COMPARISON OF PUBLIC DOMAIN SYSTEMS ADAPTED FOR PHILHEALTH'S NEEDS BY COLLECTIVE SOLUTIONS, INC.

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Statement of Work

The purpose of this project has been to review the requirements for Medicaid Information Systems in the Philippines, and to determine if the Utah IT system is an appropriate system that could be adapted to meet the needs of the PhilHealth. A simultaneous comparison of the MetaVance® (EDS) system was also carried out for the purpose of having information available on an alternative to the Utah IT system in the event that the Utah IT system is determined to be inappropriate.

Objective:

The objective of these two comparisons is to determine the applicability of each system to the needs of PhilHealth, any modifications necessary to adapt either system to meet PhilHealth's requirements, and the estimated cost of such modifications.

The comparison was performed using the requirements provided in the Operations Management Information System (OMIS) Request for Proposal (RFP). These are included in ***Attachment 1: Requirements Matrix***. Any supporting detail, assumptions, constraints, or qualifiers will be included in ***Attachment 2: Requirements Detail***.

Approach:

Given the magnitude of this comparison and the short timeframe allotted, Collective Solutions, Inc (CSI) has developed a two-phased approached designed to provide as much information as possible within the shortest possible timeframe.

This involved obtaining assistance from MAXIMUS for the comparison of the Utah Medical Managed Care System (MMCS) public domain system and EDS for the MetaVance® proprietary system. This assistance has been provided with the understanding that MSH, CSI, and PhilHealth are under no obligation to either EDS or MAXIMUS for the purchase or licensing of products or services. It is recognized, however, that without the assistance of the developers of each system who are already knowledgeable in the overall design, subsystem interfaces, program logic, program code and language, table structures, indices, interfaces, etc. a comparison of this kind would not have been possible.

Phase 1: Initial Comparison

During this phase, the vendors worked with CSI to perform the initial comparison of the requirements to their respective systems. A number of the requirements can only be defined with additional detail to support a valid comparison effort and provide a realistic cost estimate. CSI performed the necessary research using the two OMIS RFPs, answers to questions by the proponents during the procurement effort conducted by PhilHealth, reports and deliverables developed by Charlene Angelo during prior consultancy engagements and any other materials available to CSI. ***Attachment 2: Requirements Detail*** was indexed according to the requirement

defined in ***Attachment 1: Requirements Matrix,*** and included any additional detail that could be extracted concerning that particular requirement. A significant amount of time was spent consolidating all of the various documents that support a particular requirement statement and then "fed" to each vendor. For a requirement that could not be answered adequately, the "Unknown" column has been checked.

Also, during this time, CSI will work with the vendors to provide an estimated cost for any modifications. The modifications will be ranked according to level of effort as follows:

- Minimum – this change is ***estimated*** to require a minimal level of effort
- Medium – this change is ***estimated*** to require a level of effort between minimum and maximum and is therefore called medium.
- Maximum – this change is ***estimated*** to require a significant level of effort

Phase 2: Walkthrough and Validation

At the conclusion of the initial comparison and cost estimate, a walkthrough and validation was performed between CSI and each vendor to answer any outstanding questions, confirm our understanding of each requirement, resolve any outstanding questions, and to identify any particular areas of concern that were identified during Phase 1.

Final Comparison Report

This report includes ***Attachment 1: Requirements Matrix*** for both systems and ***Attachment 2: Requirements Detail***, with cost estimates and any additional information that can be provided to assist MSH and PhilHealth in the successful analysis of the comparison.

Key Considerations:

The cost estimates provided have been based upon working with the vendors to determine the level of effort required by someone knowledgeable with the system, technically qualified and fully experienced to perform the modifications based upon the requirements as stated in ***Attachments 1 and 2***. It is important to note that cost estimates for system modifications are typically provided by the firm or individual who will be making the modification(s). To provide a cost estimate and then have another individual or firm actually perform the modification would be extremely risky. It would not be appropriate to hold one firm/individual accountable for estimates provided by another and vice versa.

These costs should be confirmed and considered very preliminary. The costs available for the Utah MMCS are much more definitive than those for MetaVance®. In fact, EDS recommended using MetaVance® "out of the box" and customizing the business operations instead of the software. In many cases, this makes sense since MetaVance® is based upon industry best practices and assumes very efficient operations. Therefore, the costs associated with MetaVance® are provided by Collective Solutions are not as reliable as if the vendor could perform a more detailed analysis of the PhilHealth requirements.

The requirements in the OMIS RFP that are being used for this comparison have never been prioritized or weighted. At the conclusion of this effort, there will likely be costs associated with modifications for a requirement that is of a low priority. In order to eliminate unnecessary costs, it will be critical that the requirements be prioritized by PhilHealth. Some direction can be provided by MSH, CSI or both, however, this is a very important process that the end users/owners of a system must resolve.

This should be performed using the supporting detail provided in ***Attachment 2: Requirements Detail*** to assist in eliminating outdated requirements, change the wording of requirements or add new requirements. The goal in crafting a requirements statement is to describe the desired **end result that is to be achieved** rather than dictating the **technical methodology used to meet the end result**. When dictating a specific methodology or technology, it is likely that unnecessary costs are incurred because the software vendor must alter the system to follow that methodology even though the desired objective is achieved using the system as is. Also, as technologies/methodologies change and advance, the requirement is too restrictive to allow for PhilHealth to take advantage of these advances.

Once PhilHealth completes this prioritization activity, it is likely that some modifications can be eliminated and the cost of customization, therefore, reduced. Also, the requirements do not have to be updated as frequently, because desired objectives do not change as often as the mechanisms used to meet those desired objectives.

Attachment 1: REQUIREMENTS MATRIX

SUMMARY

Subsystem	MetaVance	Utah MMCS
General Requirements	14	20
Member Eligibility	1	3
Claims Processing	3	22
Accreditation	5	5
Quality Assurance	11	36
Premium Contribution	6	19
Billing and Collection	29	48
Ad Hoc	1	1
System & Database Admin	3	4
Total	***73***	***158***

General Requirements

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer #
	Capture complete membership information of the employed, retired, indigent and individually paying members in geo-based formats		X	G-001
	Reduce the lead-time for posting of contribution collection from at least 15 days to 3 days upon receipt of employees' remittance report		X	G-002
	Access information to and from health facilities using the Department of Health's Hospital Operations Management Information System required in eligibility checking and electronic claims processing as necessary.	X		G-003
	Detect double-filing and other claims that are deemed either as characterized by inappropriate health care or fraudulent and forward these to the PHIC Utilization Review and Intervention Department, the PHIC Fraud Prevention and Detection Unit and/or the Legal Services Group, respectively		X	G-004
	Ensure the provision of quality health care services by making library of standards for drugs and procedures accessible to health care providers and members	X	X	G-005
	Generate management reports, executive information and PHIC indicators as listed in the issues and concerns for the development of an EIS			G-006
	Client server architecture on a Wide Are Network			G-007
	Related Database Management System (RDMS)			G-008
	The decentralized data processing approach shall support real-time processing for inquiries and batch processing for transactions and validation of data across regions. This approach aims to support the decentralization of operations.			G-009

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer #
	For inquiry processing, the regional staff would enter the required fields, locate the response locally. Raw data of transactions processing would be batched and uploaded to the Regional Node. At the end of the day, the Node uploads all regional updates to the Central Office for storage. This approach creates instantaneous updating of the RHIO and Node databases which will be synchronized with the Central Office every twenty-four (24) hours		X	G-010
	The registration forms retrieved are forwarded to the Service Offices at the 75 provinces for encoding the personal details and the benefits availed of. A profile for members consisting of every member and his respective beneficiaries his premium contributions and availment of benefits by the member and his beneficiaries will be maintained locally		X	G-011
	The employed NHIP members will pay their premium contributions through accredited collecting agents such as the banks every end of the month, and other collecting agents such as the PHIC offices and the drop boxes daily. Remittance reports will be submitted by the employers to PHIC on such payments every 10th day of the end of the quarter. There has to be an online reconciliation of the actual payments reported by the collecting agents and the remittance reports of the employers	X	X	G-012
	The member's eligibility to available Medicare benefits shall be computed at the RHIO and validated at the Central Office. The status on the member eligibility shall be accessed from the Web-enabled RDBMS. This is determined by applying the following 5 business rules:			G-013

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer #
	1) determining whether the claim application was filed within the prescribed 60 day filing period;		X	G-013a
	2) the period payment acceptability which is one quarter for every preceding 9 months;		X	G-013b
	3) the complete payment applicable for the period;		X	G-013c
	4) the benefit balance based on the remaining unutilized benefits; and		X	G-013d
	5) the remaining confinement days that can be applied for Medicare benefit claim for reimbursement		X	G-013e
	Access via Internet the claims application of accredited health care providers such as the hospitals and clinics through the Hospital Operations Management Information System (HOMIS). HOMIS is Sybase/Powerbuilder-based system developed by the Department of Health in order to standardize hospital systems and facilitate the monitoring and evaluation of health services being rendered.	X		G-014
	The Wide Area Network of PHIC shall interconnect the Luzon Regional Health Insurance Offices (RHIOs) in Luzon to the LUZON NODE, the Visayas RHIOs to the VISAYAS NODE, and the Mindanao RHIOs to MINDANAO NODE via leased lines. The Luzon Nodes, the Visayas Node and the Mindanao Nodes shall interconnect to the PHIC Central Office via leased lines. Provincial Office of PHIC called the Service Office shall interconnect to the WAN through dial-up connections	X	X	G-015

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer #
	Presently, the Service Offices have existing local databases which are aggregated at the RHIO databases. PHIC envisions the future aggregation of the RHIO databases at the major nodes and these nodes at the Central Office. The turnaround time of uploading Regional Node databases to the Central Office should take not more than 24 hours.	X		G-016
	PHIC needs to measure the health outcomes based on the health services rendered by the health care providers and professionals and determine the member satisfaction in the delivery of these health care services.	X	X	G-017
	A member profile would include a comparison of the diagnosis and the treatment provided on one hand, and the results of the treatment on the other hand based on the clinical or medical record attached to the claims application. Electronically, this should be made accessible through a file transfer between the HOMIS and PHIC 's OMIS	X	X	G-018
	Member satisfaction can be derived through a conduct of survey which may be done periodically at random.	X	X	G-019
	PHIC shall implement a system of assessing outcomes of service rendered by health care providers to include the following:	X		G-020
	1) review of mortality and morbidity rates, post-surgicalinfection rates and other health outcomes indicators;	X	X	G-020a
	2) undertaking of outcomes research projects; and	X	X	G-020b
	3) client satisfaction surveys.	X	X	G-020c

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer #
	There shall also be an assessment of the advantage and appropriateness of medical technologies, equipment, devices, and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives. The computerized system should be able to capture the specific data that will be used for such an assessment	X	X	G-021
	Total	**14**	**20**	

Member Eligibility

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Validation			
	Detect duplication of members, employers, and dependents by members			M-001
	Update deficiency of received application			M-002
	Ensure uniqueness of PIN/PEN			M-003
	Flag data deficiency within 3 seconds upon member record entry			M-004
	Monitor applications in the pipeline			M-005
	Generation of endorsement proof list and reports registration	X	X	M-006
	Function			
	Cover all types of members			M-007
	Monitor Enrollment and Renewal of Eligible Indigent Member			M-008
	Monitor change of Member Category			M-009
	Track Employment History		X	M-010
	Create Membership Database based on the name, date of birth, birthplace, income, employment		X	M-011
	Update Membership Database within 3 seconds per record update on membership status, eligibility, benefit amount balances, confinement period balances, premium contributions/ balances			M-012
	Assign unique number to applicants within 3 seconds upon system acceptance of validated membership entry			M-013

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Query			
	Perform an alpha-numeric search query from database having at least 500K records within three (3) seconds or less			M-014
	Reports			
	Generate individual and batch proof list report			M-015
	Generate PIN / PEN Generation Report			M-016
	individual and batch proof list report			M-017
	Statistical Reports (Daily/ Monthly & Quarterly)			M-018
	Total SS Members with generated PHIC Number Report			M-019
	Total Active GCIS Members Reports			M-020
	Totals	1	3	

Claims Processing

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Validation			
	Validation of Member/Employer status			C-001
	Validation of Quality Contribution		X	C-002
	Validation of Confinement Period		X	C-003
	Validation of Hospital accreditation		X	C-004
	Validation of Double Filing		X	C-005
	Validation of benefit balance		X	C-006
	Validation of Same Illness in 90 days		X	C-007
	Validation of Filing Period		X	C-008
	Perform member eligibility and claims payment validation within 3 seconds, of ten (10) concurrent users			C-009
	Functions			
	Perform computation on claim charges vs. benefit package		X	C-010
	Perform monitoring and payment computation of Claims Review		X	C-011
	Generate Voucher	X	X	C-012
	Generate status report of claims payment 2 hours after release of checks or notice to ADB		X	C-013
	Perform analysis of data periodically and on need to generate the following information:			C-014
	Member and AHCP balances on benefit amounts and confinement periods; and		X	C-015

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Claims payments payable to members and AHCP.		X	C-016
	Process claims with or without settling authority		X	C-017
	Prepares Claims cover letter			C-018
	Update outstanding and settled claims		X	C-019
	Reporting			
	Generate status report of claims payment 2 hours after release of checks or notice to ADB			C-020
	Prints claims summary by line, by client, by accredited health care providers and by account officer		X	C-021
	Summary of Validated Data from Region (Amount paid and Claim paid)		X	C-022
	Summary of Validated Data from Region (Claims Received)		X	C-023
	Daily/ Monthly/ Bi-monthly Status Report	X		C-024
	Report of Disbursement for Benefit Claims		X	C-025
	Monthly Report of GSIS/ SSS Benefit Claims		X	C-026
	Summary of GSIS/ SSS Benefit Claim Secondary Reports		X	C-027
	Medical Evaluation Reports	X	X	C-028
	Total	**3**	**22**	

Accreditation Information System (Provider)

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Functions			
	Can the system evaluate and assess the completeness of the submitted application forms and other necessary documents required for accreditation?	X	X	A-001
	Can the system process payment of the Accreditation Fee and generate a receipt?	X	X	A-002
	Can the system generate a letter notifying the applicant of what requirements are lacking?			A-003
	Can the system generate the documents and agenda required for a pre-accreditation inspection?			A-004
	Can the system generate an inspection report?	X	X	A-005
	Can the system generate a approved/denied notification letter to applicant?			A-006
	Can the system notify the Legal and Claims Processing Departments of approved/denied status?			A-007
	Can the system generate an Accreditation Status report?	X	X	A-008
	Can the system generate an Accreditation number and Certificate?	X	X	A-009
	Can the system generate a letter to all Institutions included in the Accreditation Committee Meeting?			A-010
	Total	**5**	**5**	

Quality Assurance

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Functions			
	Computation of Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR)	X	X	Q-001
	Access data from Claims Department		X	Q-002
	Develop validation modules for the libraries	X	X	Q-003
	Perform analysis of data periodically and on need to generate information on program and fund utilization.			Q-004
	Reports			
	Number of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and ambulatory surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order		X	Q-005
	Number of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.		X	Q-006

