AGREEMENT TO AMEND THE ALBERTA MEDICAL ASSOCIATION AGREEMENT ("Amending Agreement")

Made effective November 1, 2016 (the "Effective Date").

BETWEEN:

Her Majesty the Queen in right of Alberta, as represented by the Minister of Health ("AH")

- and -

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

RECITALS:

A. AH and AMA entered into the Alberta Medical Association Agreement (the "AMAA") made effective April 1, 2011.

B. AMA and AH, along with Alberta Health Services ("AHS"), held collaborative discussions further to a Memorandum of Agreement signed by AH and AMA on January 22nd, 2016.

C. Through this process, the parties undertook extensive discussions concerning priority issues including immediate financial viability of the health care system; shared stewardship of limited health care resources; enhanced opportunities for Physician participation in health care system decision making; and governance.

D. As a result of the good faith discussions, AH and AMA have agreed to amend the AMAA in accordance with the terms of this Amending Agreement.

THEREFORE, in consideration of the terms of the AMAA and this Amending Agreement, the parties agree as follows:

1. The AMAA is amended:

   (a) by adding subsection 1(a.1) after subsection 1(a) as follows:

   "(a.1) "AHS" means Alberta Health Services."

   (b) by adding subsections 1(b.1) and (b.2) after subsection 1(b) as follows:

   "(b.1) "Benefits" means benefits as defined in the *Alberta Health Care Insurance Act*, as may be amended from time to time.

(b.2) "Contingencies" means the amount of AH expenditures in a fiscal year relating to Physicians, including payments for the provision of Insured Medical Services, that are solely attributable to any of the following:

(i) unilateral new programs initiated by either AH or AHS which increase net utilization (e.g., wait list reduction);

(ii) extraordinary public health measures (e.g., SARS);

(iii) actions taken at AH's sole discretion such as the addition of new insured services into the SOMB;

(iv) AHS off-loading of Physician services to the Physician Services Budget; and

(v) any other contingency as agreed to by the Management Committee."

(c) by adding subsection 1(g.1) after subsection 1(g) as follows:

"(g.1) "Physician Services Budget" means all AH expenditures relating to Physicians including, but not limited to, payments for the provision of Insured Medical Services, payments for Physician Support Programs and payments for Physician Assistance Programs, but does not include payments provided by AH to AHS for the purpose of AHS funding of Insured Medical Services."

(d) by adding subsections 1(l) through (u) after subsection 1(k) as follows:

"(l) "2015/16 Actual Expenditures" means the amount of AH's actual expenditures relating to Physicians for the 2015/16 fiscal year, as of June 30th, 2016. For clarity, the 2015/16 Actual Expenditures do not include the 2015/2016 AHS payments for Physician services and expenditures relating to the ARP conditional grant and program support and Physician development programs (the Medical Resident Services Allowances, Rural Physician Action Plan, Alberta International Medical Graduate Program; Postgraduate Medical Education Program and Internationally Education Health Professionals Program).

(m) "2016/17 Actual Expenditures" means the amount of AH's actual expenditures relating to Physicians for the 2016/17 fiscal year, as of June 30th, 2017. For clarity, the 2016/17 Actual Expenditures do not include the 2016/2017 AHS payments for Physician services and expenditures relating to the ARP conditional grant and program support and Physician development programs (the Medical Residents Services Allowances, Rural Physician Action Plan, Alberta International Medical Graduate Program; Postgraduate Medical Education Program and Internationally Educated Health Professionals Program).

(n) "2016/17 Available Amount" means the total of:

2015/16 Actual Expenditures **plus**

(the greater of 0% and 2016/17 COLA) x 2015/16 Actual Expenditures **plus**

2016/17 Physician Growth **plus**

2016/17 Contingencies.

(o) "2017/18 Available Amount" means the total of:

2016/17 Available Amount **plus**

(the greater of 0% and 2017/18 COLA) x 2016/17 Actual Expenditures **plus**

2017/18 Physician Growth **plus**

2017/18 Contingencies.

(p) "2016/17 Holdback" means the 2016/17 Retention Benefit;

(q) "2017/18 Holdback" means the total of:

2017/18 Retention Benefit **plus**

the greater of $0 and the Agreed Increase for 2017/18 [i.e. COLA, pursuant to subsection 5(b)(iii)] [held in abeyance pursuant to subsection 5(g)(ii)].

(r) "2016/17 Physician Growth" means the total of:

[(A – B) + (C – D)] x $200,000

Where:

A = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)

B = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2015/16 fiscal year (as at the date of service of March 31, 2016 and paid by June 30, 2016)

C = the number of Physicians (excluding any Physicians counted in A) who submitted claims for fee-for-service Benefits to AH in excess of $50,000 in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)

D = the number of Physicians (excluding any Physicians counted in B) who submitted claims for fee-for-service Benefits to AH in excess of $50,000 in the 2015/16 fiscal year (as at the date of service of March 31, 2016 and paid by June 30, 2016)

(s) "2017/18 Physician Growth" means the total of:

{[(A – B) + (C – D)] x $200,000} + {[(E – F) + (G – H)] x $164,000}

Where:

A = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2017/18 fiscal year (as at the date of service of March 31, 2018 and paid by June 30, 2018)

B = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)

C = the number of Physicians (excluding any Physicians counted in A) who submitted claims for fee-for-service Benefits to AH in excess of $50,000 in the 2017/18 fiscal year (as at the date of service of March 31, 2018 and paid by June 30, 2018)

D = the number of Physicians (excluding any Physicians counted in B) who submitted claims for fee-for-service Benefits to AH in excess of $50,000 in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)]

E = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)

F = the number of Physicians who received payment of Benefits for the provision of Insured Medical Services through participation in a clinical ARP or academic ARP in the 2015/16 fiscal year (as at the date of service of March 31, 2016 and paid by June 30, 2016)

G = the number of Physicians (excluding any Physicians counted in E) who submitted claims for FFS Benefits to AH in excess of $50,000 in the 2016/17 fiscal year (as at the date of service of March 31, 2017 and paid by June 30, 2017)

H = the number of Physicians (excluding any Physicians counted in F) who submitted claims for FFS Benefits to AH in excess of $50,000 in the 2015/16 fiscal year (as at the date of service of March 31, 2016 and paid by June 30, 2016)

(t) "2016/17 Reconciliation Gap" means the total of:

2016/17 Actual Expenditures **minus** 2016/17 Available Amount.

(u) "2017/18 Reconciliation Gap" means the total of:

2017/18 Actual Expenditures **minus** 2017/18 Available Amount."

