

WRITTEN SECTION REPORTS

(REPORT PERIOD JUNE 24, 2017 THROUGH SEPTEMBER 22, 2017)

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

The N.C. Physician Advisory Group met on 07/27/17 and 08/24/17

The Pharmacy & Therapeutic Committee met on 07/11/17, 08/08/17, and 09/12/17

Recommended Policies

- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – 07/27/17
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – 07/27/17
- 3D, Hospice Services – 07/27/17
- 10C, Local Education Agencies (LEAs) – 07/27/17
- 11C, Ventricular Assist Devices – 08/24/17
- 12B, Human Immunodeficiency Virus (HIV) Case Management – 08/24/17

Recommended Pharmacy

- PA Criteria: Antinarcotism/Antihyperkinesia Agents (Armodafinil) – 08/24/17
- PA Criteria: Immunomodulators (Kevzara, Orencia) – 08/24/17
- PA Criteria: Neuromuscular Blockers (Dysport)– 08/24/17
- PA Criteria: Opioid Dependence Therapy Agents (Suboxone Film)– 08/24/17
- PA Criteria: Opioid Analgesics – 08/24/17
- Annual Preferred Drug List Update (Part 2) – 08/24/17

PAG Notification

- State Plan Personal Care Services (PCS) – 07/27/17

2. Policies posted for Public Comment

- Outpatient Pharmacy Clinical Edits - Behavioral Health – Pediatric – 06/20/17
- Outpatient Pharmacy Clinical Edits - Behavioral Health – Adult – 06/20/17
- PA Criteria: Hepatitis C Virus Medications (Solvaldi)– 06/22/17
- State Plan Personal Care Services (PCS) – 06/30/17
- PA Criteria: Anti-Inflammatory Medications (Dupixent) - 07/06/17
- PA Criteria: Spinraza - 07/06/17 PA Criteria: Systemic Immunomodulators (Humira and Enbrel) - 07/06/17
- PA Criteria: Cystic Fibrosis (Kalydeco) - 07/06/17
- Preferred Drug List (PDL) - 07/10/17 and 7/19/17 to correct an oversight
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older – 08/02/17
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age – 08/02/17
- 3D, Hospice Services – 08/02/17
- 10C, Local Education Agencies (LEAs) – 08/02/17
- 11C, Ventricular Assist Devices (VAD)– 08/31/17
- PA Criteria: Hepatitis C Virus Medications (Solvaldi)– 09/01/17
- 12B, Human Immunodeficiency Virus (HIV) Case Management – 09/06/17
- PA Criteria Opioid Dependence Therapy Agents (Suboxone Film) – 09/06/17

3. New or Amended policies posted to DMA website

- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers – 07/01/17
- 1A-30, Spinal Surgeries – 08/01/17
- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone – 08/01/17
- 1E-2, Therapeutic and Non-therapeutic Abortions – 08/01/17
- 1T-2, Special Ophthalmological Services – 08/01/17
- 5A-1, Physical Rehabilitation Equipment and Supplies – 08/01/17
- 5A-2, Respiratory Equipment and Supplies – 08/01/17
- 5A-3, Nursing Equipment and Supplies – 08/01/17
- 5B, Orthotics & Prosthetics – 08/01/17
- 1-I, Dietary Evaluation and Counseling and Medical Lactation Services – 08/03/17
- 3L, State Plan Personal Care Services (PCS) – 08/04/17
- 1E-1, Hysterectomy – 09/01/17
- 10A, Outpatient Specialized Therapies – 09/01/17

4. Outpatient Pharmacy

Update on Claims Reprocessing Due to Pharmacy Reimbursement Methodology Changes

This is an update to the article in the July 2016 Pharmacy Newsletter.

The claim reprocessing timeframe outlined in the July notification has changed. The claim reprocessing will still begin on August 15, but rather than ending on November 21, 2017, it will continue through March 27, 2018. The extended timeframe is intended to help reduce the impact on providers in a given checkwrite.

