WRITTEN SECTION REPORTS

REPORT PERIOD MARCH 1 - MAY, 2022

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

The Pharmacy & Therapeutic Committee met on 03/08/2022, 04/12/2022, and 05/10/2022
The N.C. Physician Advisory Group met on 03/24/2022, 04/28/2022, and 05/26/2022
* The N.C. Physician Advisory Group AD HOC Meeting on 06/01/2022

Recommended Clinical Coverage Policies

- 1S-4 Genetic Testing – 03/24/2022
- 1A-5 Child Medical Evaluation and Medical Team Conference for Child Maltreatment – 03/24/2022
- 8A-7: Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ASAM Level 1WM) (new policy) – 03/24/2022
- 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring (ASAM Level 2WM) (new policy) – 03/24/2022
- 8C Outpatient Behavioral Health – 04/28/2022
- 1E-3 Sterilizations - 06/01/2022
- 5A-2 Respiratory Equipment and Supplies - 06/01/2022
- 8D-4 Clinically Managed Population Specific High Intensity Residential Services (New Policy) - 06/01/2022

PAG Notifications

- 3B Program of All-Inclusive Care for the Elderly (PACE) – 04/28/2022
- 1F Chiropractic Services: – 04/28/2022
- 1C-1 Podiatry Services – 04/28/2022
- 6A Routine Eye Examination and Visual Aids for Beneficiaries Under 21 Years of Age – 04/28/2022
- 6B Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older – 04/28/2022
- 2A-1 Acute Inpatient Hospital Services - 06/01/2022

Recommended Pharmacy Criteria

- Prior Approval Criteria- Immumodulators-Actemra-03/24/2022
- Prior Approval Criteria- Immumodulators – Humira-03/24/2022
- Prior Approval Criteria- Immumodulators – Avsola- 03/24/2022
- Prior Approval Criteria- Modulators – Cosentyx-03/24/2022
- Prior Approval Criteria- Immumodulators – Orencia-03/24/2022
- Prior Approval Criteria- Immumodulators -Otezla- 03/24/2022
- Prior Approval Criteria- Immumodulators – Remicade-03/24/2022
- Prior Approval Criteria- Immumodulators- Arcalyst-03/24/2022
- Prior Approval Criteria- Monoclonal Antibodies- 03/24/2022
- Prior Approval Criteria- Immumodulators- Xeljanx/Xeljanz XR- 04/128/2022
- Prior Approval Criteria- Immumodulators- Rinvoq- 04/28/2022
- Prior Approval Criteria- Immumodulators- Skyrizi- 04/28/2022
- Prior Approval Criteria- Immumodulators- Stelara-04/28/2022
- Prior Approval Criteria- Monoclonal Antibodies-04/28/2022
- Annual Preferred Drug List (PDL) changes- 05/26/2022

2. Pharmacy Items Posted for Public Comment

- Prior Approval Criteria- Immunomodulators- Actemra - 05/20/2022 - 07/04/2022
- Prior Approval Criteria- Immunomodulators- Rinvoq - 05/20/2022 - 07/04/2022
- Prior Approval Criteria- Immunomodulators- Humira - 05/20/2022 - 07/04/2022
- Prior Approval Criteria- Immunomodulators- Xeljanz - 05/20/2022 - 07/04/2022
- Prior Approval Criteria- Immunomodulators- Xeljanz XR - 05/20/2022 - 07/04/2022
- Prior Approval Criteria- Immunomodulators-Avsola - 05/23/2022 - 07/07/2022
- Prior Approval Criteria- Immunomodulators-Cosentyx - 05/23/2022 - 07/07/2022
- Prior Approval Criteria- Immunomodulators-Skyrizi - 05/23/2022 - 07/07/2022
- Prior Approval Criteria- Immunomodulators-Orencia - 05/25/2022 - 07/09/2022
- Prior Approval Criteria- Immunomodulators-Arcalyst - 05/25/2022 - 07/09/2022
- Prior Approval Criteria- Immunomodulators-Otezla - 05/25/2022 - 07/09/2022
- Prior Approval Criteria- Immunomodulators-Remicade - 05/25/2022 - 07/09/2022
- Prior Approval Criteria- Immunomodulators-Taltz - 05/25/2022 - 07/09/2022
- Annual PDL changes - 05/27/2022 - 07/16/2022
- Prior Approval Criteria-Monoclonal Antibodies - 06/01/2022 - 07/16/2022
- Prior Approval Criteria-Growth Hormones - 06/01/2022 - 07/16/2022
- Prior Approval Criteria- Lupus - 06/01/2022 - 07/16/2022
- Prior Approval Criteria-Nexletol - 06/01/2022 - 07/16/2022
- Prior Approval Criteria-PCSK9 Inhibitors - 06/01/2022 - 07/16/2022