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Amount of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.		X	Q-007
	Amount of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital), per month, quarter, semester, and year by region and nationwide arranged in descending order.		X	Q-008
	Number of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.		X	Q-009
	Amount of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.		X	Q-010
	Number of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide, arranged in descending order.		X	Q-011

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Amount of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide arranged in descending order.		X	Q-012
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region and nationwide, per month, quarter, semester and year in descending order.	X	X	Q-013
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region, per month, quarter, semester and year, arranged in descending order.	X	X	Q-014
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectable etc.) per diagnosis per professional and per region, per month, quarter, semester and year arranged in descending order.	X	X	Q-015
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per professional and per region, per month, quarter, semester and year, arranged in descending order.	X	X	Q-016

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Number of claims paid per diagnostic procedure (specific X-ray, ultrasound, Computed Tomography scan, Magnetic Resonance Imaging laboratory procedures, e.g. Chest Postero Anterior, Skull CT scan, abdominal ultrasound, Complete Blood Count, Blood Urea Nitrogen, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.		X	Q-017
	Amount paid per diagnostic procedure (specific X-ray, ultrasound, CT scan, MRI, laboratory procedures, e.g. Chest P.A., Skull CT scan, abdominal ultrasound, CBC, BUN, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide.		X	Q-018
	Number of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, eg. Chest PA, skull CT-scan, abdominal ultrasound...) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.		X	Q-019
	Amount of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, eg. Chest PA, skull CT-scan, abdominal ultrasound) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.		X	Q-020

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Amount claimed for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.		X	Q-021
	Amount paid for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.		X	Q-022
	Average length of confinement per diagnosis, per institutional provider per region, per month, quarter, semester, and year.		X	Q-023
	Average length of confinement per diagnosis, per professional, per region, per month, quarter, semester, and year arranged in descending order.		X	Q-024
	Number of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.	X	X	Q-025
	Number of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.	X	X	Q-026
	Amount of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year.	X	X	Q-027

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Amount of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by specialty, by region and nationwide per month, quarter, semester and year.	X	X	Q-028
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.		X	Q-029
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.		X	Q-030
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.		X	Q-031
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.		X	Q-032

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail
	Average value per claim per diagnosis, per institutional provider, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.		X	Q-033
	Average value per claim per diagnosis, per professional, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.		X	Q-034
	Average age of patient per claim per diagnosis per institutional provider per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.		X	Q-035
	Average age of patient per claim per diagnosis per professional per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.		X	Q-036
	Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR) per hospital by category and region per month, quarter, semester and year arranged in descending order.	X	X	Q-037
	Total	***11***	***36***	

Premium Contributions

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Validation			
	Validate on-line the premium contribution against the membership database		X	P-001
	Functions			
	Process and print Collection notice to/from ACB/ACA	X	X	P-002
	Update accounts of members		X	P-003
	Generate Correction of Bill Report (Hardware)	X	X	P-004
	Generate Correction of Bill Report (Software)	X	X	P-005
	Maintains premium date of remittance based on inception or payment date		X	P-006
	Data capture of Remittance Information such as insurer's OR number and OR date		X	P-007
	Allows for all or selective tagging of records for remittance	X	X	P-008
	Posting of remittance information to individual coverages		X	P-009
	Maintains reference table of depository back account of employers	X	X	P-010
	Generates entries to disbursement vouchers.		X	P-011
	Electronic processing of addition, reduction, cancellation, or spoilage of premium contributions		X	P-012
	Query			
	Generate Account Receivable by Generate ACB		X	P-013
	Generate Unpostable/Unpaid Collection Records		X	P-014
	Reporting			
	Generate Notice of Non-Payments		X	P-015

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Statement of Member's Remittance / Contribution, monthly		X	P-016
	Statement of Agency Remittance / Contribution, monthly		X	P-017
	Summary of Posted Contributions		X	P-018
	Weekly accomplishment report	X	X	P-019
	Total	***6***	***19***	

Billing and Collection

Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
Functions			
Update employer record for all remittance reported by ACB/ACA for 15 days		X	B-001
Compute the floating period of 15 days + 5 days grace period allotted by PHIC to all its ACB/ACA and update corresponding bank record	X	X	B-002
Reconcile billing statement and ME-5, MI-5 and Min-5; compute balances and update record	X	X	B-003
Accept and display Web-based validation request for the payments of member's premium contribution	X	X	B-004
Generate files for refunds		X	B-005
Perform analysis of data periodically and on need to generate the following information:	X		B-006
1)accredited collecting agents and accredited depository banks floating period	X	X	B-007

Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
2) premium contributions and other charges receivable from members		X	B-008
Send billing statement via Web	X	X	B-009
Cross-referencing of Premium Contributions	X	X	B-010
Online or batch computer generation of receipts	X	X	B-011
Collection fund Transfer	X	X	B-012
Online Collection Reports and OR Register		X	B-013
Query			
Online member generation of statement of accounts		X	B-014
Reporting			
Generate AR Reports		X	B-015
Process billing and print billing statement for ACB/ACA on late remittances		X	B-016
Generate list of Active /Inactive Employers/ Members by end-of –month		X	B-017
Print a bill for mailing to the LGUs and Individually-paying members' thirty (30) days before the anniversary date of NHIP membership	X	X	B-018
Generate file for adjustment on next bill		X	B-019
Generate files for refunds		X	B-020
Generate Debit/Credit Memo due to Adjustment of payments	X	X	B-021
Generate and print statement for Agency and LGUs		X	B-022
Generate Summary of Billing Statement		X	B-023
Generate Collection Report and Member Report	X	X	B-024
HIP Premium Contribution, quarterly	X	X	B-025

Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
Report of Collections and Deposits, monthly		X	B-026
Report of Fund Transfers (MOOE), monthly	X	X	B-027
Statement of Account		X	B-028
Collection Progress Reports Delivered to RHIO/ACBs, monthly	X	X	B-029
Aging of Unpaid Penalties & Interest from ACBs Late Remittances	X	X	B-030
Summary of Daily Collection Report, monthly	X	X	B-031
RHIOs Collection Report Purely on NHIP Premium Contribution, quarterly	X	X	B-032
RHIOs Collection Report Purely on NHIP Premium Contribution, monthly		X	B-033
Daily Collection Report		X	B-034
Report of Collection and Deposit, National Capital Region	X	X	B-035
Summary of Over-The-Counter Collection	X	X	B-036
Weekly Accomplishment Report	X	X	B-037
Premium Collection Management Master Database		X	B-028
Premium Collection Management System Data Entry Prooflist		X	B-039
Premium Collection Management System Monthly/ Quarterly Remittance Report		X	B-040
Premium Collection Management System Quarterly Remittance Statement	X	X	B-041
Premium Collection Management System Monthly Underpayment/Overpayment Report		X	B-042

Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly ACBs Collection Report, quarterly/every 15th day	X	X	B-043
Bank Collection Report, every 15th day	X	X	B-044
Collection Report thru Modified Disbursement Scheme. Direct Remittance Scheme - Servicing Banks Purely on NHIP Premium Contribution, quarterly/monthly	X	X	B-045
Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly	X	X	B-046
Home Office Collection Report Purely on NHIP Premium Contribution, quarterly	X	X	B-047
Consolidated Report of Collection Purely on NHIP Premium Contribution by Fund Type	X	X	B-049
Monthly Accomplishment Report - Bank Remittance Section	X	X	B-050
Total	***29***	***48***	

Ad Hoc

Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
Functions			
Can track documents while in-process or after processing, with reference to manual storage		X	H-001
Can do an audit trail of the processing and storage of the respective IS	X		H-002
Total	***1***	***1***	

System and Database Administration

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
Functions				
	Library Maintenance			S-001
	Geographic Code Table Maintenance			S-002
	Detect and log any change to the databases to record date and time of users			S-003
	User Friendly			S-004
	Facility for Computer-based Training	X	X	S-005
	Online interface to fax and e-mail facilities	X	X	S-006
	Multilateral coding system for refferors/ agents	X	X	S-007
	Reference table look up			S-008

Priority	Requirement	MetaVance Mod	Utah MMCS Mod	Detail Refer#
	Three-level security: network, system and application levels			S-009
	Provide for back-up/restore procedures			S-010
	Archiving of historical insurance coverage information		X	S-011
	Includes utilities for security/password, batch/job controls, backup and restore procedures			S-012
	Total	***3***	***4***	

ATTACHMENT 2: REQUIREMENTS DETAILS

Accreditation Information System

Detail Reference Number	Requirement Requirement Detail

Requirements are self explanatory

Additional information provided as clarification

Ad-Hoc Workflow refers to the routing of the documents and files, electronically and manually. The need to link with the manual processing of documents, either in-process or after completing the processes. The document flow and the processes for each transaction are indicated in the business processes of each Information System.

- Membership Registration
- Billing and Collection
- Premium Contributions
- Claims Process
- Quality Assurance
- Executive Information

Billing and Collection Information System

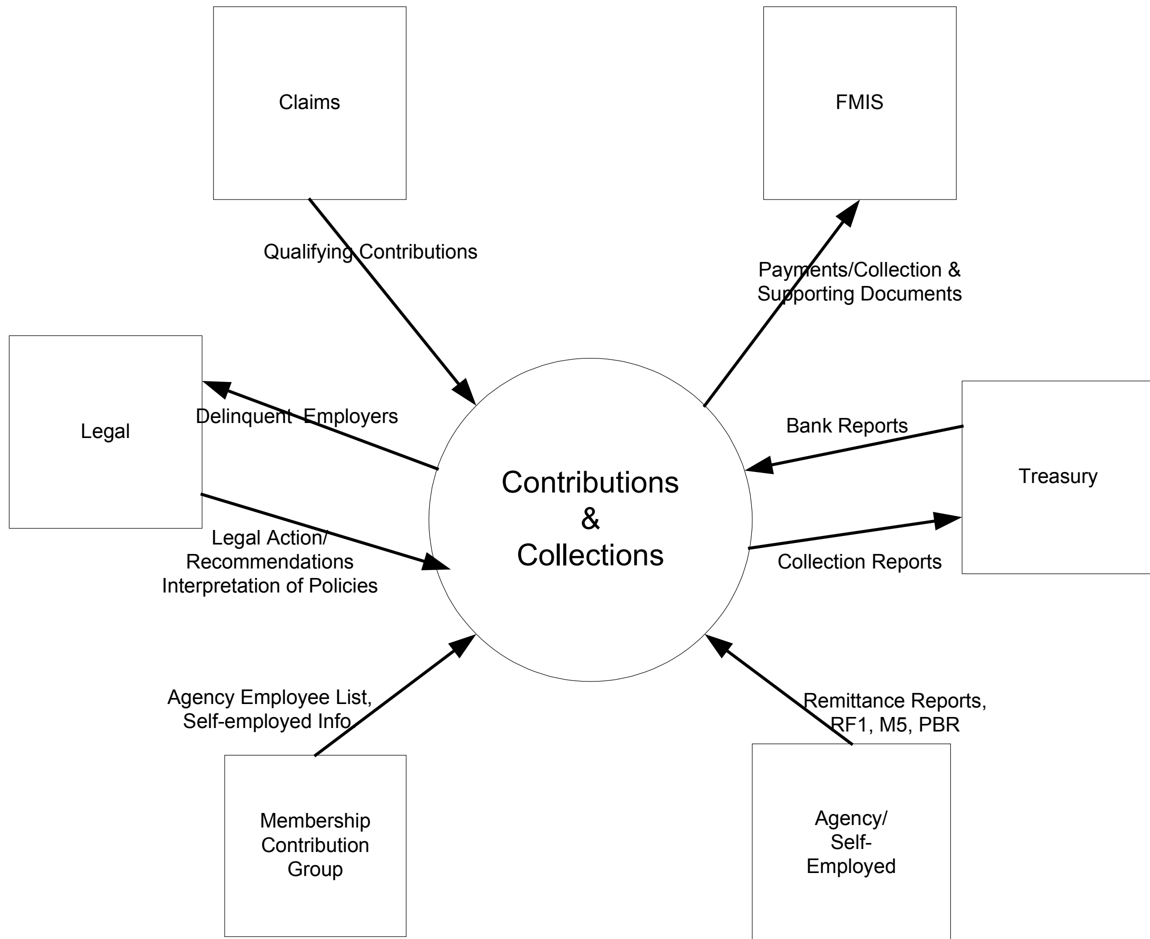
Detail Reference Number	Requirement Requirement Detail
B-003	Reconcile billing statement and ME-5, MI-5 and Min-5; compute balances and update record ME-5, MI-5 and Min-5 are Contribution Payment Return Forms Transactions from the remitting ACBs and ACAs and the individually payment members include: 1) Receipt of bank statement from government banks and the amount remitted by ACBs and ACA for the period—done once a month. 2) Reconciliation of the banks reports (CRF2) with the documents (ME-5, MI-5) 3) Receipt of Bank Remittance Report (RF2A) with corresponding documents every 15th and 30th of the month. 4) Reconciliation of bank remittance report (RF2A) 5) Accredited Collecting Agents – Receipt of collection report of the ACA for over the counter payments
B-013	Online Collection Reports and OR Register

Detail Reference Number	Requirement Requirement Detail
	Define OR Register.
B-025	HIP Premium Contribution, quarterly Define HIP
B-045	Collection Report thru Modified Disbursement Scheme. Direct Remittance Scheme - Servicing Banks Purely on NHIP Premium Contribution, quarterly/monthly Unable to locate definition.