As outlined in the June 2016 and July 2016 Pharmacy newsletters ([Medicaid website](#)), the Pharmacy Reimbursement Methodology changes were implemented in NCTracks on July 31, 2016.

Pharmacy claims processed and paid in NCTracks from January 1 through July 30, 2016, will be reprocessed with the new NADAC reimbursement methodology.

Initially, a sample set of claims were pulled and pended for analysis in advance of the claims reprocessing. These claims transactions posted to the Remittance Advice (RA) in the August 1, 2017, checkwrite but did not have financial activity.

Subsequently, the reprocessed pharmacy claims will be reflected in the checkwrites between August 15, 2017, and March 27, 2018. (There will be one additional checkwrite cycle after analysis of the reprocessed claims. A notice will be sent when the date of the final checkwrite cycle is determined).

The reprocessed claims will be reported in a separate section of the paper Remittance Advice (RA) with the unique Explanation of Benefits (EOB) code 06025 - CLAIM REPROCESSED TO PAY USING NADAC (NATIONAL AVERAGE DRUG ACQUISITION COST) PRICING METHODOLOGY. The EOB 06025 will only appear on the paper RA and will not appear on the X12 835. The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

Important Reprocessing Information: Reprocessing does not guarantee payment for the claims. Pharmacy claims will be reprocessed with the new reimbursement methodology. Also, while some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to the reprocessed claims. Therefore, the reprocessed claims could deny.

The claim reprocessing will likely result in a recoupment of funds. If there are not sufficient funds from claims paid in the August 15, 2017, through March 27, 2018, checkwrites to satisfy the recoupment, an Accounts Receivable (AR) will be created. Recoupment of the AR will begin with the subsequent NCTracks checkwrite and the recoupment process will continue at each checkwrite until the full amount due is recouped.

If funds are insufficient to collect the full amount due from the NPI for which the AR was generated, NCTracks will automatically seek to recoup the AR from other NPIs with the same Internal Revenue Service Taxpayer Identification Number. For more information about the AR process, see the [NCTracks February 29, 2016, announcement](#).

Pharmacy Reimbursement Methodology Changes

On July 21, 2017, the Centers for Medicare & Medicaid Services (CMS) notified the Division of Medical Assistance (DMA) that our State Plan Amendment (SPA TN# 17- 0003) had been reviewed and was approved effective April 1, 2017. The purpose of the proposed changes is to align the State Plan with changes to CFR 447.512 and 447.518 enacted in the covered outpatient drugs final rule (CMS-2345-FC).

This SPA implements changes to the pharmacy reimbursement methodology for ingredient costs and the professional dispensing fees for clotting factor based on a survey of costs for Hemophilia Treatment Centers (HTCs) and non-HTCs. A state maximum allowable cost (SMAC) rate will be established based on actual acquisition costs for all clotting factor drugs to determine reimbursement of the ingredient cost and the professional dispensing fees for all clotting factor drugs will be \$0.04 per unit for HTCs and \$0.025 per unit for non-HTCs.

Moreover, the SPA specifies that drugs purchased through 340B covered entities, Federal Supply Schedule, nominal price, and specialty drugs will be reimbursed at their actual acquisition costs.

This reimbursement methodology IS NOT programmed in NCTracks at this time. Once programming is completed, pharmacy claims paid between April 1, 2017, and when the updated reimbursement methodology is implemented into NCTracks will be reprocessed according to the updated reimbursement methodology.

Until then, pharmacies will continue to be paid according to the current reimbursement methodology. Pharmacies are advised that this may result in an overpayment. Once the claims reprocessing is completed, any overpayment will be recouped against future payments.

Updated Prior Approval Criteria for Opioid Analgesics

Due to decades of prescribing more opioids, North Carolina is experiencing an opioid epidemic. From 1999 to 2016 more than 12,000 North Carolinians died from opioid-related overdoses. This epidemic is devastating families and communities. It is overwhelming healthcare providers and is straining prevention and treatment efforts.