(e) by deleting section 4 and replacing it with the following:

"4. (a) For health matters that touch and concern Physicians but which are not within the stated scope and purposes of this AMA Agreement, such as those matters referred to in sections 3(b)(iv) and 3(b)(v) hereof, AH will consult with and seek the advice of AMA, from time to time. In this regard:

(i) AMA and AH will initially negotiate and sign agreements describing the parameters of the consultation process for each of Electronic Medical Records, Primary Medical Care/Primary Care Networks and System-Wide Efficiencies and Savings;

(ii) AMA and AH will undertake the activities contemplated within Schedule 7 of this Agreement; and

(iii) AH will consult with the AMA on various other items, including but not limited to: Physician resource planning; primary care evolution; health information technology and management; and system-wide appropriateness and evidence-based improvements.

(b) For clarity, section 6 of the Agreement does not apply to any commitments undertaken pursuant to section 4, including those contemplated within subsection 4(i)-(iii) hereof."

(f) by adding subsections 5(f) – (j) as follows:

"(f) (i) Notwithstanding anything in this AMA Agreement, including the Schedules, the parties agree to recommend to the Minister of Health changes to rules regarding the application of fee-for-service billing codes in the SOMB, pursuant to the timelines and process outlined in Schedule 8, the implementation of which the parties reasonably expect to result in an annualized $100 million reduction in AH expenditures against these fee-for-service billing codes.

(ii) For clarity, the parties agree that the timelines and process outlined in Schedule 8, including recommendation to the Minister of Health for implementation, are not subject to Schedule 4 of the AMA Agreement, including sub-

paragraph 3(c)(iii) thereof, and do not require PCC involvement.

(iii) For clarity, the savings arising from the individual fee review process undertaken by PCC in 2015/2016 (the Fee Review Savings) constitute part of the $100 million reduction contemplated in subsection 5(f)(ii) above and in Schedule 8. The parties agree that the Fee Review Savings are not subject to sub-paragraph 3(c)(iii) of Schedule 4 of the AMA Agreement.

(g) Each party agrees to work towards the 2016/17 Reconciliation Gap and 2017/18 Reconciliation Gap having values less than $0. However, in the event these amounts are greater than $0:

(i) the AMA acknowledges it is responsible for the financial impact of the 2016/17 Reconciliation Gap and 2017/18 Reconciliation Gap being greater than $0 in the manner set out in subsection 5(j) of the AMA Agreement; and

(ii) notwithstanding anything in this AMA Agreement, AH will withhold payment of the amounts of the 2016/17 Holdback and the 2017/18 Holdback pending completion of the reconciliation process in each fiscal year set out in subsection 5(j) of the AMA Agreement.

(h) Notwithstanding subsection 5(b)(iii) of this AMA Agreement, the parties agree that, for the purposes of the 2017/2018 Holdback, the Agreed Increase of COLA for the 2017/2018 fiscal year will be held in abeyance for the purposes of subsection 5(j) and will not be applied on April 1, 2017, but may be implemented retroactively to April 1, 2017 pursuant to the reconciliation process.

(i) The Reconciliation Committee shall meet at least once every two months to monitor Actual Expenditures against Available Amounts (pro-rated for that two-month period).

(j) As soon as possible after the end of each of the 2016/17 and 2017/18 fiscal years but no later than June 30, the Reconciliation Committee shall meet to calculate the 2016/17 Reconciliation Gap and 2017/18 Reconciliation Gap respectively and shall reconcile funds as follows:

For 2016/17:

If the 2016/17 Reconciliation Gap is greater than the 2016/17 Holdback, AH shall retain the 2016/17 Holdback

If the 2016/17 Reconciliation Gap is greater than $0 and less than or equal to the 2016/17 Holdback, AH shall retain the 2016/17 Reconciliation Gap from the 2016/17 Holdback and release the

remainder of the 2016/17 Holdback to the benefit of Physicians and authorize the AMA to pay a full or pro-rated Retention Benefit to Physicians for the 2016/2017 fiscal year (depending on amount available) in accordance with the relevant grant agreement, or in some other manner that the parties agree to.

For 2017/18:

If the 2017/18 Reconciliation Gap is greater than the 2017/18 Holdback, AH shall retain the 2017/18 Holdback.

If the 2017/18 Reconciliation Gap is greater than $0 and less than or equal to the 2017/18 Holdback, AH shall retain the 2017/18 Reconciliation Gap from the 2017/18 Holdback and release the remainder of the 2017/18 Holdback to the benefit of Physicians in the following manner and order (depending on the amounts available):

- a full or pro-rated Agreed Increase of COLA for the 2017/2018 fiscal year will be accounted for and a retroactive adjustment made to the SOMB effective April 1, 2017; and

- a full or pro-rated Retention Benefit for the 2017/2018 fiscal year (depending on amount available) will be paid by the AMA to eligible Physicians in accordance with the relevant grant agreement."

(g) by adding subsection 6(d) as follows:

"(d) Notwithstanding subsection 6(a)(ii) and Schedule 1, the parties agree to commence negotiations as of the Effective Date of the Amending Agreement. The parties will exchange written details of the matters within the scope of the Agreement desired to be negotiated, which are not restricted to the Financial Matters. For the purposes of these negotiations, the parties acknowledge the AMA's continued representation of Physicians. The choice of the parties, or either of them, to negotiate matters beyond the Financial Matters shall not otherwise expand or in any way alter Schedules 1 or 5 of this Agreement."

(h) by deleting subsection 7(a) and replacing it with the following:

"(a) there will be an AMA Agreement Management Committee (the "Management Committee") comprised of the then Deputy Minister of AH, the then Chief Executive Officer of AMA, and the then President and Chief Executive Officer of AHS. However, each of AH, AMA and AHS may, at its sole discretion, designate another representative to fill its respective position;"

(i) in subsection 8(c)(i) by replacing "1 for AH" with "1 combined vote for AH and AHS,";

(j) in subsection 8(c)(ii) by adding ", one (1) AHS member" after "one (1) AH member,";

(k) by adding sections 8.1 to 8.4 after section 8 as follows:

"8.1 Advisory Committee

(a) There will be an Advisory Committee (the "AC"), for which the parties recommend to the MC that the formal terms of reference for the AC incorporate the principles as described in the attached Schedule 9 – Advisory Committee.

(b) The AC will take general direction from and will report to the Management Committee.

8.2 Reconciliation Committee

(a) There will be a Reconciliation Committee (the "RC"), for which the parties recommend to the MC that the formal terms of reference for the RC incorporate the principles as described in the attached Schedule 10 – Reconciliation Committee.

