NorthWind, LLC

Network Evaluation Questionnaire

Name of Organization:
Address:
City, State, Zip:
Telephone:
Contact Name:
Title:
Email:

General Questions

1: Describe ownership and history of the organization and service area.
2: Describe your fee for accessing the network, i.e., PEPM, % of savings, etc…
3: Do you lease any networks as a wrap around or do you lease your network to other networks.
4: Describe services you provide, such as, case management or utilization review and the associated fees.

Enrollment Profile:

5: Provide the following membership information by benefit plan type (product) and highlight your product differences. Identify if the benefit plan is a subset of a larger network.

Benefit Plan Type (product)	**Number of Covered Lives** Most Recent Count (as of ____ / _____ / ____)
PPO	________________________________
EPO	________________________________
Other (specify)	________________________________
Total Number of Lives	________________________________

6: What is the minimum steerage coinsurance differential that is required in your benefit plan design?

Physician Information:

7: Do primary care physicians have "gatekeeper" responsibilities within your system? Y / N
If no, how are specialty utilization and out-of-pocket referral costs controlled?

8: Describe your physician selection / credentialing and termination criteria (including disciplinary action policies and procedures.) How often are physicians recredentialed? What percent of your physicians are credentialed?

9: Provide the following physician counts: total # PCP's, total # board certified PCP's, total # specialists, total # board certified specialists.

Physician Fee Schedule by CPT-4 Code:

10: Provide fee schedules on diskette or by email to mfiechter@northwindllc.com. If schedules vary by area or product, provide each schedule and corresponding area or product. If more appropriate, express fee schedule in another form, i.e... 145% of RBRVS.

Hospital Information:

11: Is hospital reimbursement at the lesser of billed charges or contracted price? Y / N

12: Is outpatient reimbursement limited to not exceeding the contracted inpatient price? Y / N

13: Describe and document your hospital selection, credentialing and termination criteria.

Hospital Reimbursement Information – required for each network hospital:

14: If the reimbursement is a discount from billed charges, indicate the discount given. If DRG based, provide conversion factors or reimbursement by DRG. If per diem, provide per diems as shown below. Show all categories for which a per diem has been negotiated

15: Regarding Outliers:
Provide outlier arrangement details for DRG or per diem contracts.
In specifying outlier arrangements, be specific, i.e... "entire charge amount reverts to a 25% discount off billed charges once charges exceed $40,000."

Sample Hospital Reimbursement Information

STATE	Name	Contract Type	Effective & Term Date of Current Contract	Disc %	DRG Factor	Min Disc	Max Disc	Per Diem Arrangements						Outlier
								Med	Surg	ICU	CCU	Normal Delivery	C-Sectn	
IN	ABC Hosp	DFFS[1]		10%										
IN	DEF Hosp	DFFS[2]		15%										
IN	GHI Hosp	DRG			5500									[3]
IN	JKL Hosp	Per diem				5%		1250	1250	2800	2850	2000	3000	None
MI	MNO Hosp	Per diem				5%	30%	1300	1300	3100	3100	2250	3750	None
MI	XYZ Hosp	Per diem						1300	1250	3200	3200	2250	3700	[4]

[1]DFFS = Discounted Fee For Service
[2]DFFS = 15% for al charges except outpatient services which are discounted 10%
[3]Charges above $35,000 arre reimbursed @ 17% discount off billed charges
[4]Entire charge reimbursed at 25% for charges that exceed $30,000

16: Provide us with a claimant-by-claimant listing of all in-network claims over $30,000 before and after repricing (billed and repriced), for the latest 12-month period. Identify the network hospital for each claimant, hospital state and zip code. See sample below.

Sample Claimant Information

Claimant	Billed	RePriced	Hospital	Hosp. State	Hosp. Zip
#1.	100,000	90,000	ABC	IN	46202
#2.	40,000	30,000	XYZ	MI	48201

If your provider contracts differ between the different products you offer, please provide this information separately.

Provide all claim information on diskette, cd-rom or by email to mfiechter@northwindllc.com.

Medical Management & Quality Assurance:

17: Number of Medical Directors and staff, i.e... 3 RN's, 2 LPN's, etc… and average year's clinical experience.

18: Describe your inpatient and outpatient pre-admission certification, concurrent review process, discharge planning and retrospective review processes.

19: Describe your case management program and how cases are identified for potential case management.

20: Provide copies of any reports that demonstrate medical management capabilities and / or savings.

21: Indicate accreditation, such as, National Committee for Quality Assurance (NCQA), America Accreditation Health Care Commission, and Utilization Review Accreditation Commission (URAC).

22: Describe your quality assurance and improvement program and provide a copy of the guidelines.

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