On June 27, 2017 at the NC Opioid Misuse and Overdose Prevention Summit, NC Governor Roy Cooper and NC Department of Health and Human Services Secretary Mandy Cohen announced [North Carolina's Opioid Action Plan](#), which outlines the key actions that we collectively believe will have the greatest impact on reducing opioid addiction and overdose death. The goal is to change the trajectory of opioid deaths and reduce opioid overdose deaths by 20% by 2021.

NC's Opioid Action Plan was developed with community partners to combat the opioid crisis. It is a living document that will be updated as we make progress on the epidemic and are faced with new issues and solutions. Strategies in the plan include:

- Coordinating the state's infrastructure to tackle the opioid crisis.
- Reducing the oversupply of prescription opioids.
- Reducing the diversion of prescription drugs and the flow of illicit drugs.
- Increasing community awareness and prevention.
- Making naloxone widely available.

- Expanding treatment and recovery systems of care.
- Measuring the effectiveness of these strategies based on results.

Over the past several months, the NC Division of Medical Assistance (DMA) Pharmacy Program has worked collaboratively with our Pharmacy and Therapeutics Committee and Physicians Advisory Group to update clinical coverage criteria for the use of opioids for pain management based on the [Centers for Disease Control \(CDC\) Guideline for Prescribing Opioids for Chronic Pain](#) and to align clinical coverage criteria with the strategies of reducing the oversupply of prescription opioids available for diversion and misuse.

These updates began on May 1, 2017, when the refill threshold for all opioids and benzodiazepines prescriptions was increased from 75% to 85%.

Beginning **August 27, 2017**, prior approval will be required for opioid analgesic doses for N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries which:

- Exceed 120 mg of morphine equivalents per day
- Are greater than a 14-day supply of any opioid, or,
- Are non-preferred opioid products on the [NC Medicaid Preferred Drug List \(PDL\)](#)

The prescribing provider may submit prior authorization requests to NCTracks through the NCTracks portal or by fax. New opioid analgesic prior authorization forms and revised clinical coverage criteria will be available on the NCTracks website.

Beneficiaries with diagnosis of pain secondary to cancer will continue to be exempt from prior authorization requirements.

This change also includes a new feature for prescribers to view only lock-in drugs or opioid analgesics when performing medication history searches for beneficiaries. However, the data represents only opioid claims paid by NC Medicaid and should not be used as a replacement for reviewing the [NC Controlled Substance Reporting System \(CSRS\)](#) as required by clinical coverage criteria and the recently passed [Strengthen Opioid Misuse Prevention \(STOP\) Act, S.L. 2017-74](#).

Educational Resources for Providers

New information related to managing Opioid usage by NC Medicaid and NC Health Choice (NCHC) beneficiaries has been published by the NC Division of Medical Assistance (DMA). DMA realizes that the changes in Opioid criteria may impact prescribing behavior and have partnered with Community Care of North Carolina (CCNC) to communicate these changes and provide educational resources to NC providers. The new educational resources include:

- Prior Approval Criteria for Opioid Analgesics
- Non-Opioid Alternatives
- DMA Opioid Safety – STOP Act Crosswalk
- FAQ on Naloxone Standing Order
- Provider Considerations for Tapering of Opioids
- NC DMA Preferred Drug List Opioid Daily MME

Links to these Opioid educational resources are on the NC DMA [Outpatient Pharmacy Services web page](#) and the [Pharmacy Services web page](#) of the NCTracks provider portal.

For more information about the changes to Opioid criteria, refer to the [August 2017 Medicaid Bulletin](#) and the [July 2017 Pharmacy Newsletter](#).

