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: $_____Med./Surg.$_____ ICU	**Option A**: $_____Average Per Diem
Option B: $_____Average Per Diem	**Option B:** Amount Paid
Option C: _____% Percentage of Charges	**Option C:** Other (Specify):
Option D: Other (Specify):	

CAPITATION CONTRACTS

Please provide the following information for the capitation contracts with various Managed Care Organization.

PLEASE PROVIDE COPY OF THE DOFR FOR EACH HMO AND EACH TYPE OF MEMBERSHIP

HMO 1				
Street Address				
City, State, Zip				
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				
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				
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				
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				
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 Care		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**
Deductible: $	**Co-Insurance: %**	**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**

CURRENT AND HISTORICAL CLAIMS DATA REQUESTED

Please include all enrollees for the **current and past three years** who:

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

The information should include LINE 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)