

## WRITTEN SECTION REPORTS

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## Medical Care Advisory Committee

### Report from Clinical Policy and Programs Report Period September 17, 2016 through December 2, 2016

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

The N.C. Physician Advisory Group met on 09/22/16 and 10/26/2016  
The Pharmacy & Therapeutic Committee met on 10/11/16 and 11/08/16

#### Recommended Policies:

- 9, Outpatient Pharmacy - 10/27/16
- 1N-1, Allergy Testing - 10/27/16

#### Recommended Pharmacy:

- PA Criteria Narcotic Analgesics (amend criteria and name change to Opioid Analgesics) - 09/22/16
- PA Criteria Hepatitis C Virus Medications (Addition of VIEKIRA XR) - 10/27/16

#### 2. Policies posted for Public Comment:

- 1S-3, Laboratory Services - 10/25/16
- PA Criteria Opioid Analgesics (formerly Narcotic Analgesics) - 10/25/16
- PA Criteria Hepatitis C Virus Medications (Addition of VIEKIRA XR) - 10/31/16
- 1N-1 Allergy Testing - 11/16/16

#### 3. Amended or New policies posted to DMA website:

- 1A-7, Neonatal and Pediatric Critical and Intensive Care Services - 09/15/16
- 8A, Enhanced Mental Health and Substance Abuse Services - 10/01/16
- 9, Outpatient Pharmacy Program - 10/01/16
- 5A, Durable Medical Equipment - 11/01/16
- 8-P, North Carolina Innovations - 11/01/16
- 10A, Outpatient Specialized Therapies - 11/01/16

#### 4. Outpatient Pharmacy:

##### Reimbursement for Pharmacist-Administered Vaccines:

Effective January 1, 2016, NC Medicaid will reimburse pharmacies for covered vaccines as permitted by G.S. 90-85.15B (see below) when administered to NC Medicaid beneficiaries 19 years of age and older by an immunizing pharmacist.

Information about rules and regulations regarding pharmacist-administrated vaccinations can be found on the N.C. Board of Pharmacy webpage. The specific text of the statute can be found on House Bill 832.

### **N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL) Changes:**

Effective October 1, 2016, Harvoni, Eplclusa (for genotypes 2 and 3), Technivie (for genotype 4), Viekira Pak, Viekira XR, and Zepatier will have preferred status on the PDL. Daklinza, Eplclusa (for genotypes 1, 4, 5, and 6), Olysio, and Sovaldi will be non-preferred.

Clinical criteria will continue to apply for all Hepatitis C treatments.

Effective October 1, 2016, aripiprazole tablets will be moved to preferred status on the 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. These changes only apply to Abilify Tablets. Abilify Discmelt and Abilify Oral Solution will remain preferred and aripiprazole ODT and oral solution will remain non-preferred on the PDL.

Effective November 1, 2016, the N.C. Division of Medical Assistance (DMA) made changes to the PDL as approved by the Preferred Drug List Review Panel during their annual meeting held on September 29, 2016. Providers can find the current PDL on the DMA PDL web page at 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.

### **Automatic Refills and Shipments:**

Medication adherence is very important in achieving successful outcomes from medication therapy. While section 5.7 of Outpatient Pharmacy Clinical Coverage Policy #9 (see below) does not allow automatic refills, it does not prohibit a pharmacy from using refill reminders to encourage a beneficiary's adherence to their medication regimen, as long as the reminders are for medications the beneficiary is currently receiving.

**Subsection 5.7** Automatic refills and automatic shipments are not allowed. Medicaid and NCHC do not pay for any prescription (original or refill) based on a provider's auto refill policy. Medicaid and NCHC do not pay for any prescription without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the beneficiary in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the beneficiary's medication regimen.

The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Beneficiaries or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a beneficiary or their responsible party will be subject to recovery. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery or possible suspension or termination of their provider agreement.

