

# WRITTEN SECTION REPORTS

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(REPORT PERIOD DECEMBER 2, 2014 - APRIL 1, 2015)

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

The N.C. Physician Advisory Group met on 12/04/14, 01/22/15, 02/17/15, 02/26/15, 03/26/15

The Pharmacy & Therapeutic Committee met on 1/20/15, 2/10/15, 3/10/15

### Recommended Policies

- PA Criteria Hepatitis C Virus Medications (Sovaldi, Olysio, and Harvoni)(12/04/14)
- PA Criteria Sovaldi (12/4/14)
- PA Criteria Olysio (12/4/14)
- 1S-4 Genetic Testing (formerly Cytogenetic Studies) (2/17/15)
- 8A-2, Facility-Based Crisis Service for Children and Adolescents (01/22/15)
- PA Criteria Hetlioz (tasimelteon) (01/22/15)
- PA Criteria Hepatitis C Virus Medications (Viekira PAK)(01/22/15)
- PA Criteria Systemic Immunomodulators (Otelza) (01/22/15)
- PA Criteria Oral Inhaled Steroids (Breo Ellipta) (01/22/15)
- PA Criteria Pulmonary Fibrosis Treatment Agents (Esbriet& Pfov) (01/22/15)
- 10-D, Independent Practitioners Respiratory Therapy Services (02/26/15)
- Preferred Drug List Amendments for Viekera Pak, Millipred, Veripred (02/26/15)
- PA Criteria Narcotic Analgesics (Hyslinga) (02/26/15)
- PA Criteria Sedative Hypnotics (Belsomra) (02/26/15)
- 8-C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers (03/26/15)
- 3-L, Personal Care Services (03/26/15)
- 1A-6, Invasive Electrical Bone Growth Stimulation (03/26/15)

### PAG Administrative Notification

- 1E-5 Obstetric Services
- 2015 Annual CPT Update

### PAG Consult

- 1S-4, Genetic Testing (12/04/14)
- 4A, Dental Services (2/26/15)

## 2. POLICIES POSTED FOR PUBLIC COMMENT

- 1A-40, Fecal Microbiota Transplantation (FMT)
- PA Criteria Hepatitis C Virus Medications (12/19/14 & 2/2/15)
- PA Criteria Sovaldi (Termination)
- PA Criteria Olysio (Termination)
- PA Criteria Systemic Immunomodulators (Otelza)
- PA Criteria Pulmonary Fibrosis Treatment Agents (Esbriet& Pfov)
- PA Criteria Oral Inhaled Steroids (Breo Ellipta)
- PA Criteria Hetlioz (tasimelteon)
- 8A-2, Facility-Based Crisis Service for Children and Adolescents
- 1S-4, Genetic Testing
- PA Criteria Narcotic Analgesics (Hyslinga)
- PA Criteria Sedative Hypnotics (Belsomra)

3. **POLICIES POSTED FOR ADDITIONAL PUBLIC COMMENT**

- 8A-1, Assertive Community Support Team (ACT)

4. **AMENDED OR NEW POLICIES POSTED TO DMA WEBSITE**

- 10-A, Outpatient Specialized Therapies (12/1/14)
- 10-B, Independent Practitioners (IP) (12/1/14)
- 1K-7, Prior Approval for Imaging Services (01/01/15)
- 1N-1, Allergy Testing (02/01/15)

5. **OUTPATIENT PHARMACY**

**Pharmacy Prior Authorization for Hepatitis C Drugs and Selection of a Preferred**

DMA posted for 45-day comment updated criteria for Hepatitis C Drugs. New products continue to come to market and although these medications are novel and documented to produce an 80-90% curative rate, they are incredibly expensive. To ensure that only those who truly need product receive it, and that it is used according to FDA guidelines, PA criteria is being established and updated. In addition, the Pharmacy and Therapeutics Committee (P&T) and the Physicians Advisory Group (PAG) have approved the request for Viekira Pak to be the preferred Hepatitis C product effective March 21, 2014.

**New Pharmacy Prior Authorization for Hetlioz®**

DMA received approval from P&T and PAG for new Prior Authorization (PA) criteria for Hetlioz®. This is a very expensive medication and is used to treat a sleep disorder that only affects those who are blind. The PA criteria ensures that only those who need the medication can obtain it, while limiting its availability for off-labeled use.

**New Pharmacy Prior Authorization for Esbriet® and Ofev®**

DMA received approval from P&T and PAG for new PA criteria for Esbriet® and Ofev®. These are very expensive medications for pulmonary fibrosis. The criteria ensures that only those who need this medication can obtain it, while limiting its availability for off-labeled use.

**Pharmacy Reimbursement**

It was noted at the previous MCAC that pharmacy reimbursement will change due to Session law. This still has an effective date of January 1, 2015, but we are waiting for the Center for Medicare and Medicaid Services (CMS), approval of the State Plan Amendment for this change. Once CMS approves the change, we will begin using the CMS national survey, the National Average Drug Acquisition Cost, (NADAC), survey. 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.