Clinical Coverage Policies Posted for Public Comment

- 8B, Inpatient Behavioral Health Services - 03/28/2022 - 05/12/2022
- 1E-7, Family Planning - 04/01/2020 - 05/16/2022
- 1S-4, Genetic Testing - 04/19/2022 - 06/03/2022
- 1C-1, Podiatry Services - 05/06/2022 - 06/05/2022
- 8C, Outpatient Behavioral Health Services - 05/18/2022 - 07/02/2022
- 1F, Chiropractic Services - 05/25/2022 - 06/24/2022
- 1A-5, Child Medical Evaluation & Medical Team Conference for Child Maltreatment - 05/26/2022 - 07/10/2022

3. New or Amended Policies Posted to Medicaid Website

- 5A-2 Respiratory Equipment and Supplies - 03/15/2022
- 1E-5, Obstetrics - 04/01/2022
- 1E-6, Pregnancy Medical Home – 04/1/2022
- 8A, Enhanced Mental Health and Substance Abuse Services - 04/1/2022
- 2B-1, Nursing Facility Services - 04/15/2022
- 8P, NC Innovations - 05/1/2022
- 1M-3, Childbirth Education – 05/15/2022
- 1M-5, Health and Behavior Intervention – 05/15/2022
- 5A-3, Nursing Equipment and Supplies – 05/15/2022
- 8A-2, Facility-Based Crisis Service for Children and Adolescents – 05/15/2022

New or Amended PA Criteria Posted

- Prior Approval Criteria- Aduhelm-04/01/2022
- Prior Approval Criteria- Epidiolex-04/01/2022
- Prior Approval Criteria- Calcitonin Gene Related Migraine Therapy-04/01/2022
- Prior Approval Criteria- Continuous Glucose Monitor Supplies (CGM)-04/01/2022

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

Updates to Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies
May 17, 2022

All temporary Durable Medical Equipment (DME) policy flexibilities outlined in COVID-19 Special Bulletins remain in effect as of this publication date. See COVID-19 Special Bulletins for details.

An updated version of Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies, with an amended date of May 15, 2022, was posted to the NC Medicaid Clinical Coverage Policy web page. Following is a summary of updates:

In Subsection **5.3.4 Phototherapy**, prior approval was removed from phototherapy (bilirubin) light with photometer (HCPCS code E0202) when clinical coverage guidelines are met. And coverage for the treatment of hyperbilirubinemia within the first 30 calendar days of life was updated to allow for coverage during the first 31 calendar days of life. These revisions are effective retroactively to Nov 1, 2021.

New coverage was added for manual pump operated enema systems (HCPCS codes A4453, A4459) with new Subsection **5.3.9 Manual Pump-Operated Enema System**, and the following medical necessity criteria. This revision is effective retroactively to Oct 1, 2021:

A manual pump-operated enema system, such as the Peristeen® Anal Irrigation System, may be considered medically necessary when all the following coverage criteria are met:

a. Beneficiary has a diagnosis of neurogenic bowel dysfunction. Refer to Attachment A, Section B for the required ICD-10 diagnosis code;
b. Beneficiary is two years of age and older;
c. Beneficiary suffers from fecal incontinence, chronic constipation, and time-consuming bowel management procedures; and
d. Initial management involving diet, bowel habit, laxatives, or constipating medication has failed.