### **Durable Medical Equipment Program**

#### **Time Limits for Retroactive Medicaid DME Prior Authorization Requests:**

Effective October 1, 2016, Durable Medical Equipment (DME) providers will have up to three months after a beneficiary becomes retro-actively eligible for Medicaid to submit prior authorization requests. The three-month limit will be measured from the date the retro-active Medicaid eligibility was entered into NCTracks DME providers may contact the N.C. Division of Medical Assistance (DMA) call center for the “date added” of the appropriate eligibility segment.

#### **5. Long-Term Care and Support Services:**

##### **State Plan Personal Care Services (PCS):**

The Division of Medical Assistance (DMA) amended clinical coverage policy 3L, *State Plan Personal Care Services (PCS)*, effective July 1, 2016 to include additional program requirements agreed upon in the settlement of Federal Class Action lawsuit, *Pettigrew v. Brajer* and to provide clarifications in other areas of policy. The Settlement requires DMA to assure that the PCS eligibility criteria used to authorize or reauthorize, or determine the number of PCS hours for Medicaid beneficiaries, is the same regardless of residential setting. Based on the settlement, DMA assures that the eating Activity of Daily Living (ADL) is assessed in a comparable manner. Each PCS applicant or beneficiary is assessed for each ADL task and Instrumentals of Daily Living (IADL) task, if applicable, that comprise the eating ADL. In addition to required eligibility and procedural comparability, the settlement also detailed steps to be taken to assure that proper notice and the right to a hearing are provided when PCS is denied, reduced, or terminated and to reassess or reinstate services to some class members whose PCS vs. previously denied or terminated. DMA has also implemented a Reconsideration process for beneficiaries making **initial** requests for services to be reconsidered, if their approval of services was less than the maximum of 80 hours per month. DMA is currently in the monitoring phase of the Settlement Agreement.

In addition to the changes made to the PCS Policy per *Pettigrew v. Brajer*, DMA is working closely with the Independent Assessment Entity, Liberty Healthcare, to ensure that assessments are being conducted in accordance with policy as well as performing internal quality audits to ensure PCS providers are in compliance with the policy requirements. Regional Provider trainings were held in October and November to share with providers Liberty Healthcare’s focus on quality, review of the usage and requirements of the PCS IT platform, refresher of the mediation and appeal process, and review of the program requirements including but not limited to submission of PCS required forms.

### **Community Alternatives Program for Children (CAP/C):**

DMA is in the process of revising the CAP/C Clinical Coverage Policy and amending the CAP/C 1915 (c) Home and Community-Based Services (HCBS) waiver for another five-year waiver cycle. The CAP/C waiver expired on June 30, 2015 and the Centers for Medicare and Medicaid Services granted the DHHS a waiver extension to allow the Division of Medical Assistance to engage stakeholders for the purpose of soliciting comments and recommendations to make the necessary changes to the CAP/C waiver and clinical coverage policies.

The proposed amendments to the CAP/C waiver and revisions to clinical coverage policy will include:

1. End-dating CAP/C nursing as a waiver service and replacing that service with a State Plan service, Private Duty Nursing.
2. End-dating Palliative Care type services as waiver services and replacing those services with State Plan Behavioral Health and Hospice Bereavement counseling.
3. Combining the total allotted budgets for modifications (home and vehicle) and assistive technology into one pool. Each wavier beneficiary will be granted a total budget of \$28, 000.00 per a five-year cycle to plan modifications and assistive technology. The allotment may be used as desired within policy guidelines. Once the total allotment is expended, future requests will be denied.
4. Combining the annual adaptive tricycle budget to a five-year waiver cycle budget for a total budget of \$3,000.
5. Maintaining In-Home aide, a personal care type service as a CAP/C waiver service.
6. Adding consumer-direction as an option for families who are approved to participate in the CAP/C waiver. The two services available for consumer direction are Pediatric Nurse Aide and In-home Aide services. These two services have an accompanying respite category which will be consumer-directable. Nursing services are not consumer-directable but individuals approved to receive private duty nursing may be eligible to direct respite care when all requirements and precautions of care needs are met.