Board of Pharmacy Issues Guidance to Pharmacists on Implementation of the Strengthen Opioid Misuse Prevention (“STOP”) Act

The North Carolina General Assembly has passed, and the Governor has signed into law, the **Strengthen Opioid**

Misuse Prevention (STOP) Act, S.L. 2017-74. The STOP Act is an effort to combat the opioid abuse and misuse epidemic. The STOP Act makes changes to the laws governing controlled substance prescribing, controlled substance dispensing, and the North Carolina Controlled Substance Reporting System July 2017 7 (“CSRS”). This FAQ guidance discusses those changes: <http://www.ncbop.org/PDF/GuidanceImplementationSTOPACTJuly2017.pdf>.

Pharmacy Behavioral Health Clinical Edit Implements July 30, 2017

On May 1, 2017, new pharmacy point of sale (POS) clinical edits for behavioral health medications became effective for pediatric and adult beneficiaries prescribed such medications. These edits are specifically related to dosage and quantity prescribed which exceeds the Food and Drug Administration (FDA) approved maximum dosage, dosage schedule and in class therapeutic duplication.

A 90-day grace period was allowed to provide an opportunity for providers and pharmacists to identify and address any therapeutic issues that may be impacted by these new POS behavioral health clinical edits.

The 90-day grace period has been completed and DMA plans to implement only one of the POS behavioral health clinical edits for pediatrics and adults at this time. **The pediatric and adult edit for antipsychotic drug claims for quantities exceeding the dosages recommended by the FDA will deny beginning on July 30, 2017.** The message below will be returned to the pharmacist for all claims that deny for this edit:

“Qty exceeds the pediatric/adult dosage recommended by the FDA for atypical antipsychotics.”

Bypassing this edit will require an override that should be used by the pharmacist when the prescriber provides clinical rationale for the therapy issue identified by the edit. The edit override is 10 entered in a submission clarification code field.

More detailed information about all of the POS behavioral health clinical edits for pediatrics and adults is available on the Pharmacy PA Criteria page in NCTracks found at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-newformat.html>.

Coverage for Spinraza™ (nusinersen injection, for intrathecal use)

Effective with date of service June 1, 2017, or later, the North Carolina Medicaid Pharmacy Program covers nusinersen injection, for intrathecal use (Spinraza™) through the Outpatient Pharmacy program after approval for use by Prior Authorization. Spinraza™ is not covered through the Physicians’ Drug Program.

Spinraza™ coverage criteria and a temporary request form can be found on the [NCTracks Pharmacy webpage](#).

FDA Requests Voluntary Removal of Opana ER for Risks Related to Abuse

Endo Pharmaceuticals has announced that it will voluntarily remove Opana ER (oxycodone ER) from the market. This decision comes after FDA’s request in June for Endo to remove reformulated Opana ER from the market.

Endo plans to work with the FDA to coordinate the orderly removal of Opana ER.

Endo news release: <http://www.endo.com/news-events/pressreleases?c=123046&p=irol-newsArticle&ID=2284981>

Generic Dispensing Rate Adjustments

Generic dispensing rate adjustments go into effect on August 1, 2017. These rates are based on the [Generic Dispensing Rate Report](#) for second quarter 2017.

Claim Level Generic Dispensing Rate (GDR) Reports

DMA has developed a Generic Dispensing Rate (GDR) report at the claim level detail to help pharmacy providers identify missed opportunities to maximize their generic dispensing rate. A pharmacy provider may obtain their claim level GDR report by e-mailing Medicaid.GDR.Report@dhhs.nc.gov. The e-mail request must include the following information:

- Pharmacy name
- Pharmacy NPI number
- Name and contact info for the person requesting the report
- E-mail address where the report should be sent
- GDR report quarter(s) being requested

The claim level GDR report(s) will be sent in Excel format and via secured e-mail within five business days following receipt of the request.

