



NATIONAL ASSEMBLY OF QUÉBEC

SECOND SESSION

FORTY-THIRD LEGISLATURE

Bill 2

**An Act mainly to establish collective
responsibility with respect
to improvement of access to medical
services and to ensure continuity
of provision of those services**

Introduction

**Introduced by
Mr. Christian Dubé
Minister of Health**

**Québec Official Publisher
2025**

EXPLANATORY NOTES

The main purpose of this bill is to improve access to medical services.

For that purpose, the bill entrusts every territorial department of family medicine with the mission to affiliate all the eligible persons in its territory with practice environments where services are provided by general practitioners or specialized nurse practitioners. It sets out the terms relating to the distribution of the persons among those practice environments and entrusts the Régie de l'assurance maladie du Québec with responsibility for putting in place a mechanism designed to enable eligible persons to be so affiliated.

The Government is granted the power to establish, by regulation, the remuneration methods for health professionals and the terms governing the management of that remuneration. The Government is also granted the power to determine, for the purposes of that remuneration, the obligations relating to the taking in charge of insured persons, as well as the different possible vulnerability levels of such persons. The bill entrusts the Régie with responsibility for determining a person's vulnerability level, and provides that the government regulation may identify the information to be used by the Régie to that end, specify who is required to communicate that information to it and prescribe the administrative and penal sanctions applicable in case of failure to comply with those rules.

The bill adds, to insured services, the taking in charge by a general practitioner of a person affiliated with a practice environment. It provides that the service is to be paid by capitation, at the tariff provided for in an agreement entered into with the body representative of general practitioners on the basis of the vulnerability level of the persons taken in charge. It provides that general practitioners who provide insured services in a practice environment are collectively entitled to that capitation remuneration and establishes rules relating to its payment by the Régie. General practitioners in the same practice environment are also allowed to adopt rules determining how the remuneration will be allocated between them.

The bill also contains provisions that establish, until a regulation is made by the Government, the remuneration method for general practitioners who practise in a private health facility, a local

community service centre and certain other practice environments. Those provisions specify that those practitioners are to be paid according to a blended remuneration method, which comprises capitation remuneration, hourly rate remuneration and additional remuneration for certain services. Those provisions also prescribe the standards relating to the taking in charge of insured persons by the physicians concerned as well as, among other things, the vulnerability levels to be taken into account for the purposes of the capitation remuneration, the information to be used by the Régie to determine an insured person's vulnerability level, and the professionals who must provide the Régie with that information.

In addition, the bill contains provisions concerning a collective supplement to be paid to general practitioners and medical specialists in exchange for the achievement of objectives for improving access to medical services or for ensuring the quality of those services. It provides that those objectives, which may be national, territorial or local depending on the groups of physicians or the practice environments to which they apply, are established by government regulation, and it establishes them until a first regulation is made. It also provides that the implementation of the means to achieve the objectives is the responsibility of the national, territorial or local medical collectivities formed by the physicians.

The bill establishes the rules relating to the calculation of the collective supplement and the rules relating to its payment by the Régie. As in the case of capitation remuneration, the physicians forming a medical collectivity are allowed to adopt rules determining how the collective supplement to which they are entitled is to be allocated between them. The bill provides that the Government may, by regulation and for the cases it determines, prescribe special terms for the calculation of the collective supplement, and it establishes rules to reduce the impact of the collective supplement on the remuneration of physicians 65 years of age or older at the time the regulation comes into force.

Various other measures are proposed by the bill. In particular,

(1) it provides for the establishment of family medicine and specialized medicine coverage plans as well as programs to promote the practice of medicine in groups;

(2) it gives the Government the power to prescribe, by regulation, rules for the remuneration of administrative activities and tasks performed by health professionals within the meaning of the Health Insurance Act, by providing that they are to be remunerated by means

of tokens whose value is set in a agreement entered into with the bodies representative of the professionals concerned and which are granted by the Government to public bodies in the health and social services sector;

(3) it enacts a first regulation providing for the use of such tokens by Santé Québec for the remuneration of certain administrative tasks within territorial departments and groups of family medicine;

(4) it allows the Government to set the maximum tariff of the accessory costs that may be demanded from an insured person for a service provided by a non-participating physician, and it prohibits physicians from demanding a payment from an insured person unless the person has been given an itemized invoice;

(5) it allows a health and social services institution to use the name and contact information of a person for the purpose of soliciting a gift to the institution or its foundation, unless the person concerned has refused;

(6) it gives to the Régie, considering the changes made to the remuneration methods by the bill, the power to prescribe, by regulation, the amount reimbursed for professional services provided outside Québec or the method for determining that amount; and

(7) it adds community pharmacies to the service providers that must not use the services of a personnel placement agency or independent labour, except to the extent allowed by government regulation.

The bill also provides for the renewal, until 31 March 2028, of all the agreements entered into with bodies representative of physicians that are currently applicable, and it determines the amounts of the global resource envelopes for the remuneration of physicians until that date. It makes the amendments to those agreements that are necessary for implementing the measures set out in the bill, in particular by adjusting the tariffs according to which services are remunerated to take into account the collective supplement, and by establishing the tariffs applicable under the blended remuneration method for general practitioners. The Minister is empowered to make amendments to those agreement in certain circumstances.

Moreover, the bill enacts the provisions required to ensure continuity of physicians' professional activities. In particular, the bill prohibits them and the groups that represent them from undertaking concerted actions that would negatively affect access to services or

hamper the proper conduct of the training path for resource persons in the field of health and social services. The Minister is given the power to put in place, in the practice environments the Minister determines, measures for ensuring the attendance of physicians and supervision of the services rendered, including the preparation of weekly schedules for the physicians' professional activity.

The bill contains remedial measures as well as sanctions, including penal sanctions, in case of contravention of the provisions intended to ensure continuity of professional activities. Those sanctions include, for physicians, a reduction of their remuneration and disciplinary consequences and, for the groups representative of physicians, the withholding at source of the dues that should be paid to them. The bill also sets out the obligations of universities that have a faculty of medicine as concerns continuity of provision of academic and research activities to the students entitled to it, as well as sanctions attached to the contravention of those obligations.

Lastly, the bill includes consequential, transitional and final provisions.

LEGISLATION AMENDED BY THIS BILL:

- Act to promote access to family medicine and specialized medicine services (chapter A-2.2);
- Health Insurance Act (chapter A-29);
- Act respecting the governance of the health and social services system (chapter G-1.021);
- Act respecting administrative justice (chapter J-3);
- Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2);
- Act respecting the Régie de l'assurance maladie du Québec (chapter R-5);
- Act respecting health and social services information (chapter R-22.1);
- Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation (2015, chapter 25);

– Act mainly to reduce the administrative burden of physicians (2024, chapter 29).

Bill 2

AN ACT MAINLY TO ESTABLISH COLLECTIVE RESPONSIBILITY WITH RESPECT TO IMPROVEMENT OF ACCESS TO MEDICAL SERVICES AND TO ENSURE CONTINUITY OF PROVISION OF THOSE SERVICES

AS health services and social services play an essential role in increasing the entire population's quality of life, in safeguarding the right to life, personal security and integrity of persons, in maintaining social cohesion and in Québec's economic prosperity;

AS medical services are an important part of the response to the entire population's needs with respect to health services and social services;

AS population growth and aging and the growing number of socially vulnerable persons will cause increased needs with respect to health services and social services, including medical services;

AS gaps in access to medical services can have real and significant consequences for the persons who need those services;

AS the pressure tactics implemented by the members of the Fédération des médecins omnipraticiens du Québec and the Fédération des médecins spécialistes du Québec are jeopardizing the next generation of professionals in the field of health and social services as well as the modernization of the health and social services system, which are essential for maintaining and improving access to medical services;

AS those pressure tactics are in addition to the harmful effects caused by the status quo alone;

AS, consequently, it is imperative to protect, maintain and improve access to those services in order to achieve a balance with the entire population's needs for those services;

AS all actors in the field of health and social services must be engaged in and take responsibility for meeting that objective;

AS it is necessary, for those purposes, to put in place the appropriate means for enabling the medical profession to work collectively toward meeting that objective and for ensuring the continuity of its activities;

THE PARLIAMENT OF QUÉBEC ENACTS AS FOLLOWS:

CHAPTER I

TAKING IN CHARGE OF THE ENTIRE POPULATION

ACT RESPECTING THE GOVERNANCE OF THE HEALTH AND SOCIAL SERVICES SYSTEM

1. Section 76 of the Act respecting the governance of the health and social services system (chapter G-1.021) is amended by replacing subparagraph 7 of the second paragraph by the following subparagraph:

“(7) the putting in place, by the Régie de l’assurance maladie du Québec, of a mechanism designed to enable

(a) any eligible person, within the meaning of the sixth paragraph of section 447, to be affiliated with an environment referred to in that section or in section 101.1;”

(b) any insured person within the meaning of the Health Insurance Act to find a health or social services professional who

i. belongs to a class of professionals that is identified by the Minister,

ii. practises in premises that belong to a class identified by the Minister and are located in a territory to which the Act respecting health services and social services for the Inuit and Naskapi or the Act respecting health services and social services for Cree Native persons (chapter S-5) applies, and

iii. agrees to provide medical care to the person in collaboration, if applicable, with other professionals;”.

2. The Act is amended by inserting the following chapter after section 101:

“CHAPTER VIII

“TAKING IN CHARGE

“101.1. Every three months, Santé Québec determines, for each of the vulnerability levels established by a regulation made under section 21.1 of the Health Insurance Act (chapter A-29), the number of persons who may be newly taken in charge in each practice environment, other than an environment referred to in section 447, in which services in the field of health and social services are provided by at least one health or social services professional remunerated by Santé Québec, including a nurse practitioner specialized in primary care.

To that end, Santé Québec consults the territorial department of family medicine responsible for the territory in which the practice environment is situated and takes into account the capacity of Santé Québec or, where applicable, of the operator of that environment to discharge the obligations set out in section 101.3.

Santé Québec communicates to the territorial department of family medicine concerned the numbers determined under the first paragraph for the practice environments in its territory.

“101.2. When the territorial department of family medicine receives the communication from Santé Québec, it affiliates with each practice environment referred to in the communication, according to the numbers determined, eligible persons of its territory who are referred to in the third paragraph of section 447.

The second and third paragraphs of section 447.3, section 447.4 and the first paragraph of section 447.5 apply, with the necessary modifications, to the affiliation of a person with a practice environment under the first paragraph. Section 447.6, except subparagraph 3 of the first paragraph, applies in the same manner to the disaffiliation of such a person.

Santé Québec may have access to the information indicated in the repertory kept by the Régie de l'assurance maladie du Québec under the first paragraph of section 447.5 concerning the practice environments referred to in section 101.1.

“101.3. Santé Québec must discharge, with respect to the persons affiliated with a practice environment referred to in section 101.1, the same obligations as those that must be performed by a general practitioner in order for those persons to be taken in charge within the meaning of a regulation made under section 21.1 of the Health Insurance Act (chapter A-29).

Where such a practice environment is not operated by Santé Québec, Santé Québec may, by agreement, delegate to the operator of that environment the performance of the obligations to which Santé Québec is bound under the first paragraph.”

3. Section 447 of the Act is amended

(1) by replacing “The territorial department of family medicine” in the first paragraph by “The main mission of the territorial department of family medicine is the affiliation with a practice environment of all the eligible persons of its territory. For that purpose, it”;

(2) the second paragraph,

(a) by replacing “place of practice” by “practice environment”;

(b) by striking out “and of management of the various clienteles”;

(3) by inserting the following paragraphs after the second paragraph:

“Every three months, the department must distribute the eligible persons of its territory who are registered under the mechanism referred to in subparagraph *a* of subparagraph 7 of the first paragraph of section 76. The department distributes those persons among each of the following practice environments in its territory, provided at least one physician belonging to the department offers insured services there:

(1) premises where a private health facility is operated;

(2) a local community service centre; and

(3) other premises, in the case where the physicians who provide insured services there benefit from a program established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2) to promote the practice of family medicine in groups in a multidisciplinary practice environment.

Each of the persons distributed under the third paragraph to a practice environment is consequently affiliated with that environment.”;

(4) by replacing “It” in the third paragraph by “The department”;

(5) by adding the following paragraph at the end:

For the purposes of this chapter,

(1) “eligible person” means a person who holds a health insurance card or eligibility card issued in accordance with the Health Insurance Act (chapter A-29) that is valid, provided that the person is not a user who is lodged in a facility maintained by an institution and in respect of whom a contribution may be required under section 765;

(2) “insured service” means an insured service within the meaning of subparagraph *a* of the first paragraph of section 1 the Health Insurance Act.”

4. The Act is amended by inserting the following sections after section 447:

“447.1. Despite the third paragraph of section 447, a territorial department of family medicine may include, in the practice environments among which it distributes the eligible persons of its territory, practice environments from another department’s territory, to the extent that the conditions established by that other department are met.

For the purposes of the first paragraph, each department must establish conditions with respect to, in particular, the maximum number of persons from another territory that may be affiliated with practice environments in its territory for each of the vulnerability levels established by a regulation made under section 21.1 of the Health Insurance Act (chapter A-29).

The conditions established under the second paragraph are submitted to Santé Québec, which approves them with or without modification. The conditions must be modified whenever Santé Québec so requests.

Santé Québec may establish those conditions if the territorial department of family medicine fails to establish or modify them within the time it indicates.

“447.2. The Régie de l’assurance maladie du Québec may communicate to the territorial department of family medicine the information it holds concerning the identity and the vulnerability level of the eligible persons of the department’s territory who are referred to in the third paragraph of section 447.

“447.3. The distribution of eligible persons among practice environments that is carried out by the territorial department of family medicine must be proportional to the capacity of those environments to take them in charge, in accordance with the provisions of a regulation made under section 21.1 of the Health Insurance Act (chapter A-29).

The distribution of eligible persons must favour their affiliation with a practice environment that is near their place of residence.

The Minister may issue directives to the department concerning that distribution. Such directives are binding on the department.

“447.4. The territorial department of family medicine informs the Régie de l’assurance maladie du Québec of the identity of the persons it affiliates and of the practice environment with which they are affiliated.

“447.5. The Régie de l’assurance maladie du Québec keeps up to date a repertory indicating, for each of the practice environments referred to in section 447, the persons affiliated with that environment and their vulnerability level determined under section 38.0.2 of the Health Insurance Act (chapter A-29).

The Régie may communicate to a territorial department of family medicine the information indicated in the repertory concerning the practice environments in its territory, the persons affiliated with those environments and their vulnerability level. The Régie may also communicate to the representative of a practice environment referred to in section 38.0.4 of that Act the information indicated in the repertory concerning the persons affiliated with that practice environment and their vulnerability level.

“447.6. A person is disaffiliated from a practice environment in the following cases:

(1) where the person applies to the Régie de l’assurance maladie du Québec for disaffiliation;

(2) where the Régie becomes aware that the person has ceased to be a resident or temporary resident of Québec within the meaning of the Health Insurance Act (chapter A-29);

(3) following instructions to that effect sent by the territorial department of family medicine to the Régie

(a) where no physician in the practice environment is able to establish and maintain a relationship of mutual trust with the person; or

(b) where the person is a user lodged in a residential and long-term care centre operated by a public institution or a private institution under agreement; or

(5) in any other case determined by government regulation.

A government regulation may prescribe conditions and terms applicable to a disaffiliation referred to in the first paragraph and, if applicable, the terms according to which a person disaffiliated from a practice environment is affiliated with a new practice environment by a department.

“447.7. A family physician who provides insured services in a practice environment is responsible for the taking in charge of the persons affiliated with that environment under the fourth paragraph of section 447, in accordance with the provisions of a regulation made under section 21.1 of the Health Insurance Act (chapter A-29).

The other health or social services professionals practising in that environment also contribute to that taking in charge.

ACT TO PROMOTE ACCESS TO FAMILY MEDICINE AND SPECIALIZED MEDICINE SERVICES

5. Section 11 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2) is amended

(1) by striking out subparagraph 1 of the first paragraph;

(2) in the second paragraph,

(a) by striking out “prescribe the cases in which and conditions under which physicians may add to their caseload of patients a person other than a person registered in the system referred to in subparagraph 1 of the first paragraph. The Government may, likewise,”;

(b) by replacing “of that paragraph” by “of the first paragraph”.

6. Section 19 of the Act, amended by section 68 of chapter 21 of the statutes of 2017 and section 851 of chapter 34 of the statutes of 2023, is again amended by striking out “or the general practitioner’s obligation under section 11” in the second paragraph.

7. Sections 21 and 24 of the Act are amended by striking out “, subparagraph 1 of the first paragraph of section 11” in the first paragraph.

ACT TO MAKE THE HEALTH AND SOCIAL SERVICES SYSTEM MORE EFFECTIVE

8. Section 844 of the Act to make the health and social services system more effective (2023, chapter 34) is amended by striking out subparagraph *a* of paragraph 1.

SPECIAL TRANSITIONAL PROVISIONS

9. An insured person within the meaning of the Health Insurance Act (chapter A-29) who, on 1 April 2026, is registered with a family physician under Entente particulière relative aux services de médecine de famille, de prise en charge et de suivi de la clientèle entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec is deemed, as of that date,

(1) to be affiliated, in accordance with section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), amended by section 3 of this Act, with the practice environment corresponding to the usual follow-up location indicated in the person’s registration; and

(2) to be associated with the physician with whom the person was registered, that physician being primarily responsible, in that practice environment, for ensuring the longitudinal follow-up of that person’s state of health and of the care the person receives.

If an insured person’s residence was indicated as the usual follow-up location in the person’s registration, that person is instead deemed to be so affiliated with the practice environment within which the physician with whom the person is registered provides insured services. If the physician provides such services in more than one practice environment, the insured person is deemed to be so affiliated with the practice environment nearest the person’s residence.

In addition, an insured person within the meaning of the Health Insurance Act who, on 1 April 2026, is registered with a facility (“cabinet”) under Lettre d’entente n° 393 concernant la clientèle en attente au guichet d’accès à un médecin de famille entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec is deemed, as of that date, to be affiliated, in accordance with section 447 of the Act respecting the governance of the health and social services system, amended by section 3 of this Act, with the practice environment corresponding to that facility.

10. The Programme de financement et de soutien professionnel pour les groupes de médecine de famille (GMF), the Cadre de gestion des groupes de médecine de famille universitaires (GMF-U) and the Programme de désignation accès-réseau pour les groupes de médecine de famille (GMF), established by the Minister of Health and Social Services, are deemed, for the purposes of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), amended by section 3 of this Act, to be programs established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of this Act.

11. Section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), amended by section 3 of this Act, is to be read, from 1 April 2026 and until the date of coming into force of section 1 of this Act, as if “subparagraph *a* of subparagraph 7 of the first paragraph of section 76” in the third paragraph were replaced by “subparagraph 1 of the second paragraph of section 14 of the Act mainly to establish collective responsibility with respect to improvement of access to medical services and to ensure continuity of provision of those services (*insert the year and chapter number of this Act*)”.

12. In the application of section 447 de la Act respecting the governance of the health and social services system (chapter G-1.021), amended by section 3 of this Act, before 1 July 2026, a territorial department of family medicine is required to distribute on a priority basis persons whose vulnerability level is “major health condition”.

From that date and until 31 December 2026, it is required to distribute on a priority basis persons whose vulnerability level is “major health condition”, “moderate health condition” or “minor chronic health condition”.

13. The first regulation made by the Government before (*insert the date that is one year after the date of assent to this Act*) for the purposes of section 447.6 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 4 of this Act, may, despite section 11 of the Regulations Act (chapter R-18.1), be enacted on the expiry of 15 days after the publication of the draft regulation in the *Gazette officielle du Québec*. Despite section 17 of that Act, the regulation comes into force on the date of its publication in the *Gazette officielle du Québec* or on any later date indicated in the regulation.

14. From 1 April 2026 and until the date of coming into force of section 1, section 2 of the Act respecting the Régie de l’assurance maladie du Québec (chapter R-5) is to be read as if the first sentence of the sixth paragraph were struck out.

During that period, the Régie de l'assurance maladie du Québec sets up a system designed to enable

(1) any eligible person, within the meaning of the sixth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), amended by section 3 of this Act, to be affiliated with a practice environment referred to in that section or in section 101.1 of the Act respecting the governance of the health and social services system, enacted by section 2 of this Act; and

(2) any insured person, within the meaning of the Health Insurance Act (chapter A-29), to find a health or social services professional who

(a) belongs to a class of professionals that is identified by the Minister,

(b) practises in premises that belong to a class identified by the Minister and are located in a territory to which the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (chapter S-5) applies, and

(c) agrees to provide medical care to the person in collaboration, if applicable, with other professionals.

CHAPTER II

REMUNERATION OF HEALTH PROFESSIONALS

DIVISION I

REMUNERATION METHODS

HEALTH INSURANCE ACT

15. Section 1 of the Health Insurance Act (chapter A-29) is amended by inserting the following subparagraph after subparagraph *r* of the first paragraph:

“(s) “public body in the field of health and social services”: the Ministère de la Santé et des Services sociaux, Santé Québec, a public institution other than a Santé Québec institution, the Nunavik Regional Board of Health and Social Services established under section 530.25 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2), the Health and Welfare Commissioner, the Commission sur les soins de fin de vie, Urgences-santé, Héma-Québec, the Institut national d'excellence en santé et en services sociaux, the Institut national de santé publique du Québec and the Board;”.

16. Section 3 of the Act is amended by replacing the fifteenth paragraph by the following paragraph:

“The Board also assumes, in accordance with the provisions of the Act and the regulations, the cost of the following services rendered by a health professional:

(a) services rendered for the performance of administrative activities or tasks determined by a regulation made under section 69; and

(b) services rendered for the performance of administrative activities or tasks, up to the number of remuneration tokens allotted to the professional by a public body in the field of health and social services, from among those granted to the body by the Government.”

17. Section 19 of the Act is amended by replacing “different methods of remuneration which include fee-for-service remuneration, flat-rate fees and salary” in the second paragraph by “the value, for each of the categories of tokens established by government regulation, of the tokens remunerating the services referred to in subparagraph *b* of the fifteenth paragraph of section 3 that are rendered by a health professional for the performance of administrative activities or tasks”.

18. The Act is amended by inserting the following section after section 19:

“**19.0.1.** For the purposes of the remuneration of the services referred to in subparagraph *b* of the fifteenth paragraph of section 3 that are rendered for the performance of administrative activities or tasks, the Government may, by regulation,

(1) establish categories of remuneration tokens;

(2) determine the cases, conditions and terms according to which the tokens may be used by a public body in the field of health and social services; and

(3) determine the terms and conditions according to which the value of the remuneration tokens is paid to a health professional by the Board.

