WRITTEN SECTION REPORTS

(REPORT PERIOD MARCH 25, 2017 THROUGH JUNE 23, 2017)

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

The N.C. Physician Advisory Group met on 05/25/17 and 06/22/17
The Pharmacy & Therapeutic Committee met on 05/09/17 and 06/13/17

Recommended Policies

- 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) – 05/25/17
- 1B-3, Intravenous Iron Therapy – 05/25/17

Recommended Pharmacy

- PA Criteria: Hepatitis C Treatments – 05/25/17
- Annual Preferred Drug List Update (Part 1) – 05/25/17
- PA Criteria: Cystic Fibrosis (Kalydeco) – 06/22/17*
- PA Criteria: Spinraza – 06/22/17*
- PA Criteria: Anti-Inflammatory Medications (Dupixent) – 06/22/17*
- PA Criteria: Immunomodulators – 06/22/17*
- Annual Preferred Drug List Update (Part 2) – 06/22/17*

*These policies are scheduled to present at the 06/22/17 PAG meeting. This report is compiled before that meeting.

2. Policies posted for Public Comment

- PA Criteria: Spinraza – 04/06/17
- PA Criteria: Topical Anti-Inflammatory Medications (Eucrisa) – 04/06/17
- Preferred Drug List: Exceptions – 04/06/17
- Preferred Drug List: Neuropathic Pain – 04/06/17
- 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring – 04/27/17
- 1-I, Dietary Evaluation and Medical Lactation Services – 04/27/17
- 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) – 06/01/17
- 1B-3, Intravenous Iron Therapy – 06/01/17
- 5A-1, Physical Rehabilitation Equipment and Supplies – 06/15/17
- 5A-2, Respiratory Equipment and Supplies – 06/15/17
- 5A-3, Nursing Equipment and Supplies – 06/15/17
- 5B, Orthotics & Prosthetics – 06/15/17

3. *New or Amended policies posted to DMA website*

- 1A-2, Preventive Medicine Annual Health Assessment - 04/01/17
- 1E-2, Therapeutic and Non-therapeutic Abortions - 04/01/17
- 8A, Enhanced Mental Health and Substance Abuse Services - 04/01/17
- 3K-2, Community Alternatives Program for Disabled Adults (CAP/DA) - 04-18/17
- 1A-13, Ocular Photodynamic Therapy - 05/01/17
- 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older - 05/12/17
- 3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age - 05/12/17

- 1E-3, Sterilization Procedures - 06/01/17
- 9, Outpatient Pharmacy Program - 06/01/17
- 10A, Outpatient Specialized Therapies - 06/01/17
- 10B, Independent Practitioners (IP) - 06/01/17

4. *Outpatient Pharmacy*

Changes in Manufacturer, Centers for Medicare and Medicaid Services (CMS) Drug Rebate Agreements

The following changes have been made by manufacturers with their CMS Drug Rebate Agreements. It is listed by manufacturer's code, which are the first five digits of the National Drug Code (NDC).

Terminated Labelers

25021	SAGENT PHARMACEUTICALS, INC.	Effective	04/01/2017
60842	KALEO, INC. (Voluntary)	Effective	04/01/2017

Drugs manufactured by the two labelers above that terminated their CMS drug rebate agreement, will no longer be covered by NC Medicaid effective April 1, 2017.

Non-Covered "Nephro" Products Manufactured by Valeant

Labeler 00187, Valeant Pharmaceuticals North America LLC, has confirmed that the following non-drug products do not meet the definition of a covered outpatient drug as set forth in Section 1927(k)(2) of the Social Security Act. Thus, they are not eligible for inclusion in the Medicaid Drug Rebate Program (MDRP). These products are considered a non-covered service for NC Medicaid. The non-drug products that are ineligible for rebates are:

NDC	Product Name
00187-5268	**Nephrocaps Softgels**
00187-5269	**Nephrocaps QT**

Claims that Contain NDCs Related to Vaccine CPT Codes

Currently, providers are required to submit NDCs with vaccine CPT codes by some private insurers. However, NCTracks will deny vaccine claims submitted with a non- rebatable NDC, such as those for vaccines.

