# PROVIDER SERVICES AGREEMENT

This Provider Services Agreement (“Agreement”) is made and entered into between Morningstar, Inc (“Payer”) and (“Provider”), (together referred to as the “Parties”). This Agreement is effective as of the date on the signature page of this Agreement (“Effective Date”),

WHEREAS, Payer provides and arranges for the delivery and management of Covered Services to eligible Members;

WHEREAS, Provider desires to provide Covered Services to Members in Payer’s Products;

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement and other good and valuable consideration, the Parties hereto, intending to be legally bound, hereby agree as follows:

# SECTION 1: DEFINITIONS

* 1. Clean Claim.: A claim for payment for a Covered Service that has no defect or impropriety. A defect or impropriety includes, but is not limited to, lack of data fields required by Payer or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall not include a claim from a practitioner that is under investigation for fraud or abuse regarding that claim. The term shall be consistent with the Clean Claim definition set forth in applicable Federal or State laws and regulations.
  2. Copayment: The portion of the reimbursement for Covered Services that a Member is obligated to pay as a fixed dollar amount before a Covered Service is provided under a particular Product. Provider must collect Copayment from a Member prior to the provision of Covered Services, unless the Member requires Emergency Services as defined under this Agreement.
  3. Covered Services. The Medically Necessary health care services and supplies that are to be provided by Provider to Members for which a Member has coverage pursuant to the applicable Product.
  4. Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.
  5. Emergency. "Emergency" means the sudden and unexpected onset of a condition or symptoms requiring medical or surgical care to screen and/or treat the Member, and which is secured immediately after the onset (or as soon thereafter as the care can be made available), and is of such immediate nature that the Member's life or health might be jeopardized if he or she is not treated as soon as possible.
  6. Medically Necessary. Medical services or hospital services which are determined by Payer to be: (a) rendered for the treatment or diagnosis of an injury or illness; (b) appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; (c) not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and (d) furnished in the most economically efficient manner which may be provided safely and effectively to the Member.
  7. Member. An individual who, on the date of service, is eligible to receive Covered Services under a Product.
  8. Fee Schedule. “Fee Schedule” means the maximum amount which Network will pay for a specific service.
  9. Payer. Payer means any entity which is financially responsible for the provision of Covered Services to Members, including but not limited to a self-funded employer, multiple employer trust or union trust, or governmental entity which maintains appropriate licensure, if applicable, and that has entered into an agreement with Payer for the provision of Covered Services to Members through a Product.
  10. Product. Product means a health care benefits program or arrangement offered by a Payer which, pursuant to a written agreement with Payer utilizes participating providers to provide Covered Services to Members pursuant to the terms and conditions set forth in the corresponding Product Description, as defined below.
  11. Product Addendum. Product Addendum means the written attachment to this Agreement which sets forth specific terms and conditions for the provision of Covered Services to Members enrolled in Products. To the extent that the requirements set forth in this Agreement conflict with the provisions in the Product Addendum, the terms of the Product Addendum shall control.
  12. Product Description. Product Description means the written description located in the Provider Manual of any and all Products. Product Descriptions summarize the Covered Services to which Members may be entitled and for which participating providers may be reimbursed. Notwithstanding the forgoing, participating providers must verify Member eligibility and benefits to ensure proper reimbursement for the provision of Covered Services.
  13. Provider Manual. Provider Manual means the rules, policies and procedures adopted by a Product to be followed by Provider in providing services and doing business with Payer and Payers under this Agreement. Provider Manual will be made available to Provider on Payer’s website. Payer reserves the right to revise the Provider Manual in its discretion from time to time, with or without advance notice to Provider, including modifications to Payer procedures, documents or requirements, including those associated with utilization review, quality management and improvement, quality assurance, and credentialing, that have a substantial impact on the rights or responsibilities of Provider.
  14. Quality Management Program. The functions, including but not limited to, credentialing, recredentialing and certification of Providers, site visits, review and audit of medical and other records, medical outcomes, peer review and Provider appeals and grievance procedures performed or required by Payer, or any other permitted person or entity, to review the quality of Covered Services rendered to Members. Provider shall be notified on a periodic basis by Payer of changes or additions to such Quality Management Program that are relevant to Provider and the terms of this Agreement.
  15. Utilization Management Program. The functions including, but not limited to Preapproval, Referral and prospective, concurrent and retrospective review, case management and disease management performed or required by Payer or any other permitted person or entity, to review and determine whether medical services or supplies which have been or will be provided to Members are Covered Services under a Product and meet the criteria as Medically Necessary.