72-hour Emergency Supply Available for Pharmacy Prior Authorization Drugs

Pharmacy providers are encouraged to use the 72-hour emergency supply allowed for drugs requiring prior authorization. **Federal law requires that this emergency supply be available to Medicaid beneficiaries for drugs requiring prior authorization** (Social Security Act, Section 1927, [42 U.S.C. 1396r-8\(d\)\(5\)\(B\)](#)). Use of this emergency supply will ensure access to medically necessary medications.

The system will bypass the prior authorization requirement if an emergency supply is indicated. Use a "3" in the Level of Service field (418-DI) to indicate that the transaction is an emergency fill.

Note: Copayments will apply and only the drug cost will be reimbursed. There is no limit to the number of times the emergency supply can be used.

PDL Panel Meeting

The annual meeting of the Preferred Drug List (PDL) Review Panel will be held on Thursday, September 21, 2017, 10 a.m. to 5 p.m. at The State Library Building located at 109 East Jones Street, Raleigh, NC.

Speakers may register to speak for PDL drug classes which are open for review in the [proposed PDL](#). To register to speak at the PDL Review Panel meeting, send an email to DMA.PDLReviewMeeting@lists.ncmail.net by 10 a.m. on September 20, 2017. Please include the name of the speaker, the represented organization and the drug name. You may attach any clinical information regarding the drug you wish the PDL Panel to review beforehand. Presentations are allowed only in the PDL drug classes with proposed changes and should not exceed three minutes.

Progestational Class New to PDL

Effective September 1, 2017, North Carolina Medicaid will be adding a new class of drugs to the Preferred Drug List (PDL). The new class will be Progestational Agents. Makena® and compounded 17P will be listed as preferred products.

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

The CMS Home Health Final Rule – 42CFR, Part 440.70 became effective for Clinical Coverage Policies 5A-1, 5A-2, 5A-3 and 5B on July 1, 2017. To provide guidance and ensure a smooth transition, the DME clinical policy manager held weekly calls with CSRA and the provider community during the months of July and August. The calls were discontinued at the end of August due to an absence of demand and good compliance with the final rule.

6. Outpatient Specialized Therapies

DMA 10-A, Outpatient Specialized Therapies was a Non-PAG revision implemented 9-1-2017.

10-C, Local Education Agencies (LEA) was a PAG revision and it is currently out for public comment until 9-16-2017. Amendments to Clinical Coverage Policy (CCP) 10C include:

- Policy revised to more closely align to CCP 10A and CCP 10B.
- The addition of the new occupational therapy evaluation and re-evaluation codes (97165, 97166, 97167 and 97168) and physical therapy evaluation and re-evaluation codes (97161, 97162, 97163 and 97164) that were implemented 1-1-2017 and have been included in the policy.
- Removed from policy, "Assessment services are billable only for students receiving assessment services prescribed through an IEP. Initial assessments done for the purpose of identification for Special Education Services are only reimbursable from Medicaid after the development of an IEP that lists the service as one being needed by the beneficiary. If the assessment does not reveal "medical necessity" for the services, the assessment cannot be billed." Evaluation services, when administered by a licensed professional, regardless of outcome, should be billable when administered to Medicaid beneficiaries. Evaluation services are billable when administered by a licensed occupational therapist, physical therapist, speech/language pathologist, and psychologist regardless of the results for every other provider type.

7. Home Care Services

DMA responded to an informal request from CMS for clarity and language changes to the Home Health State Plan Amendment pages in regards to Federal and State Tribal Authority.

A Private Duty Nursing Services (PDN)

DMA revised the PDN Clinical Coverage Policies 3G-1 & 3G-2:

- **3G-1, Private Duty Nursing for Beneficiaries 21 Years of Age and Older**
 - Prior authorization (PA) certification period extension: PA certification periods will be extended to 6 months instead of 60 days. Documentation for reauthorization shall be submitted 30 days prior to the end of the current approved certification period – this will include the signed CMS-485 Plan of Care.
- **3G-2: Private Duty Nursing for Beneficiaries Under 21 Years of Age**
 - PDN and schools: Clarification of how and when providers are to document nursing in school, how PDN services in the home will be covered when beneficiary is out of school, and new documentation that will be help capture this information (Verification of School Nursing form).
 - Congregate care: Expansion of definition to include the maximum ratio of beneficiaries to private duty nurse and specific billing codes that will indicate whether a RN or LPN is providing the congregate care.
 - Prior authorization (PA) certification period extension: PA certification periods will be extended to 6 months instead of 60 days. Documentation for reauthorization shall be submitted 30 days prior to the end of the current approved certification period – this will include the signed CMS-485 Plan of Care.