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

DMA is in the process of revising the CAP/DA Clinical Coverage Policy and amending the CAP/DA 1915 (c) Home and Community-Based Services (HCBS) waiver to make the following amendments:

1. To reflect an increase in the number of approved waiver beneficiaries to be served by the CAP/DA waiver. NC Session Law 2016-94 granted the CAP/DA waiver an additional three-hundred and twenty (320) waiver slots to target a population of individuals with Alzheimer's disease. The amendment of the waiver will identify this population as a reserve group. DMA will manage these additional slots statewide. Individuals with a diagnosis of Alzheimer's disease will be prioritized immediately and granted a waiver slot. Upon capacity of the additional 320 slots, individual meetings the eligibility criteria for Alzheimer's disease will be prioritized to the top of the statewide Alzheimer's waitlist for processing when an Alzheimer's disease slot or a county slot becomes available.

2. To reflect an increase in the number of case management hours granted to each waiver beneficiary per calendar year. Currently, CAP/DA beneficiaries are allocated 42 hours per year of case management time. To be consistent with other 1915 (c) waivers managed by DMA, the annual allotment for case management will increase from 42 hours to 80 hours per calendar year.
3. To reflect an addition to the waiver service package by adding vehicle modification as a new waiver service. This addition will allow consistency of other 1915 (c) waivers managed by DMA.

## **6. Behavioral Health**

### **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 are in the process of scheduling two to three open forums in December to obtain a wider stakeholder feedback. The target date for submission of the SPA to CMS is 12/31/16.

### **TBI Waiver:**

DMA responded to a formal request for additional information from CMS on the TBI waiver. We are waiting for a response from CMS.

### **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 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/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.

### **Clinical Coverage Policy 8P NC Innovations Waiver:**

Clinical Coverage Policy 8P NC Innovations Waiver was updated per the Technical Amendment and was posted on 11/1/16.

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

DMA has been working with CMS to develop the final version of the HCBS transition. DMA is submitting changes to the plan per the request of CMS. Once approved, the plan will be posted for public comment. The 'My Individual Experience Survey' has been implemented to assess individuals' experiences with waiver service. As of the writing of this report, 728 responses have been received. For more information, please see the HCBS website at:

<https://www2.ncdhhs.gov/hcbs/myexperience.html>.

**Mobile Crisis Management:**

DMA continues to work with DMHDDSAS on improving Clinical Coverage Policy 8A, Mobile Crisis Management (MCM). Meetings with each LME-MCO and their MCM have been held to assess the current landscape of MCM services and guide the discussion on improvements that can be made to the policy to further enhance our state's crisis continuum. These listening sessions were completed in October 2016. The input gathered will be reviewed and used to develop a revised policy draft. The revised draft will then be shared with a wider stakeholder group, prior to completing a revised policy for review by PAG.

**Psychosocial Rehabilitation (PSR):**

DMA is planning revision of the PSR policy and will be reaching out to PSR provider's and MCOs for their feedback concerning this service prior to beginning policy revisions.

**Services for Substance Use Disorders:**

DMA in collaboration with DMH are reviewing the Substance Use Disorder Treatment Continuum and, in the process, will be reaching out to MCOs and providers of substance use disorder services to solicit comments and feedback about evidence-based treatments and services that would constitute a complete continuum of services for individuals with substance use disorders.

**Nurse Practitioners:**

DMA and DMH are working with nursing organizations, providers, and MCOs to find a means to support Nurse Practitioners in continuing to provide behavioral health services under the Outpatient Clinical Services Policy 8C.

**Tenancy Supports:**

DMA continues to work with DMHDDSAS on developing a new State Plan service for housing related activities, tentatively named Tenancy Support Services. Community stakeholder workgroups have been held and the Medicaid policy draft is in process.

