

## **WRITTEN SECTION REPORTS**

---

## (REPORT PERIOD DECEMBER 3, 2016 THROUGH MARCH, 24, 2017)

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

The N.C. Physician Advisory Group met on 12/08/16, 01/26/17, 02/23/17 and 3/23/17

The Pharmacy & Therapeutic Committee met on 01/10/17, 02/14/17 and 03/14/17

#### Recommended Policies

- 1A-30, Spinal Surgery – 12/08/16
- 1A-42, Balloon Ostial Dilation – 12/8/16
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – 12/08/16
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – 12/08/16
- 3K-1, Community Alternatives Program for Children (CAP/C) – 12/08/16
- 3K-2, Community Alternatives Program for Disabled Adults (CAP/DA) – 12/08/16
- 1-F, Chiropractic Services – 01/26/17
- Annual CPT and HCPCS Update – 01/26/17
- 1G-2, Skin Substitutes– 02/23/17
- 10-A, Outpatient Specialized Therapies– 02/23/17
- 10-B, Independent Practitioners– 02/23/17
- 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring – 03/23/17

#### Recommended Pharmacy

- PA Criteria Neuromuscular Blocking Agents – 12/08/16
- PA Criteria Cystic Fibrosis Agents – 12/08/16
- Preferred Drug List (PDL) COPD Agents: Spiriva Respimat – 01/26/17
- Preferred Drug List (PDL) Antidepressants: Fluoxetine – 01/26/17
- Preferred Drug List (PDL) Antihyperkinesia/ADHD: Dyanavel – 01/26/17
- PA Criteria Antiemetic Agents: Aprepitant – 02/23/17
- PA Criteria Exondys 51 – 02/23/17
- PA Criteria Topical Anti-Inflammatory Medications: Eucrisa – 03/23/17
- PA Criteria Spinraza – 03/23/17

### 2. Policies Posted for Public Comment

- PA Criteria Hepatitis C Virus Medications (Addition of VIEKIRA XR) – 12/09/16
- 1-I, Dietary Evaluation and Counseling and Medical Lactation Services – 12/13/16 (15-Day Additional)
- 3K-2, Community Alternatives Program for Disabled Adults (CAP/DA) – 12/14/16
- 1A-42, Balloon Ostial Dilation – 12/16/16
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – 12/16/16
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – 12/16/16
- 3K-1, Community Alternatives Program for Children (CAP/C)– 12/16/16 (Comment period extended to 02/08/17)
- PA Criteria Neuromuscular Blocking Agents – 01/03/17
- PA Criteria Cystic Fibrosis Agents – 01/03/17
- 1A-30, Spinal Surgery – 01/23/17
- 9, Outpatient Pharmacy – 02/09/17
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – 02/24/17 (9-Day extension after original posting)

- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – 02/24/17 (9-Day extension after original posting)
- 1-F, Chiropractic Services – 03/08/17
- 10-A, Outpatient Specialized Therapies – 03/08/17
- 10-B, Independent Practitioners – 03/08/17
- PA Criteria: Antiemetic Agents – 03/10/17
- PA Criteria: Exondys 51 – 03/10/17
- 1G-2, Skin Substitutes – 03/13/17

### **3. New or Amended Policies Posted to DMA website**

- 8-P, North Carolina Innovations – 12/15/16
- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone – 02/01/17
- 1N-1, Allergy Testing – 02/01/17
- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone – 02/21/17 (Typo Correct)
- 3K-2, Community Alternatives Program for Disabled Adults (CAP/DA) – 02/22/17 (Effective 10/01/2013)
- 3K-1 Community Alternatives Program for Children (CAP/C) – 03/01/17
- 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) – 03/01/17
- 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia – 03/01/17
- 11A-3, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia – 03/01/17
- 11A-5, Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias – 03/01/17
- 11A-6, Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors – 03/01/17
- 11A-7, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma – 03/01/17
- 11A-8, Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis – 03/01/17
- 11A-9, Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms – 03/01/17
- 11A-10, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma – 03/01/17
- 11A-11, Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma – 03/01/17
- 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells – 03/01/17
- 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood – 03/01/17
- 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) – 03/01/17
- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone – 03/15/17
- 1S-3, Laboratory Services – 03/15/17
- 5B, Orthotics and Prosthetics – 03/15/17

#### 4. Outpatient Pharmacy

##### Preferred Brands with Non-Preferred Generics - NC Medicaid Preferred Drug List (PDL)

The NC Medicaid Outpatient Pharmacy Program will implement **changes to the Preferred Drug List (PDL)** on **November 1, 2016**.

