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1.1	Company background, organization and management	Please tell us about your company's history and experience	Privately owned. Organized in 1998 by two individuals. Owners and staff worked for another TPA, purchased by Humana, so principals started company. Continued growth, but did so slowly to maintain service levels. Specialize in group health only. No workman's comp.
1.11	Company background, organization and management	What is your disaster recovery plan?	No formal plan presented.
1.12	Company background, organization and management	Whay source do you use for your medical review policies (Milliman, Interqual, etc.?)	NA - they outsource this function
1.3	Company background, organization and management	How many clients do you currently serve?	Currently have 28-30 group health self-funded and 40 COBRA only groups. 5,000 employee lives, 12,000 total lives are enrolled in their system
1.4	Company background, organization and management	What types of services/products do you offer?	Currently have 28-30 group health self-funded and 40 COBRA only groups. Can perform TPA services for medical, dental and RX claims only.
1.5	Company background, organization and management	How many employees do you have?	25 total employees. However, PBA feels that they can add staff quickly to meet service needs based on local contacts. Can use claims examiners that will work off site. Own 2500 sq ft adjacent building in addition to 4000 sq ft current office for expansion needs.
1.6	Company background, organization and management	Do you have a website? What is the URL for it?	www.preferredtpa.com. Clients can access benefits, order ID, check claim status, link to PPO network. PBA still get a lot of phone calls and they take pride in the personal service the render to their clients. Provide dedicated people to answer calls. PBA can supply ID cards. They print and mail ID cards themselves. They do not outsource any mailing functions
1.7	Company background, organization and management	Are you accredited? By whom? For what services? When was you last accredidation performed?	Outsource UM to Hines & Assoc.in Illinois. Do precerts then they Fax or can check on-line for precerts. Hines & Assoc. are URAC accredited for UM.
1.8	Company background, organization and management	What automated system(s) do you use to process enrollment, claims, UM, member services, case management, and correspondence?	Use Eldorado claims payment system. System is fully integrated between eligibility, benefits & claims. Handles eligibility, claims, fax, realtime links for providers. Generates letters, COB. Can't pay non-member claims. Same system since 1997. Eldorado out of Phoenix .

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2.14	Administrator shall maintain a standard fidelity bond for the benefit of HMOCAP insuring against loss arising out of the handling of funds from the following: employee dishonesty; forgery or alteration; theft, disappearance, and destruction; and robbery and safe burglary under this Agreement when such loss occurs directly or indirectly as the result of actions of Administrator, its officers, directors, employees, agents or assignees. The amount of the bond shall be not less than $1,000,000. Administrator shall submit such evidence or certifications as HMOCAP may require as to proof that the bond will be posted and maintained at the time of contract execution and will remain effective throughout the duration ol this Agreement.	Do you have a fidelity bond of at least $1,000,000 to cover errors, omissions and theft?	Copy of Fidelity Bond obtained and verified.
2.16	Administrator will assist HMOCAP in enforcing the subrogation provisions that exist in the insolvent HMO's subscriber contracts, including but not limited to, obtaining subscriber's written consent and aclcnowledgment of the subrogation right, attempting to ascertain the existence of other plans or insurance policies, and attempting to ascertain the existence and location of any responsible parties.	How do you handle subrogation? What process do you have in place to identify potential cases? What is your success rate of recovery for your other clients?	Identified manually by claims payers. Based on accident diagnosis on claims. When an accident diagnosis is suspected, they will send a questionnaire asking for injury information. they then follow up with attorney letter. Claims detail report will be produced to see if any other related claims paid already. Correspondence is set to automatically follow up, along with follow up calls.

