Appendix 50, Attachment C, Exhibit 1: Addendum State Requirements Matrix

July 7, 2008

Table Legend:

- **(A)** System capability is in the Baseline System or COTS and configuration is required via manual table updates to meet proposed solution (Y/N)*
- **(B)** System capability is in the Baseline System or COTS and software modification is required to meet proposed solution (Y/N)*
- **(C)** System capability is not in the Baseline System and requires new functionality via software modification to meet proposed solution (Y/N)
- **(D)** Enter the Proposal Section (A–L) that reflects the fulfillment of the Section 40 of this RFP requirement and page number(s).
- **(E)** Will meet requirement (Y/N)

* If both A and B above apply, indicate Yes (Y) in each column.
** Non-Medicaid only

40.1 General Requirements

40.1.1 General System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Multi-Payer Requirements					
40.1.1.1	Provides capability in a Replacement MMIS for a single system process to coordinate recipient benefits among the DMA (including Title XIX and Title XXI), DMH, DPH, Migrant					

Requirement #	Requirement Description	A	B	C	D	E
	Health Program in the Office of Rural Health and Community Care (ORHCC), and to ensure the proper assignment of the financially responsible payer, benefit plan, and pricing methodology for each service tendered in a claim					

40.1.2 General Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Regulatory Compliance					
40.1.2.12	Fiscal Agent (DDI and Operations Phases) shall ensure that the Replacement MMIS incorporates compliance with appropriate Federal and State regulations, statutes, and policies concerning the protection of personally identifiable information and/or financial information. Regulations, statutes, and policies include, without limitation: • 45 CFR Parts 160, 164 (Health Insurance Portability and Accountability Act) • 42 U.S.C. 1320(d) (Public Health, Approval of Special Projects) • 42 CFR Parts 2, 51, 431 (Confidentiality of Mental Health and Substance Abuse information) • 42 CFR Parts 430-502 (Applicable to Medicare/Medicaid) • 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act. • Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. • Title XIX, Section 1903 (42 U.S.C. 1396b) Social Security: Payment to States • Title XIX, Section 1927 (42 U.S.C. 1396r-8) Social Security: Payment for covered outpatient drugs • Omnibus Budget Reconciliation Act of 1990 (OBRA'90) • Federal MMIS certification standards • Financial Accounting Standards Board Generally Accepted Accounting Principles					

Requirement #	Requirement Description	A	B	C	D	E
	(GAAP) • Part 11 of the State Medicaid Manual • North Carolina State Plans for Medicaid, Mental Health, Developmental Disabilities, and Substance Abuse, and Public Health • US DHHS Title VI Language Access Policy • Recipient eligibility policies from the NC DHHS Eligibility Information System (EIS) and the Common Name Data Service (CNDS) • NC State Law S 1048 (Identity Theft Protection Act) • 10A NCAC Chapters 21 & 22, Medical Assistance • 10A NCAC 26B (Confidentiality Rules For Mental Health, Developmental Disabilities, and Substance Abuse Services) • 10A NCAC Chapter 45, DPH Payment Programs • NC DHHS OSP. 2005. DHHS Application Security Policy. • NC OSCIO. 2004. Application Security Policy with Guidelines, Statewide Information Technology Policy. • N.C.G.S. §126: State Personnel System • N.C.G.S. § 131D: Inspection and Licensing of Facilities • N.C.G.S. §131E: Health Care Facilities and Services • N.C.G.S. § 132: Public Records • The Privacy Act of 1974 5 U.S.C. § 552a • NCAC 10A Chapter 13 - NC Medical Care Commission • NCAC 10 A Chapter 14 - Division of Facility Services • NCAC 10A Chapter 26 - Mental Health, General • NCAC 10A Chapter 27 - Mental Health, Community Facility and Services • NCAC 10A Chapter 28 - Mental Health, State Operated Facilities • Government Auditing Standards (http://www.gao.gov/govaud/yb2003.pdf) • Information Systems Audit Standards (http://www.isaca.org/stand1.htm). • NC DHHS Privacy and Security policies • Title XXI of the Social Security Act					

