NOTICE OF INTENT TO CONTRACT

FOR

SAFENET PLAN OPTION

HEALTH CARE SERVICES

ISSUED BY

THE STATE OF LOUISIANA

DIVISION OF ADMINISTRATION

OFFICE OF GROUP BENEFITS

October 20, 2003

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A. Background and Purpose

The of the Office of Group Benefits (OGB) is authorized by statute to provide health and accident benefits and life insurance to State employees, retirees and their dependents. Plan participant eligibility includes employees of State agencies, institutions of higher education, local school boards that elect to participate in the Program and certain political subdivisions. Eligibility does not include local government entities or municipalities.

OGB provides self-insured health and accident benefit plans for approximately 97,000 employees/retirees (covered contracts) and 183,000 covered lives. The term, covered contract, as used in this NIC is defined as any class of coverage in which a plan member is enrolled, whether single, two-party or family. Therefore, a covered contract includes the employee or retiree and any covered dependents. The self-insured benefit plans available to plan participants, effective July 1, 2003 are: Preferred Provider Option (PPO), administered by OGB; Exclusive Provider Option (EPO) (HMO-like benefit design with out-of-network benefits, administered by United HealthCare in Region 6 and administered by OGB and all other Regions; and the Managed Care Option (MCO) (HMO-like benefit design, no out-of-network benefits) administered by FARA Benefits Services, Inc.

The OGB also contracts with HMOs through a competitive negotiation process to offer HMO services to plan participants as an enrollment option. The HMOs currently under contract with the Program are Vantage Health Plan and Ochsner Health Plan. Approximately 29,000 (covered contracts) and 61,000 covered lives are involved and are insured on a capitated basis with the referenced HMOs.

The Louisiana State University System is currently offering its employees a consumer-driven pilot program with an additional defined contribution plan option.

The services sought pursuant to this Notice of Intent to Contract (NIC) will be an additional option, the Safenet Plan Option (SafeNet) open to employees who are eligible to participate in OGB, but who have not had health care coverage for more than one year. The plan design has not been finalized at this time. It will be developed in accordance with the authority granted to OGB pursuant to R.S. 42:801, et.seq. and Act 528 of 2003, the Louisiana Safety Net Health Insurance Program (copy attached)

B. Service Region

The Service Region established by and defined by U. S. Postal Service ZIP Codes for which provider networks are solicited through this NIC include:

Region 6 - Baton Rouge Area (Zip Codes 707 & 708).

C. Health Care Services Sought and Criteria for Participation

1. Hospital Services

a. One or more acute care hospital facilities may be selected for participation. To be eligible for selection as an acute care hospital facility, the hospital shall provide the following services :

i. General medical and surgical facilities (inpatient and outpatient);
ii. Intensive and critical care units;
iii. Emergency care facility;
iv. Cardiovascular care unit;
v. Obstetrical care, unless the Program contracts directly with an obstetrical care hospital facility in the region;
vi. Rehabilitation; and
vii. Skilled nursing unit.

b. In geographic areas within Region 6 where the bidder(s) may not offer or is(are) unable to offer adequate access to members, such as rural areas, OGB reserves the right to contract with acute care hospital facilities (possibly including LSU hospital facilities), at its discretion, in order to provide appropriate access to its members

c. As a condition of participation in the SafeNet Plan Option network, participating hospitals must contract with hospital based physicians including radiology, pathology, anesthesiology, emergency medicine, and others at such hospital who agree to participate in the SafeNet Plan Option as part of the physician network.