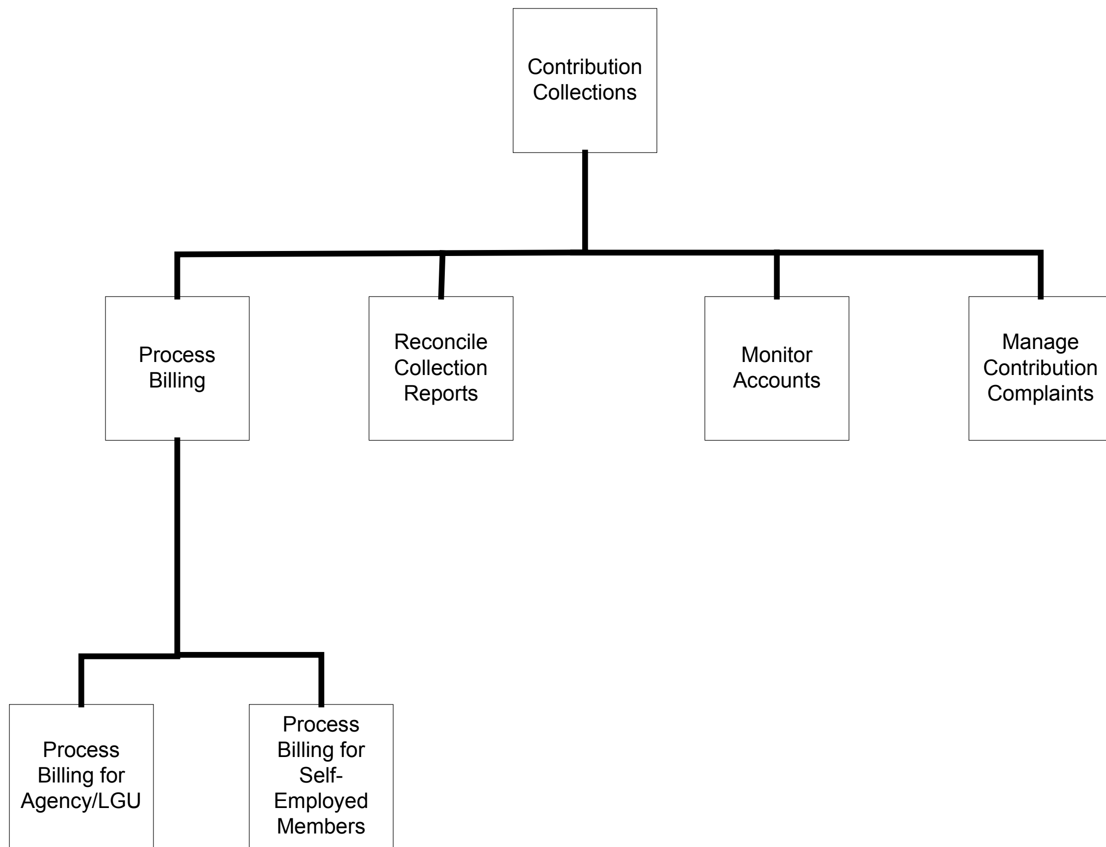
Additional information on the Billing and Collection Information System

1. Maintain premium contribution calendar by type of membership and age to determine receivables by pay period. The billing system can use this calendar in the generation of bills for the employer in behalf of its employees, the Department of Budget and Management as PHIC counterpart in financing the indigent program and the Indigent Program sponsor Local Government Unit (LGU) which may either be the Municipal, Provincial or City Government.
2. PHIC needs to compute balances and surcharges in addition to regular premium contribution due at specific premium pay period one week before the printing and/or generation of bills.
3. Billing statements for employers and sponsor government units need to be generated and printed for specific billing period. For the other NHIP members, the dues should be made available as soon as the computation is completed during the billing period.
4. The monthly bank statement on premium contributions received from employers will be compared by PHIC with the report of the employers premium contributions submitted by the ACBs. PHIC allow the accredited banks a floating period on premium contributions. Other collecting agents remit premium contributions on a daily basis.

Contribution Collection System Context Diagram



Contributions Collection System Functional Hierarchy Diagram



Claims Processing System

Detail Reference Number	Requirement Requirement Detail
C-002	Validation of Quality Contribution Should read Validation of Premium Contribution The current system cannot readily verify eligibility because premium contributions are not posted immediately. Premium contributions – members should have paid at least 3 monthly premiums contributions within the immediate 6 months prior to the first day of availment.
C-003 C-007	Validation of Confinement Period Validation of Same Illness in 90 days Limit of 45 days on a confinement period 90 day interval for availment of benefit for same illness referred to as single period of confinement.
C-008	Validation of Filing Period 60 days within date of discharge
C-012	Generate Voucher A voucher includes the voucher date, item description, item amount, HP accreditation number, bank code, bank account number, requesting unit and approving authority.
C-014 C015	Perform analysis of data periodically and on need to generate the following information: Member and AHCP balances on benefit amounts and confinement periods How does a AHCP have balances on benefit amounts?
C-017	Process claims with or without settling authority What is settling authority?
C-018	Prepares Claims cover letter What cover letter?

Claims Processing Guidelines

Claims processing observes the Fee for Service Guidelines on Claims Payment, as well as the following rules.

a. The health care provider shall file the claim using the prescribed forms.

b. All claims for payment of services rendered shall be filed within sixty (60) calendar days from the date of discharge of the patient.

Otherwise, the claim shall be barred from payment except if the delay in the filing of the claim is due to calamities and other fortuitous events. If the claim is sent through mail, the date of mailing as stamped by the post office of origin shall be considered as the date of filing.

If the delay in the filing of claims is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.

If the delay in the filing of the claims is caused by the health care provider and the Medicare benefits had already been deducted, the claim will not be paid. If the claim is not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider.

Claims returned for completion of requirements should be refiled within sixty (60) calendar days from receipt of notice. The date of reckoning shall be based on the date the returned claims were received by the health care institution or member, as stamped on the envelope or receipt by the postal / courier service, if sent through the mail, or on the claims as stamped by the Corporation, in case of directly-filed claims. The date of mailing as stamped on the envelope or receipt by the postal / courier service, if the claim is sent through mail, or on the date stamped by the Corporation, in case of directly-filed claims shall be considered as the date of re-filing.

c. When the member has complied with the requisites for availment, the health care provider shall deduct from the total charges all expenses reimbursable by the Corporation upon discharge. Payment of medical benefits shall be made directly to the health care provider.

d. Health Care institutions are not allowed to charge processing fees from the member when claiming reimbursement from the corporation.

e. No direct payment to the member is allowed except in the following cases:

1. he member or dependent was confined abroad;
2. drugs, medicines and other medical supplies bought by the member within the confinement period and supported with official receipts and which were used during such confinement;
3. full payment was made by the member because of failure to submit the required documents;

4. the member paid professional fees directly. In this case, the health care provider shall have the responsibility of informing the member of the existence of this payment option and shall issue an official receipt or waiver in favor of the member.

f. The Corporation may deny or reduce any benefit provided herein when the claims are attended by any of the following circumstances:

1. over-utilization and under-utilization of services;
2. unnecessary diagnostic and therapeutic procedures and interventions;
3. irrational medication and prescription;
4. fraud;
5. gross, unjustified deviations from currently accepted standards of practice and/ or treatment protocols;
6. inappropriate referral practices;
7. use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs; or,
8. use of drugs other than those recognized in the latest PNDF and those for which exemptions were granted by the Board.

Further, the Corporation may deny or reduce the payment for claims when such claims are attended by fraudulent, false or incorrect information and when the claimant fails without justifiable cause to comply with the pertinent provisions in the law and the rules and regulations.

When the claim is reduced or denied, the amount thus reduced or denied shall not be charged directly or indirectly to the beneficiary involved.

The outcome of a peer review conducted by a professional organization or health care institution without the authority or consent of the Corporation shall not in any way bind the latter with respect to payment of claims.

g. All prescriptions and orders for drugs and medicines in institutional health care providers shall be in generic terminology. DOH Administrative Order No. 62 s. 1989, “Rules and Regulations to Implement Prescribing Requirements Under the Generics Act of 1988” shall be used as the guide in evaluating the appropriateness of prescription and written orders in the patient chart.

Drugs and medicines that are de-listed by the DOH through the BFAD because of failure to satisfy the eligibility standards/registration criteria and cause adverse drug reaction shall also be used as reference guide in parallel with the prescribed edition of the PNDF.

h. Primary hospitals are required to submit a copy of the prescribed PhilHealth Form and/ or clinical records of patient in connection with their claims. Otherwise, such claims shall not be processed.

i. Secondary and tertiary hospitals may be required, on a case-to-case basis, to submit clinical records in order to facilitate the processing of claims.

j. All employee hospitalization claims under the Employees' Compensation Program, shall be automatically considered as claims under NHIP. Provided, that the claim has been filed within the reglementary period of sixty (60) calendar days.

k. When the claims filed by a health care institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims shall be accompanied by a justification in writing. Otherwise, the same shall not be processed.

l. Any operation performed beyond the accredited capability of the accredited health care institution shall be considered a violation and a claim for such will be denied by the Corporation, except when the same is done in an emergency case or when referral to a higher category health care institution is physically impossible. Primary care hospitals shall be compensated only for simple surgical operations as determined by the Corporation.

m. All claims for services filed by a health care institution after its category is downgraded pursuant to this Rules shall be paid based on rates for such downgraded category, as determined by the Corporation.

n. Professional fees for services are rendered by salaried health care providers may be retained by the health care institution in which services are rendered for pooling and distribution among health personnel. The manner of distributing the professional fees is left to the discretion of the health care institution.

o. Public health care institutions shall be allowed to retain charges paid for use of facilities. Such revenues shall be kept in a Trust Fund and shall be used to defray operating costs to maintain or upgrade equipment, plant or facility and to maintain or improve the quality of service in the public sector except for remuneration of personnel services.

p. All claims, except those under investigation, shall be acted upon within sixty (60) calendar days.

q. Hospital confinements of less than twenty-four (24) hours shall not be compensated under the NHIP except in the following instances:

1. when the patient died;
2. when the patient is transferred to another health care institution; or,
3. in emergency cases.

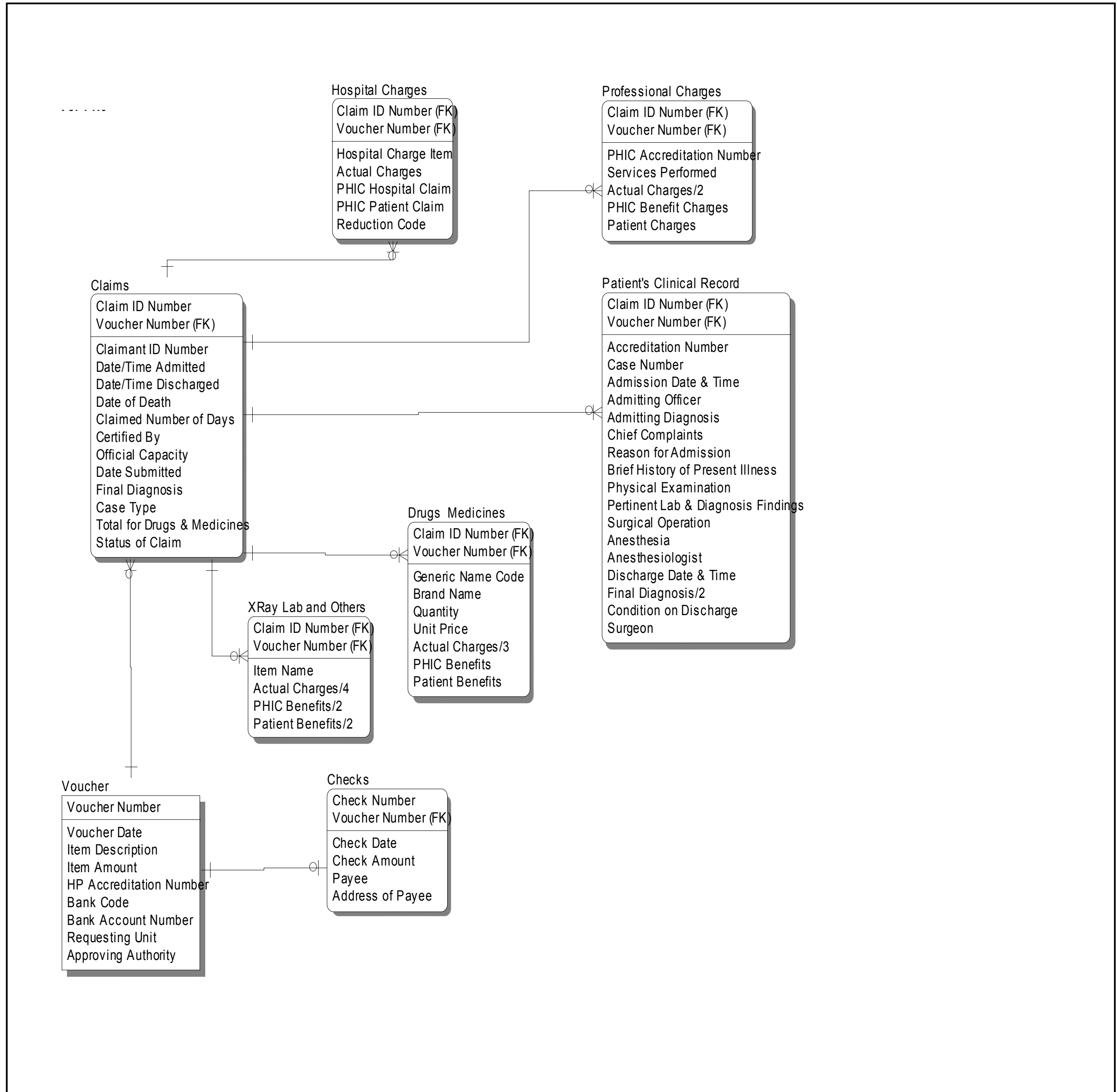
r. Claims of health care institutions that are not accredited but with current license from the DOH shall be compensated, Provided that the following are met:

1. The claim is based on an emergency as determined by the Corporation;
2. The physical impossibility to transfer the patient to an accredited health care institution as determined by the Corporation.

If the above conditions are met, hospital charges, drugs, medicines and medical supplies purchased by the member shall be reimbursed, provided, that official receipts are submitted together with the claim. Likewise, the professional fees of accredited health care professionals shall be reimbursed by the Corporation. When filed, such claims should include the complete clinical chart of the patient.

All claims of health care institution that are not accredited by the Corporation and not licensed / accredited / cleared to operate by the DOH shall not be paid.

