

WRITTEN SECTION REPORTS

REPORT PERIOD DECEMBER 2, 2018 THROUGH MARCH 1, 2019

1. Policies Presented to the N.C. Physician Advisory Group (PAG)

The N.C. Physician Advisory Group met on 01/24/2019 and 02/28/2019

The Pharmacy & Therapeutic Committee met on 01/08/2019 and 02/12/2019

Recommended Pharmacy

- 9A, Over-The-Counter Products – 01/24/2019
- Preferred Drug List (PDL) – 01/24/2019
- Prior Approval Criteria Topical Antifungal Agents – 01/24/2019
- Prior Approval Criteria Topical Anti-Inflammatory Medications – 01/24/2019
- Prior Approval Criteria Monoclonal Antibody – 01/24/2019
- 9, Outpatient Pharmacy Program – 02/28/2019
- Prior Approval Criteria Antimalarial Drugs – 02/28/2019
- Prior Approval Criteria Monoclonal Antibody – 02/28/2019
- Prior Approval Criteria Opioid Analgesics – 02/28/2019
- Prior Approval Criteria Topical Local Anesthetics – 02/28/2019

Recommended Clinical Coverage Policies

- 1E-3, Sterilization Procedures – 01/24/2019
- 1K-2, Bone Mass Measurement – 01/24/2019
- 3D, Hospice Services – 01/24/2019
- 5A-3, Nursing Equipment and Supplies – 01/24/2019
- 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions – 02/28/2019

PAG Notifications

- 8A, Enhanced Mental Health and Substance Abuse Services – 01/24/2019

2. Policies posted for Public Comment

- Prior Approval Criteria Entresto (sacubitril/valsartan) – 12/06/2018
- Prior Approval Criteria Hemantinics – 12/06/2018
- Prior Approval Criteria Systemic Immunomodulators – 12/06/2018
- Prior Approval Criteria Opioid Analgesics – 12/06/2018
- Prior Approval Criteria Topical Local Anesthetics – 12/06/2018
- 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older – 12/20/2018
- Preferred Drug List (PDL) Progestational Agents – 12/21/2018
- Prior Approval Criteria Topical Antihistamines – 12/21/2018
- Prior Approval Criteria Migraine Therapy Calcitonin Gene-Related Inhibitors – 12/21/2018
- Prior Approval Criteria Growth Hormones – 12/21/2018
- Prior Approval Criteria Gocovri – 12/21/2018
- Prior Approval Criteria Therapeutic Continuous Glucose Monitoring Systems (CGM) and Related Supplies – 12/21/2018
- Expanding Coverage for Gardasil 9 – 01/02/2019

- 1K-2, Bone Mass Measurement – 02/13/2019
- Preferred Drug List (PDL – 02/19/2019 (Removed 02/21/19 – at the direction of John Stancil)
- Prior Approval Criteria Topical Antifungal Agents – 02/19/2019
- Prior Approval Criteria Topical Anti-Inflammatory Medications – 02/19/2019
- Prior Approval Criteria Monoclonal Antibody – 02/19/2019
- 1E-3, Sterilization Procedures – 02/21/2019
- 8A, Enhanced Mental Health and Substance Abuse Services – 02/26/2019
- 3D, Hospice Services – 02/28/2019

3. New or Amended policies posted to Medicaid website

- 8A-1, Assertive Community Treatment (ACT) Program – 12/03/2018
- 8A-2, Facility-Based Crisis Management for Children and Adolescents – 12/03/2018
- 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21 – 12/03/2018
- 8J, Children's Developmental Service Agencies (CDSAs) – 12/15/2018 – PAG
- 1A-5, Child Medical Evaluation and Medical Team Conference for Child Maltreatment – 12/31/2018
- 1G-2, Skin Substitutes – 12/31/2018
- 1N-2, Allergy Immunotherapy – 12/31/2018
- 1S-4, Genetic Testing – 12/31/2018
- 1T-2, Special Ophthalmological Services – 12/31/2018
- 1E-7, Family Planning Services – 01/02/2019
- 1A-26, Deep Brain Stimulation – 02-01-2019
- 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures – 02-01-2019
- 1K-1, Breast Imaging Procedures – 02-01-2019
- 1K-7, Prior Approval for Imaging Services – 02-01-2019 – 02-01-2019
- 8J, Children's Developmental Service Agencies (CDSAs) – 02-01-2019
- 9B, Hemophilia Specialty Pharmacy Program – 02-01-2019
- 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older – 03/01/2019
- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers – 03-01-2019

