WRITTEN SECTION REPORTS

(REPORT PERIOD SEPTEMBER 1, 2015 THROUGH DECEMBER 1, 2015)

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

The N.C. Physician Advisory Group met on 10/22/15
The Pharmacy & Therapeutic Committee met on 10/13/15, 11/10/15

Recommended Policies

- 1E-5, Obstetrics

Recommended Pharmacy

- PA Criteria Systemic Immunomodulators
- PA Criteria PCSK9 Inhibitors
- PA Criteria Growth Hormones
- PA Criteria Triptans
- Preferred Drug List (PDL) – Butrans, Consentyx

PAG Administrative Notification

- 1K-7, Prior Approval for Imaging Services
- PA Criteria - Brand-Name Drugs (DAW1) – Termination
- PA Criteria - Incivek (telaprevir) – Termination
- PA Criteria - Victrelis (boceprevir) – Termination

PAG Consult

- None

2. POLICIES POSTED FOR PUBLIC COMMENT

- PA Criteria Systemic Immunomodulators - Cosentyx
- PA Criteria PCSK9 Inhibitors- New PA Criteria
- PA Criteria Narcotic Analgesics - Oxecta/Oxado
- PA Criteria Hematinics - Mircera
- PA Criteria - Growth Hormones -Zomacton
- 1K-7, Prior Approval for Imaging Services
- Clinical Edits - Behavioral Health Pediatric
- Clinical Edits - Behavioral Health Adult
- Preferred Drug List (PDL) - Butrans, Consentyx
- PA Criteria – Triptans - Zecuity
- PA Criteria - Brand-Name Drugs (DAW1) – Termination
- PA Criteria - Incivek (telaprevir) – Termination
- PA Criteria - Victrelis (boceprevir) - Termination

3. POLICIES POSTED FOR ADDITIONAL PUBLIC COMMENT

- PA Criteria – PCSK9 Inhibitors - Repatha
- PA Criteria – Systemic Immunomodulators - Humira
- 3D, Hospice Services

4. AMENDED OR NEW POLICIES POSTED TO DMA WEBSITE

- 1A-15, Surgery for Clinically Severe or Morbid Obesity (9/01/15)
- 10D, Independent Practitioners Respiratory Therapy Services (9/03/15)
- 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 (10/01/15)
- 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older (10/01/15)
- 1E-1, Hysterectomy (10/15/15)
- 1E-4, Fetal Surveillance (10/15/15)
- 3L, State Plan Personal Care Services (PCS) (11/01/15)
- 5A, Durable Medical Equipment (11/01/15)
- 8A-1, ACT-Stand-Alone Service Definition (11/01/15)
- 1E-7, Family Planning Services (11/15/15)

(ALL POLICIES WERE UPDATED TO REFLECT THE OCTOBER 1, 2015 IMPLEMENTATION DATE FOR ICD 10.)

The following new or amended behavioral health policies are in process:

1. **8A-1, ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM**
   This policy was first posted with an effective date of August 1, 2015. This service definition was taken out of CCP 8A, Enhanced Mental Health and Substance Abuse Services, and made a standalone policy, CCP 8A-1. In the process, a sentence regarding training requirements for vocational staff was inadvertently left out. The sentence has been replaced and the updated policy should be ready to post December 1, 2015.

2. **8A-2, Facility Based Crisis for Children and Adolescents (FBC-C)**
   FBC-C was posted for internal DMA comment, presented to PAG in January, posted for 45 day comment in April and was posted in September for another 15-days public comment. The clinical policy has been approved; however, approval for final posting is pending approval of the fiscal note. Once the fiscal note is approved this policy can be posted.

3. **8A, Intensive In-Home (IIH) (Service Definition)**
   No change: Awaiting approval from CMS regarding fiscal impact due to the revised policy to reflect the legislative mandate to increase family to team ratio to 1:12 from 1:8.

4. **8C Outpatient Behavioral Health Services Provided by Direct Enrolled Providers**
   The updated policy was posted on October 1, 2015. The most significant changes:
   - Incident to billing was removed. All associate professional now must enroll under their own NPI.
   - The five-hour limit for psychological testing was removed. PA is now required; however, the number of hours authorized will vary based on medical necessity and the beneficiary's level of need.
   - A referral from a primary care physician, CCNC, or LME-MCO is no longer required for children seeking behavioral health outpatient therapy.
   - Fully licensed professionals are now allowed to sign their own treatment plan and that signature will also serve as a service order.
   - Extended the sunset clause to allow two more years for a nurse practitioner to receive his/her Psychiatric Mental Health Nurse Practitioner certification; due date is now June 30, 2017.
   - Clarified the elements of an assessment completed in an integrated care practice when a beneficiary is seen six sessions or less. Prior to the seventh session, a full comprehensive clinical assessment is required.