Rather than requiring Medicaid and NCHC providers to bill differently for Medicaid and NCHC than they do for private insurers, effective Jan. 1, 2017, NCTracks will bypass Edit 00996 - SUB NDC IS NON-REBATABLE. Providers can now add NDCs for vaccines onto Medicaid and NCHC claims for better uniformity among claims submission requirements by the various insurers.

Providers are required to use appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code.

Below are the claim types and vaccine procedure (CPT) codes impacted by this implementation:

- Medicare Part B, Outpatient, Professional, and Health department claims
- 90585, 90620, 90621, 90632, 90636, 90644, 90645, 90647, 90648, 90649, 90651, 90656, 90658, 90670, 90675, 90680, 90681, 90685, 90686, 90687, 90688, 90696, 90698, 90700, 90703, 90704, 90706, 90707, 90710, 90713, 90714, 90715, 90716, 90723, 90732, 90733, 90734, 90736, 90744, 90746

New-to-Market Drug Additions to the NC Medicaid Preferred Drug List

Effective April 1, 2017, new-to-market drugs in the NC Medicaid Preferred Drug List (PDL) classes will be updated quarterly on the posted PDL and listed as "NR" (not reviewed). This is to clarify PDL placement for new-to-market drugs. Per policy, new-to-market drugs default to non-preferred status until they can be reviewed by the PDL Review Panel during their annual meeting in the fall.

Proposed Pharmacy Clotting Factor Reimbursement Methodology Changes

Effective April 1, 2017, DMA will be making changes to the reimbursement methodology for clotting factor. This reimbursement model IS NOT programmed in NCTracks at this time.

The current State Plan Amendment follows, but is subject to change depending on CMS approval:

> Payment for Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTC), Centers of Excellence or any other pharmacy provider:
>
> Reimbursement for clotting factor purchased through the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:
>
> 1. The 340B state maximum allowable cost (SMAC) plus a per unit professional dispensing fee; or
> 2. The provider's usual and customary charge to the general public or their submitted charge.
>
> Reimbursement for clotting factor purchased outside of the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:
>
> 1. The state maximum allowable cost (SMAC) plus a per unit professional dispensing fee; or
> 2. The provider's usual and customary charge to the general public or their submitted charge.
>
> This reimbursement is applicable to both pharmacy and procedure coded professional claims.
>
> The per unit professional dispensing fee will be 4 cents per unit for HTC pharmacies and 2.5 cents per unit for all other pharmacies.
>
> Clotting factor per unit professional dispensing fees shall be established by a clotting factor dispensing fee survey conducted no less than every three years.

The calculated actual acquisition costs and 340B ceiling prices will serve as the basis for establishing the SMAC reimbursement rates. There will be one rate listing for specialty pharmacies and one rate listing for HTC pharmacies. The SMAC rate listings will incorporate an additional 5.5 cents per unit for specialty pharmacies and an additional 7.5 cents per unit for HTC pharmacies, as well as a 0.015 cents per unit for Medication Therapy Management (MTM) for both type pharmacies.

Preferred Brands with Non-Preferred Generics - NC Medicaid Preferred Drug List

If a brand is "Preferred" with a "Non-Preferred" generic equivalent, prior authorization for DAW-1 is not needed. Likewise, "medically necessary" is NOT needed on the face of the prescription. Below is an updated chart of preferred brands with non-preferred generics.

As a reminder, a 72-hour emergency supply may be provided if a prescription is awaiting prior authorization. A "3" in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill.