Requirement #	Requirement Description	A	B	C	D	E
	• Applicable State Law (currently, GS 108A-70.20 [NCHC]) • DHHS Cash Management Plan (http://www.ncdhhs.gov/control/index.htm) • Federal Section 508 (http://www.section508.gov)					
	Data Transfer and Conversion					
40.1.2.19	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, the Migrant Health Program in the ORHCC, and NC Health Choice (NCHC)					
40.1.2.20	Fiscal Agent (Operations Phase) shall convert all legacy data from DMA, DMH, DPH, the Migrant Health Program in the ORHCC, and NC Health Choice (NCHC) to maintain benefit plans and data relationships in a multi-payer environment					

40.2 Recipient Requirements

40.2.1 Recipient System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.2.1.124 **(New)**	Provides capability to produce NCHC original and replacement recipient identification cards					
40.2.1.125 **(New)**	Provides capability to produce NCHC original and replacement recipient benefit booklets					

40.2.2 Recipient Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.2.2.9 **(New)**	Fiscal Agent shall respond to recipients by telephone and/or in writing to issues or questions related to premium payment and cost sharing					
40.2.2.10 **(New)**	Fiscal Agent shall address and respond to all NCHC recipient inquiries about claims payment, prior approval and any other questions except those regarding eligibility					
40.2.2.11 **(New)**	Fiscal Agent shall respond to requests to issue replacement recipient benefit booklets for NCHC recipients					
40.2.2.12 **(New)**	Fiscal Agent shall respond to requests to issue replacement recipient identification cards for NCHC recipients					

40.3 Eligibility Verification System Requirements

40.3.1 EVS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.3.1.8	Provides capability to issue a reference number to a provider for Medicaid and/or NCHC eligibility inquiry and responses issued from the EVS					

40.4 Automated Voice Response System Requirements

40.4.1 AVRS System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.4.1.12	Provides capability to process inquiries made by Medicaid and NCHC recipients entering the recipient's ID number, DOB, and SSN					
40.4.1.22	Provides capability for call flows for the following provider inquiry types: • Claim status • Checkwrite • Drug coverage • Procedure code pricing • Modifier verification • Procedure code and modifier combination • Procedure code pricing for Medicaid Community Alternatives Program services • Prior approval for procedure code • Medicaid and NCHC dental benefit limitations • Medicaid and NCHC refraction and eyeglass benefits • Medicaid and NCHC prior approval for durable medical equipment (DME), orthotics, and prosthetics • Prior Approval for DPH benefits • Recipient eligibility, enrollment, cost sharing and Medicaid and NCHC service limits • Sterilization consent and hysterectomy statement inquiry • Referrals • Medicaid and NCHC Carolina ACCESS Emergency Authorization Overrides					
40.4.1.24	Provides capability for call flows for responses for the following Medicaid recipient inquiry					

Requirement #	Requirement Description	A	B	C	D	E
	types: • Medicaid eligibility • Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers • Third party liability • Medicare coverage • Well child checkup dates • Hospice eligibility • Cost sharing, such as premium payments, deductibles, co-payments, and balances					
40.4.1.26	Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the AVRS					
40.4.1.38 **(New)**	Provides capability to support call flows for responses for the following NCHC recipient inquiry types: • NCHC eligibility • Managed care enrollment information, including the primary care provider name, address, and daytime and after-hours phone numbers • Third Party Liability • Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds					
	Web Inquiry					
40.4.1.29	Provides capability to return a reference number to a provider for DMA/Medicaid and NCHC eligibility verification inquiry and responses issued from the Web					
40.4.1.39	Provides capability for NC Health Choice recipient access to recipient eligibility and enrollment information, including but not limited to:					

Requirement #	Requirement Description	A	B	C	D	E
(New)	• NCHC eligibility • Managed care enrollment information to include the primary care provider name, address, and daytime and after-hours phone numbers • Third Party Liability • Cost sharing, such as premium payments, co-payments, deductibles and deductible balances and out-of-pocket thresholds					

40.6 Reference Requirements

40.6.1 Reference System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.6.1.23	Provides capability for a procedure code data set that contains the current five-character (5-character) HCPCS/CPT code and can accommodate the future six-character (6-character) HCPCS codes, second-level HCPCS codes, State-specific local Level III codes, ICD-9 procedure codes, NCHC-specific service codes, and can accommodate the future ICD-10 procedure codes, and acceptance of a one-character (1-character) or a two-character (2-character) field for HCPCS pricing modifier(s); and at a minimum, the following elements: • Valid tooth surface codes and tooth number/quadrant designation • Date-specific pricing segments by program code, provider taxonomy, and/or provider type and or specialty • Five (5) date-specific pricing segments, including two (2) occurrences of pricing action • Five (5) status code segments with effective beginning and end dates for each segment					

