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Capitation Payment

Definition
Under the HMO agreement outlined in the Medical Service Agreement (MSA), physicians will receive a monthly capitation (cap) payment for every member that selects them as their Primary Care Physician (PCP). Cap is paid regardless of the number of times the member visits their PCP. Having an eligible member select a PCP within the IPA guarantees a monthly cap payment to the IPA. Capitation will continue to be paid for a member who is enrolled in a HMO approved Travel Benefit time period.

The capitation payment, which is made to the IPA by the 10th of each month, is a "net" capitation payment. The specific steps for calculating the net capitation payment are detailed below.

Calculation of Capitation Payment
BlueCap (current capitation system), calculates current and retroactive capitation amounts paid to the IPAs. The cap payment amount is derived from the Capitation Payment Exhibit listed in the MSA.

Current and retroactive calculations are listed in the Capitation Summary report. The Capitation Summary is available monthly to the IPA along with their cap check or emailed to the IPA if the IPA has an Electronic Funds Transfer (EFT) agreement. If the IPA has any questions about the calculation of its monthly capitation check, this Summary should be consulted first.

The Capitation Payment Summary Key
Use the following key to understand the HMO Capitation Payment Summary.

- **Month**: Month for which capitation is being paid
- **IPA Number and IPA NPI Number**: Identification number and the National Provider Identifier (NPI) of the IPA to whom capitation is being paid
- **Current and Retroactive Capitation**: Dollar amount of current and retroactive calculated capitation
- **Additional Adjustments/Payments**: Dollar amount (positive or negative) of manual adjustments to the month's capitation
- **Description**: A brief description of the Additional Adjustment/Payment
Sample HMO Capitation Payment Summary

BlueCross BlueShield of Illinois
P.O. Box 7344
Chicago, IL 60680-7344

Medical Group Name
Address, City, Zip, ST

CAPITATION SUMMARY
FOR THE MONTH OF JANUARY, 2019
EFT IDENTIFICATION
SUMMARY FOR PAYEE ID 7

<table>
<thead>
<tr>
<th>MEDICARE ADVANTAGE HMO</th>
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<tbody>
<tr>
<td>CURRENT AND RETROACTIVE CAPITATION</td>
</tr>
<tr>
<td>ADDITIONAL ADJUSTMENTS/PAYMENTS</td>
</tr>
<tr>
<td>TOTAL AMOUNT FOR CAPITATION PERIOD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDITIONAL ADJUSTMENTS/PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>NO EXTRA PAYMENTS OR ADJUSTMENTS FOR CAP PERIOD</td>
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Comparison of Capitation Payment Summary with the Eligibility List Summary

The Eligibility List Summary is a computer count of all active members as of the date the Eligibility List is generated.

To reconcile the current month’s capitation, check the following:

- Download the Capitation Reconciliation report from the Blue Access for ProvidersSM for the month in question. Sum the totals of the PCP_RETRO_CAP_AMT and PCP_CURR_CAP_AMT. Add the results of these two fields. The total should be equal to the Current and Retroactive Capitation total from the Capitation Summary.

The following rules apply regarding retroactive changes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limit (in member months)</th>
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</thead>
<tbody>
<tr>
<td>MA</td>
<td>Member Add:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>MC</td>
<td>Member Cancel:</td>
<td>Limited to 3 member months</td>
</tr>
<tr>
<td>TI</td>
<td>Transfer In:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>TO</td>
<td>Transfer Out:</td>
<td>Limited to 24 member months</td>
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<tr>
<td>RI</td>
<td>Reinstate:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>NC</td>
<td>Name Change:</td>
<td>Limited to 24 member months</td>
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<tr>
<td>BC</td>
<td>Date of Birth Change:</td>
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<tr>
<td>CC</td>
<td>Cancel Date Change:</td>
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<tr>
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<tr>
<td>HC</td>
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<tr>
<td>RA</td>
<td>Rate Adjustment:</td>
<td>Limited to 24 member months</td>
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</tbody>
</table>
Organ Transplant Services (Catastrophic) Claims

The HMO considers organ transplants as catastrophic. Group Approved services related to these conditions that are usually the IPA’s responsibility become the HMO’s responsibility. These situations are:

- Organ transplants
- Related pre-surgical laboratory and diagnostic tests performed by the designated transplant facility
- Follow-up within 365 days of the transplant, provided IPA obtained prior approval for organ transplant from the HMO

The HMO will pay the approved provider directly. Each claim must be stamped “Group Approved”. In addition, a note indicating the type of service “Pre-transplant” or “Transplant-related” must be written by the stamp. Use black or blue ink only, do not use a highlighter pen.

Quality Improvement Program

Overview

The HMO Quality Improvement Program (QIP) is intended to reward the IPA for maintaining high quality and patient satisfaction standards in the delivery of covered services as outlined in the MSA.

The HMO shall pay the IPA for participating in QI activities with payment based upon performance as specified below. QIP Clinical Measure performance thresholds will be established by the HMO on an annual basis. (Refer to your current year QIP).

Part D Prescription Drug Fund

The Prescription Drug Fund is determined annually and subject to the execution of the MSA. It is based on the relative performance of the IPA in judiciously managing the use of the prescription drug benefit.

Prescription drug usage and formulary usage will be reported to the IPA quarterly in the Top Prescribers Report in the D2 tool. This report is physician-specific for the top 150 prescribers for the IPA. It also calculates the total prescription drug and formulary usage for all prescribers in the IPA. The IPA will share with the HMO the net surplus or deficits, as applicable, of the HMO Part D fund as outlined in the MSA Capitation Payment Exhibit.

All prescription drug reports are based on monthly membership snapshots as submitted to the HMO by Prime Therapeutics and adjustments for retroactive members are not taken into consideration. Therefore, appeals based on retroactive membership adjustments are not permitted.

Copayments

Copayments are the payment for Covered Services that the Member may be responsible for paying each time a medical service is accessed as outlined in the Member’s Evidence of Coverage.

Types of out-of-pocket costs your member may pay for covered services, which can be referenced by reviewing the member’s annual Evidence of Coverage (EOC). The EOC is located and may be accessed through the plan documents on the BCBSIL.com website under Medicare Tools and Resources > Forms and Documents. See below for direct link. Please reference the member’s ID card for the specific plan type.


Coinsurance

Coinsurance is the percentage a member may pay of the total cost of certain medical services based on their plan type. Co-Insurance percentages may be referenced and is outlined in the Member’s Evidence of Coverage (EOC). The EOC is located and may be accessed through the plan documents on the BCBSIL.com website under Medicare Tools and Resources > Forms and Documents. See below for direct link. Please reference the member’s ID card for the specific plan type.

QMB
Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Members are asked to show proof of Medicaid or QMB eligibility at the time of a provider visit. QMB status may be identified in the monthly eligibility files. Please reference the MA HMO Membership section for identification instructions of a QMB Member.