2. Physician Services

a. One or more physician networks may be selected for participation in Region 6. To be eligible for selection, a physician network shall have at least twenty (20) primary care physicians. Primary care physicians are licensed medical doctors practicing in the areas of family practice, general practice, internal medicine, pediatrics, and obstetrics/gynecology. A minimum of four (4) physicians must practice in each of the following categories:

i. Family Practice, General Practice, or Internal Medicine;
ii. Pediatrics; and
iii. Obstetrics/Gynecology.

b. In addition to the primary care physician requirements, the physicians network shall include physicians practicing in the areas of Allergy, Anesthesiology, Cardiology, Cardiovascular Surgery, Chiropractic, Dermatology, Endocrinology, Gastroenterology, General Surgery, Hematology, Nephrology, Neurology, Neurosurgery, Oncology, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Pulmonology, Radiology, and Urology. OGB may relax or enlarge this requirement based upon its contracting experience with a particular specialty.

c. Physicians may not participate in more than one selected SafeNet Plan Option network. Any physician who is included in more than one selected network will be placed in the network that has offered the fee proposal most advantageous to the OGB.

D. **Term of Contract Fee Proposals, Continued Provider Participation**

The term of any Contract awarded pursuant to this NIC will be 36 months commencing July 1, 2004 and ending June 30, 2007. All fee proposals shall be firm for the full initial term (July 1, 2004 - June 30, 2007), and all Participating Providers shall agree to continue participation for the full term except for reasons of suspension or revocation of required license or certification, retirement from practice, or relocation of practice/service out of the service Region.

E. **Definitions**

As used in this NIC, the following terms shall be defined as set forth below:

1. Covered Individual(s) means eligible employees, retirees and dependents who are enrolled in OGB's SafeNet Plan Option Plan such that they are entitled to receive Covered Services.

2. Covered Services mean those health care services that may be provided to Covered Individuals by Participating Providers and for which benefits are provided pursuant to the SafeNet Plan schedule of Benefits.

3. Participating Provider mean a Physician, Hospital, laboratory, mammography or other radiological service, or any other duly licensed institution or health care professional contracted to provide health care services to Covered Individuals.

4. Denied Services means services which have been denied as not usual, customary, reasonable or medically necessary or which are Non-Covered Services.

5. Inpatient Services means any Covered Services which are provided to a Covered individual who is confined or placed under observation at the Participating Hospital for a period of twenty-four (24) hours or more. Inpatient Services include any Covered Services by a Participating Physician or other professional, who as his/her usual and customary practice, would charge a fee which is included within the Participating Hospital's billing.

6. Outpatient Services means all Covered Services rendered by Participating Providers other than Inpatient Services.

7. Utilization Review means procedures including prior authorization of identified outpatient services, pre-admission review and concurrent stay review for inpatient services, and other review to determine whether the health care services ordered, provided or rendered are usual, customary, reasonable or medically necessary.

F. **SafeNet Plan Option Participating Provider Contractual Obligations**

1. Participating Providers agree not to reject any Covered Individual as a patient for Covered Services solely by reason of the alleged inadequacy of any provision in the Contract. Participating Providers agree: (1) not to differentiate or discriminate in the treatment of or in the quality of services delivered to Covered Individuals on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, sexual orientation, place of residence, disability, or health status; and (2) to render health services to all Covered Individuals in the same manner, in accordance with the same standards and within the same time availability as offered to other patients.

2. Participating Providers agree that they shall provide at their sole expense all personnel services, facilities, instruments, and supplies required for the rendering of Covered Services to Covered Individuals and shall devote such time and resources necessary to perform their obligations.

3. Participating Providers shall afford Covered Individuals at least the same quality of medical care as is provided to their other patients. Care provided to Covered Individuals shall be performed according to the usual and customary standards of competence as is required by community standards and in accordance with all laws, rules and regulations of all governmental authorities, both federal and state, which have governing authority with respect to reasonableness, medical necessity and quality of medical care.

4. Participating Hospitals represent and warrant that they are currently, and for the duration of the Contract shall remain, licensed as a hospital in accordance with applicable licensing laws, as amended from time to time.

5. Participating Hospitals shall comply with those laws and regulations promulgated pertinent to the operation of hospitals during the term of the Contract.