B Home Health

Additional modifications were made to CCP 3A to further support compliance with the federal implementation of the Home Health Final Rule. The recent revisions are technical policies changes, that will be posted for public comment following the September 28, 2017, PAG Notification.

Proposed Policy Actions:

- Clarify the process for providers and beneficiaries who would like to request medical supply items that are not listed on the Fee Schedule.
- Modify the criteria for Home Health Aide Services, clarifying that services are available without the requirement of skilled nursing or specialized therapy services.

- Remove the ambiguous language indicating that Home Health Services must be provided in the primary private residence (home) of the beneficiary and clarify that the beneficiary is not required to be homebound to receive services.

C Hospice

DMA revised the PDN Clinical Coverage Policies 3D:

- **Requirements General**

The first (1st) benefit period and second benefit period (2nd) are both 90 calendar days. This begins the initial admission to Hospice service based on the original election date for the beneficiary and the **Notice of Election required (new)**. At the first (1st) benefit period, the hospice provider(s) shall upload the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement per 42 CFR 418.24 via online portal through DMA medical system NCTracks Provider Portal.

- **Certification Prior Approval Requirements**

The third (3rd) benefit periods and each subsequent are all 60 calendar days. The Hospice provider(s) shall upload all document via online portal through DMA medical system NCTracks Provider Portal. Instead of the fifth (5th) benefit period. CRSA will be process all prior approvals except the PCS coordination forms.

- **Routine Home Care (RHC) Rates Policy**

The FY2016 Medicare Hospice Final Rule replaces the single RHC per diem rate with two different RHC payment rates

- A higher payment rate for the first 60 days of hospice care
- A reduced payment rate for 61 days and over of hospice care

A 60-day gap in hospice services is required to reset the counter that determines if a patient is qualified for the 1-60 payment category.

- **Service Intensity Add-On (SIA)**

The SIA payment is in addition to the per diem RHC rate when all of the following criteria are met:

- The day is an RHC level of care day
- The day occurs during the last 7 days of the patient's life, and the patient is discharged expired
- Direct patient care is furnished by a registered nurse (RN) or social worker that day
- The SIA payment will equal the Continuous Home Care (CHC) hourly payment rate, for a minimum of 15 minutes and up to 4 hours total per day
- Payment change is budget neutral and paid for through a reduction in the RHC rate
- Going forward, yearly fluctuations in the total size of the add-on will impact the yearly RHC rates
- New G-codes will be used to identify RN versus LPN visits

RC0235 will be used to price details at an hourly rate the same way RC0652 currently pays.

HCPCS Codes currently on file as non-covered will be updated under separate FMR:

- G0299 – Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, Each 15 Minutes
- G0300 – Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting, Each 15 Minutes
- G0155 - Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes

8. Behavioral Health IDD Section Updates:

Treatment for Autism Spectrum Disorder:

The draft State Plan Amendment (SPA) has been complete and is pending submission to CMS.

TBI Waiver:

DMA responded to a formal request for additional information from CMS on the TBI waiver specifically regarding the Home and Community Based Standard (HCBS) process and ensuring that all potential sites are fully compliant with CMS's Final HCBS rule. . We are currently making clarifying corrections as requested by CMS.