The changes could affect pharmacy stocking needs, generic substitution, product substitution, and POS overrides. If a brand is Preferred with a Non-Preferred generic equivalent, prior authorization for DAW-1 is not needed. Likewise, “brand medically necessary” is NOT needed on the face of the prescription. Below is a chart of preferred brands with non-preferred generics.

As a reminder, a 72-hour emergency supply may be provided if a prescription is awaiting prior authorization. A “3” in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill.

<b>2016-2017 NC Medicaid and Health Choice Preferred Drug List Effective 11.1.2016 (bold items are newly preferred)</b>	
<b>Preferred Brand</b>	<b>Non-Preferred Generic</b>
Abilify Discmelt and Solution	aripiprazole ODT and Solution
Adderall XR	amphetamine salt combo ER
Aggrenox	aspirin-dipyridamole ER
Aldara	imiquimod
Alphagan P	brimonidine
Androgel	testosterone
Astepro	azelastine
Avelox	moxifloxacin
Bactroban Cream	mupirocin cream
Baraclude	entecavir
Benzaclin	clindamycin/benzoyl Peroxide
Catapres-TTS	clonidine patches
Cedax	ceftibuten
Celebrex	celecoxib
Cipro Suspension	ciprofloxacin suspension
Copaxone	Glatopa
Derma-Smoothe-FS	fluocinolone 0.01% Oil
Desoxyn	methamphetamine
Diastat Accudial/Pedi System	diazepam rectal / system
Differin	adapalene
Diovan	valsartan
Epivir HBV	lamivudine HBV
Exforge	amlodipine / valsartan
Exforge HCT	amlodipine / valsartan / HCT
Focalin / Focalin XR	dexmethylphenidate / ER
Gabitril	tiagabine
<b>Grifulvin V</b>	Griseofulvin
Hepsera	adefovir
Kadian ER	morphine sulfate ER
Lovenox	enoxaparin
Metadate CD	methylphenidate CD
Methylin Solution	methylphenidate solution
Metrogel Topical	metronidazole gel topical

Natroba	spinosad
Nexium (Rx)	esomeprazole
Niaspan ER	niacin ER
Orapred ODT	prednisolone ODT
Oxycontin	oxycodone ER
Patanase	olopatadine
Prandimet	repaglinide / metformin
Provigil	modafinil
<b>Pulmicort respules</b>	budesonide respules
<b>Retin-A Cream/Gel</b>	tretinoin cream/gel
Ritalin LA	methylphenidate LA
Rythmol SR	propafenone SR
Soritane	acitretin
Symbyax	olanzapine / fluoxetine
Tobradex Drops	tobramycin / dexamethasone drops
Tegretol XR Tablet	carbamazepine XR
Tricor	fenofibrate
Trilipix	fenofibric acid
<b>Vancocin Capsule</b>	vancomycin capsule
Verelan PM	verapamil ER PM
Vivelle-Dot Patch	estradiol patch
Zovirax Suspension	acyclovir suspension

## **N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes**

Effective November 1, 2016, the N.C. Division of Medical Assistance (DMA) will make changes to the [N.C. Medicaid and N.C. Health Choice Preferred Drug List \(PDL\)](#).

Below are a few highlights of the changes:

- Long Acting Insulin class: non-preferred drugs require trial and failure of 1 preferred instead of 2 preferred drugs
- Invokamet has been moved to preferred status. (still requiring trial and failure of a metformin containing product)
- All strengths of Accuneb are preferred.
- Astelin nasal spray has been moved to non-preferred status.
- Vivitrol has been moved to preferred status.
- Exemption added to Viberzi for beneficiaries with Irritable Bowel Syndrome with Diarrhea.
- Exemption added to Epaned Solution for children under 12 years old.