6. Participating Providers, prior to providing Covered Services, shall be responsible for verifying with OGB that an individual is a Covered Individual and eligible for Covered Services. Participating Providers further recognize OGB's right to coordination of benefits or subrogation for Covered Individuals.

7. In an Emergency, the Participating Provider shall immediately proceed to render medically necessary Emergency services to the Covered Individual.

8. Except in an Emergency, Participating Providers shall assure that Inpatient Services are provided to a Covered Individual only when the Participating Hospital receives certification from OGB or its utilization management contractor in advance of admission of such Covered Individual. However, pre-certification shall not be required for consultations, laboratory or radiological evaluations arising from routine obstetrical or gynecological services.

9. In the event Emergency inpatient care is required, Participating Providers shall verify said Covered Individual status and eligibility for service within two (2) business days from when Emergency treatment commenced.

10. In the event the Participating Provider renders health care services to individuals who are not Covered Individuals or eligible for Covered Services, the Participating Provider shall bill the individual directly and shall not submit a claim for payment to OGB.

11. Participating Providers shall cooperate with OGB's programs that monitor and evaluate whether Covered Services provided to Covered Individuals in accordance with the **Agreement** are medically necessary and consistent with professional standards of medical care generally accepted in the medical community. Such programs include, but are not limited to, utilization management, quality assurance review, and grievance and appeal procedures.

12. Participating Hospitals and other contracted facilities shall submit to OGB completed bills for payment of claims on its UB92 summary billing form for charges for those Covered Services included in the Plan for each Covered Individual receiving such services. Participating Physicians and other contracted providers of professional services shall submit charges to OGB on a HCFA 1500 form. All claims must be submitted within 12 months from the dates of services.

13. In addition to those amounts which OGB is obligated to pay, Participating Providers may bill and collect from a Covered Individual only the amount specified to be the Covered Individual's responsibility and the Participating Provider's billed charges for Non-Covered Services provided to a Covered Individual. The Participating Provider may not bill for Non-Covered Services unless the Covered Individual has consented to the services after being made aware that said services are Non-Covered Services and are not payable by OGB. Participating Providers may not otherwise balance bill Covered Individuals.

14. Participating Providers agree to comply with the Utilization Review requirements of OGB, including prior authorization of identified outpatient services, pre-admission certification and concurrent stay review for inpatient services, and case management. There shall be NO OBLIGATION FOR PAYMENT to the Participating Provider by OGB or by the Covered Individual for any services rendered for which certification has not been obtained as required.

15. If Participating Provider has qualified as a "health care provider" under the Louisiana Medical Malpractice Act in accordance with R.S. 40:1299.41 et seq., the liability of Participating Provider is limited in accordance with law. In such case, Participating Provider shall provide OGB with evidence of his/her/its financial responsibilities in the form of a current Certificate of Enrollment.

    If Participating Provider is not a participant in the Louisiana Medical Malpractice Act, or if said participation shall lapse during the term of the contract, the Participating Provider shall maintain at his/her/its own expense a valid current policy or policies of general liability and malpractice insurance of at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in aggregate. Evidence of such insurance shall be provided to OGB .

16. Provider shall not submit duplicate claims to OGB for services rendered for Plan Participants. Any second or subsequent claim submitted by Provider within forty-five (45) days of previous claim for that service shall be deemed a duplicate claim in violation of this provision. In such event, OGB may, at its option, terminate the Contract for cause.

G. **OGB's Contractual Obligations**

1. OGB shall pay Participating Providers for Covered Services provided to Covered Individuals and shall pay in accordance with the terms and conditions set forth in any contracts awarded as a result of this NIC. OGB shall pay within thirty (30) calendar days of receipt of the claim, if received with all necessary billing information, or advise the Participating Provider of the reasons for non-payment. However, OGB shall have the right to question particular claims or items, review medical information, utilization review, assignment and release forms, and require resubmission of claims for payment provided Participating Provider is notified of the same within fifteen (15) working days from the date the claim is received. After Participating Provider resubmits the claim to , OGB shall have thirty (30) calendar days from receipt in which to pay Participating Provider.