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2.7	Administrator shall fully indemnify, defend, and hold harmless HMOCAP from any claim, loss, damage, attorneys' fees, cost or expense by reason of, or arising from, any accident or injury to HMOCAP and/or Administrator, as well as any claim, loss, damage or destruction of the property owned, leased, or used by the Administrator in the course of Administrator's work in the perfomlance of this Agreement. Administrator also agrees to and shall maintain comprehensive liability and casualty insurance coverage, and such other insurance coverage against such risks as is in accordance with sound business practices for the benefit of Administrator and HMOCAP. Within five days of the date of execution of this Agreement, Administrator shall provide to HMOCAP a current certificate of insurance naming HMOCAP as an additional insured. Administrator shall provide HMOCAP a copy of any new certificate of insurance within five days of expiration of any certificate previously submitted to satisfy the conditions of this provision. The maintenance of insurance coverage shalk not abrogate the provisions of Se	Do you maintain liability coverage? Errors and omissions coverage? What are the coverage limits?	Liability Coverage Declarations Sheet reviewed and verified.
2.17.	Administrator shall coordinate benefits among other insurance companies and health and accident benefit plans when HMOCAP is not the primary plan according to the coordination of benefits provisions contained in the HMO contracts.	Please share your COB process. How do you identify suspected cases? How does your claim process identify and pend or deny COB related claims? How do you link various claims related to a COB episode of care?	Initial enrollment form asks if they have other insurance. System flagged for COB. If they get EOB from other insurer, they will research back for other payments. This is also a manual process.

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2.4.	AdIninistrator warrants that it has the ability to import data, export data, and electronically transfer data from an insolvent HMO system to Administrator's data processing and management system. AdIninistrator warrants that should it not have the ability to per form these functions when necessary, Administrator will use its best good faith effor t to acquire the capability to import data, export data, and electronically transfer data from an insolvent HMO system to Administrator's data processing and management system.	What is your plan to meet this requirement?	Don't have specific plan to do this. They have been told by Bruce that they don't have to worry about past claims. They don't have a plan to work deductibles if they don't have claims history. They think that they can do this via Excel downloads?
2.6.	No subcontracts for the performance of any functions or duties under this Agreement (including Network Access Agreements) may be entered into by Administrator without obtaining prior written approval of HMOCAP.	Do you plan on subcontracting or otherwise delegating any responsibilities required under your agreement?	Use Hines & Assoc if needed. Included an optional UR fee in proposal. Also Case management performed by Hines & Assoc. Not sure how Hines & Assoc would be able to transition care information from the HMO
2.8.	Administrator shall maintain third party administrator licenses or any other necessary licenses as required by Florida law. Administrator shall initially provide HMOCAP with the current licensing information, which will include the license number, effective date, and renewal date of licensing. Administrator shall provide HMOCAP with updated infor ination as said licenses are renewed.	When is your license due for renewal?	Copy of TPA License obtained
3.1 .I.	Administrator, coordinating with Receiver, shall be responsible for initial determination of those individuals or groups who are subscribers of HMO on the date it was placed in rehabilitation and remain as subscribers under the contract.	How will you identify and maintain enrollee eligibility data when you initially take over an HMO's members? How will you identify other group health coverage for members that may be primary?	They plan on obtaining the enrollment data extract from the HMO and then download into their system under a separate platform from their other business. They set up benefit plans individually as needed. Load eligibility by network and benefit plan.
3.1 1.	Administrator is responsible, at its expense, for training all personnel and staff assigned to implement this Agreement, and must provide appropriate staff to effectively carry out the duties and responsibilities contained in this Agreement.		Do all adjustments manually, bundling, CCI, diagnosis. Use Ingenix books for coding.

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3.1 1.	Management staff shall have experience in the health insurance and medical management field and shall serve as the direct points of contact with HMOCAP and shall have the day-to-day responsibilities for contact operations.	What experience and training do your managers in each area possess? What is the average length of employment of your staff? What training and instructional materials are they provided to do their jobs? How do you communicate changes in procedures or policy?	Average 8-10 years. Low turnover. Most claim staff have at least 20 years experience.
3.1.2.	If necessary, forms necessary to apply for and continue coverage and administer this Agreement will be devised and designed and printed by Administrator.	Do you have enrollment forms that you use for other clients? How do you handle the enrollment process?	Have application forms that are used for current clients.
3.1.3.	Administrator shall, at its expense, establish, maintain and update files on eligible individuals or groups. Files shall be maintained in Administrator's computer system in accordance with the requirements of this Agreement. Administrator shall, on a regular basis, keep and maintain at a minimum the following information: Name Complete current residence address (street, road, city, or county, and zip code) Benefit information Anniversary date of policy Billing data Premium payment mode	Please show us your enrollment system. How are members linked to benefit plans? Do you maintain history of enrollment, premium payments, PCP assignment?	Can have member in system more than once active at the same time. SS# is basis for matching. Can assign and maintain PCP.
3.1.4.	For all subscribers, Administrator shall bill premiums on either a monthly bank draft or regular monthly basis. All premium billings will be based on rates established by HMOCAP.	How will you bill for premiums from employers or individuals who are members of the HMO? Please show us how your system will handle this.	Send monthly statement. Load premiums by rate tier. They feel that they can duplicate billing format generated by the HMO. They have no electronic capabilities for this. It would be paper billing