# SECTION 2: PROVIDER OBLIGATIONS

2.1 Scope of Services. Provider agrees to provide Covered Services to Members who have selected, or are otherwise assigned to, Provider in accordance with the terms of this Agreement and the Payer’s preauthorization and other Utilization Management Program polices as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider shall participate in all of Payer’s Products that Provider is qualified to provide services under provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by the Payer.

2.2. Access to Services. Provider agrees to provide on a twenty-four (24) hours a day, seven (7) days a week basis Covered Services to Members. Provider shall be responsible for determining whether Members are eligible for Covered Services on the basis of the most current Eligibility List issued for the month in which services are being furnished. Provider agrees that the average waiting time in Provider's office for an appointment scheduled by a Member shall be no greater than thirty (30) minutes. Provider shall make arrangements for coverage by a Covering Physician whenever Provider is unavailable. Provider may not utilize a non-participating physician as a Covering Physician without the express written approval of Payer's medical director. Provider shall be responsible for compensation payments to the Covering Physician and any non-participating physicians.

* 1. Emergency Services. Provider agrees to assist Members in obtaining Emergency Services, as necessary (including on-call after-hours telephone referral services) and/or assist the Payer to obtain, on behalf of a Member, crisis intervention services on a twenty-four (24) hours a day, seven (7) days a week basis.
  2. Outreach Services. Provider agrees to conduct affirmative outreach any time that a Member misses a scheduled appointment and will document such affirmative outreach attempts in the Member’s medical record.
  3. Excluded Services. This Agreement excludes services that Payer has elected to obtain under an arrangement between Payer and a national or regional vendor or provider or a capitated provider. Provider will not be reimbursed and will not bill Members for any such excluded services. If Payer notifies Provider that it no longer chooses to exclude a particular service from this Agreement, then that service will no longer be excluded.
  4. Referral Services. Provider will refer Members to providers participating in the Payer network whenever Provider is unable to provide Medically Necessary services. Provider is responsible for the care delivered by providers to whom Provider refers Members. Provider shall arrange for Referral Services according to the procedures established by Payer as set forth in the Provider Manual. Evidence of Referrals made by Provider must be submitted to Payer's Utilization Management department via immediate facsimile transmission, via U.S. Mail, or other pre-approved methodology within three (3) days of the date of arrangement of Referral Services. Referrals made to non-contracting specialists for non-contracted services without authorization from Payer's Utilization Management department shall be prohibited except for in the case of Emergency Services. Further, Provider will evaluate the outcome of the Referral Services and coordinate the Member's further medical needs.
  5. Provider’s Practitioners. Provider shall ensure that any employed practitioner shall accept all Members. Provider shall notify Payer within ten (10) days of the addition of a new practitioner.
  6. Pre-Authorization. The Payer’s Utilization Management Programs include requirements for pre- authorization of certain services. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from the Payer. The Covered Services subject to prior approval are more fully described in the Provider Manual and other Payer notices.
  7. Professional Liability Insurance. Provider shall maintain general liability, professional liability, worker’s compensation and other insurance to insure Provider, its employees, and its agents and contractors against claims, liabilities, damages or judgments arising directly or indirectly in connection with the performance or nonperformance of services under this Agreement. Provider shall ensure that professional liability insurance in an amount equal to the greater of the amount required by law, or the prevailing community standard is maintained for it, but in no event less than three Million Dollars ($3,000,000) per occurrence and five Million Dollars ($5,000,000) in the aggregate. Provider agrees to provide Payer with written evidence, acceptable to Payer, of its insurance coverage within three (3) business days of such request by Payer. Provider also agrees to notify, or to ensure that its insurance carriers notify Payer at least thirty (30) days prior to any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage provided for above.
  8. Utilization Management Requirements. Whether announced or unannounced, Provider agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by the Payer, and to follow practice guidelines as described in the Provider Manual and other Payer notices.
  9. Exclusive agreement clause: If the provider agrees to be in a exclusive agreement with the payer, then the provider will be paid 25% over and above the allowable reimbursement amounts. Exclusive agreement with the provider will only be allowed if the provider has both PCP and specialty physicians’ recruits. There will be quarterly check conducted by the payer to observe the ratio of PCP and specialist physicians. The ideal ratio of PCP and specialists for striking a exclusivity agreement is 3:2