2. If Covered Services provided to Covered Individuals hereunder are covered, in whole or in part, under any state or federal medical care program or under another contractual entitlement program, including a private group health services or indemnification program wherein OGB would be the secondary payer, OGB shall only remit its pro rata share of payment pursuant to coordination of benefit rules adopted by the National Association of Insurance Commissioners. It shall be the responsibility of the Participating Provider to notify the Office of Group Benefits (OGB) of the same and collect payment from the primary or other payer(s), persons or entities, following the Participating Provider's customary collection practices. The Participating Provider shall report all such collections to OGB within thirty (30) days after receipt of such payment, and the Participating Provider shall remit any refund due to within thirty (30) days of collection or appropriate adjustment shall be made.

3. OGB shall furnish each Covered Individual with an identification card and shall maintain a coverage verification system. OGB shall make payment or it's pro rata share of same to a Participating Provider for Covered Services provided to a Covered Individual.

4. Financial incentives shall be included by OGB to encourage use of Participating Providers by Covered Individuals.

5. OGB will provide Participating Providers with a copy of the utilization review requirements and with copies of changes in the Utilization Review guidelines thirty (30) days prior to the effective date.

H. **General Contractual Obligations**

1. All Contractor participating providers will cooperate with management controls such as on site audits and utilization review. Contractor participating providers will comply with OGB's current utilization review procedures.

2. The Contract may be amended at any time by written agreement of the parties and approval of the Louisiana Office of Contractual Review.

3. Cancellation of the Contract

    a. The Contract may be canceled at any time only by written agreement of the parties.
    b. If either party fails to fulfill in a timely and proper manner its material obligations under the Contract, or if either violates any of the material covenants, agreements, or stipulations of the Contract, the aggrieved party shall thereupon have the right to terminate the Contract by giving written notice to the other party of such termination and specifying the effective date thereof, at least thirty (30) days before the effective date of such termination, during which time the breaching party shall have the right to cure the said breach. If the breach is not cured during the right to cure period, the agreement shall then be deemed terminated.
    c. The Contract may be terminated upon one day's notice with regard to any Contractor participating provider whose medical license is revoked or suspended; who institutes insolvency or bankruptcy proceedings, or fails to maintain insurance coverage as required.

4. The parties hereby agree to cooperate in good faith to effectuate the provisions of the Contract.

5. The Contract shall be construed in accordance with and governed by the laws of the State of Louisiana, and the venue of any action brought in connection with the Contract will be the Parish of East Baton Rouge, State of Louisiana.

6. Neither party shall be responsible for delays or failure in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to acts of God, strikes, riots, lockouts, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failures, earthquakes, or other disasters.

7. Contractor and each Contractor participating provider hereby grant to the Legislative Auditor of the State of Louisiana, auditors, or those designated by , the option of auditing all nonproprietary and non-privileged records of Contractor and the Contractor participating providers pertinent to the Contract. Records will be made available during normal working hours and upon receipt of reasonable notice.

8. To the extent required by law, all information to which Contractor and the Contractor participating providers has access hereunder will not be disclosed by Contractor or the Contractor participating providers to a third party, including , without a plan participant's consent. It is understood that certain information considered to be confidential may be disclosed to the personnel and agents of Contractor and Contractor participating providers in the performance of the Contract. The Contractor and the Contractor participating providers shall protect such information with the same degree of care each accords to its own confidential information.

9. Contractor will designate one or more persons who shall have the duty of acting as a

point of contact with OGB to assure the expeditious execution of the Contract.

