Capitation Payment

Definition

Under the HMO agreement outlined in the Medical Group Service Agreement (MSA), physicians will receive a monthly capitation payment for every member that selects them as their Primary Care Physician (PCP). The Cap payment is made regardless of the number of times the member visits their PCP. Only having an eligible member select the IPA as their PCP guarantees a monthly Cap payment to the IPA.

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 IPA's. The Cap payment amount is derived from the Cap schedules listed in the MSA. The schedules rates are age and gender specific and are also specific to member co-payment amounts. All Cap schedules are linked to Benefit Plans. Benefit Plans are designed to meet individual Employer Group insurance needs. Therefore the employer group and the benefit plan selected, will determine the Cap Schedule used to pay the IPA for a certain member.

Current Cap
"Current" capitation is calculated by multiplying the number of members enrolled by the capitation rates in effect for the age- gender category.

Retro Cap
"Retroactive" capitation is calculated by adding or subtracting the capitation rates for the Members added or deleted from the IPA Eligibility List for periods prior to the current month.

Both the "current" and "retroactive" calculations are listed in the Capitation Summary. The Capitation Summary is mailed on a monthly basis to the IPA along with their cap check or e-mailed to the IPA if the IPA has an Electronic Funds Transfer 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 on page 4.

a. Month: Month for which capitation is being paid.

b. IPA Number and IPA NPI Number: Identification number and the National Provider Identifier of the IPA to whom capitation is being paid.

c. Current and Retroactive Capitation: Dollar amount of current and retroactive calculated capitation.

d. Additional Adjustments/Payments: Dollar amount (positive or negative) of manual adjustments to the month's capitation.

e. Description: A Brief description of the Additional Adjustment/Payment

Sample HMO Capitation Payment Summary

BlueCross BlueShield of Illinois 300 East Randolph Chicago, Illinois 60601-5099

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CAPITATION SUMMARY

a FOR THE MONTH OF DECEMBER, 2009

b **SUMMARY FOR PAYEE ID 123 NPI# 1234567890**

HMOI

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

ADDITIONAL ADJUSTMENTS/PAYMENTS

	DESCRIPTION	ADJUSTMENT AMOUNT
e	NO EXTRA PAYMENTS OR ADJUSTMENTS FOR CAP PERIOD	$ .00

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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 of the Eligibility List is generated. This Summary also identifies all active Medicare Primary members.

Also included in the above totals are "overage dependents". Certain employers carry coverage for dependents beyond the age of 23 years. For these "overage dependents" the HMO pays regular capitation for the age and sex of the member.

In order to reconcile the current month's capitation, check the following:

a) Download the Capitation Reconciliation report from the Provider Portal 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 equate to the Current and Retroactive Capitation total from the Capitation Summary.

The following rules apply regarding retroactive changes:

MA	Member Add:	Limited to 24 member months
MC	Member Cancel:	Limited to 3 member months
TI	Transfer In:	Limited to 24 member months
TO	Transfer Out:	Limited to 24 member months
RI	Reinstate:	Limited to 24 member months
NC	Name Change:	Limited to 24 member months
BC	Date of Birth Change:	Limited to 24 member months
CC	Cancel Date Change:	Limited to 24 member months
EC	Effective Date Change:	Limited to 24 member months
GC	Gender Change:	Limited to 24 member months
MM	Medicare Maintenance:	Limited to 24 member months
HC	History Change:	Limited to 24 member months
RA	Rate Adjustment:	Limited to 24 member months

REQUEST FOR MANUAL CAPITATION ADJUSTMENT

Note: *ALL FIELDS with an asterisk (*) ARE MANDATORY AND MUST BE COMPLETED IN ORDER FOR YOUR FORM TO BE PROCESSED. If any of the fields are left blank, your form will not be processed and will be returned.*

***Date:** _____ ***Subcriber Name** _____

***MG Name:** _____ ***Member(s) Name:** _____

***MG Site Number:** _____ ***Member(s) DOB** _____

***Contact Name:** _____ ***Member Group #** _____

***Contact Phone Number:** _____ ***Member ID #:** _____

***Contact Fax Number:** _____ ***Eligibility Period(s) in Question (for example, 7/1-8/1/2003):** _____

***Type of Issue: (Please attach the pertinent eligibility list pages)**

☐ **PCP Issue**
☐ **WPHCP Issue**

☐ **Newborn Capitation** – Services rendered in birth month, cap not paid
What months should you have received capitation? _____
Amount of Cap due: $ _____

☐ **Retroactive Capitation** -
What months did you receive cap? _____
What months should you have received cap? _____
Amount of Cap due: $ _____

☐ **Current Capitation** -
What months did you receive cap? _____
What months should you have received cap? _____
Amount of Cap due: $ _____

☐ **Other** (please include what month member appeared on eligibility list, if you received cap and if cap is due): _____
_____
_____
_____
_____
_____

***Amount of Cap due: $** _____

****Email this form to: MANUALCAP@BCBSIL.COM or Fax to: 312-819-1650****
(Note: Emailing the form will expedite processing)

Do not write below this line - For office Use only

Response:

☐ Capitation adjustment of $ _____ will be made on the _____Capitation Payment Summary Report. This is _____ months @ $_____ for a total of $_____.

☐ Eligibility system has been updated. The change will be reflected on the _____Eligibility List.

☐ No capitation is due - Capitation was already paid on _____. (copy of page attached)

☐ Other: _____
_____
_____

Preparer: _____ Response Date: _____

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Utilization Management Fund

In addition to Capitation Fees, each IPA can earn a Utilization Management Fund. This Fund is based on the difference between the number of units actually utilized in the IPA's Anniversary Year, and the target number of units established for the IPA, as described in the Medical Service Agreement.

The Utilization Management Fund amount is divided into two separate payments - an Interim Payment and a Final Payment. See the following pages for an example calculation of the Interim and Final Utilization Management Fund.