Claims Processing Information System



Claims Processing Data Model

Executive Information System

Detail Reference Number	Requirement Requirement Detail

Detail Reference Number	Requirement Requirement Detail
	There is no existing system for Executive Information generation. The reports required are listed below

Financial Indicators

Expenditure
Total costs
a) PHIC Total
b) RHIO, NCR Total
c) Total, previous month
d) Total, previous year
e) Total, previous quarter
f) Total, plan

Total expenses for benefits
a) PHIC Total
b) RHIO, NCR Total
c) Total, previous month
d) Total, previous year
e) Total, previous quarter
f) Total, plan

Total expenses for benefits per insured
a) PHIC Total
b) RHIO, NCR Total
c) Total, previous year
d) Total, previous quarter
e) Total, plan

Total expenses for administration
a) PHIC Total
b) RHIO, NCR Total
c) Total, Department
d) Total, Project
e) Total, previous year
f) Total, previous quarter
g) Total, plan

Total expenses for administration per capita of beneficiary
a) PHIC Total
b) RHIO, NCR Total
c) Total, previous year

d) Total, previous quarter

Total expenses for administration per activity
a) Total, Department
b) Total, previous month
c) Total, previous year
d) Total, previous quarter
e) Total, plan

Total expenditure for PHIC staff
a) PHIC Total
b) PHIC HQ
c) RHIO, NCR
d) Total, Departments
e) Total, Project
f) Total, previous year
g) Total, previous quarter
h) Total, plan

Total expenditure for PHIC staff per insured
a) PHIC Total
b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Total expenditure for PHIC staff per activity (per claim handled)
a) Total, Departments
b) Total, Project
c) Total, previous month
d) Total, previous year
e) Total, previous quarter
f) Total, plan

Expenses inpatient total
a) PHIC Total
b) RHIO, NCR
c) Total, previous month
d) Total, previous year
e) Total, previous quarter
f) Total, plan

Expenses inpatient per case
a) PHIC Total
b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Expenses inpatient total, per case according to hospital category
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous year
e) Total, previous quarter

Expenses inpatient total, per case according to ownership (pup/priv)
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year
f) Total, previous quarter

Expenses inpatient total, Room and board
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

Expenses inpatient total, X-ray and laboratory
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

Expenses inpatient total, drugs and medicines
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

Expenses inpatient total, Operating room
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

Expenses inpatient total, professional fees
a) PHIC Total

b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

1) General Practitioners
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year
2) Specialist
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year
3) Surgeon
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year
4) Anesthesiologist
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous month
e) Total, previous year

Expenses drugs total
a) PHIC Total
b) RHIO, NCR
c) Total, previous month
d) Total, previous year
e) Total, previous quarter
f) Total, plan

Expenses drugs total per insured
a) PHIC Total
b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Expenses drugs per insured
a) PHIC Total

b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Expenses drugs per confinement
a) PHIC Total
b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Expenses drugs per diagnosis
a) PHIC Total
b) RHIO, NCR
c) Total, previous year
d) Total, previous quarter

Expenses drugs per prescribing unit (specialty)
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous year
e) Total, previous quarter

Expenses drugs per generic name
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous year
e) Total, previous quarter

Expense drugs total per generic name and distributor
a) PHIC Total
b) RHIO, NCR
c) Total, previous month

Expense drugs total per generic name and distributor
a) PHIC Total
b) RHIO, NCR
c) Providers
d) Total, previous year
e) Total, previous quarter

Income
Total Income
1) PHIC Total
2) Total, previous month

3) Total, previous year
4) Total, previous quarter
5) Total, plan

Income from contributions
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

Government Employed
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

a) Government Employed per member
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

Private Employed
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

a) Private Employed per member
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

From Individual-Paying Members
1) PHIC Total

2) RHIO-NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

a) From Individual-Paying Members average per member
1) PHIC Total
2) RHIO-NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter

Income from the government
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter
6) Total, plan

Income distribution of employees
1) PHIC Total
2) RHIO, NCR
3) Total, previous year
4) Total, previous quarter

Accrued Receivables
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter

Accrued Receivables older than one year
1) PHIC Total
2) RHIO, NCR
3) Total, previous month
4) Total, previous year
5) Total, previous quarter

Income from contributions in % of total income
1) PHIC Total
2) Total, previous year
3) Total, previous quarter

Income from invested funds
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter
5) Total, plan

Income from invested funds in percent of the invested funds (ROI)
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter
5) Total, plan

Other income
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter
5) Total, plan

Solvency, liquidity
Reserve
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter
5) Total, plan

Reserve in number of monthly expenditures for claims
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter
5) Total, plan

Total current assets compared to current liabilities
1) PHIC Total
2) Total, previous month
3) Total, previous year
4) Total, previous quarter

Return on investment
Surplus, deficit

Non-financial indicators

Workload and performance indicators
Membership indicators
Demand indicators (like health statistics)
Provider indicators (quality and quantity indicators)

Combined indicators (ratios of financial and non- financial indicators)

Membership Registration Information System

Detail Reference Number	Requirement Requirement Detail
M-001	Detect duplication of members, employers, and dependents by members Data currently carried in the Member Module includes the LGU (Membership Data Model) and agency (employer data table) data.
NOTE:	While the data carried in the current system is listed in the Membership Data Model at the end of this section, it is not clear whether all of these data items would be required if the current system were replaced.
M-002	Update deficiency of received application Applications are sent through the employer or by mail, and are processed by the Central Office/RHIO (Regional Health Insurance Office), applications are also taken in person. Minor deficiencies that will not adversely affect the registration of a member are processed. Major deficiencies generate a Deficiency Action From. This form along with the registration form are returned to PHIC and forwarded to the employer/employee for correction and resubmission.
NOTE	If another deficiency or exception form is acceptable to PhilHealth then no modification would be necessary.
M-003	Ensure uniqueness of PIN/PEN The PIN is the PhilHealth Identification Number it refers to the permanent and unique number issued by the Corporation to its members and contained in the PhilHealth ID card. The PEN is the PhilHealth Employer Number and refers to the permanent and unique number issued by the Corporation to employers Data encoding of the basic information to generate PIN/PEN are functions divided into two sessions. The first session is intended to generate the PIN/PEN. The basic requirements of the system to generate a PIN/PEN for the member are Name,

Detail Reference Number	Requirement Requirement Detail
	Birthplace, and sex; for the employer are Employer's Name, Tax Identification Number and Address. The second session of data encoding comprises the rest of the information on the registration documents of the member/employer and his/her dependents. The system generates a unique numbering assignment for every registered member. It has a capacity to accommodate the entire population, estimated in the billions. A system validation is in place to check duplication of the registrant. Once data is validated the PIN/PEN is printed on the registration documents.
M-004	Flag data deficiency within 3 seconds upon member record entry During the encoding of the registration form flag errors Minor or Major so Deficiency Action forms can be attached to the registration form if necessary, for return and correction by the member/employer.
M-005	Monitor applications in the pipeline Encoding and return of deficient documents requires a document tracking function.
M-007	Cover all types of members Employed (Government and Private Sector) ***Indigents*** Individually Paying (Self-employed, overseas Pilipino workers, Employers and Employees of International Organizations and Foreign Governments based in the Philippines, Privately sponsored, individuals separated from employment and intend to continue membership, parents who are not qualified as legal dependents, indigents or retirees, children who are qualified as legal dependents, unemployed persons who are qualified as indigent, citizens of the Philippines residing in other countries) Non-paying members such as retirees.
M-008	Monitor Enrollment and Renewal of Eligible Indigent Member The Indigent Program is a stand alone application developed through the assistance of a Non-Government Organization (NGO) Project, the Social Health Insurance Networking and Empowerment (SHINE), with focus on maintaining membership and contribution records of indigent Members. The maintenance (enhancement and modification) of the system is solely handled by SHINE The Indigent population is reevaluated yearly. Indigents are household members whose contributions are totally subsidized by the government.

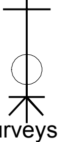
Detail Reference Number	Requirement Requirement Detail
M-009	Monitor change of Member Category Dependents of NHIP become eligible members when they turn 19. The age limit for legal dependents is 18 years old.
M-010	Track Employment History The employment history is part of the Membership Data, see attached data model.
M-011	Create Membership Database based on the name, date of birth, birthplace, income, employment. See attached data model.
NOTE	The requirement states that the membership database must contain name, date of birth, birthplace, income, employment. The MetaVance® system meets this requirement and actually includes more information that is required. However, the Membership Data Model is a unique data model and the membership data should be converted into the database that is compatible with the system selected.
M-006	Generation of endorsement proof list and reports registration
NOTE:	It is not clear what is meant by “endorsement proof list and reports registration.”
M-015 M-017 M-018	Generate individual and batch proof list report Individual and batch proof list report Statistical Reports (Daily/ Monthly & Quarterly)
NOTE:	The MetaVance® System does generate these types of reports. We assume this requirement to be met in the absence of any specific report layouts, required data items, etc.
M-021 G-001	Capture complete membership information of the employed, retired, indigent and individually paying members in geo-based formats Currently incomplete member records are not updated to include information about the accurate number of qualified dependents, premium contributions, balances reflecting overpayment, underpayment, and surcharges, if any; medical history and survey data. The capability to referencing between the member records with the supporting documentation is also desired.
NOTE:	The requirement for geo-based formats is not supported by the detailed explanation for this in the RFP. Geographic Information Systems process raw spatial data and store the information in a grid system of cells. This data is used in a number of industries, but typically in health care it is used to determine member to provider ratios by geographic area to analyze access to health care. The MetaVance® system does support the used of geo-based formats for those types of analyses.

Detail Reference Number	Requirement Requirement Detail
M-023 G-013	The member's eligibility to available Medicare benefits shall be computed at the RHIO and validated at the Central Office. The status on the member eligibility shall be accessed from the Web-enabled RDBMS. (See claims for business rules a-e). The Wide Area Network shall interconnect the Luzon Regional Health Insurance Offices (RHIOs) in Luzon to the Luzon Node, the Visayas RHIOs to the Visayas Node, and the Mindanao RHIOs to the Mindanao Node via leased lines. The Luzon Nodes, the Visayas Node and the Mindanao Nodes shall interconnect to the PHIC Central Office via leased lines. Provincial Office of PHIC called the Service Office shall interconnect to the WAN through dial-up connections. The turnaround time of uploading Regional Node databases to the Central Office should take no more than 24 hours.

LGU

LGU Code/3

LGU Name
Address/3
Mailing Address
Postal code/3
Telephone Number/3
Fax Number/3
Email Address/3
MOA Effective Date
LGU Representative
LGU Classification
Contribution Scheme



Family Surveys

LGU Code/3

Respondent Code Number
Address/4
Administered By
Designation
Date of Survey
Household Name
Relation
Sex/3
Civil Status/2
Date of Birth/3
Educational Attainment
Occupational Skills
Occupational Class
Income
Insurance
Natured of disability
Health/Nutritional status
Immunization
Housing Condition
Length of Residence
Toilet System
Refuse Disposal System
Water System
Problems Identified
Community Problems
Response to Problems
Community Resources
Affiliated Organization

Household Replacements

Member Id Number (FK)
LGU Code/3 (FK)

Cause of Disqualification
Proposed Replacement
Action Taken
Remarks
Submitted by
Certified By
Date Submitted
Date Certified

Agency

Agency ID Number

Name of Agency
TIN/2
Address/2
Postal Code/2
LGU Code/2
Telephone Number/2
Fax Number/2
Email Address/2
Date Operation Started
Nature of Business
Type of Agency
Agency Representative
Main Office Name
Main Office Address

Member: Head of the Family

Member ID
LGU Code/3 (FK)

Member Type
TIN
SSS/GISS Number
Last Name
First Name
Middle Name
Date of Birth
Place of Birth
Sex
Civil Status
Address
LGU
Postal Code
Telephone Number
Fax Number
Email Address
Date of Coverage/2
Membership Status

Employee List

LGU Code/3 (FK)
Member ID Number (FK)
Member Spouse ID No. (FK)
Agency ID Number (FK)

Position
Salary
Date of Employment
Effective Date of Coverage
Premium Class
Status/2

Member: Dependents

Member ID Number (FK)
Dependent ID Number (FK)
LGU Code/3 (FK)

Name of Dependent
Sex/2
Relationship to Member
Date of Birth/2

Member: Spouse

Member ID Number (FK)
Member Spouse ID Number
LGU Code/3 (FK)

Member Type
TIN
SSS/GISS Number
Last Name
First Name
Middle Name
Date of Birth
Place of Birth
Sex
Civil Status
Date of Coverage
Address
LGU Code
Postal Code
Telephone Number
Fax Number
Email Address

Membership Data Model

Premium Contribution Information System

Detail Reference Number	Requirement Requirement Detail
P-001	Validate on-line the premium contribution against the membership database The employed NHIP members will pay their premium contributions through accredited collecting agents such as the banks every end of the month, and other collecting agents such as the PHIC offices and the drop boxes daily. Remittance reports will be submitted by the employers to PHIC on such payments every 10th day of the end of the quarter. There has to be an online reconciliation of the actual payments reported by the collecting agents and the remittance reports of the employers
P-004	Generate Correction of Bill Report (Hardware) Hardware???
P-005	Generate Correction of Bill Report (Software) Subsequent to reconciliation and posting of contributions notices of non-payment for delinquent accounts and un-posted collections will be issued to employers/member. If a request for adjustment (in case of overpayment/underpayment) is received, PHIC investigates the validity of the request and issues resolutions for correction and adjustments.
P-007	Data capture of Remittance Information such as insurer's OR number and OR date What is OR?
P-012	Electronic processing of addition, reduction, cancellation, or spoilage of premium contributions What is spoilage?

The following is a brief description of the Premium Contributions flow:

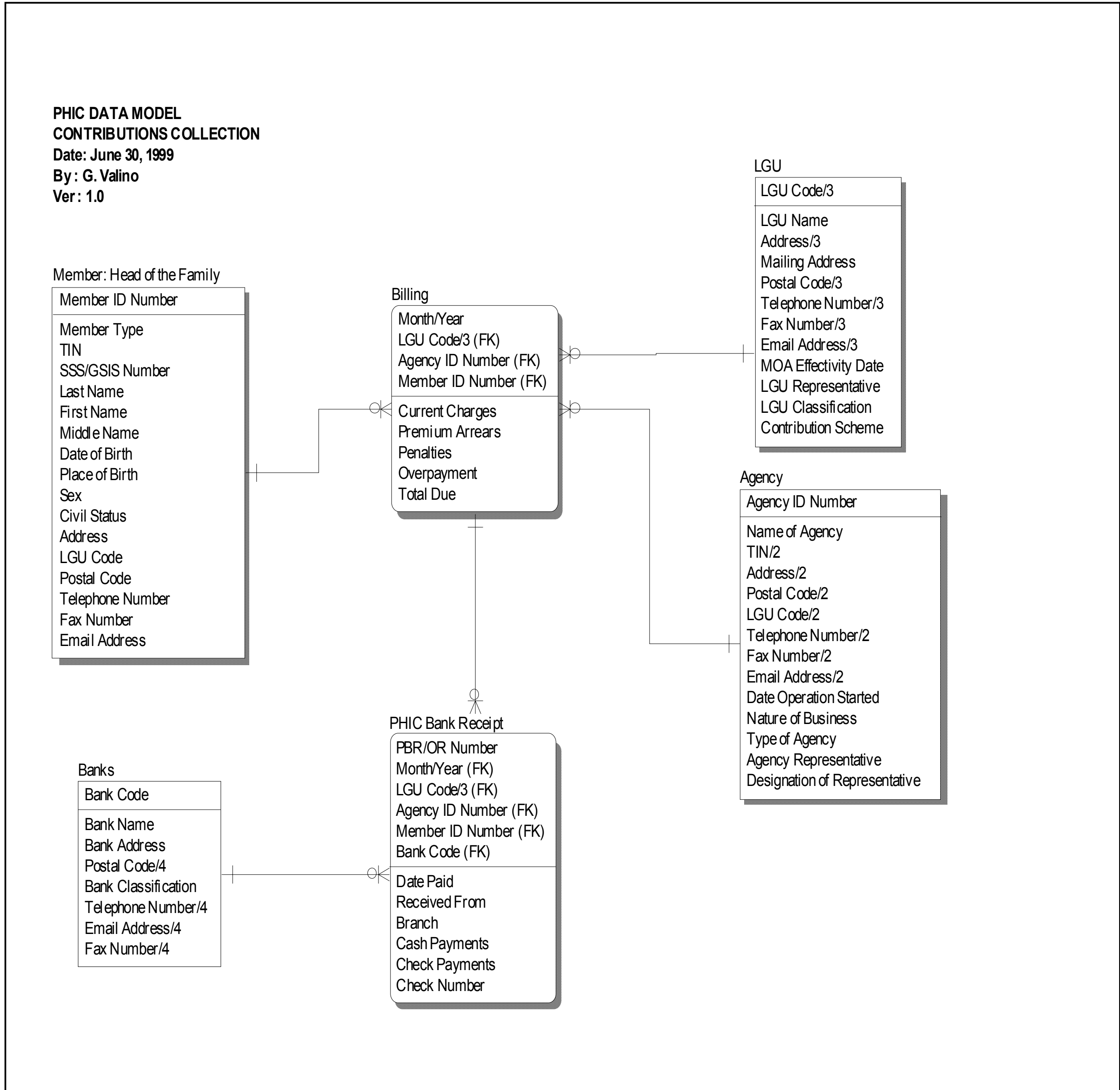
- Maintain inventory of Employers
- Track employees of the employer for every pay period
- Reconcile the remittance report from the employer with the employee list
- Reconcile the remitted amount against the amount received by the Treasury as documented by the bank reports

- Reconcile quarterly the employers premium contributions against the amount deposited by the same employer over the past three months
- Un-reconciled payments would go to adjustment processing. Amount is considered un-postable until validation.
- Post premium payments, this process post all validated payments to the system, allowing inquiry of all contributions for member.
- Posted payments are valid and final. Adjustments are made using other programs and procedures.