Note: If the above medical necessity criteria are met, then prior authorization is not required

In **Attachment A: Claims-Related Information, Section B**, **ICD-10-CM Diagnosis Code K59.2** (neurogenic bowel, not elsewhere classified) was added as an acceptable diagnosis for the manual pump-operated enema system.

In **Attachment A: Claims-Related Information, Section C: Procedure Code(s)**, the following updates were made:

Coverage and quantity limits were added for HCPCS codes **A4453** (Rectal catheter for use with the manual pump-operated enema system, replacement only) and **A4459** (Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type).

Per the CMS annual update, HCPCS code **A4397** (Irrigation supply; sleeve, each) was end-dated Dec 31, 2021, and replaced with HCPCS codes **A4436** (Irrigation supply; sleeve, reusable, per month) and **A4437** (Irrigation supply; sleeve, disposable, per month), effective Jan 1, 2022.

Added language to clarify that the quantity limit for HCPCS codes **A4450** (Tape, non-waterproof, per 18 square inches) and **A4452** (Tape, waterproof, per 18 square inches) is 80 units **per month**.

In **Attachment B: Provision of DME and Medical Supplies on the Date of Discharge from Specified Facilities**, the asterisk indicating that an item requires prior approval was removed. The **BOLD** indicating Medicare is the primary payer for an item was also removed.

In **Attachment C: Completing a Claim for DME or EN Services**, NCHC was removed from block one.

Additional Resources

The DME fee schedule and full text of Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies is available at North Carolina Medicaid's Durable Medical Equipment (DME) web page. All COVID-19 Special Bulletins are available here.

Updates to Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies
An amended version of Clinical Coverage Policy 5A-2, Respiratory Equipment. and Supplies with an effective date of Feb. 1, 2022, is posted March 16, 2022

Please note that this bulletin has been updated on April 26, 2022, to correct the effective date.

All temporary Durable Medical Equipment (DME) policy flexibilities outlined in COVID-19 Special Bulletins remain in effect as of this publication date. See COVID-19 Special Bulletins for details.

An amended version of Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies with an effective date of Feb. 1, 2022, was posted to the NC Medicaid Clinical Coverage Policy web page. Following is a summary of updates:

In Attachment A: Claims-Related Information, Section C: Procedure Code(s), the following updates were made:

Quantity limits were updated from four per year to four per month for existing HCPCS codes A7520 (tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each), A7521 (tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC) silicone or equal, each), and from one per month to four per month for A7525 (tracheostomy mask, each).

Coverage and quantity limits were added for HCPCS codes A4604 (Tubing with integrated heating element for use with positive airway pressure device) and A7046 (Water chamber for humidifier, used with positive airway pressure device, replacement, each).

As documented in the October 2009 NC Medicaid bulletin, eight asthma supply codes that can be issued and reimbursed for physicians, physician assistants, and nurse practitioners have been denoted with a plus (+) sign.

Additional Resources

The DME fee schedule and full text of Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies is available at NC Medicaid's DME web page. All COVID-19 Special Bulletins are available here.

5. Outpatient Specialized Therapies/Local Education Agencies (LEAs)

Updates to Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies
May 17, 2022

All temporary Durable Medical Equipment (DME) policy flexibilities outlined in COVID-19 Special Bulletins remain in effect as of this publication date. See COVID-19 Special Bulletins for details.

An updated version of Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies, with an amended date of May 15, 2022, was posted to the NC Medicaid Clinical Coverage Policy web page. Following is a summary of updates:

In Subsection **5.3.4 Phototherapy**, prior approval was removed from phototherapy (bilirubin) light with photometer (HCPCS code E0202) when clinical coverage guidelines are met. And coverage for the treatment of hyperbilirubinemia within the first 30 calendar days of life was updated to allow for coverage during the first 31 calendar days of life. These revisions are effective retroactively to Nov 1, 2021.