5. **1A-41, OFFICE BASED OPIOID TREATMENT: USE OF BUPRENORPHINE**
   Policy posted for internal 10-day comment. This policy follows national guidelines and incorporates guidance from other state policies on the prescribing of buprenorphine in the office setting for treatment of opioid use disorder. The policy outlines admission criteria, timeframes for treatment, continued stay, discharge criteria, and other provider requirements for prescribing buprenorphine and monitoring treatment.

6. ADDITIONAL BEHAVIORAL HEALTH UPDATES:

- A draft 1915(c) waiver for children who are seriously and emotionally disturbed is being prepared to submit to the legislature.

- Our LME-MCOs have the authority to develop and implement alternative service definitions to provide additional services for which they have identified as a need in their catchment area. DMA has now approved six alternative service definitions.

- DMA and the Division of Mental Health, Developmental Disability, and Substance Abuse Services continue to work collaboratively to finalize a fidelity-based Supported Employment policy. This policy will be based off of the Individual Placement and Support model; designed to assist people with severe mental illness obtain and maintain competitive employment.

- DMA is looking into the possibility of adding two new behavioral health state plan services; Tenancy Support and Critical Time Intervention. Tenancy Supports is a service designed to promote community integration for beneficiaries with disabilities, adults needing long term service and supports, and those experiencing chronic homelessness. Critical Time Intervention is a time-limited, intensive case management service. It is designed to help vulnerable people during times of transition in their lives by strengthening their network of support in the community.

BEHAVIORAL HEALTH IDD UPDATES:

1. Treatment for Autism Spectrum Disorder:

The state is exploring options to provide additional services to this population, with assistance from Mercer and stakeholder engagement. DMA and Mercer have scheduled telephone meetings with the four largest providers of Applied Behavioral Analysis as identified by the NC Association for Behavioral Analysis. These discussions will center on utilization patterns and staffing models, with the results being factored into an estimated budget, and timeline for the state to implement Intensive Behavioral Treatment services.

2. TBI Waiver:

Session Law 2015-241, SECTION 12H.6.(b) instructed the Department to report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid Traumatic Brain Injury (TBI) waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served;
(2) The expenditures to date and a forecast of future expenditures; and
(3) Any recommendations regarding expansion of the 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 the TBI Medicaid Waiver based on the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. The Committee recommended the development of a home and community based services TBI Waiver that:

- encompasses the needs of individuals with long-term care needs and more intensive rehabilitative needs;
- begins the TBI Waiver in a specific geographic area; and
- phases the TBI Waiver into other areas of the state after evaluating the program and making changes based on successes and lessons learned

3. **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 of 2015 and is currently under review by CMS. The requested effective date is 4/1/16.

4. **Home and Community Based Services Rule:**
   An update to the State's HCBS transition plan was to CMS for review. It contained updated information as well as clarification requested by CMS. The provider self-assessment for CAP DA and Innovations waiver services ended 9/15/15. The provider self-assessment for (b)(3) services ended 10/15. DMA and the PIHPs have until 12/31/15 to complete their review of the self-assessments with an analysis due to DMA by 1/15/16. A draft of an individual experience assessment is currently under review by stakeholders. Additional information on the HCBS Rule can be found at http://www.ncdhhs.gov/hcbs/index.html

NC HEALTH CHOICE EXTENDED COVERAGE BENEFIT ELIMINATED

With the enactment of Session Law 2015-241, Appropriations Act of 2015 (State budget) on September 18, 2015, the law authorizing the NC Health Choice Extended Coverage benefit was repealed. Section 12H.14.(c) of the Act repealed N.C. General Statute §108A-70.21(g), which authorized the purchase of Extended Coverage for NC Health Choice beneficiaries who had become ineligible for insurance because of a family income increase. Since the repeal of the law was effective upon signing, the Extended Coverage benefit is no longer available.

Individuals and their families or guardians were encouraged to obtain health insurance coverage through an employer-based insurance plan or North Carolina's Federally-facilitated Marketplace at: www.healthcare.gov.

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA) AND CHILDREN (CAP/C)

The CAP program waives certain NC Medicaid requirements to furnish an array of home and community based services to Medicaid eligible individuals with disabilities who are at risk of institutionalization. The services are designed to provide an alternative to institutionalization for beneficiaries who prefer to remain in their primary private residences, and would be at risk of institutionalization without these services.

The program supplements the formal and informal services and supports already available to a beneficiary, and is intended for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial and functional needs of the beneficiary.

In 2011, the Division of Medical Assistance (DMA) implemented a project to merge the Community Alternatives Program Waivers, Community Alternatives Program for Children CAP/C and Community Alternatives Program for Disabled Adults CAP/DA. In March 2014, The Centers for Medicare and Medicaid Services (CMS) implemented an HCBS Final Rule to encourage states to combine waivers that targets similar populations.

