WRITTEN SECTION REPORTS

REPORT PERIOD JUNE 1, 2021 THROUGH AUGUST 31, 2021

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

The Pharmacy & Therapeutic Committee met on 08/10/2021
The N.C. Physician Advisory Group met on 06/24//2021 & 08/26/2021

Recommended Pharmacy

- Prior Approval Criteria- Hepatitis C- 08/26/2021
- Prior Approval Criteria- Zolgensma- 08/26//2021
- Prior Approval Criteria- Cystic Fibrosis- 08/26/2021
- Prior Approval Criteria-Aduhelm-08/26/2021

Recommended Clinical Coverage Policies

- 1K-7 Prior Approval for Imaging Services (terminate existing policy) 06/24//2021
- 11A-17 CAR T-Cell Therapy 06/24//2021

PAG Notifications

On 06/24//2021 PAG was notified of amendments to the following NON-PAG policies to remove Prior Approval criteria:

- 11A-1 Hematopoietic Stem-Cell Transplantation for Acute Lymphoblastic Leukemia (ALL)
- 11A-2 Hematopoietic Stem-Cell Transplantation for Acute Myeloid Leukemia (AML)
- 11A-3 Hematopoietic Stem-Cell Transplantation for Chronic Myeloid Leukemia (CML)
- 11A-5 Allogeneic Hematopoietic Transplantation for Genetic Diseases and Acquired Anemias
- 11A-6 Hematopoietic Stem-Cell Transplantation in the Treatment of Germ Cell Tumors
- 11A-7 Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma
- 11A-8 Hematopoietic Stem-Cell Transplantation for Multiple Myeloma POEMS Syndrome and Primary Amyloidosis
- 11A-9 Allogeneic Stem-Cell Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms
- 11A-10 Hematopoietic Stem-Cell Transplantation (HSCT) for Central Nervous System (CNS) Embryonal Tumors & Ependymoma
- 11A-11 Hematopoietic Stem-Cell Transplantation for Non-Hodgkin Lymphomas
- 11A-14 Placental and Umbilical Cord Blood as a Source of Stem Cells
- 11A-15 Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
- 11A-16 Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic
- Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
- 11B-1 Lung or Lobar Lung Transplantation
- 11B-2 Heart (Cardiac) Transplantation

- 11B-3 Islet Cell Transplantation
- 11B-5 Liver Transplantation
- 11B-6 Heart-Lung Transplantation
- 11B-7 Pancreas Transplant
- 11B-8 Small Bowel, Small Bowel/Liver or Multivisceral Transplants

2. Policies Posted for Public Comment

- 11A-17 CAR T-Cell Therapy - 8/10/2021 - 9/24/2021

3. New or Amended Policies Posted to Medicaid Website

- 10C, Outpatient Specialized Therapies (LEAs) - 6/15/2021
- 1A-22, Medically Necessary Circumcision - 6/15/2021
- 1G-2, Skin Substitutes - 6/15/2021
- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone - 7/1/2021
- 10B, Independent Practitioners (IP) - 7/1/2021
- 9, Outpatient Pharmacy Program 7/1/2021
- 1S-5, Genetic Testing for Susceptibility to Breast and Ovarian Cancer (BRCA) - 7/1/2021
- 11B-1, Lung Transplantation - 7/1/2021
- 11B-2, Heart Transplantation - 7/1/2021
- 11B-3, Islet Cell Transplantation - 7/1/2021
- 11B-5, Liver Transplantation - 7/1/2021
- 11B-6, Heart/Lung Transplantation - 7/1/2021
- 11B-7, Pancreas Transplant - 7/1/2021
- 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants - 7/1/2021
- 11A-1, Hematopoietic Stem-Cell Transplantation for Acute Lymphoblastic Leukemia (ALL) - 7/1/2021
- 11A-2, Hematopoietic Stem-Cell Transplant for Acute Myeloid Leukemia - 7/1/2021
- 11A-3, Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia - 7/1/2021
- 11A-5, Allogeneic Hematopoietic Transplant for Genetic Diseases and Acquired Anemias - 7/1/2021
- 11A-6, Hematopoietic Stem-Cell Transplantation in the Treatment of Germ Cell Tumors - 7/1/2021
- 11A-7, Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma - 7/1/2021
- 11A-8, Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis - 7/1/2021
- 11A-9, Allogeneic Stem-Cell Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms - 7/1/2021
- 11A-10, Hematopoietic Stem-Cell Transplantation (HSCT) for Central Nervous System (CNS) Embryonal Tumors & Ependymoma - 7/1/2021
- 11A-11, Hematopoietic Stem-Cell Transplant for Non-Hodgkin's Lymphoma- 7/1/2021
- 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells - 7/1/2021
- 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood - 7/1/2021
- 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) - 7/1/2021