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In **Attachment C: Completing a Claim for DME or EN Services**, NCHC was removed from block one.

Additional Resources

The DME fee schedule and full text of Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies is available at North Carolina Medicaid's Durable Medical Equipment (DME) web page. All COVID-19 Special Bulletins are available here.

Updates to Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies
An amended version of Clinical Coverage Policy 5A-2, Respiratory Equipment. and Supplies with an effective date of Feb. 1, 2022, is posted March 16, 2022

Please note that this bulletin has been updated on April 26, 2022, to correct the effective date.

All temporary Durable Medical Equipment (DME) policy flexibilities outlined in COVID-19 Special Bulletins remain in effect as of this publication date. See COVID-19 Special Bulletins for details.

An amended version of Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies with an effective date of Feb. 1, 2022, was posted to the NC Medicaid Clinical Coverage Policy web page. Following is a summary of updates:

In Attachment A: Claims-Related Information, Section C: Procedure Code(s), the following updates were made:

Quantity limits were updated from four per year to four per month for existing HCPCS codes A7520 (tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each), A7521 (tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC) silicone or equal, each), and from one per month to four per month for A7525 (tracheostomy mask, each).
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5. Outpatient Specialized Therapies/Local Education Agencies (LEAs)

Temporary COVID-19 flexibilities previously reported, remain in effect through 6/30/22 (extended from 3/31/22 to 6/30/22).

Clinical Coverage Policy 10C Local Education Agencies (LEAs) policy was amended on 2/1/22 as follows: Under Psychological and Counseling Services, changed language from 'All evaluation services must be provided by a
licensed psychologist or school psychologist' to "All providers shall function within the scope of practice of their state license and certification."

Upcoming policy change to be made:

- 10C: Transportation section to be added (following SPA approval) which allows reimbursement for transportation services for Medicaid beneficiaries on the days that specialized therapy services are received in the school setting.

6. Long-Term Services and Supports (LTSS)

Community Alternatives Program for Children (CAP/C) 1915(c) Home and Community-based Services (HCBS) Waiver

NC Medicaid is in the process of renewing the CAP/C HCBS waiver with an anticipated approval date of October/November 2022. The renewal waiver will propose two new initiatives to improve the quality of care and decrease gaps in service provision. These new initiatives are listed below; however, they must be approved by the Centers for Medicare and Medicaid Services (CMS) before being administered through the CAP/C waiver.

- Payment of care to a legally responsible person when extraordinary conditions are met. A new service will be created called Coordinated Caregiving.
- The ability of children with skill needs similar to children receiving private duty nursing to direct care through self-directed care.

Other changes to the CAP/C waiver will include:

- Increasing the unduplicated participant count by gradually expanding the utilization limits by 500 new slots each year starting in waiver year two to 6,000 by the fifth year of the waiver approval period.
- Updating the rate methodology to show the increase in the direct care worker rates per Senate Bill 108.
- Expanding the service definitions of specific home and community-based services to assist with mitigating risks from viruses and other social determinants.

Community Alternatives Program for Disabled Adults (CAP/DA) 1915(c) Home and Community-based Services (HCBS) Waiver

NC Medicaid is in the process of amending the CAP/DA HCBS waiver with an anticipated approval date of October/November 2022. The changes proposed in the amended waiver are listed below; however, they must be approved by the Centers for Medicare and Medicaid Services (CMS) before being administered through the CAP/DA waiver.

- Increasing the Alzheimer's Disease and Related Disorder slots by 114 slots totaling that resource pool to 424, increasing the program's unduplicated participant count to 11,638. These additional slots were approved per Senate Bill 108 and will be made available to fill with new applicants by June 30, 2022.
- Updating the rate methodology to show the increase in the direct care worker rates per Senate Bill 108.
- Expanding the service definitions of specific home and community-based services to mitigate risks from viruses and other social determinants.

