine Specialists will receive retroactive payments to April 1, 2025, based on the proposed primary care retroactive allocations below:

1. 18% plus first year 1 GEI;
2. Pay out based on proportionate earnings.

Family Medicine Specialists shall not be eligible for retroactive payments related to the *Collaborative Care Clinic Additional Support Options*.

Schedule G – Appendix 1

NEW BRUNSWICK PRIMARY CARE COMPENSATION MODELS

GROUP-BASED PRACTICE ATTESTATION AGREEMENT

PHYSICIAN NAME: _____ **(**the **"Physician")**

Practitioner (Medicare) Number: _____

ADDRESS: _____

_____

DATE: _____

Pursuant to Schedule ___ of the *2025 Physician Services Agreement ("**PSA**")*, the Physician agrees to practice group-based, longitudinal family medicine in exchange for primary care compensation under the *Group-Based Compensation Model*. The Physician shall comply with the following eligibility criteria:

Group-Based Practice Eligibility Criteria	**Physician Initials**
I am practicing as part of a Group-Based Practice which consists of, at minimum, two (2) physicians or one (1) physician and one (1) nurse practitioner.	
I agree to use an Electronic Medical Record (EMR) in my primary care practice. • My selected EMR is: _____ (identify EMR service provider).	
Our Group-Based Practice will ensure cross-coverage of each other's patients for urgent services during short-term absences of a member of the group.	
I agree to provide data or limited access to my EMR, if required, for the purposes of assessing my "Third Next Available" appointment.	
I agree that our practice will respect and operate as per the applicable clinical guidelines of the College of Physicians and Surgeons of New Brunswick.	

My Group-Based Practice will include the following providers:

Medical Practitioner Name	**Medical Practitioner Number**	**Group Practice Number**

My Group-Based Practice will include the following **Nurse Practitioner** providers:

Nurse Practitioner Name	Nurse Practitioner Number	Group Practice Number

Under the *GBP Compensation Model*, the Physician shall be eligible for the following compensation:

- FFS claims paid at 100%
- GBP Age/Gender Capitation – Base Rate Average: $80/patient
- After-hours Premium: +25% (18:00 – 06:59 W/Ends & Holidays)
- Continue delegated billing per November 1, 2024 Medicare Memo

The Physician must maintain adherence to the eligibility criteria in order to receive funding under the *GBP Compensation Model*. Should the Physician fail to comply with the above noted eligibility criteria, the Physician shall not be eligible for payment from Medicare under the *GBP Compensation Model* and will revert to a *Solo Practice Compensation Model*.

Upon receipt of this Application, the Minister agrees to pay and the Physician agrees to accept primary care compensation in accordance with the terms set out herein, as negotiated under the PSA.

This Agreement may be signed originally or electronically, and in two or more counterparts, each of which shall be deemed an original, and together shall constitute one and the same agreement.

Physician Name: _____

Physician Signature: _____

PURPOSE: The purpose of this document is to define the financial and administrative supports offered to family medicine specialists by the Minister in relation to the start-up and operational costs of participating in Collaborative Care Clinics in the Province of New Brunswick.

Start-up Costs: To be negotiated between the parties based on need.

EMR: Electronic Medical Record solutions will be fully funded within the program.

Table 1: Overhead Support for FFS Physicians, based on Panel Size:

Team Panel Size	Fee per Patient
< 999	.50/pt
1000-1499	.75/pt
1500-1999	1.00/pt
2000-2499	1.25/pt
2500+	1.50/pt

Overhead supports can include: office & medical supplies, phone, etc.

Table 2: Administrative Support/ Medical Office Assistant (MOA) support, based on panel size:

Team Panel Size	MOA
< 1875	1.0 FTE or Funding
1875-2499	1.5 FTE or Funding
2500+	2.0 FTE or Funding

NOTE: Family medicine specialists shall receive funding equivalent to 50% of annual NB collective agreement rates applicable for MOA support.

Table 3: LPN, RN, support based on panel size:

Team Panel Size	LPN/RN
0-1499 pts	0.5 FTE or Funding
1500-1999 pts	1.0 FTE or Funding
2000 -2499	2.0 FTE or Funding
2500+	3.0 FTE or Funding

NOTE: Family medicine specialists shall have an RHA resource or receive funding equivalent to 50% of annual NB collective agreement rates applicable for LPN/RN support. Family medicine specialists may bill for in-scope delegated acts of LPN/RN if they are employed directly by physician or Collaborative Care Clinic.

Table 4: Nurse Practitioners:

• **RHA Employee**
• **Private Physician Hire:** Salary to be funded in line with the applicable collective bargaining agreement.
• NPs will be expected to attach a minimum of 500 patients to the team
• The physician will be eligible to bill capitation for the patients rostered to the NP

Table 5: Allied Health Professionals:

• **The type** of Allied Health Professional provided to the Team will depend on population health needs of the community served and availability of staff or services.
• **Amount:** Minister will provide an equivalent of funding for 1.0 FTE Allied Health Professional to support up to *12,000/ population based on community need and resources available. • Alternatively, Family medicine specialists shall receive 25 dollars per patient to purchase allied health services.
• **Allied Health Professional can include**: Social Worker, Licensed Counseling Therapist, Registered Dietitian, Physiotherapist, Occupational Therapist, Respiratory Therapist, Pharmacist, Advanced/ Community Paramedic, Patient Navigator.

COLLABORATIVE CARE CLINIC ACCOUNTABILITY AGREEMENT

THIS AGREEMENT (the "**Agreement**") is made as of the ____ day of _____, 20__ (the "**Effective Date**"), by and among:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK AS REPRESENTED BY THE MINISTER OF HEALTH (referred to as the "**Minister**"),

-and-

[*Primary Care Physician Name*], a licensed physician practicing in the Province of New Brunswick and having their principal office at [●] (referred to as "[PHYSICIAN]"),

-and-

[*Primary Care Physician Name*], a licensed physician practicing in the Province of New Brunswick and having their principal office at [●] (referred to as "[PHYSICIAN]"),

-and-

[*Primary Care Physician Name*], a licensed physician practicing in the Province of New Brunswick and having their principal office at [●] (referred to as "[PHYSICIAN]", and together with [PHYSICIAN], [PHYSICIAN], sometimes collectively referred to as the "**Physicians**"),

(Collectively, the Minister and the Physicians may be referred to as the "**Parties**" to this Agreement)

RECITALS

WHEREAS the Minister has resolved to provide financial support to the Physicians for the operation of the [***Name of Collaborative Care Clinic***] Collaborative Care Clinic (referred to as the "**Clinic**");

AND WHEREAS the Clinic will provide various clinic-based primary care services to patients in New Brunswick and in all cases in accordance with the best practices of the profession and applicable provincial healthcare regulations.

NOW THEREFORE, in consideration of the covenants and conditions contained in this Agreement, the Parties agree as follows:

1. CONTEXT AND PURPOSE

The purpose of this Agreement is to establish a collaborative, clinic-based model of primary care aimed at promoting timely access to comprehensive, patient-centered care through the integration of physicians, nurses, and allied health professionals, while creating a sustainable and efficient healthcare environment that supports both patients and healthcare providers (the "**Purpose**").

The Parties acknowledge that this Agreement addresses the commitment and obligations of the Parties with respect to the Purpose and does not address remuneration of the Physicians which is provided for in the Physician Services Agreement, currently in effect, between the New Brunswick Medical Society and the Minister (the "**PSA**").

This Agreement is made in accordance with the current PSA and respects the *Medical Services Payment Act* (New Brunswick), the *Regional Health Authority Act* (New Brunswick), the *Financial Administration Act* (New Brunswick), and all other applicable policies, conventions and laws (collectively, the "**Applicable Law**"). The Parties to this Agreement acknowledge that, should any conflict exist or arise between the Applicable Law and this Agreement, the Applicable Law shall prevail.

2. COMMITMENT OF THE PARTIES

2.1 **Minister Obligations.** During the Term (as defined below), the Minister shall:

a) provide financial support in accordance with the Individual Financial Agreements entered into between the Minister and each Physician, collectively attached hereto as **Schedule "A"**.

2.2 **Physicians Obligations.** During the Term, the Physicians shall:

a) practice as part of a team consisting of a minimum of two (2) family medicine specialists or one (1) family medicine specialist and one (1) nurse practitioner and the integration of an interdisciplinary team inclusive of nursing, allied health professionals, and medical office assistants. The Physicians shall immediately notify the Minister in writing of any change in the composition of the Clinic that may affect the Clinic's eligibility under this Agreement;

b) appoint a lead primary care physician for the team who shall be designated to act as a liaison between the Physicians and the Minister (the "**Lead Primary Care Physician**");

c) work with the interdisciplinary team, in a collaborative, integrated practice approach, all in accordance with the Purpose. The Physicians acknowledge that Practice Support is available through the New Brunswick Medical Society;

d) provide comprehensive primary care services, which includes health promotion, health prevention and screening, treatment and management of chronic diseases and minor illness/injuries, referrals to/coordination with other levels of care (e.g. specialists), primary mental health care, healthy child development, primary maternity care, rehabilitation services, and palliative and end-of-life care;

e) collaborate with the Minister to develop a plan for improving access to primary care of unattached patients;

f) make best efforts to ensure that additional patients integrated into the practice will be accepted through the official Provincial waitlist for unattached patients and reside in the same community or region in which the practice is located;

g) work to improve access to regular appointments for patients with a goal of providing access within five days;

h) support all members of the Clinic to practice within their full scope;

i) comply with the billing and reimbursement process for supporting integrated collaborative practice (including payments to non-RHA employed NP services) and submit all forms, invoices and supporting documentation in accordance with said process by the end of each calendar month; and

j) deliver safe, high-quality primary care in accordance with established standards and Applicable Law.

3. LOCATION AND HUMAN RESOURCES MANAGEMENT

a) Clinic members are not required to be co-located permanently in the same location to be considered part of the Clinic. However, the interdisciplinary team must be organized and available in a manner that ensures proximity for patient care. Clinics that are not co-located must implement secure methods for sharing patient information and communicating care plans to maintain continuity of care.

b) The Parties acknowledge and agree that this Agreement does not constitute, and shall not be construed as constituting, an association for the purpose of establishing a partnership, joint venture, agency, or employer–employee relationship between the Parties. Nothing in this Agreement shall be interpreted as giving rise to any employment relationship between the Minister and any employee, contractor, or agent of the Physicians or the Clinic, and any such relationship is expressly disclaimed by the Minister.

4 ELECTRONIC MEDICAL RECORDS & PRIVACY

a) The Physicians shall use an Electronic Medical Record system ("**EMR system**") for the management of patient information. In accordance with Applicable Law, the Physicians will be the custodian of their patient records and are responsible for ensuring that the EMR system used, whether privately licenced or otherwise, complies with all privacy, security, regulatory requirements.

b) The Physicians shall permit data collection from the EMR system through direct access by the Minister for administrative records related to patient access and attachment. Such access shall be sufficient to enable the Minister to carry out the performance-monitoring and review obligations set out in Section 5 below. The cost of such EMR system access, to the extent it results in additional costs beyond the basic monthly EMR subscription fees reimbursed by the Minister, shall be paid by the Minister.

5 PERFORMANCE MONITORING AND REVIEW

a) The performance of the Clinic will be assessed through key metrics as set out in **Schedule "C" – Performance Metrics**. These metrics will be shared by the Physicians monthly and reviewed as part of ongoing monitoring and evaluation. Patient and staff feedback may also be incorporated to inform quality improvements and ensure alignment with shared goals.

b) Both Parties will conduct regular review meetings, at a minimum quarterly, to evaluate the Clinic's progress against agreed-upon targets. Clinic Data will be shared transparently in aggregate, in compliance with privacy laws, to support informed decision-making. These meetings will focus on identifying opportunities for improvement while respecting the operational independence of the Clinic. Individual clinic or Physician-level Performance Metrics shall not be shared publicly without prior written consent of the Physicians.

c) The Clinic will be accountable for achieving performance targets and implementing quality improvement initiatives as needed. This will be done in collaboration with the Minister, ensuring continuous progress toward meeting established benchmarks.

6 TERM AND TERMINATION

a) This Agreement is effective from the Effective Date, unless and until it is terminated in accordance with this Agreement.

b) Each of the Parties may terminate this Agreement with ninety (90) days' written notice, ensuring that patient care is not disrupted. If the Agreement is terminated by a single Physician (the "**Departing Physician**"), the remaining Physicians and the Minister (collectively, the "**Remaining Parties**") shall reasonably determine, within forty-five (45) days of receipt of the notice of termination, whether the Clinic can continue without the participation of the Departing Physician. If the Clinic can continue without Departing Physician, an amended agreement, on substantially the same terms as this Agreement, shall be executed by the Remaining Parties forthwith. In the event of termination, the Parties agree to fulfill all

obligations up to the termination date and work together in good faith to facilitate an orderly and seamless transition of patients and services.

c) In the event that the Physicians breach a term, condition, or obligation of this Agreement or the Primary Care Schedule attached to the PSA, the Minister may provide written notice specifying the nature of the breach and the steps required to remedy it. The Physicians shall have forty-five (45) days from receipt of such notice, or such longer period as may be reasonably necessary if the breach cannot be remedied within forty-five (45) days and the Physicians have commenced and are diligently pursuing corrective action, to remedy the breach to the satisfaction of the Minister. Failure to remedy the breach within the applicable period shall constitute grounds for immediate termination of this Agreement by written notice.

7 DISPUTE RESOLUTION

a) Any disputes arising from this Agreement will first be addressed through good-faith negotiations between the Parties. If unresolved, disputes shall be referred to binding arbitration pursuant to the *Arbitration Act* (New Brunswick).

8 PUBLIC ANNOUNCEMENTS AND MEDIA PARTICIPATION

a) The Physicians shall acknowledge the financial support of the Minister in all public communications they produce relating to the establishment of the Clinic, in a form and manner approved by the Minister.

b) The Physicians shall obtain the Minister's prior written consent for any public acknowledgement of the Minister's financial support, including, but not limited to news releases, public statements, public displays, and public or media events relating to the establishment of the Clinic.

c) If the Physicians intend to issue any media announcement or host any public event related to the establishment of the Clinic, they shall provide the Minister with at least thirty (30) calendar days' prior written notice and a reasonable opportunity to review, comment on, or attend the proposed announcement or event.

d) The Physicians agree to participate in public announcements, media availability, and related communications activities concerning the establishment of the Clinic and the financial support, when organized by the Minister or when requested by the Minister, at times mutually agreed upon by the Parties, acting reasonably and in good faith.

9 GENERAL PROVISIONS

a) This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto.

b) No failure or delay by the Minister in exercising any right under this Agreement shall operate as a waiver of that right. Any waiver by the Minister must be in writing and signed by the Minister and applies only to the specific matter identified in it.

c) This Agreement may be executed in counterparts, each of which is deemed an original, but all of which together are deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, email or other means of electronic transmission (including PDF format) is deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

d) This Agreement, together with any other documents incorporated herein by reference and all related exhibits and schedules, constitutes the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersedes all prior and contemporaneous understandings and agreements, both written and oral, with respect to such subject matter. In the event of conflict between the terms of this Agreement and the Primary Care Schedule of the PSA, the terms of the Primary Care Schedule shall prevail.

e) This Agreement and any other documents incorporated herein by reference shall be governed by the laws of the Province of New Brunswick and the federal laws of Canada applicable therein.

f) The Parties intend that those sections of this Agreement which by their nature are intended to survive, shall survive the termination or expiry of this Agreement.

g) The headings in this Agreement are inserted for convenience or reference only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

h) All notices, requests, consent, claims, demands, waivers or other communications hereunder (each, a "**Notice**") shall be in writing and addressed to the Parties at the addresses as each may direct in writing from time to time.

i) If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability will not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK AS REPRESENTED BY THE MINISTER OF HEALTH

_____

Name: Eric Beaulieu

Title: Deputy Minister of Health

Date:

PHYSICIANS:

_____	_____
Witness	**[PHYSICIAN NAME]**
_____	_____
Witness	**[PHYSICIAN NAME]**
_____	_____
Witness	**[PHYSICIAN NAME]**

Schedule "A"

Individual Financial Agreement

THIS FINANCIAL AGREEMENT (the "**Agreement**") is entered into on this ____ day of _____, 20__ (the "**Effective Date**"), by and between:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK AS REPRESENTED BY THE MINISTER OF HEALTH
(the "**Minister**")

And

Dr. [*NAME*]
[STREET] ,
[City], NB [postal code]
Contact: Dr. [NAME]
Title: Family Medicine Specialist
Email:
Phone:
(the "**Physician**")

PURPOSE

The purpose of this Agreement is to define the financial obligations and responsibilities of the Minister in relation to the operation of the [***Name of Collaborative Care Clinic***] Collaborative Care Clinic.

1. Financial Support

1.1 As a condition of eligibility for financial support under this Agreement, the Physician shall maintain minimum applicable patient panel size as set out in **Schedule "B": Individual Minimum Physician Panel Size** and shall further commit to working collaboratively with the Minister toward mutually agreed-upon targets for attaching additional patients and improving patient access. Any failure to maintain Minimum Panel Size or to demonstrate reasonable efforts towards achieving these mutually agreed-upon targets may result in a review and adjustment of funding in accordance with sections 1.2 and 2.1 of this Agreement.