Requirement #	Requirement Description	A	B	C	D	E

	• Indicator of covered/not-covered and effective and end dates by program code
	• Allowed amount for each pricing segment
	• Multiple modifiers and the percentage of the allowed price applicable to each modifier or procedure code/modifier combination
	• State-specified restrictions on conditions to be met for a claim to be paid, including, but not limited to:
	  ○ Recipient eligibility
	  ○ Pricing Action Code
	  ○ Category of service
	  ○ Specialty
	  ○ Lab certification
	  ○ Recipient age/sex restrictions
	  ○ Allowed diagnosis codes
	  ○ Prior approval required
	  ○ Medical review required
	  ○ Place of service
	  ○ Pre- and post-operative days
	  ○ Appropriate diagnosis
	  ○ Acceptable place of service
	  ○ Units of service
	  ○ Once-in-a-lifetime indicator
	  ○ Attachments required
	  ○ Valid provider type/specialty
	  ○ NDC codes and units
	  ○ Claim type
	  ○ Purge criteria
	  ○ Provider subspecialty
	  ○ Drug Coverage (effective/term dates)
	  ○ Health Check reporting indicator
	  ○ Family Planning indicator					

Requirement #	Requirement Description	A	B	C	D	E
	○ Family Planning Waiver Indicator • Narrative language of procedure codes in both short and long description • Indication of when or whether claims for the procedure can be archived from online history (such as once-in-a-lifetime procedures) • Indication of TPL actions, such as cost avoidance, benefit recovery, or pay and chase by procedure code • Indication of third party payers, non-coverage by managed care organizations by managed care organization type • Other information, such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, and Medicare coverage indicator					
40.6.1.43	Provides capability to apply State-approved policy to: • HCPCS, including CPT, American Dental Association (ADA) codes, HCPCS Level II codes, NDCs, State local codes, International Classification of Diseases diagnosis and procedure codes (ICD-9) and future ICD codes • Drug codes • Edits • Rate methodology and calculations • Professional services fees • NCHC-specific services					
40.6.1.89	Provides capability to create Fee Schedule reports detailed in the bullets below: • Adult Care Home Personal Care • Ambulance • Ambulatory Surgical Centers/Birthing Centers • Behavioral Health (separate schedules) • Certified Clinical Supervisor and Addictions Specialist • Children's Developmental Service Agencies • Licensed Clinical Social Worker and Licensed Professional Counselor and Licensed Marriage and Family Therapist					

Requirement #	Requirement Description	A	B	C	D	E
	• Licensed Psychological Associate • Mental Health Enhanced Services • Mental Health (LME) • Mental Health Non-Licensed Clinical Fee Schedule • Nurse Practitioner • Nurse Specialist • Prospective Rates • Psychologist • Residential Treatment Level III and IV • Community Alternatives Program (CAP) Rates (separate rates) • CAP/AIDS • CAP/Children • CAP/DA • CAP/Mentally Retarded-Development Disability (MR-DD) • DRG Weight Table • Dental Services • Durable Medical Equipment • Federally Qualified Health Center • Home Health Agency Services • Home Infusion Therapy • Hospice • Local Education Agency Practitioners • Local Health Department • Multi-specialty Independent Practitioner • Nursing Facility Rates • Occupational Therapy • Orthotics and Prosthetics • Physical Therapy					

Requirement #	Requirement Description	A	B	C	D	E
	• Physician Drug Program • Respiratory Therapy • Rural Health Center • Speech and Audiology Services • NCHC services					
40.6.1.94 **(New)**	Provides capability to create NC Title XXI Tables Manual and edit resolution documents					
40.6.1.95 **(New)**	Provides capability to indicate whether pricing is performed on the revenue code or the NCHC-specific service when a combination of the two is billed					

40.7 Prior Approval Requirements

40.7.1 Prior Approval System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Pre-Admission Certification					
40.7.1.68** **(New)**	Provides capability to capture pre-admission certification and length-of-stay recommendations by the pre-certification reviewer					
40.7.1.69** **(New)**	Provides capability to process claims based on pre-admission and length-of-stay recommendations					