# SECTION 3: CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

* 1. Compensation. Payer shall compensate Provider for Covered Services provided to Members in accordance with the provisions and procedures set forth in the Product Addendum and incorporated herein and in accordance with the Provider Manual and applicable law. Payer may, in its sole discretion, amend the Product Addendum. Provider shall participate in additional Products offered by Payer. Provider shall accept such compensation as payment in full for services rendered with the exception of any applicable copayments, coinsurance or deductible that may be due to Provider from Member. Notwithstanding any terms to the contrary, Payer shall compensate Provider for Covered Services in an amount equal to the lesser of billed charges and the amount set forth in the Product Addendum. Unless Company provides prior written approval to Provider, Provider shall make arrangements for and only accept Compensation Amounts by way of electronic funds transfer via the automated clearing house network (EFT-ACH).
  2. Claims Submission. Provider agrees to comply with all billing requirements as detailed in the Provider Manual. Where fee for service payment is required under applicable Product requirements, Provider shall submit to Payer Clean Claims in a format approved by Payer for Covered Services rendered to a Member within two forty (240) calendar days after such services are rendered. Where Payer is the secondary payer under Coordination of Benefits or where Provider billed another payer because Provider had a reasonable basis to believe that such other payer was the primary payer, such two forty (240) day period shall commence once the primary payer or other payer, as the case may be, has made payment on or has denied the claim. Payer shall not be under any obligation to pay Provider on any claim not timely submitted.
  3. Payment. Unless the claim is disputed, Payer shall make payment on each of Provider’s Clean Claims for Covered Services rendered to a Member, provided that Provider submits claims within the time required by applicable State or Federal law. Payer shall deny payment on any claims not submitted within the required time period. Claims payments to Provider shall be in accordance with the policies and procedures applicable to the Members' Product**.** Payer shall have the right to offset claim payments to Provider by any amount owed by Provider to Payer. Provider shall not be entitled to reimbursement if it is subsequently found that a Member’s coverage under an applicable Product Agreement was terminated prior to the date of service, regardless of any authorizations that may have been issued. Payer may delegate claims payment to a third party. Payments for Covered Services under this Agreement are subject to the Payment Policies. Those Policies may change from time to time.
  4. Medicaid Payments. For Medicaid Products, in the event the State Department of Health fails to provide or delays payment to Payer for the provision of Covered Services to Medicaid Members, Payer will suspend payment to Provider until such time as Payer receives payment from the Department. Payer will compensate Provider in a timely manner once payment is received from the Department. To the extent that the Department reduces any payments provided to Payer under the Medicaid program in any manner, Payer also will make corresponding reductions to any payments to Provider.
  5. Penalties. Provider agrees that to the extent penalties, fines or sanctions are assessed against Payer by a regulatory agency with governing authority over the services provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions if they arise from Provider’s failure to comply with Provider’s obligations under this Agreement, including but not limited to, Provider’s failure or refusal to respond to Payer’s or a regulatory agency’s request for medical records or credentialing information, the failure to provide other information required to be provided to Payer under this Agreement, or Provider’s failure to comply with the terms of Payer’s Provider Manual. In the event such payment is not made in a timely manner, Payer shall have the right to offset claims payments to Provider by the amount owed by Provider to Payer.
  6. Hold Harmless. Provider agrees, and shall ensure its subcontractors agree, that in no event, including, but not limited to, nonpayment, insolvency, or breach of this Agreement, shall Provider or subcontractor bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against Members or persons other than Payer acting on behalf of Member for Covered Services provided pursuant to this Agreement. Provider shall look only to Payer for compensation for Covered Services. This provision shall not prohibit collection of Copayments, coinsurances or deductibles in accordance with the terms of the applicable Member’s Product.
  7. **Billing for Non-Covered Services:** Provider agrees to notify Members in writing and in advance of any proposed services that Provider has reason to believe will not be covered or for which Provider has reason to believe that otherwise required preauthorization has not been obtained or has been denied and which, as a result, will be the personal obligation of the Member and not covered under this Agreement.
  8. **Billing Errors:**Provider agrees to refund to Managed Care Payers any amounts paid to Provider in error. Managed Care Payers reserve the right to offset against future amounts payable to Provider any such overpayments that are not repaid by Provider.