Program of All-Inclusive Care for the Elderly (PACE)
Elderhaus has submitted its application to CMS for Service Area Expansion (SAE) in March. Elderhaus will be adding zip code 28479 in Brunswick County to its approved service area. Final approval of expansion is pending and is contingent upon CMS approval of the application, satisfactory plan to address any outstanding corrective action requests, and maintaining a fiscally sound operation as required in 42 CFR 460.80.

Pace@Home's application to CMS for SAE was approved in January. The PO added ten zip codes to their currently serviced counties of Catawba, Lincoln, Burke, Caldwell, and Alexander.

Pace of the Triad will be building a new PACE center and is not expected to submit their application until December 2022 at the earliest and expects to be operational the first quarter of 2024. They are proposing to add Forsyth, Stokes, and Surry counties to their currently serviced counties of Guilford and Rockingham.

Carolina SeniorCare will be building a new PACE center and is not expected to submit their application to CMS until September 2022 at the earliest and expects to be operational late 2023 or early 2024. They are proposing to add Beaufort, Carteret, Craven, Jones, Lenoir, Onslow, and Pamlico to their currently serviced counties of Rowan, Davidson, Davie, and Iredell.

Senior Total Life Care will be building a new PACE center and is not expected to submit their application to CMS until June 2022 at the earliest and expects to be operational June 2023. They are proposing to add Rutherford County to their currently serviced counties of Gaston, Cleveland, and Lincoln.

7. Behavioral Health IDD Section

- 1915(i) -fiscal SPA is being completed for submission to CMS.

Behavioral Health Clinical Policy Updates:

- CCP 8A – Enhanced Mental Health and Substance Abuse Services - Mobile Crisis Management stakeholder engagement webinars have been completed. Mobile Crisis Management SPA has been updated to include feedback from ECBI.

- CCP 8B Inpatient Behavioral Health Services- policy posted for 45-day public comment, comment period has ended. Public comment is scheduled to be reviewed by DHB and DMHDDSAS staff on 5/25/2022.

- CCP 8C- policy has posted for 45-day public comment on 5/18/2022 and will remain posted through 7/2/2022.

- CCP 8A-11 Medically Monitored Inpatient Withdrawal Management- waiting on signed fiscal impact/note to move forward with posting for public comment. Rate has been reviewed and a fiscal impact/note has been developed, but not signed. Policy was reviewed by PAG in December and recommendation was to approve.

- CCP Clinically Managed Population-Specific High Intensity Residential Program- waiting on signed fiscal impact/note to move forward with posting for public comment. Rate has been reviewed and a fiscal impact/note has been developed, but not signed. Policy was reviewed by PAG in October and recommendation was to approve.

- CCP Clinically Managed High-Intensity Residential Services Adult & Adolescent- facilitated stakeholder engagement for the Adolescent level of care 4/21/2022, stakeholder engagement for Pregnant and Parenting Women is scheduled for 6/13/2022, stakeholder engagement for adult is to be scheduled at this time.

- CCP 2A-1- policy is being revised due to House Bill 382 (March 24, 2021)- policy is going to PAG for notification in May 2022. Have reached out to CMS with questions regarding policy revisions required by HB 382. A fiscal SPA will be submitted to CMS for this change.
- CCP Individual Support and Transitional Support draft policy, for (i) Option, has been reviewed by DMH and stakeholder engagement will be held during June 2022.
- CCP 8A-2, Facility-Based Crisis Service for Children and Adolescents, was revised with amendments effective May 15, 2022.

PROVIDER OPERATIONS REPORT

The Provider Operations team enhanced the monitoring of NC Medicaid Managed Care Standard Plans this quarter.