Example Calculation of the Interim and Final Utilization Management Fund

1) Calculate enrollment for six-month period by category of member. (The Final UM Fund would use a twelve month period).

	Adult Male	Adult Female	Child Male	Child Female
June	124	119	56	62
July	133	120	58	65
August	140	138	58	66
September	150	148	59	67
October	155	127	60	70
November	122	134	60	75
Total Member Months	824	786	351	405
Total Member Years (Member Months ÷ 12)	68.67	65.5	29.25	33.75

For the purpose of this Fund, an Adult Male or Adult Female is considered any member 18 years of age or older, whether a Subscriber or dependent, who has selected the IPA as his/her Participating IPA. A Child is any member less than 18 years of age, either male or female.

2) Calculate target units per category using factors* stated in the Medical Service Agreement.

	Adult Male	Adult Female	Child Male	Child Female
Total Member Years	68.67	65.5	29.25	33.75
multiplied by HMO Illinois factors	0.4517	0.5882	0.3081	0.2806
Total Target Units	31.02	38.53	9.01	9.47

To determine the number of Total Target Units for the IPA's population, add the Total Target Units Per Category. [31.02 + 38.53 + 9.01 + 9.47 = 88.03]

* **Check Medical Service Agreement for that time period for correct factors.**

3) From claim records determine incurred units during six month period. (The Final UM Fund would use a twelve month period).

	Actual Days	Unit Value	Charged Units
Hospital days(Class I, Contracting Facility)	25	1.0	25
Extended Care Facility days (Contracting)	12	0.50	6
Home Health Care Visits (Contracting Facility)	10	0.33	3.30
Hospital Based Ambulatory Surgery Cases(Class I Contracting Facility)	5	1.00	5
Free Standing Ambulatory Surgery Cases	1	1.00	1
Total			40.30

4) To determine the number of units assumed but unutilized; subtract the results from step 3 (total charged units) above from step 2 (total target units) above.

Target Units	88.03
Units Charged	47.73
Total Units saved	30.42

5) Multiply results of 4) by the amount cited in the Medical Service Agreement for each assumed but unutilized unit.**

a. Interim Calculation of Utilization Management Fund:

Total number of units assumed but not utilized	47.73
Multiplied by amount for each unit (as cited in MSA)	$675.00
Total Utilization Management Fund earned	$32,217.75
Interim Amount (Earned amount ÷ 2)	$16,108.88
less monthly advance or other payments, (if applicable)	$6,403.29
Interim Utilization Management Fund earned and paid to the IPA	$9,705.59

This amount, if positive, as in this example, will be paid to the IPA. If the interim amount is negative, no payment will be made for the Interim Calculation.

b. Final Calculation of Utilization Management Fund:

Total number of units assumed but not utilized	71.00
Multiplied by amount for each unit (as cited in MSA)	$675.00
Total Utilization Management Fund earned	$47,925.00
less Interim Amount paid	$9,705.59
less monthly advance or other payments, (if applicable)	$582.12
Final Utilization Management Fund earned and paid to the IPA	$37,637.29

** Check Medical Service Agreement for that time period for correct amount per unit.

Calculation of Target Units

a. The target number of units for each IPA is calculated based on enrollment figures. The IPA's target units for each type of Member can be found in the Medical Service Agreement. The enrollment figures for the first six months of the Calendar Year are used for the Interim Payment. The enrollment figures for all twelve months of the Calendar Year are used for the Final Payment.

b. The number of members in each category is totaled for the month. A six or twelve-month figure is then calculated - depending on whether the Interim or Final UM Fund Calculation is being done. These totals are also known as “member months”.

c. The six or twelve-month total is then divided by 12 to arrive at an annualized member count. This figure is also known as “member years”.

d. The annualized member count in each category is then multiplied by the target factor stated in the Medical Service Agreement. All categories are added together to arrive at the total number of target units for the IPA. This total is the number of units expected to be utilized by the IPA's HMO members during the period covered by the calculation.

Calculation of the Actual Units Utilized

a) **Hospital:** Consists of all group-approved inpatient units, charged as Class I (1.00 Unit) or Class II (2.00 Units) in a contracting hospital. If inpatient days are incurred in a non-contracting hospital without prior approval from the HMO, each day will be charged as four (4.0) units.

If a Member is admitted as an inpatient due to an Emergency Medical Condition to a hospital within a 30-mile radius of the IPA; each day will be charged to the Utilization Management Fund. If the hospital is out of area (more than 30 miles from the IPA) no units will be charged.

b) **Extended Care Facility Days:** Each day of confinement in a Class I contracting facility will count as one-half (0.5) unit; Class II will be a 1.5 unit. Each day of confinement in a non-contracting facility will count as 4 units, if prior approval for use of the non-contracting provider was not obtained from the HMO.

c) Home Health Care Visits: Each home visit will count as one-third (0.33) unit if a contracted facility is used. If prior approval was not obtained from the HMO for group-approved services provided by a non-contracting facility, the IPA shall be responsible for payment of all claims submitted by such non-contracting entity.

d) Hospice Care: The number of units charged will be according to the type of facility in which the care is rendered.

e) Day/Night Psychiatric Care: Each day of confinement will count as one quarter (0.25) unit in a contracting facility.

f) Outpatient Surgery: Utilization of Hospital-based ambulatory surgery or free-standing ambulatory surgery centers will be charged either as a Class I (1 unit) or Class II (2.00 units) depending on the facility used. If a non-contracted provider is used, four (4) units will be charged.

Certain medical procedures performed in an outpatient or free-standing facility, which could have been performed in a physician’s office, will be charged an additional 0.50 unit, in addition to the regular unit charge.