The provisions of an agreement providing for the remuneration of a service referred to in a regulation made under the first paragraph cease to have effect on the date of coming into force of that regulation.”

19. The Act is amended by inserting the following section after section 21:

“**21.1.** The Government may, by regulation,

(1) establish the remuneration methods for professionals in the field of health and the terms for the management of that remuneration; and

(2) for the purposes of the remuneration of professionals in the field of health,

(a) define terms for the taking in charge of an insured person by such a professional and the obligations that the professional must perform in order for such taking in charge to take place; and

(b) establish different vulnerability levels for insured persons and prescribe the criteria to be used to determine the vulnerability level for each of them.

A regulation made under the first paragraph may allow an agreement to depart, to the extent determined by the regulation, from its provisions concerning a remuneration method.

In addition, if the regulation provides for the application of standards or methodologies established by another government or a body, it may provide that references to those standards or methodologies include any later amendments made to them.

The Minister must, before a regulation is made under the first paragraph, consult the representative organizations concerned from among those with which the Minister has entered into an agreement.”

20. Section 22 of the Act is amended

(1) by inserting “and with the provisions of a regulation made under section 21.1” at the end of the first paragraph;

(2) by inserting “and of a regulation made under section 21.1” after “the agreement” in the introductory clause of the second paragraph;

(3) by inserting “or with a regulation made under section 21.1” after “in conformity with an agreement” in the seventh paragraph.

21. Section 22.2 of the Act is amended

(1) in the first paragraph,

(a) by inserting “, with a regulation made under section 21.1” after “non-conformity with the agreement”;

(b) by striking out the last sentence;

(2) by replacing the sixth paragraph by the following paragraph:

“A professional in the field of health who believes he has been wronged by a decision rendered under the first paragraph may, within 60 days of notification of the decision, contest it before the Administrative Tribunal of Québec. A

person who wishes to appeal a decision rendered under the second paragraph must do so within the same time before the Superior Court or the Court of Québec, according to their respective jurisdictions.”;

(3) by inserting the following paragraph after the seventh paragraph:

“For the purposes of this section, the cost of the taking in charge that is assumed by the Board under subparagraph *f* of the first paragraph of section 3 may also be recovered by compensation out of the total amount of capitation remuneration fees determined by the Board under section 38.0.11 to which the group of general practitioners who provide insured services in the practice environment concerned is entitled.”

22. The Act is amended by inserting the following section after section 22.2:

“22.2.1. The sixth paragraph of section 22.2 also applies to a decision rendered at the end of any proceeding provided for in the agreement against a decision of the Board, as if it were a decision rendered under the first paragraph of that section.”

23. Section 54 of the Act is amended by replacing the first paragraph by the following paragraph:

“Disputes resulting from the interpretation or application of an agreement for which no specific contestation proceeding is provided for by this Act are submitted to a council of arbitration, to the exclusion of any court of civil jurisdiction.”

24. Section 69 of the Act is amended

(1) in the first paragraph,

(a) by replacing “the eleventh” in subparagraph *i.1* by “subparagraph *a* of the fifteenth”;

(b) by inserting the following subparagraph after subparagraph *i.1*:

“(i.2) establish categories of tokens remunerating the services referred to in subparagraph *b* of the fifteen paragraph of section 3 that are rendered for the performance of administrative activities or tasks, determine the cases, conditions and terms according to which the tokens may be used by a body to which they are granted as well as the terms and conditions according to which the value of the remuneration tokens is paid to a health professional by the Board;”;

(c) by inserting the following subparagraphs after subparagraph *m.1*:

“(m.2) establish the remuneration methods for health professionals and the terms for the management of that remuneration;

“(m.3) for the purposes of the remuneration of health professionals,

i. define terms for the taking in charge of an insured person by a health professional and the obligations that must be performed by that professional in order for such taking in charge to take place; and

ii. establish different vulnerability levels for insured persons and prescribe the criteria for determining the vulnerability level for each of them;”

(2) by replacing “or i.1” in the third paragraph by “to i.2, m.2 and m.3”.

ACT RESPECTING ADMINISTRATIVE JUSTICE

25. Section 3 of Schedule I to the Act respecting administrative justice (chapter J-3) is amended by inserting “22.2,” after “18.4,” in paragraph 2.

ENACTMENT OF THE REGULATION RESPECTING THE REMUNERATION OF SERVICES RENDERED BY A HEALTH PROFESSIONAL FOR THE PERFORMANCE OF ADMINISTRATIVE ACTIVITIES OR TASKS

26. The Regulation respecting the remuneration of services rendered by a health professional for the performance of administrative activities or tasks, appearing below, is enacted:

“REGULATION RESPECTING THE REMUNERATION OF SERVICES RENDERED BY A HEALTH PROFESSIONAL FOR THE PERFORMANCE OF ADMINISTRATIVE ACTIVITIES OR TASKS

“DIVISION I

“ACTIVITIES OF TERRITORIAL DEPARTMENTS OF FAMILY MEDICINE

“1. Category A tokens may be granted to Santé Québec to remunerate the performance, by the medical directors of the territorial departments of family medicine, of the tasks arising from the functions conferred on those departments by the Act respecting the governance of the health and social services system (chapter G-1.021).

At least once every five years, Santé Québec distributes those tokens among each of the territorial departments of family medicine.

Where more than one physician is appointed medical director of family medicine for the same territorial department in a year, each of those physicians is entitled to payment of the value of the tokens allocated to that department in proportion to the number of weeks they were the medical director during the year.

“2. Category B tokens may be granted to Santé Québec to remunerate the performance, by a general practitioner and as part of the activities of a territorial department of family medicine, of the following tasks:

(1) in the case of a physician who is a member of the supervisory committee of the department, other than the medical director of family medicine

(a) the tasks arising from the functions conferred on the department by the Act respecting the governance of the health and social services system (chapter G-1.021); and

(b) the tasks performed within the scope of a mandate entrusted to the department’s supervisory committee by the president and executive director of the territorial institution responsible for the territory of that department; or

(2) in all other cases, the tasks performed by a physician within the scope of a mandate entrusted to the physician by the department’s medical director with the authorization of Santé Québec.

At least once every five years, Santé Québec distributes those tokens among each of the territorial departments of family medicine.

No physician remunerated according to the fixed-fee remuneration method may claim from the Board payment of the value of the tokens granted to Santé Québec by this section.

“DIVISION II

“ACTIVITIES OF TERRITORIAL DEPARTMENTS OF SPECIALIZED MEDICINE

“3. Category C tokens may be granted to Santé Québec to remunerate the performance, by the medical directors of the territorial departments of specialized medicine, of the tasks arising from the functions conferred on those departments by the Act respecting the governance of the health and social services system (chapter G-1.021).

At least once every five years, Santé Québec distributes those tokens among each of the territorial departments of specialized medicine.

Where more than one physician is appointed medical director of specialized medicine for the same territorial department in a year, each of those physicians is entitled to payment of the value of the tokens allocated to that department in proportion to the number of weeks they were the medical director during the year.

“DIVISION III

ACTIVITIES RELATED TO THE ADMINISTRATION OF A FAMILY MEDICINE GROUP

“4. Category D tokens may be granted to Santé Québec to remunerate the performance, by a general practitioner, of the administrative tasks required for the management of premises where the physicians benefit from a program established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of the Act mainly to establish collective responsibility with respect to improvement of access to medical services and to ensure continuity of provision of those services (*insert the year and chapter number of this Act*).

At least once every five years, Santé Québec distributes those tokens among each of those environments.

The Programme de financement et de soutien professionnel pour les groupes de médecine de famille (GMF), the Cadre de gestion des groupes de médecine de famille universitaires (GMF-U) and the Programme de désignation accès-réseau pour les groupes de médecine de famille (GMF) established by the Minister of Health and Social Services are deemed, for the purposes of this section, to be programs established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of the Act mainly to establish collective responsibility with respect to improvement of access to medical services and to ensure continuity of provision of those services (*insert the year and chapter number of this Act*).”

DIVISION II

BLENDED REMUNERATION METHOD APPLICABLE TO GENERAL PRACTITIONERS

HEALTH INSURANCE ACT

27. Section 1 of the Health Insurance Act (chapter A-29) is amended by striking out subparagraph f.1 of the first paragraph.

28. Section 1.1 of the Act is repealed.

29. Section 3 of the Act is amended

(1) by adding the following subparagraph at the end of the first paragraph:

“(f) the taking in charge, by the general practitioners subject to the application of an agreement who provide insured services in a practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), of the insured persons affiliated with that environment according to the repertory kept under section 447.5 of that Act.”;

(2) by adding the following paragraph at the end:

“Subparagraph *f* of the first paragraph does not apply to the territories referred to in sections 530.1 and 530.89 of the Act respecting health services and social services for the Inuit and Naskapi or to the territory of the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons.”

30. Section 10 of the Act is amended

(1) by replacing “by the Board for such services paid in Québec” in the fourth paragraph by “by a regulation made under the second paragraph of section 72.1 or in accordance with that regulation”;

(2) by inserting “government” in the fifth paragraph before “regulation”.

31. Section 22 of the Act is amended

(1) by replacing the third paragraph by the following paragraph:

“A professional in the field of health who is subject to the application of an agreement is entitled, in the following cases, to be remunerated in accordance with the first or second paragraph, even if the professional did not provide the insured service personally:

(a) in the case of a pharmacist, where the service was legally provided by one of the pharmacist’s employees; and

(b) in the case of a physician, with regard to the capitation remuneration paid to him under the provisions of Division III.0.1 for the taking in charge of an insured person referred to in subparagraph *f* of the first paragraph of section 3.”;

(2) by replacing “No health professional” in the thirteenth paragraph by “Subject to the provisions of Division III.0.1, no health professional”.

32. Section 22.1 of the Act is amended

(1) by replacing both occurrences of “90” in the second paragraph by “45”;

(2) by adding the following paragraph at the end:

“This section does not apply to a service referred to in subparagraph *f* of the first paragraph of section 3.”

33. The Act is amended by inserting the following division after section 38:

“DIVISION III.0.1

“TAKING IN CHARGE OF INSURED PERSONS BY GENERAL PRACTITIONERS

“§1.—*Capitation remuneration*

“38.0.1. General practitioners who provide insured services in a practice environment are remunerated for the taking in charge referred to in subparagraph *f* of the first paragraph of section 3 according to the capitation tariff specified in the agreement for the vulnerability level of the insured person taken in charge.

Where two or more general practitioners provide insured services in the same practice environment, they are collectively entitled to the remuneration referred to in the first paragraph. The amount of fees paid to each of them is determined in accordance with the provisions of subdivision 3.

For the purposes of this division, “practice environment” means a practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021).

“38.0.2. The Board determines the vulnerability level of each insured person in accordance with the criteria prescribed by a regulation made under the first paragraph of section 21.1.

The Government may, in that regulation,

(1) identify the information to be used by the Board to determine a vulnerability level and prescribe the intervals at which the Board must do so;

(2) determine the cases in which and the conditions on which a person or a group is required to collect the information identified under subparagraph 1 and communicate it to the Board or is authorized to do so, and prescribe, if applicable, the terms according to which that information must be communicated to the Board;

(3) determine the administrative measures that may be applied by the Board in case of failure to comply with a provision made under subparagraph 2; and

(4) identify, among the provisions made under subparagraph 2, those whose violation constitutes an offence and renders the offender liable to a fine the minimum and maximum amounts of which are set by the Government.

An administrative measure referred to in subparagraph 3 of the second paragraph is prescribed by 60 months from the date of the failure to comply. The fourth, fifth, sixth and ninth paragraphs of section 22.2 and, if applicable, section 22.3 apply, with the necessary modifications, to a decision imposing

such an administrative measure, as if it were a decision rendered under the first paragraph of section 22.2. A reference in those sections to a health professional is then a reference to the offender who is subject to the administrative measure.

Where the administrative measure determined under subparagraph 3 of the second paragraph is a monetary administrative penalty, the regulation fixes the amount of the penalty taking into account the nature and seriousness of the failure to comply, without exceeding \$2,500. Despite the third paragraph, the imposition of such a penalty is prescribed by two years from the date of the failure to comply.

The maximum penalties fixed under subparagraph 4 of the second paragraph may vary according to, among other things, the seriousness of the offence, without exceeding \$5,000 in the case of a natural person or \$15,000 in any other case.

“38.0.3. Despite the first paragraph of section 22, no general practitioner may, in any case, exact or receive payment from an insured person for taking the person in charge within the meaning of subparagraph *f* of the first paragraph of section 3.

“§2. — Capitation remuneration management terms

“38.0.4. Where two or more general practitioners provide insured services in the same practice environment, they must designate a representative of the practice environment.

They may also establish operating rules for the practice environment.

“38.0.5. Unless the operating rules of a practice environment provide otherwise, they come into force and are amended, replaced or revoked where a majority of the general practitioners who provide insured services in that environment give their consent.

The operating rules of a practice environment are binding on the general practitioners who provide insured services in that environment and, if the rules so provide, on the environment’s representative.

“38.0.6. Unless the operating rules of a practice environment provide otherwise, the appointment and the removal from office of its representative as well as the modification of the latter’s mandate come into force where a majority of the general practitioners who provide insured services in that environment give their consent.

No person who, in the preceding five years, was found guilty of an offence under section 29.60 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2) may act as the representative of a practice environment, be an administrator or officer of a group acting in that

capacity or be the holder of control of such a group within the meaning of sections 6 and 8 to 10 of the Trust Companies and Savings Companies Act (chapter S-29.02).

“38.0.7. The representative of a practice environment is the mandatory of the general practitioners who provide insured services in that environment in their relations with the Board regarding the capitation remuneration to which they are collectively entitled.

“38.0.8. The representative of a practice environment must register with the Board. Section 2.0.13 of the Act respecting the Régie de l’assurance maladie du Québec (chapter R-5) applies to that registration as if it were an application referred to in that section.

Where the representative of a practice environment is registered with the Board, the latter communicates to the representative the identification number it assigns to the practice environment.

The representative of a practice environment must keep the registration up to date.

“38.0.9. General practitioners who provide insured services in the same practice environment may establish rules for the allocation among them of the capitation remuneration for the taking in charge, from the date of coming into force of those rules, of an insured person within the meaning of subparagraph *f* of the first paragraph of section 3.

Unless the operating rules of the practice environment provide otherwise, the establishment, amendment and revocation of the allocation rules require the consent of a majority of the general practitioners who provide insured services in that environment.

The allocation rules are binding on the general practitioners who provide insured services in that environment and on the environment’s representative.

“38.0.10. The allocation rules for the capitation remuneration may, in particular, be designed

- (1) to improve access to primary care services;
- (2) to promote the contribution of each physician with regard to the primary care services offered to the persons affiliated with the practice environment;
- (3) to support physicians who engage in research work or who carry on teaching activities; and
- (4) to encourage the provision of services every day of the week, as well as in the evening and on weekends.

The allocation rules may also

(1) determine the conditions for the participation of a physician in the allocation of the capitation remuneration, which may, in particular, be tied to the achievement of targets set out in the allocation rules;

(2) determine, despite any contrary provision of this division, the cases in which and conditions on which the allocation of the capitation remuneration may include a physician who no longer provides insured services in the practice environment; and

(3) confer a discretionary power on any person whose appointment is provided for by the allocation rules and prescribe the terms and conditions according to which that power may be exercised.

“§3.— *Capitation remuneration payment terms*

“38.0.11. The total amount of capitation remuneration fees to which the group of general practitioners who provide insured services in a practice environment is entitled, for a calendar quarter, is determined by the Board on the basis of the number of insured persons who, on the last day of the quarter, were affiliated with that environment according to the repertory kept under section 447.5 of the Act respecting the governance of the health and social services system (chapter G-1.021) as well as of their vulnerability level indicated in the repertory.

Where more than one general practitioner provides insured services in the same practice environment, the Board communicates that amount to the environment’s representative within 15 days after the end of each calendar quarter in order for the representative to break down the amount.

In order for general practitioners who provide insured services in the same practice environment to be entitled to the amount determined under the first paragraph, a representative of that practice environment must be registered with the Board before the end of the calendar quarter for which the amount is determined.

“38.0.12. On receiving the amount of fees communicated under section 38.0.11, the representative of the practice environment breaks down that amount in accordance with the allocation rules established by the physicians who provide insured services in that practice environment.

In order for those physicians to be entitled to those fees, the representative of the practice environment must submit to the Board a statement of that breakdown, duly completed, within 30 days of the communication referred to in section 38.0.11.

The Board may extend that period if the representative of the practice environment demonstrates to the Board that the representative was in fact unable to act sooner.

“38.0.13. For the purposes of the breakdown of the amount to be allocated, the representative of a practice environment may request that the Board communicate to him any information from among the information provided for by a regulation that the Board may make. Such a request must be made at least 30 days before the end of the calendar quarter concerned. The Board shall attach the information so requested to the amount of fees it communicates to the representative under section 38.0.11.

The information communicated under the first paragraph must not allow an insured person to be identified.

“38.0.14. The Board shall pay the amount of fees determined under section 38.0.11 in accordance with the breakdown communicated to it by the representative of the practice environment.

Where a general practitioner practises alone, that amount is paid to the practitioner by the Board within 75 days after the end of each calendar quarter.”

34. Section 69 of the Act is amended by inserting the following subparagraphs after subparagraph *n* of the first paragraph:

“(n.1) identify the information to be used by the Board to determine a vulnerability level and prescribe the intervals at which the Board must do so;

“(n.2) determine the cases in which and the conditions on which a person or a group is required to collect that information and communicate it to the Board or is authorized to do so, and prescribe, if applicable, the terms according to which that information must be communicated to the Board;

“(n.3) determine the administrative measures that may be applied by the Board in case of failure to comply with a provision made under subparagraph *n.2*; and

“(n.4) identify, among the provisions determined under subparagraph *n.2*, those whose violation constitutes an offence and renders the offender liable to a fine the minimum and maximum amounts of which are set by the Government;”.

35. Section 72.1 of the Act is amended

(1) by inserting the following paragraph after the first paragraph:

“The Board may also, with respect to the services referred to in section 10 and on the basis of a regulation made by the Government under the fifth paragraph of that section, make a regulation

(1) determining the amount of the reimbursement to which an insured person is entitled for an insured service referred to in that section, or the method for establishing that amount; and

(2) determining any other necessary standard for the purposes of the fourth paragraph of that section.”;

(2) by replacing “the first paragraph” in the second paragraph by “this section”;

(3) by replacing “the regulation made under the first paragraph” in the third paragraph by “a regulation made under this section”.

36. The Act is amended by inserting the following section after section 72.1:

“73. The Minister may, at all times, suggest that the Board make a regulation under the second paragraph of section 72.1 or amend it as considered necessary by the Minister. If the Board fails to make such amendments within the time fixed by the Minister, the Government may, by regulation, make a regulation or amendments to a regulation that the Board fails to make.

DIVISION III

COSTS EXIGIBLE FROM INSURED PERSONS

37. Section 22 of the Health Insurance Act (chapter A-29) is amended by inserting “furnished by a health professional subject to the application of an agreement or by a professional who has withdrawn” after “insured service” in the eleventh paragraph.

38. Section 22.0.0.2 of the Act is amended

(1) by inserting “, for costs incurred for the purpose of providing that service or to have access to the service” at the end of the second paragraph;

(2) by inserting the following paragraph after the second paragraph:

“Where a maximum tariff is prescribed under the second paragraph, directly or indirectly requiring an insured person to make a payment in excess of that tariff for access to the service concerned, and granting an insured person privileged access to such a service in exchange for such a payment, are prohibited.”;

(3) by replacing “A physician who contravenes” in the third paragraph by “Every person who contravenes the third paragraph or”.

39. Section 22.0.0.1 of the Act is amended

(1) by replacing the third and fourth paragraphs by the following paragraph:

“The notice posted under the first paragraph must mention the right of the person from whom payment is exacted contrary to this Act to claim reimbursement under the provisions of section 22.0.1.”;

(2) by replacing “, third or fourth paragraph” in the sixth paragraph by “or third paragraph”.

40. The Act is amended by inserting the following section after section 22.0.0.2:

“22.0.0.3. No payment may be exacted from an insured person for a service rendered by a physician, for costs incurred for the provision of the service, or for access or privileged access to the service, unless an itemized invoice is given to the insured person. The invoice must state the tariff claimed for each of the services provided to the insured person and each of the fees claimed from the person, as well as any other information determined by regulation.

The invoice must mention the right of the person from whom payment is exacted contrary to this Act to claim reimbursement under the provisions of section 22.0.1.

Every person who contravenes the first paragraph is guilty of an offence and is liable to a fine of \$2,500 to \$25,000 and, in the case of a subsequent offence, to a fine of \$5,000 to \$50,000.”

41. Section 69 of the Act is amended by replacing subparagraph *n* of the first paragraph by the following subparagraphs:

“(m.4) determine the information that must be mentioned on the itemized invoice that must be given to an insured person from whom payment is exacted;”;

“(n) establish standards to determine the emergency cases in which the Board shall pay the remuneration provided for in an agreement to a health professional who has withdrawn or a non-participating professional, for insured services which he renders to an insured person;”.

DIVISION IV

SPECIAL TRANSITIONAL PROVISIONS

§1.—*Blended remuneration method, taking in charge and vulnerability*

I.—*Introductory provision*

42. Until a first regulation is made by the Government under the first paragraph of section 21.1 of the Health Insurance Act (chapter A-29), enacted by section 19 of this Act, a reference to a regulation made under that section 21.1 is a reference to the provisions of this subdivision.

The provisions of this subdivision cease to have effect on the date of coming into force of that first regulation.

II. — *Blended remuneration method*

43. Every general practitioner subject to the application of an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) is remunerated exclusively according to the blended remuneration method where the practitioner practises in a private health facility, a local community service centre, a specialized medical centre or another practice environment, but, in the last case, only if the practitioner benefits from a program established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of this Act, to promote the practice of family medicine in groups in a multidisciplinary practice environment.

The blended remuneration method includes the following components: the capitation remuneration provided for in Division III.0.1 of the Health Insurance Act, enacted by section 33 of this Act, an hourly rate remuneration, and an additional remuneration for certain services.

44. Despite section 43, a physician is not remunerated according to the blended remuneration method in the following cases:

(1) for any service for which an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) after (*insert the date of assent to this Act*) specifically provides that the fee-for-service remuneration method applies to that service where it is provided in a practice environment referred to in section 43 of this Act; or

(2) for the services rendered in the performance of administrative activities and tasks referred to in the fifteenth paragraph of section 3 of the Health Insurance Act.

