McPhee
& ASSOCIATES, INC.
Managed Care Insurance

REQUEST FOR PROPOSAL

CAPITATED PROVIDER
STOP-LOSS QUESTIONNAIRE

www.McPheeAssociates.com

THE INFORMATION CONTAINED IN THIS REQUEST AND TRANSMITTED WITH IT IS TO BE USED ONLY FOR THE UNDERWRITING OF STOP-LOSS INSURANCE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND WILL NOT BE RELEASED TO ANY PARTIES OTHER THAN THE APPROPRIATE INSURANCE CARRIERS FOR THE PURPOSE OF GETTING QUOTES.

GENERAL INFORMATION

Name of Medical Group	
Street Address	
City, State, Zip	
Contact	
Title	
Telephone Number	
Fax Number	
E Mail Address	

Name of Hospital	
Street Address	
City, State, Zip	
Contact	
Title	
Telephone Number	
Fax Number	
E Mail Address	

If this is an MSO or other type of entity, please provide the data under the section for Medical Group and identify type of entity. If an MSO, please provide name and address of the medical groups to be covered.

COVERAGE DESIRED

REQUESTED EFFECTIVE DATE:

Physicians Deductible:		$		$		$		Other:
Hospital Deductible:		$		$		$		Other:
Global Deductible (Hospital & Physician Combined)		$		$		$		$

Coinsurance:		80%		90%		Other:

MAXIMUM ELIGIBLE EXPENSE

PHYSICIANS:	
IN-NETWORK (CONTRACTED PROVIDERS)	**Out-of-Network (Non-Contracted Providers)**
_____% RBRVS of _____Year	Option A: ____% RBRVS of _____Year
Provide conversion factor of Anesthesiology if different than above:	Option B: Amount Paid
Other (Specify):	Option C: Other (Specify):
List any specialists/providers paid other than above:	

HOSPITAL:	
IN-NETWORK (CONTRACTED) PROVIDERS	**OUT-OF-NETWORK (NON-CONTRACTED PROVIDERS)**
Option A: $_____Med./Surg.$_____NICU/CCU/ICU	Option A: $_____Average Per Diem
Option B: $_____Average Per Diem	Option B: Amount Paid
Option C: _____% Percentage of Charges to	Option C: Other (Specify):
Option D: Other (Specify):	

CAPITATION CONTRACTS

Please provide the following information regarding the capitation contracts you have with various Managed Care Organization. Use the back of this form or attach additional sheets as necessary.

HMO 1				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	Medi-Medi (D-SNP)
	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD
	Medicaid Expansion	Other (Specify):		

HMO 2				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	Medi-Medi (D-SNP)
	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD
	Medicaid Expansion	Other (Specify):		

HMO 3				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	Medi-Medi (D-SNP):
	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD
	Medicaid Expansion	Other (Specify):		

HMO 4				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	Medi-Medi (D-SNP):
	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD
	Medicaid Expansion	Other (Specify):		

HMO 5				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	Medi-Medi (D-SNP):
	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD
	Medicaid Expansion	Other (Specify):		

ENROLLMENT - A SPREADSHEET IS ALSO ACCEPTABLE

CURRENT ENROLLMENT AS OF _____ (Provide Date)

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

MEMBER MONTHS - CURRENT YEAR - FROM _____ THROUGH _____

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

MEMBER MONTHS - PREVIOUS YEAR - FROM _____ THROUGH _____

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

MEMBER MONTHS - 2 YEARS AGO - FROM _____ THROUGH _____

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

MEMBER MONTHS - 3 YEARS AGO - FROM _____ THROUGH _____

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

MEMBER MONTHS - PROJECTED FOR NEXT YEAR

HMO	Comm./ POS	Exchange	Medicare Advantage	Medi-Medi (D-SNP)	Medicare C-SNP	Medicare I-SNP	Medicaid Non-SPD	Medicaid SPD	Medicaid Expansion
1									
2									
3									
4									
5									

PROVIDER INFORMATION

VENDOR	NUMBER UNDER CONTRACT TO YOU	VENDOR	NUMBER UNDER CONTRACT TO YOU
Physicians – Primary		Physicians – Specialty Care	
Hospitals		Anesthesiologists	
Oncologists		Cardiologists	
Neonatologists		Neurologists	
List any other specialists with special arrangements. Attach additional sheets if necessary.			

HOSPITALS ONLY	List contracted hospitals with their per diem or discount arrangement. *Include outlier (stop-loss) arrangements, if any.*			
NAME	CARDIAC	MED./SURG.	ICU	NICU
If there are any special arrangements for Trauma, Burn, Transplants, Oncology, Neurology, or Level 4 NICU, please provide data:				

PROVIDER	List any provider that is subcapitated – and exactly what is subcapitated *Include outlier arrangements, if any.*

UTILIZATION AND CONTROL PROCEDURES

Please provide details on utilization review procedures and large case management arrangements used by your facility/organization to control costs. Please use back of form or attach separate sheets as needed.

1. Control over utilization:
2. Prevent excess length of hospital in-patient stays:
3. Assure quality medical service to members:
4. Provide meaningful peer review:

BED DAYS PER THOUSAND		
Commercial:	Medicare Advantage:	Medicare SNP:
Medicaid Non-SPD:	Medicaid SPD:	Other:
AVERAGE COST PER DAY (AVERAGE PER DIEM)		
Commercial:	Medicare Advantage:	Medicare SNP:
Medicaid Non-SPD	Medicaid SPD:	Other

STOP-LOSS EXPERIENCE

Please provide the following information on the current reinsurance arrangement(s) you have on your current capitation contracts. Complete for each different reinsurance arrangement in force. Use back of form or attach separate sheets as needed.

Name of Present Carrier		
Current Contract Period		
Current Coverage	Deductible: $	Co-Insurance: %
	Maximum Benefit: $	Rates: $ Per member per month

SUBMIT A COPY OF THIS COVERAGE WITH THIS FORM

The information contained in this request and transmitted with it constitutes the data upon which a proposal will be based. In submitting this proposal request, the undersigned warrants that he or she has made a diligent effort to verify the information contained herein; and that, to the best of their knowledge and belief, such information accurately represents the facts; and that no pertinent information has been omitted or altered.

Signature	**Date**
Title	**Company**

DOCUMENTS TO ACCOMPANY THIS APPLICATION

- Copy of capitation agreement(s) with HMO(s) or **division of responsibility matrix (DoFR**).
- Please include all enrollees for the current and past three years who:

1. Have reached 50% or more of the lowest deductible requested.
2. Are in the hospital and are expected to exceed 50% of the lowest deductible requested.
3. Are under treatment or a serious condition which can be expected to exceed 50% of the lowest deductible requested in total expenses; or
4. Have been identified as candidates for a major operation, extensive care or awaiting evaluation or on a transplant list.

The information should include details as the following for each member (broken down by type of Membership - Commercial, Medicare Advantage, Medicare SNP, Medicaid Non-SPD, Medicaid SPD, etc.):

1. Name of member or I.D. number
2. Line item details including billed, paid, CPT codes, revenue codes, quantity, etc. with total expenses to date
3. Diagnosis/prognosis
4. Expected final expense total
5. If member is currently hospitalized
6. If Hospital Coverage is to be quoted, if possible, provide a breakdown between inpatient hospital days and subacute days (SNF, ECF, Rehab facility, HHC)