1.2 The Minister agrees to provide monthly financial support in accordance with the amounts set out in the following table:

Item	Agreement Description	Monthly Amount Minister contributes
The parties agree that the physician's panel size for calculation of financial support as of the Effective Date is [**Insert panel size #**].		
Overhead Support	Calculated based on patient panel size and progressive Table 1 in Schedule D.	
Medical Office Assistant (MOA)	Physician employs MOA & Minister provides funding for 50% of eligible FTE salary rate based on panel size and Table 2 in Schedule D.	
Licensed Practical Nurse (LPN)	Physician employs LPN & Minister provides funding for 50% of eligible FTE salary rate, based on panel size and Table 3 in Schedule D.	
Nurse Practitioner (NP)	Physician employs NP & Minister provides funding for 100% of FTE salary rate. **NPs will be required to attach a minimum of 500 patients**	
Registered Nurse (RN)	Physician employs RN & Minister provides funding for 50% of eligible FTE salary rate, based on panel size and Table 3 in Schedule D.	
Allied Health Professional (AHP)	Physician purchases allied health services for patients as specified in Schedule D & Minister provides funding for $25 per patient based on panel size and submitted invoice.	

NOTE 1: Funding calculations are based on annually adjusted panel sizes, applicable salaries, fees and cost-sharing formulas in effect as of the Effective Date. Minister reimbursements for MOA/LPN/RN/NP funding shall be calculated annually, based on the applicable Collective Agreement ("**CA**") salary rate, for each respective individual position. Any additional adjustments shall be subject to the terms outlined in the Agreement.

NOTE 2: Payments for MOA, LPN, NP, RN and AHP will be payable when supports are in place, as evidenced by monthly submission of invoice.

NOTE3: Refer to **"Schedule D**" for description and additional information for financial support.

1.3 In addition to the monthly financial supports available under section 1.2, the Minister may provide the Clinic with a one-time EMR Start-Up or Transition Incentive of up to $10,000 per eligible primary care provider, in accordance with the eligibility requirements set out in Schedule D to this Agreement. The Minister shall also reimburse all basic monthly EMR subscription fees for the Clinic, subject to the submission of all required forms, invoices, and supporting documentation in accordance with section 3.1 below, and subject to the limitations described in Schedule D to this Agreement.

1.4 The Parties shall annually reassess the Physician's practice and the achievement of performance indicators and, based on this assessment, adjust the financial support and the monthly invoice. The Physician may not adjust the invoice independently; all reviews and adjustments will be done jointly with the Minister.

2.0 Changes and Funding Adjustments

2.1 The Physician shall immediately notify the Minister in writing of any change in the composition of the Clinic, including the addition, departure, or change in status of any physician, nurse practitioner, licensed practical nurse, registered nurse, allied health professional, or medical office assistant, where such change may affect the amount of financial support payable pursuant to this Agreement. The Minister reserves the right to review and adjust the financial support payable under this Agreement to reflect such changes, effective as of the date the change occurred.

3.0 Billing, Reimbursement, and Recordkeeping

3.1 The Physician shall comply with the Minister's billing and reimbursement process, as amended from time to time, and shall submit all required forms, invoices, and supporting documentation in accordance with that process by the end of each calendar month or within such other timelines as specified in writing by the Minister. Payment shall be made in accordance with the Minister's administrative and payment practices in effect at the time of processing.

3.2 During the Term and for seven (7) years after termination or expiry of this Agreement, the Physician shall maintain records sufficient to account for all funding received and expenses incurred, which the Minister, or the Auditor-General, may review, inspect, or audit on fifteen (15) business days' written notice during normal business hours, in accordance with Applicable Law. This provision shall survive the termination or expiry of this Agreement for the period set out herein.

4.0 Term and Termination

4.1 This Agreement shall be effective upon the date of signing and shall remain in effect unless terminated by either party upon providing ninety (90) days' prior written notice. This Agreement shall automatically terminate if the Collaborative Care Clinic Accountability Agreement is terminated for any reason, or if the Physician ceases to be a party to that agreement. This Agreement may be renewed annually, upon the agreement of the parties.

4.2 A temporary leave of absence by the Physician, including parental leave, medical leave, or other leave, shall not constitute a cessation of participation in the Clinic or termination of this Agreement, provided that the Physician demonstrates an intention to return to practice at the Clinic, and the Clinic continues to meet the applicable eligibility requirements, or alternative arrangements satisfactory to the Minister are made. In the event of such leave, financial support shall continue, subject to the prior written approval

of the Minister, and provided that the Physician's patient panel continues to have reasonable access to primary care services during the period of leave.

5.0 Amendments

5.1 Any amendments or modifications to this Agreement must be in writing to be valid

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

Dr. [NAME's] Collaborative Practice	HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK REPRESENTED BY THE MINISTER OF HEALTH
_____	_____
Name: Dr. [NAME] Date:	Name: Date:

Schedule "B"
Individual Minimum Physician Panel Size

The minimum physician panel size required for physicians working in a Collaborative Care Clinic (subject to adjustments agreed by the Parties)

FTE	Minimum Panel Size
1.0 FTE	1400 Patients
0.8 FTE	1120 Patients
0.6 FTE	840 Patients
0.4 FTE	560 Patients

NOTE 1: Panel size requirements may be increased or reduced based on specific clinical circumstances not specified in this Agreement, where mutually agreed by the Parties in writing. Without limiting the foregoing, the addition of LPN or RN resources may increase the roster size by up to 500 patients per 1.0 FTE, and the addition of Allied Health resources may increase the roster size by up to 100 patients per 1.0 FTE.

NOTE 2: Minimum panel size is not a condition precedent to entering this Agreement.

NOTE 3: Minimum panel size will be reduced to reflect other duties, including hospitalist work, palliative care, obstetrics coverage, and other responsibilities which may be imposed by the Department of Health via the Regional Health Authorities. The Parties will reduce patient panel size expectations to reflect proportional time out of office to ensure patient panel sizes remain reasonable and attainable.

Schedule "C"

Performance Metrics

The list of metrics (indicators) to be collected by the Minister from the Clinic monthly:

Indicator Name	Definition	Metric measured
Patient encounters/visits	Total Number of patient encounters (appointment or visit) includes in-person and virtual/telephone.	# visits per provider
Attached Patients to Primary Care Provider	Total Number of 'rostered' or 'active' patients assigned to the primary care provider.	Total # patients per provider
Third Next Available Appointment	National measure for 'access' in primary care. Average number of days a patient will wait until the 3rd available 'Regular' appointment for the primary care provider.	# of days
Same Day/Next Day Appointment	Patients are able to make a 'same day' or 'next day' appointment to address an urgent health care need.	Yes or No
Extended Hours Service	Clinic offers some services after 'regular business hours'.	Yes or No
Interdisciplinary Team Composition	Composition of Collaborative Care Clinic's interdisciplinary team	

NOTE 1: Additional metrics may be established and tracked for continuous improvement

SCHEDULE "D":
Additional Information for Financial Support

This Schedule D provides additional information relating to the financial support described in the Financial Agreement (Schedule A) and forms an integral part of the Collaborative Care Clinic Accountability Agreement.

EMR Funding Eligibility and Coverage

Subscription Fee Reimbursement

All basic monthly EMR subscription fees for the Clinic will be reimbursed. Reimbursement applies to both Certified and uncertified EMR solutions. Invoices will be required.

Basic monthly EMR subscription fees eligible for reimbursement under this Agreement must be commercially reasonable and aligned with: (i) the reimbursement rates and funding parameters established under the Electronic Medical Records Program pursuant to the 2025 Physician Services Agreement (PSA); and (ii) prevailing rates for other Certified EMR solutions operating within the Province.

Where the basic monthly EMR subscription fees materially exceed the amounts established under the PSA or the prevailing rates for other Certified EMR solutions in the Province, the Minister may, in its sole discretion, determine the reimbursement amount and may limit the reimbursement accordingly.

Transition to Common Certified EMR

The overall goal is for clinics to transition to a single, common Certified EMR.

To support this transition, eligible Primary Care Providers (**PCP**) may receive a one-time EMR Start-Up/Transition Incentive of $10,000 per PCP to enable:

- initial implementation of a common Certified EMR where none currently exists;
- consolidation and data transfer into a common Certified EMR where multiple EMRs are in use; or
- migration from an uncertified EMR to a common Certified EMR.

The incentive is payable once per PCP and is intended solely to support the implementation of, or transition to, a common Certified EMR.

Overhead

Financial support for physicians working in Collaborative Care Clinics (CCC) in private clinics (non-RHA facilities).

Overhead payments will be calculated based on individual physician patient panel size to a maximum of 5000 patients and will be paid monthly by the Minister. Overhead payments are calculated on a progressive basis, i.e. first 999 patients @ .50 and the next 500 @ .75, etc. See table 1 for increments.

Table 1

Physician Panel Size	Fee per Patient	Incremental Max (per month)	Total Max (per month)	Incremental Max (per year)	Total Max (per year)
< 999	.50/pt	$499.50	$499.50	$5,994.00	$5,994.00
1000-1499	.75/pt	$375.00	$874.50	$4,500.00	$10,494.00
1500-1999	1.00/pt	$500.00	$1,374.50	$6,000.00	$16,494.00
2000-2499	1.25/pt	$625.00	$1,999.50	$7,500.00	$23,994.00
2500-5000	1.50/pt	$3,750.00	$5,749.50	$45,000.00	$68,994.00

Patients rostered to nurse practitioners (NP) will not be included in the calculation for overhead payments.

Medical Office Assistant (MOA)

Funding support for MOA will be calculated based on all patients rostered to a physician and to a nurse practitioner employed by that physician. Physicians may receive 50% of the eligible FTE salary rate.

Table 2

Physician/NP Panel Size	Funding
< 1875	50% of 1.0 FTE
1875-2499	50% of 1.5 FTE
2500-3749	50% of 2.0 FTE
3750 - 5000	50% of 3.0 FTE

NOTE 1: If a physician chooses to hire additional MOA support, the physician will be responsible for the additional costs.

NOTE 2: The maximum eligible Physician/NP Panel Size is 5,000 patients.

Licensed Practical Nurse (LPN)/ Registered Nurse (RN)

Physicians choosing the CCC model of remuneration are expected to optimize nursing and allied health resources, which includes delegating services where appropriate to ensure all are working to optimal scope of practice.

Funding support for nursing will be calculated based on all patients rostered to a physician and to a nurse practitioner employed by that physician. The number of FTEs may be all one classification or a mix within the FTE funding indicated by panel size. i.e. a physician with a panel of 2100 patients might opt to have 2.0 FTE RN or 2.0 FTE LPN or 1.0 of each.

Physicians may receive 50% of the eligible FTE salary rate when they have nursing support in place. It is required that the nursing resource work a minimum of 0.2 FTE (equivalent of one day per week).

Table 3

Physician/NP Panel Size	Funding
0-1499	50% of 0.2 - 0.5 FTE
1500-1999	50% of 1.0 FTE
2000 -2499	50% of 2.0 FTE
2500-5000	50% of 3.0 FTE

NOTE 1: If a physician chooses to hire additional nursing support, the physician will be responsible for the additional costs.
NOTE 2: The maximum eligible Physician/ NP Panel Size is 5,000 patients.

Nursing Delegation: Physicians may bill fee-for-service for in-scope delegated services.

Nurse Practitioners (NP)

Physicians may receive 100% of the FTE salary rate for an NP.

NPs working in CCCs will be expected to attach a minimum of 500 patients and work towards 800 patients by the end of year two. Consideration can be made for overall caseload complexity of patient roster and experience of the NP. The CCC model is designed to ensure appropriate team-based support for all providers, including NPs.

For CCCs that include both physicians and NPs, capitation may be billed for patients rostered to any primary care provider, including those rostered to NPs, in accordance with the funding model.

Allied Health Professionals (AHP)

Annual funding support for the reimbursement of AHP services is available to Physicians at a rate of $25 per patient, including patients rostered to NPs. Physicians may access this funding on a monthly draw-down basis throughout the contract year, up to the maximum amount determined by their patient panel size. All reimbursement claims must be supported by invoices.

When determining allied health resources, consideration will be given to the wait time for mental health service within the community.

Allied Health Professionals may include the following: Social Worker, Licensed Counseling Therapist, Registered Dietitian, Physiotherapist, Occupational Therapist, Respiratory Therapist, Pharmacist, Psychologist, Registered Massage Therapist, Speech Language Pathologist, Chiropractor, other Allied Health Professional as approved by the Minister.

NOTE: Funding calculations are based on annually adjusted panel sizes, applicable salaries, fees and cost-sharing formulas in effect as of the Effective Date. Minister reimbursements for MOA/LPN/RN/NP funding shall be calculated annually, based on the applicable Collective Agreement ("**CA**") salary rate, for each respective individual position.

SCHEDULE H

FFS Retention Fund

Overview

1. The Government of the Province of New Brunswick (the "Province") and the New Brunswick Medical Society ("NBMS") have agreed to establish a program (the "Program") that will aim to maximize retention of participating fee for service medical practitioners within the Province. Salaried physicians and locum physicians are not eligible to participate in the Program.

2. Each practice that meets certain criteria with respect to the length and continuity of practice in the Province (an "Eligible Practice"), will be entitled to receive a payment from the Fund at the conclusion of practice in the Province as evidenced by the surrender of the billing number of the principal physician of the qualifying fee for service physician's practice ("Qualifying Practice").

3. For each fiscal year commencing on April 1, 2005, the Province will credit to a notional account (the "Fund") a dollar amount ("Contribution") with respect to each "Qualifying Practice".

    (a) The contribution will be made by the end of the first quarter based upon an estimate for the current Fiscal Years and an adjustment for variance with respect to the prior year estimate.

    (b) The annual incremental cost associated with adding new positions to the fund will be borne by the Department.

    (c) The cost of movement between ranges will be the responsibility of the Society.

    (d) Should the Program / Fund be terminated, for any reason, the Province and the NBMS will negotiate an alternative application for the Contribution and any residual in the Fund.

4. The annual dollar amount of the "Contribution" for each "Qualifying Practice" will be determined by multiplying the number of units awarded to the "Qualifying Practice" by the applicable unit value for that Fiscal Year.

    (a) The unit value cannot be altered during the fee-for-service (FFS) Distribution Phase.

    (b) The number of units awarded to a "Qualifying Practice" will be based upon the physician's number of years of service on a fee-for-service basis to NB Medicare as well as the location and based on the FFS Full-time Equivalent (FTE) of the "Qualifying Practice".

        See Attachment A - Tables 1, 2 & 3.

    (c) Years of service as a locum physician will not be included in the "years of service" count.

5. No Units will be awarded to a Qualifying Practice for the year in which it becomes an Eligible Practice.

6. Similar to other programs that have been established as a result of compensation negotiations between the NBMS and the Province, this Retention Program will be administered by the NBMS and payments will be issued by the NBMS using funds received from NB Medicare. The NBMS will submit periodic requests to NB Medicare for the amount of funds required to issue payments to eligible physicians.

7. The NBMS does and will not hold an actual pool of funding equal to the cumulative funds total for the Program. Neither will the Province, although the Province is disclosing a related liability on its financial statements. Payments from the Program are deducted from a "notional" fund balance.

8. Notional interest shall accrue each fiscal year on the balance of the Fund at the "Special Purpose Rate" as defined in NB Regulation 83-227 under the Financial Administration Act. The amount of the notional interest rate will be calculated on the last day of the previous quarter and credited to the balance of the Fund on the last day of the quarter.

9. Each Qualifying Practice must have one and only one principal physician. No physician may be the principal physician of more than one Qualifying Practice at any one time. A Qualifying Practice may be either an individual physician or a professional corporation. Where a group of fee for service physicians practice together in a partnership, the interest of each partner in that partnership shall be deemed a separate Qualifying Practice and the Units shall be held by the partner physician directly. For the purposes of the Program, only the services provided by the principal physician will be considered as services provided by the Qualifying Practice.

Transfer of Units

10. On the transfer of the principal physician from one Qualifying Practice to another, the first Qualifying Practice may transfer Units to the second Qualifying Practice. For example, where a physician practicing as the proprietor of a Qualifying Practice chooses to incorporate the practice, the Units held by the physician as proprietor of the first Qualifying Practice may be transferred to the professional corporation.

Categorization of Practices as "Rural" or "Urban"

11. The determination of the location of a practice will be done by application of the definition used with respect to the Program of Supplementary Funding for CME in effect on the first day of each fiscal year. For the year commencing April 1, 2005, a practice will be considered rural if the practice locations are beyond, and not falling between:
    - Moncton, Dieppe and Riverview
    - Saint John, Rothesay, Hampton, Quispamsis and Grand Bay/Westfield
    - Fredericton, Oromocto and New Maryland.

12. Where a practice has more than one location in a particular year (either by reason of a move or a practice carried out from multiple locations), the practice will be deemed to be "rural" for that particular year if not less than 75% of the billings of that practice were generated in a community or communities meeting the definition of "rural".

13. A determination of the location of practice as "rural" or "urban" for the fiscal years commencing prior to April 1, 2005 will be made for each practice. The Province will provide the NBMS with a list setting out the determination of location for each practice in the Province in the relevant period and will notify the principal physician of each practice of such determination. Each new practice

established following April 1, 2005 will be assigned an urban or rural location through agreement between the Province and NBMS.

Determination of Eligibility to Receive a Payment from the Fund

14. A practice will be an Eligible Practice and eligible to receive payment from the Fund as determined on the date of the relinquishment of the practitioner number of its principal physician if either:

    (a) The principal physician has provided service on a fee-for-service basis in the Province for not less than 15 continuous years. Temporary breaks in FFS service will not constitute a break in continuous service if:

        i. the break is of less than 12 months duration; or

        ii. the break of more than 12 months duration is for educational purposes with the prior approval of the Province and NBMS; or

    (b) The principal physician has provided service on a fee-for-service basis in the Province for not less than 20 years in total, provided that there has not been an interruption in FFS service in excess of 3 years in that period, other than a break for educational purposes (as set out in 14(a)(ii) above), with the prior approval of the Province and the NBMS.