45. For the purposes of this subdivision,

“local community service centre” means a local community service centre governed by the Act respecting the governance of the health and social services system (chapter G-1.021);

“private health facility” means a private health facility within the meaning of the second paragraph of section 481 of that Act; and

“specialized medical centre” means a participating specialized medical centre within the meaning of the second paragraph of section 575 of that Act.

46. Section 43 does not apply to the territories referred to in sections 530.1 and 530.89 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or to the territory of the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons (chapter S-5).

III.—*Taking in charge of insured persons*

47. For the purposes of remunerating the taking in charge referred to in subparagraph *f* of the first paragraph of section 3 of the Health Insurance Act (chapter A-29), an insured person affiliated with a practice environment according to the repertory kept under section 447.5 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 4 of this Act, is taken in charge where a general practitioner who provides insured services in that environment discharges the following obligations with respect to that person:

(1) provide the primary care services in the field of health and social services required by the person's condition or, where those services are not available in that practice environment, ensure that the services can be obtained by the person and contribute to them to the extent necessary; and

(2) provide the medical follow-up required by the person's condition in a manner that contributes to the continuity of the care the person receives.

A general practitioner may discharge the obligations set out in the first paragraph through other health or social services professionals practising in the same practice environment.

A general practitioner is not considered to have failed to take a person in charge solely because the physician is unable to provide, personally or through other health or social services professionals, a service responding to an emergency.

IV.—*Vulnerability levels*

48. The Régie de l'assurance maladie du Québec determines yearly the vulnerability level of an insured person for the year beginning on the following 1 April.

An insured person's vulnerability level is one of the four levels set out in the following subparagraphs, according to the health profile group to which the person concerned belongs:

(1) healthy, in the case of the following health profile groups:

(a) non-user;

(b) user with no health condition;

(c) healthy newborn;

(d) minor acute health condition; or

(e) obstetrics;

(2) minor chronic health condition, in the case of the following health profile group: minor chronic health condition;

(3) moderate health condition, in the case of the following health profile groups:

(a) other mental health disorder;

(b) other cancer;

(c) moderate chronic health condition;

(d) moderate acute health condition; or

(4) major health condition, in the case of the following health profile groups:

(a) major cancer;

(b) major mental health disorder;

(c) major health condition in a newborn;

(d) major chronic health condition;

(e) major acute health condition; or

(f) palliative state.

The Régie determines the health profile group to which a person belongs by applying the Population Grouping Methodology of the Canadian Institute for Health Information, as it may be amended from time to time, on the basis of the diagnoses established regarding that person in the three preceding calendar years. To do so, the Régie takes into consideration the diagnoses that, at the time of the determination,

(1) appear in a medical-administrative database referred to in section 49; or

(2) were communicated to it under section 50.

The vulnerability level of a person newly registered with the Régie is “healthy”, until the beginning of the calendar year following the determination of the level under the first paragraph.

49. For the purposes of subparagraph 1 of the third paragraph of section 48, a medical-administrative database is a database of which the Régie is a depositary under an agreement entered into with the Minister of Health and Social Services under the fourth paragraph of section 2 of the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) and which contains information concerning

(1) diagnoses established regarding users enrolled in any hospital centre to receive emergency services; or

(2) diagnoses established regarding users admitted to any hospital centre to receive general or specialized care, including psychiatric care, and regarding users enrolled for day surgery.

50. A professional subject to the application of an agreement within the meaning of the Health Insurance Act (chapter A-29) who has the authority to establish a diagnosis must communicate to the Régie de l'assurance maladie du Québec, on the statement of fees submitted by the professional to the Régie, the diagnosis established by the professional regarding an insured person, as documented in the person's record.

Furthermore, any other professional who has the authority to establish a diagnosis must communicate to the Régie, using the form provided by it for that purpose, the diagnosis established by that other professional regarding an insured person, as documented in the person's record, to the extent that the insured person consents to the communication.

51. A professional who has the authority to establish a diagnosis and who communicates to the Régie de l'assurance maladie du Québec a diagnosis not corresponding to the diagnosis documented by the professional in the insured person's record must pay the Régie the amount corresponding to any increase in the capitation remuneration paid by the Régie for the taking in charge of the insured person concerned that is caused by that discrepancy. The same applies to such a professional who, through the documentation produced by the professional, enters such a diagnosis in a database referred to in section 49.

The Régie may recover from the professional, by compensation or otherwise, the amount owed under the first paragraph, which may be established by statistical inference on the sole basis of information obtained by a sampling, according to a method consistent with generally accepted practices.

52. A monetary administrative penalty of \$250 may be imposed by the Régie de l'assurance maladie du Québec on a professional who has the authority to establish a diagnosis who

(1) through the documentation produced by the professional, enters a diagnosis in a database referred to in section 49 that does not correspond to the diagnosis documented by the professional in the insured person's record; or

(2) does not comply with section 50.

53. A professional who has the authority to establish a diagnosis is liable to a fine of at least \$500 and not more than \$5,000 if the professional

(1) through the documentation produced by the professional, enters a diagnosis in a database referred to in section 49 that does not correspond to the diagnosis documented by the professional in the insured person's record; or

(2) does not comply with section 50.

§2.— *Other transitional provisions*

54. Until an order is made by the Government under subparagraph *b* of the fifteenth paragraph of section 3, the following tokens are granted to Santé Québec annually for the purposes of the remuneration of the services referred to in that subparagraph that are rendered by a health professional for the performance of administrative activities or tasks:

(1) 29,417 category A tokens;

(2) 21,598 category B tokens;

(3) 22,377 category C tokens; and

(4) 171,136 category D tokens.

55. The provisions regarding the remuneration methods for health professionals that are contained in an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) remain applicable, insofar as they are compatible with the provisions of subdivision 1, the Health Insurance Act and its regulations, until they are replaced by those of a regulation made under section 21.1 of that Act, enacted by section 19 of this Act.

56. Disputes validly submitted to a council of arbitration referred to in section 54 of the Health Insurance Act (chapter A-29) before 1 April 2026 are continued before that council of arbitration.

57. Division III.0.1 of the Health Insurance Act (chapter A-29), enacted by section 33 of this Act, does not apply to a general practitioner who, on 31 March 2026, adheres to the fixed-fee remuneration method, until the general practitioner ceases to take advantage of that remuneration method.

58. Until a first regulation is made by the Régie de l'assurance maladie du Québec under the second paragraph of section 72.1 of the Health Insurance Act (chapter A-29), amended by section 35 of this Act, the amount that an insured person may demand under the fourth paragraph of section 10 of that Act must not exceed the basic tariff that was provided for, at the time the insured

service was provided to the person, in an agreement referred to in section 19 of that Act for the remuneration by the act of that service before the carrying out of the rules governing the placing of a ceiling on activities.

However, in the case of a service received after 31 December 2025, that amount is determined according to the tariff in force on that date.

59. Section 43 also applies to a physician practising in a practice environment where the physician benefits from one of the following programs established by the Ministère de la Santé et des Services sociaux, until that program is replaced by a program referred to in that section:

(1) the Programme de financement et de soutien professionnel pour les groupes de médecine de famille (GMF);

(2) the Cadre de gestion des groupes de médecine de famille universitaires (GMF-U); or

(3) the Programme de désignation accès-réseau pour les groupes de médecine de famille (GMF).

60. Section 43 does not apply to a general practitioner who, on 31 March 2026, adhered to the fixed-fee remuneration method, unless the practitioner notifies the Régie de l'assurance maladie du Québec of their intention to adhere to the blended remuneration method from the following calendar quarter.

CHAPTER III

COLLECTIVE SUPPLEMENT

ACT TO PROMOTE ACCESS TO FAMILY MEDICINE AND SPECIALIZED MEDICINE SERVICE

61. The Act to promote access to family medicine and specialized medicine services (chapter A-2.2) is amended by inserting the following after section 1:

“CHAPTER II

“ACCESS TO SERVICES

“DIVISION 0.1

“GENERAL PROVISIONS”.

62. Section 2 of the Act is amended by replacing “of this Act” in the introductory clause by “of this chapter”.

63. Section 3 of the Act is amended by replacing “to this Act” by “to this chapter”.

64. The Act is amended by striking out the following after section 3:

“CHAPTER II

“ACCESS TO SERVICES”.

65. The Act is amended by inserting the following chapter after section 29.18, enacted by section 4 of chapter 29 of the statutes of 2024:

“CHAPTER III.1

“COLLECTIVE SUPPLEMENT

“DIVISION I

“INTRODUCTORY PROVISIONS

“29.19. This chapter establishes a collective supplement to be added to the remuneration of physicians and to foster the achievement, by medical collectivities whose composition is provided for in this chapter, of objectives for improving access to the medical services insured under the Health Insurance Act (chapter A-29) or for ensuring the quality of those services.

“29.20. The collective supplement amount must not exceed an amount corresponding to 15% of the remuneration provided for in an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) for the insured services provided by the physicians from among the services referred to in the first paragraph of section 3 of that Act. It is calculated and paid in accordance with the provisions of subdivision 3 of Division III.

For the purposes of this chapter, any other amount paid by the Board to a physician under an agreement entered into under section 19 of the Health Insurance Act is considered the remuneration for a service referred to in the first paragraph.

However, the regulation made under section 29.23 may prescribe that an amount is not taken into account in determining the collective supplement in the cases, on the conditions or to the extent determined by the regulation.

“29.21. For the purposes of this chapter, “physician” means a physician who is subject to an agreement entered into under section 19 of the Health Insurance Act (chapter A-29).

“29.22. This chapter does not apply to the territories referred to in sections 530.1 and 530.89 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or to the territory of the Cree Board of Health and Social Services of James Bay established by the Act respecting health services and social services for Cree Native persons (chapter S-5).

Nor does it apply with regard to a physician adhering to the fixed-fee remuneration method or the salary method.

“DIVISION II

“DETERMINATION OF OBJECTIVES

“29.23. The Government determines, by regulation, the objectives for improving access to the medical services insured under the Health Insurance Act (chapter A-29) or for ensuring the quality of those services. The Regulation also prescribes the intervals at which the achievement of each of those objectives is evaluated.

An objective must be national, territorial or local. Its achievement is evaluated at intervals corresponding to a calendar quarter or to a year beginning on the first day of such a quarter.

“29.24. An objective is national if it applies to one of the following groups of physicians:

- (1) the group formed of all physicians;
- (2) the group formed of all general practitioners;
- (3) the group formed of all medical specialists;
- (4) the group formed of all physicians belonging to one or more of the specialties indicated in the regulation made under section 29.23 from among the specialties defined by the board of directors of the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26); or
- (5) the group formed of all physicians who provide insured services within the meaning of the Health Insurance Act (chapter A-29) within practice environments belonging to one or more of the categories indicated in the regulation made under section 29.23 from among the categories provided for in section 29.27.

The achievement of a national objective is evaluated globally according to the performance of the group concerned.

“29.25. An objective is territorial if it applies to a group formed, in each territorial department identified in the regulation made under section 29.23, of the members of those departments who are referred to in one of the following subparagraphs:

- (1) all physicians;
- (2) all general practitioners;

(3) all medical specialists;

(4) all physicians belonging to one or more specialties indicated in the regulation made under section 29.23 from among the specialties defined by the board of directors of the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26); or

(5) all physicians who provide insured services within the meaning of the Health Insurance Act (chapter A-29) within practice environments belonging to one or more of the categories indicated in the regulation made under section 29.23 from among the categories provided for in section 29.27.

Where a territorial objective applies to more than one territorial department, its achievement is evaluated separately according to the performance of the group formed in each of those departments.

In this chapter, “territorial department” means a department formed under section 439 of the Act respecting the governance of the health and social services system (chapter G-1.021).

“29.26. An objective is local if it applies to one or more of the practice environments belonging to a category provided for in section 29.27.

Where a local objective applies to more than one such practice environment belonging to the same category, its achievement is evaluated separately according to the performance of each of the practice environments concerned.

“29.27. The categories of practice environments are as follows:

(1) premises where a private health facility is operated within the meaning of the second paragraph of section 481 of the Act respecting the governance of the health and social services system (chapter G-1.021);

(2) participating specialized medical centres within the meaning of the second paragraph of section 575 of that Act;

(3) institutions governed by that Act;

(4) clinical departments and services formed within an institution referred to in paragraph 3;

(5) facilities of the institutions referred to in paragraph 3; and

(6) any other category of practice environments that the regulation made under section 29.23 may indicate.

“29.28. The Government must, in the regulation made under section 29.23 and for each objective determined by the Government,

(1) specify the indicator to be used to measure achievement of the objective; and

(2) assign to that objective its number of shares in the collective supplement.

The number of shares assigned to an objective is determined on the basis of the priority given by the Government to the achievement of the objective.. That number must not be less than 1 or greater than 5, the number 1 being attributed to the objectives whose achievement is the lowest priority and the number 5 being attributed to those whose achievement is the highest priority.

“29.29. If the regulation made under section 29.23 provides for the application of standards or methodologies established by another government or a body, it may provide that references to those standards or methodologies include any later amendments made to them.

“29.30. The Minister must, before a regulation is made under section 29.23, consult the following persons, bodies and groups:

(1) the organizations representative of physicians that are referred to in section 19 of the Health Insurance Act (chapter A-29);

(2) a group representative of persons insured under the Health Insurance Act who receive services in the practice environments to which that regulation may apply;

(3) the Collège des médecins du Québec;

(4) Santé Québec and, where objectives the Government intends to determine in the regulation are applicable to them, private institutions;

(5) the Health and Welfare Commissioner; and

(6) the deans of the faculties of medicine of Québec.

“DIVISION III

“IMPLEMENTATION OF MEANS TO ACHIEVE OBJECTIVES

“§1.—*Medical collectivities*

“29.31. It is up to all the physicians of a group to which a national objective applies to implement means to achieve that objective. Those physicians compose a national medical collectivity.

Where such an objective applies to a group composed of both general practitioners and medical specialists, the implementation of the means to achieve the objective is common to two national medical collectivities, one composed of all the general practitioners in the group and the other composed of all the medical specialists in the group.

“29.32. It is up to all the physicians who, in a territorial department, compose the group to which a territorial objective applies to implement means to achieve that objective. Those physicians compose a territorial medical collectivity.

“29.33. It is up to all the physicians who provide insured services within a single practice environment to which a local objective applies to implement means to achieve that objective. Those physicians compose a local medical collectivity.

However, where such an objective applies to a private health facility in which only one physician practises, that physician is, with regard to that objective, part of the medical collectivity composed of all the physicians of the territorial department who practise alone in a private health facility.

“29.34. Depending on the nature of the objectives determined under section 29.23, a physician may be part of more than one medical collectivity.

“29.35. Subject to the special provisions of sections 29.36 to 29.39, the terms governing the management of the capitation remuneration that are set out in sections 38.0.4 to 38.0.7, the first and third paragraphs of section 38.0.8 and section 38.0.9 of the Health Insurance Act (chapter A-29) apply to management of the collective supplement within a medical collectivity, with the following modifications and any other necessary modifications:

(1) a reference to a practice environment is a reference to a medical collectivity within the meaning of this chapter;

(2) a reference to general practitioners who provide insured services in the same practice environment is a reference to the physicians composing a medical collectivity within the meaning of this chapter;

(3) a reference to capitation remuneration is a reference to the collective supplement within the meaning of this chapter; and

(4) the allocation rules that a medical collectivity may establish under section 38.0.9 of the Health Insurance Act pertain to the allocation of the collective supplement associated with the services provided as of the coming into force of those rules.

“29.36. The operating rules of a national medical collectivity or a territorial medical collectivity may, in particular,

(1) determine categories of physicians regarding which special allocation rules may be established, on the basis of, in particular, the specialty to which the physicians belong, their practice environment or the territory in which the practice environment is situated;

(2) establish the method for fixing the collective supplement amount to be allocated among the physicians belonging to a category determined under subparagraph 1; and

(3) where they delegate the power to establish allocation rules, determine to what extent and on which conditions that power may be subdelegated.

The operating rules may promote the principle of subsidiarity, that is, the principle whereby powers and responsibilities must be delegated to the appropriate level of authority so that decision-making centres are adequately distributed and brought as close as possible to the physicians concerned.

“29.37. In the case of a national medical collectivity, its representative is

(1) in the case of a collectivity composed of general practitioners, the organization representative of general practitioners that is referred to in section 19 of the Health Insurance Act (chapter A-29);

(2) in the case of a collectivity composed of medical specialists,

(a) if the collectivity is composed exclusively of physicians belonging to the same specialty, the professional association which is affiliated with the organization representative of medical specialists that is referred to in section 19 of the Health Insurance Act and which groups the physicians belonging to that specialty; and

(b) in the other cases, the organization representative of medical specialists that is referred to in section 19 of the Health Insurance Act.

Unless otherwise provided by a national medical collectivity’s operating rules, those rules are established by the general meeting of the representative organization or of the professional association, as applicable, that is the representative of that collectivity.

“29.38. In the case of a territorial medical collectivity or a local medical collectivity referred to in the second paragraph of section 29.33, its representative is the territorial department of which the physicians composing the collectivity are members.

The operating rules of such collectivities are established by the territorial department’s supervisory committee, unless otherwise provided by the collectivities’ operating rules.

“29.39. The allocation rules for the collective supplement may, in particular, be designed

(1) to encourage the achievement of the objectives determined under section 29.23;

(2) to promote the contribution of each physician to the implementation of means taken by the collectivity to achieve an objective determined under section 29.23; and

(3) to support physicians who engage in research work or who carry on teaching activities.

The allocation rules may also

(1) determine the conditions for the participation of a physician in the allocation of the collective supplement, which may, in particular, be tied to the achievement of targets set out in the allocation rules;

(2) determine, despite any contrary provision of this Act, the cases in which and conditions on which the allocation of the collective supplement allotted to that collectivity may include a physician who is no longer part of the collectivity; and

(3) confer a discretionary power on any person whose appointment is provided for by the allocation rules and prescribe the terms and conditions according to which that power may be exercised.

“29.40. The Minister must, from the coming into force of an objective determined by a regulation made under section 29.23,

(1) in the case of a national or territorial objective, publish on a website the indicator used to measure achievement of that objective and its level of achievement; and

(2) in the case of a local objective, give, to the representatives of the local medical collectivities that are to implement the means to achieve the objective, access, by means of a digital platform, to the indicator used to measure achievement of that objective and to its level of achievement.

The Minister must update at least once a month the information published or to which access is given under the first paragraph of section 27.

“§2. — Exemption

“29.41. The representative of a territorial medical collectivity or a local medical collectivity, acting on its behalf, may, in the cases and on the conditions that a regulation made under section 29.23 may prescribe, apply to the Minister for the collectivity to be exempted, in whole or in part, from the application of an objective determined by that regulation.

The exemption granted by the Minister applies from the evaluation period that begins after the date the exemption was granted. However, it may be retroactive to the date of coming into force of a regulation made under section 29.23 where the application for exemption was made within 60 days of that coming into force.

Where an exemption is granted, the Minister must mention the reason for doing so in the decision the Minister sends to the representative of the medical collectivity.

“29.42. Where the Minister exempts in whole a medical collectivity from the application of an objective, the collectivity is released from implementing the means to achieve the objective concerned. It is also excluded from the allotment of any collective supplement in connection with that objective, except in the cases and on the conditions that may be prescribed by a regulation made under section 29.23 and according to which it is deemed to meet that objective for the purposes of subdivision 3.

Where the Minister exempts in part a medical collectivity from the application of an objective, the Minister sets, with regard to the collectivity, the lesser level according to which the achievement of the objective will be evaluated. The Minister may also reduce, for that collectivity, the number of shares in the collective supplement assigned to that objective, which may then, despite the second paragraph of section 29.28, be less than 1.

The regulation made under section 29.23 may prescribe the conditions, criteria and terms according to which the Minister determines that new level as well as those according to which the Minister reduces the number of shares in the collective supplement assigned to that objective.

“29.43. The representative of a medical collectivity to which an exemption was granted under section 29.41 must notify the Minister without delay of any change in the situation of the collectivity that could call into question its entitlement to the exemption.

“29.44. The Minister may modify or revoke an exemption granted under section 29.41 where the Minister finds that the reason for which the exemption was granted no longer exists.

Before modifying or revoking an exemption, the Minister must give the representative of the medical collectivity concerned prior notice in writing of that intention and give the representative at least 30 days to submit observations.

The modification or revocation of an exemption applies from the evaluation period that begins after the date on which it was decided by the Minister.

“29.45. The Minister notifies the Board without delay of the exemptions granted, modified or revoked under sections 29.41 and 29.44

“29.46. The Minister may request that the Board investigate, itself or through a person it designates, any matter referred to in this subdivision and that it report its findings to the Minister. Sections 20 to 21 of the Act respecting the Régie de l’assurance maladie du Québec (chapter R-5) apply on the occasion of such an investigation, with the necessary modifications.

“29.47. The representative of a medical collectivity, acting on its behalf, may apply in writing to the Minister for a review of a decision referred to in section 29.41 or 29.44 within 60 days of notification of the decision.

Within 90 days of receiving the application for review, the Minister reviews the case and renders a decision with reasons. The Minister notifies the applicant in writing of the decision, of the applicant’s right to contest it before the Administrative Tribunal of Québec and of the time limit for bringing such a proceeding.

“29.48. The review decision may, within 60 days of its notification, be contested before the Administrative Tribunal of Québec by the representative of the medical collectivity concerned by the decision, acting on behalf of the collectivity.

Moreover, the representative of a medical collectivity may contest before the Tribunal the decision whose review the representative applied for if the Minister does not dispose of the application within 90 days of receiving it. However, that time limit runs from the date on which the representative submitted observations or produced documents if the representative requested more time for any of those purposes.

In the cases provided for in this section, the burden of proof that the Minister’s decision is ill-founded is on the representative of the medical collectivity.

The Tribunal may only confirm or quash the contested decision. At any time during the proceedings, the Tribunal may, with the parties’ consent, render judgment on the face of the record.

“§3. — Calculation and terms of payment of the collective supplement

“29.49. A physician must, to be entitled to be remunerated by the Board for an insured service within the meaning of the Health Insurance Act (chapter A-29), indicate in the statement of fees the physician submits to the Board under that Act the identification number of the practice environment in which the physician provided the service for which payment is claimed.

The Government may, in a regulation made under section 29.23, prescribe standards relating to the practice environment that must be indicated in the statement of fees submitted to the Board by a physician. The Government may also prescribe in the regulation the obligation, for physicians practising in a practice environment for which a national or territorial objective is determined,

to register the environment with the Board for it to be assigned an identification number. If applicable, section 2.0.13 of the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) applies to such a registration as if it were an application referred to in that section.