Appendix B (of the Medical Service Agreement) contains a list of CPT codes for procedures which are expected to be performed in the provider office setting. When a claim contains surgical codes which are all from this list, and the procedure(s) were performed in a surgicenter, hospital outpatient department, or GI lab, rather than a provider office, an additional 0.5 units will be charged to the UM Fund in the annual UM Fund reconciliation. (This is in addition to the units normally charged for any surgical procedure in an outpatient facility.)

An Exception Request process is available, however, to waive this charge for a given claim, when mitigating clinical circumstances exist.

Automatic Exceptions (no form needed)

BCBSIL will review claim data and make certain automatic exceptions. The following exceptions are automatic, and do not require a written exception request from the IPA:

- Inpatient services
- Emergency Room services
- 23-hour Observation services
- Service in question is performed in conjunction with a non-office surgical procedure (not on Appendix B), on the same claim

All Other Exceptions - faxed form required – (Note: form is located at end of this section)

If the only surgical CPT codes on the claim are on the Appendix B list, and none of the above circumstances apply, the IPA must fax a completed Exception Request form to be granted an exception. The IPA must attach a copy of the physician's claim and any supporting information. A copy of the facility claim, if available, should be included.
This exception request is a retrospective process, after the date of service but at least 90-days prior to the final UM Fund calculation.

Please complete the identifying information at the top of the form.

Several types of situations (children under age 14, use of laser for skin lesions, fluoroscopy used) do not require a narrative explanation. In the case of one of these, check the appropriate box, sign the form and fax it as directed.

All other situations will need a written explanation of the reason the service could not be performed in an office setting, including the type of anesthesia that was used.

Please be aware of the following examples of explanations which will not generally be accepted:

- "The surgeon felt it was necessary." [*For what reason?]*
- "The office is not equipped to perform the procedure." [*The Appendix B list of CPT codes was based on the fact that the majority of surgeons perform them in the office setting.*]
- "A procedure in this location is at high risk for bleeding or infection." [*If there is something unique about the location (i.e., a deep lesion in the axilla), please specify*.]

Once a decision has been made, the HMO will fax a copy of the completed form back to the IPA at the number specified on the form.

The IPA may not challenge the 0.50 chargeback if there is no approved UM Fund Exception on file.

g. Hospital Observation: Group approved all hours will count as one half (0.50) unit

Additional information regarding units charged for special circumstances can be found in the Medical Service Agreement.

Calculation of Utilization Management Fund Amount Due to the IPA

a. The actual units are then subtracted from the target units.

b. The difference, if positive, is then multiplied by the amount cited in the Medical Service Agreement for each assumed but unutilized unit.

Office-Based Surgery (Appendix B) - Exception Request to the Utilization Management Fund Form

A written notice from IPA to waive a Utilization Management Fund assessment for a particular surgical procedure on the Appendix B list. This is a retrospective process to address UM fund charges – Do not delay care. Please fax completed form to: **Augie DeLisa RN (312-228-9060)**. **Attach physician claim form and any supporting information.**

IPA Name:_____ IPA # _____

IPA Contact Name: _____ Fax: _____

E-mail _____ Phone _____

Subscriber Group & ID: _____

Subscriber's Name:_____

Patient's Name: _____ Date of birth _____

Date(s) of Service:_____

Place of Service: ☐ Surgicenter ☐ Other
☐ Hosp Outpatient

CPT Code(s): _____

Exception Requests that do not require written explanation or claim form. (Check any that apply and sign below):

☐ Child under age 14 ☐ Fluoroscopy used in procedure
☐ Laser destruction of skin lesion

All other Exception Requests DO need a written explanation. (Please explain in the space below and/or on attachment.):

Specify anesthesia: ☐ Local ☐ Regional ☐ Other _____
☐ General ☐ Conscious sedation

Please explain why this procedure had to be performed in a non-office setting.
Also, if anesthesia other than local was needed, please explain why this was the case.

Signature of Requestor: _____ Date of Request _____

For BCBSIL use only:

BCBSIL decision: _____ Reason: _____

BCBSIL signature _____ Date _____

OFFICE-BASED SURGERY (APPENDIX B)
EXCEPTION REQUEST TO THE UTILIZATION MANAGEMENT FUND

Payment of Utilization Management Fund

a. Monthly Advance

On or before the 10th day of each month, the HMO will make an advance payment to the IPA at the rate of 3% of the IPA's previous year's Utilization Management Fund amount. This is an optional provision that should be discussed with your Provider Network Consultant. A written request needs to be submitted to the HMO; an Amendment to the Medical Service Agreement will need to be executed to begin/continue this advance payment.

b. Interim Payment

The interim payment is due to the IPA 190 days following the end of the sixth month of the Anniversary Year. This will be one-half of the Utilization Management Fund amounts earned in that period, minus any advance payments paid to the IPA.

c. Final Payment

The final payment will be paid to the IPA 190 days following the end of the Anniversary Year. If the amount due is positive, the HMO will pay the IPA the earned amount minus any interim payment and advance payments. If the amount due is negative, any unearned and previously paid interim or advance payments must be paid to the HMO by the IPA within 30 days of the HMO informing the IPA of the amount due.

Example:

At the time the interim payment is due, the HMO calculates a Utilization Management Fund earned amount of $10,000 for the IPA. The HMO pays the IPA $5,000 (one-half the calculated amount). No advance monthly payments were paid because no Utilization Management Fund amount was earned the previous year.

At the time of the final payment, the HMO calculates an earned amount of $15,000 for the IPA. Since an interim payment of $5,000 has already been paid, the HMO will pay the IPA the difference between the final payment amount and the interim payment, or $10,000.

d. Upon Termination

In cases where the Medical Service Agreement is terminated, one-half of the Utilization Management Fund will be paid 175 days following the date of termination. This is called the Preliminary Final UM Fund Calculation. A second calculation (called the Final Final) will be made 395 days after the date of termination. The reason for the second calculation is to include any units which were not processed and paid during the initial calculation. Any amount owed to the IPA will be paid 30 days following this Final Final Calculation. If an overpayment has been made to the IPA, the IPA will pay the HMO within 30 days of notification of the amount overpaid.