    (c) A physician remunerated under the medical pay plan who has changed his principle mode of remuneration from FFS to Salary, will retain past shares prior to the transfer date (per 14 (a) and (b)) and would not accumulate any further shares during the year of transfer.

15. Where the principal physician of a practice ceases to practice in the Province by reason of death prior to relinquishment of the practitioner number the practice will be an Eligible Practice, as at the date of death of the physician regardless of the number of years of service of that physician. An amount will be payable to the estate based upon the number of units accumulated by the physician multiplied by the calculated unit value at the time of payment.

16. The practice of a permanently disabled principal physician will be an Eligible Practice at the date on which the Province or the NBMS is notified of the disability and the practitioner number is relinquished as a result of that disability, regardless of the number of years of service. A physician will be considered permanently disabled upon examination by an independent physician acceptable to both the Province and the NBMS who certifies that the physician is not capable of practicing medicine and will not become capable of practicing in his or her lifetime by reason of a recognized medical condition.

Forfeiture of Units in the Fund

17. A practice will forfeit all Units on the third anniversary of the day on which an interruption of service commenced, other than a break for educational purposes of the principal physician with the prior approval of the Province and NBMS.

18. For the purposes of determining the number of Units outstanding, an Eligible Practice will be deemed to have redeemed all Units on the first day of the fiscal year in which it became an Eligible Practice.

Determination of Payment to an Eligible Practice

19. Upon becoming an Eligible Practice, a practice will be entitled to receive a payment equal to the sum of:

    (a) the Eligible Practice's proportionate share in the Fund determined as at the last day of the last completed fiscal year (the "Determination Date"); and

    (b) the amount of the Contribution (prorated) made to the Fund with respect to that practice for the year in which it becomes an Eligible Practice.

20. Within 60 days of notification that a practice has become an Eligible Practice the NBMS will provide the principal physician of that Eligible Practice with a statement setting out the amount of the payment to which that Eligible Practice is entitled. In the event the NBMS is unable to provide a precise calculation of the amount of the payment within that time period, it shall provide an estimated amount.

21. Unless directed otherwise by the principal physician, the NBMS shall make a payment to the Eligible Practice as soon as reasonably practicable upon receipt of payment from the Province. However, the NBMS will have no obligation to pay any amount to the Eligible Practice unless and until it has received payment from the Province of the required amount.

Tax Liability Related to the Payment to an Eligible Practice

22. According to the advance rulings obtained from the Canada Revenue Agency (CRA):

    (a) The payment from the Program to an Eligible Practice must be declared as income in the year that the Medicare billing number is surrendered.

    (b) The Society will issue a Form T4A or T4A-NR Supplementary (Non-Resident of Canada) to the Eligible Practice, after the payment has been made.

    (c) Neither the Province nor the Society is required to withhold any amount from the payment to the eligible practice unless the payment is subject to the application of subsection 105 (1) of the Regulations (Income Tax Act) where such payment is made to a person who is not a resident in Canada for the purposes of the Income Tax Act at that time.

    Note: The CRA did not issue a ruling with respect to the GST/HST status of the payment to the eligible practice but provided an interpretation that to the extent that the payments are provided through the Medicare Plan they would appear to be consideration for an exempt supply pursuant to section 9 of Part II of Schedule V to the Excise Tax Act.

Payment Processing and Administration

23. Quarterly, or at such other interval as may be agreed by the Province and the NBMS, (the "Reporting Interval"), the NBMS shall deliver to the Province a request for payment from the Fund. The amount requested shall include:

    (a) All amounts payable in the next Reporting Interval with respect to Eligible Practices but only to the extent such amounts have not been previously requested and paid; and

(b) Amounts payable to NBMS to defray its costs of the administration of the Program. While the NBMS intends to recover its entire costs of administering the Program, including capital costs, the Society will not profit from the Program. The definition of Capital costs shall be consistent with the Society's audited Financial Statements.

(c) The notional balance of the Fund will be reduced by the amount of any payments made by the province to the Society whether according to paragraph (a) or (b).

(d) The Canada Revenue Agency has ruled that the payments from the Province to the Society with respect to administration costs are consideration for a taxable supply and are therefore subject to GST/HST. No deduction shall be made from the Fund with respect to such tax.

24. The Province shall have the right to review all requests for payment received from the NBMS and to facilitate that review, the NBMS shall provide the agents of the Province with reasonable access to all NBMS books and records related to the administration of the Fund.

Record Keeping

25. The NBMS will be responsible for the maintenance of a database, or databases as required, incorporating the information necessary to administer the Program and allowing the generation of the required reports.

26. Not more than 30 days following the end of each fiscal year, the Province will provide the following information to the NBMS with respect to each practice in the Province, as of March 31 of that fiscal year in a mutually acceptable electronic format:

(a) name of the principal physician;

(b) urban/rural designation; and

(c) FTE calculation for each physician as per the Medical Service Payment Act Section 2.2 (4).

26.1 On a quarterly basis, the Province will provide the following:

(d) on the last day of each quarter, the notional interest rate applied to the Fund (as per #8);

(e) the opening Fund balance;

(f) a listing of all physicians who have left the province or retired; and

(g) any other information deemed relevant to administer the Fund.

26.2 Prior to the start-up of the Program, the Province will provide, for each principal physician, the years of continuous and years of cumulative service in the Province as of April 1, 2005.

Reporting

27. Not more than 90 days following the end of each fiscal year the NBMS shall provide to the Province reports setting out the following information with respect to the Fund, for that fiscal year:

(a) the opening Fund balance;

(b) an estimate of contributions to the Fund for the current fiscal year and a reconciliation of the funds contributed for the previous fiscal year;

(c) amounts paid with respect to Eligible Practices, during the year;

(d) amounts paid to NBMS for administration during the year;

(e) the balance of the Fund at the end of the year;

(f) the cumulative number of Units awarded to practices and outstanding as at March 31 of the prior year; and

(g) the number of Units awarded and outstanding as at the end of the fiscal year.

28. Quarterly, or at such other interval as may be determined by the Province and the NBMS, the NBMS shall provide to the Province a report with respect to those practices which became Eligible Practices in that period setting out:

(a) name of the principal physician of each Eligible Practice;

(b) the proportionate interest in the Fund as at the last day of the last completed fiscal year;

(c) the amount of the Contribution with respect to that practice for the fiscal year in progress;

(d) the aggregate amount payable with respect to all practices which became Eligible Practices in that period.

29. NBMS will make available to each principal physician an individual report or record for each year outlining the information in the database with respect to that physician's practice. The NBMS will make available to all physicians the information set out in #27 above.

Dispute Resolution

30. In the event either the NBMS or the Province wish to question any amount, determination or other information provided under the Program, that party shall give the other notice in writing of its intention to do so not more than 60 days after receipt of the report or other notice of the amount at issue. The other party shall respond to such notice within 30 days with a written proposal to rectify the problem. If the notifying party is not satisfied with that proposal, the parties shall engage a mediator and the dispute shall then be adjudicated in accordance with the Negotiation and Dispute Resolution Regulation 2002-53 enacted under the *Medical Services Payment Act*.

Indemnification

31. The NBMS has agreed to indemnify and save harmless the Province from all actions, claims, suits, demands, loss and damage arising out of the Program.

32. Likewise, each physician who applies to receive a payment from the Program will be required to sign a document to indemnify and save harmless the NBMS from all actions, claims, suits, demands, loss and damage arising out of the Program.

Schedule I

Joint Oversight Committee – Terms of Reference

Name of Committee:	NBMS/Department of Health Joint Oversight Committee
Reports to:	NBMS: NBMS Economics Committee DOH: Office of the Associate Deputy Minister
Functions:	The Committee will be responsible for identifying potential resolutions of ongoing and/or unresolved issues including proposed Fee Schedule changes, billing and assessment rules and other administrative or financial/economic matters relating to contractual relationships between the Department of Health and the NB Medical Society for FFS and Salaried. The Committee could be used for related joint planning and establishing of priorities. The Committee will function and make recommendations by consensus. The Committee will meet a minimum of 8 times a year, ideally every 6 weeks or as required.
Membership:	The Committee will consist of seven (7) members, 3 from the NBMS and four (4) from the Department of Health. The Committee has the power to add members on an ad-hoc basis based on the issues before the Committee. The Committee will be co-chaired by the parties.

SCHEDULE J
SPECIFIC FUNDING ITEMS

	Resource Adjustment	2025-26 2.50%	2026-27 3.50%	2027-28 2.50%	2028-29 4.00%
FEE FOR SERVICE BASE [(1)]	$ 756,050,758	$ 865,635,015	$ 900,293,661	$ 931,958,225	$ 955,285,257
				(GEI $ Estimated)	**(GEI $ Estimated)**
GEI Increase:		$21,640,875	$31,510,278	$23,298,956	$38,211,410
Resource Adjustment:					
Family Medicine Specialists (18%)	$51,086,561				
Medical/surgical Specialists (12%)	$48,871,957				
Items Outside GEI:					
e-Consult		$250,105			
Hospitalist Program		$6,715,350			
On-call Programs		$2,854,884			
Emergency Department	$8,405,962				
Primary Care- 25% AHEP (See Note 2)		$3,170,967			
SJ ER AFP	$1,219,777				
MPP - Increase Autopsy Rates and Psychiatric fees		$26,465	$37,977	$28,076	$46,044
FIT Cap		$0	$116,309		
Total:	**$109,584,257**	**$34,658,646**	**$31,664,564**	**$23,327,032**	**$38,257,455**
Total Base	**$865,635,015**	**$900,293,661**	**$931,958,225**	**$955,285,257**	**$993,542,711**

Items Included in GEI:	**2025-26**
Parental Leave Program	329,000
Cancelled Surgeries	86,541
Enhance specialty travel clinic remuneration	177,478
Wellness Program	250,000
EMR	500,000
Closed Intensive Care Units	2,373,856
Total	**3,716,875**

(1) These are estimates. The actual results may vary based on reference years in section 3.1 of the agreement

(2) Primary Care - 25% After-Hours Emergency Premium (AHEP) is not to be included in retroactive calculation for 2025-26.

Schedule L

Electronic Medical Records (EMR) Program

The Department of Health and the New Brunswick Medical Society (Society) agree to continue the Electronic Medical Records (EMR) Dedicated Funding Pool with an annual budget of $1,750,000.00, to provide support to eligible Fee For Service (FFS) Physicians who adopt and implement an EMR into their practice.

First-time EMR Implementation Incentive

FFS physicians will be eligible for a one-time $10,000.00 incentive, payable upon implementation, to assist with the adoption of or transition to a provincially certified, EMR.

The Parties recognize and agree that implementing an EMR requires an investment of time, money, and energy, which may result in a period of lost or reduced clinic productivity. The Parties have agreed that this incentive shall be payable once per physician. In the event that a previously certified EMR becomes uncertified during the term of this Agreement, this incentive would be available a second time, to support any physician transitioning from a previously certified EMR to a different, provincially certified EMR. In no event will a physician receive this incentive more than two (2) times.

Physicians who receive EMR transition funding through another program are not eligible for this transition incentive.

The Parties may agree to revise these amounts by written agreement.

EMR Reimbursement Incentive

FFS physicians that do not receive reimbursement through any other program, will be eligible for:

- Annual reimbursement of up to $4,800.00 for the costs of a provincially certified, EMR; or

- Annual reimbursement of up to $3,000.00 for the costs of an EMR not provincially certified. This reimbursement incentive is temporary, funded through pre-existing program surplus, and will be available up to March 31, 2029, at which time it will be terminated.

Schedule M

PRINCIPLES OF CONSULTATION BILLINGS

These principles were drafted to assist Physicians in the appropriate billing of Consultation codes as found in the various sections of the New Brunswick Physician's Manual. Instructions regarding referrals, physical examinations, documentation required, applicability of the after-hours emergency premium, and consultation billings when physicians are receiving sessional payment are provided.

Introduction

A billable consultation refers to the situation where a recognized provider (see Chapter 1, Section 1.7.1 (h) or Section 1.7.2 (j) of the Physician Manual) specifically requests the opinion of a physician who is competent to give advice in the requested field because of the complexity, obscurity or seriousness of the case. The request may result from the referring provider's own assessment of the patient or from his concurrence with a request by the patient or a person acting on behalf of the patient.

A consultation IS:

- Initiated by the referring physician, not the consultant.
- A written or verbally requested assessment of a patient that is correctly documented in the patients clinical file, including date and time of the request.
- Made by an approved allied healthcare professional.
- A request for reassessment of a patient after a change in the existing condition

A consultation IS NOT:

- A follow-up care visit/service provided to a patient where an existing diagnosed condition has been managed by the consultant/physician/specialty.
- A subsequent visit arranged by the consultant for follow-up (see visit code listed in the specialty section).
- To provide temporary/routine patient coverage for patients in the physician's absence.
- A transfer of care from same specialty for continuation of care.
- A referred patient for a procedure that has not received the proper assessment of a consultation.
- A referral to a specialized practice/clinic for the sole purpose of prescribing medical marijuana.

Note: A patient referred for diagnostic procedure needs complete assessment consultation in order to bill a consultation.

Required documentation in order to Support the Referral

In order to meet the billing requirements of a consultation, a written referral or documentation of a referral by telephone must be included in the file. The documentation must include:

A. Patient's name, Medicare number, and date of birth
B. Consultant's name or the name of service being referred to
C. Specialty

D. Date of the referral
E. Name of the referring practitioner
F. Reason for requesting an opinion
G. Date and time of verbal request by telephone when applicable.

Note: A form issued by the consultant to the referring practitioner, asking them to sign and return it to the consultant physician, does not constitute an acceptable consultation request.

Documentation Required in the Consultation Report

In order to fulfill a requested consultation, "The consultant is obliged to perform an assessment as per the definition of a consultation in Chapter 3, section 1.2.4 and ensure inclusion in the Consultation report.

The documentation must include:

A. Written communication back to the referring practitioner including the patient's name, Medicare number and date of birth
B. Name of the referring practitioner
C. Date of the consultation
D. Name of the consultant
E. Evidence of a history and appropriate comprehensive examination of the pertinent system(s) having been performed
F. Review of laboratory or other pertinent data (as required)
G. Opinion and further recommendations for management

Note: It is incumbent upon the physician to maintain adequate clinical records that support the service(s) being claimed when using electronic medical record software for billing a service. (Chapter 1, section 7.2)

After-Hours Emergency Premium

The definition of emergency services for the purpose of billing premiums, refers to those services which must be performed without delay because of the medical condition of the patient. The time of the service provision is not in itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. This premium is only payable when both criteria have been met; an emergency service (Chapter 3, section 1.2.2 d) provided after-hours (Chapter 4, section 2.12).

Fee-for-Service Consultation Billings and Sessional Remuneration

Unless otherwise specified, sessional fees are all inclusive rates and physicians are not to bill fee-for-service in addition to their sessional payment, regardless of where the service is provided.

Schedule N

CLOSED INTENSIVE CARE UNIT – ALTERNATE FUNDING PLANS

The New Brunswick Medical Society (the **Society**) and the Department of Health acknowledge that, prior to April 1, 2025, the terms and conditions for physician coverage and compensation in Closed Intensive Care Units (Closed ICUs) were governed by the 2020 Physician Services Master Agreement, in conjunction with individual Closed ICU Alternate Funding Plan (AFP) agreements. Effective April 1, 2025, the coverage and compensation for each Closed ICU will be governed solely by the terms outlined in its individual Closed ICU Alternate Funding Plan (AFP) agreement.

1.0 The Society and the Department of Health have agreed that effective April 1, 2025:

1.1 The terms and conditions of coverage and compensation set out within the former Schedule N of the *2020 Physician Services Master Agreement* are no longer in force and effect.

1.2 All terms and conditions governing physician coverage and compensation will be set out exclusively in each individual Closed ICU AFP agreement.

1.3 Closed ICU AFPs with 24-hour on-site coverage (currently in place at *the Dr. Everett Chalmers Regional Hospital, The Moncton Regional Hospital, the Georges L. Dumont Regional Hospital, and the Saint John Regional Hospital*) will be funded at a rate of $455 per bed, per day, 365 days per year, to be adjusted pursuant to the terms of each individual AFP.

1.4 Closed ICU AFPs with off-site, after-hours coverage (currently in place at each of the *Edmunston Regional Hospital, the Miramichi Regional Hospital, the Chaleur Regional Hospital, and the Upper River Valley Regional Hospital*) will be funded at a total cost of $1,085,571/year, per Closed ICU, to be adjusted pursuant to the terms of each individual AFP.

Schedule O

	CALCULATED
2024-25 FFS Base	2024-25 BASE
Payments for FFS claims 2024-25	506,850,931
Capitation	8,697,588
Manual Payments (sessional, collaborative practice and other)	75,199,087
AFP & APP funding (including annualization of changes)	117,604,425
CME expenses (FFS)	3,123,675
Fund for CMPA	4,869,151
Fund for Mandated on-call/second call	25,205,474
Fund for Parental Leave Program	2,300,000
Fund for Supplementary Honoraria	260,000
Fund for Province-Wide Call	600,000
Fund for Retention Fund	4,855,937
Fund for EMR	1,500,000
Fund for Wellness Program	250,000
Fund for Primary Care task Force	250,000
CME - Salaried	2,550,490
CMPA - Salaried	1,933,821
Total	**756,050,578**
2024-25 Salary Base	116,635,745
Total	**872,686,323**

Schedule P

Practice Support Program

Program

The Practice Support Program (the "**Program**") is a province-wide initiative administered by New Brunswick Medical Society (the "**Society**") to provide coordinated business and practice management support to physicians and physician team-based practices in New Brunswick. The Program shall function as a centralized support resource and may include the development and delivery of tools, advisory services, facilitation, education, and related supports intended to improve practice operations, enhance team-based care, strengthen the use of health technologies, and promote high-quality, patient-centred care.