“29.50. Within 135 days after the end of each evaluation period referred to in the second paragraph of section 29.23, the Board communicates to the representative of each medical collectivity the collective supplement amount that, for that period, may be broken down by the medical collectivity for allocation among the physicians composing the collectivity.

To that end, the Board totals the collective supplement amount that is to be allotted to that medical collectivity under section 29.50 for each of the services that was provided during the evaluation period by the physicians composing the collectivity and for which payment is claimed.

In order for the physicians composing a local medical collectivity to be entitled to the amount referred to in the first paragraph, a representative of that medical collectivity must be registered with the Board before the end of the evaluation period concerned.

“29.51. The collective supplement associated with each service is determined and allocated among the medical collectivities concerned by the service in accordance with this section.

A medical collectivity is concerned by a service where the service was provided by a physician who was part of the medical collectivity at the time the service was provided. However, a territorial or local collectivity is concerned by a service only to the extent that the service was provided, as applicable, in the territory of the territorial department of which the physicians composing the collectivity are members or in the practice environment where the physicians composing the collectivity provide insured services.

The amount of the collective supplement to be allotted to each of the medical collectivities concerned by the service following that determination and allocation corresponds to the result of the following equation:

“

$$M_c = \frac{(0.15R \times \sum P_{cs}) + (0.05R \times \sum P_{ce})}{\sum P}$$

In that equation,

M_c is the collective supplement amount, associated with a service, that is to be allotted to the medical collectivity concerned;

R is the remuneration amount that the Board has paid or intends to pay for the service under the Health Insurance Act (chapter A-29);

$\sum P$ is the sum of the shares in the collective supplement that are assigned to the objectives where the means to achieve the objectives are to be implemented by the medical collectivities concerned during the calendar quarter in which the service was provided;

$\sum P_{\alpha}$ is the sum of the shares in the collective supplement, from among those included in $\sum P$, that are assigned to objectives evaluated at the same intervals, where the means to achieve the objectives are to be implemented by the medical collectivity concerned and where the objectives were achieved during the evaluation period in which the service was provided;

$\sum P_{\alpha}$ is the sum of the shares in the collective supplement, from among those included in $\sum P$, that are assigned to objectives evaluated at the same intervals, where the means to achieve the objectives are to be implemented by the medical collectivity concerned and where the objectives were not achieved during the evaluation period in which the service was provided.

However, 10 is to be substituted for sum $\sum P$ in the equation set out in the third paragraph if that sum is less than 10.

The amount of the capitation remuneration fees paid to a general practitioner for the taking in charge, in a practice environment, of an insured person within the meaning of subparagraph *f* of the first paragraph of section 3 of the Health Insurance Act is deemed, for the purposes of this section, to have been paid to the general practitioner for a service the practitioner personally provided in that practice environment.

“29.52. A regulation made under section 29.23 may provide, in the cases and on the conditions it determines, that the equation set out in the third paragraph of section 29.51 is to be applied substituting, for the number “0.05” in the equation, any number it determines or for which it establishes the calculation method. That number must not, however, be less than 0.05 or greater than 0.15.

“29.53. On receiving the collective supplement amount communicated under section 29.50, the representative of the medical collectivity breaks down the amount in accordance with the allocation rules established by the physicians composing the collectivity.

In order for those physicians to be entitled to that amount, the representative of the medical collectivity must submit to the Board a statement of that breakdown, duly completed, within 30 days of the communication referred to in section 29.50.

The Board may extend that period if the representative of the collectivity demonstrates to the Board that the representative was in fact unable to act sooner.

“29.54. For the purposes of the breakdown of the amount to be allocated, the representative of a medical collectivity may request that the Board communicate to the representative any information from among the information provided for by a regulation that the Board may make. Such a request must be made at least 30 days before the end of the evaluation period concerned. The Board attaches the information so requested to the collective supplement amount it communicates to the representative under section 29.50.

The information communicated under the first paragraph must not allow an insured person to be identified.

“29.55. The Board pays the collective supplement amount determined under section 29.50 to the physicians composing a medical collectivity in accordance with the breakdown communicated to it by the representative of the medical collectivity.

“DIVISION IV

“ADMINISTRATIVE MEASURES

“29.56. Where the Board is of the opinion that a medical collectivity was allotted a collective supplement amount in excess of the amount to which it is entitled, it may recover the overpayment from the collectivity by compensation out of the sums subsequently allotted to the collectivity.

The right to recover an overpayment is prescribed by 60 months from the time the sums were paid. Section 22.4 of the Health Insurance Act (chapter A-29) applies, with the necessary modifications, to the amount owed following a decision rendered under the first paragraph. 31

The first paragraph does not apply where the service with which the collective supplement is associated is the subject of a decision rendered under section 22.2 or 50 of the Health Insurance Act. The reimbursement of the collective supplement is then obtained by the Board from the physician who is the subject of such a decision in the same manner as the reimbursement for the service itself is obtained.

“29.57. Where the Board cannot recover, by compensation out of the sums allotted to a medical collectivity, the amount owed following a decision referred to in section 29.56, it may, on the expiry of the time for contesting the decision before the Administrative Tribunal of Québec and, if applicable, on the expiry of 30 days after a decision of the Tribunal confirming all or part of that decision, recover that amount, by compensation or otherwise, from the physicians composing the medical collectivity. The physicians are then required to pay the amount owed in proportion to the collective supplement amount that was paid to them by the Board during the period concerned in connection with objectives where the means to achieve those objectives are to be implemented by the collectivity concerned.

To that end, the Board may issue a certificate stating the name and address of the debtor and attesting the amount owed as well as the fact that the representative of the medical collectivity did not contest the Board's decision before the Tribunal. On the filing of the certificate with the office of the Superior Court or of the Court of Québec, according to their respective jurisdictions, the decision becomes enforceable as if it were a final judgment of that court not subject to appeal and has all the effects of such a judgment.

The second paragraph of section 18.3.2 of the Health Insurance Act (chapter A-29) applies, with the necessary modifications, to the amount owed by the debtor.

“29.58. The Board may impose on the physician a monetary administrative penalty equal to 10% of the payment the physician claimed or obtained in the 60 preceding months for services that, in contravention of section 29.49 or the regulation referred to in that section, were erroneously attributed to a practice environment in the statement of fees submitted to the Board under the Health Insurance Act (chapter A-29).

The Board may collect the amount of the penalty by compensation out of the physician's fees or otherwise.

Sections 22.3 and 22.5 of the Health Insurance Act apply, with the necessary modifications, to a decision rendered under the first paragraph.

“29.59. The amount of the collective supplement overpayment referred to in the first paragraph of section 29.56 and the amount of the payment claimed or obtained for services erroneously attributed to a practice environment that is referred to in the first paragraph of section 29.58 may be established by statistical inference on the sole basis of information obtained by a sampling, according to a method consistent with generally accepted practices.

The fourth, fifth, sixth and ninth paragraphs of section 22.2 of the Health Insurance Act (chapter A-29) apply, with the necessary modifications, to a decision rendered under section 29.56 or 29.58 of this Act, as if it were a decision rendered under the first paragraph of that section 22.2. In the case of a decision rendered under section 29.56 of this Act, a reference in section 22.2 of the Health Insurance Act to the health professional is a reference to the representative of the medical collectivity acting on his or her behalf.

Section 52.1 of the Health Insurance Act applies, with the necessary modifications, to an amount owed following a decision rendered under section 29.56 or 29.58 of this Act.

“DIVISION V

“PENAL PROVISIONS

“29.60. Anyone who, so as to increase the amount of the collective supplement allotted to a medical collectivity, makes an incomplete statement or a statement containing false or misleading information or sends an incomplete document or a document containing false or misleading information is liable to a fine of \$5,000 to \$50,000 in the case of a natural person and \$15,000 to \$150,000 in any other case.

The minimum and maximum fines prescribed by the first paragraph are doubled for a subsequent offence.”

66. The Act is amended by inserting the following section after section 79:

“79.1. This Act is of public order.”

HEALTH INSURANCE ACT

67. Section 18.3.2 of the Health Insurance Act (chapter A-29) is amended by replacing the second paragraph by the following paragraph:

“If, after the certificate is issued, the Minister of Revenue allocates, in accordance with section 31 of the Tax Administration Act (chapter A-6.002), a refund owed to a debtor under a fiscal law to the payment of the amount of the debt, the allocation interrupts prescription as regards the recovery of that amount.”

68. Section 22 of the Act is amended by replacing the last sentence of the fourth paragraph by the following sentence: “This paragraph does not prevent a pharmacist from exacting the difference between the price of the medication indicated on the list and the amount whose payment is assumed by the Board, and does not prevent a physician from receiving a collective supplement amount in accordance with Chapter III.1 of the Act to promote access to family medicine (chapter A-2.2).”

69. Section 68 of the Act is amended, in the first paragraph,

(1) by replacing “or for purposes of” by “, for the exercise of the functions and powers conferred on it by Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2) or for the purposes of”;

(2) by replacing “sections 18 and” by “section 18, Division III.0.1 and section”.

ACT RESPECTING THE GOVERNANCE OF THE HEALTH AND SOCIAL SERVICES SYSTEM

70. The Act respecting the governance of the health and social services system (chapter G-1.021) is amended by inserting the following sections after section 59:

“59.1. Santé Québec grants to the persons appointed by its board of directors and who exercise management responsibilities under the immediate authority of the president and chief executive officer a variable remuneration of which at least half must be based on the achievement of the objectives determined under section 29.23 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2).

“59.2. Santé Québec must set the salary scales according to which is determined the basic remuneration paid to the persons to whom a variable remuneration is granted under section 59.1, except where those scales are determined by a regulation made under section 59.

The percentage of increase of those salary scales must not exceed the percentage of increase of the salary scales applicable to management positions set out in such a regulation.”

ACT RESPECTING ADMINISTRATIVE JUSTICE

71. Section 25 of the Act respecting administrative justice (chapter J-3), amended by section 213 of chapter 5 of the statutes of 2023, is again amended by inserting “0.01,” after “paragraphs” in the second paragraph. 33

72. Section 3 of Schedule I to the Act is amended by adding the following paragraph before paragraph 0.1:

“(0.01) proceedings under sections 27 and 29.48 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2);”.

ACT RESPECTING THE RÉGIE DE L’ASSURANCE MALADIE DU QUÉBEC

73. Section 2.0.13 of the Act respecting the Régie de l’assurance maladie du Québec (chapter R-5) is amended by replacing “this Act” in the introductory clause of the first paragraph by “a provision of this Act, the Act to promote access to family medicine and specialized medicine services (chapter A-2.2)”.

74. Section 14.1 of the Act is amended by replacing “by the Health Insurance Act and” in the first paragraph by “by the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), by the Health Insurance Act or”.

75. Section 19.1 of the Act is amended by replacing “this Act” in the first paragraph by “the provisions of this Act, subdivision 3 of Division III and Divisions IV and V of Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2)”.

76. Section 19.2 of the Act is amended by inserting “subdivision 3 of Division III and Divisions IV and V of Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2),” after “this Act,”.

77. Section 21.1 of the Act is amended by inserting “subdivision 3 of Division III or Divisions IV and V of Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2),” after “this Act,” in the first paragraph.

78. Section 38 of the Act is amended by inserting “Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2),” after “application of” in paragraph *a*.

79. Section 39 of the Act is amended, in the second paragraph,

(1) by inserting “section 29.58 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2),” after “under”;

(2) by inserting “or a regulation made under section 21.1 of that Act” after “(chapter A-29)”.

AN ACT MAINLY TO REDUCE THE ADMINISTRATIVE BURDEN OF PHYSICIANS

80. Section 1 of the Act mainly to reduce the administrative burden of physicians (2024, chapter 29) is repealed.

81. Section 11 of the Act is amended by inserting the following paragraph after paragraph 1:

“(1.1) the provisions of section 2, which come into force on (*insert the date of assent to this Act*);”.

ACT TO ENACT THE ACT TO PROMOTE ACCESS TO FAMILY MEDICINE AND SPECIALIZED MEDICINE SERVICES AND TO AMEND VARIOUS LEGISLATIVE PROVISIONS RELATING TO ASSISTED PROCREATION

82. Section 1 of the Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation (2015, chapter 25) is amended by repealing sections 41 and 42 of the Act it enacts.

SPECIAL TRANSITIONAL PROVISIONS

83. Until a regulation is made under section 29.23 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act, the objectives for improving access to medical services or for ensuring the quality of those services are those set out in Schedule I to this Act.

84. A service provided by a physician before 1 January 2026 is not taken into account in determining the collective supplement that may be broken down by a medical collectivity for allocation among the physicians composing the collectivity.

85. Until the coming into force of the first provisions of a regulation referred to in the third paragraph of section 29.20 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 64 of this Act, the following amounts are not taken into account in determining the collective supplement:

(1) in the case of general practitioners,

(a) travel expenses paid under paragraph 30.05 of Chapter VIII – Dispositions relatives aux effectifs médicaux of the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(b) premiums, expenses and other amounts paid under Division II of Schedule XII concerning different remuneration for insured services provided in the territories that are understaffed with regard to health professionals to the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(c) the remuneration paid under Schedule XIII – Rémunération des services médico-administratifs visés par la Loi sur les accidents du travail et les maladies professionnelles, la Loi sur les accidents du travail et la Loi sur l’indemnisation des victimes d’actes criminels to the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(d) the allowances paid under Schedule XVI – Programme d’allocation de congé de maternité ou d’adoption au bénéfice du médecin rémunéré à l’acte, à tarif horaire, à la vacation ou au per diem to the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec

(e) the allowances paid under Schedule XIX – Programme de formation continue to the Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(f) the remuneration paid under Lettre d'entente n° 188 concernant la rémunération des services dispensés dans le cadre du système d'évacuation aëromédicale au Québec (ÉVAQ), entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(g) the remuneration paid under Lettre d'entente n° 291 concernant la rémunération des médecins pour la formation dans le cadre du programme AMPRO^{OB} PLUS dans les établissements de santé du Québec, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(h) the lump sums paid under Lettre d'entente n° 298 concernant l'attribution et les modalités relatives au versement de forfaits d'accessibilité pour favoriser l'installation de nouveaux médecins dans la dispensation de services de première ligne dans les territoires de réseaux locaux de services de santé et de services sociaux ou, selon le cas, de sous-territoires (CLSC ou de regroupements de CLSC), entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(i) the lump sums paid under Lettre d'entente n° 351 concernant certaines modalités visant à favoriser l'installation de médecins dans certains territoires de réseaux locaux de service en pénurie grave d'effectifs médicaux, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(j) the shares reimbursed under the Entente particulière relative à l'assurance responsabilité professionnelle, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(k) the remuneration for the functions of the physician responsible for a family medicine group or the physician who assists that physician that are paid under the Entente particulière relative à certaines conditions d'exercice et de rémunération du médecin qui exerce sa profession dans un groupe de médecine de famille (GMF), entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(l) the remuneration of the medical-administrative activities assumed by the head of a university family medicine group, or of the assisting physician, paid under the Entente particulière ayant pour objet la détermination de certaines conditions d'exercice et de rémunération du médecin enseignant, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(m) the remuneration of the medical-administrative activities of an emergency department head, or of the assisting physician, paid under the Entente particulière relative à la rémunération des activités médico-administratives réalisées dans le cadre du service d'urgence d'un établissement, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(n) the remuneration of the regional medical director of pre-hospital emergency services paid under the Entente particulière relative aux services préhospitaliers d'urgence, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(o) the remuneration of the medical-administrative activities of the physician responsible for a family medicine group having been designated as an access group or of a family medicine group designated as a network group, or of the assisting physician, paid under the Entente particulière relative à certaines conditions d'exercice et de rémunération du médecin qui exerce sa profession dans un groupe de médecine de famille désigné accès-réseau (GMF-AR), entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(p) the remuneration of the medical-administrative activities head of the clinical department of general medicine, or of the assisting physicians, paid under the Entente particulière relative à certaines conditions d'exercice et de rémunération du médecin nommé chef du département clinique de médecine générale et, de ceux qui l'assistent, d'un établissement, entered into by the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(q) the travel allowance per kilometre referred to in paragraph 2.4.2 under section A – Préambule général of Schedule V to the Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(2) in the case of medical specialists,

(a) the share reimbursed under Schedule 9 – Entente auxiliaire concernant l'assurance responsabilité professionnelle to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(b) among the letters of agreement appearing in Schedule 11.A – Lettres d'entente numérotées to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie:

i. the hourly rate paid under Lettre d'entente n° 53 concernant les missions sur les territoires de la Basse-Côte-Nord, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

ii. the lump sums and travel expenses paid under Lettre d'entente n° 75 concernant la rémunération dans certaines disciplines au Centre hospitalier Lac-Mégantic, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

iii. the lump sums paid under Lettre d'entente n° 133 concernant la rémunération dans certains établissements éloignés de la Côte-Nord et du Nunavik, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

iv. the lump sums and travel expenses paid under Lettre d'entente n° 152 concernant la poursuite de stages de formation ou de perfectionnement en urgences gynéco-obstétricales de base pour les médecins spécialistes en chirurgie générale, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

v. the lump sums paid under Lettre d'entente n° 159 concernant le maintien de l'accessibilité aux services spécialisés en obstétrique-gynécologie à l'Hôpital de Gatineau aux prises avec une grave pénurie temporaire d'effectifs, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

vi. the amounts paid under Lettre d'entente n° 168 concernant la rémunération des médecins spécialistes en obstétrique-gynécologie dans le cadre du programme AMPRO^{OB} PLUS dans les établissements de santé du Québec, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

(c) the transportation expenses and allowances paid under sections 2 and 3 of Schedule 19 – La rémunération différente pour les services assurés fournis dans les territoires insuffisamment pourvus de professionnels de la santé of the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(d) the amounts paid under Schedule 20 – Mesures incitatives complémentaires to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(e) the indemnities and reimbursements for travel expenses paid under Schedule 23 – Frais de déplacement et de séjour to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(f) the remuneration paid under Schedule 24, concerning the remuneration of medical-administrative services referred to in the Act respecting industrial accidents and occupational diseases, the Workers' Compensation Act and the

Crime Victims Compensation Act, to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(g) the allowances paid under Schedule 43, concerning the establishment of a parental leave program for medical specialists, to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(h) the amounts paid under the second and third paragraphs of section 1.5 of Schedule 45 – Concernant la mise en place d'un plan de remplacement provincial en anesthésiologie réanimation to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie;

(i) the remuneration for department head activities paid under Protocole d'accord n° 23 relatif à la rémunération de certaines activités médico-administratives accomplies dans un établissement de santé, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes du Québec;

(j) the remuneration paid under Protocole d'accord n° 28 relatif à la rémunération de certaines activités professionnelles accomplies par les médecins spécialistes dans le cadre du Centre antipoison du Québec (CAPQ) ou du système d'évaluation aéromédicale au Québec (É.V.A.Q.), entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes du Québec;

(3) in all cases, the remuneration of the services referred to in the fifteenth paragraph of section 3 of the Health Insurance Act (chapter A-29).

86. Despite any contrary provision of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), the allocation rules of a medical collectivity are deemed to provide that a physician who is part of that medical collectivity and who, on 1 January 2026, was at least 65 years old, is paid a collective supplement amount that is at least equal to the part of the supplement amount communicated to the collectivity under section 29.50 of that Act, enacted by section 65 of this Act, that is associated with the services provided by that physician.

Where the equation set out in the third paragraph of section 29.51 is applied to a service provided by a physician referred to in the first paragraph, the number "0.05" in the equation is replaced by the number "0.1".

A physician referred to in the first paragraph may renounce the application of that paragraph in writing.

87. Section 29.59 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act, is, until the coming into force of paragraph 2 of section 21 of this Act, to be read as if the second paragraph were replaced by the following paragraph:

“The first paragraph of section 18.4 of the Health Insurance Act (chapter A-29) applies, with the necessary modifications, to a decision rendered under section 29.56 or section 29.58 of this Act, as if it were a decision rendered under section 18.3 of the Health Insurance Act. The fourth, fifth and eighth paragraphs of section 22.2 of that Act also apply, with the necessary modifications, to a decision rendered under section 29.56 or section 29.58 of this Act, as if it were a decision rendered under the first paragraph of that section 22.2.”

88. Within 45 days after 1 January 2027, the Régie de l’assurance maladie du Québec pays to each general practitioner subject to the application of an agreement within the meaning of the Health Insurance Act (chapter A-29) the additional collective supplement amount provided for in the third paragraph if the rate of achievement of territorial objective 1-C set out in Schedule I to this Act is at least 75% during the 2026 calendar year.

For the purposes of this section, the rate of achievement of territorial objective 1-C corresponds to the quotient, expressed as a percentage, obtained by dividing the sum determined under subparagraph 1 by the sum determined under subparagraph 2:

(1) the sum obtained by adding up, for each quarter of the 2026 calendar year, the number of territorial medical collectivities having achieved that objective from among those that are required to implement means to achieve it; and

(2) the sum obtained by adding up the number of territorial medical collectivities that are, for each quarter of the 2026 calendar year, required to implement means to achieve that objective.

The additional amount paid by the Régie under the first paragraph corresponds to

(1) if the rate of achievement of territorial objective 1-C is at least 75% but less than 85%: \$5,000;

(2) if the rate of achievement of territorial objective 1-C is at least 85% but less than 100%: \$6,000; or

(3) if the rate of achievement of territorial objective 1-C is 100%: \$7,000.

However, for each month of the 2026 calendar year in which a physician did not provide any insured service remunerated by the Régie, the amount to which the physician is entitled under the third paragraph is reduced by one-twelfth.

That additional amount is in addition to the amount paid under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

89. Within 45 days after 1 January 2028, the Régie de l'assurance maladie du Québec pays to each general practitioner subject to the application of an agreement within the meaning of the Health Insurance Act (chapter A-29) an additional collective supplement amount if the rate of achievement of territorial objective 1-C set out in Schedule I to this Act is at least 75% during the 2027 calendar year. The additional amount paid to each physician and the rate of achievement of territorial objective 1-C are determined in accordance with the provisions of section 88, with the necessary modifications.

The additional amount is in addition to the amount paid under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

90. Within 45 days after 1 January 2027, the Régie de l'assurance maladie du Québec pays to each medical specialist subject to the application of an agreement within the meaning of the Health Insurance Act (chapter A-29) the additional collective supplement amount provided for in the third paragraph if the rate of achievement of national objective 5 set out in Schedule I to this Act is at least 60% during the 2026 calendar year.