8.3 Appropriateness and Evidence-Based Improvements Committee

(a) There will be an Appropriateness and Evidence-Based Improvements Committee (the "AEBIC"), for which the parties recommend to the MC that the formal terms of reference for the AEBIC incorporate the principles as described in the attached Schedule 11– Appropriateness and Evidence-Based Improvements Committee.

(b) The AEBIC will take general direction from and will report to the Management Committee."

(l) by deleting Schedule 3 in its entirety and replacing it with a new Schedule 3, attached to this Amending Agreement as Appendix A;

(m) in Schedule 4, by deleting section 1 and replacing it with the following:

"1. Be comprised of not more than nine (9) and not less than four (4) persons. AH and AMA will each appoint up to three (3) representatives and AHS will appoint up to two (2) representatives."

(n) in the chart in Schedule 6:

(i) in the row entitled "Retention Benefit" under the column "Description", by adding "Subject to section 5 of the Agreement, "before "Physicians will receive..."; and

(ii) under the column entitled "Basis for Budget", by adding "subject to section 5 of the AMA Agreement" behind all instances of "and 2017/18".

(o) in Schedule 6, by adding section 11 after section 10 as follows:

"11. The AMA will retain any accumulated Continuing Medical Education allotments that expire in fiscal years 2015/16, 2016/2017 and 2017/2018 for the purpose of funding the Towards Optimized Practice Program (or for supporting other Physician Support Programs and Physician Assistance Programs, subject to the approval of the Minister). The parties acknowledge that any such transfers of funding will require review of the related grant agreements and such grant agreements may require amendment to facilitate such funding."

(p) by adding new Schedule 7 – Commitments, attached to this Amending Agreement as Appendix B;

(q) by adding new Schedule 8 – Savings from the SOMB, attached to this Amending Agreement as Appendix C;

(r) by adding new Schedule 9 – Advisory Committee, attached to this Amending Agreement as Appendix D;

(s) by adding new Schedule 10 – Reconciliation Committee, attached to this Amending Agreement as Appendix E; and

(t) by adding new Schedule 11 – Appropriateness and Evidence-Based Improvements Committee, as attached to this Amending Agreement as Appendix F.

2. Notwithstanding the date this Amending Agreement is signed, these amendments shall be incorporated into and form part of the AMAA as of the Effective Date.

3. The parties agree that nothing in this Amending Agreement shall in any manner whatsoever fetter the legislative and regulatory power and authority of the Government of the Province of Alberta and/or the Minister of Health.

4. Capitalized terms used but not defined in this Amending Agreement have the meaning given to them in the AMAA.

5. In all other respects, the AMAA remains unchanged and shall continue in full force and effect in accordance with its terms.

[THIS SPACE INTENTIONALLY BLANK]

6. This Amending Agreement is binding on the parties and their successors and permitted assigns.

This Amending Agreement is entered into by each of the undersigned by its authorized representative:

Her Majesty the Queen in Right of Alberta
as represented by the Minister of Health

Nov. 18, 2016.
Date

President, Alberta Medical Association
(C.M.A. Alberta Division)

Nov 1/16
Date

Appendix A to Amending Agreement

SCHEDULE 3
MANAGEMENT COMMITTEE
(Terms of Reference)

Responsibilities and Deliverables

The Management Committee ("MC") will:

1. Ensure that the scope and purposes of this AMA Agreement are followed and implemented as intended.
2. Determine Contingencies for the purpose of calculating the 2016/2017 Available Amount and the 2017/2018 Available Amount.
3. Where possible, AH and AHS will advise the AMA when implementing any programs, measures, activities or policy changes, which may constitute Contingencies. The parties agree that any failure by AH to advise the AMA of such activity does not constitute a breach of any obligations under this AMA Agreement.
4. The MC shall direct the RC to develop a comprehensive process to quantify the costs associated with Contingencies.
5. Create sub-committees as the MC requires and set formal terms of reference for such subcommittees, including the AC, RC, and AEBIC.
6. Provide broad general direction to the PCC, AC, RC, and AEBIC including, without limitation, providing guidance regarding the priorities of and the tasks and work to be undertaken by the PCC, AC, RC, and AEBIC.
7. Ensure that the PCC, AC, RC, and AEBIC have sufficient resources to undertake and complete their tasks and work.
8. Subject to the provisions of Section III of Schedule 5 – Dispute Resolution, provide direction and advice regarding the interpretation of the provisions of this AMA Agreement as requested or required by PCC, AC, RC, and AEBIC and/or AH and/or AMA, including issues touching and concerning the mandate, roles, responsibilities, duties or authority of the PCC, AC, RC, and AEBIC.
9. Provide timely reports to the Minister of Health, AMA's President, and AHS' President and CEO regarding the operation of PCC, AC, RC, and AEBIC, the operation of this AMA Agreement and any other matter deemed relevant by the MC. For certainty, the MC will keep the Minister of Health, AMA's President, and AHS' President and CEO apprised of any concerns, disputes and/or issues which may develop into and/or have developed into matters that will activate the provisions of Section III of Schedule 5 – Dispute Resolution.
10. Not have the authority to overrule/set aside a properly made decision/recommendation of the PCC.
11. Recommend to the Minister of Health, AMA's President, and AHS' President and CEO for potential appointment as the Chair of the PCC not less than three (3) and not more than five (5) persons.
12. Establish the terms and conditions of the contract for the Chair of the PCC.

13. Consult with AH, AMA, and AHS regarding the establishment of provincial strategic requirements for Physician compensation, plans and programs.
14. Ensure the appropriate alignment and cross-referencing of agenda items and findings between the various committees that report to MC.

Member Responsibilities and Goals

Each member represents the views of the member's respective organization with a goal to improve the health care delivery system. Declarations of conflict of interest shall be made by meeting participants as necessary, and participants who have a conflict of interest will recuse themselves.

Agenda Setting

AH will form the MC's agenda with input from all parties.

The agenda for MC meetings will always include an update on PCC, AC, RC, PRPC, and AEBIC, with emphasis on reports from the PCC.

Meetings

The MC will meet every three weeks, or as otherwise agreed by AH, AMA, and AHS. Every other meeting of the MC will include the AC.

All MC members (or named designates) must be present to hold a meeting.

Secretariat

AH will provide secretarial and administrative support to the MC.

Committee Costs

Each of AH, AMA, and AHS is responsible for the costs of their respective member(s)' participation on MC.