### **Change to the Beneficiary Management Lock-in Program beginning January 2017**

The North Carolina Administrative Code, 10A NCAC 22F .0704 and 10A NCAC 22F .0104, Session Law 2015-241, Section 12F.16.(l), along with 42 CFR 431.54 and the State Plan Amendment supports the State's development of procedures for the control of beneficiary overutilization of Medicaid benefits which includes implementing a Beneficiary Management Lock-In program. In accordance with Session Law 2015-268, Section 4.4., the lock-in period has been extended to two (2) years and program capacity has been expanded to include all NC Medicaid beneficiaries that meet the inclusion criteria. This change applies to beneficiaries receiving notification letters beginning January 2017. Criteria for inclusion in the Beneficiary Management Lock-In Program is listed in Clinical Coverage Policy No. 9 and below.

A Medicaid beneficiary identified for the lock-in program is restricted to a single prescriber and pharmacy in order to obtain opioid analgesics, benzodiazepines and certain anxiolytics. The beneficiary must obtain all prescriptions for these medications from their lock-in prescriber and lock-in pharmacy in order for the claim to

pay. Claims submitted that are written by a prescriber or filled at a pharmacy other than those listed on the lock-in file are denied.

A beneficiary who qualifies for the program shall be notified and locked in for two (2) years after which time they will be removed from the program if they no longer meet the criteria. Once released from the lock-in program, prescription claims continue to be monitored. If a beneficiary meets the criteria again after being released from the program, they will be re-identified for the lock-in program. The beneficiary cannot change their lock-in prescriber or pharmacy without authorization from DMA.

An NC Medicaid beneficiary shall be locked-in to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines and certain anxiolytics when one or more of the following criteria are met:

1. Beneficiary who has at least ONE of the following:
  - a. Benzodiazepines and certain anxiolytics: greater than six (6) claims in two (2) consecutive months.
  - b. Opiates: greater than six (6) claims in two (2) consecutive months.
2. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from greater than three (3) prescribers in two (2) consecutive months.

The N.C. Medicaid Program shall reimburse an enrolled Medicaid pharmacy for a four (4)-day supply of a prescription dispensed to a beneficiary locked into a different pharmacy and prescriber in response to an emergent situation. The provider shall be paid for the drug cost only and the beneficiary shall be responsible for the appropriate copayment. One emergency occurrence is reimbursed per beneficiary during each year of the two (2) year lock-in periods. Paid quantities for more than a four (4)-day supply are subject to recoupment. The pharmacy should place a “3” in the level of service field.

Beneficiaries and providers who have questions regarding the lock-in program should contact CSRA at 1-866-246-8505.

### **Upcoming PDL changes for Abilify and aripiprazole**

Effective October 1, 2016, aripiprazole Tablets were moved to preferred status on the Preferred Drug List (PDL). Abilify Tablets will remain preferred until December 31, 2016, to allow pharmacies to exhaust their inventory. Effective January 1, 2017, Abilify Tablets will move to non-preferred status on the PDL.

DMA has been made aware that brand name Abilify Solution is no longer being made. In response to this information and to ensure that beneficiaries have access to a liquid formulation of aripiprazole, aripiprazole solution (generic) has been moved to preferred status on the PDL effective **November 11, 2016**.

These changes are illustrated in the table below.

<b>BEHAVIORAL HEALTH</b>	
ATYPICAL ANTIPSYCHOTICS	
Oral	
Preferred	Non-Preferred
<i>Effective 10/01/2016-12/31/2016</i>	
Abilify® Discmelt / Tablet	aripiprazole ODT / Solution
aripiprazole Tablet / Solution	
<i>Effective 01/01/2017</i>	
Abilify® Discmelt	Abilify® Tablet
aripiprazole Tablet / Solution	aripiprazole ODT

### **Proper DAW use with Narrow Therapeutic Index Drugs**

A new prescription for a drug that is on the Narrow Therapeutic Index (NTI) list that is written under its brand or trade name **must be** filled with a generic version of the drug when one is available **unless** the prescriber has indicated that the brand name drug is necessary by handwriting “**medically necessary**” on the prescription order. A refill prescription order for an NTI drug written under its brand or trade name **may not** be substituted with a generic version of the drug without written or verbal consent from the prescriber.