Innovations Waiver:

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. Four face to face listening sessions and five web based listening sessions were held.:

We are currently working through the feedback gathered with our NC Innovations State Stakeholder group. The State Stakeholder group is made up of individuals receiving services, family members and providers. The goal is to submit the NC Innovations waiver to CMS in mid-December 2017.

Behavioral Health Clinical Policy Updates:**Services for Substance Use Disorders:**

DMA and DMH/DD/SAS completed listening sessions across North Carolina to gather feedback on the current substance use disorder service array and areas for improvement. Stakeholders noted the need for more comprehensive recovery supports such as housing and transportation services. The Department is in the process of meeting with other states to discuss their continuum of substance use disorder services. An internal review of the revised substance use continuum was completed and found to be comprehensive.

Critical Access Behavioral Health Agencies (CABHA)

CABHA certification is required per statute, state plan and policy for service providers who provide the following enhanced services, Intensive In home, Target Case Management, Day Treatment for Children and Adolescent, and Community Support Team. A special provision was submitted to the legislature to remove CABHA language. DMA is still waiting on the status of this special provision.

Community Support Team (CST)

DMA and DMH/DD/SAS are in the process of updating the CST policy to add additional emphasis on therapeutic interventions and permanent supportive housing. With these additions to CST, the plan is to not have an additional separate Transition Management Services policy. Although the plan is to only amend CST, it will require a change to the State Plan; both clinical and fiscal. The draft clinical policy has been completed. DMA is in the process of working with Provider Reimbursement to determine the rate for this amended service.

LME-MCO Contract Section Updates:**External Quality Review**

DMA continues to work on the SFY 17/18 External Quality Reviews (EQR) for each LME-MCO. EQRs focus on quality, timeliness, and access to the health care services that an LME-MCO furnishes to Medicaid beneficiaries. Trillium, Vaya, Sandhills Center and Partners have been completed. Eastpointe, Cardinal and Alliance will have their reviews in October, December and January, respectively.

Nash Transition

Effective July 1, 2017, Trillium Health Resources became the responsible LME-MCO for Nash County residents.

Community Behavioral Health Service Needs, Providers and Gaps Analysis:

The annual LME-MCO Community Behavioral Health Service Needs, Provider and Gaps Analysis 2017 submissions are currently under review by DMA and DMH/DD/SAS. LME-MCOs are required to ensure access and availability standards are met for Medicaid beneficiaries.

Mental Health and Substance Use Disorder Parity:

DMA has begun an analysis of clinical policies to determine what steps are necessary to come into compliance with the new Mental Health and Substance Use Disorder Parity final rule.

9. Long Term Services and Supports

Community Alternatives Program for Disabled Adults (CAP/DA)

The § 1915 (c) Home and Community-Based Services Waiver for the Community Alternatives Program for Disabled Adults (CAP/DA) is scheduled to expire on Sept. 30, 2018. The N.C. Division of Medical Assistance (DMA) must submit a waiver renewal application to the Centers for Medicare & Medicaid Services (CMS) no later than June 1, 2018, 90 days prior to the expiration of the waiver, to ensure the continuation of the waiver. In addition to the waiver renewal application, the Clinical Coverage Policy, 3K-2, *Community Alternatives program for Disabled Adults (CAP/DA)*, will be revised to support the clinical operation of CAP/DA.

To initiate the planning activities for the expiring waiver, stakeholder engagement is planned to seek input in future waiver processes and clinical components for a renewal waiver with an effective date of October 1, 2018. Listening sessions are scheduled across North Carolina and will begin in last October and conclude in mid-November 2017. These events are open to all stakeholder groups including beneficiaries, case management agencies, providers and Divisions within the Department of Health and Human Services.

The CAP/DA waiver is currently supporting 10,459 individuals to live safely in their home communities. Of the 10,549 participants, 112 are assigned an Alzheimer's slot, a targeted group appropriated through Session Law 2016-94, Section 12H.5. Approximately 257 individuals are in various stages of waiver approval. There are 2,009 individuals waiting for services on a county based waitlist.

