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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 actually 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 on a monthly basis 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

CAPITATION SUMMARY
FOR THE MONTH OF DECEMBER, 2009

SUMMARY FOR PAYEE ID 123  NPI# 1234567890

HMO 1

CURRENT AND RETROACTIVE CAPITATION : $ 9,409.45
ADDITIONAL ADJUSTMENTS/PAYMENTS : $ .00
TOTAL AMOUNT FOR CAPITATION PERIOD : $ 9,409.45

ADDITIONAL ADJUSTMENTS/PAYMENTS

DESCRIPTION
NO EXTRA PAYMENTS OR ADJUSTMENTS FOR CAP PERIOD

ADJUSTMENT AMOUNT
$ .00

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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.

In order 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>Change Type</th>
<th>Limitation</th>
</tr>
</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>
</tr>
<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>
</tr>
<tr>
<td>BC</td>
<td>Date of Birth Change:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>CC</td>
<td>Cancel Date Change:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>EC</td>
<td>Effective Date Change:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>GC</td>
<td>Gender Change:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>MM</td>
<td>Medicare Maintenance:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>HC</td>
<td>History Change:</td>
<td>Limited to 24 member months</td>
</tr>
<tr>
<td>RA</td>
<td>Rate Adjustment:</td>
<td>Limited to 24 member months</td>
</tr>
</tbody>
</table>
Organ Transplant Services (Catastrophic) Claims

Refer to the Claims Processing section for information on organ transplant (catastrophic) claims.
## Quality Improvement Program

### 1. 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.

<table>
<thead>
<tr>
<th>QIP- Access to Primary Care</th>
<th>Description</th>
<th>Current Claims Codes or Medical Record or Pharmacy Claims</th>
<th>LOINC Codes for labs</th>
<th>CPT2 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Health Visit and Health Assessment</td>
<td>% of Members that had an Annual Health Visit Annual PCP Visit, Health Assessment and appropriate documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QIP- Clinical Measures</th>
<th>Description</th>
<th>Current Claims Codes or Medical Record or Pharmacy Claims</th>
<th>LOINC Codes for labs</th>
<th>CPT2 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.</td>
<td>ICD9 procedure codes: V85.0-V85.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Female Members ages 42 to 69 receiving a mammogram</td>
<td>CPT codes: 77055-77057 OR HCPCS codes: G0202, G0204, G0206 OR ICD9 procedure codes: 87.36, 87.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – Eye Exam</td>
<td>Diabetic Members ages 18-75 who had a retinal or dilated eye exam by an eye doctor</td>
<td>HCPCS codes: S0620, S0621, S0625, S3000</td>
<td>None</td>
<td>2022F, 2024F, 2026F, 3072F</td>
</tr>
<tr>
<td>Diabetes Care – Kidney Disease Monitoring</td>
<td>Diabetic Members ages 18-75 who either had a urine micro albumin test or who received medical attention for nephropathy</td>
<td>CPT Codes: 82042, 82043, 82044, 84156</td>
<td>Appropriate LOINC codes</td>
<td>3060F, 3061F</td>
</tr>
<tr>
<td>Diabetes Care – Blood Sugar Controlled</td>
<td>Diabetic Members ages 18-75 whose most recent HbA1C lab test during the year that showed their blood</td>
<td>Medical Record</td>
<td>Appropriate LOINC codes</td>
<td>3044F, 3045F</td>
</tr>
<tr>
<td>Service Description</td>
<td>Eligibility Criteria</td>
<td>Documentation</td>
<td>LOINC Codes</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – Cholesterol Controlled</td>
<td>Diabetic Members ages 18-75 whose most recent LDL-C level is less than 100</td>
<td>Medical Record</td>
<td>3048F</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – Cholesterol Screening</td>
<td>Diabetic Members ages 18-75 with diabetes (type 1 or type 2) who had an LDL-C screening test</td>
<td>CPT codes: 80061, 83700, 83701, 83704, 83721</td>
<td>3048F, 3049F, 3050F</td>
<td></td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>Members ages 18-85 whose last BP of the year BP was less than 140/90</td>
<td>Medical Record</td>
<td>3074F or 3075F AND 3078F or 3079F</td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>Administration of Influenza virus vaccine</td>
<td>HCPCS codes: G0008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>Members diagnosed with rheumatoid arthritis who received at least one prescription for disease modifying anti-rheumatic drug</td>
<td>RX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation</td>
<td>Members 40 years of age or older who had an acute inpatient discharge or ED encounter for COPD exacerbation and who were dispensed appropriate medications (systemic corticosteroid within 14 days of the event or a bronchodilator within 30 days of the event)</td>
<td>RX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk for Falls Screening</td>
<td>Fall risk assessment documented in the medical record</td>
<td></td>
<td>3288F and 1100F or 1101F OR 0518F</td>
<td></td>
</tr>
<tr>
<td>Risk for Falls- Care Plan</td>
<td>Fall plan of care documented in medical record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part D Diabetes Treatment</td>
<td>Members who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people</td>
<td>RX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Part D Medication Adherence for Oral Diabetes Medications