The Program shall be delivered by the Society in a manner consistent with the purpose of the Program and the terms of this Schedule. The Society shall ensure that appropriate personnel, governance, accountability, and oversight mechanisms are in place to deliver the Program efficiently and in accordance with applicable laws and standards, and shall provide information respecting Program delivery upon request of the Minister.

Funding

Effective April 1, 2026, the Department of Health shall provide funding to the Society for the operation and administration of the Program in a fixed amount of **$750,000.00** per fiscal year during the term of the Physician Services Agreement. This amount is funded by reallocating **$250,000** annually from the Primary Care Task Force initiative and **$500,000** annually from the Family Medicine New Brunswick Program budget under the Predecessor Agreement.

Allocation and Reporting Requirement

The Society shall determine the allocation of Program funding in a manner consistent with the purpose of the Program and the terms of the Physician Services Agreement. No later than March 31 of each fiscal year, the Society shall provide written notice to the Minister setting out the proposed allocation of Program funding for the forthcoming fiscal year, including a summary-level breakdown of planned expenditures.

Schedule Q

New Service Items

Definition

A New Service Item is defined as a request for a new fee code for a service, procedure, technique, or technology that does not yet have a fee code established in the *New Brunswick Physicians Manual*.

The New Service Items (NSI) process is not to be used for fee increases or to create new codes with higher fees for services currently insured under an existing fee code.

Process

All NSI requests are to be submitted to the NBMS Economics Committee and shall be considered as part of the annual Distribution cycle under the *Physician Services Agreement*. The New Brunswick Medical Society (the **Society**) shall provide copies of all NSI requests to the Department of Health.

All requests for New Service Items shall be assessed by the Society and the Department of Health to determine whether new funding is required.

Where it is determined and agreed by the Society and the Department of Health that a NSI request is cost neutral or will produce a cost savings, such requests may be approved on written agreement of the parties.

Where it is determined that a NSI request requires new funding, and the parties agree to create a new fee code, the following rules shall apply unless otherwise agreed:

1. NSI requests initiated by the Department of Health or a Regional Health Authority shall be funded by the Department of Health.
2. NSI requests initiated by the Society or physician members shall be funded through GEI allocations to relevant sections as part of the annual Distribution cycle.

The Department of Health shall notify physicians of all new codes established under the NSI process annually, as part of the *New Brunswick Physician's Manual* update.

Schedule R

Remuneration for Surgical Cancellations

Goal:
To recognize the opportunity cost to the New Brunswick health care system of cancelled surgeries and to establish a remuneration plan for physicians for surgeries cancelled for non-medical or administrative reasons.

Fee:
100% of the fee payable to the surgeon, surgical assistant and anesthesiologist had the surgery not been cancelled due to the non-medical reason defined herein.

- Non-medical and administrative reasons:
  - Post op bed unavailable
  - Equipment unavailable or malfunction
  - OR staff or suite unavailable
- This fee will only be payable if the surgery is cancelled within 24 hours of the scheduled day of surgery (or Friday for a surgery scheduled for Monday)
- This fee will be payable only when physicians are unable to perform other surgical procedures in place of their cancelled surgeries
- *Payable once per physician per patient for the same condition within 30 days of the initial cancellation.*
- *Applicable only to scheduled procedures as booked on the OR booking card.*
- Fees will apply to surgical procedures performed in the main OR.
- Fees will apply to Short Stay Units.
- Salaried physicians (including anesthesiologists and surgical assistants) or those in an alternate funding arrangement would not be eligible.
- After Hours Emergency Premium does not apply.
- If required, the RHA will confirm whether case was cancelled or not.
- The information required for audit purposes will be provided by the RHA.
- This fee does not apply to surgery cancelled for out-of-province patients.

Note: A Short Stay Unit is defined as a unit designated to accept postoperative patients overnight. These patients are not considered in-patients.

Anesthesiologists must use the average time spent on the specific procedure being billed. Only modifiers identified during pre-anesthetic evaluation are applicable for billing.

Schedule S

PHYSICIAN WELLNESS PROGRAM

1.0 Purpose

The purpose of this document is to identify the annual funding available to the New Brunswick Medical Society ("Society") for the purposes of providing Physician Health and Wellness Program to members of the Society.

2.0 Description

The Department of Health will maintain a Protected Funding Pool to be used for providing individualized health and wellness support to physicians practicing within New Brunswick.

3.0 Benefits

The Society is authorized to utilize this Protected Funding Pool to provide physicians with access to benefits such as health promotion and wellness initiatives, specialized counseling services, and specialized in-patient treatment services.

4.0 Funding

4.1 Effective April 1, 2025, the Department of Health will increase the all-inclusive amount of $250,000 annually to $500,000 annually to fund the Physician Wellness Program under the Physician Services Agreement.

4.2 This amount provides a self-sufficient fund which will not sustain any cost overruns.

4.3 The funding pool balances shall be reconciled annually by the Department of Health and any surplus shall be available to the Society upon mutual agreement for alternate use or reallocation. Any over-expenditure of funds shall be funded with the existing surplus from other Protected Funding Pools or shall be recovered from the following year's Distribution if no funding is available in the current year.

5.0 Eligibility Criteria

5.1 The Society may establish eligibility criteria as necessary, in consultation with the Department of Health.

6.0 Program Management

6.1 The Program is administered by the Society.

6.2 A report detailing Program payments, will be submitted to the Department of Health annually by the Society on or before April 30th for the previous year.

6.3 Any interest earned by this fund after it is provided to the Society shall be retained by the Society.

Schedule T

AFP Management Framework

I. Background:

In response to the evolving nature of medical practice and the needs of Department of Health and physicians to ensure access to health care for New Brunswick patients, the New Brunswick Medical Society (**Society**) has facilitated and carried out negotiations with the Department of Health to establish Alternate Models of Remuneration, where appropriate. These Alternate Models of Remuneration are negotiated on behalf of physicians or groups of physicians who perform necessary services that often do not fit the traditional models of compensation, such as Fee-For-Service (FFS) and Salary compensation.

II. Definitions:

Alternative Funding Plan (AFP) – AFPs are contractual arrangements between the Department of Health, the Society and the Regional Health Authorities (**RHAs**). AFPs provide flexibility in practice, encouraging coordination and integration of medical services, providing stabilized compensation for highly specialized groups, specialists and sub-specialists. Each AFP includes at a minimum, all of the physicians working in the department or division, but may be expanded to include specialty or sub-specialty within the RHAs or Province. AFPs create a fixed pool of funding for clinical departments of physicians, wherein physicians have autonomy and control over allocated funds and establishing the means of meeting agreed-upon deliverables for patient care and coverage. Funds from the AFP are distributed to physicians through a practice plan that is developed by the physicians and agreed to by the Department of Health and the RHAs.

Academic Funding Plan – A less common model of alternate funding is an Academic Funding Plan. Academic Funding Plans are contractual arrangements between physicians, the Department of Health, the Regional Health Authority and may include other organizations such as hospitals, universities and private funders. Academic Funding Plans apply to individual academic departments or divisions and carry different deliverables and funding from various sources. Academic Funding Plans recognize and compensate physicians for their direct clinical services in addition to their academic, research and administrative deliverables.

III. Goals of Alternative Remuneration Models may include:

1. Improving patient care throughout New Brunswick
2. Ensuring equitable and predictable physician remuneration throughout New Brunswick
3. Ensuring effective recruitment and retention of physicians to New Brunswick
4. Ensuring practical and achievable deliverables are met
5. Ensuring access to health care and physician support in rural and remote communities, and to highly trained specialists throughout the Province

The Society and the Department of Health recognize that the use of Alternate Models of Remuneration is an evolving model of health care funding, and will be subject to review and revision, by mutual agreement, as necessary.

IV. Process:

a. Negotiation of NEW AFPs

Step 1: Physician Practice-Assessment

Physicians interested in being considered for funding under an Alternate Model of Remuneration must first prepare their own Practice-Assessment to identify specific relevant information, and to ensure they are in a position to engage in discussions with the RHA, Department of Health and the Society. The Practice-Assessment should include the following information:

i. A description of the existing group of physicians, and the scope of their practice (clinical and geographic)
ii. A description of current activities for which the group of physicians currently engages (clinical, research, teaching)
iii. An accounting of the total resource base currently dedicated to the group of physicians (total Remuneration)
iv. For salaried physicians, an accounting of benchmarks and shadow-billing data available
v. A preliminary assessment of interest within the group of physicians (alternative funding in a particular community would only be pursued if all members of that particular discipline/specialty have agreed to participate)

Upon completion of the Practice-Assessment, the group of physicians will meet with representatives of the Society to confirm all relevant information is included and establish timeframes for engaging with government.

Step 2: Identifying Common Data and Deliverables

In consultation with the Society, the group of physicians should define a common data set that will serve as a basis for articulating deliverables. Physicians interested in pursuing alternative funding will require consideration of the data concerning the relevant parties (Physicians, Government, RHA, University, other), and the deliverables associated with the funding (Clinical, Administrative, Teaching/Education, Research).

A fundamental component of this part of the process will be identifying the method of measuring performance and objectives of the Alternate Models of Remuneration.

Upon identification of the common data, deliverables and performance measurement by the physicians, the Society will engage with the Department of Health, and any other parties to the proposed agreement to identify prospective issues or matters for further consideration.

Step 3: Negotiation, Drafting and Revision of Agreement

Engaging with Department of Health, and others, the Society will facilitate the negotiation, drafting and revision of the terms of the alternative funding agreement. The Society will work with a designated representative(s) of the group of physicians, ensuring there is consensus and approval among all affected

physicians regarding the drafting of the proposed agreement. Any forms and templates created, amended or deleted pursuant to this AFP framework are subject to agreement by the AFP Advisory Committee.

All AFP contracts are expected to include the following key terms:

- Provision of additional resources will be established through a contract re-opener clause.
- Full participation of all physicians within that particular discipline/specialty, subject to the agreement of the Society, RHA and Department of Health.
- Any third-party income, with the exception of medical legal work, and external academic funding arrangements shall be returned to the payor unless otherwise specified in the AFP contract.
- Any right of physicians to bill for Mandated on-call compensation, FFS earnings, CME, CMPA, Parental Leave and the FFS Retention Fund Program must be addressed within each contract.
- Each AFP shall include a Practice Plan which must address:
    - Agreed expectations and deliverables regarding service volumes and hours/days worked by physicians; and
    - Obligations of the parties related to shadow-billing, monitoring and compliance, budget oversight, and administration.

This framework will apply to the determination of initial arrangements as well as renegotiating terms and conditions as contracts expire.

Step 4: Finalizing the Agreement

Upon completion of the negotiation of the relevant agreement, the Society will submit the following to the Department of Health and the RHA:

- AFP Proposal Agreement Template;
- AFP Funding and Costing Template;
- Practice Plan; and
- Any other applicable templates and forms.

Upon review and approval by the Department of Health and the RHA, a long-form contract shall be drafted giving effect to the purpose and intention of the AFP Proposal.

An AFP is conditional on Society and any physicians completing and submitting to the Department of Health all required forms, templates and practice plan.

b. AFP Maintenance and Revisions

An AFP Advisory Committee shall be established to consult and advise on issues of AFP negotiation and re-negotiation, as necessary. The AFP Advisory Committee shall be continued pursuant to the Terms of Reference attached as **Appendix 1**.

c. AFP Accountability

Monitoring of AFP activities and evaluation of deliverables will be conducted on an annual basis (at a minimum). Failure to meet deliverables will lead to financial and/or administrative actions, up to and including termination of the AFP.

APPENDIX 1

AFP MANAGEMENT FRAMEWORK
AFP ADVISORY COMMITTEE TOR

AFP ADVISORY COMMITTEE
TERMS OF REFERENCE

PROJECT NAME:	AFP Advisory Committee
DATE ESTABLISHED:	March 2021

PURPOSE OF THE COMMITTEE

The AFP Advisory Committee (the "Committee") will consist of representatives from the Department of Health (DH), the Regional Health Authorities (RHAs) and the New Brunswick Medical Society (NBMS). The primary function of the committee is to collaboratively address new and ongoing negotiations issues related to the creation and maintenance of AFPs.

COMMITTEE RESPONSIBILITIES

- Review data provided by the DH, RHAs, and Physician;
- Provide advice and consultation on the negotiation of newly proposed AFPs;
- Provide advice and consultation on issues that may arise within existing AFPs;
- Identify opportunities for improvement to the AFP process;
- Provide feedback and recommendations to the parties, as requested; and
- Report on a quarterly basis to the Associate Deputy Minister of Health, including all formal decision requests.

COMMITTEE MEETINGS

The Committee will hold recurring face to face and/or Video/Teleconference meetings. The Committee will meet as required. Meeting dates will be mutually agreed upon by the parties.

MEETING AGENDA & MINUTES

- A standardized agenda will be prepared prior to each meeting, issues/action items will be identified/assigned/reviewed, and formal minutes of the meeting will be recorded and distributed for review/approval at the following meeting.

- The meeting will be co-chaired by the Department of Health and the NBMS.

Membership

The Committee will consist of members of the designated parties and other ad-hoc members as required, including AFP members.

The Committee shall include two representatives from the Department of Health Medicare and Physician Services, one representative from the Department of Health Financial Services, one member from the NBMS Negotiations Committee, one member from the NBMS Membership-at-large, one representative of Vitalité Health Network Medical Administration, one representative of Horizon Health Network Medical Administration, and one member from each of Horizon and Vitalité Financial Services teams.

This Committee shall commence in January 2022, and will provide recommendations as requested.

Committee Costs

Each party will be responsible for costs associated with their respective members. Physician members will be eligible for top up funding from the Supplementary Honoraria Program.

Committee Membership

Name	Organization	Phone	E-Mail
NBMS Member-at-large Rep	NBMS		
NBMS Negotiations Committee Rep	NBMS Negotiations Committee Rep		
Horizon Medical Admin Rep	Horizon		
Vitalité Medical Admin Rep	Vitalité		
Vitalité Financial Services Rep	Vitalité		
Horizon Financial Services Rep	Horizon		
DH Financial Services Rep	DH		
Medicare and Physician Services Rep	DH		
Medicare and Physician Services Rep	DH		

Schedule U

After-Hours Emergency Premium (AHEP) Consolidation

The Parties agree to amend and consolidate the various existing language regarding AHEP under Chapter 4, Section 2.12 of the New Brunswick Physicians Manual:

2.12 *After Hours Emergency Premium

After-hours is defined as 18:00 to 06:59 hours on weekdays and all day on Saturdays, Sundays and statutory holidays; and, for non-specialists only, anaesthesia at the sacrifice of regularly scheduled office hours. The premium is *60% of the normal rate of payment with a minimum for the total billing of 30 general units or 3 anaesthesia units. Between the hours of midnight and 06:59 hours, the premium increases to *125%. When multiple services are performed, the minimum 30 general units or 3 anaesthesia units is only applicable for the primary service.

Emergency services for this purpose are defined as services, which must be performed without delay because of the medical condition of the patient. This includes non-elective caesarean sections and effective April 1, 2017, would include **non-elective** surgery done in the after-hours period, due to lack of available daytime operating room time or resources.

The premium does not apply to services performed by physicians providing scheduled on-site coverage during after-hours periods. The premium applies to the following emergency services:

a. surgical procedures performed under general, spinal or epidural anaesthesia and surgical assistance and anaesthesia related thereto;
b. procedures performed under major nerve root blocks;
c. reduction of shoulder dislocations (Service Code 502);
d. daytime anaesthesia by non-specialist at the sacrifice of regularly scheduled office hours;
e. consultations;
f. emergency hospital admissions;
g. initial assessments in intensive care and concentrated care units;
h. initial management of trauma;
i. after-hours detention;
j. cadaver - organ, tissue or bone removal;
k. obstetrical deliveries, including medically indicated induction of labour, which proceeds to delivery after hours;
l. Conscious Sedation: Conscious sedation (moderate sedation/analgesia) is a deeper level of sedation/analgesia than anxiolysis (minimal sedation). It (moderate sedation) is defined as a drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful stimulus is not considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. The medically controlled state of depressed consciousness:

- Allows protective reflexes to be maintained;

- Retains the patient's ability to maintain a patient airway independently and continuously.

Medicare Note: Claims involving premium payments must show the time of day the service was rendered including weekends and statutory holidays. The total amount billed (fee plus premium) should be entered on the same claim line. Services performed under major nerve block must be identified on the claim.