2016-2017 NC Medicaid and Health Choice Preferred Drug List	
Preferred Brand	**Non-Preferred Generic**
Abilify Discmelt	aripiprazole ODT
Adderall XR	amphetamine salt combo ER
Aggrenox	aspirin-dipyridamole ER
Aldara	imiquimod
Alphagan P	brimonidine
Androgel	testosterone
Astepro	azelastine
Avelox	moxifloxacin
Bactroban Cream	mupirocin cream

2016-2017 NC Medicaid and Health Choice Preferred Drug List	
Preferred Brand	**Non-Preferred Generic**

Baraclude	entecavir
Benzaclin	clindamycin/benzoyl Peroxide
Catapres-TTS	clonidine patches
Cedax	ceftibuten
Celebrex	celecoxib
Cipro Suspension	ciprofloxacin suspension
Copaxone	Glatopa
Derma-Smoothe-FS	fluocinolone 0.01% Oil
Desoxyn	methamphetamine
Diastat Accudial/Pedi System	diazepam rectal / system
Differin	adapalene
Diovan	valsartan
Epivir HBV	lamivudine HBV
Exelon	rivastigmine
Exforge	amlodipine / valsartan
Exforge HCT	amlodipine / valsartan / HCT
Focalin / Focalin XR	dexmethylphenidate / ER
Gabitril	tiagabine
Grifulvin V	Griseofulvin
Hepsera	adefovir
Invega ER	Paliperidone ER
Kadian ER	morphine sulfate ER
Lovenox	enoxaparin
Metadate CD	methylphenidate CD
Methylin Solution	methylphenidate solution
Metrogel Topical	metronidazole gel topical
Namenda	memantine
Nasonex	mometasone furoate
Natroba	spinosad
Nexium (Rx)	esomeprazole
Niaspan ER	niacin ER
Orapred ODT	prednisolone ODT
Oxycontin	oxycodone ER

Patanase	olopatadine
Prandimet	repaglinide / metformin
Provigil	modafinil
Pulmicort respules	budesonide respules
Retin-A Cream/Gel	tretinoin cream/gel
Ritalin LA	methylphenidate LA
Rythmol SR	propafenone SR
Seroquel XR	Quetiapine ER
Suprax	Cefixime

2016-2017 NC Medicaid and Health Choice Preferred Drug List	
Preferred Brand	**Non-Preferred Generic**
Soritane	acitretin
Symbyax	olanzapine / fluoxetine
Tamiflu	Oseltamivir
Tobradex Drops	tobramycin / dexamethasone drops
Tegretol XR Tablet	carbamazepine XR
Tricor	fenofibrate
Trileptal	Oxcarbazepine
Trilipix	fenofibric acid
Vancocin Capsule	vancomycin capsule
Verelan PM	verapamil ER PM
Vivelle-Dot Patch	estradiol patch
Voltaren	Diclofenac
Zovirax Suspension	acyclovir suspension
Zyvox	Linezolid

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 recipients 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.

Change to Early Refill Threshold for Opioids and Benzodiazepines

The N.C. Division of Medical Assistance (DMA) is increasing the Early Refill Threshold from 75% to 85% for Opioids and Benzodiazepines on May 1, 2017. The system will be changed to alert pharmacies when a patient's medication history indicates greater than 15% of the previously dispensed days' supply remains.

Pharmacists are reminded that only the "05 – Therapy dosage change" is an approved reason to override an early fill alert for any controlled substances. This override reason should only be used when a therapy change has occurred. Neither the vacation supply override nor lost prescription override will override an early refill for a controlled substance.

This change is being implemented as part of an ongoing effort to help the State of North Carolina combat the current opioid epidemic.

NC Medicaid and NC Health Choice PDL Update: Addition of New PDL Drug Class

Effective May 1, 2017, the N.C. Medicaid and N.C. Health Choice PDL will be updated to include a new PDL drug class (Neuropathic Pain). This new PDL drug class will also include drugs that were previously listed in Topical Anesthetics. There are no changes in the preferred and non-preferred status for the drugs in this new PDL drug class. This update is intended to better identify the preferred and non-preferred drug options for the treatment of neuropathic pain.