10. Personnel assigned by the Contractor participating providers to perform the services described in the Contract will be qualified to perform the assigned duties. The provider will determine which personnel shall be assigned for any particular project and to replace and reassign such personnel at any time. Each provider shall assume the responsibility for personnel providing services hereunder and will make all deductions for social security and withholding taxes, contributions for employment compensation funds, and shall maintain, at Provider's expense, all necessary insurance for its employees, including but not limited to workmen's compensation and liability insurance for each of them.

11. The Provider agrees to retain all books, records, and other documents relevant to the Contract and the funds expended hereunder for at least four (4) years after final payment or as described in 45 CFR 74:21 (B) whichever is longer.

12. Contractor and the Contractor participating providers shall abide by the requirements of all applicable local, state, and federal laws, and shall not discriminate against participants due to age, race, color, religion, sex or national origin. Furthermore, the provider shall take Affirmative Action pursuant to Executive Order 11246, and the Vocational Rehabilitation Act of 1973 to provide for a positive posture in employing and upgrading persons without regard to age, race, color, religion, sex, national origin, or handicap, and shall take Affirmative Action as provided in the Vietnam Era Veteran's Readjustment Act of 1974. Contractor and the Contractor participating providers shall also abide by the requirements of Title VI of the Civil Rights Act of 1964 and the Vocational Rehabilitation Act of 1973 and insure that all services are delivered without discrimination due to race, color, national origin or handicap. Contractor and the Contractor participating providers agree that they will not discriminate on the basis of sexual orientation in any matter relating to employment.

13. Expenditures under the Contract determined by audit or review to be ineligible for reimbursement and for which payment has been made to a provider shall be refunded to OGB by the provider.

14. The Contract shall be binding upon and shall adhere to the benefit of the parties hereto and their respective successors and assigns provided, however, that the Contract may not be assigned or transferred without the prior written consent of OGB and the State of Louisiana, Division of Administration, Office of Contractual Review.

15. Contractor and the Contractor participating providers agree that the responsibility for payment of taxes from the funds thus received under The Contract shall be the respective provider’s responsibility and identified under the provider’s Federal tax identification number.

16. The Contract is not a third party beneficiary contract and shall not in any manner whatsoever, increase the rights of any participant with respect to OGB or the duties of any participant or create any rights on behalf of participants regarding Contractor or the Contractor participating providers and Contractor reserve the right to amend or terminate the Contract as set forth herein without notice to, or consent of, any such participant.

17. OGB and Contractor hereby agree that the Contract, together with the referenced

provisions and the attachments made a part hereof, constitute the sole agreement between them and that no other representations, either oral or written, are binding upon either party.

I. NIC Process and Submission - Schedule of Events

NIC Issued	October 20, 2003
Pre-Proposers Conference	November 4, 2003
Deadline for submitting written questions	November 17, 2003
Mandatory Proposers Conference	November 25, 2003
Response provided to written questions	November 25, 2003
Proposals due	December 11, 2003
Contract award date (tentative)	December 29, 2003
Contract effective date	July 1, 2004

Pre-Proposer & Mandatory Proposers Conference

The Pre-Proposers and Mandatory Proposers Conference will be held in the boardroom of the Office of Group Benefits located at 5825 Florida Blvd., Second Floor, in Baton Rouge, LA on the dates listed in the Schedule of Events.

The Pre-Proposer Conference is elective; however a representative of your organization must attend the Mandatory Proposers Conference. OGB staff will be available to discuss the proposal specifications with you and answer any questions you may have in regards to submitted questions. The Proposer Conference is considered an integral part of the NIC process. **Any Proposer which does not have a representative attend the Mandatory Proposers Conference will not be eligible to submit a proposal.** Attendance by a subcontractor is welcome, but will not be an acceptable substitute for a representative of the primary proposing firm/organization.