40.7.2 Prior Approval Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Pharmacy Benefits Management					
40.7.2.25	Fiscal Agent shall prepare and present to the State and the DUR Board the *Annual Report,* in accordance with SSA 1927 (g)(3)(D), that includes the required information, charts and statistics pertaining to the Drug Use Review Program in the media and timing as directed by the State					
40.7.2.26	Fiscal Agent shall assure functionality of the Pharmacy Point-of-Sale Business Area, including both PRO-DUR and Retrospective DUR Program Activities, is in compliance with State policy at all times					
40.7.2.30	The Fiscal Agent shall assure that targeted interventions / communications and education of providers occur through its performance of Retro-DUR activities, as directed by the State and in accordance with Federal Regulations Subpart K, 42CFR (456.700-456.725), Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), and Social Security Act Section 1927 (g)					
40.7.2.35	Fiscal Agent shall conduct targeted provider interventions/communications using claims data findings, such as aberrant drug patterns, and provide supporting educational references/materials and activities reports (e.g., number of claims reviewed, number of exception profiles generated per recipient) as approved by the State					
40.7.2.43 **(New)**	The Fiscal Agent shall develop criteria for DUR activities using predetermined standards in accordance with Federal Regulations Subpart K, 42CFR (456.700-456.725), Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), Social Security Act Section 1927 (g) and existing evidence-based materials that conform to CMS, national and local standards					

Requirement #	Requirement Description	A	B	C	D	E
40.7.2.44 **(New)**	The Fiscal Agent shall develop criteria for DUR activities, including using therapeutic criteria from other DMA initiatives, as directed by the State					
40.7.2.45 **(New)**	The Fiscal Agent shall, upon approval by the State, poll other states for alternative practices to resolve DUR Board- or State-identified issues					
40.7.2.46 **(New)**	Fiscal Agent shall identify providers who are candidates for interventions based on standards pre-defined and approved by the State					
40.7.2.47 **(New)**	Fiscal Agent shall track all provider communications such as letters, telephone calls, and/or face to face meetings from targeted interventions					
40.7.2.48** **(New)**	Fiscal Agent shall perform expedited reviews of a denied prior approval or claim when requested during an appeal					
40.7.2.49** **(New)**	Fiscal Agent shall perform retrospective reviews of services provided without required prior approval and determine if prior approval should be authorized retroactively					
	Pre-Admission Certification					
40.7.2.50** **(New)**	Fiscal Agent shall perform pre-admission certifications (medical necessity) and length-of-stay approvals (based on industry guidelines) for NCHC recipients prior to hospital inpatient admissions					

40.7.3 Prior Approval Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.7.3.11	~~Fiscal Agent shall meet monthly with DUR, the State and/or Retrospective DUR vendors and Community Care Program and include minutes in bi-weekly Project Status Report~~					
40.7.3.14 **(New)**	Fiscal Agent shall deliver all meeting minutes to the State within five (5) business days following each meeting					
40.7.3.15 **(New)**	Fiscal Agent shall provide DUR Board agenda and meeting materials to the State no less than twenty (20) State business days prior to the scheduled quarterly meeting					

40.8 Claims Processing Requirements

40.8.1 Claims Processing System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Claim Acquisition					
40.8.1.25	Provides capability to override service limitations for Early Periodic Screening, Diagnosis, and Treatment- (EPSDT-) and NCHC Special Needs Services Plan-eligible recipients					
40.8.1.384	Provides capability to reimburse NCHC recipients for eligible out of pocket claims payment					

Requirement #	Requirement Description	A	B	C	D	E
(New)						
40.8.1.385 **(New)**	Provides capability to process claims filed by NCHC recipients					
40.8.1.386 **(New)**	Provides capability to apply service limitations across multiple health care programs and benefit plans as applicable					
	Pharmacy Point of Sale					
40.8.1.61	Provides capability to support both Prospective DUR and Retrospective DUR programs to assure that functionality of the Pharmacy Point-of-Sale Business Area is compliant with State policy at all times					
40.8.1.62	Provides capability to process all pharmacy claims in POS/PRO-DUR, applying edits/audits/overrides, informational alerts, and intervention/conflict/outcomes codes, compliant with State policy at all times					
	Retrospective Drug Utilization Review					
Requirement Deleted 40.8.1.200	~~Provides capability to generate a file of paid drug claims to the Retrospective DUR Vendor~~					
Requirement Deleted 40.8.1.201	~~Provides capability to generate a file of physician, clinic, hospital, and pharmacy provider data to the Retrospective DUR Vendor~~					