Currently a separate application which processes text files on diskette submitted by the employers and the data entry service bureau are being used to update contribution of the private pay sector.

See data model on next page.

Premium Contribution Processing and Collection Information System



Quality Assurance Information System

Detail Reference Number	Requirement Requirement Detail
Q-003	Develop validation modules for the libraries What does this one mean?

The system needs to support the following functions

Health care services quality assurance and profiling

PHIC needs to measure the health outcomes based on the health services rendered by the health care providers and professionals and determine the member satisfaction in the delivery of these health care services.

A member profile would include a comparison of the diagnosis and the treatment provided on one hand, and the results of the treatment on the other hand based on the clinical or medical record attached to the claims application. Electronically, this should be made accessible through a file transfer between the HOMIS and PHIC 's OMIS.

Member satisfaction can be derived through a conduct of survey which may be done periodically at random.

Health services outcomes quality of care, and access measurement

PHIC shall implement a system of assessing outcomes of service rendered by health care providers to include the following:

- review of mortality and morbidity rates, post-surgical infection rates and other health outcomes indicators;
- undertaking of outcomes research projects; and
- client satisfaction surveys.

Medical technology assessment

There shall also be an assessment of the advantage and appropriateness of medical technologies, equipment, devices, and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives. The computerized system should be able to capture the specific data that will be used for such an assessment.

Furthermore, whenever necessary, PHIC shall likewise assess the advantage and appropriateness of acquiring and using new, scarce and expensive medical technologies,

equipment, devices and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives, including modern dental technology employing highly technical equipment.

In this regard, PHIC may require specific types of health care providers to upgrade their facilities, equipment and manpower complement as a prerequisite to accreditation.

System and Database Administration

Detail Reference Number	Requirement Requirement Detail
S-002	Geographic Code Table Maintenance Unable to locate definition or purpose of this table. However if the Utah system provides Geo Coding is it primarily used in determining provider to member ratios for managed care?
S-007	Multilateral coding system for refferors/ agents *Unable to locate definition.*

The majority of the requirements are self-explanatory. The following is additional information.

1. Client server architecture on a Wide Area Network

Membership registration, billing and collection, posting of premium contribution, claims processing and existing ID card generation will be decentralized. Database build-up, transaction processing and inquiry processing for these information systems will run on a Wide Area Network on NT platform for front-end computing in a client server architecture. Data entry for all systems will be made at the Regional Health Insurance Offices (RHIO) and its local databases updated instantaneously.

2. Related Database Management System (RDMS)

The RDBMS should be scaleable to accommodate growth in the volume of transactions. This RDBMS must support the Executive Information System software for eventual Data Warehousing.

Data is entered at the local level (RHIO) and transmitted to the Central Office database.

3. Data Processing

The decentralized data processing approach shall support real-time processing for inquiries and batch processing for transactions and validation of data across regions. This approach aims to support the decentralization of operations.

A copy of the current Operations Management Information System is on the following page.

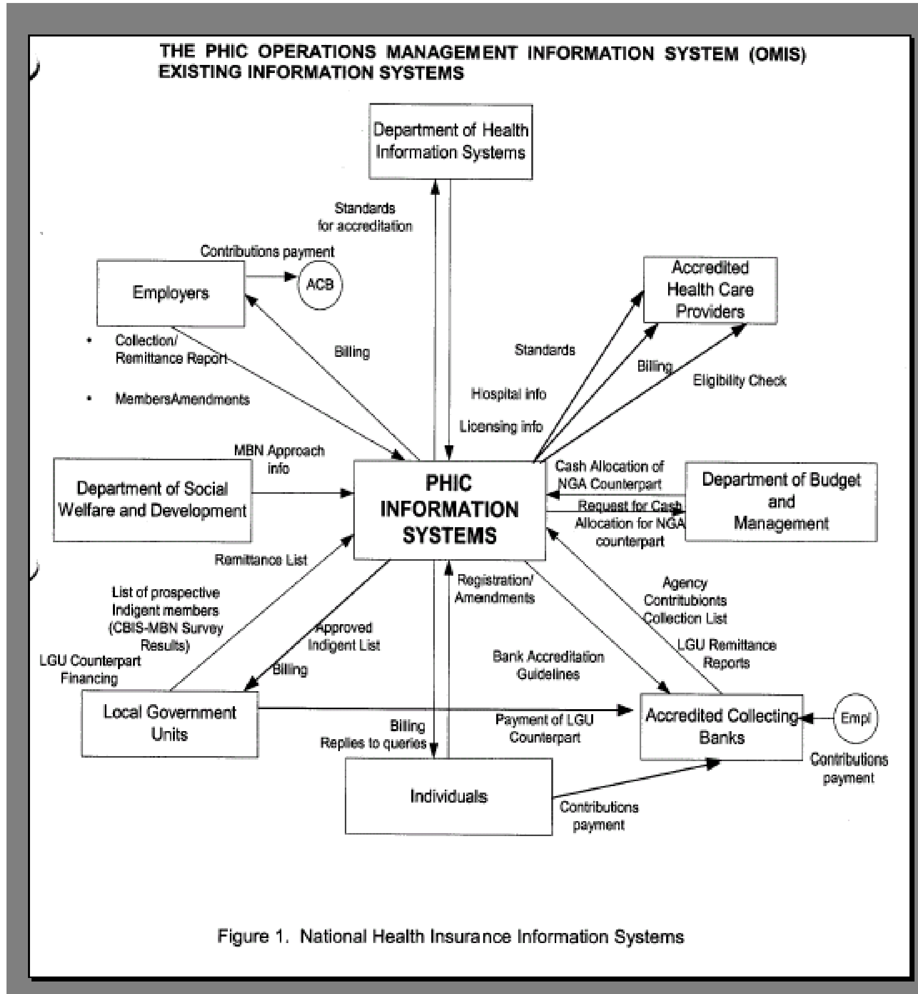


Figure 1. National Health Insurance Information Systems

ATTACHMENT 3: MAXIMUS REPORT

PHILHEALTH
SYSTEMS REQUIREMENTS ANALYSIS

Prepared for

Collective Solutions, Inc.

By

MAXIMUS, Inc.

October 11, 2002

Reviewed and Validated by Collective Solutions on October 14, 2002

The following document was prepared by MAXIMUS with input (to help define the requirements) by Collective Solutions, Inc.

> As already stated, these costs assume MAXIMUS would be making the modifications using staff already knowledgeable in the system.

Should PhilHealth decide to obtain this system and make the changes using other developers, the time and costs could change substantially.

It should also be noted that these costs were prepared in a very short period of time with a limited resources. Neither MAXIMUS nor Collective Solutions can guarantee these costs. They are provided for informational purposes only.

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PHILHEALTH SYSTEMS REQUIREMENTS ANALYSIS

In this document, we report on an analysis done to compare the functions and features of the Utah Medicaid Managed Care System (MMCS) with the requirements for the managed care system for the PhilHealth project.

OBJECTIVES

The objective of this effort is to estimate the cost required to modify and convert the Utah MMCS system to perform the functions necessary for the PhilHealth Managed Care System (PMCS). In order to do this, we have done the following:

1. Reviewed and studied the requirements and specifications for each of the modules of the PMCS as described in the requirements document attached to this report.
2. Reviewed and studied the design of the Utah MMCS, especially the data model.
3. Identified and evaluated the differences between the MMCS and the PMCS.
4. Estimated the level of effort required to modify the MMCS to meet the requirements of the PMCS.

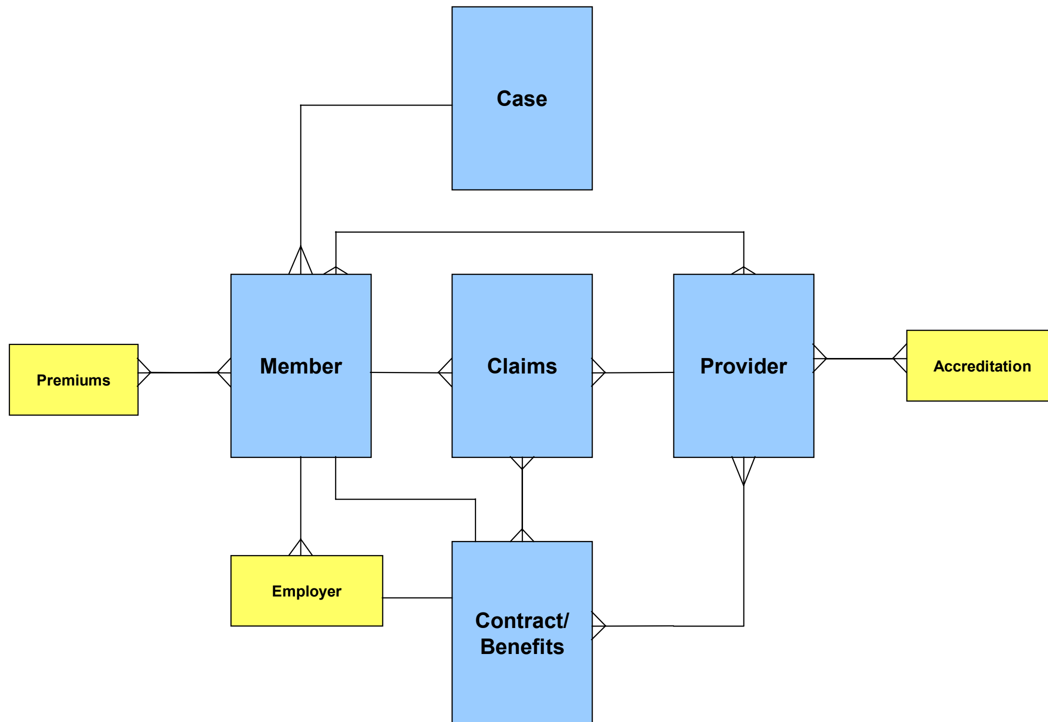
The end result of this effort is an estimate of the costs to modify the MMCS software. This does not include the cost of efforts for training and implementation tasks. It also includes development of the user interfaces, which are proposed to be done interactively, face-to-face with the end users. These components have work flow implications and need to be designed in the context of a process modeling effort. The process modeling should be carried out as an early stage task in the overall effort to implement the PMCS in the Philippines.

ANALYSIS

We have reviewed the functional requirements and features described in the requirements document attached to this report. These requirements and features describe the functional specifications for the PMCS. They do not describe the user interface requirements for the new system. The analysis efforts began with creating a simple version of the high-level data model for the PMCS, based upon the requirements in the attachment.

A simple, high-level data model for the PMCS is illustrated in ***Exhibit 1-1: PMCS Data Model***. This exhibit identifies major entities only. No attempt was made yet to go into more detail or to build attributes for these entities. For purposes of our analysis this high level is sufficient. This data model includes the Member, the Case, Claims, Provider, and Contract/Benefits as the major entities. In the PhilHealth application member premiums, employers, and accreditation for providers are also important entities, but at one level beneath the major entities.

Exhibit 1-1: PMCS Data Model

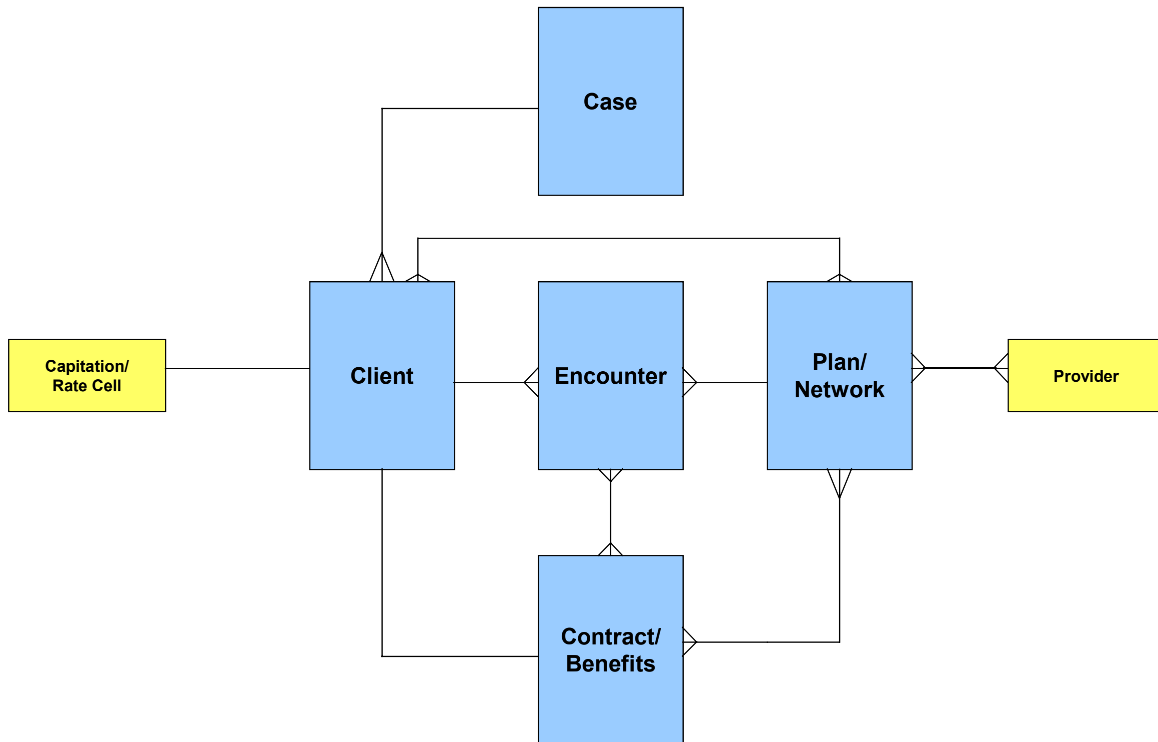


A Case is made of one or more members and a case is often a family unit. A member is assigned to a provider, perhaps more than one provider if several specialties are needed. Likewise, a provider has any number of members assigned to it. One or more providers generate claims for each member receiving services. The benefits available for adjudicating a claim are defined by one or more contracts with one or more providers.

The equivalent, high-level data model for the Utah MMCS is illustrated in ***Exhibit 1-2: Utah MMCS Data Model***. This data model is extracted from the full data model for the MMCS, which is far more complex than this simple representation suggests. However, it is easier to see the similarities and differences if we keep both data models at a similar high level and simple!

The key differences between the two data models, aside from semantic ones such as client and member, are the encounter-claim entity difference and the premium and employer entities for PMCS with no counterpart on the MMCS side. The remaining components of the two data models are essentially similar, though at the attribute level there are probably some additional differences.

Exhibit 1-2: Utah MMCS Data Model



The importance of these entity differences is that they determine what functions can be performed or added by the system. It is clear that the major work in bringing the MMCS into line with the PMCS requirements is to make changes to the data model in these two areas. Although these differences may appear minor, it is a fair amount of work to change them because changes to the data model affect every module in the system.

The next step in the analysis was to study the functional requirements for the PMCS in the light of the data model changes necessary. This approach enables us to estimate the changes, which are minor, and those that are major - where changes are needed. Changes involving no modification of the data model are minor. Changes involving modifications of the data model are major. The result of this analysis is summarized in the table that follows.

Functional Area	No. Meets	No. Exceeds	No. Minor Mods	No. Major Mods
General Requirements	9	1	18	1
Member Eligibility	17		3	
Executive Information	3			
Claims Processing	6			22
Accreditation	5			5
Quality Assurance	1		35	
Premiums	1		18	
Billing and Collection	1		5	42
Ad Hoc	1		1	
System and Database Administration	8		4	
TOTALS	**52**	**1**	**84**	**70**

We can see from this table that to bring the MMCS into line with the requirements for the PMCS will require considerable development in two functional areas – Claims Processing and Billing and Collections. Given the differences in the data models this is not a very surprising result.

In the next section, we estimate the costs of making these changes. We will also estimate the costs of actually implementing this system in the Philippines, in terms of labor effort.

COSTS

In order to understand the costs involved, we propose that the following model be used in modifying the MMCS system.

1. **Create base PMCS model in US from requirements.** In this task we would work with the requirements and create a "first cut" system by modifying the MMCS as necessary. All development work would be done in the repository and the Oracle 9iAS IDE would be used.

2. **Use Rapid Application Development (RAD) methodology to refine "first cut" system and produce final PMCS system.** Our software engineers would use the "first cut" system to conduct prototype review sessions with samples of users. The input and feedback from these sessions would be used to modify the "first cut" design and create the user interface screens and navigation for the new PMCS system. These sessions could be conducted in the Philippines over the web so that the MAXIMUS software developers could remain in the US. MAXIMUS and local field staff in the Philippines could conduct the prototype sessions with the end user staff.

3. **Complete testing and documentation of the new PMCS system.** After the system has been developed and unit tested, integration testing will be completed in the US by the MAXIMUS software engineers. Integration testing will include

stress testing and will use sample data from the PhilHealth current databases. Documentation of the system will also be produced. Technical documentation will be generated as repository output. User documentation will be prepared separately.

4. **After testing and documentation are completed, the system will be translated into Tagalog for use in the field.** This version will then constitute the final version and it can be turned over to PhilHealth for implementation or MAXIMUS can assist with implementation.

Following this model, we can estimate the labor costs for the modification as follows:

1.	Data Model Changes	$523,600
2.	Functional Modifications	
	- Minor Changes – 84 units x $5500/unit	$462,000
	- Major Changes – 70 units x $13,750/unit	$962,500
3.	RAD Refinements	$622,600
4.	Testing and Documentation	$381,700
5.	Translation	$275,000
6.	Management	$552,500
7.	Installation (approximate)	4,000,000
Total:		$7,779,900 USD

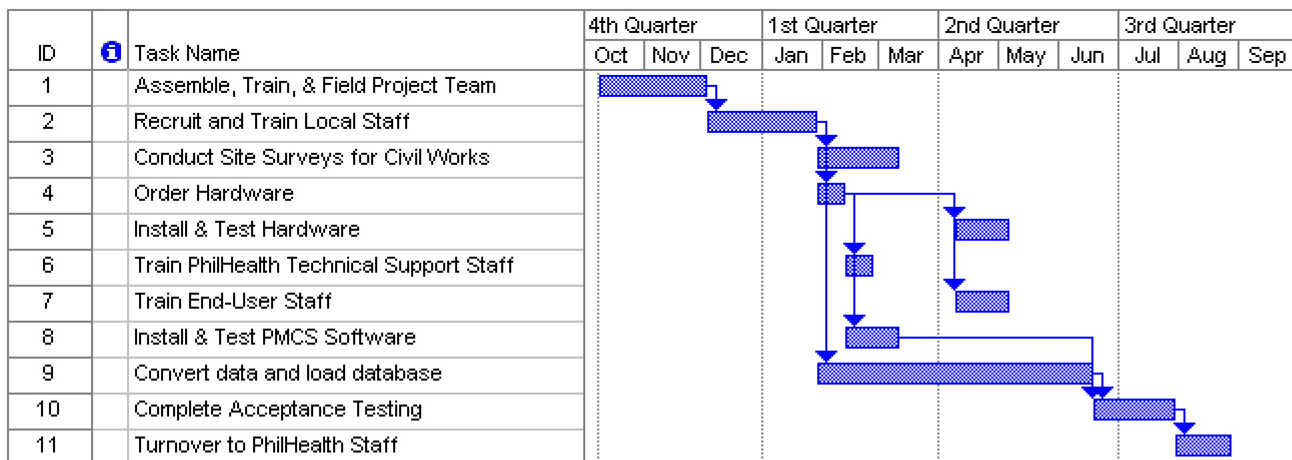
There is no system license fee included in this total cost as the core system is public domain and none is needed. There are Oracle Database and Application server license involved. Prices for those in the Philippines would need to be obtained. The elapsed time for the completion of development is of the order of nine to twelve months. We believe that the labor costs would be about 50% higher if a group not familiar with the Utah MMCS attempted to do the conversion.

The complete implementation, nationwide in the Philippines, of this new system, not including hardware, involves the following tasks:

1. Assemble, train, and field project team.
2. Recruit and train local staff.
3. Conduct site surveys to determine any civil works necessary
4. Order hardware
5. Install hardware
6. Train PhilHealth technical support staff
7. Train end-user staff
8. Install and test PMCS software
9. Convert data and load database
10. Complete acceptance testing
11. Turnover to PhilHealth Staff

A rough Gantt chart for these tasks is presented in ***Exhibit 1-3: Implementation Plan.***

Exhibit 1-3: Implementation Plan



Implementation in the Philippines might take up to a year after completion of the system development. The main driver on this is the data conversion. Data conversion is often a daunting task, especially when data to be converted exists on paper and not electronically.

Costs for the implementation would be of the order of \$3 million to \$4 million, exclusive of hardware. These are rough guesses only.

ATTACHMENT

PHILHEALTH SYSTEMS REQUIREMENTS

General Requirements

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	Capture complete membership information of the employed, retired, indigent and individually paying members in geo-based formats			**Minor**		G-001
	Reduce the lead-time for posting of contribution collection from at least 15 days to 3 days upon receipt of employees' remittance report			**Minor**		G-002
	Access information to and from health facilities using the Department of Health's Hospital Operations Management Information System required in eligibility checking and electronic claims processing as necessary.	**X**				G-003
	Detect double-filing and other claims that are deemed either as characterized by inappropriate health care or fraudulent and forward these to the PHIC Utilization Review and Intervention Department, the PHIC Fraud Prevention and Detection Unit and/or the Legal Services Group, respectively			**Major**		G-004
	Ensure the provision of quality health care services by making library of standards for drugs and procedures accessible to health care providers and members			**Minor**		G-005
	Generate management reports, executive information and PHIC indicators as listed in the issues and concerns for the development of an EIS	**X**				G-006
	Client server architecture on a Wide Are Network	**X**				G-007
	Related Database Management System (RDMS)	**X**				G-008
	The decentralized data processing approach shall support real-time processing for inquiries and batch processing for transactions and validation of data across regions. This approach aims to support the decentralization of operations.	**X**				G-009
	For inquiry processing, the regional staff would enter the required fields, and locate the response locally. Raw data of transactions processing would be batched and uploaded to the Regional Node. At the end of the day, the Node uploads all regional updates to the Central Office for storage. This approach creates instantaneous updating of the RHIO and Node databases which will be synchronized with the Central Office every twenty-four (24) hours	**X**				G-010
	The registration forms retrieved are forwarded to the Service Offices at the 75 provinces for encoding the personal details and the benefits availed of. A profile for members consisting of every member and his respective beneficiaries his premium contributions and availment of benefits by the member and his beneficiaries will be maintained locally			**Minor**		G-011

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	The employed NHIP members will pay their premium contributions through accredited collecting agents such as the banks every end of the month, and other collecting agents such as the PHIC offices and the drop boxes daily. Remittance reports will be submitted by the employers to PHIC on such payments every 10th day of the end of the quarter. There has to be an online reconciliation of the actual payments reported by the collecting agents and the remittance reports of the employers			**Minor**		G-012
	The member's eligibility to available Medicare benefits shall be computed at the RHIO and validated at the Central Office. The status on the member eligibility shall be accessed from the Web-enabled RDBMS. This is determined by applying the following 5 business rules:	**X**				G-013
	1) Determining whether the claim application was filed within the prescribed 60 day filing period;			**Minor**		G-013a
	2) The period payment acceptability which is one quarter for every preceding 9 months;			**Minor**		G-013b
	3) The complete payment applicable for the period;			**Minor**		G-013c
	4) The benefit balance based on the remaining unutilized benefits; and			**Minor**		G-013d
	5) The remaining confinement days that can be applied for Medicare benefit claim for reimbursement			**Minor**		G-013e
	Access via Internet the claims application of accredited health care providers such as the hospitals and clinics through the Hospital Operations Management Information System (HOMIS). HOMIS is Sybase/Powerbuilder-based system developed by the Department of Health in order to standardize hospital systems and facilitate the monitoring and evaluation of health services being rendered.	**X**				G-014
	The Wide Area Network of PHIC shall interconnect the Luzon Regional Health Insurance Offices (RHIOs) in Luzon to the LUZON NODE, the Visayas RHIOs to the VISAYAS NODE, and the Mindanao RHIOs to MINDANAO NODE via leased lines. The Luzon Nodes, the Visayas Node and the Mindanao Nodes shall interconnect to the PHIC Central Office via leased lines. Provincial Office of PHIC called the Service Office shall interconnect to the WAN through dial-up connections			**Minor**		G-015
	Presently, the Service Offices have existing local databases, which are aggregated at the RHIO databases. PHIC envisions the future aggregation of the RHIO databases at the major nodes and these nodes at the Central Office. The turnaround time of uploading Regional Node databases to the Central Office should take not more than 24 hours.		**X**			G-016

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	PHIC needs to measure the health outcomes based on the health services rendered by the health care providers and professionals and determine the member satisfaction in the delivery of these health care services.			**Minor**		G-017
	A member profile would include a comparison of the diagnosis and the treatment provided on one hand, and the results of the treatment on the other hand based on the clinical or medical record attached to the claims application. Electronically, this should be made accessible through a file transfer between the HOMIS and PHIC 's OMIS			**Minor**		G-018
	Member satisfaction can be derived through a conduct of survey, which may be done periodically at random.			**Minor**		G-019
	PHIC shall implement a system of assessing outcomes of service rendered by health care providers to include the following:	**X**				G-020
	1) Review of mortality and morbidity rates, post-surgical infection rates and other health outcomes indicators;			**Minor**		G-020a
	2) Undertaking of outcomes research projects; and			**Minor**		G-020b
	3) Client satisfaction surveys.			**Minor**		G-020c
	There shall also be an assessment of the advantage and appropriateness of medical technologies, equipment, devices, and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives. The computerized system should be able to capture the specific data that will be used for such an assessment			**Minor**		G-021

Member/Eligibility Requirements

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Detect duplication of members, employers, and dependents by members	**X**				M-001
	Update deficiency of received application	**X**				M-002
	Ensure uniqueness of PIN/PEN	**X**				M-003
	Flag data deficiency within 3 seconds upon member record entry	**X**				M-004
	Monitor applications in the pipeline	**X**				M-005
	Generation of endorsement proof list and reports registration			**Minor**		M-006
	Function					
	Cover all types of members	**X**				M-007

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Monitor Enrollment and Renewal of Eligible Indigent Member	X				M-008
	Monitor change of Member Category	X				M-009
	Track Employment History			Minor		M-010
	Create Membership Database based on the name, date of birth, birthplace, income, employment			Minor		M-011
	Update Membership Database within 3 seconds per record update on membership status, eligibility, benefit amount balances, confinement period balances, premium contributions/ balances	X				M-012
	Assign unique number to applicants within 3 seconds upon system acceptance of validated membership entry	X				M-013
	Query					
	Perform an alpha-numeric search query from database having at least 500K records within three (3) seconds or less	X				M-014
	Reports					
	Generate individual and batch proof list report	X				M-015
	Generate PIN / PEN Generation Report	X				M-016
	Individual and batch proof list report	X				M-017
	Statistical Reports (Daily/ Monthly & Quarterly)	X				M-018
	Total SS Members with generated PHIC Number Report	X				M-019
	Total Active GCIS Members Reports	X				M-020

Executive Information

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Provide real time information on demand	X				E-001
	With built-in audit trail facility	X				E-002
	Must have a drill down capability to go to the second and third levels detail of any information	X				E-003

Claims Processing

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Validation of Member/Employer status	**X**				C-001
	Validation of Quality Contribution			**Major**		C-002
	Validation of Confinement Period			**Major**		C-003
	Validation of Hospital accreditation			**Major**		C-004
	Validation of Double Filing			**Major**		C-005
	Validation of benefit balance			**Major**		C-006
	Validation of Same Illness in 90 days			**Major**		C-007
	Validation of Filing Period			**Major**		C-008
	Perform member eligibility and claims payment validation within 3 seconds, of ten (10) concurrent users	**X**				C-009
	Functions					
	Perform computation on claim charges vs. benefit package			**Major**		C-010
	Perform monitoring and payment computation of Claims Review			**Major**		C-011
	Generate Voucher			**Major**		C-012
	Generate status report of claims payment 2 hours after release of checks or notice to ADB			**Major**		C-013
	Perform analysis of data periodically and on need to generate the following information:	**X**				C-014
	Member and AHCP balances on benefit amounts and confinement periods; and			**Major**		C-015
	Claims payments payable to members and AHCP.			**Major**		C-016
	Process claims with or without settling authority			**Major**		C-017
	Prepares Claims cover letter	**X**				C-018
	Update outstanding and settled claims			**Major**		C-019
	Reporting					
	Generate status report of claims payment 2 hours after release of checks or notice to ADB	**X**				C-020
	Prints claims summary by line, by client, by accredited health care providers and by account officer			**Major**		C-021
	Summary of Validated Data from Region (Amount paid and Claim paid)			**Major**		C-022
	Summary of Validated Data from Region (Claims Received)			**Major**		C-023

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Daily/ Monthly/ Bi-monthly Status Report	X				C-024
	Report of Disbursement for Benefit Claims			Major		C-025
	Monthly Report of GSIS/ SSS Benefit Claims			Major		C-026
	Summary of GSIS/ SSS Benefit Claim Secondary Reports			Major		C-027
	Medical Evaluation Reports			Major		C-028

Accreditation Information System/Provider

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Can the system evaluate and assess the completeness of the submitted application forms and other necessary documents required for accreditation?			Major		A-001
	Can the system process payment of the Accreditation Fee and generate a receipt?			Major		A-002
	Can the system generate a letter notifying the applicant of what requirements are lacking?	X				A-003
	Can the system generate the documents and agenda required for a pre-accreditation inspection?	X				A-004
	Can the system generate an inspection report?			Major		A-005
	Can the system generate an approved/denied notification letter to applicant?	X				A-006
	Can the system notify the Legal and Claims Processing Departments of approved/denied status?	X				A-007
	Can the system generate an Accreditation Status report?			Major		A-008
	Can the system generate an Accreditation number and Certificate?			Major		A-009
	Can the system generate a letter to all Institutions included in the Accreditation Committee Meeting?	X				A-010

Quality Assurance

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Functions					
	Computation of Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR)			**Minor**		Q-001
	Access data from Claims Department			**Minor**		Q-002
	Develop validation modules for the libraries			**Minor**		Q-003
	Perform analysis of data periodically and on need to generate information on program and fund utilization.	**X**				Q-004
	Reports					
	Number of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and ambulatory surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order			**Minor**		Q-005
	Number of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.			**Minor**		Q-006
	Amount of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.			**Minor**		Q-007
	Amount of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital), per month, quarter, semester, and year by region and nationwide arranged in descending order.			**Minor**		Q-008
	Number of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.			**Minor**		Q-009
	Amount of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.			**Minor**		Q-010

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Number of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide, arranged in descending order.			**Minor**		Q-011
	Amount of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide arranged in descending order.			**Minor**		Q-012
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region and nationwide, per month, quarter, semester and year in descending order.			**Minor**		Q-013
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-014
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per professional and per region, per month, quarter, semester and year arranged in descending order.			**Minor**		Q-015
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per professional and per region, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-016
	Number of claims paid per diagnostic procedure (specific X-ray, ultrasound, Computed Tomography scan, Magnetic Resonance Imaging laboratory procedures, e.g. Chest Postero Anterior, Skull CT scan, abdominal ultrasound, Complete Blood Count, Blood Urea Nitrogen, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.			**Minor**		Q-017
	Amount paid per diagnostic procedure (specific X-ray, ultrasound, CT scan, MRI, laboratory procedures, e.g. Chest P.A., Skull CT scan, abdominal ultrasound, CBC, BUN, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide.			**Minor**		Q-018
	Number of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, e.g. Chest PA, skull CT-scan, abdominal ultrasound...) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.			**Minor**		Q-019

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, e.g. Chest PA, skull CT-scan, abdominal ultrasound) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.			**Minor**		Q-020
	Amount claimed for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.			**Minor**		Q-021
	Amount paid for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.			**Minor**		Q-022
	Average length of confinement per diagnosis, per institutional provider per region, per month, quarter, semester, and year.			**Minor**		Q-023
	Average length of confinement per diagnosis, per professional, per region, per month, quarter, semester, and year arranged in descending orders.			**Minor**		Q-024
	Number of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-025
	Number of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-026
	Amount of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year.			**Minor**		Q-027
	Amount of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by specialty, by region and nationwide per month, quarter, semester and year.			**Minor**		Q-028
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.			**Minor**		Q-029
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.			**Minor**		Q-030
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-031

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-032
	Average value per claim per diagnosis, per institutional provider, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-033
	Average value per claim per diagnosis, per professional, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-034
	Average age of patient per claim per diagnosis per institutional provider per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-035
	Average age of patient per claim per diagnosis per professional per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.			**Minor**		Q-036
	Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR) per hospital by category and region per month, quarter, semester and year arranged in descending order.			**Minor**		Q-037

Premium Contributions

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Validate on-line the premium contribution against the membership database			**Minor**		P-001
	Functions					
	Process and print Collection notice to/from ACB/ACA			**Minor**		P-002
	Update accounts of members			**Minor**		P-003
	Generate Correction of Bill Report (Hardware)			**Minor**		P-004
	Generate Correction of Bill Report (Software)			**Minor**		P-005
	Maintains premium date of remittance based on inception or payment date	**X**				P-006
	Data capture of Remittance Information such as insurer's OR number and OR date			**Minor**		P-007
	Allows for all or selective tagging of records for remittance			**Minor**		P-008
	Posting of remittance information to individual coverages			**Minor**		P-009
	Maintains reference table of depository back account of employers			**Minor**		P-010
	Generates entries to disbursement vouchers.			**Minor**		P-011

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Electronic processing of addition, reduction, cancellation, or spoilage of premium contributions			**Minor**		P-012
	Query					
	Generate Account Receivable by Generate ACB			**Minor**		P-013
	Generate Unpostable/Unpaid Collection Records			**Minor**		P-014
	Reporting					
	Generate Notice of Non-Payments			**Minor**		P-015
	Statement of Member's Remittance / Contribution, monthly			**Minor**		P-016
	Statement of Agency Remittance / Contribution, monthly			**Minor**		P-017
	Summary of Posted Contributions			**Minor**		P-018
	Weekly accomplishment report			**Minor**		P-019

Billing and Collection

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Update employer record for all remittance reported by ACB/ACA for 15 days			**Major**		B-001
	Compute the floating period of 15 days + 5 days grace period allotted by PHIC to all its ACB/ACA and update corresponding bank record			**Major**		B-002
	Reconcile billing statement and ME-5, MI-5 and Min-5; compute balances and update record			**Major**		B-003
	Accept and display Web-based validation request for the payments of member's premium contribution			**Minor**		B-004
	Generate files for refunds			**Minor**		B-005
	Perform analysis of data periodically and on need to generate the following information:	**X**				B-006
	1) Accredited collecting agents and accredited depository banks floating period			**Major**		B-007
	2) Premium contributions and other charges receivable from members			**Major**		B-008
	Send billing statement via Web			**Minor**		B-009
	Cross-referencing of Premium Contributions			**Major**		B-010
	Online or batch computer generation of receipts			**Major**		B-011
	Collection fund Transfer			**Major**		B-012

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Online Collection Reports and OR Register			**Major**		B-013
	Query					
	Online member generation of statement of accounts			**Major**		B-014
	Reporting					
	Generate AR Reports			**Minor**		B-015
	Process billing and print billing statement for ACB/ACA on late remittances			**Minor**		B-016
	Generate list of Active /Inactive Employers/ Members by end-of -month			**Major**		B-017
	Print a bill for mailing to the LGUs and Individually-paying members' thirty (30) days before the anniversary date of NHIP membership			**Major**		B-018
	Generate file for adjustment on next bill			**Major**		B-019
	Generate files for refunds			**Major**		B-020
	Generate Debit/Credit Memo due to Adjustment of payments			**Major**		B-021
	Generate and print statement for Agency and LGUs			**Major**		B-022
	Generate Summary of Billing Statement			**Major**		B-023
	Generate Collection Report and Member Report			**Major**		B-024
	HIP Premium Contribution, quarterly			**Major**		B-025
	Report of Collections and Deposits, monthly			**Major**		B-026
	Report of Fund Transfers (MOOE), monthly			**Major**		B-027
	Statement of Account			**Major**		B-028
	Collection Progress Reports Delivered to RHIO/ACBs, monthly			**Major**		B-029
	Aging of Unpaid Penalties & Interest from ACBs Late Remittances			**Major**		B-030
	Summary of Daily Collection Report, monthly			**Major**		B-031
	RHIOs Collection Report Purely on NHIP Premium Contribution, quarterly			**Major**		B-032
	RHIOs Collection Report Purely on NHIP Premium Contribution, monthly			**Major**		B-033
	Daily Collection Report			**Major**		B-034
	Report of Collection and Deposit, National Capital Region			**Major**		B-035
	Summary of Over-The-Counter Collection			**Major**		B-036
	Weekly Accomplishment Report			**Major**		B-037
	Premium Collection Management Master Database			**Major**		B-038
	Premium Collection Management System Data Entry Prooflist			**Major**		B-039
	Premium Collection Management System Monthly/ Quarterly Remittance Report			**Major**		B-040
	Premium Collection Management System Quarterly Remittance Statement			**Major**		B-041
	Premium Collection Management System Monthly Underpayment/Overpayment Report			**Major**		B-042
	Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly			**Major**		B-043

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	ACBs Collection Report, quarterly/every 15th day					
	Bank Collection Report, every 15th day			**Major**		B-044
	Collection Report thru Modified Disbursement Scheme. Direct Remittance Scheme - Servicing Banks Purely on NHIP Premium Contribution, quarterly/monthly			**Major**		B-045
	Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly			**Major**		B-046
	Home Office Collection Report Purely on NHIP Premium Contribution, quarterly			**Major**		B-047
	Consolidated Report of Collection Purely on NHIP Premium Contribution by Fund Type			**Major**		B-049
	Monthly Accomplishment Report - Bank Remittance Section			**Major**		B-050

Ad Hoc

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Can track documents while in-process or after processing, with reference to manual storage			**Minor**		H-001
	Can do an audit trail of the processing and storage of the respective IS	**X**				H-002

Systems & Database Administration

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Library Maintenance	**X**				S-001
	Geographic Code Table Maintenance	**X**				S-002
	Detect and log any change to the databases to record date and time of users	**X**				S-003
	User Friendly	**X**				S-004
	Facility for Computer-based Training			**Minor**		S-005
	Online interface to fax and e-mail facilities			**Minor**		S-006
	Multilateral coding system for referrers/ agents			**Minor**		S-007
	Reference table look up	**X**				S-008

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Three-level security: network, system and application levels	**X**				S-009
	Provide for back-up/restore procedures	**X**				S-010
	Archiving of historical insurance coverage information			**Minor**		S-011
	Includes utilities for security/password, batch/job controls, backup and restore procedures	**X**				S-012

ATTACHMENT 4: METAVANCE REPORT

Meta Vance Costs for Modifications

Functional Area	No. Meets	No. Exceeds	No. Minor Mod	Mo. Major Mod
General Requirements	9	0	0	3
Member Eligibility	19	0	0	1
Executive Information	3	0	0	0
Claims Processing	25	0	0	3
Accreditation	5	0	0	5
Quality Assurance	27	0	0	11
Premiums	13	0	0	6
Billing and Collection	20	0	0	29
Ad Hoc	1	0	0	1
System and Database Administration	9	0	0	3
TOTALS	**131**	**0**	**0**	**62**

Major modifications = 62 units at $13,750/unit = $852,500.00

Additionally, there are testing costs, installation costs and license fees and management. MetaVance license fees are based upon the number of members which would result in a very high fee for PhilHealth.

If we assume that these costs equal that of MAXIMUS - then the total cost for modifications and installations would be $7,207,900.00. Then PhilHealth would need to negotiate a license agreement with EDS which would be payable annually. It is doubtful that the license agreement would make the MetaVance system competitive with the Utah MMCS.

General Requirements

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	Capture complete membership information of the employed, retired, indigent and individually paying members in geo-based formats	X				G-001
	Reduce the lead-time for posting of contribution collection from at least 15 days to 3 days upon receipt of employees' remittance report	X				G-002
	Access information to and from health facilities using the Department of Health's Hospital Operations Management Information System required in eligibility checking and electronic claims processing as necessary.			X		G-003
	Detect double-filing and other claims that are deemed either as characterized by inappropriate health care or fraudulent and forward these to the PHIC Utilization Review and Intervention Department, the PHIC Fraud Prevention and Detection Unit and/or the Legal Services Group, respectively	X				G-004
	Ensure the provision of quality health care services by making library of standards for drugs and procedures accessible to health care providers and members			X		G-005
	Generate management reports, executive information and PHIC indicators as listed in the issues and concerns for the development of an EIS	X				G-006
	Client server architecture on a Wide Are Network	X				G-007

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	Related Database Management System (RDMS)	X				G-008
	The decentralized data processing approach shall support real-time processing for inquiries and batch processing for transactions and validation of data across regions. This approach aims to support the decentralization of operations.	X				G-009
	For inquiry processing, the regional staff would enter the required fields, locate the response locally. Raw data of transactions processing would be batched and uploaded to the Regional Node. At the end of the day, the Node uploads all regional updates to the Central Office for storage. This approach creates instantaneous updating of the RHIO and Node databases which will be synchronized with the Central Office every twenty-four (24) hours				X	G-010
	The registration forms retrieved are forwarded to the Service Offices at the 75 provinces for encoding the personal details and the benefits availed of. A profile for members consisting of every member and his respective beneficiaries his premium contributions and availment of benefits by the member and his beneficiaries will be maintained locally	X				G-011

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	The employed NHIP members will pay their premium contributions through accredited collecting agents such as the banks every end of the month, and other collecting agents such as the PHIC offices and the drop boxes daily. Remittance reports will be submitted by the employers to PHIC on such payments every 10th day of the end of the quarter. There has to be an online reconciliation of the actual payments reported by the collecting agents and the remittance reports of the employers			X		G-012
	The member's eligibility to available Medicare benefits shall be computed at the RHIO and validated at the Central Office. The status on the member eligibility shall be accessed from the Web-enabled RDBMS. This is determined by applying the following 5 business rules:	X				G-013
	1) determining whether the claim application was filed within the prescribed 60 day filing period;	X				G-013a
	2) the period payment acceptability which is one quarter for every preceding 9 months;	X				G-013b
	3) the complete payment applicable for the period;	X				G-013c
	4) the benefit balance based on the remaining unutilized benefits; and	X				G-013d
	5) the remaining confinement days that can be applied for Medicare benefit claim for reimbursement	X				G-013e

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	Access via Internet the claims application of accredited health care providers such as the hospitals and clinics through the Hospital Operations Management Information System (HOMIS). HOMIS is Sybase/Powerbuilder-based system developed by the Department of Health in order to standardize hospital systems and facilitate the monitoring and evaluation of health services being rendered.			X		G-014
	The Wide Area Network of PHIC shall interconnect the Luzon Regional Health Insurance Offices (RHIOs) in Luzon to the LUZON NODE, the Visayas RHIOs to the VISAYAS NODE, and the Mindanao RHIOs to MINDANAO NODE via leased lines. The Luzon Nodes, the Visayas Node and the Mindanao Nodes shall interconnect to the PHIC Central Office via leased lines. Provincial Office of PHIC called the Service Office shall interconnect to the WAN through dial-up connections			X		G-015
	Presently, the Service Offices have existing local databases which are aggregated at the RHIO databases. PHIC envisions the future aggregation of the RHIO databases at the major nodes and these nodes at the Central Office. The turnaround time of uploading Regional Node databases to the Central Office should take not more than 24 hours.			X		G-016

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	PHIC needs to measure the health outcomes based on the health services rendered by the health care providers and professionals and determine the member satisfaction in the delivery of these health care services.			X		G-017
	A member profile would include a comparison of the diagnosis and the treatment provided on one hand, and the results of the treatment on the other hand based on the clinical or medical record attached to the claims application. Electronically, this should be made accessible through a file transfer between the HOMIS and PHIC 's OMIS			X		G-018
	Member satisfaction can be derived through a conduct of survey which may be done periodically at random.			X		G-019
	PHIC shall implement a system of assessing outcomes of service rendered by health care providers to include the following:			X		G-020
	1) review of mortality and morbidity rates, post-surgicalinfection rates and other health outcomes indicators;			X		G-020a
	2) undertaking of outcomes research projects; and			X		G-020b
	3) client satisfaction surveys.			X		G-020c

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer #
	There shall also be an assessment of the advantage and appropriateness of medical technologies, equipment, devices, and modalities of treatment consistent with actual needs and current standards of medical practice and ethics and with national health objectives. The computerized system should be able to capture the specific data that will be used for such an assessment			X		G-021
	Total	**14**	**0**	**14**	**1**	

Member Eligibility

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Detect duplication of members, employers, and dependents by members	X				M-001
	Update deficiency of received application	X				M-002
	Ensure uniqueness of PIN/PEN	X				M-003
	Flag data deficiency within 3 seconds upon member record entry	X				M-004
	Monitor applications in the pipeline	X				M-005

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Generation of endorsement proof list and reports registration				X	M-006
	Function					
	Cover all types of members	X				M-007
	Monitor Enrollment and Renewal of Eligible Indigent Member	X				M-008
	Monitor change of Member Category	X				M-009
	Track Employment History	X				M-010
	Create Membership Database based on the name, date of birth, birthplace, income, employment	X				M-011
	Update Membership Database within 3 seconds per record update on membership status, eligibility, benefit amount balances, confinement period balances, premium contributions/ balances	X				M-012
	Assign unique number to applicants within 3 seconds upon system acceptance of validated membership entry	X				M-013
	Query					
	Perform an alpha-numeric search query from database having at least 500K records within three (3) seconds or less	X				M-014
	Reports					
	Generate individual and batch proof list report	X				M-015
	Generate PIN / PEN Generation Report	X				M-016
	individual and batch proof list report	X				M-017

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Statistical Reports (Daily/ Monthly & Quarterly)	X				M-018
	Total SS Members with generated PHIC Number Report	X				M-019
	Total Active GCIS Members Reports	X				M-020
	Totals	**19**	**0**	**0**	**1**	

Executive Information

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Provide real time information on demand	X				E-001
	With built-in audit trail facility	X				E-002
	Must have a drill down capability to go to the second and third levels detail of any information	X				E-003
	Total	**3**	**0**	**0**	**0**	

Claims Processing

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Validation of Member/Employer status	X				C-001
	Validation of Quality Contribution	X				C-002

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation of Confinement Period	X				C-003
	Validation of Hospital accreditation	X				C-004
	Validation of Double Filing	X				C-005
	Validation of benefit balance	X				C-006
	Validation of Same Illness in 90 days	X				C-007
	Validation of Filing Period	X				C-008
	Perform member eligibility and claims payment validation within 3 seconds, of ten (10) concurrent users	X				C-009
	Functions					
	Perform computation on claim charges vs. benefit package	X				C-010
	Perform monitoring and payment computation of Claims Review	X				C-011
	Generate Voucher			X		C-012
	Generate status report of claims payment 2 hours after release of checks or notice to ADB	X				C-013
	Perform analysis of data periodically and on need to generate the following information:	X				C-014
	Member and AHCP balances on benefit amounts and confinement periods; and	X				C-015
	Claims payments payable to members and AHCP.	X				C-016
	Process claims with or without settling authority	X				C-017
	Prepares Claims cover letter	X				C-018
	Update outstanding and settled claims	X				C-019

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Reporting					
	Generate status report of claims payment 2 hours after release of checks or notice to ADB	X				C-020
	Prints claims summary by line, by client, by accredited health care providers and by account officer	X				C-021
	Summary of Validated Data from Region (Amount paid and Claim paid)	X				C-022
	Summary of Validated Data from Region (Claims Received)	X				C-023
	Daily/ Monthly/ Bi-monthly Status Report			X		C-024
	Report of Disbursement for Benefit Claims	X				C-025
	Monthly Report of GSIS/ SSS Benefit Claims	X				C-026
	Summary of GSIS/ SSS Benefit Claim Secondary Reports	X				C-027
	Medical Evaluation Reports			X		C-028
	Total	**25**	**0**	**3**	**0**	

Accreditation Information System (Provider)

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Functions					
	Can the system evaluate and assess the completeness of the submitted application forms and other necessary documents required for accreditation?			X		A-001
	Can the system process payment of the Accreditation Fee and generate a receipt?			X		A-002
	Can the system generate a letter notifying the applicant of what requirements are lacking?	X				A-003
	Can the system generate the documents and agenda required for a pre-accreditation inspection?	X				A-004
	Can the system generate an inspection report?			X		A-005
	Can the system generate a approved/denied notification letter to applicant?	X				A-006
	Can the system notify the Legal and Claims Processing Departments of approved/denied status?	X				A-007
	Can the system generate an Accreditation Status report?			X		A-008
	Can the system generate an Accreditation number and Certificate?			X		A-009
	Can the system generate a letter to all Institutions included in the Accreditation Committee Meeting?	X				A-010
	Total	**5**	**0**	**5**	**0**	

Quality Assurance

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Functions					
	Computation of Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR)			X		Q-001
	Access data from Claims Department	X				Q-002
	Develop validation modules for the libraries			X		Q-003
	Perform analysis of data periodically and on need to generate information on program and fund utilization.	X				Q-004
	Reports					
	Number of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and ambulatory surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order	X				Q-005
	Number of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.	X				Q-006

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount of claims paid per diagnosis and surgical procedure per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.	X				Q-007
	Amount of claims paid per professional (doctors, dentists, nurses, midwives, etc), by specialty, per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital), per month, quarter, semester, and year by region and nationwide arranged in descending order.	X				Q-008
	Number of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.	X				Q-009
	Amount of claims paid per diagnosis and procedure based on date of discharge per institutional provider (hospitals and surgical clinic, etc.), by category (primary, secondary, tertiary hospital) and overall, per month, quarter, semester, and year by region and nationwide, arranged in descending order.	X				Q-010
	Number of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide, arranged in descending order.	X				Q-011

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount of claims paid per diagnosis and procedure based on date of discharge per professional (doctors, dentists, nurses, midwives, etc), by specialty, by region and nationwide arranged in descending order.	X				Q-012
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region and nationwide, per month, quarter, semester and year in descending order.			X		Q-013
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per institutional provider and per region, per month, quarter, semester and year, arranged in descending order.			X		Q-014
	Number of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectable etc.) per diagnosis per professional and per region, per month, quarter, semester and year arranged in descending order.			X		Q-015
	Amount of claims paid per drug and medicine by generic name and preparation (capsule, tablet, injectible etc.) per diagnosis per professional and per region, per month, quarter, semester and year, arranged in descending order.			X		Q-016

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Number of claims paid per diagnostic procedure (specific X-ray, ultrasound, Computed Tomography scan, Magnetic Resonance Imaging laboratory procedures, e.g. Chest Postero Anterior, Skull CT scan, abdominal ultrasound, Complete Blood Count, Blood Urea Nitrogen, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.	X				Q-017
	Amount paid per diagnostic procedure (specific X-ray, ultrasound, CT scan, MRI, laboratory procedures, e.g. Chest P.A., Skull CT scan, abdominal ultrasound, CBC, BUN, etc.) per diagnosis and procedure, per institutional provider, per month, quarter, semester, and year, per region and nationwide.	X				Q-018
	Number of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, eg. Chest PA, skull CT-scan, abdominal ultrasound...) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.	X				Q-019
	Amount of claims paid per diagnostic procedure (specific x-ray, ultrasound, CT-scan, MRI, laboratory procedures, eg. Chest PA, skull CT-scan, abdominal ultrasound) per diagnosis and procedure, per professional, per month, quarter, semester, and year, per region and nationwide, arranged in descending order.	X				Q-020

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount claimed for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.	X				Q-021
	Amount paid for Room and Board per hospital, per category, per diagnosis by region and nationwide, per month, quarter, semester, and year, arranged in descending order.	X				Q-022
	Average length of confinement per diagnosis, per institutional provider per region, per month, quarter, semester, and year.	X				Q-023
	Average length of confinement per diagnosis, per professional, per region, per month, quarter, semester, and year arranged in descending order.	X				Q-024
	Number of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			X		Q-025
	Number of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.			X		Q-026
	Amount of drugs and medicines (in generic name) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year.			X		Q-027

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Amount of drugs and medicines (in generic name) slashed per diagnosis per professional quantified in terms of number of claims, by specialty, by region and nationwide per month, quarter, semester and year.			X		Q-028
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.	X				Q-029
	Number of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year in descending order.	X				Q-030
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per institutional provider quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.	X				Q-031
	Amount of diagnostic procedures (specific name e.g. chest PA, urinalysis etc.) slashed per diagnosis per professional quantified in terms of number of claims, by region and nationwide per month, quarter, semester and year, arranged in descending order.	X				Q-032

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail
	Average value per claim per diagnosis, per institutional provider, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.	X				Q-033
	Average value per claim per diagnosis, per professional, per category, by region and nationwide, per month, quarter, semester and year, arranged in descending order.	X				Q-034
	Average age of patient per claim per diagnosis per institutional provider per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.	X				Q-035
	Average age of patient per claim per diagnosis per professional per category, by region, and nationwide, per month, quarter, semester and year, arranged in descending order.	X				Q-036
	Monthly National Health Insurance Bed Occupancy Rate (MNHIBOR) per hospital by category and region per month, quarter, semester and year arranged in descending order.	X		X		Q-037
	Total	***27***	***0***	***11***	***0***	

Premium Collections

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Validation					
	Validate on-line the premium contribution against the membership database	X				P-001
	Functions					
	Process and print Collection notice to/from ACB/ACA			X		P-002
	Update accounts of members	X				P-003
	Generate Correction of Bill Report (Hardware)			X		P-004
	Generate Correction of Bill Report (Software)			X		P-005
	Maintains premium date of remittance based on inception or payment date	X				P-006
	Data capture of Remittance Information such as insurer's OR number and OR date	X				P-007
	Allows for all or selective tagging of records for remittance			X		P-008
	Posting of remittance information to individual coverages	X				P-009
	Maintains reference table of depository back account of employers			X		P-010
	Generates entries to disbursement vouchers.	X				P-011
	Electronic processing of addition, reduction, cancellation, or spoilage of premium contributions	X				P-012
	Query					
	Generate Account Receivable by Generate ACB	X				P-013

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
	Generate Unpostable/Unpaid Collection Records	X				P-014
	Reporting					
	Generate Notice of Non-Payments	X				P-015
	Statement of Member's Remittance / Contribution, monthly	X				P-016
	Statement of Agency Remittance / Contribution, monthly	X				P-017
	Summary of Posted Contributions	X				P-018
	Weekly accomplishment report			X		P-019
	Total	***13***	***0***	***6***	***0***	

Billing and Collection

Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Functions					
Update employer record for all remittance reported by ACB/ACA for 15 days	X				B-001
Compute the floating period of 15 days + 5 days grace period allotted by PHIC to all its ACB/ACA and update corresponding bank record			X		B-002
Reconcile billing statement and ME-5, MI-5 and Min-5; compute balances and update record			X		B-003
Accept and display Web-based validation request for the payments of member's premium contribution			X		B-004

Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Generate files for refunds	X				B-005
Perform analysis of data periodically and on need to generate the following information:			X		B-006
1)accredited collecting agents and accredited depository banks floating period			X		B-007
2) premium contributions and other charges receivable from members	X				B-008
Send billing statement via Web			X		B-009
Cross-referencing of Premium Contributions			X		B-010
Online or batch computer generation of receipts			X		B-011
Collection fund Transfer			X		B-012
Online Collection Reports and OR Register	X				B-013
Query					
Online member generation of statement of accounts	X				B-014
Reporting					
Generate AR Reports	X				B-015
Process billing and print billing statement for ACB/ACA on late remittances	X				B-016
Generate list of Active /Inactive Employers/ Members by end-of -month	X				B-017
Print a bill for mailing to the LGUs and Individually-paying members' thirty (30) days before the anniversary date of NHIP membership			X		B-018

Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Generate file for adjustment on next bill	X				B-019
Generate files for refunds	X				B-020
Generate Debit/Credit Memo due to Adjustment of payments			X		B-021
Generate and print statement for Agency and LGUs	X				B-022
Generate Summary of Billing Statement	X				B-023
Generate Collection Report and Member Report			X		B-024
HIP Premium Contribution, quarterly			X		B-025
Report of Collections and Deposits, monthly	X				B-026
Report of Fund Transfers (MOOE), monthly			X		B-027
Statement of Account	X				B-028
Collection Progress Reports Delivered to RHIO/ACBs, monthly			X		B-029
Aging of Unpaid Penalties & Interest from ACBs Late Remittances			X		B-030
Summary of Daily Collection Report, monthly			X		B-031
RHIOs Collection Report Purely on NHIP Premium Contribution, quarterly			X		B-032
RHIOs Collection Report Purely on NHIP Premium Contribution, monthly	X				B-033
Daily Collection Report	X				B-034
Report of Collection and Deposit, National Capital Region			X		B-035
Summary of Over-The-Counter Collection			X		B-036

Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Weekly Accomplishment Report			X		B-037
Premium Collection Management Master Database	X				B-028
Premium Collection Management System Data Entry Prooflist	X				B-039
Premium Collection Management System Monthly/ Quarterly Remittance Report	X				B-040
Premium Collection Management System Quarterly Remittance Statement			X		B-041
Premium Collection Management System Monthly Underpayment/Overpayment Report	X				B-042
Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly ACBs Collection Report, quarterly/every 15th day			X		B-043
Bank Collection Report, every 15th day			X		B-044
Collection Report thru Modified Disbursement Scheme. Direct Remittance Scheme - Servicing Banks Purely on NHIP Premium Contribution, quarterly/monthly			X		B-045
Consolidated Report of Collection Purely on NHIP Premium Contribution, quarterly			X		B-046
Home Office Collection Report Purely on NHIP Premium Contribution, quarterly			X		B-047
Consolidated Report of Collection Purely on NHIP Premium Contribution by Fund Type			X		B-049
Monthly Accomplishment Report - Bank Remittance Section			X		B-050
Total	***20***	***0***	***29***	***0***	

Ad Hoc

Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Functions					
Can track documents while in-process or after processing, with reference to manual storage	X				H-001
Can do an audit trail of the processing and storage of the respective IS				X	H-002
Total	***1***	***0***	***0***	***1***	

System and Database Administration

Priority	Requirement	Meets	Exceeds	Needs Mod	Unknown	Detail Refer#
Functions						
	Library Maintenance	X				S-001
	Geographic Code Table Maintenance	X				S-002
	Detect and log any change to the databases to record date and time of users	X				S-003
	User Friendly	X				S-004
	Facility for Computer-based Training			X		S-005
	Online interface to fax and e-mail facilities			X		S-006
	Multilateral coding system for refferors/ agents			X		S-007
	Reference table look up	X				S-008
	Three-level security: network, system and application levels	X				S-009
	Provide for back-up/restore procedures	X				S-010
	Archiving of historical insurance coverage information	X				S-011
	Includes utilities for security/password, batch/job controls, backup and restore procedures	X				S-012
	Total	***9***	***0***	***3***	***0***	