Community Alternatives Program for Children (CAP/C)

Consumer-direction was launched statewide for the CAP/C waiver in August 2017. Consumer direction is the shift of decision-making and control of the choice of care provider and services from the service provider to the waiver participant. From the implementation of this statewide rollout, a total of 75 individuals have enrolled in this option of care. This option of care in aide in addressing access to care concerns as identified by participants in the western and southeastern regions of the state.

CAP/C is currently supporting 2,398 individuals to live in their home communities. Currently, a total of 298 waiver participation requests are being processed for consideration of waiver entry.

PROVIDER SERVICES REPORT

ENROLLMENT EXEMPTION FOR RESIDENTS AND INTERNS

DMA will continue to utilize the NPI Exemption List in NCTracks which allows residents and interns enrolled in Graduate Dental and Medical programs and Area Health Education Centers to be exempt from the provider enrollment requirement only through **January 31, 2018**. The exemption from the provider enrollment requirement does not include an exemption from the DEA registration requirement for controlled substances. This exemption list is only applicable to the prescribing provider on a pharmacy claim. All providers that meet the enrollment criteria are required to enroll.

ABBREVIATED APPLICATION FOR ORDERING, PRESCRIBING AND REFERRING PRACTITIONERS

Effective Oct. 29, 2017, an abbreviated enrollment application will be available for **ordering, prescribing, and/or referring** (OPR) practitioners. As required by 42 CFR 455.410, physicians and non-physician practitioners **must** enroll in the Medicaid program for the sole purpose of ordering, referring, or prescribing items or services for N.C. Medicaid or N.C. Health Choice (NCHC) beneficiaries.

Physician and non-physician practitioners may elect to enroll as OPR-only providers (OPR lite). Billing providers will use the NPI (National Provider Identifier) of the OPR-only provider on their claims when these providers order or refer items or services. NCTracks will not reimburse OPR-only providers when their NPI is used as rendering or attending on a claim.

The following requirements will apply to OPR lite enrollment providers:

- Revalidate every five years
- \$100 application fee
- Credentialing and Background Checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they are to be reimbursed for claims.

Note: OPR providers can request a retroactive effective date up to 365 days preceding the date of application.

OUT OF STATE PROVIDER ENROLLMENT

Effective Oct. 29, 2017, Out of State (OOS) providers who are seeking to enroll with N.C. Medicaid and NCHC will have the option to enroll using a lite- or full-enrollment application. If a provider chooses to enroll using the lite-enrollment application the following will apply:

- The provider will complete an abbreviated application.
- Enrollment is limited to one year.
- Credentialing and background checks will be required including fingerprinting, if applicable.
- If the provider chooses to enroll using the full-enrollment application the following will apply:
 - The provider will complete a full-enrollment application.
 - Enrollment will extend beyond one year.
 - The provider is required to complete re-verification every five years.
 - Credentialing and background checks will be required including fingerprinting, if applicable.
 - The provider will be required to pay the \$100 N.C. application fee during enrollment and re-verification.

Note: A provider has the option to change from lite enrollment to full enrollment by submitting a Manage Change Request (MCR). The provider will be required to pay the \$100 N.C. application fee.

MAINTAIN ELIGIBILITY PROCESS

Effective Oct. 29, 2017, NCTracks will implement a quarterly Maintain Eligibility Process to identify providers with no claim activity within the past 12 months. NCTracks will notify the provider via the secure provider portal mailbox. The provider must attest electronically to remain active in NCTracks.

When a provider is identified with having no claims activity in 12 months, a Maintain Eligibility Due Date will be set. Providers will be notified 30 days before the due date that they must submit a Maintain Eligibility Application. Upon submission of the Maintain Eligibility Application, the provider's enrollment record will be updated with the current date.

If the provider does not submit the application by the due date, the provider's participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs **will be end dated**. This will prevent fraud, waste and abuse in the N.C. Medicaid and NCHC programs.