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.8.1.202	~~Provides capability to generate a file of recipient data to the Retrospective DUR Vendor~~					
40.8.1.203	Provides capability to generate the *Annual Report* in accordance with SSA 1927 (g)(3)(D), that includes the required information, charts and statistics pertaining to the Drug Use Review Program in the media and timing as directed by the State					
40.8.1.387 **(New)**	Provides capability to generate ad hoc reports and scheduled reports for recipient and provider profilings and provider report cards					
40.8.1.388 **(New)**	Provides capability to apply DUR Board recommendations such as edits/audits, limitations, and informational alerts to the POS claims processing system upon approval by the State					

40.8.2 Claims Processing Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
	Drug Utilization Review					
Requirement Deleted 40.8.2.39	~~Fiscal Agent shall produce information to support the State in completing the CMS Annual Utilization Review Report~~					
40.8.2.40	Fiscal Agent shall prepare State-approved agendas, associated meeting materials and minutes for the DUR Board quarterly meetings					

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.8.2.41	~~Fiscal Agent shall submit quarterly extract files to the DUR vendor within five (5) State business days of the month following the quarter's end~~					
40.8.2.57 **(New)**	Fiscal Agent shall attend quarterly DUR Board meetings					
40.8.2.58 **(New)**	Fiscal Agent shall apply DUR Board recommendations such as edits/audits, limitations, and informational alerts to the POS claims processing system upon approval by the State					
40.8.2.59 **(New)**	Fiscal Agent shall provide the State with DUR Programs Project Status Reports on a biweekly basis					
40.8.2.60 **(New)**	Fiscal Agent shall attend monthly meetings with the State and additional on-site meetings as requested by the State					
40.8.2.61 **(New)**	Fiscal Agent shall prepare the agenda and minutes for its monthly meetings with the State					
40.8.2.62 **(New)**	Fiscal Agent shall be available to the State for DUR-related consultation during normal business hours					

40.8.3 Claims Processing Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.8.3.15	~~Fiscal Agent shall provide specified quarterly files to the DUR vendor within five (5) State business days of the start of the month following the quarter's end~~					

40.9 Managed Care Requirements

40.9.1 Managed Care System Requirements

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.9.1.20	~~Provides capability to create an extract file containing North Carolina Health Choice recipients linked with a provider/administrative entity and send to the North Carolina State Health Plan by the third business day of each month~~					

40.9.3 Managed Care Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
Requirement Deleted 40.9.3.11	~~Fiscal Agent shall send the Health Choice file to the North Carolina State Health Plan by the third business day of each month~~					

40.12 Drug Rebate Requirements

40.12.1 Drug Rebate System Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.1.3	Provides capability to validate units of measure from CMS and/or State drug rebate data file to Replacement MMIS drug file for consistency and reporting on exceptions					
40.12.1.14	Provides capability to maintain and retrieve drug rebate invoice and payment data indefinitely, including CMS drug data, State Drug rebate data, claim data, and operational comments					
40.12.1.20	Provides capability for unit conversion of units paid per claim to CMS/State units billed and CMS/State units billed to units paid per claim					
40.12.1.21	Provides capability to maintain units paid (as used to calculate claims pricing) and CMS/State units billed for drug rebate on Claims History					
40.12.1.29	Provides capability to make available to the State the total expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); provides capability to include mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur, by drug rebate program					
40.12.1.71**	Provides capability to capture State determined drug unit rebate amount and units of measure by drug rebate program					
40.12.1.72**	Provides capability to build and maintain the State's Drug Rebate Labeler Data					

40.12.2 Drug Rebate Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.12.2.2	Fiscal Agent shall make available to the State the total expenditures for multiple source drugs (annually) as well as other drugs (every three [3] years); the record keeping for this requirement shall include data such as mathematical or statistical computations, comparisons, and any other pertinent records to support pricing changes as they occur by drug rebate program					
40.12.2.21**	Fiscal Agent shall attend Drug Rebate Labeler Dispute meetings as required by the State					

40.12.3 Drug Rebate Operational Performance Standards

Requirement #	Requirement Description	A	B	C	D	E
40.12.3.2	Fiscal Agent shall make available to the State the total expenditures for multiple source drugs (annually) as well as other drugs (every three years) accurately and consistently ninety-nine and nine tenths (99.9) percent of the time, by drug rebate program					
40.12.3.14	Fiscal Agent shall create and forward quarterly invoices for each labeler that has a rebate agreement signed with CMS or the State, as division appropriate, and for Medicaid within five (5) State business days from receipt of CMS tape					