Pharmacists **MUST** use the Dispense as Written (DAW) code “7” in field 408-D8 when it is necessary to dispense a brand name NTI drug. The DAW 7 code means that substitution is not allowed and dispensing the brand drug is mandated by law. Please use DAW 7 for ALL NTI prescriptions, even those where “Medically Necessary” is written on the prescription.

Inappropriate use of DAW 7 for prescriptions for non-NTI drugs is subject to audit and recoupment.

### **Narrow Therapeutic Index Drugs**

Carbamazepine: all oral dosage forms

Cyclosporine: all oral dosage forms

Digoxin: all oral dosage forms

Ethosuximide

Levothyroxine sodium tablets

Lithium (including all salts): all oral dosage forms

Phenytoin (including all salts): all oral dosage forms

Procainamide

Tacrolimus: all oral dosage forms

Theophylline (including all salts): all oral dosage forms

Warfarin sodium tablets

### **Pharmacy Advertising of Flu Vaccines**

DMA has received questions regarding pharmacies advertising that they offer flu vaccines to N.C. Medicaid beneficiaries. DMA does not have any policies that prohibit this practice.

### **Pharmacy Professional Claims for Vaccines Exempt from Co-Pay and Ordering Provider**

A change was implemented in NCTracks on December 1, 2016, to exempt pharmacy professional claims for vaccines from co-pay. Co-pays should not be charged on vaccines administered by pharmacists. The exemption from co-pay is effective with date of service January 1, 2016. Pharmacy professional claims submitted prior to December 1, 2016 for which a co-pay was deducted from payment may be resubmitted for payment without the co-pay being deducted.

In addition, on December 1, 2016, a change was implemented in NCTracks to exempt pharmacy professional claims from the requirement for an Ordering Provider. (Pharmacy claims might have previously pended with Explanation of Benefits 02438 - ORDERING PROVIDER IS REQUIRED FOR THIS SERVICE.) This change allows immunizing pharmacists to screen and offer appropriately allowed vaccination(s) to Medicaid beneficiaries without obtaining a prescription or an order for that beneficiary or vaccination(s). Immunizing pharmacists are reminded that [G.S. 90-85.15B](#) requires pharmacist administered vaccines to be administered under a written protocol and in accordance with a supervising physician licensed in and has a practice physically located in NC. The exemption from the Ordering Provider requirement is effective with date of service November 1, 2016.

### **NADAC Rate Update Process**

Pharmacy providers anticipate drug manufacturer price increases in January and July each year and DMA has received questions from pharmacy providers regarding the process used to update NADAC rates. NADAC rates are updated based on manufacturer pricing changes (i.e. WAC). Myers and Stauffer LC, the CMS contractor,

receives weekly files from First Databank and implement any price changes on the First Databank and implement any price changes on the next NADAC file. Changes in the NADAC rates due to WAC changes will receive the effective date of the WAC change and therefore these NADAC rates will appear backdated so long as the effective date of the WAC change does not cross the previous effective date. For example, a WAC update for drug A has an effective date of 1/4/17 and is received on the weekly FDB file on 1/6/17. Myers and Stauffer LC would apply the update to the rate for drug A to the NADAC file published by CMS on 1/11/17 and the NADAC effective date would be 1/4/17, not 1/11/17. Myers and Stauffer LC then collects January invoices beginning February 1st and would implement the rates reflective of January purchases prices in March unless they receive a help desk call that warrants an increase/decrease to the NADAC rate.

NC pharmacy providers may contact the **NADAC Help Desk** for any questions related to the NADAC survey process or if they have questions or concerns with a specific NADAC rate, such as those related to recent large price increases or drug shortages. Please note that the NADAC Help Desk will not address pharmacy inquiries into specific NC Medicaid claim reimbursement related questions or concerns.

Myers and Stauffer LC will operate the NADAC help desk. The operating hours for the help desk are Monday through Friday from 8 AM to 8 PM EST and contact information is included below.