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3.10.1	Administrator must and shall maintain as high a degree of data confidentiality as established and determined by I-IMOCAP or as required by any applicable federal and state laws. All medical records, claim and enrollment forms, and other similar personal data inust be maintained with a high level of confidentiality and precautions taken to guarantee access to such information by appropriate sources only.	What policies and procedures do you have in place to assure HIPAA compliance regarding confidentiality of PHI? How do you train your staff on these requirements?	Confidentiality P&P reviewed. They are knowledgable about HIPAA and PHI requirements
3.10.2	The automated claims processing system used by Administrator has the necessary safeguards to limit access to such information and that all system operations effectively protect confidentiality of data.	What security is maintained regarding your computer applications and access to same? Do you have online access to data? How is security managed for that system?	Access to system via duties. Online access managed through vendor called Net Recall. Must match enrollment system data. Have BA with vendors and groups. Password protected data. Have a HIPAA officer internally.
3.2.1	Administrator shall perform medical authorization functions, including the coordination of care, the review of diagnosis, appropriate pre- authorization (i.e., pre-certification) of medical care, referrals to primary care physicians, and review the utilization of subscribers receiving medical care.	Do you have licensed clinical staff to review medical authorization requests? What is your process for utilization review? How will you communicate with providers and members about UM policy? How do you plan to coordinate care? What do your medical auths look like?	NA - they outsource this function
3.2.2	Administrator is required to have access to a licensed physician as a medical director to oversee the medical authorization functions.	Who is your Medical Director? What is his/her credentials and experience in UM?	NA - they outsource this function
3.3.	Administrator will be required to maintain the network or coordinate any supplementation of the network that is necessary to provide health care in accordance with the HMO contract in existence on the date of receivership.	Do you have a provider network? What geographic area does it cover? What is it's capacity to handle a sudden influx of new patients? What is your capability to manage network contracts and how are payment rates and contracting par status loaded into your system?	Per conversation with Bruce, they would continue with HMO's existing network and discount pricing. Will supplement with their network. Will charge % of savings to CAP Board for claims through their network. Pricing is currently done manually. Would need to load fee schedules into their system, along with provider contract information. System does not seem to have much capability to do case rate, per diem, etc.

