WRITTEN SECTION REPORTS

(REPORT PERIOD DECEMBER 1, 2015 THROUGH APRIL 15, 2016)

1. POLICIES PRESENTED TO THE N.C. PHYSICIAN ADVISORY GROUP (PAG)

The N.C. Physician Advisory Group met on 12/03/15, 01/28/16, 02/11/16, 02/25/16, 03/24/16
The Pharmacy & Therapeutic Committee met on 01/12/16, 02/09/16, 03/08/16

Recommended Policies

- 1-I, Dietary Evaluation and Counseling and Medical Lactation Services - 12/03/15
- 10A, Outpatient Specialized Therapies - 12/03/15
- 5A, Durable Medical Equipment – (Specified Facilities) 12/03/15
- 5A, Durable Medical Equipment – (Oxygen) 01/28/16
- 3K-3, Community Alternatives Program (CAP)(Waiver) - 02/11/16
- 9, Outpatient Pharmacy Services - 02/25/16
- 5A, Durable Medical Equipment (wound care & wheelchairs) 03/24/16

Recommended Pharmacy

- PA Criteria Hepatitis C Medications (Daklinza, Technivie, Viekira) - 12/03/15
- PA Criteria Cystic Fibrosis (Orkambi)- 12/03/15
- PA Criteria Narcotic Analgesics (Lazanda)- 12/03/15
- PA Criteria Nucala - 01/28/16
- PA Criteria Narcotic Analgesics (Belbuca)- 01/28/16
- PA Criteria Hepatitis C Medications (Zepatier)- 03/24/16
- PA Criteria Systemic Immunomodulators (new indication for Humira)- 03/24/16

PAG Administrative Notification

- Annual CPT and HCPCS Code Updates - 12/03/15
- Dental Code Update CDT 1354 - 01/28/16
- 5A, Durable Medical Equipment (codes added) - 03/24/16

PAG Consult

- Balloon Sinus Ostial Dilation - 01/28/16

2. POLICIES POSTED FOR PUBLIC COMMENT

- 5A, Durable Medical Equipment (Specified Facilities)– 12/11/15
- 1E-5, Obstetrics – 12/18/15
- 10A, Outpatient Specialized Therapies – 01/05/16
- PA Criteria Hepatitis C Medications (Daklinza, Technivie, Viekira) – 01/08/16
- PA Criteria Cystic Fibrosis (Orkambi)- – 01/08/16
- PA Criteria Narcotic Analgesics (Lazanda)- – 01/08/16
- 1-I, Dietary Evaluation and Counseling and Medical Lactation Services – 02/03/16
- 5A, Durable Medical Equipment (Oxygen) – 02/12/16
- PA Criteria Nucala – 03/15/16
- 9, Outpatient Pharmacy Services – 03/15/16
- PA Criteria Narcotic Analgesics (Belbuca) – 03/30/16
- PA Criteria Hepatitis C Medications (Zepatier) – 03/30/16
- PA Criteria Systemic Immunomodulators (new indication for Humira – 03/30/16

3. POLICIES POSTED FOR ADDITIONAL PUBLIC COMMENT

- 15, Ambulance Services – 01/08/16
- 10A, Outpatient Specialized Therapies – 03/11/16

4. AMENDED OR NEW POLICIES POSTED TO DMA WEBSITE

- 1B-1, Botulinum Toxin Treatment – 12/01/15
- 1D-1, Refugee Health Assessments Provided in Health Departments – 12/01/15
- 8A-1, Assertive Community Treatment (ACT) Program - 12/01/15
- 1E-2, Therapeutic and Non-Therapeutic Abortions – 01/01/16
- 1-O-1, Reconstructive and Cosmetic Surgery – 01/01/16
- 1S-4, Genetic Testing - 1/01/16
- 3D, Hospice Services – 01/01/16
- 8A-2, Facility-Based Crisis Service for Children and Adolescents – 01/01/16
- 1E-4, Fetal Surveillance – 01/01/16
- 1E-6, Pregnancy Medical Home – 01/01/16
- 1K-7, Prior Approval for Imaging Services – 01/01/16
- 3A, Home Health Services – 11/01/15
- 5A, Durable Medical Equipment and Supplies – 11/01/15
- 15, Ambulance Services – 02/01/16
- 1E-7, Family Planning Services - 02/01/16
- 3G, Private Duty Nursing (PDN) - 02/01/16
- 5A, Durable Medical Equipment and Supplies – 02/15/16
- 1E-7, Family Planning Services - 04/01/16
- 10A, Outpatient Specialized Therapies – 04/07/16

1. BEHAVIORAL HEALTH CLINICAL POLICY UPDATES:

DMA is working with DMHDDSAS on improving Clinical Coverage Policy 8A, Mobile Crisis Management.