IPA Challenges to the Utilization Management Fund

a. Monthly Paid Claims Report

To assist the IPA in tracking the actual days that will be charged against the Utilization Management Fund, the HMO provides a monthly report of paid claims. This report lists all claims paid during the month regardless of incurred (admission) date.

This report will show the member's name, date of service, provider, amounts charged and paid, and the units that may be charged to the Utilization Management Fund. It will be sent one month following the close of the month being reported. The IPA should check this list carefully to assure that all claims listed are correct and should be charged to the Utilization Management Fund. Any discrepancies found on these reports should be noted by the IPA.

The IPA cannot challenge any claim listed on the monthly Paid Claims report. A challenge can only be done on the Interim and Final Claim Summary Report that will accompany the Interim and Final Calculation of the Utilization Management Fund.

b. Interim and Final Claim Summary Report

This report documents all incurred and paid claims for the IPA's Anniversary Year. An example page and a Code key for reading this report can be found in this section of the manual. If an IPA finds a discrepancy in one of these reports, a challenge can be made to the HMO.

Refer to the HMO Policy and Procedure Section of this manual for information on how to submit a challenge to the HMO.

Code Key for the Utilization Management Fund Detail Report

Subscriber Last Name	Last name of Subscriber, not necessarily last name of the patient
SFI	Initial of Subscriber's first name
SSN	Social Security Number of Subscriber
PR	Indicates relationship of patient to Subscriber EM - Employee SP - Spouse MC - Male child FC - Female child
PROVIDER	Identification number for health care provider
GROUP	Employer Group Number
SERVICE DATE	Date service incurred
COR	Condition of Reimbursement (identifies why claim was paid)

(GA means Group Approved; NGA means Non-Group Approved)

COR 1	Inpatient GA Medical
COR 2	Inpatient NGA (Excluding Accident)
COR 3	Outpatient Group Approved Surgery
COR 4	Extended Care Facility (GA or NGA
COR 5	Home Health Care (GA or NGA)
COR 6	Catastrophic (GA or NGA)
COR 7	Inpatient GA Mental Health/Chemical Dependency
COR A	Inpatient GA Surgery
COR D	Inpatient NGA Mental Health/Chemical Dependency
COR E	Accident
COR L	Pre-Admission Testing
COR M	GA Obstetric
COR O	Other (DME, Professional Charges, Default Category)
COR P	Day/Night Psych or Chemical Dependency

Code Key for the Utilization Management Fund Detail Report (cont.)

FLAG	Identifies unusual claims payment
FLAG B	Newborn Baby's claim
FLAG C	Chemical Dependency
FLAG E	Life Threatening Emergency
FLAG L	GA "scopy" procedures (outpatient surgery with revenue codes 314,321 or 750
FLAG Q	GA outpatient claims with service procedure code = OBC and claim procedure code not 999
FLAG R	GA Observation room charges with service procedure codes = 760,762,769 or OBC with claim procedure code 999
FLAG S	GA outpatient, maternity or emergency surgery claims, including service procedure codes = 360,370,490,OR, or 481
FLAG T	Outpatient services
TOTAL DAYS	Number of days actually paid
FACTORED NET DAYS CHARGED	Number of days charged to incentive
AMOUNT CHARGED	Amount charged on claim
AMOUNT PAID	Amount of claims paid
AMOUNT NOT PAID	Amount of claims not paid

Reinsurance

Refer to the Claims Processing Section for information on reinsurance.

Non-Capitated Services (Catastrophic) Claims

Refer to the Claims Processing Section for information on non-capitated services (catastrophic) claims.

Quality Improvement Fund

The total additional compensation that can be earned under the Quality Improvement Fund is Seventeen percent (**17.00**%) of Capitation Fees plus the Special HEDIS Payments, as follows:

1. *Semi-Annual Payments*

The HMO shall pay the IPA a percentage of the Capitation Fees paid, as described below, for compliance with the stated requirements, as determined by the HMO and subject to execution of this Agreement:

Two percent (2.0%) of Capitation Fees will be paid for compliance with all of the following:

a. An HMO Administered Complaint ratio below 1.0 per 1,000 Members per year.

b. Maintenance and monthly submission, within 10 days after the end of the month, of the following documents that must meet HMO requirements and be submitted in a format acceptable to the HMO:

    1. Denial logs: For IPAs that do not have any denials to report, they must submit a copy of their inquiry policy describing their process, and provide a one month log on an annual basis;
    2. Denial files within 10 calendar days of request, once sample files are chosen;
    3. Referral log upon request;

c. Submission of a complete roster of contracted providers and the current written service agreement which the IPA is required to have executed with all providers of professional and ancillary services, as referenced in Section I.C.1.h. including the Hospital based specialists listed in Section I.C.1.a.2.m) Anesthesia, ER, Pathology, Radiology, and Neonatology, if applicable.

d. Submission of the IPA financial statements per the requirements referenced in Section I.C.9.d.

e. Participation in at least 50% of all regularly scheduled Managed Care Roundtable meetings by the IPA Medical Director or an IPA Physician.

f. Submission of complete (as verified by HMO analysis) claim and encounter data per the requirements referenced in Section I.C.9.b.

    The HMO shall calculate compliance rates for semi-annual payments at the end of two periods: January 1, 2009 through June 30, 2009, and July 1, 2009 through December 31, 2009. The HMO shall pay the IPA within 90 days of the end of each period. Compliance shall be defined as meeting the above criteria each quarter, or as otherwise required.

g. Upon termination of this Agreement, the HMO may retain an amount equivalent to outstanding bills of the IPA.