For the purposes of this section, the rate of achievement of national objective 5 corresponds to the quotient, expressed as a percentage, obtained by dividing the sum determined under subparagraph 1 by the sum determined under subparagraph 2:

(1) the sum obtained by adding up, for each quarter of the 2026 calendar year, the number of national medical collectivities having achieved that objective from among those that are required to implement means to achieve it; and

(2) the sum obtained by adding up the number of national medical collectivities that are, for each quarter of the 2026 calendar year, required to implement means to achieve that objective.

The additional amount paid by the Régie under the first paragraph corresponds to

(1) if the rate of achievement of national objective 5 is at least 60% but less than 70%: \$5,000;

(2) if the rate of achievement of national objective 5 is at least 70% but less than 80%: \$7,000;

(3) if the rate of achievement of national objective 5 is at least 80% but less than 90%: \$9,000; or

(4) if the rate of achievement of national objective 5 is at least 90% but less than 100%: \$11,000.

However, for each month of the 2026 calendar year in which a physician did not provide any insured service remunerated by the Régie, the amount to which the physician is entitled under the third paragraph is reduced by one-twelfth.

That additional amount is in addition to the amount paid under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

91. Within 45 days after 1 January 2028, the Régie de l'assurance maladie du Québec pays to each medical specialist subject to the application of an agreement within the meaning of the Health Insurance Act (chapter A-29) an additional collective supplement amount if the rate of achievement of national objective 5 set out in Schedule I to this Act is at least 60% during the 2027 calendar year. The additional amount paid to each physician and the rate of achievement of national objective 5 are determined in accordance with section 90, with the necessary modifications.

The additional amount is in addition to the amount paid under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

92. The variable remuneration provided for in section 59.1 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 70 of this Act, applies to a person whose employment contract was entered into before (*insert the date of assent to this Act*) only from the renewal of that contract or from the entering into of a new employment contract.

93. Santé Québec must, before 1 January 2026, set the first salary scales according to which is determined the basic remuneration paid to the persons to whom a variable remuneration is granted under section 59.1 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 70 of this Act.

The first salary scales must correspond to those then applicable to those persons, after being adjusted to subtract the variable remuneration that may be granted to them.

CHAPTER IV

MEASURES CONCERNING TERRITORIAL DEPARTMENTS

ACT RESPECTING THE GOVERNANCE OF THE HEALTH AND SOCIAL SERVICES SYSTEM

94. The Act respecting the governance of the health and social services system (chapter G-1.021) is amended by inserting the following section after section 445:

“445.1. The president and executive director of the institution to which a territorial department is attached may, where the department’s supervisory committee repeatedly or continuously fails to exercise the department’s functions in full, properly and without delay and where access to or the quality of services depends on it, entrust the exercise of those functions to any person the president and executive director designates.

Where a territorial department is attached to more than one institution, the power under the first paragraph is exercised by the president and executive director of the institution designated by Santé Québec.”

95. Section 449 of the Act is amended by adding the following paragraphs before paragraph 1:

“(0.1) establishing, in coherence with ministerial orientations, a territorial coverage plan for priority sectors and sectors with limited staff that specifies the family medicine services likely to best meet the needs of the entire population;

“(0.2) ensuring the coordination of medical services offered at home and in residential and long-term care centres;”.

96. Section 453 of the Act is amended by replacing the second paragraph by the following paragraph:

“For each specialty, the department must

(1) assess, in coherence with ministerial orientations, specialized medical service needs for priority sectors and sectors with limited staff; and

(2) ensure the implementation and application of Santé Québec’s decision relating to the organization referred to in the first paragraph.”

97. The Act is amended by inserting the following section after section 454:

“454.1. The territorial department of specialized medicine must report to Santé Québec on the assessment of medical service needs made under subparagraph 1 of the second paragraph of section 453.”

98. The Act is amended by inserting the following sections after section 483:

“483.1. Santé Québec must establish a national coverage plan for each medical specialty that specifies, for each local health and social services network territory, the specialized medical services likely to best meet the needs of the entire population.

In establishing a national coverage plan for a specialty, Santé Québec must take into account the assessments of the specialized medical service needs for priority sectors and sectors with limited staff that are sent to it under section 454.1 and, at its request, by the Cree Board of Health and Social Services of James Bay and the Nunavik Regional Board of Health and Social Services.

Santé Québec must also consult the professional association which is affiliated with the organization representative of medical specialists that is referred to in section 19 of the Health Insurance Act (chapter A-29) and which groups the medical specialists concerned by a national coverage plan for a specialty. Such an association may make the recommendations it considers appropriate with regard to the plan.

“483.2. A national coverage plan for a specialty established by Santé Québec under section 483.1 is submitted to the Minister, who approves it with or without amendment; the recommendations made by the professional association consulted under that section are submitted with the plan, if applicable.

The national coverage plan for a specialty so approved must, in accordance with section 483.1, be established again every two years and whenever the Minister so requests. The approved plan continues to have effect as long as the new plan has not been approved by the Minister.

The Minister may establish a national coverage plan for a specialty if Santé Québec fails to do so within the time specified by the Minister.

“483.3. The Minister may send directives to Santé Québec concerning the establishment of a national coverage plan for a specialty.

Such directives are binding on Santé Québec.”

SPECIAL TRANSITIONAL PROVISION

99. The first national coverage plans for each of the medical specialties that are provided for in section 483.1 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 98 of this Act, must be sent to the Minister not later than (*insert the date that is six months after the date of assent to this Act*).

CHAPTER V

PRACTICE OF MEDICINE IN GROUPS

ACT RESPECTING THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

100. Section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2) is amended by replacing the first paragraph by the following paragraph:

“The Minister may establish programs to promote the practice of family medicine in groups in a multidisciplinary practice environment and the practice of specialized medicine in private health facilities within the meaning of the second paragraph of section 481 of the Act respecting the governance of the health and social services system (chapter G-1.021), the second paragraph of section 95 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or subparagraph 1 of the first paragraph of section 1 of the Act respecting health services and social services for Cree Native persons (chapter S-5). The Minister may prescribe by regulation the standards the Minister considers necessary for the application of such programs, in particular terms governing the follow-up of patients by the physicians who benefit from the program, including the hours during which the physicians must be available. Before coming into force, such a program or such a regulation must be approved by the Conseil du trésor.”

ACT TO PROMOTE ACCESS TO FAMILY MEDICINE AND SPECIALIZED MEDICINE

101. Section 4 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2) is amended by replacing “family medicine group” in subparagraph 1 of the first paragraph by “practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021)”.

CHAPTER VI

SOLICITATION OF GIFTS BY A FOUNDATION OF AN INSTITUTION AND USE OF INDEPENDENT LABOUR IN COMMUNITY PHARMACIES

ACT RESPECTING HEALTH AND SOCIAL SERVICES INFORMATION

102. Section 8 of the Act respecting health and social services information (chapter R 22.1) is amended by inserting the following paragraph after the second paragraph:

“A person may also refuse to allow his or her name and contact information to be used for the purpose of soliciting a gift.”

103. Section 9 of the Act is amended by inserting “or to refuse to allow the use of his or her contact information” after “concerning him or her”.

104. The Act is amended by inserting the following section after section 63:

“**63.1.** A person’s name and contact information held by Santé Québec or by an institution other than a Santé Québec institution may be used within that body by any person who belongs to a category of persons identified in the body’s information governance policy for the purpose of soliciting a gift to the institution or to the foundation of an institution within the meaning of section 120 of the Act respecting the governance of the health and social services system (chapter G-1.021) or of section 132.2 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2), unless the person concerned has refused to allow the use of such information for that purpose under the third paragraph of section 8.”

ACT RESPECTING THE GOVERNANCE OF THE HEALTH AND SOCIAL SERVICES SYSTEM

105. Section 668 of the Act respecting the governance of the health and social services system (chapter G-1.021) is amended by inserting “a community pharmacy,” after “residence,” in the fourth paragraph.

CHAPTER VII

RENEWAL OF AGREEMENTS ENTERED INTO WITH ORGANIZATIONS REPRESENTATIVE OF PHYSICIANS

DIVISION I

GENERAL PROVISIONS

106. For the purposes of this chapter, unless the context indicates otherwise,

“agreement” means an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) with the organization representative of general practitioners or the organization representative of medical specialists; and

“physician”, “practitioner” and “specialist” mean a physician who is subject to the application of an agreement within the meaning of the Health Insurance Act.

107. Unless otherwise provided in this chapter, all the agreements that, on *(insert the date preceding the date of assent to this Act)*, are in force or continue to have effect in accordance with section 20 of the Health Insurance Act (chapter A-29) are renewed until 31 March 2028.

108. Each of the tariffs in force on 31 December 2025 provided for in an agreement and according to which the Régie de l'assurance maladie du Québec remunerates a physician under the Health Insurance Act (chapter A-29) for the services the physician provides is replaced, as of 1 January 2026, by a tariff corresponding to 86.96% of the tariff in force on 31 December 2025. The following tariffs, however, are not subject to such a replacement:

(1) the tariffs according to which is paid a remuneration that is not taken into account in determining the collective supplement under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act;

(2) the tariffs applicable to the fixed-fee remuneration method and the social benefits to which the general practitioners adhering to that remuneration method are entitled; and

(3) the tariffs applicable to the salary remuneration method and the social benefits to which the medical specialists adhering to that remuneration method are entitled.

Despite the first paragraph, the tariffs that are provided for in an agreement on 31 December 2025 continue to apply in a territory referred to in sections 530.1 and 530.89 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or in the territory of the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons (chapter S-5).

DIVISION II

GENERAL PRACTITIONERS

§1.—Provisions deemed to constitute an agreement

109. The provisions of this division, except the provisions of sections 112 and 117 that allow the Minister to make a regulation, are deemed to constitute an agreement entered into with the organization representative of general practitioners.

§2.—Overall resource envelopes

110. The overall resource envelope for the remuneration of general practitioners under the Health Insurance Act (chapter A-29) is as follows:

- (1) for the period from 1 April 2023 to 31 March 2024: \$3,033,900,000; and
- (2) for the period from 1 April 2024 to 31 March 2025: \$2,810,100,000.

That envelope, after the tariff reduction resulting from the application of section 108 and taking into account the other amendments made to an agreement by the provisions of this division, is as follows:

- (1) for the period from 1 April 2025 to 31 March 2026: \$2,748,000,000;
- (2) for the period from 1 April 2026 to 31 March 2027: \$2,243,000,000; and
- (3) for the period from 1 April 2027 to 31 March 2028: \$2,281,100,000.

III. A 1.7% portion of the overall resource envelope for the remuneration of general practitioners provided for each of the periods referred to in the second paragraph of section 110 is reserved for developments in medical practice resulting from, among other things, the effects of the growth and aging of the population, but mainly from the net addition of medical staff in family medicine.

§3.—Restriction to the blended remuneration method

II2. A general practitioner referred to in section 43 is remunerated according to the fee-for-service remuneration method instead of the blended remuneration method provided for in that section for a service referred to in a regulation of the Minister, in the cases and on the conditions that the Minister may determine.

§4.—Tariffs applicable under the blended remuneration method

II3. This subdivision establishes the tariff for each component of the blended remuneration method referred to in section 43.

II4. The taking in charge of an insured person referred to in subparagraph *f* of the first paragraph of section 3 of the Health Insurance Act (chapter A-29), amended by section 29 of this Act, is remunerated by capitation according to the quarterly tariff provided for in the following paragraphs, according to the vulnerability level of that person:

- (1) healthy: \$2.29;
- (2) minor chronic health condition: \$13.73;
- (3) moderate health condition: \$22.88; or
- (4) major health condition: \$41.19.

115. The performance of tasks constituting the practice of the medical profession is remunerated according to an hourly rate, based on a \$26.81 hourly tariff. A quarter of that tariff is payable for each completed 15-minute period, up to 12 hours per day. Those tasks include

- (1) direct follow-up tasks, that is, any activity that includes direct interaction with the patient, whether that interaction is individual or in a group;
- (2) indirect follow-up tasks, that is, any activity that involves intervening for the purposes of follow-up of the patient, including collaborating with other professionals and following up on results; and
- (3) administrative tasks, that is, tasks that are not related to the follow-up of patients, including participating in committees, producing administrative documents and performing tasks inherent in the organization of the practice environment referred to in section 43.

Where the tasks referred to in the first paragraph are performed as part of the supervision of at least one medical student, medical resident or candidate to the practice of another profession by a general practitioner designated for the purposes of a training program leading to the awarding of a diploma which gives access to the permits and specialist's certificates issued by the professional orders, the tariff provided for in that paragraph is increased

- (1) to \$72.97 per hour where the practitioner only assumes the taking in charge of and responsibility for residents in medicine; and
- (2) to \$78.09 per hour in any other case.

Where the tasks referred to in the first paragraph are performed as part of academic activities offered by a general practitioner for the purposes of such a training program, including clinical and educational supervision, formal theoretical instruction as well as teaching activities and simulation-based learning activities, and they are not referred to in the second paragraph, the tariff provided for in the first paragraph is increased to \$86.37.

The tariff provided for in this section is payable only if the tasks are performed, by the general practitioner, from the territory of Québec.

116. The services referred to in the subparagraphs below are subject to an additional remuneration, according to the tariff indicated:

- (1) interaction with a patient:
 - (a) in person, in the patient's place of residence: \$59.83;
 - (b) in person, in the practitioner's practice environment: \$16.00; and
 - (c) remotely: \$13.98;

(2) interaction with a group of patients: \$22.40; and

(3) interaction with a health and social services professional, other than a general practitioner, that takes place at the request of that professional because of the complexity or severity of the case of a patient who is a person affiliated with a practice environment in which the practitioner provides insured services according to the repertory kept under section 447.5 of the Act respecting the governance of the health and social services system (chapter G-1.021) or because of the expertise of the practitioner's with respect to that patient's condition, if that interaction is documented by the practitioner in the patient's record: \$6.34.

The tariff for an interaction referred to in subparagraph *b* of subparagraph 1 of the first paragraph is increased to \$34.97 if the interaction lasts half an hour or more.

117. Where performed on the occasion of a service referred to in section 116, a service provided for in a regulation of the Minister is also subject, in the cases and on the conditions determined in the regulation, to additional remuneration according to the tariff, from among the following, that corresponds to the heading under which the service is provided for in the regulation:

(1) minor procedure: \$3.07;

(2) standard procedure: \$6.09; or

(3) advanced procedure: \$17.59.

§5.— Other amendments to the agreements

118. Any provision of an agreement that, through, in particular, a specific tariff, an increase or a supplement, has the effect of establishing, for an insured service provided by a general practitioner in a facility (“cabinet”) or at home, a remuneration greater than the remuneration applicable for the same service provided in a facility of an institution ceases to have effect on 1 April 2026. The remuneration to which the practitioner is entitled for that service corresponds, as of that date, to the remuneration applicable where the service is provided in a facility of an institution.

For the purposes of the first paragraph, “facility of an institution” has the meaning assigned, as applicable, by the Act respecting the governance of the health and social services system (chapter G-1.021), the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (chapter S-5).

119. Services provided remotely by a general practitioner remunerated according to the fee-for-service remuneration method, from the practitioner's residence or from a facility of an institution within the meaning of the Act respecting the governance of the health and social services system (chapter G-1.021), are remunerated according to a tariff of \$7.21 for each completed 5-minute period.

Services provided remotely, before 1 April 2026, by a general practitioner remunerated according to the fee-for-service remuneration method, from premises where the practitioner operates a private health facility, are remunerated according to a tariff of \$8.66 for each completed 5-minute period.

The tariffs provided for in this section are payable only if the service is provided, by the general practitioner, from the territory of Québec.

120. The value of a category A remuneration token referred to in section 1 of the Regulation respecting the remuneration of services rendered by a health professional for the performance of administrative activities or tasks, enacted by section 26 of this Act, is set at \$70.75. The value of a category B remuneration token referred to in section 2 of that regulation is set at \$86.50 and the value of a category D remuneration token referred to in section 4 of that regulation is set at \$70.75.

121. To determine the amount of an allowance paid under Schedule XVI – Programme d'allocation de congé de maternité ou d'adoption au bénéfice du médecin rémunéré à l'acte, à tarif horaire, à la vacation ou au per diem to the Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec, the weekly average remuneration of a general practitioner must be determined by adding to the practitioner's basic remuneration the amount paid to the practitioner as a collective supplement under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

122. The following provisions cease to have effect:

(1) the provisions of section 7 of Schedule IX – Conditions d'application des tarifs de l'Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(2) the provisions of Schedule XIX – Programme de formation continue to the Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(3) the provisions of Schedule XXI – Reconnaissance de l’efficiencia to the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(4) the provisions of Schedule XXIII – Modalités spécifiques relatives au mode de rémunération mixte instauré dans les secteurs de pratique désignés to the Entente relative à l’assurance maladie et à l’assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec, to the extent that they concern the Programme de médecine de famille, de prise en charge et de suivi de la clientèle or the university family medicine groups;

(5) the provisions of Lettre d’entente n° 20 concernant certains services reliés à l’examen d’un enfant de moins de dix-huit (18) ans suivant la Loi sur la protection de la jeunesse;

(6) the provisions of Lettre d’entente n° 116 concernant l’expérimentation de certaines modalités de rémunération des médecins qui exercent dans le cadre du Centre médical Acton ou du CLSC La Chênaie;

(7) the provisions of Lettre d’entente n° 213 ayant trait à la supervision médicale dispensée dans le cadre de la formation des infirmières praticiennes spécialisées, entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(8) the provisions of Lettre d’entente n° 217 concernant la rémunération applicable au réseau de cliniques médicales de Drummondville;

(9) the provisions of Lettre d’entente n° 269 concernant certaines modalités de rémunération applicables en période de grippe saisonnière;

(10) the provisions of Lettre d’entente n° 304 concernant le transfert pour la prise en charge en bloc et suivi auprès d’un autre médecin de la clientèle inscrite du médecin qui prend sa retraite, réoriente sa pratique, déménage ou décède;

(11) the provisions of Lettre d’entente n° 305 concernant le financement et le suivi des coûts découlant de la Lettre d’entente n° 204;

(12) the provisions of Lettre d’entente n° 309 concernant le financement et le suivi de l’article 17.00 à l’Entente particulière relative aux services de médecine de famille, de prise en charge et de suivi de la clientèle, du paragraphe 8.2 de l’Entente particulière relative à la participation des médecins omnipraticiens au dossier de santé du Québec et au programme québécois de dossiers médicaux électroniques s’appliquant de façon transitoire ainsi que des coûts de la formation en regard du dossier médical électronique;

(13) the provisions of Lettre d'entente n° 321 concernant certaines modalités particulières applicables dans le cadre de la prise en charge et le suivi d'un bloc de patients sans médecin de famille attribué par le Guichet d'accès à un médecin de famille (GAMF);

(14) the provisions of Lettre d'entente n° 327 concernant certaines modalités particulières applicables pour la prestation continue des services médicaux dans un établissement ayant la mission d'un CHSLD;

(15) the provisions of Lettre d'entente n° 381 concernant certaines modalités de rémunération applicables dans le cadre d'une clinique désignée populationnelle (CDP);

(16) the provisions of Lettre d'entente n° 382 concernant certaines modalités de rémunération applicables dans le cadre d'un site non traditionnel ambulatoire (SNTA);

(17) the provisions of Lettre d'entente n° 389 concernant les modalités de rémunération particulières applicables dans le cadre de la collaboration professionnelle et interdisciplinaire entre le médecin et une infirmière praticienne spécialisée en soins de première ligne (IPSPL) ou une infirmière praticienne spécialisée en santé mentale (IPSSM) dans un cabinet privé, dans un CLSC, dans un GMF-U ou dans un CHSLD dans lequel le médecin y exerce sa profession;

(18) the provisions of Lettre d'entente n° 393 concernant la clientèle en attente au guichet d'accès à un médecin de famille, entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(19) the provisions of Lettre d'entente n° 394 concernant le financement et le suivi des coûts découlant de la Lettre d'entente n° 393 et concernant le financement du dépassement des coûts du montant alloué pour le financement de l'Amendement n° 195;

(20) the provisions of Accord n° 767 entre le ministre de la Santé et la Fédération des médecins omnipraticiens du Québec ayant trait à certaines adaptations aux modalités convenues à l'Accord n° 659 concernant la rémunération du Dr Paul-Aimé Joncas (85-217);

(21) the provisions of the Entente particulière relative à certaines conditions d'exercice et de rémunération du médecin qui exerce sa profession dans un groupe de médecine de famille (GMF), entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(22) the provisions of the Entente particulière ayant pour objet certaines conditions d'exercice et de rémunération applicables au médecin qui exerce sa profession dans une clinique réseau, entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(23) the provisions of the Entente particulière relative aux services de médecine de famille, de prise en charge et de suivi de la clientèle, entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec;

(24) the provisions of the Entente particulière ayant pour objet la détermination de certaines conditions d'exercice et de rémunération du médecin enseignant, entered into between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec, except

(a) the provisions of Division I, as regards the remuneration of the activities related to the supervision of a resident or extern performed in a health and social services institution within the meaning of the Act respecting the governance of the health and social services system (chapter G-1.021), the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (chapter S-5); and

(b) the provisions of section 7.00 of Division II;

(25) the provisions of the Entente particulière relative à la participation des médecins omnipraticiens au Dossier de santé du Québec et au Programme québécois d'adoption de dossiers médicaux électroniques conclue entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec;

(26) the provisions of the Entente particulière relative à certaines conditions d'exercice et de rémunération du médecin qui exerce sa profession dans un groupe de médecine de famille accès-réseau (GMF-AR); and

(27) the provisions of any agreement that specify a remuneration for the completion of the form during the medical assessment examination of a patient with loss of autonomy (code 09101).

DIVISION III

MEDICAL SPECIALISTS

§1.—*Provisions deemed to constitute an agreement*

123. The provisions of this division are deemed to constitute an agreement entered into with the organization representative of medical specialists.

§2. — *Overall resource envelopes*

124. The overall resource envelope for the remuneration of medical specialists under the Health Insurance Act (chapter A-29) is as follows:

- (1) for the period from 1 April 2023 to 31 March 2024: \$5,099,400,000; and
- (2) for the period from 1 April 2024 to 31 March 2025: \$5,316,200,000.

That envelope, after the tariff reduction resulting from the application of section 108 and taking into account the other amendments made to an agreement by the provisions of this division, is as follows:

- (1) for the period from 1 April 2025 to 31 March 2026: \$5,049,500,000;
- (2) for the period from 1 April 2026 to 31 March 2027: \$4,652,000,000; and
- (3) for the period from 1 April 2027 to 31 March 2028: \$4,578,600,000.

