General Provider Payment Methods

Participating Providers

Several industry-standard methods are used to pay our health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health care plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health care plan. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - **Fee-for-Service –** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.
  - **Discounted Fee-for-Service –** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
  - **Discounted Fee-for-Service, Withhold and Bonus Payments –** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5-20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

- Institutional (i.e., hospital and other facility provider) Participating Provider Payments
  - **Inpatient Care**
    - **Payments for each Case (case rate) –** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is

      unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
    - **Payments for each Day (per diem) –** Providers are paid a fixed amount for each day the member spends in the hospital or facility.
    - **Percentage of Billed Charges** – Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient or outpatient services, including home services.
  - **Outpatient Care**
    - **Payments for each Category of Services** – Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - **Payments for each Visit** – Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
    - **Payments for each Patient** – Providers are paid a fixed amount per member per calendar year for certain categories of outpatient services.

Special Incentive Payments

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their members and further based on claims savings that the provider may generate in the course of rendering cost effective care to its member. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs.
These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payment.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost we determine by comparing market prices (for Generic Drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

Nonparticipating providers are not in-network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

When you use a nonparticipating provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield plan. For services received from a nonparticipating provider (other than those described under "Special Circumstances" below), the allowed amount will be based upon one of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge or Medicare Advantage allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Cross. The allowed amount for a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the health care plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "General Information," "Whom We Pay." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

In determining the allowed amount for nonparticipating providers, Blue Cross makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. Please refer to "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for services provided by nonparticipating providers.

- Example

	Participating Provider	**Nonparticipating Provider**
Provider Charge:	$150	$150
Allowed Amount:	$100	$80
Blue Cross Pays:	80% ($80)	60% ($48)
Coinsurance You Owe:	20% ($20)	40% ($32)
Difference Up to Billed Charge You Owe:	None	$70 ($150 minus $80)
You Pay:	$20	$102

The following table illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health care plan covers 80% for participating providers and 60% for nonparticipating providers. It also presumes that the allowed amount for a nonparticipating provider will be less than for a participating provider. The difference in the allowed amount between a participating and nonparticipating provider could be more or less than the 20% difference in the example below.

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (e.g., anesthesiologists) or independent laboratory providers may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care such as in a participating hospital and were not able to choose the provider who rendered such care (nonparticipating providers in a participating hospital or your participating physician sending laboratory samples to a nonparticipating laboratory), Minnesota law provides that you are not responsible for any amounts above what would have been required to pay (such as cost sharing and deductibles) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the nonparticipating provider's services, you should submit the bill to Blue Cross for processing. If you have questions, please contact Customer Service. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law – please refer to "Emergency Care" for coverage of benefits.

The above is a general summary of our provider payment methodologies only.
Further, while efforts are made to keep this form as up-to-date as possible, provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan.