

Appendix J—Functional Requirements Matrices

As described in the RFP, DCH requires consolidated support for all of its health benefits programs, including Medicaid, PeachCare for Kids, SHBP, and BORHP. This means, for example, that DCH requires a single application software system, including consolidated database, logic, and interfaces. As one example of this, DCH expects that the bidder will propose a single provider database for all health benefits programs. (In the event the bidder cannot propose a single system, then DCH requires that the bidder at least provide the *appearance* of a single application system using a consolidated set of web-based interfaces and open system interfaces.)

Given these key points, bidders should ultimately regard the functional requirements in this Appendix J as a single set of requirements to be met using a single application system. However, these requirements are being presented for the most part as being specific either to Medicaid/PeachCare for Kids or to SHBP/BORHP for the following reasons:

1. **Clarity of Requirements:** While DCH desires to foster consistency across all of its benefits programs, and indeed in many respects program administration requirements are similar across those programs, it is also the case that many specific requirements of the programs do differ. This is especially true between Medicaid/PeachCare for Kids and SHBP/BORHP (key examples include areas such as eligibility maintenance and regulatory reporting). Many of these specific differences arise from the legal and regulatory foundations of the different programs (Title XIX and XXI in the cases of Medicaid and PeachCare, and state laws in the cases of SHBP and BORHP). Given this, it is useful to describe specific requirements separately in order to fully and accurately describe the requirements pertaining to the different programs.
2. **Phased Approach:** Further, since Medicaid/PeachCare for Kids, SHBP, and BORHP all have different implementation dates, it is potentially useful to describe separately the requirements specific to each of these programs so that bidders can determine their approach, schedule, and staffing for making system changes over the initial three years of the contract.
3. **Sources of Funding:** Finally, since Medicaid and PeachCare development is 90 percent reimbursable from the Health Care Financing Administration under the Federal Funding Program, it is important to separately describe Medicaid and PeachCare requirements from SHBP and BORHP so that in the Cost Proposal (**Appendix L**) bidders are able to distinguish between Medicaid and PeachCare development costs and SHBP and BORHP development costs.

This Appendix therefore contains three separate matrices:

- Matrix 1: General System Requirements that apply to all programs;
- Matrix 2: Medicaid/PeachCare for Kids Requirements; and
- Matrix 3: SHBP/BOR Requirements.

Each matrix lists the mandatory functional requirements and desirable functional capabilities for systems supporting the DCH/BOR programs. These functional requirements may be met through a combination of automated capabilities and manual processes. For each functional requirement, indicate your proposed system's ability to meet the requirement by checking the appropriate boxes:

- Current Capability—the proposed system currently has the capability to meet the requirement.
- Future Capability—the proposed system will have the capability to meet the requirement by the required implementation phase. An explanatory statement is required in the “Comments” section. Also include a target date for this capability.
- Manual Process—the requirement will be met through a manual process. An explanatory statement is required in the “Comments” section.
- No Capability—the proposed bidder has no capability to meet the requirement. An explanatory statement is required in the “Comments” section.

As noted above, bidders are required to include explanatory comments if any of the last three responses (Future Capability, Manual Process, or No Capability) are checked. Otherwise, bidders may optionally add comments in the space provided, as necessary, to further explain their capabilities. A reference to an appendix document may be placed in the space if the comment is too long to fit in the space. Responses to the Functional Requirements grids attached will be verified during onsite visits to the bidders.

All information must be accurate as it is incorporated into the final contract by reference.

Matrix 1: General Systems Requirements that Apply to All DCH Programs

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Technical Standards (Applies to All Programs):					
1.	All databases must be relational and comply with ANSI SQL (currently ANSI SQL 93)				
2.	The application(s) is/are directory-enabled so authentication credentials can be stored in any LDAP compliant directory the agency specifies				
3.	X.509 public key certificates are supported				
4.	IP security to provide end-to-end confidentiality of packets traveling over the Internet				
5.	SSL v3 for communication between web browser and web server				
6.	S/MIME V3.0 for securing e-mail communications				
7.	Applications are able to transmit and receive messages using TCP/IP and sockets, FTP, or serial transmission				
8.	The application(s) can be managed by an SNMP-compliant management tool				
9.	Scanned images of business documents will be committed to storage in TIFF format V5.0 using CCIT/ITU Group II or IV compression				
10.	eXtensible Markup Language (XML) is supported for data exchange among applications				

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
11.	The applications will be highly modular, using a component-based architecture that supports dynamic changes to business processes. These n-tier components (such as “autopay” can be used as part of the DCH application infrastructure by other state agencies. Each n-tier component will have a published interface				
12.	Business rules will be coded in a platform neutral language (C, C++, JAVA, COBOL)				
13.	The application will be designed to separate user interface code, business rules, and data access. Multiple user interfaces (web browser, cell phone, and PDA) are supported without a second instance of the executable image of the business rules				
14.	Isolate and generalize user interfaces to support a wide range of options (browser, voice response, PDA, etc.)				
15.	Data access is independent of the physical data location				
<i>Technical Standards Comments:</i>					

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
System Structure and Architecture (Applies to All Programs):					
16.	Web-enabled primary interface				
17.	Web-enabled secondary interface for all HIPAA transactions				
18.	Single, electronic point of entry for all HIPAA transactions for all members and providers (for Medicaid, PeachCare for Kids, SHBP and BORHP)				
19.	Modern RDBMS (no flat file systems allowed). At a minimum, the RDBMS must meet ANSI SQL93 or equivalent standards				
20.	Ability to support real-time access to and consolidation of all healthcare data (including Medicaid, PeachCare for Kids, SHBP, and BORHP)				
21.	Online help for system users				
22.	Ad hoc reporting tools				
23.	Modern job scheduling software				
24.	Screen navigation options				
25.	Alert reminders				
26.	Work flow support for routing and tracking data among users				
27.	Imaging and OCR support for processing, storing, and retrieving text documents. To ensure compatibility, hardware and software compatibility using TWAIN or ISIS facilitate interoperation of peripherals. Also, images should be stored in standard formats, such as TIFF				
28.	Security within the network (user profiles and passwords) that meets or exceeds HIPAA privacy and security regulations				
29.	Security across the Internet (e.g., user profiles and passwords, level of encryption, certificates, firewalls, etc., that meets or exceeds HIPAA privacy and security regulations)				
30.	Online and batch printing				

Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>System Structure and Architecture Comments:</i>				

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Security (Applies to All Programs):					
31.	Assigns individual system passwords that are required to access the system				
32.	Assigns individual system passwords that do not display when entered				
33.	Assigns individual system passwords that control security clearance to access specified system functions				
	Assigns individual system passwords that control security for inquiry, add, change, and delete transactions by user ID and password at the following levels:				
34.	▪ Menu				
35.	▪ Module				
36.	▪ File				
37.	▪ Record				
38.	▪ Field				
39.	Locks an individual out after three failed attempts to log onto the system; supervisor/systems area staff approval required to unlock				
40.	Auto system logoff if terminal idle for specified time period and/or end of day				
Security Comments:					

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Fraud Detection					
41.	Claims System Requirements: Able to assess the appropriateness of medical claims payments in the context of claims history for each payment, focusing on the bundling and unbundling of services to determine inappropriate or fraudulent billing activity				
<i>Fraud Detection Comments:</i>					

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
HIPAA Compliance with Transaction and Unique Identifier Standards (Applies to All Programs):					
42.	Map existing data to ASC X12N 270 Health Care Eligibility (benefit inquiry) for each data element in the system				
43.	Map existing data to ASC X12N 271 Health Care Eligibility (benefit response) for each data element in the system				
44.	Map existing data to ASC X12N 276 Health Care Status (electronic inquiry regarding claim status) for each data element in the system				
45.	Map existing data to ASC X12N 277 Health Care Status (electronic response regarding claim status) for each data element in the system				
46.	Map existing data to ASC X12N 278 Referral Certification and Authorization (response regarding claim status) for each data element in the system				
47.	Map existing data to ASC X12N 820 Health Plan Premium Payments (transfer of funds) for each data element in the system				
48.	Map existing data to ASC X12N 834 Health Plan Enrollment/Disenrollment for each data element in the system				
49.	Map existing data to ASC X12N 835 Health Care Payment/Remittance (used in conjunction with 820 regarding payment information) for each data element in the system				
50.	Map existing data to ASC X12N 837 Health Claims or Equivalent Encounter Information (Professional, Institutional, and Dental; used for claims submission and encounter data transfer) for each data element in the system				
51.	Develop transmission/translation strategies and testing process to allow the system to accept and process Transaction Standards				

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
52.	Develop error processes to identify problem areas and assist in correcting system and notifying sender that an error occurred and changes are required to process a “clean” transaction standard				
53.	Develop performance measures for acceptance and processing of a “clean” Transaction Standard				
54.	System utilizes HIPAA standard National Provider Identifier				
55.	System utilizes HIPAA standard Employer Identifiers				
<i>HIPAA Transaction/Identifier Standards Compliance Comments:</i>					

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
HIPAA Compliance with Code Sets (Applies to All Programs):					
56.	Adhere to the use of ICD-9, ICD-10, CPT, HCPCS, NDC, CDP, and CDT-3 as required by October 2002				
57.	Assess current code sets and develop capacity to accept updated code sets as scheduled				
58.	Develop error edits to identify problems that affect clean claims processing as it relates to the code sets				
59.	Accept all code sets for processing claims based on DOS				
60.	Ability to map local procedure codes to HIPAA standard code sets				
61.	Ability to map DSM-IV diagnosis codes to ICD-9 codes				
<i>HIPAA Compliance with Code Sets Comments:</i>					

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Systems Documentation:					
67.	Maintain and provide documentation that is current, comprehensive, and reflects actual operation. Documentation list includes, but is not limited to:				
68.	▪ Programming documentation				
69.	▪ Systems design documentation				
70.	▪ Computer operations documentation				
71.	▪ User documentation				
72.	▪ Organizational documentation				
73.	Systems change requests are fully documented and tracked				
74.	Provide a system/process for tracking system enhancements or modifications				
75.	All data is maintained in relational databases				
76.	Provide GUI user interface to system for DCH operational staff				
77.	Support MS-Windows environment for all online user access				
	Create and provide access to a data repository that contains, at a minimum:				
78.	▪ Adjudicated claims data				
79.	▪ Suspended claims data				
80.	▪ Adjustment/voided claims data				
81.	▪ Financial transactions				
82.	▪ Reference database				
83.	▪ Provider database				
84.	▪ TPL data, including cost avoidance interface with the TPL vendor				
85.	▪ Member database				

Matrix 1 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Systems Documentation:					
86.	Provide capability to use the data repository for report and data extraction as requested				
87.	Create and maintain a comprehensive data dictionary for system				
88.	Ability to archive data by parameters defined by the State				
89.	Provide audit trails for updates to all databases				
90.	Maintain a test environment which will mirror the production environment				
91.	Maintain five years of claims history, provider, member, reference, and third party resource data on line				
Systems Documentation Comments:					

Matrix #2: Medicaid/PeachCare Requirements

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Provider Relations Management:					
1.	Process provider enrollment applications submitted via paper				
2.	Process provider enrollment applications submitted via the Internet				
3.	Verify licensure and certification credentials and assign unique provider identification numbers, based on HIPAA standards				
4.	Cross-reference/track all relevant provider numbers such as Medicare provider number, NPI, CLIA number, license number, SSN, FEIN, NBP, DEA, etc.				
5.	Maintain a provider database that will accommodate all of the providers in the Georgia Medical Assistance Program (GMAP) network				
6.	Maintain a provider database that utilizes sophisticated editing to avoid duplication of provider records				
7.	Maintain a provider database that utilizes sophisticated editing to guarantee data integrity and accuracy through the application of user-defined edits for presence and valid field values				
8.	Maintain provider history that will record changes to licenses, names, locations, or actions; all changes must be marked with begin and end dates				
9.	Maintain a provider database that will have the ability to lock in or lock out providers to specific diagnosis codes, procedure codes and modifiers				
10.	Support required provider network reporting				
11.	Generate reports on demand to evaluate the provider network				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
12.	Generate reports and supporting documentation on demand to support DCH in provider grievance hearings and appeal processes				
13.	Generate mailings to selected providers based on user-defined criteria or by specified data fields				
14.	Generate provider mailings via e-mail or FAX				
15.	Ability to select providers by zip code, provider type, provider specialty, program participation, and other user-defined criteria				
	Upload and apply changes to the provider database from multiple external sources based on user specifications. Examples of databases are:				
16.	▪ Provider organizations				
17.	▪ State of Georgia				
18.	▪ HCFA				
19.	▪ CLIA Oscar file				
20.	▪ Licensure and certification files				
21.	Maintain agreements for billing agencies using electronic claim submissions				
22.	Maintain a provider database that will accept group provider numbers and relate and cross-reference individual providers to their groups				
23.	Maintain a provider database that will identify the out-of-state providers				
24.	Maintain a provider database that will allow multiple names, addresses, and telephone numbers for a provider				
25.	Maintain a provider database that will track number of beds and level of care for institutional facilities				
26.	Generate provider enrollment approval or denial letters				
27.	Generate 1099 notices and associated payment reports				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
28.	Support telephone inquiries from providers after hours through an automated voice response system				
29.	Create a provider enrollment process and track provider applications through the approval process				
30.	Ability to check enrollment status, deficient documentation listings, etc, via the web				
31.	Generate data extracts from the provider subsystem on request				
32.	Ability to generate user-specified correspondence to all or selected providers				
33.	Automatically generate letters to providers regarding the provider enrollment process, and where they are in the process				
34.	Maintain a database that will record and track provider credentialing data and credentialing processing status				
35.	Interface with claims processing modules to perform required editing				
	Communicate with providers through multi-channel communications:				
36.	▪ Web pages/Internet				
37.	▪ Call centers				
38.	▪ Computer integrated telephony				
39.	Allow provider to access own records via the web				
40.	Allow provider to access member eligibility data via the web				
	Track all inquiries, applications, requests for assistance, and requests for changes and, at a minimum, document the following:				
41.	▪ Initial contact date				
42.	▪ Contact source				
43.	▪ Actions taken by the subcontractor				
44.	▪ Resolution of the issues				
45.	Assign a unique provider identification number for each enrolled provider				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Maintain a provider database that contains the minimum data set prescribed by Part 11 of the State Medicaid Manual, including, but not limited to the following data elements:				
46.	▪ Provider name				
47.	▪ Corporate name				
48.	▪ Provider type				
49.	▪ Addresses and type of address, including location, payee and mailing addresses				
50.	▪ Phone numbers and type of phone number, including fax number				
51.	▪ Contract persons and their roles				
52.	▪ Service locations				
53.	▪ Payee TIN information–FEIN or social security number				
54.	▪ Application and enrollment dates				
55.	▪ Enrollment status				
56.	▪ Qualifications (i.e., current licenses held, Board Certifications, and specialties)				
57.	▪ Services offered, by service location				
58.	▪ Affiliations with groups, clinics, hospitals, HMOs or other organizations				
59.	▪ Designated payees				
60.	▪ Service coverage areas				
61.	▪ Provider specific rates				
62.	▪ Information on contracts or agreements specific to the provider				
63.	▪ Languages spoken at each service site				
64.	▪ Primary language spoken and understood by the provider				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
65.	▪ TDD/TTY capabilities for hearing impaired providers				
66.	▪ Name of billing agent				
67.	▪ Name of owner(s) of enrolled entity				
68.	▪ Social security number of provider or owner(s)				
69.	▪ Date of birth of provider or owner(s) of entity				
70.	▪ Georgia Better Health Care (PCP) Program number				
71.	▪ Provider status code				
72.	▪ Enrollment status code				
73.	▪ Suspense flag				
74.	Ability to add new data elements fields to the provider database on request				
75.	Track the numbers of provider inquiries, the nature of each inquiry, and the disposition of the inquiry				
76.	Generate provider correspondence and inquiry responses				
77.	Ability to track HEALTH CHECK eligible providers				
78.	The subcontractor will respond to inquiries regarding the status of claims submitted by providers via the Internet				
79.	Provide a voice response phone system for providers payment inquiries				
80.	Maintain a record of provider contacts for a minimum of two years				
81.	Develop or adapt training materials and audio visual supports required to conduct training of providers at a professional level				
82.	Maintain a registry of certified nurse aids				
83.	Provide on-line inquiry and real time update capability (i.e., add, change, delete) to the provider database				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
84.	Ability to track and report provider information history				
85.	Provide for automated updates to provider rates				
86.	Ability to enroll a provider under multiple categories of service				
87.	Ability to track and report temporary licenses				
88.	Verify via an interface with the Georgia Composite State Board of Medical Examiners that physicians have current and valid Georgia State Medical licenses				
89.	Ability to track and report physician Drug Enforcement Administration number (DEA#)				
90.	Identify and maintain data regarding types of certification/accreditation/specialty for each provider				
91.	Provide automated interface with all licensing entities for verification of licensure for new providers				
92.	Provide automatic update of license renewal data				
93.	Provide and maintain an indicator to identify providers who are tax exempt				
94.	Ability to track and report convictions and findings of patient abuse, and adverse findings				
	Ability to generate reports on providers by county and aggregate statewide by:				
95.	▪ Location				
96.	▪ Provider type				
97.	▪ Specialty				
98.	▪ Category of service				
99.	▪ Status Code				
100.	Capability to request and access on-line provider enrollment statistics such as enrolled providers by category of service, provider type, provider specialty, etc.				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
101.	Provide automated voice response (AVR) and an Internet-based Eligibility Verification System (EVS) for provider inquiry available 24 hours per day, 7 days per week				
102.	Provide an Internet application for nursing facilities and other providers to inquire on the certification status of nurse aides, 24 hours per day, 7 days per week				
103.	Provide an Internet application for the public to report patient abuse or adverse findings, 24 hours per day, 7 days per week				
104.	Provide access to on-line procedures, general instructions, claims resolution examples, and sample responses to assist inquiry, including updates regarding current system problems and in-process correction and modification				
105.	Provide monthly reports to DCH regarding inquiry system activity				
106.	Provide access to procedure/operation manuals on-line				
107.	Provide the capacity to pay the certified match share of claim payment when another entity holds the "state funds"				
108.	Capability to suppress printing of any automated notices for individual providers				
109.	Capability to enroll providers as non-Medicaid; information only providers for purposes of enrollment as a member of a managed care network				
110.	Ability to research providers on the National Provider Database				
111.	Ability to access national databases for background checking of physicians prior to their enrollment in the Medicaid program				
112.	Provide on-line weekly and monthly summary reports of activity related to inquiries regarding payment procedures				
113.	Record, research, and respond to complaints from providers				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
114.	Provide an automated call distribution (ACD) and reporting system to monitor the incoming and outgoing telephone calls				
115.	Ability to track and report payables and receivables by provider				
116.	Prepare and distribute a provider bulletin to notify providers of the names of the provider representatives and procedures for contacting the provider representatives				
<i>Provider Relations Management Comments:</i>					

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Member Services Management:					
117.	Maintain a member database that contains member demographic data as specified by state and federal reporting requirements; at a minimum, it must contain the minimum data set defined in Part 11 of HCFA's State Medicaid Manual				
118.	Ability to enter and update member eligibility data on-line on a real time basis				
119.	Upload PeachCare eligibility data from DHACS				
120.	Maintain a member database that can support multiple eligibility groups				
121.	Maintain a member database that can support multiple eligibility categories for each member and can apply an eligibility hierarchy as defined by DCH				
122.	Maintain a member database that will assist DCH with all reporting requirements by allowing flexible user-defined query capability				
123.	Maintain a member database that will track other insurance information				
124.	Provide a member database that will track all changes by date and maintain the history of all changes by member				
125.	Maintain a member database that will track beneficiary information				
126.	Provide online inquiry capability to the member database; inquiry screens must show multiple categories of eligibility and all date periods				
127.	Provide mnemonic name search capability on online member inquiry screens				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
128.	Maintain a member database that will assign a single unique number to an individual, as specified by the State. Once a member is assigned a number, that number shall be used for all information for that member, regardless of enrollment and terminated enrollment activity				
129.	Ability to cross-reference member SSN(s) and other insurance numbers using Master patient Index (MPI) technology				
130.	Provide sophisticated editing that will not allow duplicate member records to be created				
131.	Provide enrollment/terminated enrollment tracking and reporting on the member database; enrollment and terminated enrollment capability may be retroactive				
	Upload and apply updates to the member eligibility database from a variety of sources, as requested by user. Examples of files that may need to be uploaded are:				
132.	<ul style="list-style-type: none"> ▪ Social Security Administration (SSA) State Eligibility Verification System (SEVS) and State On-Line Query (SOLQ) 				
133.	<ul style="list-style-type: none"> ▪ BENDEX 				
134.	<ul style="list-style-type: none"> ▪ Beneficiary Earning Exchange Record (BEER) 				
135.	<ul style="list-style-type: none"> ▪ Qualified Medicare Beneficiary (QMB) Outreach 				
136.	<ul style="list-style-type: none"> ▪ Other state agencies (i.e., DOAS) 				
137.	<ul style="list-style-type: none"> ▪ Department of Human Resources (DHR) (daily files) from the Dept of Administrative Services (DOAS) system 				
138.	<ul style="list-style-type: none"> ▪ Third Party Liability (TPL) Recovery vendor 				
139.	<ul style="list-style-type: none"> ▪ Other insurers, as needed 				
140.	<ul style="list-style-type: none"> ▪ Other vendors, as needed, i.e., HCFA Medicare Part A/B Billing Files 				
141.	Ability to reconcile member records that fail edits during the upload process. Also, research and correct pended eligibility update transactions that fail edits				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
142.	Ability to track and report rejected eligibility transactions				
143.	Provide indicators in the member database for multiple categories and coverages, including, but not limited to, TPL, QMB, Qualified Disabled Working Individual, and Specified Low Income Medicare Beneficiary (SLMB)				
144.	Maintain benefit limitation status by member for reporting and inquiry				
145.	Support data extracts and online queries for individual member eligibility query				
146.	Support data extracts for tape matches with other state agencies				
147.	Support data extracts for tape matches with other insurers				
148.	Support data extracts and online queries for eligibility redetermination and status by other state agencies				
149.	Support eligibility verification or inquiries via the Internet				
150.	Provide monthly operational reports about the number of member inquiries performed, include average waiting time, call abandonment rate, and average time per call; provide breakouts by type of calls and number of hits for inquiries				
151.	Generate electronic and paper rosters of members by program and in aggregate				
152.	Interface with claims processing software to perform appropriate editing				
153.	Provide list of members enrolled/terminated enrollment in Hospice program, by provider				
154.	Provide list of members enrolled/terminated enrollment in Swing Bed program, by provider				
155.	Provide list of members enrolled/terminated enrollment in Pre-Admission Screening Annual Resident Review (PASARR) program, by provider				
156.	Provide list of members by eligibility category				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
157.	Provide list of members by special populations				
158.	Provider ad hoc member reporting as requested				
159.	Update, maintain, and allow online access to Medicare Part A and Part B buy-in information by member				
160.	Generate monthly extract for capitation payment system				
161.	Receive online updates to eligibility data				
162.	Generate Plastic Identification or Smart Card member identification cards per user-defined specifications				
163.	Ability to track and report on members by aid category				
164.	Provide reports, on request, to support the State in member grievance and appeal processes				
165.	Enable members to access to their own eligibility data via the Internet				
166.	Enable members to access data via call center technology such as CTI, Voice Response Inquiry, etc.				
167.	Maintain member policies and procedures in electronic format				
168.	Maintain member eligibility and demographic information				
169.	Generate automated member correspondence				
170.	Ability to suppress generation of beneficiary identification documents for confidential services, on request				
171.	Ability to enroll and terminate the enrollment of members in managed care programs—currently this includes the Georgia Better Health Care program				
172.	Ability to track and report newborn members				
173.	Ability to detect and notify other subcontractors or DCH of suspected fraud and abuse activity				
174.	Ability to track all system generated member correspondence				
175.	Ability to provide member correspondence on behalf of the GBHC program—if required by DCH				
176.	Ability to notify members of PCP assignment				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
177.	Ability to notify members of MCO assignment				
178.	Ability to enter into the system for emergency eligibility for members on request				
179.	Ability to offer TDD/TTY inquiry system for the hearing				
180.	Provide online access for inquiry regarding HEALTH CHECK eligibility and GBHC providers				
181.	Ability to refer HEALTH CHECK members to eligible providers				
182.	Track, record and maintain data on all HEALTH CHECK referrals for diagnosis and treatment and as necessary to produce the HCFA 416 reports				
183.	Ability to track and report on HEALTH CHECK members				
184.	Ability to track and report on HEALTH CHECK service utilization				
185.	Ability to download and maintain previous EPSDT screening history via an interface with an Immunization Tracking Registry				
186.	Maintain a matrix of the EPSDT screening sequences in order to project when the next screen due and accordingly generate notices for members				
187.	Monitor appointment scheduling and mail appointment reminders to HEALTH CHECK members or their guardians prior to scheduled appointments				
188.	Generate a roster containing the screening status of each assigned member under the age of 21				
189.	Track, record and maintain data on all HEALTH CHECK appointment notices mailed to eligible members and providers				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Provide monthly reports on HEALTH CHECK appointment scheduling, referral appointments. The reports must document the following activities:				
190.	▪ Methods of informing new eligibles				
191.	▪ Methods used to encourage participation of non-participating eligibles				
192.	▪ Community outreach activities				
193.	▪ Provider enrollment by county				
194.	▪ Provider address and directions				
195.	▪ Specialty				
196.	▪ Availability for screening services, time, days, hours				
197.	▪ Provider limitations, such as the number of eligible children the provider will accept				
198.	▪ Number of appointments scheduled				
199.	▪ Number and rate of appointments not kept by members				
200.	▪ Number of referral appointments identified by type of referral, such as hearing evaluation, surgical, laboratory				
201.	▪ Timeliness of referral appointments				
202.	Ability to track and report the number of screening appointments due				
203.	Ability to track and report the number of screening appointments made				
204.	Ability to track and report the number of follow-up appointments kept				
205.	Ability to generate surveys to members upon request				
206.	Ability to record, track, and report on voluntary and involuntary terminated enrollments from the GBHC program				
207.	Ability to auto-assign members to providers for the GBHC program				
208.	Ability to override the automatic enrollment decisions				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
209.	Ability to retroactively enroll newborns in the same plan as their mothers				
210.	Produce a PCP listing by area and county for members				
211.	Generate, via electronic means, member eligibility status and redetermination lists to other state agencies				
212.	Provide access to member data to all authorized Georgia state agencies via the Georgia Online Network (GO NET)				
213.	Update, maintain, and allow online access to current and historical Medicare Part A and Part B Buy-In information				
214.	Ability to update the member LTC records via online real time				
215.	Ability to add hospice members (residing in nursing facilities) to the member database(s) with their associated patient liability segments				
216.	Ability to lock-in members to specific providers, hospitals, pharmacies, capitated programs, or other services				
	Provide the capability for the Member database to interface with the following reports and files:				
217.	▪ Payment processing files				
218.	▪ TPL database				
219.	▪ Standard Management Reporting/Federal Reporting				
220.	▪ Utilization Management and Fraud and Abuse Detection				
221.	▪ EPSDT				
222.	▪ Provider files				
223.	▪ Reference files				
224.	▪ Service limitation files				
225.	▪ Ad Hoc reporting				
226.	▪ Member appeals				
227.	Quality Management and Improvement /Disease Management file				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
228.	Produce audit trail of all ID cards produced and all on-line real time updates made.				
229.	Produce audit trail of all inquires (online) made of SSA, SDX and BENDEX data.				
230.	Ability to automatically generate all standard and routine member correspondence				
231.	Produce necessary notices, letters, and reports to support the SSI termination “ex-parte” process				
232.	Automatically generate “Certificate of Coverage” correspondence that notifies terminated members of past periods of Medicaid eligibility				
233.	Provide on-line inquiry access to the correspondence file				
234.	Ability to support mass enrollments and terminated enrollments of members from plans, GBHC assignment, etc.				
235.	Receive and process notices of member lock-in to specific providers, hospitals, pharmacies or other services				
236.	Maintain a minimum of five years of member eligibility history on-line				
237.	Perform file purges of inactive member data as defined on a regularly scheduled basis. Archive purge data for retrieval if necessary.				
238.	Process member date of death information and post to member eligibility and demographic records				
239.	Reconcile overlapping eligibility records and determine precedence for eligibility categories				
240.	Track, record and maintain data on all screening, rescreening and transportation services				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
241.	Develop and maintain a network of medical and agency referral sources for a variety of needs including early intervention services for children from birth to age three who are physically or mentally disabled and at risk for growth and developmental delays				
242.	Track, record and maintain data on all referral appointment assistance requests received from providers				
243.	Maintain a referral database with updates from multiple sources to include all referral sources				
244.	Ability to report and query referral database by referral source and date received				
245.	Ability to update referral database on line real time				
246.	Update and maintain the recipient first-day liability amount for Medically Needy eligibles.				
<i>Member Services Management Comments:</i>					

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing:					
247.	Accept standardized claims formats for processing				
248.	Accept UB-92				
249.	Accept HCFA 1500				
250.	Accept ANSI X12 837				
251.	Accept American Dental Association standard claim form				
252.	Accept claims in multiple media				
253.	Accept files from Medicare intermediary for cross-over billings				
254.	Process claims received from Medicare intermediary in the same manner as other provider submitted claims				
255.	Log claims tapes and diskettes upon receipt				
256.	Assign a batch number to all claims tapes, diskettes, and paper claims				
257.	Establish balance and control procedures to ensure that all claims are processed				
258.	Return Medicare cross-over claims to provider electronically				
	Accept required attachments for claims adjudication, including:				
259.	▪ Medicare Explanation of Benefits (MEOB)				
260.	▪ Accident forms				
261.	▪ Other insurer remittance advices/EOBs				
262.	Upload provider claim data from paper claims using OCR/Imaging technology				
263.	Upload TPL data from vendor				
264.	Upload Medicare premium payment data				
265.	Provide claims adjudication				
266.	Provide online adjudication for claims submitted via the Internet				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
267.	Process all claims in compliance with state and federal requirements for timeliness and accuracy				
268.	Adjudicate all claims as either approved or denied, except for services identified by DCH as pending for review				
269.	Allow DCH staff access to claims processing subsystem and provide claims review capability				
270.	Process claims for multiple providers on one invoice				
271.	Process claims adjustments; maintain the original claim and link all adjustments to it in history; re-edit and re-price each adjustment claim				
272.	Provide an automated mass adjustment capability				
273.	Provide an automated retroactive rate adjustment capability				
274.	Process voided claims requests				
275.	Track suspended claims and encounters through resolution or void request				
276.	Provide ability to process adjustments, recoupments, and voids retroactively, for up to five years				
277.	Provide appropriate and sophisticated editing of claims, as defined by the user				
278.	Provide duplicate claim checking, including potential duplicates				
279.	Provide edit for insufficient data				
280.	Provide edit for invalid data				
281.	Provide edit for required data				
282.	Provide edit for other coverage				
283.	Provide edit for invalid services				
284.	Provide edit for invalid provider				
285.	Provide edit for invalid recipient				
286.	Provide edit for timely filing				
287.	Provide edit for invalid diagnosis				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
288.	Provide edit for exceeding benefit limits				
289.	Provide edit for unauthorized services				
290.	Provide edit for denying payment of services that are capitated				
291.	Provide edit for payment of services that are “carved out” of the capitation payment				
292.	Provide edit to ensure that all required attachments have been received				
293.	Provide edit for newborn eligibility				
294.	Provide edit for co-payments				
295.	Provide audit limits, as defined by user				
296.	Provide cross check of payments				
297.	Utilize TPL data in claims processing editing and pricing				
298.	Assign each claim a unique reference number (Cash Control Number)				
299.	Ability to use hierarchical claims editing process. Report all errors for a claim (Do not limit or stop editing due to failure of previous edit)				
300.	Track claims and encounters through the adjudication process from receipt through final disposition				
301.	Maintain claims processing history				
302.	Provide software to the providers for electronic submission of claims and encounters				
303.	Provide training and assistance in the installation and use of the software				
304.	Ability to report override codes and prior approval codes separately in the MMIS and SURS systems				
305.	Override claim edits and audits in accordance with State-approved guidelines				
306.	Process claims and encounters with procedure codes and modifiers, where appropriate				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Maintain a prior authorization (PA) database that contains, at a minimum:				
307.	▪ Unique PA number				
308.	▪ Ordering provider				
309.	▪ Rendering provider				
310.	▪ Effective dates				
311.	▪ Status code				
312.	▪ Authorized amount of service				
313.	▪ Service description				
314.	▪ Dollar amount of authorized service				
315.	▪ Dollar amount used and remaining				
316.	▪ Amount of service used and remaining				
317.	Upload and apply changes in authorizations from the appropriate vendor				
318.	Update authorization/precertification file as claims are paid to show number of units used and amount paid				
319.	Provide online update and creation of service authorizations				
320.	Research problem claims for adjudication				
321.	Log and track all out-of-state claims				
322.	Retain complete records of all claims activity for up to five years from the date of the initial paid claim				
323.	Provide professional guidance regarding claims collection, adjudication, and reporting procedures				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Provide fraud and abuse detection and review; adhere to NCCP standards. Monitor provider claims to detect patterns of:				
324.	▪ Fraud				
325.	▪ Abuse				
326.	▪ Excessive billing				
327.	▪ Inappropriate billing practices				
328.	▪ Unnecessary utilization				
329.	▪ Clinically inappropriate services				
<i>Claims Processing Comments:</i>					

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Claims Payment:					
330.	Price claims using multiple payment methodologies, as appropriate and according to user-defined parameters				
331.	Ability to price claims against user-defined fee schedules				
332.	Ability to price certain procedures on a per diem basis by DRG				
333.	Ability to price capitated claims				
334.	Price encounters using the appropriate payment methodology and maintain amount in database, but authorize zero payment to the provider – as required by DCH				
335.	Deduct patient liability amounts when appropriate				
336.	Deduct TPL and Medicare paid amounts as appropriate				
337.	Ability to systematically bill all available coverage in order of benefit determination				
338.	Edit billed charges for reasonableness (low and high) and report/flag exceptions				
339.	Identify allowable reimbursement for claims according to date-specific pricing criteria, as determined by the State				
340.	Provide ability to hold payment, per user-defined situations, for individual claims, all claims processed, or all claims for a particular provider				
341.	Provide EFT payment to providers				
342.	Generate and distribute remittance advices to providers electronically				
343.	Generate and distribute remittance advices to providers in hard copy when requested				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Generate remittance advice to provider that includes:				
344.	▪ Itemization of submitted claims that were paid, denied, adjusted, or voided				
345.	▪ Itemization of all financial transactions				
346.	▪ Itemization of all error conditions detecting for claims that were suspended or denied				
347.	▪ Adjusted claim information				
348.	▪ Itemizations for all DCH benefit programs including payments made via Medicaid, PeachCare for Kids, SHBP and the BORHP				
349.	Maintain controls to track each financial transaction				
350.	Maintain provider accounts showing claims paid month to date and year to date by DCH benefit plan				
351.	Ability to maintain credit balances and provide reports on providers with credit balances				
352.	Provide an automated recoupment process				
353.	Maintain a process to adjust provider 1099 reports after recoupment processing				
354.	Provide override capability of recoupment and adjustments under strict security; allow entry of comments to explain the action taken; maintain an audit history of such actions				
355.	Track provider credit balances				
356.	Respond to provider overpayments by adjustments or void of paid claim				
357.	Process manual payments in unusual or emergency situations				
358.	Generate provider checks if necessary				
359.	Maintain accounts receivables and report on activity				
360.	Accurately withhold nonfederal share of claims paid for those providers designated by the State in cases where the State share is available from another source				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
361.	Ensure payment reporting accurately reflects total expenditures for those claims where the nonfederal share was withheld				
362.	Provide capability to handle multiple capitation rates for different programs, different combinations of members, and different geographic regions				
363.	Generate one monthly capitation payment to each provider that covers all members enrolled and eligible by that provider for the GBHC program				
364.	Produce system-generated remittance advices to GBHC providers to list all members covered by the monthly capitation payment				
365.	Produce an online report detailing all refunds by check number, date, claim control number, and deposit number				
366.	Provide online summaries of transactions processed and account balances				
367.	Copy and store all checks/EFT payments using document imaging and workflow technology				
368.	Implement a cash flow management system allowing the system to hold payment of a claim for a specified period of time, as defined by the State				
369.	Execute payment claims; payment cycles weekly or biweekly as specified by DCH				
370.	Provide claims aging reports				
371.	Generate automated responses to requests for information on payment procedures by providers, carriers, or other interested parties				
372.	Ability to interface with State financial reporting system (PeopleSoft)				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Claims Payments Comments:</i>				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Reference File Maintenance:					
373.	Maintain all reference file data history. Must be maintained for a minimum of ten years				
374.	Provide effective begin and end dates for all reference file data elements that require date specific actions, such as online edits, claims edits, and reporting				
375.	Provide online inquiry for designated DCH staff to all reference file databases				
376.	Provide editing as needed to support referential and data integrity in all reference databases				
377.	Update all reference databases on an approved schedule with at least 99 percent accuracy				
378.	Upload and apply updates to CPT-4 procedure codes				
379.	Upload and apply updates to HCPCS				
380.	Upload and apply updates to revenue codes				
381.	Upload and apply updates to ICD-9 procedure codes				
382.	Upload and apply updates to State-assigned procedure codes				
383.	Upload and apply updates to ICD-9 diagnosis codes				
384.	Upload and apply updates to DSM codes				
385.	Upload and apply updates to NDC pharmacy codes				
386.	Upload and apply updates to NABP identification numbers				
387.	Upload and apply updates to CLIA numbers				
388.	Upload and apply updates to RBRVS				
389.	Upload and apply updates from or to State licensure files				
390.	Update codes for DRGs and RUGs				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	State-defined rate tables including, but not limited to:				
391.	▪ Anesthesia base rates				
392.	▪ GBHC administration fee rate				
393.	▪ EPSDT schedules				
394.	Maintain Copay database				
395.	Maintain DRG tables including diagnosis codes and complications and comorbidities				
396.	Maintain Provider type, category of service, and provider specialty codes				
397.	Maintain Fee schedules				
398.	Maintain a listing of and criteria for claims edits as prescribed by the State				
399.	HMO/MCO criteria—as deemed necessary by the state				
400.	Maintain Medical criteria				
401.	Maintain Usual and customary fees				
402.	Maintain Conversion Factor File (control file)				
403.	Maintain Place of service codes				
<i>Reference File Maintenance Comments:</i>					

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Additional Reporting:					
404.	Ability to generate data extracts on request in multiple media, including but not limited to tape, diskette, CD-ROMs, FTP files				
405.	Provide data to the State to satisfy the SURS reporting requirement				
406.	Provide data to the State to satisfy the EPSDT reporting requirement				
407.	Provide data to the State to satisfy the Federal MARS reporting requirement				
408.	Ability to analyze the frequency, extent, and type of claims processing errors				
409.	Ability to monitor third party collections and avoidances				
410.	Ability to analyze provide claim filing for timeliness				
411.	Ability to analyze drug use for cost and potential abuse				
412.	Ability to provide geographic analysis of members, costs, and providers				
413.	Ability to prepare and monitor budget allocations by categories of service				
414.	Ability to project program costs based on past experience				
415.	Ability to compare current cost with previous period to analyze cash flow				
416.	Ability to analyze program expenditures to determine relative cost benefit				
417.	Ability to analyze member access to healthcare				
418.	Ability to analyze Medicare buy-in recipient data				
419.	Ability to track and report IBNR				
420.	Ability to produce a payee ranking report				
421.	Provide data to the UM vendor, as required				
422.	Ability to produce a provider category of service ranking				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
423.	Provide automated interface with HCFA for transmission of HCFA required reports				
424.	Provide MSIS (Medicaid Statistical Information System) reporting (HCFA-2082)				
425.	Produce HCFA 64 report as specified by the State				
426.	Provide data to actuarial contractor for rate analysis as specified by the State				
427.	Produce and distribute report of expenditures by COS, Aid Category and claim type.				
428.	Produce automated HCFA 372 report of waived services and payments.				
	Utilization reporting subsystem to provide on-demand request to include, but is not limited to:				
429.	▪ Identify aberrant member usage patterns				
430.	▪ Identify under-utilization patterns				
431.	▪ Rank providers, members, and procedures by highest and lowest utilization				
432.	▪ Extracts by diagnostic and procedure codes for clinical studies				
433.	Claims and encounter processing statistics				
434.	Produce online summaries of financial system reconciliation				
435.	Ad hoc reporting and distribution system				
436.	Provide weekly summarized databases for ad hoc reporting				
437.	Provide monthly summarized databases for ad hoc reporting				
438.	Provide online ad hoc query tool				
439.	Provide random number generator for sampling				
440.	Data extract feature for expenditure data requests				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Ability to extract data and format transfer files for upload into:				
441.	▪ Lotus 1-2-3				
442.	▪ MS-Excel				
443.	▪ MS-Access				
444.	▪ MS-Word				
445.	▪ Paradox or other database software				
446.	Ability to track and report on hospice services				
447.	Ability to track and report on home health services				
448.	Ability to track and report on mental health services				
449.	Ability to track and report on rural health center services				
450.	Ability to track and report FQHC services				
451.	Ability to track and report Crossover services				
452.	Ability to track and report services or groups of services as defined by user				
453.	Ability to track and report eligibility counts and trends by aid category				
454.	Ability to track and report utilization patterns by aid category and category of service				
455.	Support for user-defined category of service groupings				
456.	Ability to track and report expenditures by state and federal categories				
457.	Ability to track and report claim lag				
458.	Ability to aggregate data on seasonal patterns of illness				
459.	Summarize and capture quality of care issues				
460.	Provide data for review of hospitalization review plans				
461.	Provide recipient data statistics and unduplicated counts by program, demographics, geographic location, etc.				
462.	Provide data on provider network as requested				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
463.	Provide data and reports on cost avoidance as requested				
464.	Generate recipient letters as requested				
465.	Generate provider letters as requested				
466.	Provide data to calculate standard performance indicators as requested				
467.	Provide data extracts to vendors as requested				
468.	Generate reports detailing Hospital reimbursement				
469.	Generate reports detailing Nursing facility reimbursement				
470.	Ability to report on patient days at Nursing facilities				
471.	Provide statistical analysis on request				
472.	Provide statistical analysis tools				
473.	Provide forecasting tools				
474.	Generate report of exceptions to billed charges				
475.	Generate additional reports such as the Indigent Care Trust Fund (ICTF) Report to payments to hospitals				
476.	Provide for the reduction of a provider's payments by 31 percent for IPS Backup Withholding while still accounting for the total payment				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Additional Reporting Comments:</i>				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Financial and Accounting Interface:					
458.	System must support accrual basis and cash basis accounting per Generally Accepted Accounting Principles (GAAP) or new Governmental Accounting Standards Board (GASB) standards, as appropriate				
459.	Provide automated interface between claims processing / claims payment subsystem and State Accounting system				
460.	Perform automated Bank Account Reconciliation (BAR)				
461.	Maintain Federal Tax Information for all contracted providers				
	Ability to make payments not related to claims processing such as:				
462.	▪ Disproportionate share hospital payments				
463.	▪ Nurse Aide Training Program payments				
464.	▪ Hospital cost settlement payments				
465.	▪ Prospective and retrospective rate changes				
466.	Ability to interface with TPL vendor				
467.	Ability to initiate EFT payment to providers, electronically				
468.	Ability to allow authorized DCH staff to enter payment requests				
469.	Ability to enter payment requests online				
470.	Ability to enter adjustment requests online				
471.	Ability to correct data on the “proof” run if errors are found				
472.	Ability to generate and submit check registers to DCH/BOR for review prior to wire transfer of funds to providers				
473.	Provide safeguards for all check deposits and receivables to ensure that only authorized changes can be made				
474.	Ability to receive and process electronic transfer of refunds from insurance companies				

Matrix 2 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
475.	Ability to separate PeachCare and Medicaid member expenditures				
476.	Provide software for supporting 1099 preparation and magnetic media reporting according to IRS specifications				
477.	Produce on-demand duplicate 1099 forms				
<i>Financial and Accounting Interface Comments:</i>					

Matrix #3: SHBP/BORHP Requirements

Matrix 3 System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
FUNCTIONAL REQUIREMENTS					
Network Administration—Pertinent to the Indemnity Network if Proposed and to the Retention of the Third Party PPO Network Data:					
1.	Maintain separate third party indemnity and PPO professional and facility networks for providers in Georgia, the National PPO Overlay, Transplant and Behavioral Health Preferred Networks, including international locations as applicable				
	Maintain various of Provider classifications:				
2.	▪ Individual Physicians				
3.	▪ Group Practices				
4.	▪ Facilities (by type of service)				
5.	▪ Ancillaries (by type of service)				
6.	– Chiropractors				
7.	– Podiatrists				
8.	– Vision				
9.	– Dental				
10.	▪ Home health care				
11.	▪ Transplant				
12.	▪ Transportation, etc.				
13.	▪ Mid-level Providers				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Network Administration Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Retention of Provider Demographic Information:					
1.	Provider name, servicing address(es), billing address, phone, and other identification for each individual and multiple office location				
2.	Effective dates and renewal dates of contracts, current and prior two years				
3.	Current network participation status for each provider contract				
4.	License date, number, and state of issuance				
5.	Board certification status				
6.	Suspend payment indicator with reason code				
7.	Assigned region and area (including national or international regions)				
8.	Ability to link individual providers or groups of providers by Tax ID Number (TIN) to member records for in-network benefits at out-of-network providers pursuant to Georgia Consumer Choice Option law				

Retention of Provider Demographic Information Comments:

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Network Administration Reporting:					
1.	Generation of product-specific provider directories for indemnity network by multiple sorting options (i.e., county, alpha order, specialty)				
2.	On-line query with print capabilities by provider type, specialty, location (zip code), ideally with map capability				
3.	On demand printing of directories by network, location, and provider type				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Network Administration Reporting Comments:</i>					
Provider Network Management for Indemnity Network:					
4.	History of provider enrollment and termination dates				
5.	Generate reports and supporting documentation on demand to support BORHP and SHBP in provider grievance hearings and appeal processes				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Provider Network Management for Indemnity Network Comments:</i>				

Provider Credentialling—Must Track for Indemnity Network:					
6.	Track any known periods of probation for providers in the indemnity network				
7.	E-mail capability of provider correspondence				
8.	Track dates of application and certification				
9.	Practice status of hospitals where provider has privileges				
10.	Activity tracking dates with user identification				
11.	Dates, places, and outcomes of medical training				
12.	Colleges and medical schools attended				
13.	Continuing medical education credits				
14.	Membership in professional societies				
15.	Malpractice coverage details				
16.	Lawsuit history				
17.	Details on negative actions of credentialling or certifying groups				
18.	Paraprofessionals in office and their function				
19.	Average number of hospital admits, consults, and census				
20.	Ancillary services in office (e.g., x-ray, certified lab, etc.)				
21.	Ownership in related ventures				
22.	Teaching appointments				
23.	Medical references				
24.	General description of practice				
25.	Accepting new patients (Y/N)				
26.	Office hours				
27.	Emergency coverage				
28.	Foreign language fluency				
29.	Appointment waiting time				
30.	Age/sex range limits on patients				
31.	Procedures performed in office				
32.	Track terminated providers and reason for termination				
33.	Track providers who have applied but have been denied a contract				
34.	Track provider applications and contracts by multiple sorting				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	options (e.g., by application date, recredentialing date, etc.)				
35	Track provider types (MD, DO, Ph.D., Masters)				
36	Integrate provider data with claims, provider profiling, etc.				
<i>Provider Credentialling Comments:</i>					
Eligibility and Enrollment:					
37	Ability to convert and replace current SHBP membership billing				

	System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	and accounting system (MEMS) for SHBP				
38	Ability to interface with the BORHP PeopleSoft system to accept eligibility				
39	Ability to generate plastic Health Benefit Plan Identification cards for SHBP and BORHP				
40	Ability to generate Health Benefit Plan Identification swipe cards for SHBP and BORHP				
41	Ability to generate HMO Notification of member action through e-mail or facsimile				
42	Accept web-enabled real time electronic enrollment				
43	Accepts and automatically processes real time electronic eligibility updates				
44	Performs duplicate checking and other system edits for member eligibility prior to allowing an add to the system				
45	Accepts employer provided ID number (nine position) or can assign a unique ID number for employee/subscriber and for dependents (standard sequencing/suffix codes)				
46	Maintains other insurance information				
47	Maintains historical enrollment data				
48	Maintains basic and customized member demographic information				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Eligibility and Enrollment Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Membership and Eligibility—Termination/Conversion:					
1.	Accept terminations for subscriber and dependent members or dependents only				
2.	Automatic generation of letters/e-mail to over age dependents and support automatic termination of dependents based on lack of response				
3.	Termination of dependents automatically when subscriber changes to individual coverage				
4.	Automatic termination of all subscribers and dependents when group contract is terminated				
5.	Allow retroactive terminations with appropriate financial controls				
6.	Can support an automated regularly scheduled COBRA eligibility update from Third Party Administrator				
7.	Supports automated compliance with HIPAA certification letter requirement				
8.	Retention of administrative and demographic data of terminated members and groups for seven years				
9.	Can support surviving spouse coverage and automatically links claims history				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Membership and Eligibility—Termination/Conversion Comments:</i>					
Membership and Eligibility—Reinstatement:					
10	Generate administrative fee billing adjustments for retroactive reinstatements				
11	Ability to reinstate members on an individual or group basis with no lapse in coverage				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Membership and Eligibility—Reinstatement Comments:</i>					
Membership and Eligibility Electronic Reporting:					
12	Generate enrollment reports to at least three levels of delineation (i.e., group, subgroup, product)				
13	Termination lists with reasons and summary totals				
14	New member lists with various breakdowns and summaries				
15	Transfers with totals and reasons				

	System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
16	Member month totals by month, including retroactivity				
17	Ability to generate monthly billings to employers				
18	Ability to generate monthly COBRA billings for SHBP (and BOR if requested)				
19	Ability to generate other self-pay billings				
20	Ability to create receivables record for each billing record generated				
21	Ability to generate personalized correspondence for events such as Loss of Dependent eligibility				
22	Ability to submit monthly enrollment files to the DSS vendor				
<i>Membership and Eligibility Electronic Reporting Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Membership Distribution and Analysis Reporting by:					
1.	Age				
2.	Location				
3.	Age/sex category				
4.	Group				
5.	Contract type/Plan type (i.e., PPO, Consumer Choice Option(s), indemnity, or HMO)				
6.	Coverage type				
7.	Age of account				
8.	SIC				
9.	Employee breakout (employee, employee +1, employee + family, etc.)				
<i>Membership Distribution and Analysis Reporting Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Administrative Expense Reports:					
10	Year-to-date monthly administrative fee charges and payments to three levels of delineation (i.e., group, subgroup, product/plan)				
11	Ability to itemize ad hoc expenses separately from PEPM administrative fees				
12	Report adjustments and other claims expense reconciliations separately from paid claims				
13	Ability to reconcile PEPM administrative fees paid against expected based on eligibility file records				
<i>Administrative Expense Report Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Claims System Utilization Controls:					
	System automatically supports customized medical management protocols, including length of stay tables and criteria:				
14	▪ By payer				
15	▪ By plan				
16	▪ By procedure (i.e., transplants)				
17	System automatically verifies member eligibility				
18	System automatically validates place of service				
19	System automatically verifies service appropriateness based on diagnosis, sex, age				
20	System automatically verifies assistant surgeon necessity				
21	System automatically verifies appropriateness for outpatient/office procedures				
22	System automatically verifies medical necessity protocols/algorithms				
23	System automatically verifies coverage based on procedure				
24	System automatically verifies diagnosis/procedure-specific LOS tables				
25	System provides automated support for care management standards varied by product				
26	System automatically verifies appropriateness of procedure based on diagnosis				
27	System automatically validates pre-certification authorization against submitted claims (define system edits)				
28	System automatically supports validation of provider licensure to perform services				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Claims System Utilization Controls Comments:</i>					
Preauthorization:					
	Identify services requiring preauthorization based on:				
29	▪ SHBP or BOR Plan design or product				
30	▪ Dollar amount of claim				
31	▪ Type of service				
32	▪ Diagnosis				
33	▪ Other				
34	▪ Provider status (par or non-par)				
35	▪ Procedure				
36	▪ Provider place of service				
37	▪ Age				
38	▪ Sex				
39	Electronic interface with third party utilization management firm for the acceptance of preadmission certifications (PAC records) and other services requiring authorization				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Preauthorization Comments:</i>					
Support Disease Management Initiatives:					
40.	Target high dollar and high incidence diseases and conditions by diagnosis, DRG, ICD-9, etc.				
41.	Electronically report all populated UB-92 or HCFA 1500 claims and provider data				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Support Disease Management Initiatives Comments:</i>					
Claims Interfaces:					
42	Ability to accept claims via electronic media (list interfaces in comments section below)				
43	Ability to accept claims via electronic interfaces with third party vendors (network managers and mental health vendors, etc.)				
44	All third party data entry and/or record retention (imaging,				

	System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
50.	Accept and process claims from super bill containing multiple services				
51.	System supports modifiers for HCPCS codes				
52.	System security to support “dollar step limit draft authority levels” for individual claims adjudicators				
53.	System security that supports the setting of processor dollar limitations as well as limitations by specific claim functions and benefit plans				
54.	Accept, retain, and use all five positions of ICD-9-CM or later versions whenever diagnostic coding is used				
55.	Accept and capture all data fields submitted via HCFA 1500, UB92, and ADA claim forms				
56.	Calculate, adjust claims, and track recovery of dollars, whether overpayment recovery is performed internally or under contract by a specialized third party				
57.	Execute payment claims; payment cycles weekly or biweekly as specified by BOR				
58.	Interface with State/BOR financial reporting system				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Claims Processing Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Claims Pricing:					
1.	Performs the automatic pricing and adjudication of claims using an RBRVS-based fee schedule				
2.	Performs the automatic pricing and adjudication of claims using a percent discount off charge discount arrangement				
3.	Performs the automatic pricing and adjudication of claims using a specific fee schedule				
4.	System automatically pays DRG reimbursement methodology based on client-assigned grouper				
5.	System edits identify duplicate DRG payments on the date of admission (e.g., to avoid duplicate payments for a patient who transferred within the same facility)				
6.	Performs pricing of each claim line item by incurred date				
7.	Claims unbundling software integrated into claims system and applied to all provider claims				
8.	Price claims with multiple items of service by line item				
9.	Ability to process a claim on a line-by-line basis				
10.	Ensure all dates are valid and reasonable (i.e., no futures dates are present)				
11.	Ensure that all items that can be obtained by arithmetic manipulation of other data items agree with the results of the manipulation (cross footing and totals)				
12.	Ensure all coded data items (procedure, diagnosis, place, type, units, modifier) consist of valid codes				
13.	Provide data to actuarial contractor for rate analysis as specified by the SHBP/BOR				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Claims Pricing Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Automatically Calculate and Compare:					
1.	System automatically verifies all mandatory data items are present and accurate				
2.	System automatically verifies the services requiring prior authorization; system automatically matches services to the appropriate authorization				
<i>Automatic Calculation/Comparison Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Deductible and Benefit Limits:					
3.	Initialize deductible and benefit limit counts when new contracts become effective				
4.	Support carry-over of deductibles from prior coverage				
5.	Track hospital day benefit limits separately by bed type/service				
6.	Allow override to benefit limits during claim adjudication with appropriate audit trail tracking				
7.	Allow benefit limits to be adjusted online as an exception with appropriate audit trail tracking reporting				
8.	Accumulate out-of-pocket amounts, benefit limits, and deductibles for a member or family in aggregate or individually by benefit classification				
9.	Differentiate PPO/non-PPO accumulators on a contract year and lifetime basis				
10.	Automatic handling of copays, application of deductibles, and percentage reductions per line item				
11.	Accumulation of lifetime maximum amounts on an individual member basis				
12.	Exclude specified service types from accumulation of deductibles, stop loss, and lifetime maximums				
13.	Supports multiple deductibles (general vs. hospital admission; in-network versus out-of-network)				
14.	Supports selective benefits towards a deductible or other form of cost share				
15.	Supports selective benefits towards the out-of-pocket maximum				
16.	Support a deductible carry-over concept				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
1.	Load 2003 and 2004 coinsurance, copayment, out-of-pocket maximums, and lifetime maximum accumulations from current TPA				
2.	Automatically adjudicate claims based on load of 2000 and 2001 accumulators from current TPA				
<i>Deductible and Benefit Limit Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Subrogation, Workers Compensation, and COB Cases:					
1.	Automatically process primary and secondary benefits for member with dual coverage with same or other employer				
Subrogation, Workers Compensation, and COB Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Miscellaneous Functions—Interfaces with UM Vendor:					
2.	Supports standards for exchanging eligibility data electronically with UM vendors at a minimum on a batch basis				
3.	Supports standards for exchanging authorizations data with UM vendors at a minimum on a batch basis				
4.	Supports standards for exchanging claims data with UM vendors on a batch basis (for profiling purposes)				
<i>Miscellaneous Functions—Interfaces with UM Vendor Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Utilization Management Reporting:					
	Ability to track and report services provided by BOR's dental indemnity program with BCBSGA				
5.	All utilization measures severity indexed by:				
6.	▪ Diagnoses				
7.	▪ Comorbidities				
8.	▪ Age				
9.	▪ Sex				
Utilization Management Reporting Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Customer Service Systems:					
1.	Electronic communications and tracking log providing access to third party vendors to interface with claims administrator				
	ACD telephone system that provides both management and client reporting of telephone statistics and department performance. These statistics should include:				
2.	▪ Telephone volumes by client				
3.	▪ Telephone volumes by specific time period				
4.	▪ Telephone volumes by CSR				
5.	▪ Average wait time				
6.	▪ Abandonment rate				
7.	▪ Average speed of answer				
8.	▪ Average length of call				
9.	▪ Busy out rate				
10.	Ability to off-load calls to trained staff during high volume call periods				
11.	Ability to identify percent of “first call resolution” and those requiring research and to track and report this information to client				
12.	Dedicated customer service unit to support client telephone inquiries/dedicated toll-free separate telephone lines for SHBP, SHBP Retirees, and BORHP				
13.	Tracking system to record and report all telephone calls received for client and to identify the reason for the call, the resolution of the call, and any call-back or follow-up actions required				
14.	Produce daily, weekly, and annual tracking and analysis reports				

	Ability to report statistics by Customer Service Representative (CSR) by:				
15	▪ Time in available				
16	▪ Time in unavailable				
17	▪ Average talk time				
18	▪ Number of calls taken				
19	Automated call routing				
20	An interactive voice response function to assist callers in accessing the appropriate department/services. (Note that the BOR will continue to have live individuals available to assist members at all of its vendors.)				
21	Toll free lines available statewide/nationwide				
22	Ability to record and store all customer service calls for up to 60 days with ready accessibility to records				
23	Online supervisory call monitoring				
24	Online real-time system monitoring by plans in-house				
25	Automatically track and report at least daily performance against expected contractual performance standards (percent calls answered in 30 seconds, abandonment rate, busy-out rate, first call resolution)				
26	Ability to immediately post and change recorded messages in the VRU system				
27	Provide a telephony system that is capable of taping conversations between service reps and members with the ability to send .WAV files to the DCH/BOR for review if requested.				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Customer Service Systems Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Correspondence:					
28	Automatic generation of correspondence/e-mail based on events or time passage				
29	Library of form letters/e-mails integrated with database				
<i>Correspondence Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Customer Service/Grievance Reports:					
30	Complaints by user-defined criteria				
	Performance measure reporting by:				
31	▪ Average days to resolution				
32	▪ Complaints resolved prior to grievance				
33	▪ Number of complaints resolved in first contact				
34	▪ Open complaint report				
35	▪ Complaints by provider and reason				
Customer Service/Grievance Report Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Customer Service/Grievance:					
1.	Contact logging and documentation system				
2.	Tracking of issue resolution				
3.	Flag system for follow up				
4.	Online inquiry to enrollment files				
	Manage resolution of claims, utilization management, management, provider, and member issues, including:				
5.	▪ Provider claims status questions				
6.	▪ Member and/or provider benefit plan questions				
7.	▪ Provider administrative requirements questions				
Customer Service/Grievance Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
System Maintenance:					
1.	Ability to add and delete users				
2.	Ability to modify security access levels on individual users				
3.	Ability to assign passwords				
4.	Ability to add printers and other hardware to the network				
5.	Ability to load new tables such as fee schedules or rates (i.e., updated CPT-4 codes)				
6.	Ability to add new codes to an existing field				
7.	Ability to modify field edits				
8.	Ability to modify standard notice text				
9.	Ability to modify variable notice text				
10.	Ability to modify an existing report				
11.	Ability to support ongoing system maintenance				
System Maintenance Comments:					

FUNCTIONAL CAPABILITIES				
Provider Compliance and Status				
Tracking Indicators for Indemnity Network:				
12	Malpractice coverage			
13	Submission of references			
14	Sanctions and history			
15	QA review standards			
16	Accessibility criteria			
17	Training standards			
18	Professional affiliations			
19	Hospital and outpatient affiliations and privileges			
20	Professional coverage requirements			
21	Board and other certifications			
22	Practice requirements			
23	User-defined pass/fail criteria			
24	Provider compliance to administrative and utilization management requirements			
<i>Provider Compliance and Status Tracking Indicator Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Eligibility and Enrollment:					
25	Maintains separate address for subscribers and each dependent				
26	Records free form comments or remarks				
27	System has the ability to match or reconcile number of employee contracts in the vendor system to the originating eligibility systems of record (PeopleSoft/MEMS replacement)				
<i>Eligibility and Enrollment Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing:					
1.	Ability to enter information such as temporary address changes at claims entry				
2.	Automatically distribute work to processors based on security and/or proficiency levels				
3.	Automatically retrieve pended/suspended claims for processing after corrections				
4.	System has built-in controls for processing claims in batches				
5.	System automatically applies age and sex edits based on claim and enrollment data				
6.	Stores system descriptions, full and abbreviated, of all procedure codes				
<i>Claims Processing Comment</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Automatically Calculate and Compare:					
11	Appropriate fee level				
12	Amount allowed				
13	Amount not covered				
14	Applicable co-payment				
15	Applicable deductible amount				
16	Facility (DRG, percent off charges) discount amount				
17	Applicable stop-loss amount				
18	Net amount to be paid				
19	Applicable coinsurance amount				
<i>Automatic Calculation/Comparison Comments:</i>					

Deductible and Benefit Limits:					
20.	Support the concept of a deductible per admission or per occurrence, with or without associated maximums				
21.	Support copays for a given number of services, with subsequent services of the same type having a percentage reduction in payment amount applied				
22.	Automatic application of annual lifetime maximum restoration amount				
23.	Permit a waiver on deductibles for certain common accidents				
<i>Deductible and Benefit Limit Comments:</i>					
Quick Access Support:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
	Real-time access to the following data without losing claims information already entered:				
24.	▪ Eligibility data				
25.	▪ Contract data				
26.	▪ Benefits data				
27.	▪ Claims history				
28.	▪ PCP history				
29.	▪ Diagnosis information				
30.	▪ Procedure information				
31.	▪ Provider files				
	Allow the ability to access by:				
1.	▪ Audit control number				
2.	▪ Dependent number				
3.	▪ Provider number				
4.	▪ Subscriber number. Note that Georgia Code may change and require that the subscriber number be different from the SSN. If this occurs, the system must be able to track subscriber ID and dependent/spouse ID back to the subscriber/spouse/dependent SSN.				
5.	▪ Dependent SSN				
6.	▪ Subscriber SSN				
7.	▪ Check number				
8.	▪ Provider name				
9.	▪ Processor				
10.	▪ Subscriber name				

	Ability to delimit claims search by:				
1.	▪ Defining claim type				
2.	▪ Defining date ranges				
3.	▪ By member only or entire family				
4.	▪ Capture, store, and edit for limit value				
	Use of “ENCODER” software to support translation to appropriate code, and maintain reference files for:				
1.	▪ CPT				
2.	▪ ADA				
3.	▪ NDC				
4.	▪ UB 82/92				
5.	▪ HCPCS				
6.	▪ ICD-9				
7.	▪ ICD-10				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Quick Access Support Comments:</i>				

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Subrogation, Workers Compensation, and COB Cases:					
1.	Automatically check every claim to identify cost avoidance or post-payment recovery procedures				
2.	Produce necessary reports and notifications				
3.	Prompt the processor to indicate whether the claim is accident related and track date of injury				
4.	Where COB amount is known, adjust claim amount appropriately				
5.	Automatically process dual Medicare coverage				
6.	Automatically verify that each claim is checked against all current and previously processed claims for which duplicate payment could exist as both an exact duplicate or suspected duplicate				
Subrogation, Workers Compensation, and COB Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Query Functionality:					
7.	Alpha diagnoses/procedures look-up				
8.	Code finder look-up of procedures/diagnosis				
9.	Diagnosis/procedure code conversion				
10.	Hot key/fast transfer to other applications				
11.	Pend for medical review/print review worksheet				
12.	Track progress of multiple levels of approval				
13.	Authorization number				
14.	Referring provider				
15.	Member number/name/SSN/ID number				
16.	Subscriber name/ID/SSN				
17.	Date authorized				
18.	Referred-to provider				
19.	Facility				
20.	Diagnosis				
21.	Procedure				
Query Functionality Comments:					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
<i>Miscellaneous Functions—Interfaces with UM Vendor:</i>					
22	Supports standards for exchanging eligibility data electronically with UM vendors on an interactive basis				
23	Supports standards for exchanging authorizations data electronically with UM vendors on an interactive basis				
<i>Miscellaneous Functions—Interfaces with UM Vendor Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Utilization Management Reporting:					
24.	In addition to the specific reports and measures listed below, the general ability through ad hoc reporting tools to report on any element from the medical claims database				
<i>Utilization Management Reporting Comments:</i>					

System Requirement		Current System Capability	Future System Capability	Manual Process	No Capability
Customer Service Systems:					
25	Scheduler ability allowing identification of high/low volume periods of time				
	Online documentation and tracking of all calls received from providers and members including, at a minimum:				
26	▪ Name				
27	▪ Receipt date				
28	▪ Type				
29	▪ Response action				
30	▪ Response date				
31	Ability to record and store all customer service calls for up to two years, with ready accessibility to records				
32	Ability for offsite monitoring of the system				
33	Automatically track and report at least daily performance against expected contractual performance standards (percent calls answered in 30 seconds, abandonment rate, busy-out rate, first call resolution)				
34	Ability to increase incoming call capacity if needed within 24 hours or less				
35	Voicemail for CSRs/Electronic Mail for CSRs				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Customer Service Systems Comments:</i>				
Correspondence:				
36. General text editing online				
37. Full word processing integrated with database				
38. Automatic download of subscriber and member addresses into document				
39. Track the status of incoming member correspondence on the same file as telephone and other inquiries				
40. Complaint/communication type code assignment				
41. Form letters with modification capability				

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Correspondence Comments:</i>				
Customer Service/Grievance:				
42	Standardized coding and menus to capture problems, actions, and notes			
43	Auto-generated correspondence based upon problem and action			

System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
<i>Customer Service/Grievance Comments:</i>				