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3.3.1	If it becomes necessary for the Administrator to supplement the provider network, Administrator must ensure that each non-network provider is properly credentialed. At a minimum, Administrator must: (i) ensure that the provider has proper license, (ii) review the medical malpractice history of each provider, and (iii) examine the national practice review data bank. Where appropriate, Administrator must confirm that each provider is in compliance with the National Commission on Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations.	What is the credentialing process for your network? Is it performed directly by your staff, or do you delegate it to another entity? Do you have peer review or quality review for your network providers? Is this performed directly or is it delegated to another entity?	NA - they outsource this function
3.4.1.	Administrator will be responsible for processing all medical and institutional claims from receipt through final payment or denial in a timely and accurate manner, consistent with the instructions provided by I-IMOCAP and this Agreement. Administrator shall perform all necessary duties, required by law, for servicing the claims of each subscriber as directed by HMOCAP. Administrator shall process such claims through automated means.	Please walk us through your claims system. How are provider rates entered? How are benefit plans entered? How are claims entered (electronic vs paper). How are claims worked in a timely manner? What clearinghouse do you work with? How do perform standard HIPAA 4010 transactions? Are you working on HIPAA 5010 compliance? What is your claims denial process? How do providers appeal claims determinations.	HealthSmart is their claims clearinghouse. Denials are on EOB for provider and member. Benefit plans are entered manually. They do have copy and tweak capabilities. Claims benefit categories are assigned manually as each claim line is entered. They can accept claims electronically, but currently most claims are paper. They file paper batches by entry date. They do not scan. They have no capability to load claims into their system electronically. They have no auto adjudication, bundling, claim check, denial, pend or other process. It is manual.
3.4.2.	Administrator shall process the claim upon receipt of proof of loss. Administrator shall pay as provided in the Policy, or as required by law, the Act, this Agreement, or as directed by HMOCAP	What do you consider to be "proof of loss"?	Claim forms
3.4.2.	As a claim is adjudicated, Administrator shall issue benefit payment checks in the name of HMOCAP to the providers or assignees on behalf of the subscriber or subscriber's authorized representatives in the proper amount as required by Section 3.4.2. above and shall explain the benefits by defining the coverage and payment amounts relative to the claim status (paid or denied).	What do your EOB's and RA's look like? Can you perform 835 transactions?	Sample EOB and RA obtained. Paper process only. No 835 capability. Pay via check, no EFT

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3.4.2.	Single payments exceeding $10,000 must be brought to the attention of HMOCAP in writing prior to disbursement of funds.Administrator shall not pay more than $25,000.00 in benefits for any one person without the written authorization of HMOCAP, and shall not pay more than $300,000.00 in benefits for any person covered.	How will you identify claims of specific dollar amount to be reviewed by HMOCAP? How will these be reviewed in compliance with HIPAA requirements with PHI?	Have a pre-check register that they send to their clients. Can select ones to send and edit report as directed by HMOCAP
3.4.2.	Administrator shall use the schedule of benefits, eligibility standards, coinsurance, deductible and copayment schedules, and claims procedures adopted and implemented in the HMO claims manual prior to the date of receivership and approved by HMOCAP.	What is your overall strategy to handle HMO functions quickly and upon short notice related to an HMO that has been placed in receivership? Please walk us through your implementation and set-up process.	They very sincerely believe that they can staff up and manually handle claims in a short period of time. The staff seems very knowledgeable about the claims payment process, coding, etc.. However, their system is designed for a small to mid-size claims payment shop and lacks electronic functionality. Even with many, many hands to process manually, we have grave concerns over their ability to take on such a project with their current system. The effort needed to load the eligibility and claims data from the HMO into ***any*** TPA system would be time and cost prohibitive, considering you only would be needed for 6 months maximum. We strongly recommend that HMOCAP reconsider their approach to this project. We suggest that HMOCAP consider awarding the bid to a company that has the capacity to come in and take over the HMO's existing system, using a skeleton HMO staff to keep things going during the receivership period. We envision this to be similar to a bank failure scenario, where the government (who is guaranteeing payment) steps in as receiver, but the bank continues day to day functions using their own systems, staff and facilities. Under this scenario, PBA may be successful in protecting the HMOCAP's interests as the third party administering the receivership, but not actually administering the day to day HMO functions for the plan using their system. Also, member concerns about their continuing coverage would be reduced during the transition.