Refer to Chapter 4, Section 2.12.1 for values and details for billing purposes

Emergency visit – A situation where the demands of the patient and/or the physician's interpretation of the condition require that he responds immediately at the sacrifice of regular office hours or routine medical practice. **The need for immediate response is the intended controlling feature.** Immediate attendance because of personal choice or availability of the physician is not considered an emergency visit. Urgent visits for acute or chronic conditions which do not interfere with routine medical practice, do not constitute emergency visits. **Emergency visits may include any visit codes for services rendered on an emergency basis at the office, home, nursing home, Extra Mural, or hospital, or emergency calls in which the patient is seen outside – e.g. on the street. All claims for emergency based visits must show the time of day the services were rendered.** [*chapter 3, section 1.2.2(d)*]

The definition of emergency services, for the purposes of billing premiums, refers to those services which must be performed without delay because of the medical condition of the patient. The time of the service is not by itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. This premium is only payable when both criteria have been met: an emergency service, provided after-hours. [*chapter 3, section "Guidelines for the billing of Consultations"*]

The premium does not apply to services performed by physicians providing scheduled on-site coverage during after-hours periods.

An after-hours emergency premium can be billed when:

- A physician requests a consultation at 21:40 hrs for a patient in kidney failure where organ function is compromised. A consultation is rendered at 22:00 hrs. The specialist bills a consultation with after-hours emergency premium. Both are payable as the "emergent" and "after-hours" criteria are met.

An after-hours emergency premium cannot be billed when:

- A physician requests a consultation on April 1 at 11:00 hrs regarding a patient's lack of appetite. A specialist renders the consultation on April 6 at 20:00 hours. The specialist bills a consultation with an after-hours emergency premium. The consultation is billable; the premium is not (providing a service 5 days after the request does not support the emergent nature of the request. [*chapter 3, section "Guidelines for the billing of Consultations"*]

SCHEDULE V

FAMILY MEDICINE NEW BRUNSWICK PROGRAM

The Family Medicine New Brunswick Program (the **FMNB Program**), operated by the New Brunswick Medical Society (the **Society**) under Schedule V of the Predecessor Agreement, attached hereto as Appendix 1, shall be discontinued and come to an end on or before March 31, 2027.

Physicians participating in the FMNB Program shall be eligible to transition to one of the new Primary Care Compensation Models established under the *2025-2029 Physician Services Agreement, Schedule G*.

The Department of Health and the Society agree that:

1. Physicians participating in the FMNB Program as of April 1, 2026, shall automatically transition to the Collaborative Care Clinic (CCC) compensation model and shall be eligible to receive all components of CCC financial/administrative supports for a period of up to twelve (12) months, ending no later than March 31, 2027. During this transition period, physicians may elect to remain in the CCC model by entering into a CCC Accountability Agreement with either the Department of Health or a Regional Health Authority or may select an alternate Primary Care Compensation Model established under the 2025–2029 Physician Services Agreement. CCC compensation during the transition period shall be provided in accordance with the applicable terms of the 2025–2029 Physician Services Agreement, Schedule G.

2. The FMNB Program shall terminate on or before March 31, 2027. The Parties agree to take all necessary administrative and contractual steps to give effect to the termination of the FMNB Program, including providing any required notice to participating FMNB physicians and formally concluding any agreements associated with the FMNB Program.

APPENDIX 1

FAMILY MEDICINE NEW BRUNSWICK PROGRAM

1.0 BACKGROUND

1.1 The Minister and the Society entered into a Memorandum of Understanding dated January 29, 2016 (the "**MOU**"), to work cooperatively in pursuing and establishing a new model of family medicine delivery within the Province of New Brunswick.

1.2 Pursuant to the MOU, the Parties agreed to develop a mutually acceptable Framework Document which would provide details on the proposed organization, administration and resources required to operationalize a new model of family medicine delivery within the Province of New Brunswick.

1.3 The Parties have developed a mutually acceptable Framework Document (hereinafter referred to as the "**FMNB Operational Guide**") which shall guide the Parties as they seek to operationalize this new model of family medicine delivery within the Province of New Brunswick.

2.0 FAMILY MEDICINE NEW BRUNSWICK

2.1 The Parties agree to establish a new model for primary care delivery within the Province of New Brunswick, which shall be known as Family Medicine New Brunswick ("**FMNB**"). The principles underpinning this model include:

(a) a patient-centered, team-based, inter-professional approach from providers;
(b) a sustainable and financially responsible approach to family medicine in New Brunswick;
(c) timely, longitudinal patient access to health-care professionals;
(d) full use of the Provincial Electronic Medical Record;
(e) a focus on disease prevention, self-care, and chronic disease management; and
(f) productive and quality focused health-care professionals.

2.2 FMNB shall be funded by the Minister, and organized as a program pursuant to the Physician Services Master Agreement of which this Schedule V forms part (the "**PSMA**").

3.0 THE FMNB OPERATIONAL GUIDE

3.1 Further to the Objectives and Vision set out in the MOU, the Parties have developed the FMNB Operational Guide dated October 21, 2016, which is intended to guide the Parties in operationalizing the vision for FMNB. The FMNB Operational Guide is hereby incorporated in and forms part of this Schedule.

3.2 The Parties agree to establish the FMNB Program Management Committee, according to the FMNB Program Management Committee Terms of Reference, as set out in the FMNB Operational Guide.

3.3 The Parties agree that the Society has a mandate to operationalize FMNB as a Physician Services Program under the PSMA, in compliance with the FMNB Operational Guide.

3.4 The Parties agree that the FMNB Operational Guide is an iterative document. Any revisions to the FMNB Operational Guide may be mutually agreed upon by the FMNB Program Management Committee.

3.5 The Parties may agree to renegotiate the terms of this Schedule and the FMNB Operational Guide as necessary as mutually agreed by the Parties.

4.0 COMMUNICATIONS

4.1 The Parties agree to consult and coordinate with each other with respect to physician and public facing communications to be released by either Party concerning the FMNB program.

5.0 PROGRAM TERMINATION

This Family Medicine New Brunswick Program may only be terminated:

(a) one year after written notice of termination is given by either Party to the other; or
(b) on a date set by mutual written agreement of the Parties.

6.0 BUDGET

The 2021 – 2026 budget for Family Medicine New Brunswick Program is as follows:

	2021-22	2022-23	2023-24	2024-25	2025-26
(Variable Cost Estimates)	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Staff, administration and information technology (salary, office space, travel, telecom, supplies, comms, strategic events, legal, translation)	$504,000	$504,000	$600,000	$600,000	$600,000
Physician Stewardship Group & PMC (Operating Board)	$24,000	$28,000	$32,000	$36,000	$40,000
Clinic On-boarding & Ongoing Cost (initial cost, honoraria, ongoing cost)	$35,000	$35,000	$35,000	$35,000	$35,000
Annual Conference	-	$65,000	$65,000	$65,000	$65,000
Patient and Physician survey	$20,000	-	$20,000	-	$20,000
Total Organizational Costs	**$583,000**	**$632,000**	**$752,000**	**$736,000**	**$760,000**

6.1 - **Electronic Medical Record (EMR) Costs:**

	2021-22	2022-23	2023-24	2024-25	2025-26
(Variable Cost Estimates)	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Projected number of physicians anticipated to be engaged in the model	**60**	**80**	**100**	**120**	**140**
EMR one-time implementation ($2k)	$20,000	$40,000	$40,000	$40,000	$40,000
EMR operational fees ($454/mo.)	$327,000	$436,000	$545,000	$654,000	$763,000
IH or other vendors /FMNB support	$15,000	$15,000	$15,000	$15,000	$15,000
Information Technology (Merge/Splits/data migration from other EMRs)	$50,000	$50,000	$50,000	$50,000	$50,000
Total EMR Costs	**$412,000**	**$541,000**	**$650,000**	**$759,000**	**$868,000**

6.2 – **Overhead Support**

	2021-22	2022-23	2023-24	2024-25	2025-26
	Year 5	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Projected number of physicians anticipated to be engaged in the model	**60**	**80**	**100**	**120**	**140**
OH Support ($5k/yr; office renos /IT/etc.)	$300,000	$400,000	$500,000	$600,000	$700,000
Total Overhead Support Costs	**$300,000**	**$400,000**	**$500,000**	**$600,000**	**$700,000**

6.3 **- Total Forecasted Funding:**

	2021-22	2022-23	2023-24	2024-25	2025-26
	Year 5	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Organizational Costs	**$583,000**	**$632,000**	**$752,000**	**$736,000**	**$760,000**
EMR Costs	**$412,000**	**$541,000**	**$650,000**	**$759,000**	**$868,000**
Overhead Support Costs	**$300,000**	**$400,000**	**$500,000**	**$600,000**	**$700,000**
Total Operational Costs	**$1,295,000**	**$1,573,000**	**$1,902,000**	**$2,095,000**	**$2,328,000**

DH will reimburse the Society semi-annually based on costs incurred up to the maximum organizational costs per year, as indicated in the table below. At the end of each fiscal year, the Society will provide DH a listing of itemized costs incurred to support the amounts invoiced to DH.

The Society is permitted to carry forward unused funds from one fiscal year to the following fiscal year in an amount up to 10% of the total organizational costs for the fiscal year, as outlined in the table below. Any remaining accumulated or annual surplus at the end of Year 9 shall be returned to DH.

The Society will submit quarterly invoices for funding with appropriate detail which will be reconciled at the end of the fiscal year.

The Operational Plan shall be amended effective April 1, 2022 to include:

- Elimination of the MGR in favour of a 6-month Professional Services Contract for new physicians joining the program; and
- Implementation of New Brunswick Age/Gender Ratio Index with Capitation at the current base rate of $96.09.

DH will reimburse the Society semi-annually based on costs incurred up to the maximum organizational costs per year, as indicated in the table below. At the end of each fiscal year, the Society will provide DH a listing of itemized costs incurred to support the amounts invoiced to DH.

The Society is permitted to carry forward unused funds from one fiscal year to the following fiscal year in an amount up to 10% of the total organizational costs for the fiscal year, as outlined in the table below. Any remaining accumulated or annual surplus at the end of Year 9 shall be returned to DH.

The Society will submit quarterly invoices for funding with appropriate detail which will be reconciled at the end of the fiscal year.

The Operational Plan shall be amended effective April 1, 2022 to include:

- Elimination of the MGR in favour of a 6-month Professional Services Contract for new physicians joining the program; and
- Implementation of New Brunswick Age/Gender Ratio Index with Capitation at the current base rate of $96.09.

Schedule W
Medical Pay Plan and
Addendum to Medical Pay Plan

Medical Officer - Administrative
Bi-weekly & Annual Rates: April 1, 2025
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES				
		1	A	B	C	D
6239 1 01	Medical Officer Administrative	9,023	9,263	9,685	10,121	10,948 *
		234,598	240,838	251,810	263,146	284,648

* STEP "D" is the maximum for positions classified as Medical Directors in hospitals;
STEP "C" is the normal maximum for all other positions..
Effective April 1, 2025 a Resource Adjustment of 12% is included in the rates above.

Medical Officer - Administrative
Bi-weekly & Annual Rates: April 1, 2026
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES				
		1	A	B	C	D
6239 1 01	Medical Officer Administrative	9,339	9,587	10,024	10,475	11,331 *
		242,814	249,262	260,624	272,350	294,606

* STEP "D" is the maximum for positions classified as Medical Directors in hospitals;
STEP "C" is the normal maximum for all other positions..

Medical Officer - Administrative
Bi-weekly & Annual Rates: April 1, 2027
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES				
		1	A	B	C	D
6239 1 01	Medical Officer Administrative	9,572	9,827	10,275	10,737	11,614 *
		248,872	255,502	267,150	279,162	301,964

* STEP "D" is the maximum for positions classified as Medical Directors in hospitals;
STEP "C" is the normal maximum for all other positions..

Medical Officer - Administrative

Bi-weekly & Annual Rates: April 1, 2028

Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES				
		1	**A**	**B**	**C**	**D**
6239 1 01	Medical Officer Administrative	9,955	10,220	10,686	11,166	12,079 *
		258,830	265,720	277,836	290,316	314,054

* STEP "D" is the maximum for positions classified as Medical Directors in hospitals;

STEP "C" is the normal maximum for all other positions..

Médecin administrateur

Taux de paie à la quinzaine et annual: Le 1er avril 2025

Régime de rémunération du personnel médical

AEG- 2,50%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL					
		1	A	B	C	D	
6239 1 01	Médecin-administrateur(trice)	9,023	9,263	9,685	10,121	10,948	*
		234,598	240,838	251,810	263,146	284,648	

* L'ÉCHELON "D" S'applique aux postes de coordinateurs provinciaux, formation médicale, dans les hôpitaux;

L'ÉCHELON "C" est le maximum normal pour les autres postes.

À compter du 1er avril 2025, un ajustement de ressources de 12 % sera inclus dans les taux ci-dessus.

Médecin administrateur

Taux de paie à la quinzaine et annual: Le 1er avril 2026

Régime de rémunération du personnel médical

AEG- 3,50%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL					
		1	A	B	C	D	
6239 1 01	Médecin-administrateur(trice)	9,339	9,587	10,024	10,475	11,331	*
		242,814	249,262	260,624	272,350	294,606	

* L'ÉCHELON "D" S'applique aux postes de coordinateurs provinciaux, formation médicale, dans les hôpitaux;

L'ÉCHELON "C" est le maximum normal pour les autres postes.

Médecin administrateur

Taux de paie à la quinzaine et annual: Le 1er avril 2027

Régime de rémunération du personnel médical

AEG- 2,50%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL					
		1	A	B	C	D	
6239 1 01	Médecin-administrateur(trice)	9,572	9,827	10,275	10,737	11,614	*
		248,872	255,502	267,150	279,162	301,964	

* L'ÉCHELON "D" S'applique aux postes de coordinateurs provinciaux, formation médicale, dans les hôpitaux;

L'ÉCHELON "C" est le maximum normal pour les autres postes.

Médecin administrateur

Taux de paie à la quinzaine et annual: Le 1er avril 2028

Régime de rémunération du personnel médical

AEG- 4,00%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL				
		1	**A**	**B**	**C**	**D**
6239 1 01	Médecin-administrateur(trice)	9,955	10,220	10,686	11,166	12,079 *
		258,830	265,720	277,836	290,316	314,054

* L'ÉCHELON "D" S'applique aux postes de coordinateurs provinciaux, formation médicale, dans les hôpitaux;

L'ÉCHELON "C" est le maximum normal pour les autres postes.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2025
Medical Pay Plan
GEI - 2.50%

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6244 301	Clinical Assistant			6,303	6,586	6,882		
				163,878	171,236	178,932		
6231 3 01	Family Medicine Specialist	8,507	8,884	9,136	9,552	9,972		
		221,182	230,984	237,536	248,352	259,272		
6233 3 01	Non-Certified Medical and Surgical Specialist			10,997	11,409	11,836		
				285,922	296,634	307,736		
6241 1 01	Medical Officer of Health I			10,997	11,409	11,836		
				285,922	296,634	307,736		
6234 3 01	Certified Medical and Surgical Specialist			12,096	12,549	13,370		
				314,496	326,274	347,620		
6242 1 01	Medical Officer of Health II			12,096	12,549	13,370		
				314,496	326,274	347,620		
6235 3 01	Clinical Program Department Head**			13,106	13,607	14,299		
				340,756	353,782	371,774		
6243 1 01	Chief Medical Officer of Health			13,106	13,607	14,299		
				340,756	353,782	371,774		
6236 1 01	Deputy Chief Medical Health Officer			11,656	12,092	12,544	13,048 *	13,567 *
				303,056	314,392	326,144	339,248	352,742

The following Market Adjustments to be applied in addition to the rates above:

Oncology of 26.25%

Psychiatry of 22.5%

Pathology and Laboratory Medicine 22.5%

Anesthesiology of 15.45%

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

****Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Effective April 1, 2025, the following Resource Adjustments are included in the rates above:

Clinical Assistant: 7.5%
Family Medicine Specialists: 17.0%
Certified and Non-Certified Specialists: 12%
Medical Officer of Health I and II, Deputy Chief and Chief Medical Officer of Health and the Clinical Program Department Head: 12%

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2026
Medical Pay Plan
GEI - 3.50%

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6244 301	Clinical Assistant			6,524	6,817	7,123		
				169,624	177,242	185,198		
6231 3 01	Family Medicine Specialist	8,805	9,195	9,456	9,886	10,321		
		228,930	239,070	245,856	257,036	268,346		
6233 3 01	Non-Certified Medical and Surgical Specialist			11,382	11,808	12,250		
				295,932	307,008	318,500		
6241 1 01	Medical Officer of Health I			11,382	11,808	12,250		
				295,932	307,008	318,500		
6234 3 01	Certified Medical and Surgical Specialist			12,519	12,988	13,838		
				325,494	337,688	359,788		
6242 1 01	Medical Officer of Health II			12,519	12,988	13,838		

				325,494	337,688	359,788		
6235 3 01	Clinical Program Department Head**			13,565	14,083	14,799		
				352,690	366,158	384,774		
6243 1 01	Chief Medical Officer of Health			13,565	14,083	14,799		
				352,690	366,158	384,774		
6236 1 01	Deputy Chief Medical Health Officer			12,064	12,515	12,983	13,505 *	14,042 *
				313,664	325,390	337,558	351,130	365,092

The following Market Adjustments to be applied in addition to the rates above:

