

**ASG Risk Management, Inc.**

**MANAGED CARE NETWORK QUESTIONNAIRE**

**General Information:**

Name:  
Address:  
Key Contact:  
Phone:  
Fax:  
Email:  
Website:

Ownership:  
Date Operations Commenced:  
Licenses/Status:  
Network Service Area by zip code and/or county/state:

Number of Carriers/TPA's Accessing Network:  
List top 3 Carriers and Number of Covered Members:

Number of Covered Members in each of last 3 years:

**Access Information:**

Number of Primary Care Physicians:  
Market Share %:

Is a gatekeeper mechanism employed:  
Do PCP's assume any risk:  
If yes, please provide details of risk mechanism:

Number of Specialists:  
Market Share %:  
(attach breakdown by major specialty area)

List any Specialties not contained in your network:

List any other medical services not available within your network:

Are there arrangements with out of area facilities for these services:  
If yes, please indicate facilities and describe contractual arrangement:

Describe facilities available for premature births, cancer, organ transplants, multiple trauma, severe burns or other high level tertiary care:

**Utilization Review/Medical Management:**

Criteria Used to review admissions and continued stay:

Does the UR staff have access to claims information:

Does the UR staff handle both in-network and out-of-network claims:

Average number of pre-certifications per month:

Percentage of members UR is performed on:

How often is concurrent review performed:

Is inpatient care managed according to “best practices” guidelines:

Average savings from UR reported to employers:

Do you have a high risk maternity program:  
If yes, describe program and how pregnant members identified:

Are any disease management programs employed:  
If yes, describe what diseases are covered, how program works and members identified:

**Hospital Utilization:**

	Current Year	Prior Year
Admissions per 1000	_____	_____
Medical Bed Days per 1000	_____	_____
Surgical Bed Days per 1000	_____	_____
Obstetrical Bed Days per 1000	_____	_____
Psych/S.A. Bed Days per 1000	_____	_____
ICU/CCU Bed Days per 1000	_____	_____
Total IP Bed Days per 1000	_____	_____

Is the above for in-network only or include out-of-network utilization:  
Describe how members are calculated for bed-day purposes:

**Network Charges:**

<u>Type of Service</u>	<u>Network Charge</u>
Monthly Access Fee	_____
Repricing	_____
Utilization Review	_____
Case Management	_____
Start Up Fee	_____
Directory Fee	_____

**Provider Reimbursement:**

**Hospitals**

- List contracted hospitals by name, address and type of facility.
- Describe reimbursement method and amounts for each facility, separately for inpatient and outpatient.
- Describe any outlier arrangements and amounts.
- Describe any case rate arrangements.
- Describe any ancillary service discount arrangements not included in hospital contract.
- Indicate expiration date for each contract.
- Indicate which, if any, facilities are used as center of excellence or on exclusive basis for high level tertiary services.

**Physicians**

- Describe reimbursement method for physicians (fee schedule, RBRVS, % of billed, etc.).
- For last 12 months, provide total in-network billed charges, eligible claims and paid claims.
- Attach fee schedule (electronically preferred) or complete attached schedule. Please attach schedule even if described as a percent of RBRVS or Medicare to ensure correct fee level is used.
- Describe how fee schedule applied – fixed, maximum reimbursable, other.
- Describe process and frequency of adjustment to fee schedules and when next change will occur and expected level of change.
- Describe any financial risk sharing or other incentive arrangements with providers.

### **Prescription Drugs**

- Name of vendor if outsourced.
- Describe pricing formula for retail pharmacy.
- Describe pricing formula for mail order pharmacy.
- Describe any formulary and/or rebate arrangements
- Describe DUR arrangements.
- Average savings for current and prior year.

### **Ancillary Services**

Describe any contractual arrangements and average savings for the following services:

- Outpatient Lab & X-Ray
- Skilled Nursing
- Home Health
- Durable Medical Equipment
- Physical, Speech & Occupational Therapy
- Chiropractic
- Podiatry
- Other

### **Supporting Data:**

The following additional information may be provided to increase the accuracy of the evaluation process:

- Copy of current provider directory.
- Service area map.
- Description of provider credentialing process.
- Description of utilization/disease management programs.
- Copies of savings reports.