125. A 1.5% portion of the overall resource envelope for the remuneration of medical specialists provided for each of the periods referred to in section 124 is reserved for developments in medical practice resulting from, among other things, the effects of the growth and aging of the population, but mainly from the net addition of medical staff in specialized medicine.

§3. — *Other amendments to the agreements*

126. Services provided remotely by a medical specialist remunerated according to the fee-for-service remuneration method are remunerated for each completed 5-minute period according to one of the following tariffs:

- (1) in the case of a service provided remotely from premises where a private health facility is operated: \$16.52; or
- (2) in the case of a service provided remotely from the professional's residence or from a facility of an institution within the meaning of the Act respecting the governance of the health and social services system (chapter G-1.021): \$13.77.

The tariffs provided for in this section are payable only if the service is provided, by the medical specialist, from the territory of Québec.

127. The value of a category C remuneration token referred to in section 3 of the Regulation respecting the remuneration of services provided by a health professional for the performance of administrative activities or tasks, enacted by section 26 of this Act, is set at \$84.90.

128. To determine the amount of an allowance paid under Schedule 43, concerning the establishment of a parental leave program for medical specialists, to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie, the average weekly practice earnings of a medical specialist must be determined by adding to the specialist's practice earnings, within the meaning of that Schedule, the amount paid to the specialist as a collective supplement under Chapter III.1 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act.

129. The following provisions cease to have effect:

(1) sections 13 and 14 of Lettre d'entente n° 241 concernant les modalités de rémunération des activités effectuées par les médecins spécialistes en période de pandémie de la COVID-19 et durant la reprise graduelle des activités médicales, entered into by the Minister of Health and Social Services and the Fédération des médecins spécialistes;

(2) Rule 6 – Malade dirigé, under section A – Préambule général in Schedule 4 to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins de l'application de la Loi sur l'assurance maladie; and

(3) those of the Protocole d'accord intervenu entre le gouvernement du Québec et la Fédération des médecins spécialistes du Québec (FMSQ) relatif à la modification du Protocole d'accord intervenu entre le ministère de la Santé et des Services sociaux (MSSS) et la FMSQ signé le 14 mars 2018 concernant la réduction de l'enveloppe budgétaire globale dédiée à la rémunération des médecins spécialistes.

The obligations performed by the parties under the memorandum of agreement referred to in subparagraph 3 of the first paragraph before it ceases to have effect under that paragraph are deemed to constitute the only obligations that were incumbent on them under that memorandum of agreement; those obligations are deemed to have been carried out in full, properly and without delay. This paragraph is declaratory.

CHAPTER VIII

CONTINUITY OF PROFESSIONAL ACTIVITIES

DIVISION I

GENERAL PROVISIONS

130. For the purposes of this chapter,

“agreement” means an agreement entered into under section 19 of the Health Insurance Act (chapter A-29) with the organization representative of general practitioners or with the organization representative of medical specialists;

“clinical department” means a clinical department referred to in the Act respecting the governance of the health and social services system (chapter G-1.021), the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (chapter S-5);

“clinical service” means a service formed within a clinical department;

“group representative of physicians” means an organization having entered into an agreement or any other group that promotes or defends the interests of physicians, whether or not it is constituted under the Professional Syndicates Act (chapter S-40);

“health and social services institution” means an institution within the meaning of the Act respecting the governance of the health and social services system, the Act respecting health services and social services for the Inuit and Naskapi or the Act respecting health services and social services for Cree Native persons;

“medical and professional services director”, in the case of the medical and professional services director of a health and social services institution, means the director referred to in section 195 of the Act respecting the governance of the health and social services system and the director of professional services referred to in the Act respecting health services and social services for the Inuit and Naskapi or the Act respecting health services and social services for Cree Native persons;

“national inspector” means the national inspector for services in the field of health and social services appointed under section 750 of the Act respecting the governance of the health and social services system;

“participating specialized medical centre” means a participating specialized medical centre within the meaning of the second paragraph of section 575 of the Act respecting the governance of the health and social services system;

“physician” means a physician subject to the application of an agreement within the meaning of the Health Insurance Act;

“practice environment” means a private health facility, a participating specialized medical centre, a clinical department, a health and social services institution, a clinical service and any other environment in which a physician practises the profession;

“private health facility” means premises where a private health facility within the meaning of the second paragraph of section 481 of the Act respecting the governance of the health and social services system is operated or premises referred to in the second paragraph of section 95 of the Act respecting health services and social services for the Inuit and Naskapi or subparagraph 1 of the first paragraph of section 1 of the Act respecting health services and social services for Cree Native persons;

“professional activity” includes any service, participation or contribution a physician provides as a physician or because they are a physician;

“services in the field of health and social services” include the services in the field of health and social services within the meaning of the Act respecting the governance of the health and social services system and the insured services within the meaning of the Health Insurance Act; and

“training path for resource persons in the field of health and social services” includes any training program leading to the awarding of a diploma which gives access to the permits and specialist’s certificates issued by the professional orders, as well as any internship, training or other term or condition for the issue of a permit or specialist’s certificate provided for in a regulation made under subparagraph 1 of the first paragraph of section 94 of the Professional Code (chapter C-26).

DIVISION II

PROHIBITED PARTICIPATION IN CERTAIN CONCERTED ACTIONS

§1.—*Prohibitions*

131. It is prohibited for a physician to participate or to continue participating in any concerted action that has the effect of

(1) stopping, reducing or slowing down the physician’s professional activity, as compared to the activity as it was engaged in before the action was undertaken, in particular by stopping, reducing or slowing down the physician’s participation in a committee, work group or other forum;

(2) negatively affecting access to or the quality of services in the field of health and social services, in particular by stopping, reducing or slowing down the physician’s participation in a program established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of this Act, or deemed to be so established under section 10 of this Act;

(3) slowing down or otherwise hampering the proper conduct of the training path for resource persons in the field of health and social services, in particular by failing to discharge the physician's obligations in that regard or ending the physician's participation in such a path; or

(4) causing the physician to become a professional who has withdrawn under section 26 of the Health Insurance Act (chapter A-29).

132. For the purposes of this chapter, an action is presumed to be a concerted action in the following cases:

(1) where the action is accomplished contemporaneously by two or more physicians; or

(2) where the action is substantially in keeping with a proposal, suggestion or encouragement by a group representative of physicians.

133. It is prohibited for a group representative of physicians to undertake or continue an action if the action involves the participation of a physician in a concerted action referred to in section 131 or incites or induces a physician to participate in such a concerted action.

Such a group must take the appropriate means to induce the physicians it represents to comply with the provisions of this subdivision.

§2. — Remedial powers

I. — Invalidation of notice of withdrawal

134. The Régie de l'assurance maladie du Québec may, within 90 days of receiving a notice informing it that a physician wishes to become a professional who has withdrawn under section 26 of the Health Insurance Act (chapter A-29), invalidate the notice if it has reasonable grounds to believe that the notice was sent in the context of a concerted action referred to in section 131. In such a case, it informs the physician of its decision.

For the purposes of section 26 of the Health Insurance Act, a notice of withdrawal invalidated under the first paragraph is deemed not to have been sent.

II. — Injunction

135. A judge of the Superior Court may grant an injunction to put an end to any failure to comply with the provisions of subdivision 1. The judge may also cancel or invalidate any act performed in contravention of those provisions.

136. An application for an injunction may be made by any interested person. It may also be made by the Régie de l'assurance maladie du Québec, the Attorney General of Québec, the Public Protector, the Collège des Médecins du Québec, Santé Québec or a health and social services institution other than a Santé Québec institution.

An application for an injunction constitutes a proceeding in itself.

137. Where an interlocutory injunction is applied for, the suretyship referred to in article 511 of the Code of Civil Procedure (chapter C-25.01) must not exceed \$500. The Régie de l'assurance maladie du Québec, the Attorney General of Québec, the Public Protector, the Collège des Médecins du Québec, Santé Québec or a health and social services institution other than a Santé Québec institution are not required to provide such a suretyship.

138. Every application made under this sub-subdivision must be served on the Attorney General of Québec.

139. Every application for an injunction under this sub-subdivision must be heard and decided on an urgent basis.

140. Where a judgment granting an injunction is served on a group representative of physicians, it is deemed to have been served on all the physicians it represents.

DIVISION III

MONITORING OF ATTENDANCE AND SERVICES

§1.—General provisions

141. This division applies only with respect to practice environments or groups of practice environments the Minister determines by order. The Minister may also, by order, put an end to the application of this division with respect to the practice environments or groups of practice environments the Minister determines.

An order made under the first paragraph comes into force on the date of its publication in the *Gazette officielle du Québec* or on any later date specified by the Minister in the order.

142. For the purposes of this subdivision, in a practice environment referred to in one of the following subparagraphs, the physician referred to in subparagraph *a* of that subparagraph is the person responsible for professional activities. That physician is, with respect to the functions conferred by this division on them in that capacity, under the responsibility of a supervisor who is the person referred in subparagraph *b* of that same subparagraph:

- (1) a clinical service:

- (a) the head of that service;
- (b) the head of the clinical department that includes that service;
- (2) a clinical department, excluding, where applicable, any service that the department includes:
 - (a) the head of that department;
 - (b) the medical and professional services director of the institution within which the department is formed;
- (3) a participating specialized medical centre:
 - (a) the medical and professional services director of that centre;
 - (b) the medical and professional services director of the Santé Québec territorial institution in whose territory the centre is situated;
- (4) a family medicine group:
 - (a) the physician remunerated for the performance of the administrative tasks required for the management of that environment;
 - (b) the medical director of family medicine of the territorial department of family medicine governed by the Act respecting the governance of the health and social services system (chapter G-1.021) in whose territory the family medicine group is situated; and
- (5) another practice environment:
 - (a) the physician appointed under section 144;
 - (b) the medical and professional services director of the Santé Québec territorial institution in whose territory the practice environment is situated.

For the purposes of subparagraph 4 of the first paragraph, a private health facility is a family medicine group, in a case where the physicians who provide insured services there benefit from a program established under section 10.4 of the Act respecting the Ministère de la Santé et des Services sociaux (chapter M-19.2), amended by section 100 of this Act, to promote the practice of family medicine in groups in a multidisciplinary practice environment or from a program referred to in section 10 of this Act.

The supervisor referred to in subparagraph *b* of subparagraph 1 of the first paragraph is, with respect to the functions conferred by this division on the supervisor in that capacity, under the responsibility of the medical and professional services director of the institution within which the department referred to in that subparagraph is formed.

The supervisor referred to in subparagraph *b* of subparagraph 4 of the first paragraph is, with respect to the functions conferred by this division on the supervisor in that capacity, under the responsibility of the medical and professional services director of the institution to which the territorial department of family medicine referred to in that subparagraph is attached.

143. For the purposes of the provisions of this division, the executive director of the Nunavik Regional Board of Health and Social Services exercises the functions conferred on the medical and professional services director with respect to a practice environment situated in the territory of that Board. The medical and professional services director of the territorial institution whose territory is contiguous with the territory referred to in section 530.89 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2) exercises, in that latter territory, the functions and powers conferred on that director by this division.

144. The physicians who practise in a practice environment referred to in subparagraph 5 of the first paragraph of section 142 must appoint a physician from among them to act as person responsible for professional activities.

Failure to make that appointment within 30 days of the date on which the provisions of this division become applicable to that environment is deemed to constitute a concerted action referred to in section 131.

145. The documents drafted or received by a person responsible for professional activities, a supervisor, a medical and professional services director or the national inspector, in the exercise of the functions conferred on them by this division, must be kept for a period of three years in the practice environment where they exercise their functions.

§2.—Functions and powers

146. The person responsible for professional activities in a practice environment exercises, in that capacity, the following functions in that environment:

(1) drawing up, for each week, a written schedule identifying, for each day of the week,

(a) the name of each of the physicians who will be required to engage in professional activity in that environment;

(b) the professional activity each of them will be required to engage in; and

(c) the time and place that activity is to be engaged in;

(2) informing each of the physicians whose name appears on the schedule of the information concerning them that is mentioned in it, allowing them to submit observations in that respect and, where the person responsible considers it necessary, modifying the schedule accordingly;

(3) seeing to it that the physicians who practise in that practice environment comply with the provisions of subdivision 3 and, where applicable, identifying any failure to comply with one of those provisions by any of them; and

(4) disclosing the failures identified to the supervisor of the person responsible for professional activities.

147. The person responsible for professional activities in a practice environment, when drawing up a schedule under section 146, must ensure that it does not have the effect of

(1) stopping, reducing or slowing down the provision of services in the field of health and social services in the practice environment;

(2) negatively affecting access to or the quality of services in the field of health and social services; or

(3) slowing down or otherwise hampering the proper conduct of the training path for resource persons in the field of health and social services.

148. The supervisor exercises, in that capacity, the following functions:

(1) deciding on the application of the measures provided for in section 158 with respect to a failure by a physician to comply with one of the provisions of subdivision 3, where the failure is identified by the supervisor in exercising the functions provided for in paragraph 2 or where the failure to comply is disclosed by a person responsible for professional activities who is under the supervisor's responsibility;

(2) seeing to it that the persons responsible for professional activities who are under the supervisor's responsibility comply with the provisions of subdivision 3 and, where applicable, identifying any failure by any of them to comply with those provisions; and

(3) in the case of a supervisor referred to in subparagraph 1 or 4 of the first paragraph of section 142, disclosing the failures identified under paragraph 2 to the medical and professional services director responsible for the supervisor.

149. The medical and professional services director exercises the following functions:

(1) deciding on the application of the measures provided for in section 158 with respect to a failure to comply with any of the provisions of subdivision 3 in the following cases:

(a) for a failure to comply on the part of a person responsible for professional activities that the director has identified in exercising the functions conferred by paragraph 2 of section 148 on the director as supervisor or disclosed to the director under paragraph 3 of that section; and

(b) for a failure to comply on the part of a physician or a person responsible for professional activities that the director has identified in exercising the functions provided for in paragraph 2;

(2) seeing to it that the supervisors referred to in subparagraph 1 or 4 of the first paragraph of section 142 who are under the director's responsibility comply with the provisions of subdivision 3 and, where applicable, identifying any failure by any of them to comply with those provisions; and

(3) disclosing the failures identified under paragraph 2 to the national inspector.

150. The national inspector exercises the following functions:

(1) seeing to it that the medical and professional services directors comply with the provisions of subdivision 3 and, where applicable, identifying any failure by any of them to comply with those provisions;

(2) deciding on the application of the measures provided for in section 158 with respect to the following failures to comply:

(a) a failure to comply identified under paragraph 1;

(b) a failure to comply disclosed to the national inspector under paragraph 3 of section 149; and

(c) a failure to comply, by a physician, a person responsible for professional activities or a supervisor other than a medical and professional services director, with any of the provisions of subdivision 3, in the case of a failure identified by the national inspector in the exercise of the functions provided for in paragraph 1.

151. A person responsible for professional activities in a practice environment may request that any physician who practises in that environment assist the person responsible in the exercise of their functions or that the physician communicate to the person responsible any information or document necessary for the exercise of those functions.

A supervisor, a medical and professional services director or the national inspector may also make such a request to any physician whose failures to comply they have the function of identifying in the exercise of the functions conferred on them by this division, including where the physician exercises the functions of a person responsible for professional activities, a supervisor or a medical and professional services director.

§3.—*Prohibitions and obligations applicable to physicians
and groups representative of physicians*

152. A physician on whom a function referred to in section 146, 148 or 149 is conferred must exercise it in full, properly and without delay. That function is deemed to be part of the physician's professional activities.

A physician whose name appears on the schedule drawn up under paragraph 1 of section 146 must exercise the professional activities identified on the schedule in accordance with the particulars stated on it.

No physician may, while engaging in those activities,

(1) reduce or slow down their professional activity;

(2) negatively affect access to or the quality of services in the field of health and social services; or

(3) slow down or otherwise hamper the proper conduct of the training path for resource persons in the field of health and social services, in particular by failing to discharge their obligations in that regard or unexpectedly ending their participation in such a path.

153. A physician is required to comply with any request made to them under section 151.

154. A group representative of physicians must take the appropriate means to induce the physicians it represents to diligently comply with the provisions of this division, in particular where a person responsible for professional activities, a supervisor or a medical and professional services director is concerned.

155. It is prohibited for a group representative of physicians to undertake or continue an action if the action involves a failure to comply with section 152 or 153 or incites or induces a physician to commit such a failure.

§4.—*Application of measures with respect to a failure to comply*

I.—*Disclosure and notice of non-compliance*

156. A person having the function of disclosing a failure to comply must, each time they identify such a failure to comply, send to the person responsible for them, as soon as possible and in writing, the following information:

(1) the name of the author of the failure to comply;

(2) the provision concerned by the failure to comply;

(3) the date of the failure to comply; and

(4) where applicable, the place where, in accordance with the schedule drawn up under paragraph 1 of section 146, the physician was required to engage in the professional activity that the physician failed to engage in.

157. A person having the function of deciding on the application of the measures provided for in section 158 must send to the author of the failure to comply a written notice of non-compliance containing the information referred to in paragraphs 1 to 4 of section 156.

The notice must also state that the author of the failure to comply may, within five days of receiving the notice, demonstrate, in writing, that serious reasons beyond their control justify the failure to comply.

158. On the expiry of the time limit indicated in the notice of non-compliance, the person having the function of deciding on the application of the measures with respect to the failure to comply stated in the notice must determine whether serious reasons beyond the control of the author of the failure that justify the failure to comply have been demonstrated to the person's satisfaction.

If of the opinion that such is the case, the person excuses the author of the failure to comply. Otherwise,

(1) the person sends a reproduction of the notice of non-compliance to the Régie de l'assurance maladie du Québec and informs the physician concerned; and

(2) if the failure to comply was committed by a person responsible for professional activities, a supervisor or a medical and professional services director in the exercise of their functions under this division,

(a) the person relieves the person responsible, supervisor or director of their functions; and

(b) the person designates, to exercise those functions, a person whose services may be retained for that purpose from among the persons appearing on the list drawn up under section 162.

The decision and the reasons justifying it must be recorded in writing and sent to the author of the failure to comply.

Before relieving the medical and professional services director of a health and social services institution of their functions under this division, the national inspector must notify the most senior officer of the institution.

II. — *Reduction of salary*

159. A physician subject to a notice of non-compliance sent to the Régie de l'assurance maladie du Québec under section 158 is required to pay to the Régie, for each day or part of a day the failure to comply mentioned in the notice lasted, an amount corresponding to 40% of the following amount:

(1) in the case of a general practitioner, the amount of their weekly average remuneration established in accordance with the provisions of Schedule XVI – Programme d'allocation de congé de maternité ou d'adoption au bénéfice du médecin rémunéré à l'acte, à tarif horaire, à la vacation ou au per diem to the Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des Médecins omnipraticiens du Québec, as those provisions read on (*insert the date of assent to this Act*); and

(2) in the case of a medical specialist, the amount of their average weekly practice earnings established in accordance with the provisions of Schedule 43, concerning the establishment of a parental leave program for medical specialists, to the Accord-cadre entre le ministre de la Santé et des Services sociaux et la Fédération des médecins spécialistes du Québec aux fins l'application de la Loi sur l'assurance maladie, as those provisions read on (*insert the date of assent to this Act*).

160. Where the notice of non-compliance sent to the Régie de l'assurance maladie du Québec under section 158 states the failure of a physician to engage in a professional activity identified in the schedule drawn up under paragraph 1 of section 146 at the place identified in the schedule, the physician is also required to pay to the Régie the cost it assumed for services the physician provided elsewhere than at that place on the date on which the failure occurred.

III. — *Person designated to exercise the functions of a person relieved of them*

161. A person designated under the third paragraph of section 158 to exercise the functions of which a person responsible for professional activities, a supervisor or a medical and professional services director was relieved has the powers conferred by this division on the person whose functions the designated person exercises.

The operator of the practice environment in which the designated person is to exercise functions must, at the latter's request, make available to the designated person the room and equipment the person considers necessary for the exercise of those functions.

162. Santé Québec must draw up a list of persons whose services are retained in the case where those persons are designated under section 158.

Santé Québec remunerates the person designated under section 158. It also pays the other costs necessary for retaining the person's services, except the costs arising from a request made under the second paragraph of section 161 concerning an environment of which it is not the operator.

163. Where a physician is relieved of the exercise of the functions conferred on the physician by this division, the group representative of physicians that represents the physician is required to reimburse the sums incurred by Santé Québec to retain the services of the person designated to exercise those functions. Where more than one such group represents the physician, those groups are solidarily liable for the reimbursement.

A group representative of physicians may be relieved of that liability if it shows that it took the appropriate means to prevent the failure to comply that led to the application of the measure referred to in the first paragraph.

DIVISION IV

RESPONSIBILITIES OF UNIVERSITIES IN CONTINUITY OF PROVISION OF THE PROFESSIONAL ACADEMIC OR RESEARCH ACTIVITIES OF PHYSICIANS

164. Every university with a faculty of medicine, its officers and its representatives must contribute to physicians resuming and continuing their professional activities at the university.

For that purpose, they must take the appropriate means to ensure that academic and research activities are provided or continue to be provided to all the students entitled to them in the training paths for resource persons in the field of health and social services, where those activities are provided by physicians.

165. No one may, by an act or omission, interfere with a student's right to be provided the academic and research activities referred to in the second paragraph of section 164, obstruct or interfere with the resumption or continuation of those activities, or contribute, directly or indirectly, to the slowing down, altering or delaying of their resumption or continuation.

166. As soon as a university finds that it is impossible for it to provide the academic and research activities referred to in the second paragraph of section 164 to all or part of the students entitled to them, it must, without delay, so report to the Minister and the Minister of Higher Education, Research, Science and Technology, indicating, in particular, the circumstances that have led to such a situation, the name of any person who has contributed to that impossibility, the groups of students affected and any other information useful for the purposes of this Act.

167. The Minister or the Minister of Higher Education, Research, Science and Technology may retain part of the amount of a subsidy that the Minister, as applicable, has granted to a university referred to in section 164, for its faculty of medicine, where of the opinion that the university is not taking the usual and appropriate means to ensure that the academic and research activities referred to in that section are provided.

DIVISION V

MODES OF PARTICIPATION IN A FAILURE TO COMPLY

168. Any person or group fails to comply with the provisions of subdivision 1 of Division II, subdivision 3 of Division III or section 165 where, by an act or omission, the person or group helps another person or group to commit such a failure.

Any person or group also fails to comply with those provisions where, by encouragement, advice, consent, authorization or order, the person or group incites or induces another person or group to commit such a failure.

The fact that no means or method to carry out the failure to comply was proposed or that the failure to comply was committed otherwise than as proposed does not constitute a defence.