# SECTION 4: PAYER’S RESPONSIBILITY

# **Payment for Covered Services:** Payer will pay Provider for, and payer will obligate Affiliated Managed Care Payers to pay Provider for, Covered Services provided to Members in compliance with the requirements of the applicable Health Benefit Program. Such payments will be made in amounts determined according to the fee schedule or formula referenced or set forth in the applicable Health Benefit Program. Fee schedules and/or formulas for determining fee amounts may provide for different payments for the same procedures depending on the number of Members seen by Provider in a specified period of time or other specified criteria. If required by a Managed Care Payer’s contractual arrangement, such payments may be paid directly to the Member, absent an assignment of benefits to Provider. Provider is responsible to collect any copayments, coinsurance amounts, or deductibles applicable to Members according to the applicable Health Benefit Program.

# **Changes in Payment Methodology or Amounts:**Payer may amend the applicable fee schedules and/or payment formulas by following the notice requirements. Affiliated Managed Care Payers may change their fee schedules without giving advance notice, provided only that the resulting Managed Care Payer schedule or formula for making payments to Providers will, on aggregate for all Covered Services, provide for payments that are equal to or greater than the payments required to be made by Payer together with any amendments to the appendices. Affiliated Managed Care Payers will implement such changes within four (4) months of any change in the Payer schedule(s) or formula(s).

# Payer Licenses: Payer and Affiliated Managed Care Payers will be responsible to maintain all licenses and certificates necessary to permit them to operate lawfully within their Service Areas.

# SECTION 5: TERMS AND TERMINATIONS

* 1. Term. The term of this Agreement shall be from the effective date of the Agreement and shall continue in effect unless and until it is terminated as provided herein.
  2. Termination Without Cause. Either party may terminate this Agreement without cause upon ninety (90) days prior written notice to the other party. If this Agreement is terminated without cause, Provider shall continue to provide Covered Services for those Members requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination. Provider shall continue to provide Covered Services to such Members so long as the Member retains eligibility under a Product, until the earlier of completion of such services or the assumption of treatment by another provider.
  3. Termination for Cause. Payer may immediately terminate or suspend this Agreement, upon written notice to Provider stating the reason for such termination, in the event: (a) that in the judgment of Payer, any act or omission by Provider places persons receiving Covered Services in immediate danger of life, health, or safety; (b) of fraud by Provider related to the provision of Covered Services; (c) that criminal proceedings are initiated against Provider or any of its executive officers or board members; (d) that Provider initiates or consents to any judicial or non-judicial insolvency proceedings, including without limitation, any composition or assignment for the benefit of creditors; (e) that Provider is the subject of any involuntary insolvency proceedings that are not terminated within thirty (30) days of initiation; (f) that Payer's agreement with any of the Products for management of their respective program is terminated, suspended, or not renewed; (g) that Provider cannot or will not comply with any amendment to this Agreement; (h) that Provider is debarred from contracting with any agency, division, or other instrumentality of the State or any Federal agency; or (i) that any of Provider’s practitioners lose their license or any other public agency approval to provide Covered Services under applicable statutes or regulations of the State or the Federal government.