- 3K-1, Community Alternatives Program for Children (CAP/C) - 7/1/2021
- 3K-2, Community Alternatives Program for Disabled Adults (CAP/DA-Choice) - 7/1/2021
- 3L, State Plan Personal Care Services (PCS) - 7/1/2021
- 8A-2, Facility-Based Crisis Management for Children and Adolescents - 08/01/2021

New or Amended PA Criteria Posted

- Prior Approval Criteria Synagis - 08/11/2021

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

June 2021 – Aug 2021

Temporary COVID-19 flexibilities previously reported, remain in effect.

An amendment to Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies is in progress to increase the maximum allowable daily rental reimbursement rate to align with Medicare, and to eliminate the prior authorization requirement for phototherapy (bilirubin) light with photometer (HCPCS E0202) when existing medical necessity criteria are met. These updates are intended to help alleviate issues of access for infants in the western region of NC.

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

June 2021 – Aug 2021

Temporary COVID-19 flexibilities previously reported, remain in effect.

An amended version of **Clinical Coverage Policy 10C, Outpatient Specialized Therapies, Local Education Agencies (LEAs)** was promulgated with an effective date of June 15, 2021. Following is a summary of updates:

In Subsection 3.5, Speech-Language Therapy, the following medical necessity guidance was added:

3.5 Telehealth

A select set of speech and language evaluation and treatment interventions may be billed by LEAs when provided to student beneficiaries using a telehealth delivery method as described in Clinical Coverage Policy 1-H. Telehealth delivery may be medically necessary when a student is medically homebound, during an extended school closure, or if their school is remote or underserved such that access to appropriately qualified providers is limited.

Note: CPT codes that may be billed when service is furnished via telehealth are indicated in **Attachment A, Section C: Codes**.

In **Attachment A, Claims-Related Information, Section C: Codes**, the following CPT codes were identified as telehealth eligible services:

CPT code	Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92526	Treatment of swallowing dysfunction and/or oral function for feeding (oral motor only)
92609	Therapeutic services for the use of speech-generating device, including programming and modification

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An amended version of **Clinical Coverage Policy 10B, Outpatient Specialized Therapies, Independent Practitioners** was promulgated with an effective date of July 1, 2021. Following is a summary of updates:

New Subsection 3.1.1, Telehealth Services, was added:

3.1.1 Telehealth Services

As outlined in Attachment A and in Subsection 3.2.1.3.e, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring, on NC Medicaid's website at https://medicaid.ncdhhs.gov.

In Subsection 3.2.1.3, Speech-Language Therapy, the following medical necessity guidance was added:

3.2.1.3 Telehealth

1. A select set of speech and language evaluation and treatment interventions may be provided to a beneficiary using a telehealth delivery method as described in Clinical Coverage Policy 1-H. Telehealth delivery may be medically necessary when a beneficiary's medical condition is such that exposure to others should be avoided, access to transportation is inconsistent, or if their location is remote or underserved such that access to appropriately qualified providers is limited.

2. To ensure a beneficiary receives high quality care aligned with best practices, the following criteria must be considered when making decisions about providing care using a telehealth delivery method:
   A. Unless in-person care is contraindicated or unavailable, telehealth must be used as an adjunct to in-person care and not as a replacement.
   B. Telehealth must be used in the best interest of the beneficiary and not as a convenience for the therapist.
   C. Telehealth must never be used solely to increase therapist productivity.