2. Special HEDIS Payments

Additional compensation for submission of data supplied in 2009 for reporting 2008 HEDIS results will be paid for compliance with the following, as determined by the HMO and subject to execution of this Agreement:

HEDIS data must be submitted by the due date, which will be no sooner than 21 days after the date of the request, and must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.

In 2009, the Special HEDIS Payment will be made only for unique members for whom the IPA supplies data in response to a specific HEDIS data request sent to the IPA. Payment will be made in accordance with the criteria sent with the HEDIS instructions.

a. $550 will be paid to the IPA for submission of documentation of care that fulfills criteria for inclusion in the HEDIS numerator for each of the following Comprehensive Diabetes Care indicators: HbA1c control, LDL cholesterol control, blood pressure control, retinal eye exam and medical attention for nephropathy.

b. $1,100 will be paid to the IPA for submission of documentation of care that fulfills criteria for inclusion in the HEDIS numerator, provided to a sampled Member for those indicators other than the Comprehensive Diabetes Care indicators that are specified in the HEDIS instructions.

c. $1,100 will be paid to the IPA for submission of documentation that fulfills criteria to exclude a Member from the HEDIS sample.

d. $75 will be paid to the IPA for submission of requested information about the sampled Member that does not fulfill criteria for inclusion in the HEDIS numerator. Documentation must appear to be complete and accurate.

e. The Special HEDIS Payments will be made within 90 days after June 30, 2009.

f. Upon termination of this Agreement, the HMO may retain an amount equivalent to outstanding bills of the IPA.

3. *Annual Payments*

The HMO shall pay the IPA a percentage of Capitation Fees paid, as described below, for compliance with the stated requirements, as determined by the HMO and subject to execution of this Agreement:

a. The HMO shall pay the IPA:

   1. One and a half percent (1.5%) of Capitation Fees for acceptable performance of utilization review activities and on-going adherence to a written Utilization Management Plan, as demonstrated through the annual HMO on-site Utilization Management audit, as described in the 2009 HMOs of BCBSIL Utilization Management Plan. For purposes of this provision, an acceptable level of performance will be a compliance rating of at least 90%.

   2. One-half percent (0.5%) of Capitation Fees for submission of a revised Utilization Management Plan by February 15, 2009 and with final approval of the Plan as meeting HMO requirements set forth in the Utilization Management Plan of the HMOs of BCBSIL by April 30, 2008. Behavioral Health UM Plan (if delegated) must be submitted with the revised UM Plan and be reviewed and approved by the delegating IPA prior to submission.

   3. One-half percent (0.5%) of Capitation Fees if overall IPA Member satisfaction rating is $\geq$ 83% AND member satisfaction with the referral process for specialists is $\geq$ 83% based on the 2009 Member Survey.

   4. One-half percent (0.5%) of Capitation Fees if the cumulative audit score for quarterly denial file audits is at least 90%. Denials that must be included on the denial/appeal log are: medical necessity (including out of network or re-directed referrals) and benefit determinations resulting in a denial. The audit will be based on denial files selected by the HMO. If denial files are not available for review, due to failure to submit a denial log or due to there being no denials, compliance cannot be determined and the IPA will not be eligible for this one-half percent (0.5%) of the QI Fund.

b. The HMO shall pay the IPA a possible total of eleven and one-half percent (11.50%) of Capitation Fees for participation in QI activities, with payment based upon performance as specified below:

QI Activity	% of Capitation available
Influenza Vaccination QI Fund Project Participation in the HMO Influenza Vaccination QI Fund Project, with submission of documentation for measurement of the 2008-09 IPA influenza vaccination rate (for Members who are 65 years of age or older or who have diabetes, CVD or asthma) by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Influenza Vaccination QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows: ▪ IPA Influenza vaccination rate ≥62%: 0.75% capitation ▪ IPA Influenza vaccination rate ≥50% but <62%: 0.50% of capitation. ▪ IPA Influenza vaccination rate ≥40% but <50%: 0.25% of capitation.	Up to 0.75%
Cervical Cancer Screening QI Fund Project Payment for the HMO Cervical Cancer Screening QI Fund Project requires submission by the specified date of documentation for measurement of the 2006-08 IPA cervical cancer screening rate for the population of female members age 24-64. Payment will be made in accordance with the criteria sent with the project mailing. Cervical Cancer Screening QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. This is a population-based project, utilizing only administrative data. Payment will be made as follows: ▪ IPA Cervical Cancer Screening rate ≥55%: 0.50% of Capitation Fees. ▪ IPA Cervical Cancer Screening rate ≥40% but <55%: 0.25% of Capitation Fees. An additional 0.25% of Capitation Fees will be paid to IPAs for cervical cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 4/1/2009 and 7/31/2009: ▪ a list was obtained from the HMO reporting vendor's website of members who, based upon claim and encounter data, are due for cervical cancer screening, and ▪ for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for cervical cancer screening, and ▪ there has been member outreach to encourage cervical cancer screening for identified members with no claim or encounter for current cervical cancer screening. (Members for whom there is other evidence of screening, such as medical record or registry documentation, may be excluded from outreach.)	Up to 0.75%
Asthma QI Fund Project Payment for the Asthma QI Fund Project requires submission of written asthma action plans that have been provided to and reviewed with identified members between 12/1/2008 and 11/30/2009 AND submission of documentation of assessment of asthma control between 12/1/2008 and 11/30/2009. Payment will be made in accordance with the criteria sent with the project mailing. Asthma QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. ▪ If written asthma action plans and evidence of assessment of asthma control are provided for ≥75% of identified Members, 1.00% of Capitation Fees will be paid. ▪ If written asthma action plans and evidence of assessment of asthma control are provided for ≥65% but <75% of identified Members, 0.75% of Capitation Fees will be paid. ▪ If written asthma action plans and evidence of assessment of asthma control are provided for ≥55% but <65% of identified Members, 0.50% of Capitation Fees will be paid. An additional 0.25% of Capitation Fees will be paid to IPAs for outreach efforts. To earn the payment, IPAs must provide documentation that by 11/30/2009: ▪ a list was obtained from the HMO reporting vendor's website of members who, based upon claim and encounter data were identified as having asthma, and ▪ for outreach purposes, the IPA provided PCPs with a list of their members identified as having a diagnosis of asthma, and ▪ there has been member outreach to encourage identified members with asthma to contact their PCP for assessment of asthma control and the development of an asthma action plan. (Members who have already had an assessment of asthma control and have received a written asthma action plan after 12/1/2008 may be excluded from outreach.)	Up to 1.25%