Appendix B to Amending Agreement

SCHEDULE 7
Commitments

1. Physician Resource Planning

a) The parties commit to the creation of a Physician Resource Planning Committee (PRPC). AH, AMA and AHS recognize the need for planned Physician growth based on population health needs through a multi-stakeholder committee, the PRPC, which would create and regularly update an evidence-based Physician resource plan (PRP), which would establish the number of Physicians needed in Alberta by type of Physician practice and location and at a minimum, reflect a need for:

i. primary care Physicians in underserviced areas;

ii. hard to recruit specialists;

iii. university appointments; and

iv. replacements for attrition.

b) The parties agree that any other committee(s) implemented to create or manage the PRP shall consult with the Management Committee.

c) The draft terms of reference for the PRPC are attached hereto as Exhibit A to this Schedule 7.

2. Audit/Physician Peer Review Processes

a) AMA and AH recognize the need to develop mechanisms for reviewing the clinical appropriateness of Physician claims for Benefits and best billing practices (Peer Review) with the goal of achieving potential cost savings in the amount of $20 million in 2016/17 and $35 million in 2017/18.

b) The parties agree that the Peer Review process may involve other activities, including developing further improvements to the AMA billing application; education efforts with AMA sections; and other collateral activities.

c) AMA and AH confirm that any Peer Review process developed must augment, and not replace, AH's current audit and compliance activity.

d) In order to assist with Physicians' compliance with best billing practices and to allow Physicians to identify where their practices align with those of their peers, AH will re-

instate the publication and distribution of non-identifying Physician billing profiles beginning April 1, 2017.

3. Centralized Patient Attachment Registry and Provider Registry

a) AH, AHS and AMA recognize the benefits to all parties that would come from the development of a Centralized Patient Attachment Registry ("CPAR") and enhancement of the provider registry as priority items. The CPAR will be connected to Alberta Health's Benefits payment system and will be used to pay Physicians in a Blended Capitation Model and may be used for any rule changes to the SOMB.

b) AH commits to implement the CPAR and provider registry system enhancement(s) on or before December 31, 2017.

c) The development and implementation of the CPAR and provider registry system enhancements will be overseen by the Health Information Executive Committee.

4. Alternative Relationship Plans

a) AH recognizes the benefits of AMA involvement in the development and maintenance of Academic and Clinical ARPs, including consultation on related Physician resources, remuneration, equity and overall planning.

b) AH agrees that at a minimum, AMA shall have representation on the following committees as voting members:

i. Provincial Academic ARP Strategy Committee, as represented by the Executive Director of the AMA; and

ii. the Provincial Academic ARP Operations Committee.

5. Improvements to the Schedule of Medical Benefits

a) AH commits to undertaking a review of the administrative process for implementing Schedule of Medical Benefits (SOMB) updates in order to make the process more streamlined and efficient. In this context, AH will consider shortening the implementation period for updates to no longer than three (3) months, and implementing semi-annual SOMB updates.

b) AH and AMA agree to expedite the Physician Compensation Committee's efforts to price insured medical services according to their relative values. These efforts will include working towards the implementation of new Physician business cost model following an independent third party study, funded equally by AH and AMA, which will be obtained through a transparent process that complies with applicable procurement rules.

6. Data Sharing

a) AMA has requested access to data from AH for the following purposes:

i. for facilitating Physician Peer Review;

ii. for Physician resource planning; and

iii. for determining Physician compensation relativity.

b) Subject to applicable laws, AH will enter into a data sharing agreement with AMA for the purposes contemplated in clause 6(a) above by thirty (30) days from the Effective Date of the Amending Agreement.

7. Integrated Care

a) The parties have undertaken several initiatives aimed at providing sustainable high quality care. These initiatives include Primary Care Networks, payment reforms, and improvements to information management and technology.

b) The parties acknowledge that increased attention must be made to integrated care throughout the health care system, which requires the integration of delivery models. Towards that end, the parties agree to create an Integrated Care Consultation Agreement pursuant to section 4 of the AMA Agreement.

Exhibit A to Schedule 7
DRAFT Terms of Reference for PRPC

Alberta Health - Physician Resource Planning Committee

(Advisory Committee to the Minister on managing physician resources)

DRAFT Terms of Reference

PURPOSE

The purpose of the (PRPC) is to advise the Minister on the appropriate supply and distribution of physicians in Alberta by developing and regularly updating an evidence-based physician resource plan (The Plan). The Plan will recommend the number of physicians required by specialty, geographic location, and conditions of practice and identify any gaps in physician supply.

The PRPC will also develop physician forecasts to identify Alberta's short and long-term needs in the context of a changing health care system.

COMMITTEE RESPONSIBILITIES

1. Develop and regularly update the Plan that specifies the short, medium and long-term provincial requirements for physician resources by specialty, geographic location, and conditions of practice.
2. Develop and recommend strategies to the appropriate stakeholders to integrate physician resource planning with the planning of other health human resources provincially and with AHS;
3. Identify and inform AHS and other stakeholders on opportunities to better coordinate and/or integrate medical services to create an integrated approach to health planning.
4. Consult with stakeholders (e.g., AMA Sections), as required, regarding their views on the future supply needs.
5. Provide advice to the Government of Alberta on:

    - Provincial physician workforce planning processes, giving consideration to key national, provincial and local drivers;

    - Forecasting models that are aligned with both AHS workforce planning processes and provincial health service and capital/infrastructure/business planning; and

    - Strategies that address provincial physician distribution and supply issues, including but not limited to enrollment in medical schools and system demand for specific physician general and specialist physicians.

REPORTING STRUCTURE

The PRPC will report to the Deputy Minister of Health.

The PRPC will consult with Management Committee.

MEMBERSHIP

- Alberta Health (Chair)
- Alberta Health Services (AHS)
- Alberta Medical Association
- College of Physicians and Surgeons of Alberta
- Faculties of Medicine
- Professional Association of Residents of Alberta
- Medical Students' Association (University of Alberta and University of Calgary combined)
- Alberta Rural Physician Action Plan (RPAP)
- Alberta International Medical Graduate Program (AIMG)
- An AHS or HQCA patient advisory group representative

MEETINGS

- Chair will determine meeting processes and the PRPC will meet at the direction of the Chair.
- The PRPC has the ability to establish working groups.
- Agendas will be developed and sent to all members in advance of meetings.
- Minutes will be prepared and circulated with the agenda.
- The PRPC will have the authority to engage experts and other resources it deems necessary to meet its mandate.
- Member organizations are to name alternate PRPC members, who will attend when the primary member is unavailable and make decisions for the organization they represent.

COMMITTEE CODE OF CONDUCT

Committee members will respect and acknowledge that matters discussed at the Committee can be of a sensitive nature and are to be kept confidential.