NEUROPATHIC PAIN	
Preferred	**Non-Preferred** **Clinical criteria apply to Lidoderm®**
duloxetine capsule (generic for Cymbalta®)	Cymbalta® Capsule
gabapentin capsule / solution (generic for Neurontin®)	Gralise® Starter Pack / Tablet
	Horizant®
	Irenka®
	Lyrica® Capsule / Solution
	Neurontin® Capsule / Solution / Tablet
	Savella® Tablet / Titration Pack
	Dermacin RX® PHN PAK
	lidocaine patch (generic for Lidoderm®)
	Lidoderm® Patch
	Qutenza® Kit

Behavioral Health Medication Edits

Effective May 1, 2017, new pharmacy point of sale (POS) clinical edits for behavioral health medications will go into effect. These edits are specifically related to dosage and quantity prescribed which exceeds the Food and Drug Administration (FDA) approved maximum dosage and dosage schedule and in class therapeutic duplication. There will be a 60-90 day grace period to allow pharmacists and providers a window of opportunity to identify and address any therapeutic issues that may be impacted by these new POS behavioral health clinical edits. Pharmacists are encouraged to contact prescribers if they identify any recipients that may be affected. The edit list can be found at the links below.

Clinical Utilization Behavioral Health Edits (Adult)-Pending Implementation

Clinical Utilization Behavioral Health Edits (Pediatric)-Pending Implementation

Generic Dispensing Rate Adjustments

Generic dispensing rate adjustments go into effect on May 1, 2017. These rates are based on the Generic Dispensing Rate Percentage Report for first quarter 2017. The report can be found at: https://ncdma.s3.amazonaws.com/s3fs-public/Pharmacy_Generic_Dispensing_Rate.pdf.

Eteplirsen injection, for intravenous use (Exondys 51) Coverage

Effective May 16, 2017, the N.C. Medicaid Program covers Exondys 51 (Eteplirsen) **only** through the Outpatient Pharmacy Program. Exondys 51 is **not** covered when billed through the Physician's Drug Program (PDP) with HCPCS code J3490. Claims submitted for Exondys 51 with HCPCS code J3490 **will be denied**.

Prior authorization (PA) through the Outpatient Pharmacy Program is required for coverage of Exondys 51. If PA is granted, the maximum length of authorization is six months.

Prescribers must request PA by contacting CSRA at 1-866-246-8505 (phone) or 1-855- 710-1969 (fax). The criteria and PA request form are also available on the NCTracks Prior Approval Drugs and Criteria web page.

More information can be found at the N.C. Division of Medical Assistance (DMA) Outpatient Pharmacy Program web page. DMA's approved PDP list is found on the DMA PDL web page.

Over-the-Counter Coverage Policy

Per Clinical Coverage Policy 9-A, *Over-The-Counter Products*, N.C. Medicaid and N.C. Health Choice cover a limited amount of over-the-counter medications (OTC's). This coverage is limited to select rebateable products in the following categories:

- Smoking deterrent agents (nicotine)
- Proton pump inhibitors
- Second-generation antihistamines
- Second-generation antihistamines-decongestant and,
- Insulins

In addition, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) offers some coverage for OTC's for beneficiaries less than 21 years of age.

DMA is aware that certain OTC's in various drug classes have been inadvertently paying at the point of sale. Corrections to the processing system have been made by our fiscal vendor to ensure that only the select OTC medications included in Policy 9-A are being covered.

Clinical Coverage Policy 9-A can be viewed on the DMA Pharmacy Services Clinical Coverage Policies web page.

Preferred Brand with Non-Preferred Generic

The N.C. General Assembly **mandates** pharmacists participating in N.C. Medicaid to substitute generic drugs for brand- or trade-name drugs unless prescribers **specifically** orders the brand-name drug, and personally indicates in their own handwriting on the prescription order "**medically necessary**." However, the General Assembly also authorizes the Secretary of the Department of Health and Human Services to prevent substitution of a generic equivalent drug, including a generic equivalent that is on the state maximum allowable cost list, when the net cost to the state of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent.

The pharmacist shall fill the prescription with the least expensive generic in the pharmacy expect under two circumstances:

- A specific brand- or trade-name drug is specified by the prescriber in the required manner, or,
- The net cost to the state of the brand-name drug has been determined to be less than the cost of the generic equivalent. In other words, on the N.C. Medicaid Preferred Drug list, the brand-name drug is preferred and its generic alternative is non-preferred.