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3.4.2.	Administrator shall not pay for any claims that were incurred before the date of receivership. Administrator shall not pay any claim that was incurred the earlier of six (6) months after the date of receivership or the date the person is no longer a subscriber as that term is defined above.	How does enrollment data interact with your claims system to ensure compliance with date of receivership restrictions vs. eligibility restrictions?	Their eligibility system is date sensitive and their system will not pay claims for enrollees outside their eligibility period.
3.4.2.	Administrator shall use its best efforts to respond to all claims in a timely manner and shall take reasonable steps to pay or deny all "clean claims" within thirty (30) days of receipt, or as required by Florida law. For all electronically submitted claims, Administrator shall, within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic aclcnowledgment of the receipt of the claim to the electronic source submitting the claim. Within 20 days after receipt of the claim, Administrator shall pay the claim or notify a provider or designee if a claim is denied or contested ("non-clean"). Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred. Claims that are determined to be "non-clean" may take longer than thirty (30) days to process. However, in no instance shall Administrator exceed sixty (60) days to either pay or deny such claims.	What is your plan to meet this requirement?	They don't think this is an issue. Once again, they believe they will meet this requirement, but we have grave concerns about their ability to do so.
3.4.2.	Administrator is responsible to process run-out claims incurred for services authorized and rendered to subscribers on or after the date of receivership per this agreement and extension of benefits services,	What is your plan to meet this requirement?	Per their conversation with Bruce, they will only have to pay claims incurred based on the date receivership. **It was unclear to all of us who actually has the responsibility for paying pending claims that were incurred prior to the receivership.**

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3.4.5.	Reasonable measures to protect against potential over-utilization, fraud, and abuse of claims shall be instituted and maintained by Administrator. Administrator shall develop and implement procedures and programs designed to detect abuse and overutilization by: Subscribers Institutional providers Medical and other health care providers Suppliers of medical services Other providers and/or individuals	What systems do you have in place to adjust claims for correct coding and payment? Do you have duplicate claim checking capability? How do you review institutional claims for correct rev code, diagnosis and procedure coding? What services are routinely subject to per-certification vs. pre-authorization? How do these link with your claims system?	They have no automated claims adjustment system regarding coding and correct payment. Their system will check for duplicates based on matches on DOS, provider, and procedure or TID match. They don't use NPI at all, and do not do HIPAA 834 or 835 transactions at this time. No field in system for NPI. Precert based on group requirements. They feel they can follow the HMO's requirements for pre-auths.
3.4.6.	Administrator, consistent with Florida law, shall implement procedures for reconsideration for questionable claims payment amounts andlor claim denials, coverage denials and rejections, policy terminations, and other similar actions. The appeals process shall exhaust all reasonable channels within the authority and organization of Administrator.	How do you manage appeals for claims denials, UM denials, enrollment terminations? How is the process documented in your files and automated system? How do you handle submission to the State?	Use outside peer review for medical claims denials and appeals. This is done on a case by case basis. Usually use a vendor called Advanced Medical Review for peer review. However, they do allow Claims examiners with experience to do medical denials or determine if peer review is need.
3.4.6.	All claims relating to a subscriber will be maintained in that file or a separate file that can be easily cross-referenced with the master file.	How will you meet this requirement?	Claims filed in batches by day. 3 months accessible on site, rest are in other building. Keep for 7 years.
3.4.7.	The claim forms and drafts shall be developed by Administrator and approved by HMOCAP. Printing, distributing, and storing these forms will be at the expense and responsibility of Administrator.	Do you have claims forms that must be completed?	Used to doing their own checks and RAs for clients. Do not outsource check printing or ID printing, etc.

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3.4.7.	Administrator shall maintain and regularly update a claims file and establish claims history for records retention. Such file shall be easily accessible and serve as the source of documentation for the claims adjudication processes. At a minimum the claims file shall contain: For each claimant -- policy number, claim number, date of claim, date claim loss reported, date claim loss paid, payee's name, diagnosis, amount of benefits claimed by type, amount of benefits paid, type of benefit paid. Claims control for date of payment, suspend, paid, denied, adjusted, applied to deductible, applied to out-of-pocket.	Please demonstrate your claims system for us. How does your claims history work? How do your accumulators work? How would you load prior claims history from the defunct HMO into your system to apply toward these accumulators and to prevent duplicate payments and to correctly calculate benefit limits, deductibles, max out of pocket, etc.?	Can cut off dollar amounts and visits. As noted above, we are not sure how they would get the information into their system
3.4.7.	Administrator shall ensure that the claims processing function is operated and maintained in an efficient and effective manner.	What is your average claims processing timeframe? What percentage are handled systematically vs manually?	Current claims volume average is 7000 claims/month (med & dental). They currently process within 10 days. Process 500 claims/day based on current staffing. Process 125/claims per examiner per day on average. They feel they can rapidly increase staff to meet needs. Using FHCP claims experience for 50,000 members, we received 79,470 claims in April. PBA currently uses 4 examiners to manually process 7000 claims per month. In order to handle an HMO's claims volume like FHCP, PBA would need to quickly add 45 new examiners to maintain their process using their Eldorado system. Once again, they sincerely believe they can do this. We have grave concerns.
3.5.1.	Administrator shall provide and maintain adequate telephone service for subscribers to assist in: (i) answering general questions relative to the policies of HMOCAP; (ii) claims adjudication; (iii) responding to specific provider and subscriber's questions; and (iv) insuring program efficiency and effectiveness by providing direct contact with those sources affected by the program and its operation.	How do you propose to handle large call volume? Do you handle customer service in one area (i.e. members, providers, claims, services all in one department) or are they transferred to various areas in your organization?	Staff up, Phone system has prompts to route calls. Route calls via phone tree. Record calls under member history log. Call reason and resolution is not reportable. They intend to use phone trees to correctly route calls, but will have humans answer the calls. We have concerns that they could adequately hire and train enough staff to meet the need.