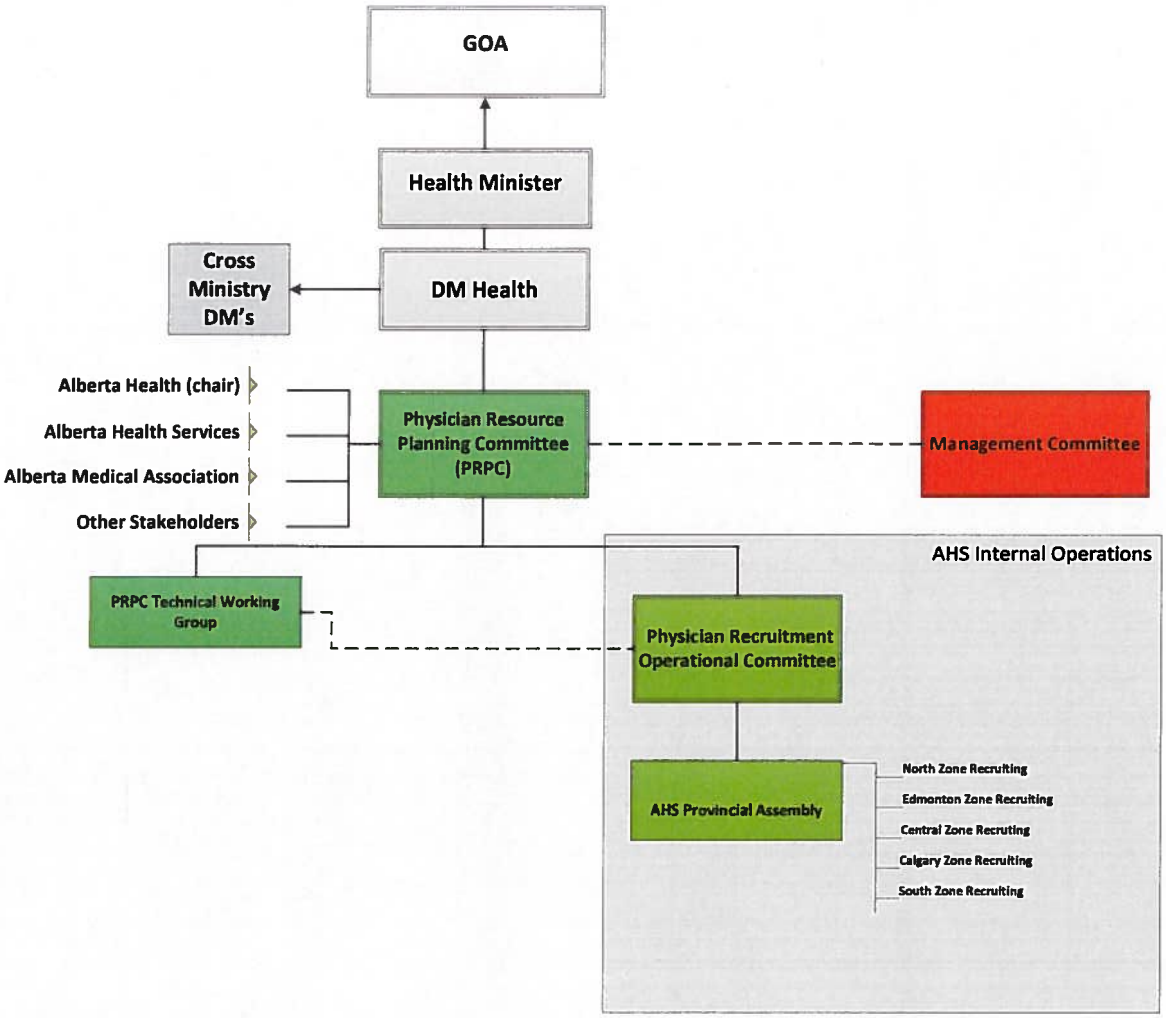
ADMINISTRATIVE SUPPORT

The PRPC shall be supported administratively by staff from Alberta Health.

Alberta Health - Physician Resource Planning Committee

(Advisory Committee to the Minister on managing physician resources)

GOVERNANCE STRUCTURE



Appendix C to Amending Agreement

SCHEDULE 8

Savings from the SOMB

1. The parties agree to create of a joint working group (SOMB Working Group), as of the Effective Date of the Amending Agreement, whose members are as follows:

   (a) three (3) representatives from AH (including representation from AHS); and

   (b) three (3) representatives from AMA.

2. The SOMB Working Group will be co-chaired, with each of AMA and AH selecting one of their respective members to act in this position (the Co-Chairs).

3. The purpose of the SOMB Working Group is to create a list of SOMB savings initiatives (the List), amounting to $100 million in annualized savings, for recommendation for implementation by the Management Committee to the Minister of Health as follows:

   (a) by November 15, 2016 for implementation on January 1, 2017 and/or April 1, 2017; and

   (b) by February 3, 2017 for implementation on April 1, 2017.

4. In creating the List, the SOMB Working Group must consider at least the following information:

   (a) existing savings initiative lists (for example, the initial list proposed by AH on July 8th, 2016, the Choosing Wisely Canada List, AH/AMA/AHS System Wide Efficiencies and Savings List); and

   (b) additional evidence-based initiatives identified by AMA, AHS or AH.

5. The creation of the List will be guided by principles selected by the SOMB Working Group and, as determined by the SOMB Working Group, the List should:

   (a) where applicable, be informed by one or more of the Choosing Wisely Canada recommendations;

   (b) be driven by best available evidence and national guidelines for high quality patient care;

   (c) consider the need to reduce inappropriate variation in Physician practices;

   (d) be objective, transparent, and driven by peer reviewed literature, other reliable data or necessary consultations with field experts;

(e) improve alignment of incentives driving high quality patient care practices across different modes of payment; and

(f) simplify existing complexity and modernize the SOMB.

6. The SOMB Working Group will decide on the contents of the List, for recommendation to the Management Committee, through a majority vote, with each member having a single vote.

7. If the SOMB Working Group achieves a majority vote in support of the contents of the List, the SOMB Working Group will provide the List to the Management Committee for recommendation to the Minister of Health for implementation.

8. If the SOMB Working Group fails to achieve a majority vote on the contents of the List, the Co-Chairs will notify the Management Committee, at least two (2) weeks in advance of each of the dates identified in Clause 3 above, of the failure to achieve a majority vote. When providing such notice, the Co-Chairs will also provide the Management Committee with the proposed list which identifies the items of dispute (the Draft List).

9. Within five (5) days of receiving notice and the Draft List as per Clause 8 above, the Management Committee will submit the Draft List to Mr. Vince Ready and Dr. David Naylor, or any other independent third party(ies) agreed upon by the parties. Such third party(ies) will engage in a final offer selection of the Draft List, based on the principles outlined in Clause 5 above and with the goal of creating a List that results in the savings as contemplated in subsection 5(f) of the AMA Agreement.