DIVISION VI

INSPECTION AND INVESTIGATION

169. The Minister may authorize any person to act as an inspector for the purpose of verifying compliance with this chapter.

To that end, the inspector may

(1) enter, at any reasonable time, any place where a physician exercises functions or carries on activities; and

(2) require the persons present to provide any information relating to the functions exercised or activities carried on by the physicians and to communicate any related document for examination or reproduction.

Any person who has custody, possession or control of the documents referred to in this section must, on request, communicate them to the inspector and facilitate their examination.

Despite subparagraph 1 of the second paragraph, no inspector may enter a room where the physician is providing medical services to a patient in the context of a therapeutic relationship. The inspector may, however, require any physician present to make themselves available, within the time set by the inspector, to provide any document or information the inspector has the right to require.

170. An inspector may, by a request delivered by any means that allows proof of receipt at a specific time, require any person to communicate, within the time and according to the conditions specified by the inspector, any information or document relating to the application of the provisions of this chapter.

171. The national inspector has, by virtue of office, the powers set out in sections 169 and 170.

The national inspector may delegate the functions and powers conferred on the national inspector by this chapter to a person who is part of the administrative unit formed under section 749 of the Act respecting the governance of the health and social services system (chapter G-1.021).

172. The Minister may designate a person to investigate any matter relating to the application of this chapter.

In the context of an investigation other than an investigation relating to an offence under Division X, the investigator has the powers and immunity of commissioners appointed under the Act respecting public inquiry commissions (chapter C-37), except the power to order imprisonment.

173. The investigator may prohibit a person from communicating any information related to an investigation to anyone except to the person's lawyer.

174. Within the scope of an inspection or investigation, no person may refuse to communicate to the inspector or investigator any information or document contained in the record of an insured person within the meaning of the Health Insurance Act (chapter A-29), or any financial document or information concerning the activities carried on by a physician.

175. Inspectors or investigators must, on request, identify themselves and produce a certificate of authority.

176. No judicial proceedings may be brought against an inspector or investigator for an act or omission in good faith in the exercise of their functions.

DIVISION VII

DISCLOSURE, COLLABORATION AND PROTECTION AGAINST REPRISALS

177. Any person may, at any time, disclose to an inspector, an investigator, the syndic of the Collège des médecins du Québec or the national inspector any information that could show

(1) that a failure to comply with a provision of subdivision 1 of Division II, subdivision 3 of Division III or section 165 has been committed or is about to be committed, or that the person has been asked to commit such a failure; or

(2) that a person or group is failing to comply with an order made under sections 135.

The first paragraph applies despite the provisions on the communication of information provided for in the Act respecting the protection of personal information in the private sector (chapter P-39.1) and the Act respecting Access to documents held by public bodies and the Protection of personal information (chapter A-2.1), except those provided for in section 33 of the latter Act. It also applies despite any other communication restrictions under a law and any duty of confidentiality or loyalty that may be binding on a person, including toward an employer or, if applicable, a client.

However, the lifting of professional secrecy authorized under this section does not apply to professional secrecy between a lawyer or a notary and a client.

178. It is prohibited to take reprisals or attempt to take reprisals in any manner whatsoever against a person on the ground that the person has, in good faith, made a disclosure or cooperated in an inspection or investigation. It is also prohibited to threaten to take a reprisal against a person so that the person will abstain from making a disclosure or cooperating in an inspection or investigation.

Sections 135 to 140 apply to a failure to comply with the first paragraph as if it were a failure to comply with the provisions of subdivision 1 of Division II.

179. No civil action may be instituted due to or as a consequence of a disclosure made in good faith under this division.

180. An inspector, an investigator, the syndic or the national inspector may not be compelled to disclose the information disclosed to them under section 177 or the identity of a person making such a disclosure or cooperating in an inspection or investigation.

DIVISION VIII

REPARATION AND SANCTIONS

§1.—*Reparation*

181. Any person who suffers injury due to a physician's participation in a concerted action referred to in section 131 or due to a failure to comply with section 152 that has not been excused may apply to the court to obtain reparation from the physician concerned or from the group representative of physicians that represents the physician.

A group representative of physicians is not required to make reparation for that injury if it shows that it took the appropriate means to prevent the concerted action or failure to comply.

182. A university referred to in section 164 is responsible for injury caused on the occasion of a failure to comply with that section unless it proves that it took the appropriate means to ensure that the academic and research activities referred to in that section are provided.

§2.—*Disciplinary sanctions*

183. A physician commits an act derogatory to the dignity of the physician's profession if the physician

- (1) participates in a concerted action referred to in section 131;
- (2) does not comply with an order rendered under section 135; or
- (3) contravenes the first paragraph of section 178.

184. The disciplinary council of the Collège des Médecins du Québec imposes on a physician found guilty of an act derogatory to the dignity of the physician's profession that is referred to in section 183 at least one of the sanctions referred to in subparagraphs *b*, *c* and *e* to *g* of section 156 of the Professional Code (chapter C-26).

A certified copy of the decision of the Administrative Tribunal of Québec concluding that there has been a failure to comply referred to in paragraph 1 of section 183 and having become final is proof, before the disciplinary council of the Collège des Médecins, of the failure to comply and, if applicable, of the facts stated in it. The same applies to a decision of the Superior Court that, under section 136, concludes that there has been a failure to comply referred to in section 183 and has become final.

§3. — *Years of practice*

185. The number of years of practice of any physician who participates in a concerted action referred to in section 131 is reduced, for the purposes of the provisions of sections 467 to 483 of the Act respecting the governance of the health and social services system (chapter G-1.021) or of sections 360 to 366.1 or 376 to 379 of the Act respecting health services and social services for the Inuit and Naskapi (chapter S-4.2), as applicable, and of the provisions of the agreements to which those provisions refer, at the rate of one half-year for every day the participation continues.

The Minister determines the number of years of practice to be subtracted under the first paragraph and notifies the physician concerned of the Minister's decision. The Minister sends a reproduction of the decision to the territorial department of family medicine or the territorial department of specialized medicine, as applicable, to which the physician belongs.

If the number of years or of fractions of years of practice of the physician is less than the total number of years by which it must be reduced under the first paragraph, the reduction in the number of years of practice is equal to the number of years or fractions of years acquired.

186. Within 30 days of receiving the Minister's decision, the territorial department of family medicine or the territorial department of specialized medicine, as applicable, must send to the physician concerned a notice informing the physician of the effects of the decision on each of the following aspects:

- (1) the specific medical activities the physician must undertake to exercise; and
- (2) the maintaining, modification or revocation of the notice of the physician's compliance with the territorial medical staffing plans or the regional medical staffing plans, as applicable.

A reproduction of that notice must be sent to the Minister and the Régie de l'assurance maladie du Québec.

Section 445.1 of the Act respecting the governance of the health and social services system (chapter G-1.021), enacted by section 94 of this Act, applies, with the necessary modifications, where the supervisory committee of a territorial department repeatedly or continuously fails to exercise the functions set out in the first paragraph in full, properly and without delay.

§4.—*Deduction at source*

187. If the Minister finds that a group representative of physicians has failed to comply with section 133 or 155, the Minister may require the Régie de l'assurance maladie du Québec to cease deducting any union assessment or special assessment or any other amount in lieu of such an assessment that the Régie should withhold under an agreement to the application of which the physicians represented by that group are subject.

The cessation lasts for a period equal to 12 weeks per day or part of a day the failure to comply continues.

The Minister notifies the decision made under the first paragraph to the group concerned.

DIVISION IX

RECOVERY AND PROCEEDINGS

§1.—*Recovery*

188. The Régie de l'assurance maladie du Québec may recover from a physician, by compensation or otherwise, the sums the physician is required to pay under section 159 or 160.

Before rendering its decision, the Régie sends to the physician a prior notice indicating the amount claimed, the grounds for its exigibility and the terms of reimbursement that may be applied and grants the physician at least 30 days to submit observations. On the expiry of the 30-day period, the Régie notifies its decision to the physician in writing, with reasons.

The recovery of the sums owed under section 159 or 160 is prescribed by 90 days from the receipt by the Régie of the notice of non-compliance referred to in those sections.

Following a decision rendered under the first paragraph, sections 22.4 and 52.1 of the Health Insurance Act (chapter A-29) apply, with the necessary modifications, to the sums that are the subject of the decision.

189. Where a physician does not contest a decision rendered under section 188 and the Régie de l'assurance maladie du Québec cannot recover the amount owed by compensation, the Régie may, at the expiry of the 60-day period for contesting the decision, issue a certificate stating the name and address of the debtor and attesting the amount owed and the debtor's failure to contest the decision. On the filing of the certificate with the office of the Superior Court or the Court of Québec, according to their respective jurisdictions, the decision becomes enforceable as if it were a final judgment of that court not subject to appeal and has all the effects of such a judgment.

The second paragraph of section 18.3.2 of the Health Insurance Act (chapter A-29) applies, with the necessary modifications, to the amount owed by the debtor.

190. The sums recovered under section 188 are paid by the Régie de l'assurance maladie du Québec to a registered charity within the meaning of the Taxation Act (chapter I-3) designated by the Government.

191. Santé Québec may recover from a group representative of physicians the amounts that it is required to pay under section 163.

Before rendering its decision, Santé Québec sends to the group a prior notice indicating the amount claimed, the grounds for its exigibility and the terms of reimbursement that may be applied and grants it at least 30 days to submit observations. On the expiry of the 30-day period, Santé Québec notifies its decision to the group in writing, with reasons.

The recovery of the sums owed under section 163 is prescribed by 60 months from the date on which the sums were incurred by Santé Québec. Those sums bear interest, at the rate provided for in the first paragraph of section 28 of the Fiscal Administration Act (chapter A-6.002), from the 31st day after notification of the decision.

192. A group representative of physicians that is subject to a decision rendered under section 191 is required to pay a recovery charge, in the cases and on the conditions determined by regulation of Santé Québec, in the amount it prescribes.

193. Sections 805 to 810 of the Act respecting the governance of the health and social services system (G-1.021) apply to the recovery of the sums owed under section 163 of this Act, with the following modifications and any other necessary modifications:

(1) a reference to the party responsible for the failure to comply is a reference to the group representative of physicians;

(2) a reference to a monetary administrative penalty is a reference to the sums owed under section 163 of this Act that are the subject of a decision made under section 191 of this Act; and

(3) a reference to the decision to impose the penalty is a reference to the decision rendered under section 190 of this Act.

194. After issuing the recovery certificate under section 808 of the Act respecting the governance of the health and social services system (G-1.021), the amount of any union assessment or special assessment or any other amount in lieu of such an assessment, which the Régie de l'assurance maladie du Québec must withhold under an agreement to the application of which the

physicians represented by a group covered by a decision rendered under section 191 are subject, may, at the request of Santé Québec, be allocated to the payment of the amount indicated in the certificate.

In such a case, the Board

- (1) first makes the allocation provided for in the first paragraph, if applicable;
- (2) then informs Santé Québec of the amount allocated to the payment of the amount indicated in the recovery certificate;
- (3) pays the balance of the assessments or of other amounts standing in lieu of them to the group entitled to it; and
- (4) sends to that group, whether or not it receives such a payment, a notice detailing the amounts withheld.

§2.—*Review*

195. A person concerned by a decision rendered under section 158 may, within 30 days of receiving it, apply to Santé Québec for a review.

Within 30 days of receiving the application for review, Santé Québec reviews the case and renders a decision with reasons. It notifies the person concerned of the decision and of their right to contest it before the Administrative Tribunal of Québec as well as of the time limit for bringing such a proceeding. It sends a reproduction of the decision to the Régie de l'assurance maladie du Québec.

The persons responsible for the review are designated by Santé Québec; where applicable, they must not come under the same administrative authority as the person who rendered the contested decision.

§3.—*Contestation proceeding*

196. A person or group concerned by a decision rendered under section 134, 187, 188, 191 or 195 may, within 30 days of its notification, contest the decision before the Administrative Tribunal of Québec.

Moreover, a person concerned by a decision rendered under section 158 may contest before the Administrative Tribunal of Québec the decision whose review the person applied for if Santé Québec did not dispose of the application within 30 days following its receipt. However, that time limit runs from the date on which the person presented observations or produced documents if the person requested more time for either of those purposes.

Contestation does not suspend the execution of the contested decision. At any time during the proceedings, the decider before which the contestation proceedings are brought may, with the parties' consent, render judgment on the face of the record.

The burden of proof that the contested decision is ill-founded is on the applicant.

197. The contestation of a decision rendered under section 188 concerning the recovery of the sums owed under section 159 or 160 pertains only to the determination of the amount the physician is required to pay to the Régie de l'assurance maladie du Québec under those sections.

198. For the purposes of a proceeding on a decision rendered under section 195, the Régie de l'assurance maladie du Québec must be impleaded and the Administrative Tribunal of Québec may only confirm or quash the contested decision.

§4.— *Other proceedings*

199. A physician is entitled to recognition of the years or fractions of years of practice the physician has lost by the effect of the application of section 185 if the physician shows that:

(1) the physician did not perform any action having one of the effects listed in the first paragraph of section 131; or

(2) the physician was prevented from complying with the provisions of section 131 despite having taken the appropriate means to comply with them, and the physician's action contravening them was not part of any concerted action.

200. A person to whom a dispute concerning the application of section 186 or 199 is referred for arbitration may only confirm or quash the contested decision. The person must do so solely on the basis of section 199.

DIVISION X

PENAL PROVISIONS

201. Anyone who contravenes a provision of subdivision 1 of Division II or of sections 154, 155, 165 or 178 is liable to the following fines for each day or part of a day the offence continues:

(1) \$200 to \$1,000 in the case of a person other than a person referred to in paragraph 2 or 3;

(2) \$4,000 to \$20,000 in the case of a physician;

(3) \$28,000 to \$140,000 in the case of an officer, employee or representative of a group representative of physicians; or

(4) \$100,000 to \$500,000 in the case of a group.

For any subsequent offence, the minimum and maximum fines prescribed in this section are doubled.

202. Anyone who does any of the following is liable to a fine of \$5,000 to \$30,000 in the case of a natural person and \$15,000 to \$100,000 in any other case:

(1) hinders or attempts to hinder

(a) a person responsible for professional activities, a supervisor, a medical and professional services director, the national inspector or the latter's delegatee in the exercise of the responsibilities entrusted to them by subdivisions 2 and 3 of Division III; or

(b) an inspector or an investigator in the exercise of their functions entrusted to them by Division VI;

(2) communicates a false or misleading document or information, refuses to provide a document or information they must send, conceals a document or information from a person referred to in subparagraph 1, or destroys a document or information requested by that person or a document or information that they are required to keep under the law;

(3) refuses or neglects to obey any order that an inspector or investigator may give under this Act;

(4) by an act or omission, helps a person to commit an offence under subparagraph 1, 2 or 3; or

(5) by encouragement, advice, consent, authorization or order, incites or induces another person to commit an offence under subparagraph 1, 2 or 3.

For a subsequent offence, the minimum and maximum fines prescribed in this section are doubled.

203. Without limiting the scope of section 168, a person or group that, by encouragement, advice, consent, authorization or order, incites or induces another person or group to commit an offence is guilty of any other offence that other person or group commits, if the person or group knew or should have known that their conduct would probably result in the commission of the offences.

204. In penal proceedings under this division, the status of member of the Ordre des médecins du Québec may be proved by the filing of a copy of the roll of that Order or of an extract from it, certified true by the secretary of the Order or by another person designated for that purpose by the Order. Likewise, the status of physician subject to the application of an agreement may be proved by the filing of the physician's registration sheet kept by the Régie de l'assurance

maladie du Québec and certified true by the secretary of the Régie or by another person designated for that purpose by the president and chief executive officer of the Régie.

DIVISION XI

SPECIAL TRANSITIONAL PROVISIONS

205. The first regulation made by the Minister before (*insert the date that is one year after the date of assent to this Act*) for the purposes of the first paragraph of section 112 or section 117 may, despite section 11 of the Regulations Act (chapter R-18.1), be made on the expiry of 10 days after the publication of the draft regulation in the *Gazette officielle du Québec*. Despite section 17 of that Act, the regulation comes into force on the day of its publication in the *Gazette officielle du Québec* or any later date indicated in it.

206. Until the date on which Divisions II and III of Chapter VIII cease to have effect under the first paragraph of section 210, the social affairs division of the Administrative Tribunal of Québec is also charged with making determinations, as concerns health services and social services, in respect of the proceedings brought under section 196 of this Act. Proceedings are heard and determined by a single member who is a lawyer or notary.

207. The Administrative Tribunal of Québec remains competent with regard to proceedings brought under section 196 and resulting from events that occurred before the date on which Divisions II and III of Chapter VIII cease to have effect under the first paragraph of section 210.

CHAPTER IX

TRANSITIONAL, MISCELLANEOUS AND FINAL PROVISIONS

208. Despite section 19 of the Health Insurance Act (chapter A-29) and any provision of an agreement, if the Minister is of the opinion that certain amendments to an agreement would improve access to insured services within the meaning of that Act and that an agreement cannot be reached on the amendments with the representative body concerned within a time the Minister considers acceptable, the Minister may make the amendments, with the approval of the Conseil du trésor. That time may not be less than 60 days.

Those amendments bind the parties and apply from the date of their publication on the website of the Régie de l'assurance maladie du Québec. They are not subject to the Regulations Act (chapter R-18.1).

209. The provisions of this Act prevail over any conflicting provisions of any agreement entered into under section 19 of the Health Insurance Act (chapter A-29).

Such an agreement entered into after (*insert the date of assent to this Act*) may, by an express provision, amend or replace any provision of Divisions I to III of Chapter VII of this Act, except the provisions of sections 112 and 117 that allow the Minister to make a regulation. However, such an agreement may, in the same manner, amend or replace any provision of such a regulation.

210. Sections 112 and 117, Divisions II to IV of Chapter VIII and section 207 cease to have effect on the date set by the Government or not later than 31 March 2028.

The provisions of a regulation made under section 112 or section 117 and the amendments made by the Minister under section 208, in force on the date those sections cease to have effect, remain in force until they are amended or replaced in accordance with an agreement entered into under section 19 of the Health Insurance Act (chapter A-29).

211. In addition to the regulatory powers provided for by this Act, the Government may, by regulation and before (*insert the date that is 18 months after the date of assent to this Act*), take any measure necessary or useful for the carrying out of this Act or the full achievement of its purposes.

Despite the provisions of sections 11 and 17 of the Regulations Act (chapter R-18.1), a regulation provided for in the first paragraph may be enacted on the expiry of 15 days from the publication of the draft regulation in the *Gazette officielle du Québec* and it comes into force on the date of its publication in the *Gazette officielle du Québec* or on any later date indicated in the regulation. The regulation may also, once published and if it so provides, apply from any date not prior to (*insert the date of assent to this Act*).

212. The provisions of Division II of Chapter VIII have effect since 8:00 a.m. on (*insert the date of introduction of this bill*). However, the provisions of Divisions VIII and X of that chapter do not apply with regard to a failure to comply with the provisions of Division II of that chapter that was committed before (*insert the date of assent to this Act*).

213. The Minister of Health and Social Services is responsible for the administration of this Act.

214. The provisions of this Act come into force on (*insert the date of assent to this Act*), except

(1) the provisions of sections 27, 28 and 30, paragraph 1 of section 32, section 33 insofar as it enacts sections 38.0.4 to 38.0.9 of the Health Insurance Act (chapter A-29), to the extent that section 29.35 of the Act to promote access to family medicine and specialized medicine services (chapter A-2.2), enacted by section 65 of this Act, refers to them, sections 35, 36 and 58, section 65 except insofar as it enacts sections 29.23 and 29.54 of the Act to promote access to family medicine and specialized medicine services, section 68, paragraph 1 of section 69, section 70, section 72 as regards the proceedings referred to in

section 29.48 of the Act to promote access to family medicine and specialized medicine services, enacted by section 65 of this Act, sections 73 to 78, paragraph 1 of section 79, sections 83 to 92, 119 and 121, paragraphs 2 and 3 of section 122, paragraph 9 of that section insofar as it puts an end to the provisions of paragraph 3.13.1 of the letter of agreement to which it refers, paragraph 14 of that section, paragraph 23 of that section insofar as it puts an end to the provisions of section 16 of the special agreement to which it refers, and paragraph 27 of that section, sections 126 and 128, and paragraphs 1 and 2 of section 129, which come into force on 1 January 2026;

(2) the provisions of sections 2 to 5, 7, 9 to 12, 14 to 18 and 20 to 23, subparagraphs *a* and *b* of paragraph 1 of section 24, paragraph 2 of that section as regards subparagraph *i.2* of the first paragraph of section 69 of the Health Insurance Act, sections 25, 26, 29 and 31, paragraph 2 of section 32, section 33 except insofar as it enacts the second paragraph of section 38.0.2 and section 38.0.13 of the Health Insurance Act, sections 43 to 47, 51 and 54 to 57, paragraph 2 of section 69, paragraph 2 of section 79, sections 112 to 118 and 120, section 122, except paragraphs 2 and 3, paragraph 9 insofar as it puts an end to the provisions of paragraph 3.13.1 of the letter of agreement to which it refers, paragraph 14, paragraph 23 insofar as it puts an end to the provisions of section 16 of the special agreement to which it refers, and paragraph 27 of that section, and section 127, which come into force on 1 April 2026;

(3) the provisions of section 19, subparagraph *c* of paragraph 1 of section 24, paragraph 2 of that section as regards subparagraphs *m.2* and *m.3* of the first paragraph of section 69 of the Health Insurance Act, section 33 insofar as it enacts the second paragraph of section 38.0.2 of the Health Insurance Act, section 34, and section 65 insofar as it enacts section 29.23 of the Act to promote access to family medicine and specialized medicine services, which come into force on 1 April 2028;

(4) the provisions of section 1, which come into force on the date of coming into force of subparagraph 7 of the second paragraph of section 76 of the Act respecting the governance of the health and social services system (G-1.021);

(5) the provisions of section 33 insofar as it enacts section 38.0.13 of the Health Insurance Act, which come into force on the date of coming into force of the first regulation made under that section 38.0.13;

(6) the provisions of sections 37 to 41, which come into force on the date of coming into force of the first regulation made under the second paragraph of section 22.0.0.0.2 of the Health Insurance Act, amended by section 38 of this Act;

(7) the provisions of section 65 insofar as it enacts section 29.54 of the Act to promote access to family medicine and specialized medicine services, which come into force on the date of coming into force of the first regulation made under that section 29.54;

(8) the provisions of section 71, which come into force on 1 January 2026 or on the date of coming into force of section 27 of the Act to promote access to family medicine and specialized medicine services, whichever is earlier;

(9) the provisions of section 72 as regards the proceedings provided for in section 27 of the Act to promote access to family medicine and specialized medicine services, which come into force on the date of coming into force of that section 27;

(10) the provisions of section 101, which come into force on the date of coming into force of section 4 of the Act to promote access to family medicine and specialized medicine services; and

(11) the provisions of sections 6 and 8, the second paragraph of section 50 and sections 105 and 141 to 163, which come into force on the date or dates to be set by the Government.