Diabetes Flowsheet QI Fund Project Payment for the Diabetes Flowsheet QI Fund Project requires submission of documentation from a diabetic flowsheet (or electronic system) that tracks, at a minimum, HbA1c, eye exam, LDL cholesterol, blood pressure and medical attention for nephropathy, and is organized to both trend results over time and remind the practitioner when a service is due. Payment will be made in accordance with the criteria sent with the project mailing. Diabetes Flowsheet QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. HbA1c Control ▪ 0.25% of Capitation fees will be paid if the diabetic flowsheets confirm that an HbA1c performed in 2009 was <8.0% for at least 60% of the identified Members. Eye Exam ▪ 0.25% of Capitation Fees will be paid if diabetic flowsheet documentation of a dilated retinal eye exam by an eye care professional in 2009 is provided for ≥60% of identified Members. If the flowsheet includes the date but does not document the results of the exam, supporting documentation of the results must be submitted. LDL-C ▪ 0.25% of Capitation Fees will be paid if diabetic flowsheet documentation of LDL-C confirms that the result of a test performed in 2009 was <100 mg/dL for ≥45% of identified Members. Medical Attention for Nephropathy ▪ 0.25% of Capitation fees will be paid if the diabetic flowsheets confirm that at least 80% of the identified Members received medical attention for nephropathy in 2009, documented by a microalbuminuria test, a macroalbuminuria test with positive results, a visit to a nephrologist, or ACE Inhibitor/ARB treatment. Blood Pressure Control ▪ 0.25% of Capitation fees will be paid if the diabetic flowsheets confirm that a blood pressure reading in 2009 was <140/90 for at least 64% of diabetics. Overall Diabetes Preventive Care ▪ 0.25% of Capitation fees will be paid if the submitted documentation confirms that at least 20% of identified diabetics met ALL of the following criteria: ▪ An HbA1c test in 2009 was <8.0%. ▪ An LDL-C in 2009 was <100 mg/dL. ▪ The Member received medical attention for nephropathy in 2009. ▪ The Member had a dilated retinal eye exam by an eye care professional in 2009. Screening for Depression ▪ 0.25% of capitation fees will be paid if documentation that the member has been screened for depression in accordance with the BCBSIL Screening for Depression Guideline is provided for at least 60% of identified Members. (Note: Members with documentation of a diagnosis of depression since January 1, 2007 will be excluded.) An additional 0.25% of Capitation Fees will be paid to IPAs for outreach efforts. To earn the payment, IPAs must provide documentation that by 11/30/2009: ▪ a list was obtained from the HMO reporting vendor's website of members who, based upon claim and encounter data, were identified as having diabetes, and ▪ for outreach purposes, the IPA provided PCPs with a list of their members identified as having a diagnosis of diabetes, and ▪ there has been member outreach to encourage members identified with diabetes to contact their PCP to obtain recommended diabetes care. (Members who have already had an HbA1c, LDL-C, blood pressure, eye exam, depression screening and medical attention for nephropathy in 2009 may be excluded from outreach.)	Up to 2.00%
Follow-Up After Hospitalization for Mental Illness QI Fund Project Payment for the HMO Follow-Up After Hospitalization for Mental Illness QI Fund Project requires submission of documentation for measurement of the October 1, 2008 - September 30, 2009 IPA Follow-Up After Hospitalization for Mental Illness rate by the specified dates. Payment will be made in accordance with the criteria sent with the project mailing. Mental Health Follow-Up data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or	Up to 0.50%

Administrator. Payment will be made as follows: ▪ IPA Follow-Up After Hospitalization for Mental Illness 7 day rate ≥75%: 0.50% of capitation. ▪ IPA Follow-Up After Hospitalization for Mental Illness 7 day rate ≥65% but <75%: 0.25% of capitation.	
Childhood Immunization QI Fund Project Payment for the HMO Childhood Immunization QI Fund Project requires submission by the specified dates of documentation for measurement of the 2009 IPA Childhood Immunization Combination 3 rate (for Members who turn 2 years of age between January 1, 2009 and December 31, 2009). Payment will be made in accordance with the criteria sent with the project mailing. Childhood Immunization QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows: ▪ IPA childhood immunization Combination 3 rate ≥75%: 0.75% of capitation. ▪ IPA childhood immunization Combination 3 rate ≥70% but <75%: 0.50% of capitation. ▪ IPA childhood immunization Combination 3 rate ≥65% but <70%: 0.25% of capitation. An additional 0.25% of Capitation Fees will be paid if documentation is provided that at least 15% of Members included in the measurement of Combination 3 received at least 2 doses of hepatitis A vaccine and at least 2 doses of influenza vaccine.	Up to 1.00%
Management of Members with Cardiovascular Conditions QI Fund Project Payment for the HMO Management of Members with Cardiovascular Conditions QI Fund Project requires submission of documentation regarding control of cardiovascular risk factors. This population-based project includes members with ischemic vascular disease as well as those with a hospitalization for acute MI, CABG or PTCA. Payment will be made in accordance with the criteria sent with the project mailing. Data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. The following risk factors will be evaluated for identified members: LDL-C Control: ▪ If documentation of an LDL-C performed between 10/1/08 and 9/30/09 confirms that the result was <100 mg/dL for ≥65% of identified Members, 0.25% of Capitation Fees will be paid. Blood Pressure Control: ▪ If documentation confirms that a blood pressure measurement between 10/1/08 and 9/30/09 was <140/90 for ≥70% of identified Members, 0.25% of Capitation Fees will be paid. Advice to Quit Smoking: ▪ If documentation is provided that ≥75% of identified members who are smokers have been advised to quit smoking between 10/1/08 and 9/30/09, 0.25% of Capitation will be paid. (For purposes of this measurement, Members whose smoking status has not been assessed are assumed to be smokers.)	Up to 0.75%