Note: CPT codes that may be billed when service is furnished via telehealth are indicated in **Attachment A, Section C: Codes**.

In Attachment A, Claims-Related Information, Section C: Codes, the following CPT codes were identified as telehealth eligible services:

CPT code	Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92526	Treatment of swallowing dysfunction and/or oral function for feeding (oral motor only)
92609	Therapeutic services for the use of speech-generating device, including programming and modification

Attachment A, Section D, Modifiers, was updated to read:

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.

Attachment A, Section F, Place of Service, was updated to add:

Telehealth claims should be filed with the provider's usual place of service code(s).

6. Long-Term Services and Supports (LTSS)

- No report this quarter

7. Behavioral Health IDD Section

- No report this quarter

PROVIDER SERVICES REPORT

Since the launch of Medicaid Managed Care, the Medicaid Provider Ombudsman operations team assisted and closed 477 cases routed through either the Medicaid Help Center or Provider Ombudsman email listserv. This resulted in an 87% case closure rate for cases, most of which were related to PHP concerns or enrollment questions.

Provider Operations continues to collaborate in a cross-functional effort to transition to a new provider data management, credentialing verification organization (PDM/CVO) model for provider enrollment and credentialing through an NCQA certified vendor. Efforts are underway for solicitation of feedback from DHHS staff (including sister agencies) on the requirements for the new system to ensure that all federal and state requirements, quality determinants, and state-specific needs are met for Medicaid and NC Health Choice provider participation in both NC Medicaid Direct and all Medicaid Managed Care programs. The new PDM/CVO model is slated for implementation by July 2023.

NC Session Law 2021-62 repealed portions of the 2020 COVID-19 Recovery Act, requiring the discontinuation of disaster applications and the resumption of provider in-person site visits and fingerprint-based criminal background check beginning July 29, 2021. As a result, Provider Operations has taken the appropriate applicable actions to adhere to the legislative requirements and is beginning the process to clear the backlog of providers for whom required enrollment requirements were delayed. As of July 29, 2021:

- 211 Emergency applications processed
- 702 provider enrollment required fingerprinting were delayed
- 11 provider enrollment required site visits were delayed

Provider recredentialing will remain suspended through the end of the federal state of emergency. To date, Provider Operations has delayed the recredentialing of 11,936 providers.

Since March 2020, Provider Operations has been processing provider requests for a Health Information Exchange (HIE) Hardship Extension, which delayed their requirement to connect to NC HealthConnex until Dec 31, 2022. However, NC Session Law 2021-26 established January 1, 2023 as the new connection deadline for NC Medicaid and state-funded health care service providers, and their affiliated entities to connect and begin submitting required data to the state-designated health information exchange (HIE), NC HealthConnex. Because the deadlines are matched, the HIE Hardship Extension request process was absolved effective Aug 1, 2021. As of that date, Provider Operations had processed 165 requests.

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 has submitted several Customer Service Requests (CSRs) to improve the Medicaid and NC Health Choice provider screening, enrollment, and termination processes:

- CSR 2435 will require Medicaid's Fiscal Agent to 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. This CSR is scheduled to implement October 24, 2021.

- CSR 2460 will require the Fiscal Agent to automate two database searches required during credentialing. This automation will reduce the chance of errors identified in the manual search process. This CSR is scheduled to implement January 30, 2022.
- CSR 2481 will require 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. This CSR is scheduled to implement October 24, 2021. Once phase one is implemented and any unforeseen issues are addressed, Provider Operations will work with the Centers for Medicare & Medicaid Services (CMS) on phase two which will expand the ownership screening process to include in-state, border and out-of-state organization providers during initial enrollment and re-verification. We anticipate phase two implementation will occur at the Provider Data Management/Credential Verification Organization (PDM/CVO) go-live on July 31, 2023.
- CSR 2487 will require the Fiscal agent to implement new denial and termination reason codes to be applied to provider taxonomies and Medicaid and NC Health Choice health plans when the Provider Operations License Limitations Review Committee renders a decision to limit, deny or terminate a provider's participation due to license limitations imposed by the licensing boards as provided in CFR 455.412. This CSR will put measures in place to prevent providers with license limitations from re-enrolling without first being reviewed and approved by the Committee.