Therefore, it is **not** necessary for the prescriber to handwrite on the prescription order "medically necessary" when a prescription order is for a preferred brand with a non- preferred generic equivalent. However, the prescriber **does** need to write "Medically Necessary" on the face of the prescription for the brand to be reimbursed at the brand price for:

- preferred brands with preferred generic alternatives, and
- non-preferred brands with non-preferred generic alternatives.

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

1. Update to Manual Pricing Calculation for Complex Rehab Technology: In collaboration with DME suppliers, and based on analysis of other states, DMA claims data and provider supplied cost data, DMA upwardly adjusted the manual pricing calculation for select complex rehab technology procedure codes from "invoice, less of all discounts plus 20%" to "invoice, less of all discounts plus 35%". This change became effective May 1, 2017.

2. Clinical Coverage Policy 5A (Durable Medical Equipment and Supplies) was Divided into Three Parts: To produce a more convenient experience for stakeholders. There was no change to the scope or coverafe of the policy. The divisions were made along clinical specialty lines. The titles for the three policies which replace Clinical Coverage Policy 5A are:
    - 5A-1, Physical Rehabilitation Equipment and Supplies
    - 5A-2, Respiratory Equipment and Supplies
    - 5A-3, Nursing Equipment and Supplies

3. Compliance with the CMS Home Health Final Rule – 42CFR, Part 440.70: Clinical Coverage Policies 5A-1, 5A-2, 5A-3 and 5B have been amended to comply with the CMS home Health Final Rule. The updated policy language will become effective July 1, 2017. Here is a summary of the final rule updates to the policies mentioned:
    - Definitions of medical equipment and supplies were updated to match the final rule language;
    - Documentation of a face-to-face encounter between the beneficiary and prescribing practitioner within 6mos of the initiation of the primary reason for DMEPOS services was added to coverage criteria;
    - A review of DMEPOS services by the prescribing practitioner at least annually was added to coverage criteria;
    - Language was added to indicate that DMEPOS could be covered for any non-institutional setting in which normal life activities take place;
    - Language restricting coverage of DMEPOS items for use in the home only was deleted;
    - References to coverage being limited to only items listed in the fee schedules were deleted.

6. ***Outpatient Specialized Therapies***

DMA is amending the OST Clinical Coverage Policies 10-A and 10-B to include the following policy revisions:

- 10-A Outpatient Specialized Therapies
    - The addition of the following surgical CPT codes to the table for beneficiaries over 21 years of age to receive 2 evaluation visits and 8 therapy treatment visits:
        - 31360 Laryngectomy, total, without radical neck dissection
        - 31365 Laryngectomy, total, with radical neck dissection
    - The addition of the following ICD-10-CM diagnosis codes to the table for beneficiaries over 21 years of age to receive 1 evaluation visit and 3 therapy treatment visits per calendar year:
        - R47.1 Dysarthria and Anarthria
        - R49.0 Dysphonia, Hoarseness
        - R49.1 Aphonia; Loss of voice
- 10-B Independent Practitioners
    - CCP 10-B Independent Practitioner was revised to more appropriately align with CCP 10A,
    - Outpatient Specialized Therapies.

- The CPT code 92569 under Audiology Assessment was end date in 2009 and was removed from policy.

The occupational therapy and physical therapy evaluation and re-evaluation CPT codes were revised 1-1-2017 and have been updated in this policy.

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 Policy with an effective date of March 1, 2017.
The PDN policy was separated in to two policies, 3G-1, PDN for Beneficiaries aged 21 years and above, and 3G-2, PDN for Beneficiaries Under the Age of 21.

- Changes to 3G-1 amended the existing PDN policy to remove beneficiaries under 21, and clarified PDN program requirements and streamlined process to reduce provider administrative burden.
- 3G-2 was created as a new standalone PDN policy 3G-2, documenting coverage for beneficiaries under 21 in support of coverage changes in the renewed CAP/C 1915 (c) Home and Community-Based Services (HCBS) waiver, which discontinued CAP/C nursing services. PDN 3G-2 included an expansion of PDN services to incorporate additional conditions, clarified PDN program requirements and streamlined process to reduce provider administrative burden. 617 children previously receiving CAP/C nursing were transitioned to PDN in Feb. 2017.
- Provider stakeholder listening sessions were conducted to detail modifications to the policies and provide Transition implementation details. Frequently Asked Questions documentation was developed and posted to the PDN program website.