Members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. This measure is defined as a Member who adheres to their prescribed drug therapy across four classes of oral diabetes medications: biguanides, sulfonylureas, and thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors.

### Part D Medication Adherence for Hypertension (ACEI or ARB)

Members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. This measure is defined as a Member who adheres to their prescribed drug therapy for angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medications.

### Part D Medication Adherence for Cholesterol (Statins)

Percent of Members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. This measure is defined as the percent of Members who adhere to their prescribed drug therapy for statin cholesterol medications.
2. Data Submission, Calculation and Attestation

A. **QIP Access to Primary Care** – Annual Health Visit and Health Assessment – IPA completion of an Annual Health Assessment and participation in the development of an Individual Patient Comprehensive Care Plan that accurately documents health information obtained during the annual exam. The Annual Health Assessment tool must be approved by the HMO and the documentation must be accurate, completed to the satisfaction of the HMO and appropriately supported by information contained within the provider’s medical record.

B. **Visit and the Member Experience Measures** will be based on HMO encounter data, medical record review and the annual HMO Member Survey.

C. IPA understands and agrees that the HMO may audit provider’s medical records to verify the accuracy of the Annual Health Assessment form and supporting documentation.

D. **QIP Clinical Measures** – IPAs are required to submit complete and accurate data and supporting documentation for each of the QIP Clinical Measures as requested by the HMO. The data must be submitted in a format acceptable to the HMO and within the time period established in the annual QIP instructions. The IPA’s data submission must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.

If it is necessary for the HMO to perform a site visit to obtain the required documentation, no QIP payment will be made to the IPA.

QIP Clinical Measure performance thresholds will be established by the HMO on an annual basis. QIP payment related to QIP Clinical Measures will be based on performance beginning in Year 2 of the MSA.

E. **Member Experience Measures** – IPA performance for the Member Experience Measures will be based on the annual HMO Member Survey.

F. **Member Retention** – The percentage of members who voluntarily leave the IPA’s practice during the calendar year will be calculated based on the HMO membership system data.
3. Annual Payment
The HMO shall pay the IPA as described below, for compliance with the stated requirements, as determined by the HMO and outlined in the MSA:

A. Partial Risk QIP Payment

1. HMO will pay the IPA $5.00 PMPM if IPA establishes and participates in the HMO Intensive Case Management Program and meets HMO requirements as outlined in the current HMO Utilization Management Plan.

2. HMO will pay the IPA $5.00 PMPM if ≥85 percent of members received an Annual Health Visit and Health Assessment including Care for Older Adults.