Toll-free phone: (855) 457-5264  
 Electronic mail: [survey@mslcrps.com](mailto:survey@mslcrps.com)  
 Facsimile: (844) 860-0236

**Preferred Drug List (PDL) Update**

On December 16, 2016, Mylan announced the launch of the authorized generic for EpiPen® (epinephrine injection, USP) Auto-Injector at a wholesale acquisition cost (WAC) greater than 50% lower than the WAC of EpiPen 2-Pak® Auto-Injectors. The authorized generic has the same drug formulation and device functionality as EpiPen Auto-Injector, a product that has been on the market for nearly 30 years, and is administered in the same way.

**Effective January 1, 2017**, Epinephrine 0.3 mg and 0.15 mg Auto-Injectors will move to preferred status and EpiPen and EpiPen Jr. will move to non-preferred status on the [NC Medicaid Preferred Drug List \(PDL\)](#).

EPINEPHRINE, SELF INJECTED	
Preferred	Non-Preferred
Adrenaclick® Auto Injector epinephrine auto injector (generic for Adrenaclick®) <i>epinephrine auto injector (generic for Epi-Pen® Auto Injector / JR Auto Injector)</i>	Auvi-Q® Auto Injector <i>Epi-Pen® Auto Injector / JR Auto Injector</i>



## 5. Practitioner, Clinical, and Facility Services

**Annual CPT and HCPCS Update** - The Division of Medical Assistance added 93 new CPT and HCPCS codes as part of the annual update process. Emphasis this year was on dialysis circuit procedures, diagnostic injections, laboratory testing, and physical/occupational therapy.

**1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring** - The Division of Medical Assistance has drafted a policy outlining medical necessity, frequency, and annual limits of drug testing for substance use disorders and chronic pain management. The purpose of this policy is to limit overutilization of testing that is designed to be one of many tools used to assess the beneficiary. Recent data analysis indicates approximately the top 1% of beneficiaries receiving drug tests account for 17% of the total tests ordered. This policy is expected to go to the PAG in March 2017.

**1A-30, Spinal Surgery** - The Division of Medical Assistance has drafted a spinal surgery policy adding PA to 87 surgical procedures per Session Law 2011-145 HB 200 Section 10.37(a)(11)(g)(4). The policy went to the PAG in October of 2016, was revised as suggested, and came off public comment March 9, 2017. Extensive system work leaves an estimated effective date of 10/31/2017.

## 6. Behavioral Health IDD Section Updates:

### **Treatment for Autism Spectrum Disorder:**

DMA has had five workgroup meetings with the stakeholder workgroups to develop a State Plan Amendment for Research Based Behavioral Health Treatment of Autism Spectrum Disorder. We held three physical stakeholder meetings in January (in Raleigh, Greenville, and Hickory), and one webinar meeting in February. We are currently working on incorporating feedback from the stakeholder meetings and preparing for submission to CMS.

### **TBI Waiver:**

DMA responded to a formal request for additional information from CMS on the TBI waiver. We are currently working with Alliance Behavioral Health to operationalize the Waiver and to ensure that potential waiver sites are compliant with CMS's Final Home and Community Based Standards rule.

### **Innovations Waiver:**

The Technical Amendment to the NC Innovations waiver went into effect on 11/1/2016. DMA and DMH conducted readiness reviews of PIHPs beginning in September to determine where technical assistance might be needed. As of the writing of this report, six of the seven reviews were completed. Overall, the PIHPs demonstrated a good understanding of resource allocation and the processes needed to ensure efficiency and fairness. When needed, corrections or additional information were requested to be submitted to DMA.

250 additional slots were approved by the Legislature in the budget to be effective 1/1/2017. DMA drafted a Technical Amendment on 11/1/2016 to add these slots.

We are in the planning stages for the NC Innovations Waiver Renewal effective 8/1/18. This planning stage encompasses stakeholder feedback and engagement on recent waiver changes and ways to promote tailored changes to increase efficiency and support greater integration.

## **Behavioral Health Clinical Policy Updates:**

### **Mobile Crisis Management:**

DMA continues to work with DMHDDSAS on improving clinical coverage policy 8A, *Enhanced Mental Health and Substance Abuse Services*, Mobile Crisis Management (MCM). Following stakeholder meetings at each LME-MCO, DMA and DMH staff met to discuss and agree to revisions to the MCM policy. DMH is researching evidence-based models of mobile crisis with the goal of having the revised policy allow providers to choose and implement an evidence-based MCM model. The revised draft will then be shared with a wider stakeholder group prior to being reviewed by the Physician Advisory Group.