# SECTION 6: GENERAL PROVISIONS

* 1. Confidentiality. The Parties will comply with all applicable State and Federal laws and regulations regarding patient privacy and security requirements, including the privacy and security provisions set forth at 42 C.F.R. §403.812. The Parties will not disclose any information or knowledge concerning the other party's operations or procedures, which is hereby deemed confidential information, except as otherwise required by law. Each party also will keep the terms of this Agreement confidential except as required by applicable law. Notwithstanding the above, Payer may disclose this Agreement in accordance with applicable law, including to applicable regulatory authorities.
  2. Indemnification. Provider will defend, hold harmless, and indemnify Payer and its directors, officers, members, agents, contractors, or employees from and against any and all claims, suits, liabilities, damages, judgments, costs, and expenses, which may be imposed upon, or suffered or incurred by, any of them as a result of claims by third parties or by employees of Provider and which arise out of, derive from, or pertain to any negligence and/ or actual or alleged acts or omissions by, or on the part of, the Provider or any of its directors, officer, agents, contractors, or employees.
  3. Independent Contractor. The relationship between the Parties will solely be that of independent contractors engaged in the operation of their own respective businesses and neither party is authorized to or shall represent that it is authorized to make any agreement, representation or warranty, or to incur any liability on behalf of the other party except as may be specifically authorized in writing by the other party.
  4. Assignment. This Agreement shall inure to the benefit of and be binding upon the Parties’ successors and assigns. Neither party may assign this Agreement or any rights or obligations pursuant to this Agreement or subcontract any obligations under this Agreement to any other entity without the prior written approval of the other party; provided, however, that Payer may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Provider.
  5. No Third-Party Beneficiary. This Agreement has been entered into solely for the benefit of Provider and Payer, and is not intended to create any legal, equitable, or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.
  6. Notices. All notices required under this Agreement will be in writing and sent by certified mail, return receipt requested, hand delivery, or overnight courier addressed as identified on the signature page.
  7. Amendments. For amendments that are a material adverse change in the terms of this Agreement, Payer can amend this Agreement by providing ninety (90) days’ advance written notice. The change will become effective at the end of the ninety (90) day notice period. If Provider objects to the material adverse change and notifies Payer of its intent to terminate within thirty (30) days of the date of the notice of amendment, the termination will be effective at the end of the ninety (90) day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law. For amendments that are not materially adverse changes in the terms of this Agreement, Payer can amend this Agreement by providing thirty (30) days’ advance written notice to Provider.
  8. Waiver. The waiver of any breach or violation of any term or provision hereof will not constitute a waiver of any subsequent breach or violation of the same or any other term or provision.
  9. Governing Law. This Agreement shall be governed in all respects by the laws of the State where Payer’s primary office is located. In the event of a lawsuit, venue shall be proper only in the county where Payer’s primary office is located.
  10. Dispute Resolution. Disputes that might arise between the Parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Provider Manual. In the event the dispute is not resolved through that process, either party can request in writing that the Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute, Provider must submit a request for arbitration within twelve (12) months of the date of the letter communicating the final decision under Payer's internal dispute resolution process. If arbitration is not requested within that twelve (12) month period, Payer’s final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Payer, Payer or the Member for any payment denied because of the failure to timely submit a request for arbitration.
  11. No Consolidation. Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between the Parties. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

# THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

# IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

# PAYER:

# MorningStar, Inc.

# Authorized Signature:

# Print Name: \_\_\_\_\_\_\_\_

# Title: \_\_\_\_\_\_\_\_

# Signature Date:

# ECM #:

# To be completed by Carolina Complete only: Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20

# PROVIDER:

# ……………………………………………..

# Authorized Signature:

# Print Name: \_\_\_\_\_\_\_\_

# Title: \_\_\_\_\_\_\_\_

# Signature Date:

# Tax Identification Number:

# State Medicaid Number:

# National Provider Identifier

# Exclusive Agreement: □Yes □No

**FEE SCHEDULE: PRIMARY CARE PROVIDER**

We are using a capitation method to reimburse the fee for the primary care provider. Capitation is a type of a health care payment system in which a doctor or hospital is paid a fixed amount per patient for a prescribed period of time by an insurer or physician association. The amount of remuneration is based on the average expected health care utilization of each patient in the group, with higher utilization costs assigned to groups with greater expected medical needs.