DMA implemented functionality granting PDN providers the ability to electronically submit requests for Prior Authorization to services via NCTracks.

b. Home Health

DMA worked to ensure compliance with the federal implementation of the Home Health Final Rule. Collaborative activities with Durable Medical Equipment and Supplies (DME), as well as CAP/C Waiver will serve to align services and decrease duplication of efforts. Activities with DME focus on synchronizing supply items and utilization limits, while activities with CAP/C are central to continued efforts to support provision of ill-aligned waiver services.

c. Hospice

In compliance with the CMS initiated Hospice Payment Reform, which became effective 1/1/16, DMA created a CSR in collaboration with NCTracks to enact the 2-Tier payment system where Hospice care is reimbursed at a higher rate for the first 60 days and at a lower rate for the remainder of care. Additionally, a Service Intensity Add-on (SIA) payment is applied for the last seven days of life on top of the routine hospice care rate. The CSR is nearing final approval and is slated for an October 2017 implementation.

DMA has created a second CSR to add functionality to decrease the timeframe from 300 to 180 days for manual review of Prior Authorization request for continuing Hospice services. This CSR includes specifications for vendor clinical review and approval within the NCTracks system.

The Hospice Program area is beginning to explore opportunities to differentiate between hospice services and palliative services to ensure beneficiaries receive appropriate services and level of care based on needs.

6. *Dental*

New Dental Procedure

Effective with date of service January 1, 2017, a new dental procedure was added for the N.C. Medicaid and N.C. Health Choice dental programs from the Current Dental Terminology (CDT) 2016 American Dental Association (ADA) code updates.

CDT Code	Description and Limitations	PA Indicator
D1354	**Interim caries arresting medicament application** • Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure • Limited to beneficiaries ages 1 to 5 • Allowed once per beneficiary per six calendar month period for the same provider • Limited to a total of four applications prior to age 6 • Allowed once per date of service • Recommended for beneficiaries who are deemed to be at risk for progression of disease to pulpal infection • Since the potential for staining of carious enamel and dentin exists, providers must obtain informed consent from the beneficiary's parent or caregiver prior to rendering the service • Reapplication of the caries arresting medicament at recall visits is only indicated if the carious lesions do not appear arrested • Treated carious lesions can be restored after treatment with a caries arresting medicament • Reimbursement rate of $24.18	N

Revised Dental Procedure

N.C. Medicaid and N. C. Health Choice coverage was revised for the treatment of beneficiaries in extended care facilities. Prior to May 1, 2017, providers were reimbursed for only one facility call per date of service per facility, regardless of the number of beneficiaries treated on that day. Effective with date of service May 1, 2017, providers can be reimbursed for a facility call (D9410) for each beneficiary receiving definitive dental treatment.

CDT Code	Description and Limitations	PA Indicator
D9410	House/extended care facility call * Includes visits to nursing facilities, long-term care facilities, adult care homes, hospice sites, institutions, etc. * A dentist can be reimbursed for one facility call per date of service **for each beneficiary** treated in the facility * Must be billed with other definitive treatment (other CDT codes) rendered on that date of service * Procedure codes for treatment must be billed on the detail lines before D9410 on the dental claim * Not allowed for post-surgical follow-up care or initial six months post-delivery care for appliances when other definitive treatment is not being rendered * Reimbursement rate of $71.16 (General Dentist)	N

9. ***Behavioral Health IDD Section Updates*:**

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 held three physical stakeholder meetings in January (in Raleigh, Greenville, and Hickory), and one webinar meeting in February. We are currently working on incorporating feedback from the stakeholder meetings and preparing for submission to CMS.

TBI Waiver:

DMA responded to a formal request for additional information from CMS on the TBI waiver. We are currently working with Alliance Behavioral Health to operationalize the Waiver. We are also working though our Home and Community Based Standard (HCBS) process to ensure that all potential sites are fully compliant with CMS's Final HCBS rule. In order work through our HCBS process, DMA and DMH are reviewing five potential sites to confirm that the review process ensures compliance with the HCBS rule.