Oncology of 26.25%

Psychiatry of 22.5%

Pathology and Laboratory Medicine 22.5%

Anesthesiology of 15.45%

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

**Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2027
Medical Pay Plan
GEI - 2.50%

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6244 301	Clinical Assistant			6,687	6,987	7,301		
				173,862	181,662	189,826		
6231 3 01	Family Medicine Specialist	9,025	9,425	9,692	10,133	10,579		
		234,650	245,050	251,992	263,458	275,054		
6233 3 01	Non-Certified Medical and Surgical Specialist			11,667	12,103	12,556		
				303,342	314,678	326,456		
6241 1 01	Medical Officer of Health I			11,667	12,103	12,556		
				303,342	314,678	326,456		
6234 3 01	Certified Medical and Surgical Specialist			12,832	13,313	14,184		
				333,632	346,138	368,784		
6242 1 01	Medical Officer of Health II			12,832	13,313	14,184		
				333,632	346,138	368,784		
6235 3 01	Clinical Program Department Head**			13,904	14,435	15,169		
				361,504	375,310	394,394		
6243 1 01	Chief Medical Officer of Health			13,904	14,435	15,169		
				361,504	375,310	394,394		
6236 1 01	Deputy Chief Medical Health Officer			12,366	12,828	13,308	13,843 *	14,393 *
				321,516	333,528	346,008	359,918	374,218

The following Market Adjustments to be applied in addition to the rates above:

Oncology of 26.25%

Psychiatry of 22.5%

Pathology and Laboratory Medicine 22.5%

Anesthesiology of 15.45%

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

**Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2028
Medical Pay Plan
GEI - 4.00%

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6244 301	Clinical Assistant			6,954	7,266	7,593		
				180,804	188,916	197,418		
6231 3 01	Family Medicine Specialist	9,386	9,802	10,080	10,538	11,002		
		244,036	254,852	262,080	273,988	286,052		
6233 3 01	Non-Certified Medical and Surgical Specialist			12,134	12,587	13,058		
				315,484	327,262	339,508		
6241 1 01	Medical Officer of Health I			12,134	12,587	13,058		
				315,484	327,262	339,508		
6234 3 01	Certified Medical and Surgical Specialist			13,345	13,846	14,751		
				346,970	359,996	383,526		
6242 1 01	Medical Officer of Health II			13,345	13,846	14,751		
				346,970	359,996	383,526		
6235 3 01	Clinical Program Department Head**			14,460	15,012	15,776		
				375,960	390,312	410,176		
6243 1 01	Chief Medical Officer of Health			14,460	15,012	15,776		
				375,960	390,312	410,176		
6236 1 01	Deputy Chief Medical Health Officer			12,861	13,341	13,840	14,397 *	14,969 *
				334,386	346,866	359,840	374,322	389,194

The following Market Adjustments to be applied in addition to the rates above:

Oncology of 26.25%

Psychiatry of 22.5%

Pathology and Laboratory Medicine 22.5%

Anesthesiology of 15.45%

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

**Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Médecin clinicien

Taux de paie à la quinzaine et annual: Le 1er avril 2025

Régime de rémunération du personnel médical

AEG- 2,50%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL						
		1	2	A	B	C	D	E
6244 301	Assistant clinique			6,303	6,586	6,882		
				163,878	171,236	178,932		
6231 3 01	Spécialiste en médecine familiale	8,507	8,884	9,136	9,552	9,972		
		221,182	230,984	237,536	248,352	259,272		
6233 3 01	Spécialiste médical et chirurgical non certifié			10,997	11,409	11,836		
				285,922	296,634	307,736		
6241 1 01	Médecin hygiéniste I			10,997	11,409	11,836		
				285,922	296,634	307,736		
6234 3 01	Spécialiste médical et chirurgical certifié			12,096	12,549	13,370		
				314,496	326,274	347,620		
6242 1 01	Médecin hygiéniste II			12,096	12,549	13,370		
				314,496	326,274	347,620		
6235 3 01	Chef de service ou de programme clinique**			13,106	13,607	14,299		
				340,756	353,782	371,774		
6243 1 01	Médecin hygiéniste en chef			13,106	13,607	14,299		
				340,756	353,782	371,774		
6236 1 01	Médecin hygiéniste en chef adjoint			11,656	12,092	12,544	13,048 *	13,567 *
				303,056	314,392	326,144	339,248	352,742

Les ajustements du marché suivants s'appliquent en plus des taux indiqués ci-dessus :

Oncologiste : 26,25 %

Psychiatre : 22,5 %

Pathologiste et spécialiste en médecine de laboratoire : 22,5 %

Anesthésiste : 15,45 %

Les échelons 1 et 2 sont des taux de paie seulement applicables aux employés qui sont médecins généralistes non certifiés

* Les échelons D et E sont des taux de paie seulement applicables aux employés qui sont médecins spécialistes certifiés.

** Les employés actuellement rémunérés comme chef de service ou pour des tâches de supervision du personnel médical recevant 4,0 %, selon le Régime de rémunération du personnel médical, continueront d'être rémunérés sur une base de «titulaire actuel seulement».

À compter du 1er avril 2025, les ajustements de ressources suivants sont inclus dans les taux ci-dessus :

Assistant clinique : 7,5 %

Spécialiste en médecine familiale : 17,0 %

Spécialiste médical et chirurgical certifiés et non certifiés : 12,0 %

Médecin-hygiéniste I et II, médecin-hygiéniste en chef adjoint, médecin-hygiéniste en chef et chef de département du programme clinique : 12,0 %

Médecin clinicien

Taux de paie à la quinzaine et annual: Le 1er avril 2026

Régime de rémunération du personnel médical

AEG - 3,50%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL						
		1	2	A	B	C	D	E
6244 301	Assistant clinique			6,524	6,817	7,123		
				169,624	177,242	185,198		
6231 3 01	Spécialiste en médecine familiale	8,805	9,195	9,456	9,886	10,321		
		228,930	239,070	245,856	257,036	268,346		
6233 3 01	Spécialiste médical et chirurgical non certifié			11,382	11,808	12,250		
				295,932	307,008	318,500		
6241 1 01	Médecin hygiéniste I			11,382	11,808	12,250		
				295,932	307,008	318,500		
6234 3 01	Spécialiste médical et chirurgical certifié			12,519	12,988	13,838		
				325,494	337,688	359,788		
6242 1 01	Médecin hygiéniste II			12,519	12,988	13,838		
				325,494	337,688	359,788		

6235 3 01	Chef de service ou de programme clinique**			13,565	14,083	14,799		
				352,690	366,158	384,774		
6243 1 01	Médecin hygiéniste en chef			13,565	14,083	14,799		
				352,690	366,158	384,774		
6236 1 01	Médecin hygiéniste en chef adjoint			12,064	12,515	12,983	13,505 *	14,042 *
				313,664	325,390	337,558	351,130	365,092

Les ajustements du marché suivants s'appliquent en plus des taux indiqués ci-dessus :

Oncologiste : 26,25 %

Psychiatre : 22,5 %

Pathologiste et spécialiste en médecine de laboratoire : 22,5 %

Anesthésiste : 15,45 %

Les échelons 1 et 2 sont des taux de paie seulement applicables aux employés qui sont médecins généralistes non certifiés

* Les échelons D et E sont des taux de paie seulement applicables aux employés qui sont médecins spécialistes certifiés.

** Les employés actuellement rémunérés comme chef de service ou pour des tâches de supervision du personnel médical recevant 4,0 %, selon le Régime de rémunération du personnel médical, continueront d'être rémunérés sur une base de «titulaire actuel seulement».

Médecin clinicien

Taux de paie à la quinzaine et annual: Le 1er avril 2027

Régime de rémunération du personnel médical

AEG - 2,50%

	NIVEAU	**TAUX DE PAIE A LA QUINZAINE ET ANNUAL**						
		1	**2**	**A**	**B**	**C**	**D**	**E**
6244 301	Assistant clinique			6,687	6,987	7,301		
				173,862	181,662	189,826		
6231 3 01	Spécialiste en médecine familiale	9,025	9,425	9,692	10,133	10,579		
		234,650	245,050	251,992	263,458	275,054		
6233 3 01	Spécialiste médical et chirurgical non certifié			11,667	12,103	12,556		
				303,342	314,678	326,456		
6241 1 01	Médecin hygiéniste I			11,667	12,103	12,556		
				303,342	314,678	326,456		
6234 3 01	Spécialiste médical et chirurgical certifié			12,832	13,313	14,184		
				333,632	346,138	368,784		
6242 1 01	Médecin hygiéniste II			12,832	13,313	14,184		
				333,632	346,138	368,784		
6235 3 01	Chef de service ou de programme clinique**			13,904	14,435	15,169		
				361,504	375,310	394,394		
6243 1 01	Médecin hygiéniste en chef			13,904	14,435	15,169		
				361,504	375,310	394,394		
6236 1 01	Médecin hygiéniste en chef adjoint			12,366	12,828	13,308	13,843 *	14,393 *
				321,516	333,528	346,008	359,918	374,218

Les ajustements du marché suivants s'appliquent en plus des taux indiqués ci-dessus :

Oncologiste : 26,25 %

Psychiatre : 22,5 %

Pathologiste et spécialiste en médecine de laboratoire : 22,5 %

Anesthésiste : 15,45 %

Les échelons 1 et 2 sont des taux de paie seulement applicables aux employés qui sont médecins généralistes non certifiés

* Les échelons D et E sont des taux de paie seulement applicables aux employés qui sont médecins spécialistes certifiés.

** Les employés actuellement rémunérés comme chef de service ou pour des tâches de supervision du personnel médical recevant 4,0 %, selon le Régime de rémunération du personnel médical, continueront d'être rémunérés sur une base de «titulaire actuel seulement».

Médecin clinicien

Taux de paie à la quinzaine et annual: Le 1er avril 2028

Régime de rémunération du personnel médical

AEG - 4,00%

	NIVEAU	TAUX DE PAIE A LA QUINZAINE ET ANNUAL						
		1	2	A	B	C	D	E
6244 301	Assistant clinique			6,954	7,266	7,593		
				180,804	188,916	197,418		
6231 3 01	Spécialiste en médecine familiale	9,386	9,802	10,080	10,538	11,002		
		244,036	254,852	262,080	273,988	286,052		
6233 3 01	Spécialiste médical et chirurgical non certifié			12,134	12,587	13,058		
				315,484	327,262	339,508		
6241 1 01	Médecin hygiéniste I			12,134	12,587	13,058		
				315,484	327,262	339,508		
6234 3 01	Spécialiste médical et chirurgical certifié			13,345	13,846	14,751		
				346,970	359,996	383,526		
6242 1 01	Médecin hygiéniste II			13,345	13,846	14,751		
				346,970	359,996	383,526		
6235 3 01	Chef de service ou de programme clinique**			14,460	15,012	15,776		
				375,960	390,312	410,176		
6243 1 01	Médecin hygiéniste en chef			14,460	15,012	15,776		
				375,960	390,312	410,176		
6236 1 01	Médecin hygiéniste en chef adjoint			12,861	13,341	13,840	14,397 *	14,969 *
				334,386	346,866	359,840	374,322	389,194

Les ajustements du marché suivants s'appliquent en plus des taux indiqués ci-dessus :

Oncologiste : 26,25 %

Psychiatre : 22,5 %

Pathologiste et spécialiste en médecine de laboratoire : 22,5 %

Anesthésiste : 15,45 %

Les échelons 1 et 2 sont des taux de paie seulement applicables aux employés qui sont médecins généralistes non certifiés

* Les échelons D et E sont des taux de paie seulement applicables aux employés qui sont médecins spécialistes certifiés.

** Les employés actuellement rémunérés comme chef de service ou pour des tâches de supervision du personnel médical recevant 4,0 %, selon le Régime de rémunération du personnel médical, continueront d'être rémunérés sur une base de «titulaire actuel seulement».

Addenda
du Régime de rémunération du personnel médical

HONORAIRES D'AUTOPSIE :

Type I : Mort subite et inattendue

Taux applicable aux autopsies		
	AEG	**Type 1**
2025-2026	**2,50 %**	859,80 $
2026-2027	**3,50 %**	889,89 $
2027-2028	**2,50 %**	912,14 $
2028-2029	**4,00 %**	948,63 $

Type II : Autopsie judiciaire

Taux applicables aux autopsies		
	AEG	**Type 2**
2025-2026	**2,50 %**	1 406,30 $
2026-2027	**3,50 %**	1 455,52 $
2027-2028	**2,50 %**	1 491,91 $
2028-2029	**4,00 %**	1 551,58 $

De plus, une prime de 35 % est accordée pour toutes les autopsies entreprises après 18 h les jours de la semaine, ainsi que pour les autopsies réalisées durant les fins de semaine et les jours fériés.

PLAFOND DES REVENUS EN HONORAIRES À L'ACTE

Les revenus en honoraires à l'acte permis aux termes du régime d'assurance-maladie pour le revenu tiré d'une pratique privée sont limités aux montants énumérés ci-dessous. Une fois le plafond annuel atteint, la rémunération s'établit à 50 % du barème des honoraires.

Plafond des revenus en honoraires à l'acte (PRHA)		
	AEG	**PRHA**
2025-2026	**2,50 %**	60 397,29 $
2026-2027	**Ajustement**	100 000,00 $
2027-2028	**2,50 %**	102 500,00 $
2028-2029	**4,00 %**	106 600,00 $

Addendum
to the Medical Pay Plan

AUTOPSY FEES:

Type I: Sudden and unexpected death

Autopsy Rates		
	GEI	**Type 1**
2025-2026	**2.50 %**	$859.80
2026-2027	**3.50 %**	$889.89
2027-2028	**2.50 %**	$912.14
2028-2029	**4.00 %**	$948.63

Type II: Forensic

Autopsy Rates		
	GEI	**Type 2**
2025-2026	**2.50 %**	$1,406.30
2026-2027	**3.50 %**	$1,455.52
2027-2028	**2.50 %**	$1,491.91
2028-2029	**4.00 %**	$1,551.58

In addition, a 35 % premium is allocated for all autopsies, initiated after 6 p.m. on weekdays, as well as for autopsies performed on weekends and holidays.

FEE FOR SERVICE INCOME THRESHOLD:

The allowable fee-for-service earnings under Medicare for private practice income are limited to the amounts listed below. Once the annual income ceiling has been reached for that year, earnings are paid at 50% of the Fee Schedule.

Fee for Service Income Threshold (FIT)		
	GEI	**FIT**
2025-2026	**2.50 %**	$ 60,397.29
2026-2027	**Adjustment**	$100,000.00
2027-2028	**2.50 %**	$102,500.00
2028-2029	**4.00 %**	$106,600.00

SERVICE DE GARDE :

À compter du 1er octobre 2005, les médecins salariés qui prennent part à la rotation d'un service de garde peuvent facturer à l'acte quand on fait appel à leurs services urgents et émergents en dehors des heures normales de travail. Les honoraires pour les services de garde rémunérés à l'acte ne seront pas appliqués au plafond annuel des revenus de pratique provenant de toutes les sources de l'Assurance-maladie.

SERVICE SUR PLACE AUX ÉTABLISSEMENTS PSYCHIATRIQUES CENTRACARE ET DU RESTIGOUCHE :

Nuit	160,00 $
Fin de semaine et jour férié	240,00 $

Nuit		
	AEG	
2025-2026	**2,5 %**	164,00 $
2026-2027	**3,5 %**	170,00 $
2027-2028	**2,5 %**	174,00 $
2028-2029	**4,0 %**	181,00 $

Fin de semaine et jour férié		
	AEG	
2025-2026	**2,5 %**	246,00 $
2026-2027	**3,5 %**	255,00 $
2027-2028	**2,5 %**	261,00 $
2028-2029	**4,0 %**	271,00 $

Le tarif unique indiqué ci-dessus est global et s'applique à toute visite, quel qu'en soit le nombre ou à tout service sur place effectué en dehors des heures régulières de jour.

ASSURANCE RESPONSABILITÉ PROFESSIONNELLE DE L'ASSOCIATION CANADIENNE DE PROTECTION MÉDICALE (ACPM) POUR MÉDECINS SALARIÉS (à compter du 1er janvier 2005)

Veuillez consulter l'annexe B de l'Entente-cadre sur les services de médecin.

DÉVELOPPEMENT PROFESSIONNEL CONTINU (DPC) :

a) Les médecins salariés à temps plein ont droit à un nombre maximal de dix jours par exercice financier

ON-CALL:

Effective October 1, 2005, salaried physicians who take part in an on-call rotation may bill fee-for-service when called in to render urgent and emergent services outside normal working hours. Fee-for-service earnings related to on-call will not be applied against the annual threshold for additional practice income from all Medicare sources.

ON SITE COVERAGE IN THE PSYCHIATRIC FACILITIES OF CENTRACARE AND RESTIGOUCHE:

Night	$160.00
Weekend and Holiday	$240.00

Night		
	GEI	
2025-2026	**2.50%**	$164.00
2026-2027	**3.50%**	$170.00
2027-2028	**2.50%**	$174.00
2028-2029	**4.00%**	$181.00

Weekend and Holiday		
	GEI	
2025-2026	**2.50%**	$246.00
2026-2027	**3.50%**	$255.00
2027-2028	**2.50%**	$261.00
2028-2029	**4.00%**	$271.00

The above single fee is all inclusive and applies to any number of visits or to on-site coverage beyond the regular daytime hours.