10. Within one (1) week of receiving the Draft List, the third party(ies) will recommend the List to the Minister of Health for implementation. For clarity:

(a) the List recommended by the third party(ies) is not subject to vote of the SOMB Working Group;

(b) the contents of the List recommended by the third party(ies) is limited to the contents in the Draft List; and

11. The parties agree that, once engaged, Mr. Vince Ready and Dr. David Naylor, or any other the third party(ies) agreed upon, will remain seized of the process outlined in this Schedule 8 throughout its duration.

Appendix D to Amending Agreement

SCHEDULE 9
ADVISORY COMMITTEE

The parties recommend to the MC that the formal terms of reference for the Advisory Committee ("AC") which, at a minimum, will reflect the following:

1. The AC will be comprised of representatives from the following organizations:
   (a) Health Quality Council of Alberta;
   (b) Institute of Health Economics;
   (c) Alberta Innovates Health Solutions;
   (d) Deans of Medicine (University of Alberta and University of Calgary); and
   (e) College of Physicians and Surgeons of Alberta.

2. The AC will report to the MC every six weeks, or as otherwise agreed by MC.

3. The AC may establish ad hoc working groups as the AC deems appropriate.

Appendix E to Amending Agreement

SCHEDULE 10
RECONCILIATION COMMITTEE

The parties recommend to the MC that the formal terms of reference for the Reconciliation Committee ("RC") which, at a minimum, will reflect the following:

1. The RC will provide analytics, report trend information, identify priorities and provide evidence and data on issues that need to be considered as appropriate to support decision making for reconciliation at MC and other committees formed pursuant to the AMA Agreement.

2. The RC will respond to requests for analytics and trend information from and report to the MC as related to the AMA Agreement.

3. The RC will be comprised of members as determined by the MC.

4. The RC may establish other ad hoc working groups as the RC deems appropriate.

5. The RC may, upon approval of the MC, engage the services of an independent third party to validate calculations and make recommendations to the MC for the purpose of calculating the 2016/2017 Reconciliation Gap and the 2017/2018 Reconciliation Gap. For greater clarity, this includes the quantification of the costs of Contingencies.

Appendix F to Amending Agreement

SCHEDULE 11
APPROPRIATENESS AND EVIDENCE-BASED IMPROVEMENTS COMMITTEE

The parties recommend to the MC that the formal terms of reference for the Appropriateness and Evidence-Based Improvements Committee ("AEBIC") which, at a minimum, will reflect the following:

1. The AEBIC will act in an advisory capacity to MC on issues and opportunities related to the improvement of healthcare system delivery.

2. The AEBIC will advise MC on issues and opportunities for implementing improvements to the appropriateness and quality of care Albertans receive. For the purposes of this AMA Agreement, quality of care will be defined by the six elements in the HQCA Quality of Care matrix: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety.

3. The AEBIC will provide advice on opportunities and activities to bridge the gap between current evidence and improving health outcomes oriented around appropriateness and quality of care.

4. The AEBIC will take general direction from and will report to the MC.

5. The AEBIC will be comprised of members as determined by the MC.

6. The AEBIC may establish ad hoc working groups as the AEBIC deems appropriate.

ALBERTA MEDICAL ASSOCIATION STRATEGIC AGREEMENT
("Strategic Agreement")

Made effective November 1, 2016

BETWEEN:

Her Majesty the Queen in right of Alberta,
as represented by the Minister of Health
("AH")

- and -

Alberta Medical Association
(C.M.A. Alberta Division)
("AMA")

- and -

Alberta Health Services
("AHS")

PREAMBLE:

A. The AMA and AH have held collaborative discussions further to the Memorandum of Agreement signed by those parties on January 22, 2016, and have agreed to include AHS in those discussions. The undersigned agree to recommend the following for ratification by their principles. Ratification is required by:

   i. The AMA Board;

   ii. The AMA membership;

   iii. AHS Board;

   iv. The Minister of Health.

RECITALS:

A. The AMA and AH are parties to the Alberta Medical Association Agreement made effective April 1, 2011 ("the **AMAA**").

B. The parties have a long history of collaboration and cooperation regarding health care matters in general and medical services in particular.

C. The parties have completed extensive discussions concerning priority issues including immediate financial viability of the health care system; shared stewardship of limited health care resources; enhanced opportunities for physician participation in health care system decision making; and governance.

D. The parties will use their best efforts to agree to a long term strategic vision/plan that will guide the development and implementation of patient-first system focused initiatives.

E. The parties have created, through the provisions of this Strategic Agreement, a set of initiatives that will foster collaboration and partnership between AHS, AH and the AMA, and leverage core capabilities within each organization.

F. Nothing in this Strategic Agreement shall constitute a waiver of any party's rights concerning representation that AMA may seek or that AHS may challenge regarding physicians employed by AHS or physicians independently contracted whose contracts expire on or after March 31, 2018.

NOW THEREFORE in consideration of the recited premises and mutual covenants, each of AMA, AHS and AH agree with the other as follows:

A. Definitions

i. "Agreement" means this Strategic Agreement and all schedules attached, all as might be amended from time to time in accordance with the provisions hereof.

ii. "Effective Date" means November 1, 2016.

iii. "Group", for the purposes of the Negotiation Framework, means one or more independent contractor physicians involved in a similar area of practice or specialty who have expressed the desire to have representation by the AMA in the course of negotiations with AHS, who have signed a Representation and Consent Form and who comprise at least 50% +1 of the total number of independent contractor physicians who may be affected by those negotiations.

B. Term of Agreement

i. This Agreement shall be effective from the Effective Date until March 31, 2018 (the "Term") unless terminated in accordance with the provisions of this Agreement.

ii. The Term of the Agreement may be extended by mutual written consent of the parties.

iii. Six (6) months prior to the expiry of the Term, AHS, AH and AMA shall meet and use best efforts to (1) establish bridging provisions upon expiry of the Agreement on March 31, 2018; or (2) determine whether the Agreement will be extended and if so, on what terms and conditions.