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. Face to face statewide listening sessions are scheduled for:

June 5, 2017	June 6, 2017	June 8, 2017	June 13, 2017
5:30-7:30 p.m.	5:30-7:30 p.m.	5:30-7:30 p.m.	5:30-7:30 p.m.
Chapel Hill Library	Guildford County DSS	Trillium Health Resources	Partners Behavioral Health
100 Library Drive, Room A	1203 Maple St., Rm 123	165 Center Street	901 S. New Hope Road
Chapel Hill, NC	Greensboro, NC	Jacksonville, NC	Gastonia, NC

Behavioral Health Clinical Policy Updates:

Mobile Crisis Management:

DMA continues to work with DMHDDSAS on improving clinical coverage policy 8A, *Enhanced Mental Health and Substance Abuse Services*, Mobile Crisis Management (MCM). Provider and LME-MCO stakeholder meetings concluded in October 2016. In April 2017, staff from DMA, DMH/DD/SAS, DSS, DJJ, providers, and consumers attended a three-day best practice conference for mobile response services in New Jersey. This trip provided DMA the opportunity to learn how mobile crisis response services are implemented in another state, and will help to focus our efforts for policy amendment.

Psychosocial Rehabilitation (PSR):

With feedback gathered from stakeholder meetings, a draft policy has been developed and will be reviewed by an internal group of DMA and DMH/DD/SAS subject matter experts.

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 substance use continuum was completed and found to be comprehensive.

Nurse Practitioners:

Section 6.1 of the DMA Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers* requires that a nurse practitioner (NP) must be certified as a psychiatric mental health nurse practitioner (PMHNP) by June 30, 2017 to provider behavioral health services under CCP 8C. A decision to amend this requirement was made after thorough research, and conversations with the nursing board, institutes of higher learning and Department staff. On June 2, 2017, Joint Communications Bulletin #253 was published to provide clarification to the LME-MCOs and providers regarding the updated requirements for NPs that are not certified as a PMHNP by July 1, 2017.

Changes to CCP 8C, Section 6.1 will be made to reflect the requirements:

- *Nurse Practitioners not certified as PMHNP may be eligible to provide psychiatric services to Medicaid beneficiaries if they meet all the requirements listed below, as demonstrated to the credentialing body of the Prepaid Inpatient Health Plan (PIHP):*
    a. *Documentation that they have three (3) full-time years of psychiatric care and prescribing experience under licensed psychiatric supervision including psychiatric assessments and psychotropic medication prescribing; and*
    b. *A signed supervision agreement with a North Carolina Licensed Psychiatrist that covers prescribing activities; and*
    c. *Continuing education requirements, going forward, which include 20 hours each year focused on psychiatric physiology, diagnosis, and psychopharmacology. (21 NCAC 36.0807)*

- *The PIHP credentialing body and the Medical Director are responsible for assessing the qualifications of Nurse Practitioners not yet certified as Psychiatric Mental Health Nurse Practitioners and for monitoring the supervision and continuing education requirements.*

- *Waiver of the requirement for three years of supervised psychiatric experience for a NP not yet certified as a PMHNP must be based on access needs of the PIHP, documented in the records of the credentialing body, approved by the PIHP Medical Director, and reassessed on an annual basis. Other details in items b. and c. above apply.*

Institution for Mental Disease (IMD)

42 CFR 438.6(e) allows for the State to give capitated payments to managed care plans for services in an institution for mental disease (IMD). These services are for enrollees ages 21 to 64 if the IMD stay is less than 15 days in a month. The IMD must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care, or a sub-acute facility providing psychiatric or SUD crisis residential services. A completed draft IMD in lieu of service definition is under review by DMA leadership. The IMD in lieu of service definition has been included in the LME-MCOs contract, and the anticipated cost of this service has been added into the PMPM rates to be effective 7/1/2017.

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. In the interim, listening sessions were held across North Carolina to gather feedback on ways clinical oversight, medical oversight and quality assurance can be incorporated into policy if the CABHA organizational structure is dissolved.