Breast Cancer Screening QI Fund Project Payment for the HMO Breast Cancer Screening QI Fund Project requires submission of documentation for measurement of the 2007-08 IPA breast cancer screening rate for the population of female members age 42-69 by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Breast cancer screening data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. This is a population-based project, utilizing only administrative data. Payment will be made as follows: ▪ IPA Breast Cancer Screening rate ≥74%: 0.50% of Capitation Fees. ▪ IPA Breast Cancer Screening rate ≥60% but <74%: 0.25% of Capitation Fees. An additional 0.25% of Capitation Fees will be paid to IPAs for breast cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 4/1/2009 and 7/31/2009: ▪ a list was obtained from the HMO reporting vendor's website of members who, based upon claim and encounter data are due for breast cancer screening, and ▪ for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for breast cancer screening, and ▪ there has been member outreach to encourage breast cancer screening for identified members with no claim or encounter for current breast cancer screening. (Members for whom there is other evidence of screening, such as medical record or registry documentation, may be excluded from outreach.)	Up to 0.75%
Colorectal Cancer Screening QI Fund Project Payment for the HMO Colorectal Cancer Screening QI Fund Project requires submission of documentation for measurement of the IPA 2008 colorectal cancer screening rate for a random sample of members age 51-75 by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Colorectal cancer screening data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows: ▪ IPA colorectal cancer screening rate ≥60%: 0.75% of Capitation Fees. ▪ IPA colorectal cancer screening rate ≥50% but <60%: 0.50% of Capitation Fees. ▪ IPA colorectal cancer screening rate ≥40% but <50%: 0.25% of Capitation Fees. An additional 0.25% of Capitation Fees will be paid to IPAs for colorectal cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 4/1/2009 and 7/31/2009: ▪ a list was obtained from the HMO reporting vendor's website of members who, based upon claim and encounter data are due for colorectal cancer screening, and ▪ for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for colorectal cancer screening, and ▪ there has been member outreach to encourage colorectal cancer screening for identified members with no claim or encounter for current colorectal cancer screening. (Members for whom there is other evidence of screening, such as medical record or registry documentation, may be excluded from outreach.)	Up to 1.00%
Controlling High Blood Pressure QI Fund Project Payment for the HMO Controlling High Blood Pressure QI Fund Project requires submission of documentation by the specified date for measurement of the IPA blood pressure control rate for members age 18-85. The blood pressure is defined as being in control if a pressure reading between 4/1/08 and 3/31/09 was <140/90. This project includes Members identified from outpatient claims and encounters and excludes Members in the 2009 Diabetes or Cardiovascular Conditions QI Fund Projects. A random sample of eligible members will be selected for data collection purposes. IPAs that have not submitted complete encounter data for 2008 to McKesson will not be eligible for this project. For purposes of this project, encounter data will be considered to be complete if at least 2.0% of the IPA membership is identified using HEDIS Controlling High Blood Pressure specifications. Payment will be made in accordance with the criteria sent with the project mailing. Controlling High Blood Pressure QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows: ▪ IPA Blood Pressure Control rate ≥72%: 0.75% of Capitation Fees. ▪ IPA Blood Pressure Control rate ≥62% but <72%: 0.50% of Capitation Fees. ▪ IPA Blood Pressure Control rate ≥50% but <62%: 0.25% of Capitation Fees.	Up to 0.75%

Wellness and Prevention Project
Payment for the HMO Wellness and Prevention QI Fund Project requires submission of documentation by the specified date for a random sample of IPA Members age 3-74 for whom claims and/or encounter data confirm an IPA visit in 2008.
 	
The IPA must submit complete 2008 encounter data to be eligible for participation in this project. Payment will be made in accordance with the criteria sent with the project mailing. Wellness and Prevention QI Fund Project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.
 	
For 2009, payment for the alcohol use assessment (for adults) and the nutrition assessment (for children) will be based upon submission of data, NOT on results. Payment will be made as follows:
 	
BMI (Body Mass Index)
• 0.25% of Capitation Fees will be paid if BMI is documented for ≥25% of identified Members.
  • For children age 3-18, either BMI or BMI percentile in 2007 or 2008 is counted.
  • For adults age 18-74, BMI in 2007 or 2008 is counted.
 	
Assessment of and/or Recommendation for Physical Activity
▪ 0.25% of Capitation Fees will be paid if assessment of and/or recommendation for physical activity is documented for ≥25% of identified Members in 2007 or 2008.
 	
For Members age ≥18, advice to quit smoking in 2007 or 2008. Members who are documented to be nonsmokers are excluded from measurement.
▪ 0.25% of Capitation Fees will be paid if ≥25% of smokers received advice to quit smoking. (For purposes of this measurement, Members whose smoking status has not been assessed are assumed to be smokers.)
 	