C. Recognition Rights

Principles of a Framework Arrangement TBD, 2016 to March 31, 2018 ("the Framework")

i. This Framework sets out a process to resolve AHS contract negotiations with its independent contractor physicians who are providing, or wish to provide insured services for the period up to March 31, 2018. For clarity, this framework does not apply to employee physicians, medical students, residents or fellows.

ii. Notwithstanding the expiry of the Term, for contracts that extend beyond March 31, 2018, AHS agrees that AMA has representation rights utilizing the Framework to represent independent contractor physicians for the application and interpretation of those contracts only up to the date of expiry of such contracts.

iii. It is understood and agreed that if independent contractor physicians are repatriated from AHS to AH during the period covered by this framework, those independent contractor physicians would be captured by the AMAA and would no longer be captured by this Framework. For the purposes of this Agreement, "repatriation" means the transfer of a written agreement which AHS has with a group of physicians (for example, Lab Physicians or Cancer Care physicians) and the budget associated with that written agreement from AHS to AH.

iv. AHS recognizes a Group of independent contractor physicians' rights to choose the AMA as their representative during the Term and in doing so, AHS also recognizes the AMA as representative of that Group.

v. The parties further agree to a negotiating framework which addresses and resolves any outstanding contracts for AMA-represented independent contractor physicians.

vi. The parties agree that independent contractor physicians need to be made aware of the opportunity to choose AMA as their negotiating representative and the AMA needs to be able to contact independent contractor physicians. Some provisions to enable this include:

- AHS will inform any independent contractor physicians at the commencement of any negotiations of the opportunity to be represented by AMA and the provisions of this negotiating framework;

- In addition, AHS will notify the AMA of the impending lapse of existing contracts with independent contractor physicians 90 days in advance of the term of such contracts which notice shall include identification of the nature of the practice or specialty of such independent contractor physicians, as well as the number of physicians contracted to AHS in the particular area of practice or specialty;

- Upon receipt of such notice, the AMA may contact the independent contractor(s) to ascertain if they desire representation from the AMA in upcoming negotiations;

- AMA will provide to AHS a Representation and Consent Form in the form appended as Schedule "A" to this Agreement for each independent contractor physician who desires the AMA's representation;

- Upon receipt of sufficient Representation and Consent Forms to constitute 50% +1 of the total independent contractor physicians in the particular area of practice or specialty, AHS will provide to AMA a copy of each existing contract between AHS and the members of the Group of independent contractor physicians, together with any other documentation relevant to the upcoming negotiations;

- A general communications strategy will be drafted and implemented jointly by AMA, AHS and AH.

vii. An independent contractor physician who signs a Representation and Consent Form has opted into the framework. An independent contractor physician may opt out of this framework by providing AMA and AHS with written notice in the form appended as Schedule "B" to this Agreement. Once an independent contractor physician has opted out, the decision will hold until the later of the expiry of his/her contract or the expiry of the Term of this Agreement.

viii. Where there are existing contracts that expire later than March 31, 2018, those independent contractor physicians will be approached regarding their interest in opting into the negotiating framework for purposes of the utilization of section xi below only. For greater clarity, section x below will not apply to these independent contractor physicians.

ix. AHS and AMA will negotiate in good faith to resolve contract disputes or the renewal of contracts whose term will expire prior to March 31st, 2018 between a Group and AHS related to payment rates and other terms and conditions.

x. Should AHS and AMA be unable to resolve these contract disputes or the renewal of contracts whose term will expire prior to March 31, 2018 on issues relating to payment rates, the matter will be sent to binding interest arbitration solely on the issue of payment rates. Each party will appoint a member to the Interest Arbitration Board and those nominees will agree on a third party as chair of the Board. If the nominees cannot agree on the third party, the chair shall be appointed by the Court of Queen's Bench of Alberta ("the Court") pursuant to the provisions of the *Arbitration Act* of Alberta ("the Act"). That Interest Arbitration Board shall resolve the dispute over payment rates only. The parties may agree to set criteria to assist the Board in its determination. It is agreed that the Interest Arbitration Board shall remain seized of any issues relating to the implementation of its decision regarding payment rates.

xi. For the resolution of disputes that arise relating to the interpretation of terms and conditions (other than payment rates) of the contracts in place, or where the contract's term will expire prior to March 31, 2018 that are in the course of renewal, for independent contractor physicians who chose to be represented by the AMA, the parties will agreed to a rights arbitration process to resolve such disputes, it being understood that the jurisdiction of the Rights Arbitration Board will be limited to the interpretation of specific terms of the contract other than payment rates. AHS and AMA will agree on a chair for the Rights Arbitration Board. If the parties cannot agree on the third party, the chair shall be appointed by the Court of Queen's Bench of Alberta ("the Court") pursuant to the provisions of the *Arbitration Act* of Alberta ("the Act").

xii. Nothing in this Framework will restrict the AMA's ongoing obligation to act in accordance with its constitution and bylaws.

D. <u>No Fettering</u>

i. Nothing in this Strategic Agreement shall in any manner whatsoever either fetter the legislative and regulatory power and authority of the Government of the Province of

Alberta and/or the Minister of Health, nor fetter the right of any party to access the courts to resolve matters of disagreement.

This Strategic Agreement is entered into by each of the undersigned by its authorized representative on the date(s) set out below but having effect on the Effective Date.

President, Alberta Medical Association (C.M.A. Alberta Division)	Nov 1 / 16 Date
President and CEO, Alberta Health Services	Nov 15, 2016 Date
Her Majesty the Queen in Right of Alberta as represented by the Minister of Health	Nov. 18, 2016. Date

SCHEDULE "A"
to the Strategic Agreement made effective
the _____ day of _____, 2016.

Authorization for Representation and Consent

I, Dr. _____, authorize the Alberta Medical Association (AMA) to represent me in negotiations with Alberta Health Services (AHS) regarding financial, workload, relationship and all other issues relating to the negotiation, renewal or extension of my contract with AHS.

I confirm that I have read and agree to abide by the "Criteria to Assist Physicians" approved by the AMA Board of Directors on July 22, 1993.

I consent to the release to the AMA by AHS of a copy of my existing contract for services, as well as copies of all other documentation or information relevant to the negotiations relating to the continuance or renewal of my contract.

Dated this ____ day of _____, 20____.

_____ _____
Signature Print Name

SCHEDULE "B"
to the Strategic Agreement made effective
the _____ day of _____, 2016.

Authorization to Opt Out of the Strategic Agreement

I, Dr. _____, hereby opt out of the negotiated bargaining framework, AMA representation and all provisions stated in the strategic agreement. I understand that by doing so, I will not be allowed to opt in to the Framework and seek the AMA's representation until such time as the later of the lapse of my existing contract with AHS, or the lapse of the Strategic Agreement with AHS.

I also understand that the terms and conditions of the my current services agreement with AHS will be honored until such time as it expires, at which time the newly negotiated agreement shall come into effect.

Dated this _____ day of _____, 20___, at the City of _____ in the province of Alberta.

_____ _____
Signature Print Name

AGREEMENT TO AMEND THE PRIMARY MEDICAL CARE/PRIMARY CARE NETWORKS CONSULTATION AGREEMENT
("Amending Agreement")

Made effective November 1, 2016 (the "Effective Date").