A clinical policy clinician attended a three-day "Train the Trainer" workshop in NYC with the developers of Critical Time Intervention. DMA is looking at the possibility of making this 9-month, intensive case management model a b(3) service.

1915(c) SED draft waiver has been submitted to the NC General Assembly for review.

CERTIFIED COMMUNITY BASED HEALTH CLINIC:

Section 223 Demonstration Program to Improve Community Mental Health Services of the PAMA ACT was enacted on April 1, 2014. It requires the establishment of a demonstration program to improve community behavioral health services. NC was one of the 24 states who received a one-year planning grant. The CCBHC planning project is a collaborative effect between DMA and DMHDDSAS. Of those 24 states, eight will be awarded a two-year demonstration in October 2016. The team is diligently working on the certification process, data collection process, prospective payment system and stakeholder engagement.

BEHAVIORAL HEALTH IDD SECTION UPDATES:

Treatment for Autism Spectrum Disorder:
The Centers for Medicare and Medicaid Services have issued guidance on EPSDT coverage of Autism Spectrum Disorder. It is their expectation that States cover a continuum of services for these individuals. To that end, the State is exploring its options to provide additional services to this population with assistance from Mercer and stakeholder engagement. DMA has requested a special provision to allow for and allocate funding to a State Plan Amendment for Evidence and Research Based Treatment of Autism Spectrum Disorder.

TBI WAIVER:

The North Carolina General Assembly has appropriated $1,000,000 for fiscal year 2015-2016 and $2,000,000 for fiscal year 2016-2017 to fund a TBI Medicaid Waiver based on the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. The draft of this waiver is currently posted for public comment prior to submission to CMS.

INNOVATIONS WAIVER:

A technical amendment to the Innovations waiver to implement resource allocation and add flexibility to service definitions was submitted to CMS in October 2015. The state is awaiting responses to a Formal Request for Additional Information which the State submitted to CMS in December 2015. The state has requested that the implementation date of the technical amendment be changed to July 1, 2016 to allow adequate time for implementation post-approval.

LME-MCO CONTRACT SECTION UPDATES:

LME-MCO Contracts:
LME-MCO contracts will be amended in April 2016. Changes will include information related to the calculation of the LME-MCO Medical Loss Ratio (the proportion of premium revenue spent on clinical services and quality improvement) and Program Integrity Requirements.

External Quality Review:
CMS requires that states conduct external quality reviews (EQRs) of contracted managed care organizations to analyze aggregate information on quality, timeliness, and access to the health care services that an MCO furnishes to Medicaid recipients. DMA has identified the Carolinas Center for Medical Excellence (CCME) as the LME-MCO EQR vendor for 2016. CCME will review each of the 8 LME-MCOs in 2016, beginning in May.

2. OUTPATIENT PHARMACY

Pharmacy Reimbursement
On January 11, 2016, the Centers for Medicare & Medicaid Services (CMS) notified DMA that our State Plan Amendment (SPA) 14-047 had been reviewed and, consistent with 42 CFR 430.20, was approved with an effective date of January 1, 2016.

North Carolina's approved SPA updating its pharmacy reimbursement methodology is also aligned and consistent with the regulations within the Covered Outpatient Drugs policy, which was published by CMS on January 21, 2016.

The new reimbursement methodology will use an average acquisition cost (AAC) to reimburse brand and generic drug ingredient costs. The CMS National Average Drug Acquisition Cost (NADAC) survey will be used to determine the AAC when NADAC is available. If NADAC pricing is not available, the state will calculate the AAC as the Wholesale Acquisition Cost (WAC) + 0%. Reimbursement methodology will continue to include the lesser of NADAC, or WAC in absence of NADAC, and the State Maximum Allowable Cost (SMAC) rate on file.

DMA will also reimburse pharmacies for their cost of dispensing using a tiered professional dispensing fee as follows:

- $13.00 when 85% or more claims per quarter are for generic or preferred brand drugs,
- $7.88 when less than 85% of claims per quarter are for generic or preferred brand drugs, and
- $3.98 for non-preferred brand drugs.