In addition, 0.25% of Capitation Fees will be paid for submission of data for the following indicators for ≥90% of identified Members. This portion of the payment is based upon submission of data, not on results:
▪ For Members age 3-17, documentation of counseling for nutrition or referral for nutrition education in 2007 or 2008
▪ For Members age ≥18, assessment of alcohol use and, for alcohol users, screening for problem drinking using a standardized assessment tool in 2007 or 2008.
	Up to 1.00%

Patient Safety Physician Education Project Payment for the Patient Safety Physician Education QI Fund Project is based upon the percentage of IPA Physicians who complete the American Board of Medical Specialties Patient Safety Improvement Program between 1/1/2008 and 10/31/2009. Payment will be made in accordance with the criteria sent with the project mailing. Payment will be based on the better of the PCP rate and the All-Physician rate. PCP Thresholds ▪ IPA Physician completion rate ≥65%: 1.0% of Capitation ▪ IPA Physician completion rate ≥55% but <65%: 0.75% of Capitation ▪ IPA Physician completion rate ≥40% but <55%: 0.50% of Capitation ▪ IPA Physician completion rate ≥30% but <40%: 0.25% of Capitation All-Physician Thresholds ▪ IPA Physician completion rate ≥35%: 1.0% of Capitation ▪ IPA Physician completion rate ≥30% but <35%: 0.75% of Capitation ▪ IPA Physician completion rate ≥25% but <30%: 0.50% of Capitation ▪ IPA Physician completion rate >20% but <25%: 0.25% of Capitation	Up to 1.00 %

c. The HMO shall pay the IPA for quality site survey compliance scores of 90% for both physical site reviews and medical record content review, as determined by the HMO, which includes: accessibility, facility inspection, preventive care review, medical record quality of care and medical record entry for a possible total of one-half percent (0.5%) of Capitation Fees.

   Site visit compliance rates for the year ending December 31, 2009 will be based on the medical record review of all PCPs within the IPA for whom a review was completed in 2008. Subsequent reviews will occur biennially from the date of the last review.

d. The HMO shall calculate compliance rates for annual payments for the year ending December 31, 2009 and payment to the IPA will occur within 90 days of the end of this period. Upon termination of this Agreement, the HMO may retain an amount equivalent to outstanding bills of the IPA.

Prescription Drug Fund

The Prescription Drug Fund is determined annually and subject to the execution of the Medical Service Agreement. 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 total percentage of generic usage for the IPA for the year, on a paid date basis, according to the Top Prescribers Report will be used to calculate the Prescription Drug Fund Payment.

All RX 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.

> Appropriate management of prescription drug costs will be measured based on the generic drug utilization of the IPA by all providers. The HMO will pay the IPA an additional ten percent (10.0%) of Capitation Fees if generic drugs account for sixty-seven percent (67.00%) or more of total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA eight percent (8.0%) of Capitation Fees if generic drugs account for sixty-three to sixty-six point nine percent (63.00%-66.99%) of the total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA six percent (6.0%) of Capitation Fees if generic drugs account for sixty to sixty-two point nine-nine percent (60.00%-62.99%) of the total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA four percent (4.0 %) of Capitation Fees if generic drugs account for fifty-six to fifty-nine point nine-nine percent (56.00%-59.99%) of the total prescriptions for Members enrolled with the IPA and two percent (2.0%) of Capitation Fees if generic drugs account for fifty-three to fifty-five point nine-nine percent (53.00% - 55.99%) of the total prescriptions for Members enrolled with the IPA.

Co-Payments

1. Benefits for all covered services rendered by a physician on an outpatient basis (except for Maternity Services) can be subject to a co-payment per visit. These amounts vary by Benefit plan. Refer to the most current Benefit Matrix located at www.bcbsil.com for this information.

   Effective January 1, 2007, 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 co-payment per visit.

   Services rendered by any other health professional are not subject to the co-payment. 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 co-payment (see related note below).
2. When Medicare is primary and the HMO is secondary, the IPA, at their discretion, may charge the member an office visit co-payment when applicable, (for those members whose policies include an office visit co-payment).
3. When a member (with a co-pay) also has co-coverage as a dependent through a spouse's HMO insurance (who has a lesser or no co-pay); the lesser co-pay should be collected. Eligibility should be verified for both benefit plans.
4. 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 co-pay would not be applicable. Refer to Scope of Benefits Section for further information.
5. Some Benefit Plans have a two or three tier co-payment structure. The first is for a Primary Care Physician (PCP) office visit. PCPs include Family Practice, General Practice, Internal Medicine, Pediatrics and Obstetrics-Gynecology. 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.
6. Psychiatric care rendered under the supervision of a physician by a psychiatric social worker or other mental health professional is subject to a co-pay. Due to the Serious Mental Illness Legislation - effective with the employer group renewal after January 1, 2007 - a specialist co-pay will apply for all serious mental illness claims. The mental health co-pay, as indicated on the benefit matrix, will apply for all non-serious mental health services. A rehab co-pay (if applicable) will apply for speech therapy for treatment of pervasive developmental disorder claims.
7. There are some benefit plans that include an outpatient rehabilitative therapy co-payment. In determining the co-payment 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 co-payment. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.
8. For Chiropractic Services: If the chiropractor is acting as a Primary Care Physician (PCP), a PCP co-pay should be collected. If the member is being referred to the chiropractor by the PCP, the chiropractor is considered a specialist. The specialist co-pay should then be collected.
   Chiropractor Manipulations: If an office visit (E&M) code is billed with the manipulation code, an office visit co-pay should be collected. If the manipulation is billed without an office visit (E&M) code, no co-pay should be collected.
9. Routine eye exam co-payments: If a member has a three tier co-payment structure – a wellness co-payment should be collected. If a member has a two tier co-payment structure, a PCP co-payment should be collected.
10. Co-payments required by the member's benefit plan are not to exceed 50% of the Usual and Customary Fee for any single service.
11. For ABA Therapy: An outpatient rehabilitative therapy co-payment applies. In determining the co-payment 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 co-payment.