Between 2011 -2015 work groups met to identify waiver processes to aid in the merger of these two waivers. These work groups analyzed the six waiver assurances and case management practices to identify similarities, differences and methods for consolidation.

Recommendations from these work groups were used to draft the proposal of the combined 2015 CAP waiver. This draft waiver will be submitted to CMS for review and approval in December 2015.

LOOKING FORWARD

1. The implementation of a merged waiver for the CAP/C and CAP/DA programs will increase administrative efficiency of the delivery home and community based services:

   - Assists with streamlined waiver processes
   - Assists with person-centered planning to exercise choice and assumed risk
   - Provides greater access to community inclusion and integration
   - Target group age: 0 to 115+
   - Total of 15,214 per waiver year (11, 214 adults and 4, 000 children)

2. Services Covered under the Merged Waiver

Adult Day Health
Case Managements
Institutional and Non-Institutional Respite
Personal Care
Expanded Skilled Nursing Services
Financial Management Services
Assistive Technology
Community Transition
Home Accessibility and Adaption (Home Modification)
Meal Preparation and Delivery
Participant Goods and Services
Personal Emergency Response System
Specialized Medical Equipment and Supplies
Training, Education, and Consultative Services
Vehicle Modification

3. Operational Enhancements

The implementation e-CAP, a new case management and business system increased the efficiency of CAP/DA administration for case managers:

- Assists with management of daily administrative functions
- Acts as quality assurance system
- Houses the service request form to determine basis eligibility for CAP/DA participation

The NCTracks and NC FAST transition improved program efficiency:

- Better management of enrolled waiver providers
- Improved process for determining of prior approval for level of care for waiver participation
- Eliminated a number of waiver claims that did not meet waiver criteria

OUTPATIENT PHARMACY

1. New Pharmacy Prior Authorization for PCSK9 Inhibitors

DMA received approval from P&T and PAG for new Prior Authorization (PA) criteria for PCSK9 Inhibitors. This is a very expensive medication used to treat high cholesterol in patients with Hetero- or Homozygous Familial Hypercholesterolemia or for patients with a prior cardiovascular event whose cholesterol is not controlled by a statin. The PA criteria ensures that only those who need the medication can obtain it.

2. Pharmacy Reimbursement

DMA has been trying to move to a new reimbursement method since January of this year. We have resubmitted the State Plan Amendment (SPA) at the request of the Center for Medicare and Medicaid Services (CMS), with a new dispensing fee survey. A new effective date of January 1, 2016 will be in effect once CMS approves the SPA. We will begin using the CMS national survey, the National Average Drug Acquisition Cost (NADAC) survey to establish reimbursement rates. This survey tries to price medication at actual acquisition cost. Because this lowers the price we pay on medications we will be raising dispensing fees to pharmacy providers to offset this reduction in medication spend.

CMS MEDICAID PROGRAM INTEGRITY REVIEW

The Center for Medicare and Medicaid Services (CMS) Investigations and Audit Group recently concluded a focused review of the North Carolina Medicaid Program. PER CMS the review was designed to evaluate the effectiveness of North Carolina's program integrity activities in managed care and North Carolina's policies, procedures, and oversight of non-emergency medical transportation (NEMT). Extending over several months the review consisted of comprehensive questionnaires, extensive interviews with staff from the managed care and NEMT programs as well as onsite visits to both state and provider facilities. On October 16 the CMS review team held an informal exit conference with state Medicaid management to present observations of the review. It is expected that CMS will issue the final report to the state within the next several months. The state will be afforded the opportunity to provide a formal response to the CMS findings.

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

QC staff have begun visiting county departments of social services to conduct Corrective Action Record Reviews (CARR) reviews of Medicaid and CHIP eligibility cases. During these visits, desk reviews of Medicaid eligibility determinations are completed and information is shared with counties regarding deficiencies in documentation and verification for the cases reviewed. County departments of social services are encouraged to use the information to train staff to prevent future errors.

INCREASED ENROLLMENT OF BENEFICIARIES TO A PRIMARY CARE PROVIDER (PCP)

The N.C. Division of Medical Assistance (DMA) will be auto-assigning an eligible population of Medicaid and NC Health Choice (NCHC) beneficiaries with a Community Care of N.C. (CCNC) primary care provider (PCP), also referred to as a health home. This initiative began September 2015. CCNC is an enhanced primary care case management program which provides patient-centered, community-based, and evidence-based health care. Its goals are to improve quality and access to care, support appropriate utilization of services, and promote cost-effectiveness through care coordination within health homes.

Using the NCTracks Medicaid Management Information System (MMIS), targeted Medicaid and NCHC beneficiaries will be linked to a CCNC PCP in their county of residence. Medicaid caseworkers in the county department of social services offices will answer beneficiary questions about assigned CCNC providers.

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 will be 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 reverify. 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.

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