New or Amended PA Criteria Posted

- Prior Approval Criteria Epi Pen- 12/05/2018
- Prior Approval Criteria Opioid Analgesics- 02/13/2019
- Prior Approval Criteria Hematinics- 02/25/2019
- Prior Approval Criteria Immunomodulators- 02/25/2019
- Prior Approval Criteria Topical Antihistamines- 02/25/2019
- Prior Approval Criteria Cystic Fibrosis- 02/26/2019
- Prior Approval Criteria Entresto- 02/26/2019
- Prior Approval Criteria Gocovri- 02/26/2019
- Prior Approval Criteria Topical Local Anesthetics- 02/26/2019
- Prior Approval Criteria Migraine Therapy Calcitonin Gene Related Peptide Inhibitors–02/26/2019

4. Durable Medical Equipment and Supplies, and Orthotics & Prosthetics (DMEPOS)

- On January 24, 2019, the PAG approved amendments to clinical coverage policy 5A-3, Nursing Equipment & Supplies. Revisions included expanding coverage of continuous glucose monitors (CGMs) and supplies to recipients 21yoa and older; updating prior authorization (PA) criteria for CGMs; transitioning therapeutic CGMs to the pharmacy benefit; adding quantity limits for sterile and non-sterile gloves; simplifying criteria for replacing non-functional external insulin infusion pumps; updating criteria for replacing damaged/lost equipment

and supplies due to natural disasters; updating guidelines for utilization of sterile and non-sterile gloves and premoistened incontinence wipes; updating instructions for PA submissions of unlisted DME and medical supplies for adults; and adding coverage for HCPCS code A7048 (vacuum drainage collection unit and tubing kit) e.g.: PleurX.

5. Outpatient Specialized Therapies/Local Education Agencies (LEAs)

- On January 25, 2019 CMS approved SPA #18-0005 which allowed expansion of the documentation options available for Local Education Agencies (LEAs) to use as a basis for providing Medicaid reimbursable school-based audiology services, occupational, physical and speech/language therapies, counseling/psychological services and nursing services. The SPA language allows services to be provided in the school-setting when based on documentation in a student's Individual Education Program (IEP) as well as an Individual Family Service Plan (IFSP), a section 504 Accommodation Plan, an Individual Health Plan (IHP) or a Behavior Intervention Plan (BIP). The amendment also adds vision and hearing screening to the list of reimbursable school-based services.
- Related clinical coverage policy 10C, Outpatient Specialized Therapies, Local Education Agencies (LEAs) completed its public comment period Sept 24, 2018. NCTracks system work is currently being completed to operationalize the changes permitted by the approved SPA, as well as comply with the 2019 CPT code annual update. Once the system work is completed, the policy will be finalized for posting and a provider communication plan will be implemented.

6. Long-Term Services and Supports (LTSS)

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) - Section 12006 of the CURES Act requires states to implement an EVV system for Personal Care Services (PCS) by January 1, 2020 and for Home Health Care Services (HHCS) by January 1, 2023. NC Medicaid Services to be included in EVV are State Plan Personal Care Services, Four (4) 1915 (c) Waivers (Community Alternatives Program for Children (CAP/C), Community Alternatives Program for Disabled Adults (CAP/CA), Innovations, and Traumatic Brain Injury) and Home Health Services. EVV is a method used to verify visit activity for services delivered as part of Home and Community Based Services (HCBS) programs. EVV offers a measure of accountability to help ensure that individuals who are authorized to receive services, receive them. EVV systems must verify:

- Date of Service
- Location of service delivery
- Individual providing service
- Type of service performed
- Individual receiving service
- Time service begins and ends

Medicaid began efforts to comply with the CURES Act and has initiated Stakeholder engagement with its first workgroup meeting being held February 7, 2019 and the release of a Request for Information (RFI) on February 18, 2019. The EVV RFI will survey the marketplace and solicit information on the design and implementation of an EVV system as mandated by Section 12006 of the 21st Century CURES Act. Responses to this RFI will be received until 2:00 PM ET, March 25, 2019. For additional information regarding EVV you may visit the NC Medicaid EVV webpage at <https://medicaid.ncdhhs.gov/electronic-visit-verification>. Questions and Comments may be sent to Medicaid.EVV@dhhs.nc.gov

Program of All-Inclusive Care for the Elderly (PACE) Service Area Expansion

The North Carolina Department of Health and Human Services (NC DHHS), Division of Health Benefits (DHB) released a Request for Applications (RFA) for the expansion of the Program of All-Inclusive Care for the Elderly (PACE) on September 26, 2018. The RFA solicited applications from existing qualified PACE providers seeking to

expand their existing service areas into areas where PACE was not available. The RFA was in direct response to the recommendation to “consider the expansion of PACE” which was included in the March 2018 Study of the Program of All-Inclusive Care Legislative Report.