BETWEEN:

Her Majesty the Queen in right of Alberta,
as represented by the Minister of Health
("AH")

- and -

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

RECITALS:

A. AH and AMA entered into the Primary Medical Care/Primary Care Networks Consultation Agreement (the "Agreement").

B. AMA and AH held collaborative discussions further to a Memorandum of Agreement signed by AH and AMA on January 22nd, 2016.

C. Through this process, the parties undertook extensive discussions concerning priority issues including immediate financial viability of the health care system; shared stewardship of limited health care resources; enhanced opportunities for physician participation in health care system decision making; and governance.

D. As a result of the good faith discussions, AH and AMA have agreed to amend the Agreement in accordance with the terms of this Amending Agreement.

THEREFORE, in consideration of the terms of the Agreement and this Amending Agreement, the parties agree as follows:

1. The Agreement is amended:

   (a) by adding Article 3(f) as follows:

      "e) The parties agree on the need to ensure other providers are informed and consulted on all matters relevant to their professional scope of practice.

(b) by adding Article 5(f) and Article 5(g) as follows:

f) The parties, through the Management Committee established pursuant to the Alberta Medical Association Agreement made effective April 1, 2011 (the AMA Agreement), shall determine the appropriate staff complement and other resources to support the PCN Committee.

g) As a priority, the PCN Committee shall work to develop a provincial framework that will apply to all PCNs ("the Framework").

i. The Framework will stipulate requirements that will apply to all PCNs, including a listing of any exceptions (subject to approval of the Framework by the Minister of Health).

ii. Once the PCN Committee has developed the Framework, the AMA, including the AMA's PCN Physician Leads Executive, will develop a ratification process for the Framework. The ratification process is intended to provide a reasonable and fair representation of the PCN membership. Accordingly, the ratification process may involve a double majority system, or such other system that achieves the goal of fair representation of both PCN physician groups and PCN physicians.

iii. AHS will follow its own ratification process.

iv. Following ratification, the PCN committee will recommend the Framework to the Minister of Health for approval

v. The Framework will include an amending procedure clarifying which issues can be amended by the Minister of Health on the advice of the PCN Committee and which require formal ratification as defined in this clause.

(c) by adding Article 6 through Article 8 as follows:

"6. BLENDED CAPITATION MODEL

a) The parties shall establish a Blended Capitation Model Committee ("BCMC") to oversee the development of a Blended Capitation Alternate Relationship Plan and will be managed according to the provisions of the AMA Agreement.

b) The BCMC will be a consultative body for and provide advice on the development, implementation, and evaluation of alternative methods to compensate Physicians in primary care, including the implementation and assessment of the Blended Capitation Model.

c) The parties support the maximum annual compensation for participating physicians being the sum of

   i. 85% of the applicable rate of payment for each affiliated patient for each stipulated risk cohort; plus

   ii. 15% of the amount of claims for Benefits for program services provided to the affiliated patients.

d) The parties commit to initially implement five (5) clinics in a Blended Capitation Model by no later than February 2017. By Spring 2018, and based on evolving the Blended Capitation Model using the learning from the initial five (5) clinics, the parties will implement ten (10) more Blended Capitation clinics throughout Alberta.

e) The BCMC will make best efforts to accelerate a phased implementation of blended capitation programs, including shared gain options that draw on savings to be achieved through diagnostic imaging, pharmaceuticals and other components of healthcare system delivery. The parties will implement a demonstration project with staged expansion of enrollment and continued evaluation as to the effectiveness of various models.

f) The BCMC will take general direction from and will report to the MC.

g) The BCMC will be comprised of members as determined by the MC.

h) The BCMC may establish ad hoc working groups as it deems appropriate.

i) The BCMC may engage external expert resources as required.

7. OTHER COMMITTEES

a) The Parties, working with others, will review the existing committees and committee structures within primary care and make changes as necessary to improve functioning and to clarify roles and responsibilities. The Parties recognize the appropriate role each plays in primary care. Specifically, AH commits to the continued participation of the AMA on those committees which work on primary care.

8. NO FETTERING

a) Nothing in this agreement shall in any manner whatsoever fetter the legislative and regulatory power and authority of the Government of the Province of Alberta and/or the Minister of Health."

(d) Notwithstanding the date this Amending Agreement is signed, these amendments shall be incorporated into and form part of the Agreement as of the Effective Date.

(e) Capitalized terms used but not defined in this Amending Agreement have the meaning given to them in the Agreement.

(f) In all other respects, the Agreement remains unchanged and shall continue in full force and effect in accordance with its terms.

(g) This Amending Agreement is binding on the parties and their successors and permitted assigns.

This Amending Agreement is entered into by each of the undersigned by its authorized representative.

Deputy Minister
Alberta Health

Executive Director
Alberta Medical Association

INTEGRATED CARE CONSULTATION AGREEMENT

BETWEEN

Her Majesty the Queen in right of Alberta
as represented by the Minister of Health
("AH")

-and-

Alberta Medical Association
(C.M.A. Alberta Division)
("AMA")

-and-

Alberta Health Services
("AHS")

WHEREAS:

A) The Parties have undertaken several initiatives aimed at providing sustainable high quality care.

B) These initiatives include Primary Care Networks, payment reforms and improvements to information management and technology.

C) Attention must be made to integrated care throughout the health care system which requires the integration of delivery models and the support mechanisms that are being developed.

1. The Parties shall work towards an integrated care delivery strategy, working within existing committees and structures, or creating new committees and structures where necessary ("Consultation").

2. The Consultation will consider the following:

a) community-based integration programs, bringing together community and AHS resources;

b) the role of funding and physician payment models in the integration of care;

c) the opportunities for stewardship and performance incentives which consider the impact of physician decisions on utilization of health system resources;

d) the opportunities presented by Strategic Clinical Networks for aligning care and promoting evidence-based decisions; and

e) access of physicians to change-management support programs offered by all the parties, with an emphasis on promoting integrated care.

3. The parties agree that AMA will work on accountability models including but not limited to:

    a) models that address relativity such as the Adjusted Net Daily Income (ANDI) approach; and

    b) models that consider increased accountability for utilization such as a section accountability model.

4. The Management Committee shall develop recommendations to the Minister in regards to the above matters, and report on all activities as required.

5. This agreement is in force until March 31st, 2018.

This Integrated Care Consultation Agreement is entered into by each of the undersigned by its authorized representative:

Her Majesty the Queen in Right of Alberta
as represented by the Minister of Health

Nov. 18, 2016.
Date

Executive Director, Alberta Medical Association
(C.M.A. Alberta Division)

31 Oct 2016
Date

President and CEO, Alberta Health Services

Nov 15, 2016
Date