**Psychosocial Rehabilitation (PSR):**

Meetings with PSR providers and the LME-MCOs have been held and this feedback has been compiled with recommendations for changes to the policy. One of the changes is the consideration of changing the name from Psychosocial Rehabilitation to Psychiatric Rehabilitation. The goal is to offer providers of Psychiatric Rehabilitation the option of providing an evidence-based model of psychiatric rehabilitation.

**Services for Substance Use Disorders:**

DMA in collaboration with DMH are in the process of scheduling listening sessions in Asheville, Greenville, and Raleigh with substance use disorder providers and LME-MCOs to solicit their feedback as to the continuum of services to treat substance use disorders and on current gaps in treatment. These listening sessions will also focus on evidence-based treatment models that can be utilized.

**Nurse Practitioners:**

DMA has published a bulletin outlining a way in which nurse practitioners providing outpatient behavioral health services under clinical coverage policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, may continue providing these services even if they have not yet obtained the Psychiatric Mental Health Nurse Practitioner certification. DMA is drafting language to modify the 8C policy allowing nurse practitioners to continue practicing if they can document psychiatric prescribing experience and are supervised by a psychiatrist. Details will be included in the outpatient 8C policy.

**Tenancy Supports:**

DMA continues to work through the promulgation process with Tenancy Supports/Transition management services. We are working with Duke University and The Coalition to End Homelessness on a Robert Wood Johnson grant. We look forward to being able to utilize some of the research findings produced through this grant to ensure our policy is in line with best practice standards.

**Institute for Mental Disease (IMD)**

42 CFR 438.6(e) allows for the State to give capitated payments to managed care plans for services in an institution for mental disease (IMD). These services are for enrollees ages 21 to 64 if the IMD stay is less than 15 days in a month. The IMD must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care, or a sub-acute facility providing psychiatric or SUD crisis residential services. DMA has drafted an IMD in lieu of service definition has been reviewed by the LME-MCOs and feedback has been incorporated. It is currently under review by DMA leadership. After approval, LME-MCOs will need to request to provide this in lieu of service. The anticipated cost of this service has been added into the PMPM rates to be effective 7/1/2017.

**Critical Access Behavioral Health Agencies**

Three CABHA Listening Session are scheduled for March (Asheville, Raleigh, Greenville) to discuss the sunset of CABHA requirements.

**Enhanced Behavioral Health Services: Intensive In-Home Service**

Session Law 2014-100 required the N.C. Department of Health and Human Services (DHHS) to submit N.C. State Plan Amendment (SPA) 14-022 to the Centers for Medicare & Medicaid Services (CMS) requesting approval to modify the service definition and rate for Intensive In-home Service (IIH). This amendment was approved by CMS on Jan. 5, 2017, and reflects a team-to-family ratio of one IIH team to 12 families and a new rate of \$239.66 per day for the Medicaid Fee-for-Service (FFS) and N.C. Health Choice (NCHC) programs. To allow sufficient time for providers to implement changes, updates to Medicaid Clinical Policy 8A, *Enhanced Mental Health and Substance Abuse Services*, and the new IIH rate will become effective with claims processed on or after April 1, 2017.

An initiative to develop additional revisions to IHH is being initiated in March 2017 in concert with the sun setting of CABHA requirements. Stakeholders will have opportunities for input and review. The goals of these revisions will be:

- a. to ensure adequate clinical oversight and supervision of this service and
- b. to provide flexibility in its design to permit the provision of Evidence based practices and models.

### **LME-MCO Contract Section Updates:**

#### **PIHP Contracts:**

DMA has completed contract negotiations with the LME-MCOs. Contract changes primarily focus on the implementation of new Medicaid Managed Care Final Rules. The new contract will go into effect on July 1, 2017.

#### **External Quality Review**

DMA has completed the SFY 16/17 External Quality Reviews (EQR) of each LME-MCO. EQRs focus on quality, timeliness, and access to the health care services that an LME-MCO furnishes to a Medicaid beneficiary. Individual LME-MCO reports are in process and will be posted to the DMA website once final.