Four PACE organizations submitted applications. PACE of the Triad located in Greensboro, NC and Senior Total Life Care located in Gastonia NC were informed on December 27, 2018 of NC DHHS DHB’s approval for further application to CMS to expand the service area of the PACE organizations. PACE of the Triad was approved to expand PACE services to Forsyth, Stokes and Surry Counties. Senior Total Life Care was approved to expand PACE services to unserved portion of Cleveland County and to Rutherford County.

PASRR Program Update

Effective December 1, 2018, the North Carolina Medicaid Uniform Screening Tool (NCMUST) application and operation of the Level 1 PASRR screen process transitioned from a NC Medicaid vendor to NC DHHS ITD and NC Medicaid. The transition enables NC DHHS to achieve a more efficient screening process for PASRRs and provide NC DHHS with direct knowledge of issues and barriers that may impact the timely processing of PASRR Level 1 screens and Level 2 evaluations.

Community Alternatives Program for Disabled Adults (CAP/DA)

Over the last 16 months, NC Medicaid engaged stakeholders to renew the expiring §1915 (c) Home and Community-Based Services (HCBS) Waiver for the Community Alternatives Program for Disabled Adults (CAP/DA). From that engagement NC Medicaid was able to solicit innovative community living initiatives and supportive services to address social determinants of health for participants enrolled in the CAP/DA waiver. A draft waiver application was posted for a 30-day public comment period on January 4, 2019. The target date to submit the renewed waiver application to the Centers for Medicare & Medicaid Services (CMS) is March 1, 2019. From the submission date of the renewed waiver application, CMS has 90-days to review the application and make a recommendation for its approval and effective dates. While CMS is reviewing the renewed waiver application, the CAP/DA waiver will continue operating at the levels approved in the fifth-year of the 2013-2018 waiver application. However, the rate for the personal care service in the CAP/DA waiver will increase to \$3.90/15mins with an effective date of January 1, 2019.

7. Behavioral Health IDD Section

Treatment for Autism Spectrum Disorder:

The policy for Research Based Interventions for the Treatment of Autism Spectrum Disorder was presented to the Physician’s Advisory Group on December 6, 2018 and will then be posted for public comment.

TBI Waiver:

Alliance is currently moving individuals through the Level of Care and Individual Service Plan processes. The first few individuals are actively receiving TBI Waiver Services.

Innovations Waiver:

The NC Innovations Waiver has been to CMS for review. Working through responses to feedback from CMS, hoping to receive final approval for April 1st start but that is pending CMS final approval.

Behavioral Health Clinical Policy Updates:

Services for Substance Use Disorders:

The goal of the 1115 SUD demonstration waiver is to improve access to SUD services in North Carolina. North Carolina, along with most other states, selected the American Society of Addiction Medicine (ASAM) criteria as our best practice model. Four new services will be created (Clinically Managed Low Intensity Residential, Clinically Managed Population Specific High-Intensity Residential Services, Ambulatory Withdrawal Management with Extended On-Site Monitoring, and Clinically Managed Residential Withdrawal Management) and the other SUD services will be revised to be compliant with ASAM. Our application also included a waiver of the IMD exclusion

for SUD services. We will be submitting revised State Plan Amendments, policies, and rules over the next several years.

Community Support Team (CST)

NC Medicaid is currently working on the rate methodology. Once rate is clarified, DMA will submit SPA to CMS and initiate policy promulgation process.

Peer Support Specialist (PSS)

NC Medicaid submitted the proposed State Plan Amendment to EBCI and are awaiting feedback. Service rate/reimbursement determination request has been submitted to NC Medicaid's Reimbursement Section.

Outpatient Behavioral Health

Policy was updated to reflect the 2019 CPT Coding update for psychological and neuropsychological testing services. Policy [with technical changes] has been submitted to NC Medicaid's Policy Development Office Administration.

LME-MCO Contract Section Updates:

1915 (b) Waiver

The 1915 (b) waiver renewal has been submitted to CMS. CMS has requested additional information and NC Medicaid is working on responses to those question. The proposed effective date is 4/1/19.