PROFESSIONAL LIABILITY COVERAGE (CMPA) FOR SALARIED PHYSICIANS (effective January 1, 2005):

Refer to Schedule B of the Physician Services Agreement.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD):

a) Full-time salaried physicians are allowed up to ten days per fiscal year for the purpose of attending

pour assister aux activités approuvées de DPC. Il est possible d'accumuler ces jours sur une période de deux ans.	approved CPD events. These days can be accumulated over a two-year period.
b) Les médecins salariés à temps partiel ont droit à des jours de DPC calculés au prorata.	b) Part time salaried physicians are entitled to CPD days on prorated basis.
CONGÉS :	**VACATION LEAVE:**
À compter du 1er avril 2009, le cumul des crédits de congé sera calculé au taux suivant :	The accumulation of vacation credits, effective April 1, 2009, shall be at a rate of:
a) 1 jour $^2/_3$ par mois, soit quatre (4) semaines par année à compter de la date d'embauche; b) 2 jours $^1/_{12}$ par mois, soit cinq (5) semaines par année à compter du 181e mois d'emploi continu.	a) 1 2/3 days per month, 4 weeks per annum from date of hiring; b) 2 1/12 days per month, 5 weeks per annum, commencing with the 181st month of continuous employment.
Remarque : Les médecins salariés ayant le statut d'employé sont protégés par les *Directives en matière de ressources humaines applicables au personnel de gestion et aux employés non syndiqués* (Partie I ou III des services publics), selon l'employeur (ministère de la Santé ou une régie régionale de la santé).	Note: The salaried physicians with employee status are covered by the Human Resources Policies for Management and Non-Union Employees, Parts I or III, depending on the employer (Department of Health or Regional Health Authorities).

SCHEDULE "X"

OTHER ITEMS

1.0 FEE FOR SERVICE PHYSICIANS

1.1 *Time of Day*

Time of day shall continue to be a billing requirement for office-based consults and visit codes, including virtual care.

1.2 *Nursing Home Formula*

1.2.1 The Parties agree to establish a joint working group to review and update the existing formula for determining sessional hours provided to nursing homes.

1.2.2 The Parties will make reasonable efforts to complete this work within one year of execution of the Physician Services Agreement.

1.3 *Fee Schedule Conversion*

The Parties agree to establish a joint working group to review the feasibility of converting the existing unit and unit value-based tariffs into a standardized dollar-based structure.

1.4 *Professional Standards Communications*

The Society agrees that it will actively promote the College of Physicians and Surgeons of New Brunswick, *One Problem per Visit* (Professional Standard) through its member communications channels.

1.5 *New Brunswick Physicians Manual, Rule 13*

The Parties agree to work towards the elimination of Rule 13 within the *New Brunswick Physicians Manual* (for those specialties that wish to remove it) during the term of this Agreement.

1.6 Enhanced Specialty Travel Clinics

The Parties agree to amend the *New Brunswick Physicians Manual* to:

1.6.1 Permit physicians to bill consultation and follow-up office visit codes at office-based fee-code values when they provide specialty care in travel clinics in rural or underserviced areas (as defined in the *New Brunswick Physicians Manual*).

1.6.2 Permit surgeons to bill travel stipend code 8889 when traveling to provide RHA-approved surgical services in rural communities.

1.6.3 Eliminate service code 8898 - Travel Clinic/Telemedicine session, 1st patient seen and service code 8899 - Travel Clinic/Telemedicine session – Consultation, 1st patient seen.

1.7 Good Faith Program Funding for Uninsured Patients

1.7.1 The Parties agree to establish a Joint Committee within six months of execution of this Agreement to review the instances and discuss potential solutions regarding obstetricians not receiving payment for providing services to patients who are either uninsured or do not yet hold a valid Medicare number.

1.8 Gender Pay Equity

1.8.1 The Parties agree to establish a Joint Working Group to review comparable procedures for Obstetrics and Gynecology with comparable procedures for Urology to determine if fee codes should be adjusted to ensure equitable value for similar work.

1.8.2 A mutually agreed upon expert shall be hired to lead the working group to establish a procedure and process to evaluate these types of issues.

1.8.3 Associated costs will be shared between the Department of Health and the Society.

1.8.4 Upon completion, the Working Group will present its non-binding recommendations to the Parties.

1.8.5 Working Group members will include representatives from the Department of Health, the Society, the RHAs and ad hoc members as required for additional expertise.

1.9 ***Implementing Recommendations in Clinical Teaching Report***

The Parties agree to create a Joint Implementation Taskforce to review the recommendations of the Clinical Teaching Remuneration Report submitted by the Society in May 2024. The Taskforce shall make recommendations to the government within twelve months of execution of this Agreement.

1.10 Changes to the Billing Number System

The Parties agree to create a Working Group with representatives from the Department of Health, the Society and the RHAs to:

1.10.1 Identify and attempt to resolve contractual situations where family physicians may be restricted from practicing in a community setting;

1.10.2 Review the process of activating and deactivating physician billing numbers with the aim of reducing administrative burden on all parties.

1.10.3 Complete its work and report back to the Parties within twelve months of execution of this Agreement.

1.11 Physician Billing Training

1.11.1 The Parties agree that Physician Billing Training continues to be mandatory.

1.11.2 NB Medicare provides a web-based, pre-recorded training tool, with 24/7 access, to permit remote completion of elements common to all physicians from the Physicians' Manual (e.g., Chapters 1 to 4) which physicians must complete within three months of commencing practice.

1.11.3 Additional training on billing rules, service codes, policies, and procedures as per the Physicians' Manual is provided by the Medicare Practitioner Liaison Officers.

1.11.4 Refresher training sessions are also available to all physicians on request.

2.0 MEDICAL PAY PLAN (MPP) PHYSICIANS

2.1 *Fee For Service Income Threshold (FIT)*

2.1.1 The Parties agree that effective April 1, 2026, the FIT amount will be $100,000.00/year.

2.1.2 The FIT shall increase by the FFS GEI for each year of this Agreement.

2.1.3 There shall be no retroactivity applied to previously claimed FIT amounts.

2.1.4 FFS income for locum coverage is excluded from the FIT calculation provided prior approval has been granted by Medicare.

2.1.5 Exceptions to this policy will be considered on a case-by-case basis for priority services as agreed upon by the Parties.

2.1.6 The *Medical Pay Plan Policy* shall be amended to reflect the changes noted above.

2.2 Working on Statutory Holidays

2.2.1 The Parties agree to amend the Medical Pay Plan Policy to reflect that physicians working on statutory holidays are entitled to accrue banked time off of up to 1.5 days off for each day of work.

2.3 *No Moratorium for Salaried Physicians*

2.3.1 The RHAs will continue to have the authority to offer this remuneration option for new salaried physician positions at their sole discretion.

2.4 *FN 2016*

2.4.1 The Department of Health acknowledges receipt of the report prepared by Thomas Maston Consulting entitled "Review of FN2016: Administrative Support to Salaried Physicians" and commits to reviewing same with the RHAs within six (6) months of execution of this Agreement. The Department of Health further commits to implementing the recommendations as agreed to between the RHAs and the Department of Health.

2.5 ***Coroners Autopsy Fees and Psychiatric Facility Fees***

2.5.1 The Parties agree that the *Addendum to the Medical Pay Plan Policy* attached as **Schedule W** shall be amended to increase Coroners Autopsy Fees and On-site Coverage in Psychiatric facilities by an amount equivalent to each year's FFS GEI for the term of this Agreement.

2.6 ***Dedicated time for Research and Teaching***

2.6.1 MPP physicians may apply to the RHAs for approval to permit up to 0.2 FTE of their work time to be allocated to non-clinical teaching. This time shall be recognized and taken into account when establishing and assessing clinical benchmarks. The Parties agree that this issue shall be referred to the Tripartite Committee between the Society, the Department of Health, and the RHAs, for resolution.

Schedule Y

NEW BRUNSWICK PRIMARY CARE NETWORK

A. Patient Registry

Terms

The Patient Registry (rostering system) will document all primary care providers in New Brunswick and the patients formally attached to each provider.

Each primary care provider is responsible for the identifying and reporting of individuals on their roster which are included in the Patient Registry. This is an ongoing process. Physicians must verify their roster quarterly and document the verification in the Medicare System.

Conditions

Upon request by the Department of Health, a primary care provider who does not provide a current and accurate patient list to the Department of Health as noted above shall not be entitled to any new patient complete examination and chart initiation fees.

B. NB Health Link

Mandate

NB Health Link (NBHL) is the health system's entry point for any New Brunswicker that does not currently have a primary care provider.

NBHL will support timely access to primary care leveraging all health system partners and existing physical infrastructure across the province.

C. Physician Remuneration for Participation in NBHL

The current remuneration for Physicians participating in the NBHL is as follows:

1. Primary Care Base Physician Remuneration

    a. $45.00/visit
    b. These visits can be performed in person or through a virtual setting.

2. Additional Physician Remuneration

    a. Additional amounts as agreed to by the Parties and communicated in a memo issued by the Department of Health.

3. Additional Benefits

    a. Every participating clinic or physician will have access to:

        i. Electronic Medical Record (EMR) and virtual care platform to ensure continuity of care for the patients of the network
        ii. Nurse triage and support
        iii. GNB provided infrastructure and facilities.

4. Fee for Service Income Threshold (FIT)

    a. Salaried physicians who want to participate in the NBHL outside their Medical Pay Plan arrangements will require an approved Written Declaration Form for Fee-for-Service Income prior to any services being rendered. These FFS earnings will be exempt from the FIT.

SCHEDULE "Z"

Hospitalist Program

The New Brunswick Medical Society (**Society**) and the Department of Health agree that effective April 1, 2026, the terms and conditions of coverage and compensation set out within the former Schedule Z of the 2020 Physician Services Master Agreement are no longer in force and effect.

The Society and the Department of Health agree that each of the existing Provincial Hospitalist Program Alternate Funding Plan (**AFP**) agreements shall remain in force, subject to the following agreed upon revisions:

1. Each Hospitalist line shall be comprised of an average of 16 family medicine inpatients per day, depending on acuity.

2. Effective April 1, 2026, each line of patients will be funded at a rate of $1,800 for 24-hours, with eight (8) hours of on-site coverage between 06:00 - 18:00 and off-site availability between 18:00 - 06:00. Funds will be allocated in accordance with the AFP Practice Plan.

3. Hospitalist physicians may bill fee-for-Service for emergency services while providing off-site coverage.

4. Effective on the date of signing the PSA, the variable, performance-based remuneration contained in the existing Hospitalist Program shall end.

5. The number of funded lines will be determined by the Department of Health by identifying the total number of inpatient beds covered by the Hospitalist Program as reported by RHA patient census.

   **Example: If a hospital has an average census of 128 family medicine inpatients, it would be entitled to receive 8 funded lines ($1,800/day) of 16 patients, or $14,400/day x 365 = an AFP pool of $5,256,000 / year, for daily coverage.*

6. Should any reorganization of family medicine inpatient care occur, the AFP Practice Plan will be revised to reflect the reorganized responsibilities.

7. The Department of Health agrees to permit the expansion of the Provincial Hospitalist Program to non-regional hospitals, where the Department of Health, the RHA and the Society agree to the terms of an AFP contract. Until such time that an AFP agreement is reached hospitalists working in non-regional hospitals will be eligible to be paid at a rate of $187.50/hr. This rate will also apply to hospitalists working in non-regional hospitals that will not move to an AFP.

8. If the daily average of inpatients increases or decreases within a hospital for a minimum period of three (3) months, the number of funded lines will be adjusted. The Department of Health will

develop a formal process for the RHAs to request additional lines should the RHA determine that there is a short-term or immediate need.

9. Key Performance Indicators (KPIs) will continue to be monitored and may evolve on agreement of the Department of Health, the RHAs and the Society; however, KPI review will no longer be a factor in assessing remuneration of participating Hospitalists.

10. Physicians will continue to be permitted to bill FFS for discretionary exceptions outlined in the FFS Billing Exceptions Section of the AFP Practice Plan as approved by the RHA and Department of Health provided the services do not interfere with a Physician's availability to provide Hospitalist services to Inpatients.

The Parties agree to revise and update all existing Alternate Funding Plan contracts and Practice Plans to reflect the above-noted changes.

Schedule AA

Virtual Care

Virtual Care Permanent

The Department of Health and the New Brunswick Medical Society (**Society**) agree to permanently enable the provision of and payment for, specific insured, medically necessary services, rendered virtually, by medical practitioners in the Province of New Brunswick in accordance with the following:

1. That the specific service codes set out in **Appendix 1** to this Schedule, shall be incorporated into the *New Brunswick Physicians' Manual*.

2. That physicians are remunerated at the same rate for virtual care as in person care.

3. That no distinction is made in terms of remunerating different virtual modalities including services provided asynchronously, excluding the eConsult program, via secure email or text messaging between patient and provider.

4. Virtual Care services must meet the following criteria/guidelines:
    - Initiated by the patient.
    - Provided by the physician unless stated otherwise.
    - Documented in the patient chart for auditing and monitoring purposes.
    - No add-ons or premiums can be billed in addition unless stated otherwise.
    - Not applicable to consultations and visits requiring a physical examination.
    - Can only be billed once per day per patient.
    - Not billable for scheduling or other administrative activities

    ➢ All other existing criteria outlined in the Physicians' Manual must be met and documented in order to bill these service codes.

5. That physicians are required to continue to include location code "19" (virtual care) on their claim submission to signify the service was performed virtually.

6. That Department of Health/Regional Health Authorities approved episodic care clinics (walk-in clinics) providing virtual care must provide patients with the option of in-person care, consistent with the New Brunswick College of Physicians and Surgeons Professional Standard for Virtual Care requirements to initiate a virtual care encounter. Code 3 – Walk-in Clinic Visits will continue to apply for virtual and in-person visits.

7. The provider and patient are expected to be in New Brunswick at the time of service unless otherwise stated.

a. This provision is intended to ensure appropriate access to in-person care in New Brunswick and is not intended to allow for routine or ongoing provision of services where the provider is based outside New Brunswick. This provision shall not be interpreted as prohibiting or invalidating the provision of virtual services solely because the provider or patient is temporarily outside the province at the time of service.

Expansion of eConsult Program

The New Brunswick eConsult (electronic consultation) Program is defined as a service which enables synchronous and asynchronous healthcare provider to healthcare provider advice through a digital platform.

Currently, the eConsult Program is eligible for billing solely when services are rendered asynchronously through the eHealthNB platform. The Department of Health shall initiate work required to enable synchronous eConsult communication through eHealthNB platform within six (6) months of the execution of the Physician Services Agreement (PSA). In the event that the technology necessary to support synchronous eConsult communication through the eHealthNB platform has not been implemented within eighteen (18) months of the execution of the PSA, the Parties agree that a manual billing process shall be established for the applicable service codes until such time as the required technology becomes operational.

Consulting physicians must be registered with the Department of Health to participate in the eConsult Program. All respective fees are payable at the same rate, whether care is provided synchronously or asynchronously.

The Department of Health agrees that effective on the signing of the PSA and with no retroactive application, the eConsult Program shall be expanded to include:

- a referral fee of $25.00/patient payable to a referring physician;
- a consulting fee of $50.00/15 minute increment, or part thereof, for each patient, payable to the consultant physician.

All existing criteria outlined in the *New Brunswick Physicians' Manual* in Chapter 3, Section 1.2.4 must be met and documented to bill the service codes.

APPENDIX 1 TO SCHEDULE AA

ITEMS COMMON TO ALL PRACTITIONERS	
Service Code	**Service description**
3	Walk-in Clinic - visit
9	Nursing Home - Each additional patient
193	Patient counseling - per 15 minutes
200	Detention - per 15 minutes
216	Family counseling - per 15 minutes
2001	Nursing Home - First patient seen during visit
FAMILY MEDICINE	
Service Code	**Service description**
1	Office visit
10	Major or regional consultation
12	Repeat consultation
20	Psychotherapy - per 15 minutes
218	Preanesthetic consultation – non-specialist
8101	Seniors' office visit - add
8116	Opiate addiction- office visit
8161	Medical Assistance in Dying (MAID)
8985	Complex Patient Care Visit – add on
9143	Cannabis - office visit
ANAESTHESIA	
Service Code	**Service description**
217	Preanesthetic consultation - Specialist
218	Preanesthetic consultation - non-specialist
1505	Major or regional consultation
1084	Repeat consultation
8901	Seniors visit - add to major consultation only
9143	Cannabis - office visit
1499	Office visit
CARDIAC SURGERY	
Service Code	**Service description**
100	Major or regional consultation
101	Repeat consultation
8901	Seniors visit- add to major consultation only
9200	Non-referred first office visit (once per 365 days)
9203	Office visit - Follow up

DERMATOLOGY	
Service Code	**Service description**
125	Major or regional consultation
126	Repeat consultation
8901	Seniors visit - add to major consultation only
119	Non-referred first office visit (once per 365 days)
121	Office visit - Follow up
GENERAL INTERNAL MEDICINE	
Service Code	**Service description**
8764	Major or regional consultation
8765	Repeat consultation
8901	Seniors visit- add to major consultation only
8760	Non-referred first office visit (once per 365 days)
8763	Office visit - Follow up
8161	Medical Assistance in Dying (MAID)
GENERAL SURGERY	
Service Code	**Service description**
31	Major or regional consultation
33	Repeat consultation
8901	Seniors visit- add to major consultation only
26	Non-referred first office visit (once per 365 days)
29	Office visit - Follow up
NUCLEAR MEDICINE	
Service Code	**Service description**
4096	Major or regional consultation
4097	Partial Clinical Evaluation
NEUROLOGY	
Service Code	**Service description**
161	Major or regional consultation
162	Repeat consultation
8901	Seniors visit - add to major consultation only
156	Non-referred first office visit (once per 365 days)
159	Office visit - Follow up
NEUROSURGERY	
Service Code	**Service description**
186	Major or regional consultation
188	Repeat consultation
8901	Seniors visit - add to major consultation only
189	Non-referred first office visit (once per 365 days)
192	Office visit - Follow up