Written Questions on the NIC

Written questions regarding the NIC are to be submitted and received in the Office of the Chief Executive Officer for the Office of Group Benefits not later than 4:30 p.m. on the date set forth in the schedule of events above. **Please submit any and all questions regarding the NIC <u>in writing</u>. OGB representatives will not be able to respond to individual telephone inquiries.**

Proposal Due Date

Originals and five copies of your response to the NIC must be delivered to the Office of the Chief Executive Officer for not later than 4:30 p.m. on the date set forth in the schedule of events above. All proposals should be clearly marked: "SafeNet Plan Option Proposal" identifying the services for which the proposal is submitted, Hospital and/or Physician services.

Mailing and Delivery Address

A. Kip Wall, CEO
State of Louisiana
Office of Group Benefits

Delivery: 5825 Florida Blvd., 2nd Floor
Baton Rouge LA 70804

Mailing: P. O. Box 44036
Baton Rouge LA 70806

Fax: (225)925-4721

E-Mail
Address:

Internet
Address:

J. Proposal Evaluation and Criteria

Proposal Evaluation

Proposals will be evaluated to assure that all minimum requirements have been met. Failure to meet the requirements will result in rejection of the entire proposal without further consideration. Failure to provide any information requested in this NIC may also result in disqualification of the proposal.

Minimum Requirements Include:

During the evaluation process oral and/or written discussions will be conducted with proposers whose proposals are determined to be reasonably susceptible of being selected for award. You may be asked to provide additional information which was not asked in the NIC or clarify a proposal response.

Evaluation Criteria

After determining that a proposal satisfies the minimum requirements, a comparative assessment of the relative benefits and deficiencies of each proposal, including information obtained during oral or written discussions, will be made using the following criteria:

Category	Points	Major Areas to be Addressed
1. Financial	60	Cost of Services, Practitioner and Facility Fee Proposals
2. Market Acceptability	40	Claims data will be used to determine the market share factors to be used in awarding points for market acceptability.
Total Points	**100**	

Financial (60 points) – Each bidder's practitioner and facility fee proposals will be factored for projected utilization. The respondent whose cost proposal is determined to be lowest will be awarded the full 60 points for this category. Points will be awarded to other bidder's proposals through proportionate comparisons to the lowest cost proposal.

Market Acceptability (40 points) – Claims data will be used to determine the market share factors to be used in awarding points for market acceptability.

K. Instructions on Proposal Content and Format

Proposers should respond thoroughly to all questions and statements noted in this NIC. Proposers should follow the instructions below when compiling your NIC response:

1. Please place your NIC response in a three ring binder.

2. Use a tab to divide your NIC response into the appropriate tabbed sections. The tab must extend beyond the right margin of the paper so that it can be read from the side and is not buried within the document.

3. Order of Presentation:

Tab 1
Cover Letter - must include a clear statement of the services for which the proposal is submitted.

Tab 2
Please provide responses to the Narrative Questions below.

1. Please provide the following information regarding the Proposal Coordinator/Contact Person for this NIC:

	Response
Name	
Title	
Address	
Telephone Number	
Facsimile Number	
E-Mail Address	

2. Please provide the name of the individual(s) responsible for negotiating and executing contracts on behalf of your organization:

	Response
Name	
Title	
Address	
Telephone Number	
Facsimile Number	
E-Mail Address	

3. Please provide the following:

	Response
Type of Business Entity	
Corporate/Tax Status	
Federal Tax Identification Number	
State of Domicile*	

*Note: If not domiciled in the State of Louisiana, please attach a certificate of authority from the Louisiana Secretary of State indicating authority to do business in this state.

4. Please identify and provide the state and/or federal licensing or regulatory entity(ies) that exercise jurisdiction over your firm or organization.

5. Please provide utilization for the time period of July 1, 2002 – June 30, 2003 utilizing the format below:

Category	# of Admissions, Cases or Total $ Paid
Inpatient Admissions	#
Ambulatory Surgical Cases (ASC)	#
Outpatient $ Paid	$

Tab 3
Signed Compliance Statement Acknowledging Services Required in this NIC.

