PartnerRe

Specialty ACO – Request for Quotation

CLIENT SPECIFIC INFORMATION

Name of Provider: ____________________

Principal Address: ____________________

Domiciled State (if different): ____________________

Number of Years in ACO: ________

Reason if ever left ACO and when: ____________________

Current Carrier: ____________________

MEDICARE ACO SEPARATE BY ARRANGEMENT

ACO Payment Arrangement: ☐ Track 2 ☐ Pioneer

*Note, Track 1 is a shared savings only model and not eligible for coverage.

Estimated number of Covered Persons: ____________________

Covered Services Medicare Parts A & B ☐ Yes ☐ No

If no, please explain: ____________________

If less than 3 years with the ACO, do you have prior or current experience with Medicare Advantage plans? ☐ Yes ☐ No

If yes, please describe your arrangements and loss ratios: ____________________

Max amount of loss share $________________ ________________%

COMMERCIAL ACO SEPARATE BY ARRANGEMENT

Contracted payer: ____________________

Estimated number of Covered Persons: ____________________

Covered Services: ____________________

Methodology for establishing the budget and actual PMPMs: ____________________

____

____

Covered services in the budget and chargeable PMPM by each Policy Period: ____________________

Ratio and terms of Provider's loss of actual charges to budget

Max amount of loss share $________________ ________________%

MEDICAID ACO SEPARATE BY ARRANGEMENT

Contracted payer: ____________________

Estimated number of Covered Persons: ____________________

Covered Services: ____________________

Methodology for establishing the budget and actual PMPMs: ____________________

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Covered services in the budget and chargeable PMPM by each Policy Period: ____________

Ratio and terms of Provider's loss of actual charges to budget

Max amount of loss share $________________ ________________%

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REQUESTED COVERAGE

Policy Period: ______________________________

Final settlement due date (e.g. 6, 12, 18 months after the end of the period): ______________________

Are you looking for specific excess of loss coverage? ☐ Yes ☐ No If yes, please indicate preference below

Specific Deductible: $ __________

Policy Limit: $ __________

Coinsurance: __________%

Reimbursement/Payment Methodology: ______% of Medicare

If different, please indicate: ______%

Are you looking for aggregate excess of loss coverage? ☐ Yes ☐ No If yes, please indicate preference below

☐ Attachment Point: ______% (e.g. 105%, 110%) ☐ PMPM Budget: $ ______

Policy Limit: $ __________

Coinsurance: __________%

PROVIDER NETWORK

Please provide the following information for your provider network:

	Name	Location	Est. days per thousand usage
Owned facilities			
Physician groups			
Contracting hospitals (non-owned)			
Referral hospitals (not part of network)			

Please describe any of your specialized expertise e.g. medical specialists, nursing professionals, allied health professionals, etc.

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AGGREGATE COVERAGE DUE DILIGENCE AUDIT WILL REVIEW THE FOLLOWING:

- ☐ Electronic capability to track a Covered Person's care
- ☐ Means to stay current with changing medical protocols
- ☐ Staff performing administrative functions, clinical functions, and administrative and clinical oversight functions
- ☐ Interdisciplinary Care Team (ICT)
- ☐ Communication network to the providers/members/public
- ☐ Specific care management goals of your business
- ☐ Health Risk Assessment (HRA) tools that your organization uses to identify the specialized needs of members
- ☐ Add-on services you provide vulnerable/need and chronic sub-populations of your membership

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DOCUMENTS TO ATTACH WITH THIS FORM

- ☐ Preliminary or final baseline/benchmark report; “base period aligned beneficiary expenditures for Medicare coverage only
- ☐ Managed or unmanaged experience for the prior three years
- ☐ Actuarial verification of Benchmark or PMPM and projected savings
- ☐ Claims probability distribution supporting the Benchmark or PMPM
- ☐ ACO contracts for non-Medicare ACO coverage

BROKER OF RECORD

Broker of Record: ☐ Yes ☐ No If yes, number of years as BOR: ____________

Date Quotation Due: ____

Broker Commission (requested): ____________________________________

SIGNATURE

This proposal will be based upon the information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.

Signature: ______________________________________ Date: ____________

Title: ____

Phone: ____

E-mail Address: ____________________________________

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