Mental Health and Substance Use Disorder Parity

NC Medicaid has submitted a State Plan Amendment (SPA) to CMS demonstrating compliance with NC Health Choice and the Federal Mental Health and Substance Use Disorder Parity rules. CMS has approved this SPA.

Provider Satisfaction Surveys

NC Medicaid contracts with the Carolinas Centers for Medical Excellence (CCME) to administer annual provider satisfaction surveys to LME-MCO providers. A summary report of findings will be published in early 2019.

Consumer Satisfaction Surveys

NC Medicaid contracts with the Carolinas Centers for Medical Excellence (CCME) to administer annual consumer satisfaction surveys to Medicaid members and legal guardians of members receiving LME-MCO services. NC Medicaid uses the nationally recognized Experience of Care & Health Outcomes (ECHO) survey. This survey includes supplemental questions for adults and children. The surveys have been administered and collected. Preliminary results show a lower number of respondents for the 2018 survey, presumably in correlation to 2 major hurricanes occurring during the collection period. A summary report of findings will be published in early 2019.

External Quality Reviews (EQRs)

Federal regulations require states to conduct external quality reviews of managed care organizations such as the LME-MCOs. These reviews are an analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that the managed care organization provides to Medicaid members. NC Medicaid contracts with the Carolinas Center for Medical Excellence (CCME), an EQRO, to conduct these reviews annual. Reviews have been completed for Trillium, Eastpointe, Sandhills Center, Partners Behavioral Healthcare, Vaya Health and Cardinal Innovations. The Alliance Behavioral Healthcare review will occur in March 2019. CCME will develop a state-wide summary report once all reviews have been completed. Review reports and the summary report will be posted to the NC Medicaid website once all reviews have been completed.

PROVIDER SERVICES REPORT

CENTRALIZED CREDENTIALING VENDOR SELECTED

A contract has been awarded to Wipro Infocrossing to serve as the Provider Data Contractor (PDC), as NC Medicaid transitions to Managed Care. Wipro Infocrossing, will assist the North Carolina Medicaid Managed Care program to identify the credentialing status of providers contracting with Prepaid Health Plans (PHPs).

To minimize the administrative burden on providers as NC Medicaid transitions to managed care, the PDC will supplement the state's existing provider credentialing data to support the PHP's ability to make quality determinations during provider Medicaid Managed Care network contracting activities.

PHPs will rely upon the provider credentialing information to determine if a provider meets the PHP's quality standards and should be allowed to participate in the PHP's provider network. This streamlined process will facilitate providers enrolling with a PHP for the first time as well as providers currently participating in NC Medicaid or NC Health Choice.

- The PDC will be responsible for obtaining the primary source-verified credentialing data for NC Medicaid and NC Health Choice enrolled providers.
- The PDC will not be permitted to reach out to providers to update the provider's information, though providers are encouraged to keep their credentialing file up to date.
- To ensure that PHPs have access to information from a credentialing process that is held to consistent, current standards, the credentialing data will be primary source-verified under the standards of NCQA.
- PHPs will be required to accept verified information from the PDC and will not be permitted to require additional credentialing information from a provider to make their quality determination.

CREDENTIALING UPDATES FROM THE NC MEDICAL BOARD

NCTracks receives files from the North Carolina Medical Board the first week of every month. The files list all licenses issued and renewed during the previous month for Physicians (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Anesthesiologist Assistant (AA) providers. The files are used by NCTracks during the credentialing process and to update license renewals on provider records.

When completing an initial enrollment application, providers will be required to enter a valid license number to proceed through the application and to allow the data to be automatically updated in the future. License renewals will be updated in NCTracks automatically.

OUT OF STATE PROVIDER ENROLLMENT

Out-of-state providers, including border-area providers, must be enrolled in Medicare or their home-state Medicaid program to enroll in North Carolina Medicaid and NC Health Choice programs. If Medicare participation cannot be verified, NCTracks will contact the home-state Medicaid program for verification. Required Medicare participation based on taxonomy will be verified, and home-state Medicaid participation will not be required.

To successfully administer screenings, application fees and revalidation requirements, as specified in the Code of Federal Regulations at 42 CFR 455.410, 42 CFR 455.414, 42 CFR 455.450 and 42 CFR 455.460, states must validate Medicare enrollment and, for out-of-state providers, proof of home state Medicaid participation. States can rely on the results of other states' screenings to eliminate additional costs and burdens to state Medicaid programs and providers.