Monitoring the Fiscal Agent's performance during provider enrollment record maintenance and termination has continued, as well as monitoring performance of vendors, contractors, and prepaid health plans (PHPs). Provider Operations ensures approved providers meet the qualification requirements and that ineligible providers are terminated in a timely manner when they fail to meet the Medicaid and NC. Health Choice (NCHC) program standards. Provider Operations is also responsible for monitoring the Fiscal Agent's performance during the provider enrollment application process to ensure approved providers meet qualification requirements and documentation is maintained to effectively evaluate the approved enrollment of Medicaid and NC Health Choice Providers. During this quarter, Provider Operations monitored 19 licensure boards and 3 state agency boards, reviewing approximately 135 board sanctions associated with providers, and approximately 121 provider applications.

There are continued efforts to collaborate with health plan administrators to ensure PHP contract compliance, especially as standard plans are working to operationalize provider operations liquidated damages (LDs) including LDs owned by all business units. The Provider Operations team is revising internal monitoring procedures to incorporate a process for reporting contract noncompliance to Plan Administration. The team is beginning to monitor and validate PHP network file errors and communicate the results to identified PHPs for resolution.

Provider Operations has experienced an increase in Provider Hearings in the Medicaid Direct program. As of August 30, 2021, there were 25 informal hearing requests as opposed to an average of 8 requests per month prior to August 2020. There have been 5 contested case petitions filed this year as opposed to an average of 2or 3 per year previously. The increases in appeals of adverse actions can be attributed in part to the quarterly Maintain Eligibility program which is an automated solution serving to identify and terminate providers that have not billed for Medicaid and/or NC HealthChoice services within 12 months; the adverse action determinations made by the Provider Operations Limited License Review Committee, whose function is to review all license limitations imposed by boards and render decisions on what, if any, action we must take on the enrollment record of those providers participating in Medicaid and NC Health Choice; and, actions taken by

the fiscal agent to generate notifications to providers with expiring credentials at designated intervals, resulting in suspension and subsequent terminate of providers who fail to update their required credentials.

We closed out the state fiscal year in June with our AHEC partner having met all contracted deliverables to continue providing and supporting educational activities and services for essential and rural providers. For the months of June and July there were a total of 1185 encounters between the thirty AHEC coaches and practices, either virtually, through email, by phone, or in person. Additionally, there have been 67 Advanced Medical Home (AMH) encounters between AHEC and providers. Since the start of our current fiscal year, we have co-hosted one Hot Topics webinar and two Virtual Office Hours sessions.

Our business unit is actively working to build the framework for the BH I/DD (Behavioral Health Intellectual/Developmental Disability) Tailored Plan for Provider Operations.

- Since contract awards in July and the Tailored Plan Kickoff in early August, Provider Operations has held four Deep Dive sessions for the six Tailored Plans (TPs) detailing Provider Data Management; Enrollment, Disenrollment, Suspensions and Terminations; Deliverables; and Provider Engagement and Communications.
- We continue to work on our Outbound Deliverable templates to assist the TPs with content creation and standardizing the format of their submissions. The initial three Inbound Deliverables to Provider Operations were due at the end of August, and we are currently in an active review period for those, as well as for the six Implementation Plans. Meetings began with each of the TPs to review and offer feedback regarding their deliverables as they relate to Provider Operations. Following that, Provider Ops will meet on a twice-weekly cadence with the TPs to ensure timelines and requirements are met and to offer more support where needed to implement the BH I/DD Tailored Plan.
- Provider Operations has been working cross-functionally with the Enrollment Broker (EB) to revise the EB Provider Directory and include all information necessary for Tailored Plans and the population they'll serve. We've added content to the video tutorial as well.

Provider Operations worked diligently to contribute to the successful launch of Medicaid Managed Care on July 1. We also continue to evaluate and implement internal business rules, take in new/revised guidance from authorities, and maintain strong collaborations with contracted vendors to ensure transparent and accountable oversight to achieve the goals and mission of the Medicaid Managed Care and Medicaid Direct programs.