Tab 4
Signed Compliance Statement Acknowledging Contractual Obligations Required in this NIC.

Tab 5
Provider Files

Two files must accompany your NIC response.
Full names (including first and last), complete and accurate full addresses, and tax identification numbers of all participating providers, including type of practice (specialty) must be provided where applicable. Both files must be in Excel or ascii, delimited text format. Paper copies WILL NOT be accepted.

A.) Please provide a file which lists all FACILITIES in your network. Please utilize the format represented below when providing your response.

Tax ID #	Facility Name	Type of Facility	Complete Address	Region	City	Zip Code

B.) Please provide a file which lists all PHYSICIANS (individually) in your network that have admitting privileges to the facilities represented in A. above. Please utilize the format represented below when providing your response.

Tax ID #	Full Name	Complete Address	Region	City	Zip Code	Specialty	Board Certification (Indicate "Yes" or "No")

Tab 6

A.) Please provide a copy of the agreement authorizing the proposing firm or organization to submit a proposal and NIC response and enter into a contract for and on behalf of the participating providers, together with a copy of the signature page for each participating provider.

B.) For each provider listed in Attachment 5 (A & B), you must provide a signature page acknowledging their agreement to enter into this contract with. Your organization's name must be noted on the signature page of each signature page.

Tab 7

Please provide in writing proposed contractual exclusivity provision language.

Tab 8

Proposed Pricing – Proposals will be reviewed on the following bases:

A.) Hospitals

1. <u>Inpatient Services</u> – OGB's SafeNet Plan Option is using DRG rates for inpatient services. DRG rates are the ONLY type of reimbursement will accept for inpatient services. Please provide the following:

2003 DRG Conversion Factor Used For Medicare/HCFA	Proposed DRG Conversion Factor

2. <u>Oupatient Surgery</u> - Please provide your Ambulatory Surgical Case (ASC) rates by category (as defined by Medicare/HCFA) for 2003.

Category	Description	Medicare/HCFA ACS Rate
Group 1		$
Group 2		$
Group 3		$
Group 4		$
Group 5		$

Category	Description	Medicare/HCFA ACS Rate
Group 6		$
Group 7		$
Group 8		$

3. <u>Other Outpatient Services</u> – For services that do not fall into the categories above (Inpatient or ASC), please provide your proposed Discount from Charges.

Discount From Charge (Represent as a Percentage)

B.) Physicians and Other Providers of Professional Services

1. <u>Fee Schedule by CPT Code</u> – Utilizing Medicare/HCFA's 2003 RBRVS schedule, please provide your proposed % of RBRVS.

% of 2003 Medicare RBRVS

Tab 9

A.) Please provide below the total number of each physician specialty for the region(s) in which you are quoting:

Practicing Specialty	Total # of Physicians
Family Practice, General Practice, or Internal Medicine	
Pediatrics	
Obstetrics/Gynecology	
Allergy	
Anesthesiology	
Cardiology	
Cardiovascular Surgery	
Dermatology	
Endocrinology	
Gastroenterology	
General Surgery	
Hematology	
Nephrology	
Neurology	
Neurosurgery	
Oncology	
Opthalmology	
Orthopedics	

Practicing Specialty	Total # of Physicians
Otolaryngology	
Pathology	
Pulmonology	
Radiology	
Urology	

B.) Please provide below the total number of facilities

Facility Description	Total # of Facilities
Acute Care Facilities	
Tertiary Care Facilities	

C.) For hospital organizations, please confirm that your organization has the following physicians on staff at each proposed hospital in each proposed region:

Physician Specialty	Confirmation that Each Specialty is Represented in each proposed facility "Yes" (Y) of "No" (N)	If NO, please list the hospital name
Radiology		
Pathology		
Anesthesiologist		
Emergency Medicine		
List Other		
List Other		
List Other		
List Other		