**Kindly refer to the below capitation pricing model:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Factor | | Previous Year | | | Projected for next Year | | |
| Age | Female | Male | Female | Male | Total | Female | Male | Total |
| 0-5 | 0.85 | 0.85 | 4725 | 4770 | 9495 | 4650 | 4800 | 9450 |
| 6->15 | 0.4 | 0.4 | 6750 | 6380 | 13130 | 6550 | 6420 | 12970 |
| 16-25 | 1.1 | 0.5 | 7100 | 7125 | 14225 | 7045 | 7175 | 14220 |
| 26-35 | 1.3 | 0.6 | 7780 | 7880 | 15660 | 7930 | 8025 | 15955 |
| 36-45 | 1.3 | 0.7 | 12650 | 13020 | 25670 | 13050 | 13190 | 26240 |
| 46-55 | 1.5 | 1 | 6720 | 5905 | 12625 | 6800 | 6045 | 12845 |
| 56-65 | 2.2 | 2.3 | 3780 | 2920 | 6700 | 3990 | 3100 | 7090 |
| 65+ | 2.3 | 2.6 | 1550 | 945 | 2495 | 1625 | 975 | 2600 |
|  |  |  |  |  |  |  |  |  |
| Total Member Month |  |  |  |  | 100000 |  |  | 101370 |
| Total factor |  |  |  |  | 1.021 |  |  | 1.029 |
| Change in Factor |  |  |  |  |  |  |  | 1.007835 |

*These policies apply to all Payer’s plan products. The member’s contracted health plan benefits must be in effect on the date that services are rendered. Payer reserves the right to review and update our Reimbursement Policies periodically.*

Payer reimburses its providers based on the current CMS Medicare fee schedule. We will adopt any reimbursement or methodology changes required by CMS guidance or federal or state laws/regulations, and we do incorporate annual CMS increases or decreases to the fee schedule. Although we use the CMS fee schedule, we occasionally may process claims outside of the standardized CMS payment logic.

The primary fee schedules are:

* CMS Inpatient Prospective Services (IPPS)
* CMS Outpatient Prospective Services (OPPS)
* Physician Fee Schedule (MPFS)
* Durable medical equipment, prosthetics and orthotics, and supplies (DMEPOS)
* CMS Laboratory Fee Schedule
* CMS Average Sales Price (ASP)
* Home Health PPS
* Hospice PPS
* Other applicable CMS fee schedules

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Category** |  | **Annual services/1000 members** | **Average cost/service**  **(in $)** | **Gross PMPM**  **(in $)** | **Copay**  **(in $)** | **Net PMPM**  **(in $)** |
|  |  |  |  |  |  |  |
| **Inpatient facility** |  | 250 | 1200 | 25 | 0 | 25 |
|  |  |  |  |  |  |  |
| **Outpatient Facility** |  |  |  |  |  |  |
|  | Emergency room | 153 | 280 | 3.57 | 50 | 2.93 |
|  | Outpatient surgery | 75 | 1250 | 7.81 |  | 7.81 |
|  | Diagnostic X-ray | 210 | 275 | 4.81 |  | 4.81 |
|  | Diagnostic Lab | 300 | 40 | 1.00 |  | 1.00 |
|  | Other outpatient facility | 250 | 200 | 4.17 |  | 4.17 |
| Total Outpatient facility |  |  |  |  |  | 20.72 |
|  |  |  |  |  |  |  |
| **Physician Services** |  |  |  |  |  |  |
|  | Office Visits | 2945 | 50 | 12.271 | 10 | 9.82 |
|  | Surgery | 420 | 300 | 10.500 |  | 10.50 |
|  | Deliveries | 15 | 1800 | 2.250 |  | 2.25 |
|  | Radiology | 800 | 75 | 5.000 |  | 5.00 |
|  | Lab | 2800 | 15 | 3.500 |  | 3.50 |
|  | Other | 1520 | 135 | 17.100 |  | 17.10 |
| Total Physician facility |  |  |  |  |  | 48.17 |
| **Pharmacy** |  |  |  |  |  |  |
|  | Brand | 4050 | 50 | 16.88 | 12 | 12.825 |
|  | Generic | 2700 | 15 | 3.38 | 7 | 1.8 |
| Total Pharmacy |  |  |  |  |  | 14.625 |
|  |  |  |  |  |  |  |
| Sub Total |  |  |  |  |  | 108.52 |
| Age/Gender Adjustment |  |  |  |  |  | 1.007 |
| Grand Total-Projected Capitation Requirement |  |  |  |  |  | **109.52** |

**CAPITATION MODEL:**