(THE FOLLOWING BEHAVIORAL HEALTH POLICIES ARE IN THE PROCESS OF BEING PROMULGATED OR AMENDED.)

1. **8A-1 Assertive Community Treatment (ACT) Team**

ACT was posted for 15-day public comment for a second time to account for additional changes made to the policy. Most notable, the ability for an ACT team to have a second TMACT fidelity review should they score below the required 3.0 and meet additional benchmarks; and clarifying that telepsychiatry is not allowed on an ACT team. The comments are being reviewed with DMHDDSAS. Comments were generally favorable to the changes. A new fiscal note is also being completed.

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, and was posted for 45-day public comment. This comment period closed on March 19, 2015.

3. **8A Mobile Crisis Management (MCM)**

The Department initially published a joint communication bulletin (JCB) to clarify allowable billable places of service. December 31, 2014 was given as the final date of service where MCM could be billed in the emergency department. The Department published a subsequent JCB extending the end date to February 28, 2015. With that extension the LME-MCOs had to submit a transition plan to the Department outlining their use of MCM in hospital, which hospitals utilize MCM, and how they are going to address and meet the needs of the community when MCM is no longer allowed as a billable Medicaid service in hospital. Concurrently, DMA and DMHDDSAS are working together to revise this policy to account for the place of service change as well as improve the overall policy to ensure our beneficiaries are served in the community and closer to home. Once the changes to MCM are fully promulgated, this policy will be pulled from the larger 8A policy and will become a stand-alone policy; most likely policy 8A-3.

4. **Intensive In-Home (IIH)**

Policy was revised to reflect legislative mandate to increase family to team ratio to 1:12 from 1:8. Policy was presented at PAG, posted for 45 external review, and SPA was updated to reflect the ratio change and fiscal impact. Approval from CMS is still pending.

5. **8C Outpatient Behavioral Health Services Provided by Direct Enrolled Providers**

This policy was presented to PAG in March 26. The following is a list of prospective changes to the policy:

- Terminating "incident to" billing ability for associate level licensed professionals. These professionals must now direct enroll.
- Terminating the 5-hour daily maximum for psychological testing.
- Requiring an assessment - not a comprehensive clinical assessment - be completed for beneficiaries seen in an integrated care setting. This is in accordance with administrative rule.
- Providing a 2-year extension to sunset clause that expires on June 30, 2015 requiring all nurse practitioners who are currently working in the behavioral health arena to acquire their psychiatric mental health nurse practitioner certification.

6. **Additional Behavioral Health Updates:**

Effective July 1, 2015 all claims for reimbursement of PRTFs services, which are submitted on the Institutional Claim Form UB-04, must now include, on line #76, the name and National Provider Identification (NPI) of the beneficiary's attending psychiatrist, in addition to the name and NPI of the billing provider.

The attending physician must be the psychiatrist who has overall responsibility for the medical care and treatment. The attending physician must be enrolled in North Carolina Medicaid with a psychiatric taxonomy, with a specialization in child and adolescence (or general psychiatry with experience with children), to be in compliance with North Carolina Medicaid Clinical Policy 8D-1 and North Carolina Administrative Code 10A-27G.1902.

This will bring North Carolina Medicaid billing practices for PRTFs into compliance with federal CMS requirements.

### **BEHAVIORAL HEALTH IDD SECTION UPDATES:**

#### **1. 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.

#### **2. TBI Waiver:**

Session Law 2014-100, Section 12I.2 SECTION 12H.6 instructed the Department of Health and Human Services, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in conjunction with the North Carolina Advisory Council, to design and draft a 1915(c) waiver to add a new service package for Medicaid beneficiaries with traumatic brain injury (TBI). At this time, there has not been an allocation to fund the Traumatic Brain Injury Medicaid Waiver. DMA and DMH/DD/SAS have presented a report to the Legislature describing the proposed waiver and funding that would be needed to implement the waiver.

#### **3. Innovations Waiver:**

DMA and DMH/DD/SAS, in conjunction with the Deputy Secretary of Behavioral Health and Developmental Disabilities Services, Dave Richard, continue to meet with a stakeholder group formed to develop a resource allocation model for the Innovations waiver, as well as to recommend changes to the waiver to promote flexibility in service provision and to promote self-direction. Our intent is to submit an amendment to the Innovations waiver to make these changes by April 30, 2015 with an implementation date of January 2016.

#### **4. Home and Community Based Services Rule:**

DMA and DMH/DD/SAS are working with a stakeholder group in the development of a transition plan to ensure compliance with the Home and Community Based Service Rule. This rule outlines requirements on person-centered planning and home and community based settings for several Medicaid authorities which states can use to provide Home and Community Based services. In North Carolina, this is relevant to the three 1915(c) waivers which are operated by DMA. A stakeholder group has been meeting to inform the transition plan and provider self-assessment. Listening sessions and family chats were held across the state and feedback was solicited. Additional information on the HCBS Rule can be found at <http://www.ncdhhs.gov/hcbs/index.html>. The transition plan will be submitted to CMS on March 16, 2015 which describes how the state will come into compliance with the new requirements.