Once programming is completed, pharmacy claims paid between January 1, 2016, and when the updated reimbursement methodology is implemented into NCTracks, will be reversed and rebilled according to the updated reimbursement methodology.

DURABLE MEDICAL EQUIPMENT PROGRAM

Expanded Types of Facilities and Documentation Requirements for Select DME Codes
Effective February 15, 2016, Durable Medical Equipment (DME) providers requesting select DME codes that require prior approval, when a beneficiary is being discharged home from a skilled nursing facility, short term physical disability rehabilitation center or hospital, can electronically submit a prescriber's (physician, physician assistant or nurse practitioner) order, discharge summary or history and physical note and any supporting documentation using the NCTracks provider portal.

DME providers will no longer be required to submit the signed Certificate of Medical Necessity Prior Approval (CMN PA form 372-131) for select DME codes at the time of discharge to home from a skilled nursing facility, a short term physical disability rehabilitation center or a hospital.

Note: There has been no change in Clinical Policy 5A, Durable Medical Equipment and Supplies, criteria. All Clinical Policy 5A criteria still apply with this new process.

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. However, shortly after NCTracks implementation in 2013, this process was suspended due to the backlog of pended provider managed change requests. Beginning November 2015, the recredentialing process has been reinstated.

Providers will receive a recredentialing/reverification letter, or an invitation via their NCTracks secure portal in-box or e-mail, when they are scheduled to begin the recredentialing process. This process is completed in the "Status and Management" section of the NCTracks Provider Portal under the section titled "Re-verification." A reverification application will only appear when it is time to re-verify. Providers are required to pay a $100 application fee for recredentialing/reverification.

Recredentialing is not optional. 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 Programs will be terminated**. Providers must submit a re-enrollment application to be reinstated.

ADDITIONAL BACKGROUND CHECKS DURING NCTRACKS ENROLLMENT

The System for Award Management (SAM) is the official U.S. government system that consolidated the capabilities of the:

- Central Contractor Registration (CCR)/FedReg,
- Online Representations and Certifications Application (ORCA), and
- Excluded Parties List System (EPLS).

According to §455.436 (federal database checks), the SAM database must be used to determine if there are final adverse actions that would disqualify an individual or organization from participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs. This system must be used for applicants, and for individuals and entities the applicant has identified as having a managing relationship and ownership with. As of Jan. 4, 2016, the SAM database check is being applied to enrollment, re-enrollment, re-verification and Manage Change Request (MCR) processes where credentialing is required. NCTracks uses the SAM database to identify applicants who should be disqualified from participation in the N.C. Medicaid or NCHC program because of a final adverse action on an individual or entity with a managing relationship to that applicant.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PROVIDER ENROLLMENT

As required by the Affordable Care Act, any vendor who provides NEMT services must enroll as a Medicaid provider through NCTracks, the Medicaid Management Information System. As enrolled Medicaid providers, vendors will no longer be reimbursed by the County Department of

Social Services (DSS). However, they are required to contract with the County DSS. The vendors will bill for transportation services through NCTracks.

The planned implementation date for NEMT vendors to begin submitting claims in NCTracks is August 1, 2016. NEMT vendors must begin enrolling prior to that date. DMA estimates that NEMT vendors can begin enrolling as Medicaid providers by May 2016. CSRA, the fiscal agent who runs NCTracks, will provide training on the enrollment requirements, including webinars, online training, or instructor-led training.

MEDICAID & HEALTH CHOICE PROVIDER FINGERPRINT-BASED CRIMINAL BACKGROUND CHECKS

In accordance with 42 CFR 455.434(b), providers designated as a "high" categorical risk will soon be required to submit a set of fingerprints to the North Carolina Division of Medical Assistance (DMA) through its enrollment vendor, CSRA, as a part of the federally mandated provider screening process. "High" risk providers are listed under 42 CFR 424.518 (c) and the North Carolina General Statute, 108C-3(g). The requirement for fingerprint based criminal background checks applies to both the "high" risk provider and 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. Providers will be able to identify all locations in North Carolina where fingerprinting services will be offered.

Providers required to submit fingerprint evidence will be notified in writing of the requirement. A deadline for compliance will be established and the providers who fail to meet the deadline will be denied participation in the NC Medicaid and Health Choice programs. Providers enrolled by Medicare or another State's Medicaid or CHIP program are not required to complete fingerprint- based criminal background checks to enroll in NC Medicaid and Health Choice.

# # #