3. HMO will pay an additional $5.00 PMPM for submission of complete and accurate data for ≥ percent of identified members for the QIP Clinical Measures as outlined in the MSA. This payment is based on submission of data for the QIP Clinical Measures, not on results for Year 1 of the MSA. Beginning Year 2 of the MSA, payment will be based on submission of data for the QIP Clinical Measures as outlined and achieving Clinical Measures quality results established by the HMO on an annual basis.

4. The HMO will calculate compliance rates for the calendar year and payment to the IPA will occur within 90 days of the end of each period.

5. Upon termination of the MSA, the HMO may retain an amount equivalent to outstanding bills of the IPA.

B. Global Risk QIP Payment

1. HMO will pay the IPA 1 percent of Part A/B premium as outlined in the MSA Quality Improvement Program exhibit if IPA establishes and participates in the HMO Intensive Case Management Program and meets HMO requirements as outlined in the current HMO Utilization Management Plan.

2. HMO will pay the IPA 1 percent of Part A/B premium as outlined in the MSA Quality Improvement Program exhibit if ≥85% of members received an Annual Health Visit and Health Assessment including Care for Older Adults.

3. The HMO will pay an additional 1 percent of Part A/B premium as outlined in the MSA Quality Improvement Program exhibit for submission of complete and accurate data for ≥95 percent of identified members and achieving quality results established by the HMO annually for QIP Clinical Measures as determined by the HMO.

4. The HMO will calculate compliance rates for the calendar year and payment to the IPA will occur within 90 days of the end of each period.

5. Upon termination of the MSA, the HMO may retain an amount equivalent to outstanding bills of the IPA.
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

1. Benefits for all covered services rendered by a physician on an outpatient basis (except for maternity services) can be subject to a copayment per visit.

   An outpatient office based service rendered by an Advanced Practice Nurse (includes Certified Nurse Midwife, Certified Nurse Practitioner, Certified Registered Nurse Anesthetist and Certified Clinical Nurse Specialist) or a Physician Assistant can also be subject to a copayment per visit.

   Services rendered by any other health professional are not subject to the copayment. Examples of these services would include (but are not limited to) lab draws or medication injections provided by a nurse or technician. The only exception to this is when the member has an outpatient rehabilitative copayment (see related note below).

2. When a member (with a copay) also has co-coverage as a dependent through a spouse’s HMO insurance (who has a lesser or no copay), the lesser copay should be collected. Eligibility should be verified for both benefit plans.

3. When the visit is for the purpose of pharmacological management for mental health medications, the PCP/specialist office visit copay (dependent upon who is providing the service) should be collected. The outpatient mental health copay would not be applicable. Refer to Scope of Benefits section for further information.

4. The Benefit Plan has a tiered copayment structure. The first is for a PCP office visit. PCPs include Family Practice, General Practice, Internal Medicine and Geriatrics. The second tier is for a specialist physician office visit. The third tier is for a wellness office visit. A wellness visit is defined by the use of the Preventive Medicine Services codes (99381-99249) that are used to report routine evaluation and management of adults and children in the absence of patient complaints or counseling and/or risk factor reduction intervention services to healthy individuals.

5. Psychiatric care rendered under the supervision of a physician by a psychiatric social worker or other mental health professional is subject to a copay.

6. In determining the copayment for outpatient therapy, the following should be considered: a single date of service by the same provider will be counted as one treatment/visit for the collection of a copayment. In other words, if a member is sent for Physical Therapy (PT) but at the visit the member is also provided Speech Therapy (ST), there is only one visit, regardless of the fact that more than one modality of treatment was provided. A copayment should also be collected for a PT, ST or Occupational Therapy (OT) evaluation visit, if applicable.

Coinsurance

There are co-insurance percentages on certain HMO and POS in-network services and all POS-out-of-network services. For specific percentages, the current year Benefit Matrices posted under MA HMO Resources should be used.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSIL contracts with Prime Therapeutics, a separate company, to provide pharmacy benefit management and other related services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC.

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