OBSTETRICS & GYNAECOLOGY	
Service Code	**Service description**
54	Major or regional consultation
56	Repeat consultation
8901	Seniors visit- add to major consultation only
48	Non-referred first office visit (once per 365 days)
50	Office visit - Follow up
OPHTHALMOLOGY	
Service Code	**Service description**
69	Major or regional consultation
71	Repeat consultation
8901	Seniors visit - add to major consultation only
8629	Paediatric consult (≤l6 years old), add
282	Complete examination at the request of an Optometrist
64	Non-referred first office visit (once per 365 days)
66	Office visit - Follow up
ORTHOPEADIC SURGERY	
Service Code	**Service description**
81	Major or regional consultation
83	Repeat consultation
8901	Seniors visit - add to major consultation only
76	Non-referred first office visit (once per 365 days)
78	Office visit - Follow up
OTOLARYNGOLOGY	
Service Code	**Service description**
107	Major or regional consultation
109	Repeat consultation
8901	Seniors visit - add to major consultation only
102	Non-referred first office visit (once per 365 days)
104	Office visit - Follow up
PAEDIATRICS	
Service Code	**Service description**
93	Major or regional consultation
94	Repeat consultation
85	Non-referred first office visit (once per 365 days)
90	Office Visit - Major Chronic Health problems (once per 30 days)
87	Office visit - Follow up
239	Family counseling- per 15 minutes
PHYSICAL MEDICINE	
Service Code	**Service description**
202	Major or regional consultation
287	Repeat consultation
8901	Seniors visit - add to major consultation only
288	Non-referred first office visit (once per 365 days)
290	Office visit - Follow up
9000	Scheduled family team conference
PLASTIC SURGERY	
Service Code	**Service description**

305	Major or regional consultation
306	Repeat consultation
8901	Senior's visit- add to major consultation only
307	Non-referred first office visit (once per 365 days)
308	Office visit - Follow up
PSYCHIATRY	
Service Code	**Service description**
321	Major or regional consultation
322	Repeat consultation
9146	Child consult - add
9145	Senior consult - add
324	Non-referred first office visit (once per 365 days)
325	Office visit - Follow up
8116	Opiate addiction- office visit
331	Psychiatric care: assessment and treatment
332	Psychotherapy, per 15 minutes
340	Diagnostic and/or therapeutic interview
341	Group Psychotherapy, per15 minutes
2837	Family Psychotherapy, per 15 minutes
9352	Forensic Psychiatry – Court ordered out-patient assessments
RESPIROLOGY	
Service Code	**Service description**
8310	Major or regional consultation
8311	Repeat consultation
8901	Seniors visit- add to major consultation only
8242	Non-referred first office visit (once per 365 days)
8245	Office visit - Follow up
RHEUMATOLOGY	
Service Code	**Service description**
8315	Major or regional consultation
8316	Repeat consultation
8901	Seniors visit - add to major consultation only
8344	Non-referred first office visit (once per 365 days)
8347	Office visit - Follow up
UROLOGY	
Service Code	**Service description**
343	Major or regional consultation
345	Repeat consultation
8901	Seniors visit - add to major consultation only
346	Non-referred first office visit (once per 365 days)
349	Office visit - Follow up
MATERNAL FETAL MEDICINE	
Service Code	**Service description**
8360	Major or regional consultation
8361	Repeat consultation
8363	Non-referred first office visit (once per 365 days)
8364	Regional examination
8365	Office visit - Follow up

THORACIC SURGERY	
Service Code	**Service description**
9396	Major or regional consultation
9397	Repeat consultation
8901	Seniors visit - add to major consultation only
9394	Non-referred first office visit (once per 365 days)
9395	Office visit - Follow up
VASCULAR SURGERY	
Service Code	**Service description**
9372	Major or regional consultation
9373	Repeat consultation
8901	Seniors visit - add to major consultation only
9370	Non-referred first office visit (once per 365 days)
9371	Office visit - Follow up
CARIDOLOGY, INTERVENTIONAL CARDIOLOGY, CARDIAC ELECTROPHYSIOLOGY	
Service Code	**Service description**
9515	Major or regional consultation
9516	Repeat consultation
8901	Seniors visit- add to major consultation only
9517	Non-referred first office visit (once per 365 days)
9518	Office visit - Follow up
8441	Remote monitoring - ICD
8440	Remote monitoring - Pacemakers
8439	Remote monitoring - Loop recorder
CLINICAL ALLERGY AND IMMUNOLOGY	
Service Code	**Service description**
9570	Major or regional consultation
9571	Repeat consultation
8901	Seniors visit- add to major consultation only
9572	Non-referred first office visit (once per 365 days)
9573	Office visit - Follow up
CRITICAL CARE MEDICINE	
Service Code	**Service description**
9576	Major or regional consultation
9577	Repeat consultation,
8901	Seniors visit- add to major consultation only
9578	Non-referred first office visit (once per 365 days)
9579	Office visit - Follow up
ENDOCRINOLOGY AND METABOLISM	
Service Code	**Service description**
9590	Major or regional consultation
9591	Repeat consultation
8901	Seniors visit- add to major consultation only
9592	Non-referred first office visit (once per 365 days)
9593	Office visit - Follow up
GASTROENTROLOGY	
Service Code	**Service description**
9607	Major or regional consultation
9608	Repeat consultation

8901	Seniors visit- add to major consultation only
9609	Non-referred first office visit (once per 365 days)
9610	Office visit - Follow up
GERIATRICS	
Service Code	**Service description**
9625	Major or regional consultation
9626	Repeat consultation
8901	Seniors visit- add to major consultation only
9627	Non-referred first office visit (once per 365 days)
9628	Office visit - Follow up
8161	Medical Assistance in Dying (MAID)
HEMATOLOGY	
Service Code	**Service description**
9640	Major or regional consultation
9641	Repeat consultation
8901	Seniors visit- add to major consultation only
9642	Non-referred first office visit (once per 365 days)
9643	Office visit - Follow up
MEDICAL MICROBIOLOGY AND INFECTIOUS DISEASE	
Service Code	**Service description**
9656	Major or regional consultation
9657	Repeat consultation
8901	Seniors visit- add to major consultation only
9658	Non-referred first office visit (once per 365 days)
9659	Office visit - Follow up
MEDICAL ONCOLOGY	
Service Code	**Service description**
9671	Major or regional consultation
9672	Repeat consultation
8901	Seniors visit- add to major consultation only
9673	Non-referred first office visit (once per 365 days)
9674	Office visit - Follow up

NEPHROLOGY	
Service Code	**Service description**
9686	Major or regional consultation
9687	Repeat consultation
8901	Seniors visit- add to major consultation only
9688	Non-referred first office visit (once per 365 days)
9689	Office visit - Follow up
RADIATION ONCOLOGY	
Service Code	**Service description**
9702	Major or regional consultation
9703	Repeat consultation
8901	Senior's visit- add to major consultation only
9704	Non-referred first office visit (once per 365 days)
9705	Office visit - Follow up

ANNEXE 1 À L'ANNEXE AA

ÉLÉMENTS COMMONS A TOUS LES MÉDECINS	
Code de service	**Description du service**
3	Clinique sans rendez-vous -visite
9	Foyers de soins- chaque patient additionnel
193	Counseling auprès d'un patient - par 15 minutes
200	Surveillance exclusive - par 15 minutes
216	Counseling familial - par 15 minutes
2001	Premier patient vu pendant la visite
MÉDECINE FAMILIALE	
Code de service	**Description du service**
1	Visite en cabinet
10	Consultation majeure ou spécifique
12	Consultation subséquente
20	Psychothérapie- par 15 minutes
218	Consultation préanesthésique - non-spécialiste
8101	Visite pour les personnes âgées, en supplément
8116	Dépendance aux opiaces - Visite en cabinet
8161	Aide médicale à mourir (AMAM)
8985	Visite pour soins aux patients complexes – en supplément
9143	Cannabis - visite en cabinet
ANESTHÉSIE	
Code de service	**Description du service**
217	Consultation préanesthésique - Spécialiste
218	Consultation préanesthésique - Non-spécialiste
1505	Consultation majeure ou spécifique
1084	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9143	Cannabis – visite en cabinet
1499	Visite en cabinet

CHIRURGIE CARDIAQUE	
Code de service	**Description du service**
100	Consultation majeure ou spécifique
101	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9200	Première visite – cabinet non référé (une fois par 365 jours)
9203	Visites en cabinet - suivi
DERMATOLOGIE	
Code de service	**Description du service**
125	Consultation majeure ou spécifique
126	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
119	Première visite en cabinet non référé (une fois par 365 jours)
121	Visites en cabinet - suivi
MÉDECINE INTERNE GÉNÉRALE	
Code de service	**Description du service**
8764	Consultation majeure ou spécifique
8765	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
8760	Première visite en cabinet non référé (une fois par 365 jours)
8763	Visites en cabinet - suivi
8161	Aide médicale à mourir (AMAM)
CHIRURGIE GÉNÉRALE	
Code de service	**Description du service**
31	Consultation majeure ou spécifique
33	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
26	Première visite en cabinet non référé (une fois par 365 jours)
29	Visites en cabinet - suivi
MÉDECINE NUCLÉAIRE	
Code de service	**Description du service**
4096	Consultation majeure ou spécifique
4097	Évaluation clinique partielle

NEUROLOGIE	
Code de service	**Description du service**
161	Consultation majeure ou spécifique
162	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
156	Première visite en cabinet non référé (une fois par 365 jours)
159	Visites en cabinet - suivi
NEUROCHIRURGIE	
186	Consultation majeure ou spécifique
188	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
189	Première visite en cabinet non référé (une fois par 365 jours)
192	Visites en cabinet - suivi
OBSTÉTRIQUE ET GYNÉCOLOGIE	
Code de service	**Description du service**
54	Consultation majeure ou spécifique
56	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
48	Première visite en cabinet non référé (une fois par 365 jours)
50	Visites en cabinet - suivi
OPHTHALMOLOGIE	
Code de service	**Description du service**
69	Consultation majeure ou spécifique
71	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
8629	Consultation pédiatrique (≤l6 ans), ajouter
282	Examen ophtalmologique complet à la demande d'un optométriste
64	Première visite en cabinet non référé (une fois par 365 jours)
66	Visites en cabinet - suivi
CHIRURGIE ORTHOPÉDIQUE	
Code de service	**Description du service**
81	Consultation majeure ou spécifique
83	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
76	Première visite en cabinet non référé (une fois par 365 jours)
78	Visites en cabinet - suivi
OTO-LARYNGOLOGIE	
Code de service	**Description du service**

107	Consultation majeure ou spécifique
109	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
102	Première visite en cabinet non référé (une fois par 365 jours)
104	Visites en cabinet - suivi
PÉDIATRIE	
Code de service	**Description du service**
93	Consultation majeure ou spécifique
94	Consultation subséquente
85	Première visite en cabinet non référé (une fois par 365 jours)
90	Visite en cabinet – Troubles de santé majeurs chroniques (une fois tous les 30 jours)
87	Visites en cabinet - suivi
239	Counseling familial, par 15 minutes
MÉDECINE PHYSIQUE ET RÉADAPTATION	
Code de service	**Description du service**
202	Consultation majeure ou spécifique
287	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
288	Première visite en cabinet non référé (une fois par 365 jours)
290	Visites en cabinet - suivi
9000	Conférence d'équipe familiale
CHIRURGIE PLASTIQUE	
Code de service	**Description du service**
305	Consultation majeure ou spécifique
306	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
307	Première visite en cabinet non référé (une fois par 365 jours)
308	Visites en cabinet – suivi
PSYCHIATRIE	
Code de service	**Description du service**
321	Consultation majeure ou spécifique
322	Consultation subséquente
9146	Consultation d'enfants, en supplément
9145	Consultation de personnes âgées, en supplément
324	Première visite en cabinet non référé (une fois par 365 jours)
325	Visites en cabinet - suivi
8116	Dépendance aux opiaces - Visite en cabinet

331	Soins psychiatriques : évaluation et traitement
332	Psychothérapie, par tranche de 15 minutes
340	Entrevue à des fins diagnostiques ou thérapeutiques
341	Soins psychiatriques ou psychothérapie de groupe – 2 personnes ou plus, par 15 minutes
2837	Soins psychiatriques ou psychothérapie familiale, par 15 minutes
9352	Évaluations de patients en consultation externe par ordonnance de la cour
PNEUMOLOGIE	
Code de service	**Description du service**
8310	Consultation majeure ou spécifique
8311	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
8242	Première visite en cabinet non référé (une fois par 365 jours)
8245	Visites en cabinet – suivi
RHUMATOLOGIE	
Code de service	**Description du service**
8315	Consultation majeure ou spécifique
8316	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
8344	Première visite en cabinet non référé (une fois par 365 jours)
8347	Visites en cabinet - suivi
UROLOGIE	
Code de service	**Description du service**
343	Consultation majeure ou spécifique
345	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
346	Première visite en cabinet non référé (une fois par 365 jours)
349	Visites en cabinet - suivi

MÉDECINE FOETALE	
Code de service	**Description du service**
8360	Consultation majeure ou spécifique
8361	Consultation subséquente
8363	Première visite comportant un examen en complet
8364	Examen spécifique
8365	Autres visites en cabinet
CHIRURGIE THORACIQUE	
Code de service	**Description du service**
9396	Consultation majeure ou spécifique
9397	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9394	Première visite en cabinet non référé (une fois par 365 jours)
9395	Visites en cabinet - suivi
CHIRURGIE VASCULAIRE	
Code de service	**Description du service**
9372	Consultation majeure ou spécifique
9373	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9370	Première visite en cabinet non référé (une fois par 365 jours)
9371	Visites en cabinet - suivi
CARDIOLOGIE, CARDIOLOGIE INTERVENTIONNELLE, ÉLECTROPHYSIOLOGIE CARDIAQUE	
Code de service	**Description du service**
9515	Consultation majeure ou spécifique
9516	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9517	Première visite en cabinet non référé (une fois par 365 jours)
9518	Visites en cabinet - suivi
8441	Surveillance à distance - DCI
8440	Surveillance à distance - Cardiostimulateur
8439	Surveillance à distance - Enregistreur en boucle
IMMUNOLOGIE CLINIQUE ET ALLERGIE	
Code de service	**Description du service**
9570	Consultation majeure ou spécifique
9571	Consultation subséquente

8901	Visite pour les personnes âgées, en supplément
9572	Première visite en cabinet non référé (une fois par 365 jours)
9573	Visites en cabinet - suivi
MÉDECINE DE SOINS INTENSIFS	
Code de service	**Description du service**
9576	Consultation majeure ou spécifique
9577	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9578	Première visite en cabinet non référé (une fois par 365 jours)
9579	Visites en cabinet – suivi
ENDOCRINOLOGIE ET MÉTABOLISME	
Code de service	**Description du service**
9590	Consultation majeure ou spécifique
9591	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9592	Première visite en cabinet non référé (une fois par 365 jours)
9593	Visites en cabinet - suivi
GASTROENTÉROLOGIE	
Code de service	**Description du service**
9607	Consultation majeure ou spécifique
9608	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9609	Première visite en cabinet non référé (une fois par 365 jours)
9610	Visites en cabinet - suivi
GÉRIATRIE	
Code de service	**Description du service**
9625	Consultation majeure ou spécifique
9626	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9627	Première visite en cabinet non référé (une fois par 365 jours)
9628	Visites en cabinet - suivi
8161	Aide médicale à mourir (AMAM)

HÉMATOLOGIE	
Code de service	**Description du service**
9640	Consultation majeure ou spécifique
9641	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9642	Première visite en cabinet non référé (une fois par 365 jours)
9643	Visites en cabinet - suivi
MALADIES INFECTIEUSES et MICROBIOLOGIE MÉDICALE	
Code de service	**Description du service**
9656	Consultation majeure ou spécifique
9657	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9658	Première visite en cabinet non référé (une fois par 365 jours)
9659	Visites en cabinet - suivi
ONCOLOGIE MÉDICALE	
Code de service	**Description du service**
9671	Consultation majeure ou spécifique
9672	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9673	Première visite en cabinet non référé (une fois par 365 jours)
9674	Visites en cabinet - suivi
NÉPHROLOGIE	
Code de service	**Description du service**
9686	Consultation majeure ou spécifique
9687	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9688	Première visite en cabinet non référé (une fois par 365 jours)
9689	Visites en cabinet - suivi
RADIO-ONCOLOGIE	
Code de service	**Description du service**
9702	Consultation majeure ou spécifique
9703	Consultation subséquente
8901	Visite pour les personnes âgées, en supplément
9704	Première visite en cabinet non référé (une fois par 365 jours)
9705	Visites en cabinet - suivi

Schedule BB

Emergency Department Funding

The Parties agree that funding for Emergency Medicine shall include:

1. One Emergency Department sessional rate of payment to serve as a base rate for all Emergency Departments in the Province, eliminating the *Rural* and *Urban* rate differential in force under the Predecessor Agreement.

2. Effective April 1, 2025, a one-time Resource Adjustment of 12% shall be applied to the rate of $247.27 to establish the new Emergency Department sessional rate, effective for all Physicians providing services within all New Brunswick Emergency Departments.

3. Fixed GEI (General Economic Increase) funding applied to the new Emergency Department sessional rate for the term of the Agreement, as set out in the table below:

	Regional ER Rate
April 1, 2025 – **Resource Adjustment (12%)**	$276.94
April 1, 2025 – GEI (2.5%)	$283.87
April 1, 2026 – GEI (3.5%)	$293.80
April 1, 2027 – GEI (2.5%)	$301.15
April 1, 2028 – GEI (4.0%)	$313.19

4. Negotiations of the Saint John Regional Hospital Emergency Department AFP to commence on or before December 31, 2025.