#### **Community Behavioral Health Service Needs, Providers and Gaps Analysis:**

DMA and DMH/DD/SAS are expanding the scope of services tracked for choice of provider and service access to include Long Term Support Services (Innovations Waiver services), beginning with the 2017 Community Behavioral Health Service Needs, Provider and Gaps Analysis submission. This comes about as the result of changes in the Medicaid Managed Care Final Rules section pertaining to Network Adequacy.

#### **Transition of Care Plan:**

The Transition of Care Plan will help ensure that when mergers or consolidations of LME-MCOs occur, individuals have continued access to service during a period of transition, thereby preventing detriment to the individual's health or to reduce risk of hospitalization or institutionalization where the transition policy not in effect. This Plan was the result of new Medicaid Managed Care Final Rules found under the Continued Services section.

## **7. Long Term Services and Supports**

### **Community Alternatives Programs for Children (CAP/C)**

DMA revised the CAP/C Clinical Coverage Policy and renewed the CAP/C 1915 (c) Home and Community-Based Services (HCBS) waiver for another five-year waiver cycle with an effective date of Mar. 1, 2017.

The renewed CAP/C HCBS waiver and the revised clinical coverage policy include the following:

1. Ability to serve 4,000 participants
2. The waiver's average cost neutral point of institutional care for all services, waiver, and non-waiver services is \$129,000 per waiver beneficiary per waiver year.
3. Meet the clinical and needs-based eligibility requirements for waiver participation.
4. The clinical based eligibility requirements are: a) meet the medical-complexity criteria and level of care; and b) be determined at-risk of institutionalization through a comprehensive assessment.
5. Determined to need one waiver service when clinical and need-based eligibility criteria are met to return to or maintain integration in the community.
6. The CAP/C waiver service packet includes the following array of home and community-based services:
  - a. Assistive technology - adaptive equipment in the home, ex: track system; total utilization amount in combination with other modification-type services (home and vehicle modification) is \$28,000 per the 5-year waiver approved cycle

- b. Case management - two types: case manager or care advisor- community navigation service for the purpose of assessing, planning, monitoring, and linking and follow-up; utilization amount is 80 hours per calendar year per waiver participant, 20 hours more than previous waiver
  - c. Community transition services - Personal items to assist with re-integration to the community; utilization amount is a one-time dollar allotment of \$2,500 per a 5-year waiver cycle period
  - d. Financial management services - for consumer-directing beneficiary only; liaison between the waiver beneficiary and Medicaid for claim reimbursement and the Internal Revenue Services (IRS) for employer tax filing
  - e. Home accessibility and adaptive services - home modification and adaptive equipment in the home, ex: bath modification or widening of doorway; total utilization amount in combination with other modification-type services (home and vehicle modification) is \$28,000 per the 5-year waiver approved cycle
  - f. In-home Aide services - personal care for a waiver beneficiary with activities of daily living limitations that requires the assistance to be provided by an NAI paraprofessional
  - g. Participant Goods and service - a medically necessary adaptive item for a waiver participant that is not available through State Plan Medicaid, waiver or non-waiver; utilization amount is \$800 per waiver participant per fiscal year
  - h. Pediatric nurse aide services - personal care for waiver beneficiary with activities of daily living limitation that requires the assistance to be provided by an NAI paraprofessional
  - i. Respite - institutional and non-institutional care to offer caregiver relief; utilization amount is 720 hour per waiver participant per each fiscal year
  - j. Specialized medical equipment and supplies - assistive devices of tricycle and vehicular vest
  - k. Training, education and consulting services - services for a waiver beneficiary, primary caregiver or a hired worker through consumer direction to learn more about the pathology of the beneficiary's disease and coping mechanisms; utilization amount is \$500 per waiver participant per each fiscal year
  - l. Vehicle modification - modification to a vehicle to allow safe transport; total utilization amount in combination with other modification-type services (home and vehicle modification) is \$28,000 per the 5-year waiver approved cycle
7. Previous CAP/C home and community-based services that were discontinued in the renewed waiver:
- a. CAP nursing services - replaced by Private Duty Nursing (PDN) – all children receiving this service were transitioned to PDN in Feb. 2017
  - b. Palliative Care type services - replaced with Hospice Palliative Counseling/Bereavement Counseling and behavioral health counseling when criteria are met
  - c. Reusable incontinence supplies and liners - items are available through the Medicaid State Plan Durable Medical Equipment and Supplies or Home Health
8. 2,400 individuals are receiving CAP/C services
9. 267 individuals are in one of three phases (clinical based eligibility, need-based eligibility, or plan of care development) of waiver eligibility