### **LME-MCO CONTRACT SECTION UPDATES:**

1. Merger between CenterPoint Human Services and Partners Behavioral Health Management has been suspended.
2. The consolidation between East Carolina Behavioral Health and CoastalCare was preliminarily approved by Secretary Vos. The onsite readiness review is scheduled for April 14.
3. DMA and Mercer are providing onsite technical assistance to the LME-MCOs around encounter claims due to the significant error rates. The final results of the 2014 Medicaid Waiver provider satisfaction survey have been shared with the MCOs and will be shared with CMS. MCOs were encouraged to present the results to their local provider council for feedback.

## **PAYMENT ERROR RATE MEASUREMENT (PERM)**

On a three year cycle the Centers for Medicare and Medicaid Services (CMS), through the Payment Error Rate Measurement (PERM) program, measures improper payments in Medicaid and Children's Health Insurance Program (CHIP) and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. CMS considers the error rate a measurement of payments made to the state that did not meet statutory, regulatory or administrative requirements.

CMS has given preliminary approval to the PERM Corrective Action Plan (CAP) submitted by the state in response to the errors identified in the 2103 PERM cycle. Within the next several months the state will be providing a presentation to CMS based on the action plan identified in the PERM CAP.

The next PERM cycle that North Carolina is required to participate in begins in October 2015 and will encompass claims and eligibility activities for the Federal Fiscal Year 2016 (October 1, 2015-September 30, 2016).

## **MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)**

On August 15, 2013 states were directed to implement Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility reviews for fiscal years (FY) 2014 - 2016. States will be conducting four streamlined pilot measurements over the three year period. The review pilots are based on how eligibility for applicants to the Medicaid and CHIP programs is determined under the Affordable Care Act (ACA). The Medicaid and CHIP Eligibility Review Pilots provide targeted, detailed information on the accuracy of eligibility determinations using the ACA rules, and provide states and the Centers for Medicare and Medicaid Services (CMS) with critical feedback during initial implementation.

In January CMS issued guidance for the third round of pilot reviews. CMS has made significant changes to the guidance from previous rounds. Per initial CMS guidance the third round pilot findings were due to CMS no later than June 30, 2015. However, due to the timing of the release of the third round guidance and the number of changes made from Round two, CMS is allowing states to submit pilot findings as late as August 31, 2015. Detailed reporting guidance will be issued by CMS at a later date.

# RECIPIENT AND PROVIDER SERVICES REPORT

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## **RE-CREDENTIALING PERIOD**

The Division of Medical Assistance has changed the length of time required before a provider must re-credential in NCTracks from three years to five years. Providers who are currently re-credentialing will complete the process already underway. The due date for their next re-credentialing will be set to five years from the approval date. Providers who have received a letter notifying them that re-credentialing is due soon, but have not yet started the re-credentialing process, can disregard the letter. Their re-credentialing due date will be extended by two years.

**Note:** Re-credentialing applies to providers who are enrolled for an indefinite period of time. It does not apply to any time-limited enrolled providers such as Out-of-State (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.

## **MEDICAID COVERAGE FOR FORMER N.C. FOSTER CARE CHILDREN**

The Patient Protection and Affordable Care Act (ACA) requires states to cover former foster care children up to the age of 26 if certain criteria are met. As of January 1, 2014, children who turn age 18 and are terminated from North Carolina foster care continue to receive Medicaid under eligibility category MFC (Medicaid to Former Foster Care Children), if they do not fall into any other Medicaid eligibility category.

NCTracks has implemented changes related to MFC. Providers will now see MFCGN or MFCNN as the category of eligibility on the eligibility verification responses for these recipients.

## **OWNER/MANAGING RELATIONSHIPS OF PROVIDER SUBJECT TO OIG EXCLUSION**

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has the authority to exclude individuals and entities from federally-funded healthcare programs. The termination of an NCTracks provider may occur due to the identification of an owner/managing relationship with an OIG exclusion. Owners/managing relationships were not previously included in the monthly evaluation process using OIG exclusion data.

## **PROVIDER TRAINING FOR INITIAL ENROLLMENT**

According to the North Carolina (NC) Session Law 2011-399, State Senate Bill 496 108C-9.c, all newly enrolling N.C. Medicaid and N.C. Health Choice (NCHC) providers must complete N.C. Medicaid and NCHC Provider Online Training. As the bill states: *Prior to being initially enrolled in the North Carolina Medicaid or Health Choice program, an applicant's representative shall attend training.* The training is subject to change every six months due to biannual updates to Medicaid policy and procedures.