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3.5.1.	Adnlinistrator must provide reasonable assurance that: (i) the lines are accessible; (ii) the lines are attended by qualified staff during regular business hours and kept in the name of HMOCAP; and (iii) all calls will be answered and eighty percent (80%) of such calls answered by the third ring.	What is the experience and qualifications of staff designated to answer calls? Do you have after hours call answering capability?	Have same stipulation for existing groups. They do not have after hours call capability.
3.5.1.	Appropriate written records and statistics shall be maintained by Administrator relative to the nunlber of incoming calls, and the types of inquiries handled by Administrator.	How will your system record the number, timeframes and types of call received?	They don't have this. Would have to develop
3.5.1.	Written responses to both telephone and fax inquiries shall also be documented in a similar manner. The files should be maintained in such a manner that all letters, documents, and payments involving a subscriber can be easily and readily located in a single file as to each subscriber.	How will you meet this requirement?	They have a letter writing system that will handle this through their Eldorado system so member files and member notes can be in one place.
3.5.1.	Statistical data and information relative to the number of inquiries, the subject of inquiries, the means by which the inquiry was received (telephone, written, and fax) shall be maintained by Administrator on a regular basis and provided to HMOCAP on request.	How will you meet this requirement?	They don't have this. Would have to develop
3.5.1.	Office and telephone service should be available each working day from 8:30 a.m. to 5:00 p.m., Eastern Standard Time.	How will you meet this requirement?	Their hours are 8-5
3.5.2.	Administrator shall, within a reasonable time, respond to all types of correspondence received in writing from providers, subscribers and others directly associated with the provision of care to subscribers. Administrator shall maintain adequate staff who can, in a timely manner, respond to routine as well as specific written inquiries relative to coverages and procedures. All inquiries must clearly identify that Administrator is responding on behalf of HMOCAP.	How is correspondence handled within your organization? How are records stored? How is data regarding calls shared across your organization?	All correspondence goes through Eldorado. Can program for follow up letters to be sent.
3.5.2.	A complaint log shall also be maintained.	How will you meet this requirement?	They could not provide an example of Complaint Log

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3.8.1.	All bank accounts and depository relationships shall be with banks and financial institutions located in the State of Florida. All bank accounts and depository relationships shall be in the name of HMOCAP and shall be under the ultimate control of I-IMOCAP.	Do you have existing bank accounts and relationships with Florida financial institutions that can be quickly leveraged to set up HMOCAP accounts for purposes of claims payment and premium collection? What financial institutions do you usually work with?	Yes. Work with SunTrust. Have worked with them since 1997
3.8.1.	Administrator must establish and maintain a separate bank account(s) in the name of HMOCAP for all financial receipts and disbursements pertaining to its business transactions as directed by HMOCAP.	How will you meet this requirement?	Yes. Work with SunTrust. Have worked with them since 1997
3.8.1.	Administrator shall establish and maintain a separate account in the name of HMOCAP to deposit funds collected as premium. Funds deposited into this account may be transferred only when authorized by HMOCAP, which shall have sole signatory authority on such account.	How will you meet this requirement?	Yes. Work with SunTrust. Have worked with them since 1997
3.8.1.	All financial accounting systems andlor methods used by Administrator must establish and have clear audit trails of all financial transactions and records executed and maintained by Administrator. Administrator shall maintain all financial records consistent with sound business practices and generally accepted accounting principles.	What financial reporting does your system produce? How will you meet this requirement?	Have a whole suite of reports that can record where the money goes. Called "Renewal Reports". They can prepare for HMOCAP