40.14 Financial Management and Accounting Requirements

40.14.1 Financial Management and Accounting System Requirements

Requirement #	Requirement Description	A	B	C	D	E
	MMIS Accounts Receivable Process					
40.14.1.53	Provides capability to produce and send correspondence related to recipient premiums in the recipient's preferred language					
40.14.1.55	Provides capability for refund functionality based on generally accepted accounting principles with documented internal controls that ensure timely, complete and accurate processing and payment of refunds and adjustments of recipient premium payments					
40.14.1.56	Provides capability to process financial accounting records for recipient premiums, including payments, refunds and adjustments, for retroactive, current, and future months					
40.14.1.57	Provides capability to produce reports for recipient premiums, including payments, refunds, adjustments and cost sharing (e.g., recipient co-insurance, deductibles, co-payments, etc.) processes					
40.14.1.59	Provides capability to ensure that the total annual aggregate cost sharing, including fees, for all children in a family receiving NCXIX or NCHC benefits shall not exceed a specified threshold of the family's income for the benefit year					
	Premium Payment and Collection (New)					
40.14.1.96 **(New)**	Provides capability to process recipient premiums, including payments, refunds, adjustments, collection, tracking, imaging, recording and reconciliation, in accordance with GAAP, via system financial management and accounting functions with online					

Requirement #	Requirement Description	A	B	C	D	E
	update and inquiry capability					
40.14.1.97 **(New)**	Provides capability for automated calculation of recipient premiums on a sliding scale					
40.14.1.98 **(New)**	Provides capability for online display of recipient premium payment history to include all payments, refunds and adjustments					
40.14.1.99 **(New)**	Provides capability for online display of recipient cost-sharing data such as premiums, deductible, co-pays, etc.					
40.14.1.100 **(New)**	Provides capability for determining and tracking premium due dates					
40.14.1.101 **(New)**	Provides capability for issuance of recipient premium notices, including invoices, notices of non-payment, cancellation notices, receipts, refunds and adjustments within the specified time frame for each recipient					
40.14.1.102 **(New)**	Provides capability for accounts payable functionality to track and age all unpaid refunds					
40.14.1.103 **(New)**	Provides capability to generate notification of premium payment status to the Eligibility Information System (EIS) in near real time					
40.14.1.104	Provides capability to pay the cost for dependent coverage provided under a private insurance for NCHC recipients who are eligible under State-defined criteria					

Requirement #	Requirement Description	A	B	C	D	E
(New)						
40.14.1.105 **(New)**	Provides capability to subtract recipient premiums, co-payments and other cost-sharing fees from the service cost prior to collecting FFP					
40.14.1.106 **(New)**	Provides capability for actuarial determination of premiums for recipients who purchase coverage in State health programs					

40.14.2 Financial Management and Accounting Operational Requirements

Requirement #	Requirement Description	A	B	C	D	E
40.14.2.33	Fiscal Agent shall produce refunds and adjustments of recipient premiums					
40.14.2.72 **(New)**	Fiscal Agent shall establish operational accounting procedures for recipient premiums, in accordance with GAAP, including payments, refunds, adjustments, collection, processing, tracking, imaging, recording and reconciliation					
40.14.2.73 **(New)**	Fiscal Agent shall accept and post recipient payments and issue refunds and adjustments for retroactive, current and future months					
40.14.2.74 **(New)**	Fiscal Agent shall process and track all recipient premiums, including payments, refunds and adjustments and reconcile to the monthly bank statements to ensure a complete accounting and disposition of all financial transactions					
40.14.2.75	Fiscal Agent shall ensure that all refunds returned as undeliverable are properly tracked as unpaid and that the financial data is adjusted accordingly					

Requirement #	Requirement Description	A	B	C	D	E
(New)						
40.14.2.76 **(New)**	Fiscal Agent shall update recipient premium payment history online to reflect all payments, refunds and adjustments					
40.14.2.77 **(New)**	Fiscal Agent shall establish a receipt system to handle cash premium payments and refunds					
40.14.2.78 **(New)**	Fiscal Agent shall deposit funds into a State-owned account as required by State and Federal policy					
40.14.2.79 **(New)**	Fiscal Agent shall prepare financial statements and expenditure reports and submit them as directed by the State					
40.14.2.80 **(New)**	Fiscal Agent shall accept, at a minimum, cash, check, money order, and credit/debit card for recipient premium payments					