SCHEDULE I
(Sections 83 and 88 to 91)

OBJECTIVES TO IMPROVE ACCESS TO INSURED
MEDICAL SERVICES

CHAPTER I

NATIONAL OBJECTIVES

NATIONAL OBJECTIVE 1-A

Objective: 75% of users who show up to the emergency department of an institution's facility are taken in charge within 90 minutes from the moment triage of those users begins.

The level to assess achievement of this objective is, however, set at 45% on 1 January 2026. It then increases by 5 percentage points for each of the following six-month periods until it reaches 75%.

Indicator: Average time taken, during the evaluation period, for users who show up to the emergency department of an institution's facility to be taken in charge.

The moment a physician practising at the emergency department is assigned, as attending physician, to a user registered in that department corresponds to the moment the user is taken in charge at the emergency department.

Group of physicians concerned: All physicians.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 1-B

Objective: 77.5% of users who show up to the emergency department of an institution's facility are taken in charge within 90 minutes from the moment triage of those users begins.

The level to assess achievement of this objective is, however, set at 47.5% on 1 January 2026. It then increases by 5 percentage points for each of the following six-month periods until it reaches 77.5%.

Indicator: Average time taken, during the evaluation period, for users who show up to the emergency department of an institution's facility to be taken in charge.

The moment a physician practising at the emergency department is assigned, as attending physician, to a user registered in that department corresponds to the moment the user is taken in charge at the emergency department.

Group of physicians concerned: All physicians.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 1-C

Objective: 80% of users who show up to the emergency department of an institution's facility are taken in charge within 90 minutes from the moment triage of those users begins.

The level to assess achievement of this objective is, however, set at 50% on 1 January 2026. It then increases by 5 percentage points for each of the following six-month periods until it reaches 80%.

Indicator: Average time taken, during the evaluation period, for users who show up to the emergency department of an institution's facility to be taken in charge.

The moment a physician practising at the emergency department is assigned, as attending physician, to a user registered in that department corresponds to the moment the user is taken in charge at the emergency department.

Group of physicians concerned: All physicians.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 2

Objective: The average length of stay in the emergency department of an institution's facility does not exceed

(1) for users on stretchers: 14 hours; and

(2) for ambulatory users: 4 hours.

The level to assess achievement of the objective set out in subparagraph 1 of the first paragraph is, however, set at 16 hours 30 minutes on 1 January 2026. It is then reduced by 30 minutes for each of the following six-month periods until it reaches 14 hours.

The level to assess achievement of the objective set out in subparagraph 2 of the first paragraph is set at 4 hours 45 minutes on 1 January 2026. It is then reduced by 15 minutes for each of the following six-month periods until it reaches 4 hours.

Indicator: Average length of stay, during the evaluation period, of users in the emergency department of an institution's facility.

Group of physicians concerned: All physicians.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 5.

NATIONAL OBJECTIVE 3-A

Objective: 16.5 million appointment slots are made available per year.

Indicator: Number of appointment slots in family medicine made available during the evaluation period.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar years.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 3-B

Objective: 17 million appointment slots are made available per year.

Indicator: Number of appointment slots in family medicine made available during the evaluation period.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar years.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 3-C

Objective: 17.5 million appointment slots are made available per year.

Indicator: Number of appointment slots in family medicine made available during the evaluation period.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar years.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 4-A

Objective: In the facilities listed in Chapter IV of this Schedule, 90% of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) with respect to emergency care, obstetrics and hospitalization are performed.

Indicator: Percentage of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) performed, during the evaluation period, with respect to emergency care, obstetrics and hospitalization.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 4-B

Objective: In the facilities listed in Chapter IV of this Schedule, 95% of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) with respect to emergency care, obstetrics and hospitalization are performed.

Indicator: Percentage of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) performed, during the evaluation period, with respect to emergency care, obstetrics and hospitalization.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 4-C

Objective: In the facilities listed in Chapter IV of this Schedule, 98% of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) with respect to emergency care, obstetrics and hospitalization are performed.

Indicator: Percentage of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) performed, during the evaluation period, with respect to emergency care, obstetrics and hospitalization.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 4-D

Objective: In the facilities listed in Chapter IV of this Schedule, 100% of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) with respect to emergency care, obstetrics and hospitalization are performed.

Indicator: Percentage of the medical services provided for in the coverage plan referred to in paragraph 0.1 of section 449 of the Act respecting the governance of the health and social services system (chapter G-1.021) performed, during the evaluation period, with respect to emergency care, obstetrics and hospitalization.

Group of physicians concerned: All general practitioners.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 5

Objective: The waiting time for 90% of consultation requests is less than the time corresponding to the priority rating indicated by the referring physician as part of the mechanism for access to specialized medical services put in place by Santé Québec.

However, the level to assess achievement of this objective is set as follows for the periods listed below:

(1) if the time corresponding to the priority rating indicated by the referring physician as part of the mechanism for access to specialized medical services put in place by Santé Québec is 28 days or less,

(a) for the six-month period beginning on 1 January 2026, the waiting time for 55% of consultation requests is less than the time corresponding to the priority rating indicated by the physician;

(b) for the six-month period beginning on 1 July 2026, the waiting time for 65% of consultation requests is less than the time corresponding to the priority rating indicated by the physician;

(c) for the six-month period beginning on 1 January 2027, the waiting time for 75% of consultation requests is less than the time corresponding to the priority rating indicated by the physician; and

(d) for the six-month period beginning on 1 July 2027, the waiting time for 85% of consultation requests is less than the time corresponding to the priority rating indicated by the physician; and

(2) in any other case,

(a) for the six-month period beginning on 1 January 2026, the waiting time for 99% of consultation requests is not more than 24 months;

(b) for the six-month period beginning on 1 July 2026, the waiting time for 99% of consultation requests is not more than 18 months; and

(c) for the six-month period beginning on 1 January 2027, the waiting time for 99% of consultation requests is not more than 15 months.

Indicator: Percentage of consultation requests for which the waiting time, as at the last day of the evaluation period, is less than the time referred to in the objective.

Groups of physicians concerned: The groups composed, respectively, of the physicians of each specialty defined by the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26).

Evaluation intervals: Calendar quarters.

Number of shares assigned: 5.

NATIONAL OBJECTIVE 6-A

Objective: 97% of surgeries are performed within not more than 12 months after the surgery request.

The level to assess achievement of this objective is, however, set at 95% for the six-month period beginning on 1 January 2026.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 12 months after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;
- (14) all medical specialists in ophthalmology;
- (15) all medical specialists in otolaryngology–head and neck surgery; and
- (16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 6-B

Objective: 98% of surgeries are performed within not more than 12 months after the surgery request.

The level to assess achievement of this objective is, however, set at 96% for the six-month period beginning on 1 January 2026.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 12 months after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;
- (14) all medical specialists in ophthalmology;
- (15) all medical specialists in otolaryngology–head and neck surgery; and
- (16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 6-C

Objective: 99% of surgeries are performed within not more than 12 months after the surgery request.

The level to assess achievement of this objective is, however, set at 97% for the six-month period beginning on 1 January 2026.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 12 months after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;
- (14) all medical specialists in ophthalmology;
- (15) all medical specialists in otolaryngology–head and neck surgery; and
- (16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 7-A

Objective: 95% of oncology surgeries are performed within not more than 56 days after the surgery request.

The level to assess achievement of this objective is, however, set at 90% on 1 January 2026. It then increases by 2.5 percentage points for each of the following six-month periods until it reaches 95%.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 56 days after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;
- (14) all medical specialists in ophthalmology;
- (15) all medical specialists in otolaryngology–head and neck surgery; and

(16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 7-B

Objective: 97% of oncology surgeries are performed within not more than 56 days after the surgery request.

The level to assess achievement of this objective is, however, set at 92% on 1 January 2026. It then increases by 2.5 percentage points for each of the following six-month periods until it reaches 97%.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 56 days after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;
- (14) all medical specialists in ophthalmology;

- (15) all medical specialists in otolaryngology–head and neck surgery; and
- (16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 7-C

Objective: 99% of oncology surgeries are performed within not more than 56 days after the surgery request.

The level to assess achievement of this objective is, however, set at 95% on 1 January 2026. It then increases by 2 percentage points for each of the following six-month periods until it reaches 99%.

Indicator: Percentage of surgeries, from among those performed during the evaluation period, that are performed within not more than 56 days after the surgery request.

Groups of physicians concerned: The following groups:

- (1) all medical specialists in anesthesiology;
- (2) all medical specialists in surgery;
- (3) all medical specialists in cardiac surgery;
- (4) all medical specialists in colorectal surgery;
- (5) all medical specialists in general surgery;
- (6) all medical specialists in general oncology surgery;
- (7) all medical specialists in pediatric surgery;
- (8) all medical specialists in orthopedic surgery;
- (9) all medical specialists in plastic surgery;
- (10) all medical specialists in thoracic surgery;
- (11) all medical specialists in vascular surgery;
- (12) all medical specialists in neurosurgery;
- (13) all medical specialists in obstetrics and gynecology;

- (14) all medical specialists in ophthalmology;
- (15) all medical specialists in otolaryngology–head and neck surgery; and
- (16) all medical specialists in urology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 8-A

Objective: 90% of medical imaging examinations are interpreted within less than 5 days after the examination.

The level to assess achievement of this objective is, however, set at 80% on 1 January 2026. It then increases by 2.5 percentage points for each of the following six-month periods until it reaches 90%.

Indicator: Percentage of medical imaging examinations, from among those interpreted during the evaluation period, that are interpreted within less than 5 days after the examination.

Groups of physicians concerned: All physicians in the following specialties:

- (1) nuclear medicine;
- (2) radiation oncology; and
- (3) diagnostic radiology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 8-B

Objective: 92.5% of medical imaging examinations are interpreted within less than 5 days after the examination.

The level to assess achievement of this objective is, however, set at 82.5% on 1 January 2026. It then increases by 2.5 percentage points for each of the following six-month periods until it reaches 92.5%.

Indicator: Percentage of medical imaging examinations, from among those interpreted during the evaluation period, that are interpreted within less than 5 days after the examination.

Groups of physicians concerned: All physicians in the following specialties:

- (1) nuclear medicine;
- (2) radiation oncology; and
- (3) diagnostic radiology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 8-C

Objective: 95% of medical imaging examinations are interpreted within less than 5 days after the examination.

The level to assess achievement of this objective is, however, set at 85% on 1 January 2026. It then increases by 2.5 percentage points for each of the following six-month periods until it reaches 95%.

Indicator: Percentage of medical imaging examinations, from among those interpreted during the evaluation period, that are interpreted within less than 5 days after the examination.

Groups of physicians concerned: All physicians in the following specialties:

- (1) nuclear medicine;
- (2) radiation oncology; and
- (3) diagnostic radiology.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

NATIONAL OBJECTIVE 9-A

Objective: 90% of medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system (chapter G-1.021) are performed.

Indicator: Percentage of the medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system performed during the evaluation period.

Groups of physicians concerned: The groups composed, respectively, of the physicians of each specialty defined by the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26).

Evaluation intervals: Calendar quarters, as of 1 July 2026.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 9-B

Objective: 95% of medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system (chapter G-1.021) are performed.

Indicator: Percentage of the medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system performed during the evaluation period.

Groups of physicians concerned: The groups composed, respectively, of the physicians of each specialty defined by the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26).

Evaluation intervals: Calendar quarters, as of 1 July 2026.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 9-C

Objective: 98% of medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system (chapter G-1.021) are performed.

Indicator: Percentage of the medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system performed during the evaluation period.

Groups of physicians concerned: The groups composed, respectively, of the physicians of each specialty defined by the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26).

Evaluation intervals: Calendar quarters, as of 1 July 2026.

Number of shares assigned: 1.

NATIONAL OBJECTIVE 9-D

Objective: All medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system (chapter G-1.021) are performed.

Indicator: Percentage of the medical services provided for in the coverage plans approved under section 483.2 of the Act respecting the governance of the health and social services system performed during the evaluation period.

Groups of physicians concerned: The groups composed, respectively, of the physicians of each specialty defined by the Collège des médecins du Québec under subparagraph *e* of the first paragraph of section 94 of the Professional Code (chapter C-26).

Evaluation intervals: Calendar quarters, as of 1 July 2026.

Number of shares assigned: 2.

CHAPTER II

TERRITORIAL OBJECTIVES

TERRITORIAL OBJECTIVE 1-A

Objective: 90% of eligible persons, within the meaning of the sixth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), having a “healthy” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment within the meaning of the fourth paragraph of section 447 of that Act and 95% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

The level to assess achievement of this objective is, however, set as follows for the periods listed below:

(1) for the quarter beginning on 1 April 2026, 90% of eligible persons having a “major health condition” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician; and

(2) for the six-month period beginning on 1 July 2026, 90% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

Indicator: As at the last day of the evaluation period, percentage of affiliation with a practice environment, within the meaning of the fourth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), and, if applicable, of association with a physician of eligible persons, within the meaning of the sixth paragraph of that section, who have a vulnerability level referred to in the objective.

An eligible person is associated with a physician when, in that practice environment, the physician takes the primary responsibility for ensuring the longitudinal follow-up of the person's state of health and of the care the person receives.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine and who practise in a practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021).

Evaluation intervals: Calendar quarters, as of 1 April 2026.

Number of shares assigned: 1.

TERRITORIAL OBJECTIVE 1-B

Objective: 90% of eligible persons, within the meaning of the sixth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), having a “healthy” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment within the meaning of the fourth paragraph of section 447 of that Act and 95% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

The level to assess achievement of this objective is, however, set as follows for the periods listed below:

(1) for the quarter beginning on 1 April 2026, 92.5% of eligible persons having a “major health condition” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician; and

(2) for the six-month period beginning on 1 July 2026, 92.5% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

Indicator: As at the last day of the evaluation period, percentage of affiliation with a practice environment, within the meaning of the fourth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), and, if applicable, of association with a physician of eligible persons, within the meaning of the sixth paragraph of that section, who have a vulnerability level referred to in the objective.

An eligible person is associated with a physician when, in that practice environment, the physician takes the primary responsibility for ensuring the longitudinal follow-up of the person's state of health and of the care the person receives.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine and who practise in a practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021).

Evaluation intervals: Calendar quarters, as of 1 April 2026.

Number of shares assigned: 2.

TERRITORIAL OBJECTIVE 1-C

Objective: 90% of eligible persons, within the meaning of the sixth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), having a “healthy” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment within the meaning of the fourth paragraph of section 447 of that Act and 95% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

The level to assess achievement of this objective is, however, set as follows for the periods listed below:

(1) for the quarter beginning on 1 April 2026, 95% of eligible persons having a “major health condition” vulnerability level, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician; and

(2) for the six-month period beginning on 1 July 2026, 95% of eligible persons having a vulnerability level other than “healthy”, within the meaning of section 48 of this Act, are affiliated with a practice environment and associated with a physician.

Indicator: As at the last day of the evaluation period, percentage of affiliation with a practice environment, within the meaning of the fourth paragraph of section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021), and, if applicable, of association with a physician of eligible persons, within the meaning of the sixth paragraph of that section, who have a vulnerability level referred to in the objective.

An eligible person is associated with a physician when, in that practice environment, the physician takes the primary responsibility for ensuring the longitudinal follow-up of the person's state of health and of the care the person receives.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine and who practise in a practice environment referred to in section 447 of the Act respecting the governance of the health and social services system (chapter G-1.021).

Evaluation intervals: Calendar quarters, as of 1 April 2026.

Number of shares assigned: 2.

TERRITORIAL OBJECTIVE 2-A

Objective: For 98% of open beds in residential and long-term care centres, an on-call physician is able at all times to answer the requests concerning the users lodged there.

Indicator: Percentage of open beds in residential and long-term care centres for which an on-call physician is able at all times, during the evaluation period, to answer the requests concerning the users lodged there.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

TERRITORIAL OBJECTIVE 2-B

Objective: For 99% of open beds in residential and long-term care centres, an on-call physician is able at all times to answer the requests concerning the users lodged there.

Indicator: Percentage of open beds in residential and long-term care centres for which an on-call physician is able at all times, during the evaluation period, to answer the requests concerning the users lodged there.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

TERRITORIAL OBJECTIVE 2-C

Objective: For all open beds in residential and long-term care centres, an on-call physician is able at all times to answer the requests concerning the users lodged there.

Indicator: Percentage of open beds in residential and long-term care centres for which an on-call physician is able at all times, during the evaluation period, to answer the requests concerning the users lodged there.

Groups of physicians concerned: The groups composed, respectively, of the general practitioners who are members of each of the territorial departments of family medicine.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

CHAPTER III

LOCAL OBJECTIVE

LOCAL OBJECTIVE 1-A

Objective: The consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility are carried out within an average of less than 3 hours 10 minutes after the consultation request.

The level to assess achievement of this objective is, however, set at 4 hours 40 minutes on 1 January 2026. It is then reduced by 15 minutes for each of the following six-month periods until it reaches 3 hours 10 minutes.

Indicator: Average time taken, during the evaluation period, to perform the medical consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility.

Practice environments concerned: Every facility where a hospital centre is operated.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 1.

LOCAL OBJECTIVE 1-B

Objective: The consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility are carried out within an average of less than 3 hours 5 minutes after the consultation request.

The level to assess achievement of this objective is, however, set at 4 hours 35 minutes on 1 January 2026. It is then reduced by 15 minutes for each of the following six-month periods until it reaches 3 hours 5 minutes.

Indicator: Average time taken, during the evaluation period, to perform the medical consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility.

Practice environments concerned: Every facility where a hospital centre is operated.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

LOCAL OBJECTIVE 1-C

Objective: The consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility are carried out within an average of less than 3 hours after the consultation request.

The level to assess achievement of this objective is, however, set at 4 hours 30 minutes on 1 January 2026. It is then reduced by 15 minutes for each of the following six-month periods until it reaches 3 hours.

Indicator: Average time taken, during the evaluation period, to perform the medical consultations requested between 8 a.m. and 5 p.m. for a user in the emergency department of an institution's facility.

Practice environments concerned: Every facility where a hospital centre is operated.

Evaluation intervals: Calendar quarters.

Number of shares assigned: 2.

CHAPTER IV

FACILITIES TO WHICH NATIONAL OBJECTIVE 4 APPLIES

01 – CISSS DU BAS-SAINT-LAURENT

01 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE TROIS-PISTOLES

01 – CLSC DE POHÉNÉGAMOOK

01 – HÔPITAL D’AMQUI

01 – HÔPITAL DE MATANE

01 – HÔPITAL DE NOTRE-DAME-DU-LAC

01 – HÔPITAL NOTRE-DAME-DE-FATIMA

02 – CIUSSS DU SAGUENAY – LAC-SAINT-JEAN

02 – HÔPITAL D’ALMA

02 – HÔPITAL DE DOLBEAU-MISTASSINI

02 – HÔPITAL DE LA BAIE

02 – HÔPITAL ET CENTRE D’HÉBERGEMENT DE ROBERVAL

03 – CIUSSS DE LA CAPITALE-NATIONALE

03 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE SAINT-RAYMOND

03 – HÔPITAL ET CLSC DE LA MALBAIE

04 – CIUSSS DE LA MAURICIE-ET-DU-CENTRE-DU-QUÉBEC

04 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
AVELLIN-DALCOURT

04 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
CHRIST-ROI

04 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DU HAUT-SAINT-AURICE

04 – HÔPITAL SAINTE-CROIX

04 – HÔTEL-DIEU D’ARTHABASKA

05 – CIUSSS DE L'ESTRIE – CENTRE HOSPITALIER UNIVERSITAIRE
DE SHERBROOKE

05 – CENTRE DE SANTÉ ET DE SERVICES SOCIAUX DU GRANIT

05 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DES SOURCES

07 – CISSS DE L'OUTAOUAIS

07 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE MANSFIELD-ET-PONTEFRAC

07 – HÔPITAL ET CHSLD MÉMORIAL DE WAKEFIELD / WAKEFIELD
MEMORIAL HOSPITAL

08 – CISSS DE L'ABITIBI-TÉMISCAMINGUE

08 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE LA SARRE

08 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE TÉMISCAMING-KIPAWA

08 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE VILLE-MARIE

08 – HÔPITAL DE ROUYN-NORANDA

08 – HÔPITAL DE VAL-D'OR

09 – CISSS DE LA CÔTE-NORD

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE FERMONT

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE FORESTVILLE

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE LA BASSE-CÔTE-NORD

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE LA MINGANIE

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE PORT-CARTIER

09 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DES ESCOUMINS

09 – CLSC ET HÔPITAL LE ROYER

09 – CLSC NASKAPI

09 – HÔPITAL ET CLSC DE SEPT-ÎLES

10 – CENTRE RÉGIONAL DE SANTÉ ET DE SERVICES SOCIAUX DE LA
BAIE-JAMES

10 – CENTRE DE SANTÉ DE CHIBOUGAMAU

10 – CENTRE DE SANTÉ DE RADISSON

10 – CENTRE DE SANTÉ ISLE-DIEU

11 – CISSS DE LA GASPÉSIE

11 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE GRANDE-VALLÉE

11 – CLSC ET CENTRE DE SERVICES AMBULATOIRES DE
MURDOCHVILLE

11 – CLSC ET CENTRE DE SERVICES AMBULATOIRES DE PASPÉBIAC

11 – HÔPITAL DE CHANDLER

11 – HÔPITAL DE GASPÉ

11 – HÔPITAL ET CLSC DE SAINTE-ANNE-DES-MONTS

11 – HÔPITAL ET GROUPE DE MÉDECINE DE FAMILLE
UNIVERSITAIRE DE MARIA

11 – CISSS DES ÎLES

11 – HÔPITAL DE L'ARCHIPEL

15 – CISSS DES LAURENTIDES

15 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
D'ARGENTEUIL

15 – CENTRE MULTISERVICES DE SANTÉ ET DE SERVICES SOCIAUX
DE RIVIÈRE-ROUGE

15 – HÔPITAL DE MONT-LAURIER

16 – CISSS DE LA MONTRÉGIE-OUEST

16 – HÔPITAL BARRIE MEMORIAL / BARRIE MEMORIAL HOSPITAL