- Requested PHPs submit updated Credentialing/Recredentialing policies to ensure adherence to NC Medicaid expectations
- Added contract language around the timely submission of policies to NC Medicaid for review, as well as timely uploads to the PHP public facing websites approval was achieved.
- Continued monitoring of Standard Plans as required to ensure compliance, with referral to the Managed Care oversight team of identified noncompliance incidents. This includes validation of non-enrolled Medicaid provider data errors identified on the PHP Network File and issuing corrective action plans. The PHPs provide reports regarding their corrective action plans to show how the discrepancies are being resolved timely.

The Provider Operations team also continues to work with the NC Medicaid Managed Care Tailored Plans on implementation of the BH I/DD (Behavioral Health Intellectual/Developmentally Disabled) Tailored Plan and Prepaid Inpatient Health Plan (PIHP) Medicaid Direct contracts, both set to launch on December 1, 2022.

- The Tailored Plan team continues to review and approve all Provider Operations post-contract award inbound deliverables submitted by the Tailored Plans and meets weekly with each Tailored Plan individually to assist with Provider Operations-related questions and issues that arise during Implementation, as well as provide technical support and guidance.
- Provider Operations meets weekly with the Enrollment Broker (EB) and Member Operations team on the implementation of the business and technical requirements developed to update the Medicaid and NC Health Choice Provider and Health Plan Lookup Tool with Tailored Plan content. In April and May, the team performed 4 weeks of rigorous User Acceptance Testing (UAT) to test the proposed changes and found 35 defects. The EB has resolved 22 of the defects and is actively working to correct the remaining defects ahead of the projected June 15, 2022, launch date for the updated Lookup Tool.
- Throughout March, the Provider Operations team reviewed and amended the provider sections of the PIHP Medicaid Direct Contract, set to launch on December 1, 2022, alongside TP, then worked with the internal DHHS teams and the six Tailored Plans to finalize those changes for review by Legal and Contracting.
- Tailored Plan Readiness Review activities kicked off in March and Provider Operations completed Round 1 of the Tailored Plan Desktop Review and the Call Center Virtual Onsite Reviews this month.
- The Tailored Plan team continues to work on the development and approval of TP and PIHP Medicaid Direct Business Procedures and monitoring processes.

The Provider Data Management/Credentialing Verification Organization (PDM/CVO) project is in the process of selecting a vendor and currently in the silent period. The contract is expected to be awarded to an NCQA certified vendor by this summer, with planning and design to follow. Go live is scheduled for mid-2023.

Our NC Area Health Education Center (AHEC) partner completed 1,352 contacts in March and 1, 264 in April for a total of 2,616 contacts to providers in performing its regional coaches' provider engagement and technical support activities. The contacts were completed via virtual meeting, on-site visit, telephone conversation, or via e-mail communication.

The Medicaid Provider Ombudsman received 676 cases directly through the Provider Ombudsman Listserv during this quarter. The team responded directly to 226 of those and worked to assign other cases to the appropriate business owner including the PHPs, General Dynamics Information Technology/NCTracks, or an operational unit within DHB. The Provider Ombudsman follows up with the business owner if a case has aged for 7 days or greater and open cases are also monitored bi-weekly through closure. Trends continue to be tickets related to Claims/Finance and Provider Enrollment.

The Provider Relations team successfully reviewed over 1,500 mass changes, 319 Carolina ACCESS applications, 51 CCNC Network Affiliation requests, and nine Eastern Band of Cherokee Indians-Tribal Option enrollment requests. This represents an increase of over 40% in the total volume of requests since last quarter.

In response to findings cited in the Office of State Auditor (OSA) Performance Audit published February 2021, and Single Audit Report for the year ending June 30, 2020, Provider Operations submitted several Customer Service Requests (CSRs) to improve the Medicaid and NC Health Choice (NCHC) provider screening, enrollment, and termination processes. These changes include:

- Primary source verification of all credentials at time of re-verification/re-credentialing. When re-verification/re-credentialing resumes at the end of the federal Public Health Emergency (PHE), Medicaid's Fiscal Agent will conduct primary source verification of all credentials required for enrollment for all individual and organization providers during re-verification/re-credentialing as required in CFR 455.450.
- Automation of two database searches, Adverse Actions Report (AAR) and Provider Penalty Tracking Database (PPTD). This automation reduces the chance of errors identified in the manual search process during credentialing. The monitoring efforts around this reporting have been updated to reflect this change.
- Validation of ownership and managing employee information. NC Medicaid now requires the Fiscal Agent to implement the first of a two-phased process for ownership and managing employee disclosure screening prior to initial enrollment for in-state organizations. Once phase one is implemented and any unforeseen issues are addressed, the final phase will be the verification for all organizations, including border and out-of-state providers, during initial enrollment and re-verification.
- Application of new denial and termination reason codes for provider taxonomies and Medicaid and NC Health Choice health plans when the Department renders a decision to limit, deny or terminate a provider's participation due to license limitations imposed by their respective licensing boards as provided in CFR 455.412. This change also added measures to prevent providers with license limitations from re-enrolling without first being reviewed and approved by the Department.
- Development of a new process to bump up a provider to a high categorical risk level from limited or moderate when it is determined that the provider, owners, or managing employees have been excluded from OIG, Medicare, SAM or any other Federal Health Care Program within the past 10 years. Although implementation is pending, this change will improve the documentation and oversight needed for providers flagged as high risk.

Provider Operations is actively involved in the following audit activities:

- 2022 Office of State Auditor (OSA) Single Audit
- 2022 Internal Enhancing Accountability in Government through Leadership and Education (EAGLE) Audit
- RY2023 Payment Error Rate Measurement (PERM) Audit
- 2021 Internal Office of Inspector General (OIG) Risk Assessment Audit as performed by NC Medicaid Office of Compliance and Program Integrity (OCPI)
- Office of Internal Auditor (OIA) Follow-up to 2021 Single Audit Findings Items

Monitoring the Fiscal Agent's performance of provider enrollment and termination and the performance of vendors, contractors, and prepaid health plans (PHPs) was carried out in accordance with our Provider Operations' Monitoring Plan to ensure approved providers meet qualification requirements and that ineligible providers are terminated in a timely manner when they fail to meet the Medicaid and N.C. Health Choice (NCHC) program standards.

During this quarter, Provider Operations monitored the following to determine if the actions taken by the referenced entities impacted a provider's Medicaid and NCHC participation:

- 137 licensure disciplinary actions imposed by 19 N.C. licensure boards
- 467 notifications from four N.C. Divisions (Health Services Regulation, Aging and Adult Services, Social Services and Public Health)
- 105 notifications from the Centers for Medicare and Medicaid Services (CMS)

In addition, 155 provider applications processed by our Fiscal Agent were monitored to ensure proper approval, denial and termination decisions were rendered; and 59 monthly LexisNexis background checks were monitored to ensure our Fiscal Agent took proper action on provider records.

NC Medicaid's Fiscal Agent reports certain provider termination action to CMS, the U.S. Department of Health and Human Services (HHS-OIG) and the National Practitioner Databank (NPDB) in accordance with federal and state regulations. During this quarter Provider Operations monitored the following number of actions to ensure they were reported timely and accurately:

- 8 actions reportable to CMS
- 1 action reportable to HHS_OIG
- 7 actions reportable to NPDB

NC Medicaid's Fiscal Agent is responsible for initiating provider screenings, site visits, and initial enrollment on-line training, which is conducted by Public Consulting Group (PCG). During this quarter, Provider Operations monitored the following activities carried out by PCG to ensure compliance with state and federal rule and regulations:

- 20 site visits
- 28 on-line trainings

The Provider Operations' Monitoring Plan also requires management quality control review of monitoring activities conducted by its staff including, but not limited to the activities listed above. During this quarter, management reviewed 434 items.

The above-mentioned activities also run alongside staff involvement in provider communication and engagement activities, the development of new Division initiatives, and continued partnering and vendor management activities, which include the fiscal agent (GDIT), Enrollment Broker, and PCG.