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3.8.4.	The financial records kept and maintained by Administrator on behalf of HMOCAP shall clearly isolate all business revenues and disbursements by type of transaction. At a minimum, financial records shall accurately reflect: Premium income receipts Benefit dollars disbursed Upon placement of all subscribers of the insolvent I-IMO in new, solvent health plans, and more frequently as directed by HMOCAP, Administrator must promptly determine and report to HMOCAP the net premiums, incurred losses, and administrative expenses for the entire period of the insolvency or for the period specified by the HMOCAP.	How will you meet this requirement? What accounting firm do you work with to create your financials?	Have a whole suite of reports that can record where the money goes.
3.8.4.	Administrator shall generate data reports to assist HMOCAP in the transfer of subscribers to an assuming health insurer(s) or health maintenance organization(s). Administrator shall generate data reports to assist prospective assuming health insurer(s) or health maintenance organization(s) considering assumption and/or assuming the subscribers. Administrator shall undertake any and all reasonable efforts to facilitate the transfer of subscribers to an assuming health insurer or health maintenance organization.	What data reports can be generated by your system by employer group, benefit plan, line of business in relation to claims, premium and enrollment? What ad hoc reporting capability to you have? Do you create the programming for these reports internally, or do you have a vendor that does this for you?	Will provide samples
4.1.2	Administrator shall provide Utilization Review Services as required by, and at the sole discretion of, HMOCAP. Utilization Review Services shall include, but not be limited to, Acute Medical/Surgical/Psychiatric Preadmission Review, Concurrent Review, Discharge Planning, Large Case Management Identification and Potential Shock Loss Notification.	Please walk us through your UM/UR process. What is your average turn-around time on requests, how do providers appeal initial determinations?	NA - they outsource this function

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4.1.3.	Administrator shall provide Large Case Management Services as required by, and at the sole discretion of, HMOCAP. Large Case Management Services shall include the management of any type of catastrophic or chronic condition including, but not limited to, transplant, oncology, neonate, rehab (including spinal chord andlor head injuries) home health, sltilled nursing, hospice, diabetes, coronary artery disease, and pain management. Should HMOCAP request Large Case Management Services,	How do you identify and manage large shock loss cases and reporting of same? What case management resources to you have available and use to manage these cases, especially in a time of uncertainty when the HMO is insolvent?	Manual process. Examiners have **list** of trigger diagnoses. Contact case management nurse to start review. Precert companies know ahead of time because of contacts about benefits. Run reports monthly (50% Report). Send email internally then added to report, and people who have accumulation of claims that reach pre-set thresholds.
5.5.	Upon the identilication of an overpayment that is more than 100% of the amount that should have been paid on a claim, Administrator shall, at its expense, promptly make all reasonable and diligent attempts to collect such overpayment and shall promptly reimburse I-IMOCAP upon receipt of such overpayment from the person or party paid or benefited by such overpayment, except amounts of $10.00 or less shall not trigger this provision. Administrator may utilize claims reversals as a method of reimbursing overpayments. If this collection method is unsuccessful within a reasonable period, Administrator shall, with Administrator's own funds, reimburse HMOCAP the full amount of such overpayment.	How do you handle refund requests? Does you system have the capability of doing withholds from future payments	5-10% of all claims processed are audited. Generate refund requests. Audits performed randomly. Reports of claims to be audited are generated by the system. Manager performs audits. Conduct ongoing pre-payment audits of large dollar claims. $35,000 limit for senior examiners. 4 claims examiners. Claims paid per groups, not specialties.