LME-MCO Contract Section Updates:

PIHP Contracts:

New DMA / LME-MCO contracts will go into effect on July 1, 2017. Contract changes were primarily related to new Federal Medicaid Managed Care Rules.

External Quality Review
DMA has initiated the SFY 17/18 External Quality Reviews (EQR) for each LME-MCO, beginning with Trillium in June 2017. EQRs focus on quality, timeliness, and access to the health care services that an LME-MCO furnishes to Medicaid beneficiaries.

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.

Transition of Care Plan:
The Transition of Care Plan will help ensure that when mergers or consolidations of LME-MCOs occur, individuals have continued access to service during a period of transition, thereby preventing detriment to the individual's health or to reduce risk of hospitalization or institutionalization where the transition policy not in effect. This Plan was the result of new Medicaid Managed Care Final Rules found under the Continued Services section.

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.

10. *Long Term Services and Supports*

Community Alternatives Programs for Children (CAP/C)
The newly amended Community Alternatives Program for Children (CAP/C) Home and Community-Based Services waiver was implemented statewide on March 1, 2017. With a start date of February 2017, seven (7) specific provider and beneficiary trainings have been conducted in the areas of waiver objectives, eligibility, roles and responsibility of a case manager and case management entity, care coordination, and what I need to know about the waiver.

A new initiative for the CAP/C waiver is the option of directing care through a process called consumer-direction. 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. In 2015, CAP/C launched a pilot program for consumer-direction in four (4) specific catchment areas to identify best practice strategies for statewide implementation of consumer direction. In April 2017, a CAP/C workgroup met to analyze the CAP/C consumer-direction pilot. From the recommendation of the workgroup, a best-practice consumer-direction packet was created for individuals interested in directing their care. A rollout of this best practice packet will implement on June 27, 2017 through statewide trainings to both the waiver beneficiary/primary caregiver and CAP providers. Full statewide implementation of the consumer-direction program will occur by late July 2017.

CAP/C is currently supporting 2,644 individuals to live in their home communities.

Community Alternatives Program for Disabled Adults (CAP/DA)
In February 2017, the amended Community Alternatives Program for Disabled Adults (CAP/DA) Home and Community-Based Services waiver was approved by the Centers for Medicare and Medicaid Services (CMS) to add an additional 320 slots to target individuals with Alzheimer's Disease and related disorders (Session Law 2016-94, Section 12H.5). The amended waiver was approved with an effective date of January 1, 2017. Individuals meeting the Alzheimer's Disease and related disorders eligibility criteria are automatically prioritized to a waiver slot.

The currently approved five-year CAP/DA Home and Community-Based Services waiver will expire on September 30, 2018. To initiate the planning activities for the expiring waiver, stakeholder engagement will start

in October 2017 to seek input in future waiver processes and clinical components for a renewal waiver with an effective date of October 1, 2018.

The CAP/DA waiver is currently supporting 10,387 active individuals to live safely in their home communities. Approximately 350 individuals are in various stages of waiver approval; over 800 referrals are pending clinical eligibility approval and 2,095 individuals are waiting for services on a county based waitlist.

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.

FINGER-PRINT BASED CRIMINAL BACKGROUND CHECKS

In accordance with 42 CFR 455.410(a), the Centers for Medicare & Medicaid Services (CMS) requires state Medicaid agencies to screen enrolled providers for "categorical risk" according to the provisions of Part 455 subpart E.
Under 42 CFR 455.450, state Medicaid agencies are required to screen all applications for "categorical risk", including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation.
In addition, under 42 CFR 455.434(b), N.C. Medicaid and N.C. Health Choice providers designated as "high categorical risk" under 42 CFR 424.518(c) and N.C.G.S. 108C-3(g), or any person with a 5 percent or more direct or indirect ownership interest in the organization - as those terms are defined in 42 CFR 455.101 - will be required to submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA. **Implementation will be July 30, 2017, and is retroactively effective for providers enrolled or revalidated on or after Aug. 1, 2015.**

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.
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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.

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. 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 (NCHC) Programs will be terminated**. Providers must submit a re-enrollment application to be reinstated.

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