**Certified Community Based Health Clinic (CCBHC):**

The CCBHC grant proposal was submitted to SAMHSA on the October 31, 2016. The pool of applicants has been narrowed down to two urban sites; Freedom House in Chapel Hill and Cone Behavioral Health in Greensboro; and two rural sites; Daymark in North Wilkesboro and Monarch in Albemarle. All four sites will participate in the demonstration grant if North Carolina is selected by SAMSHA. We should have a decision from SAMSHA by January 1, 2017.

**LME-MCO Contract Section Updates:****PIHP Contracts:**

DMA has executed three contract amendments with the LME-MCOs, including but not limited to changes in such topics as enrollee rights and enrollment/disenrollment, Program Integrity, and Transitions to Community Living (Dept. of Justice Settlement). DMA is continuing to have internal discussions regarding the incorporation of the Medicaid Managed Care Final Rules components into the contracts as well. Discussions involve topics such as mental health parity, monitoring, continuation of services during transition, and network adequacy. DMA and LME-MCOs are scheduled to have final contract negotiation meetings in December and January, prior to submitting the contracts to CMS for review.

## PROVIDER SERVICES REPORT

### PROVIDER RECREDENTIALING:

The Centers for Medicare and Medicaid Services requires that all Medicaid providers are revalidated (recruited) 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 recertification process also includes a criminal background check on all owners and managing relationships associated with the provider record.

Every active NCTracks Provider must be recertified. It is crucial that all providers who receive a recertification notice promptly respond and begin the recertification process. Providers will receive a recertification letter 45 days before their recertification due date. If the provider does not complete the recertification process **within the allotted 45 days, payment will be suspended** until the recertification process is completed. The provider will also receive a termination notice. If the provider does not complete the recertification 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.

### 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. Effective Sept. 1, 2016, NEMT vendors are able to submit claims in NCTracks.

### ENROLLMENT OF ORDERING, PRESCRIBING OR REFERRING PROVIDERS:

Attending, rendering, ordering, prescribing or referring providers must be enrolled in the Medicaid and NC Health Choice programs effective Nov. 1, 2016. DMA has implemented new editing in NCTracks to be compliant with the Federal guidelines (42 CFR 455.410). Providers that are not enrolled will have claims pend for 90 days to allow enrollment in the Medicaid and NCHC programs. If a provider does not enroll claims will deny after 90 days.

### RENDERING PROVIDER SERVICE LOCATION:

Effective Feb 6, 2017, rendering providers must have the addresses of all facilities where they perform services listed as provider service locations under their National Provider Identifiers (NPIs) in NCTracks. The system uses a combination of NPI, taxonomy code, and service location in processing claims. If the address where the service was rendered is not listed in the provider record as a service location for the rendering provider's NPI, the claim will suspend. This will delay the completion of claim adjudication and payment.



**PROVIDER AFFILIATION:**

Attending/rendering providers are required to be affiliated with the billing providers who are submitting claims on their behalf. Effective Feb. 6, 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.

**ENROLLMENT OF ATTENDING, RENDERING, ORDERING, PRESCRIBING OR REFERRING PROVIDERS:**

Beginning with date of service Feb. 1, 2016, the presence of the National Provider Identifier (NPI) of a non-enrolled ordering, prescribing or referring provider on a N.C. Medicaid or N.C. Health Choice (NCHC) has resulted in a “pay and report edit” appearing on the Remittance Advice (RA). DMA will notify providers when the edit disposition will change from a “pay and report” status to “suspend” status. When the edit is changed to suspend claims, if an attending, rendering, ordering, prescribing or referring provider does not enroll within the 90-day timeframe, the billing provider will receive a denial with an EOB stating that “the attending, rendering, ordering, prescribing or referring provider is not enrolled.” This will permit the billing provider to notify the attending, rendering, ordering, prescribing or referring provider to begin the enrollment process on NCTracks.

Targeted for an August 1, 2016, implementation, will be the requirement of the provider’s NPI as a data element on the claim for the following programs. All providers should note that any NPI entered on a claim will be validated, even if it is not required for that service/claim type.

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