**Community Alternatives Programs for Disabled Adults (CAP/DA)**

DMA revised the CAP/DA Clinical Coverage Policy and renewed the CAP/DA 1915 (c) Home and Community-Based Services (HCBS) waiver to comply with NC Session Law 2016-94 which granted CAP/DA an additional three-hundred and twenty (320) waiver slots to target a population of individuals with Alzheimer's disease and related dementia. The renewed waiver and revised clinical coverage policy has an effective date of Jan. 1, 2017.

Individual meeting the qualifying diagnosis for Alzheimer's Disease and related dementias will be prioritized immediately and assigned a waiver slot until the maximum limits are reached. Once the maximum limits are reached, individuals meeting the eligibility criteria will be prioritized as first on an existing waiting list. The qualifying Alzheimer's Disease and related dementias diagnoses are:

<b>ICD-10</b>	G30.9; G30.0; G30.1; G31.01; G31.09; G31.83; F03.90; F01.50; F01.51; G10; F03.90; F10.97; F10.27; F03.91; F84.2
---------------	---

In addition to the 320 waiver slots, 20 additional case management hours were approved per waiver participant per each calendar year. Each waiver beneficiary will be granted 80 hours of case management per calendar year.

10,340 individuals are actively receiving CAP/DA services. 81 individuals are in one of two phrase (need-based eligibility or plan of care development) of waiver eligibility.

2,279 individuals are waiting for services on a county based waitlist.

## RECIPIENT AND PROVIDER SERVICES REPORT

---

### PROVIDER RECREDENTIALING

The Centers for Medicare and Medicaid Services requires that all Medicaid providers are revalidated (recredentialed) at least every five years. This is to ensure that provider enrollment information is accurate and current. The provider's credentials and qualifications will be evaluated to ensure that they meet professional requirements and are in good standing. The recredentialing process also includes a criminal background check on all owners and managing relationships associated with the provider record.

Every active NCTracks Provider must be recredentialed. It is crucial that all providers who receive a recredentialing notice promptly respond and begin the recredentialing process. Providers will receive a recredentialing letter 45 days before their recredentialing due date. If the provider does not complete the recredentialing process **within the allotted 45 days, payment will be suspended** until the recredentialing process is completed. The provider will also receive a termination notice. If the provider does not complete the recredentialing process within thirty (30) days from payment suspension and termination notice, **participation in the N.C. Medicaid and Health Choice (NCHC) Programs will be terminated.** Providers must submit a re-enrollment application to be reinstated.

### PROVIDER AFFILIATION

Attending/rendering providers are required to be affiliated with the billing providers who are submitting claims on their behalf. Effective May 1, 2017, the claim edit disposition will change to pend. Once the disposition is changed, a claim failing the edit will suspend for 60 days. If the affiliation relationship is not established within 60 days, the claim will deny. Providers must correct any affiliation issues immediately.

### FINGER-PRINT BASED CRIMINAL BACKGROUND CHECKS

In accordance with 42 CFR 455.410(a), the Centers for Medicare & Medicaid Services (CMS) requires state Medicaid agencies to screen enrolled providers for "categorical risk" according to the provisions of Part 455 subpart E. Under 42 CFR 455.450, state Medicaid agencies are required to screen all applications for "categorical risk", including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation. In addition, under 42 CFR 455.434(b), N.C. Medicaid and N.C. Health Choice providers designated as "high categorical risk" under 42 CFR 424.518(c) and N.C.G.S. 108C-3(g), or any person with a 5 percent or more direct or indirect ownership interest in the organization - as those terms are defined in 42 CFR 455.101 - will be required to submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA. **Implementation will be July 30, 2017, and is retroactively effective for providers enrolled or revalidated on or after Aug. 1, 2015.**

# # #