

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850



State Demonstrations Group

April 25, 2019

Dave Richard
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Mr. Richard:

The state of North Carolina submitted its Substance Use Disorder (SUD) Implementation Protocol as required by special terms and condition (STC) 19 of the state's section 1115(a) demonstration (11-W00313/4) entitled "North Carolina Medicaid Reform Demonstration." The Centers for Medicare & Medicaid Services has reviewed the SUD Implementation Protocol and determined it is consistent with the requirements outlined in the STCs; therefore, with this letter, the state may begin receiving Federal Financial Participation for North Carolina Medicaid recipients residing in the Institutions for Mental Disease setting under the terms of this demonstration for the period starting with the date of this approval letter through October 31, 2023. A copy of this approved protocol is enclosed and is also hereby incorporated into the STCs as Attachment D.

If you have any questions, please contact your project officer, Ms. Sandra Phelps, at (410) 786-1968 or by email at Sandra.Phelps@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Angela D. Garner
Director
Division of System Reform Demonstration

Enclosure

cc: Bill Brooks, Director DMFO CMCS – South
Shantrina Roberts, Deputy Director DMFO CMCS – South



North Carolina

Substance Use Disorder Implementation Plan Protocol

March 8, 2019

NC DHHS Division of Health Benefits

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Introduction

Like many states, North Carolina is facing an opioid crisis that has rapidly intensified in recent years. Opioid overdose deaths in North Carolina have increased from just over 100 deaths in 1999 to 1,384 in 2016, including a 39% increase in overdose deaths from 2015-2016.^{1,2} Since 1999, over 13,000 North Carolinians have died from an opioid overdose. Despite significant efforts to turn the tide on the opioid crisis—including launching North Carolina’s Opioid Action Plan, passing the bipartisan Strengthen Opioid Misuse Prevention (STOP) Act, and making changes to North Carolina’s Medicaid program—the number of people dying from opioid overdoses each month continues to increase.

As part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina’s Department of Health and Human Services (the Department) is pursuing a Section 1115 demonstration to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina’s prescription drug monitoring program (PDMP).

The following implementation plan provides an overview of North Carolina’s current Medicaid SUD delivery system and then details North Carolina’s strategic vision for comprehensive SUD delivery reform across six milestones identified by the Centers for Medicare & Medicaid Services (CMS).

Department Overview

The Department includes the following divisions that have significant roles in the delivery and regulation of SUD services for Medicaid enrollees:

- **Division of Health Benefits (North Carolina Medicaid).** The division within the Department responsible for implementing Medicaid transformation and managing the North Carolina (NC) Medicaid and Health Choice (CHIP) programs.
- **Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS).** The division that serves as the single state authority for the Substance Abuse and Mental Health Services Administration (SAMHSA) and administers state-funded mental health, developmental disability and substance abuse services.
- **Division of Health Services Regulation (DHSR).** The division that certifies and monitors healthcare providers.

¹ North Carolina’s [Opioid Action Plan](https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%2008-22-2017.pdf), 2017-2021. Available at <https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%2008-22-2017.pdf>.

² North Carolina Opioid Overdose Factsheet, June 2017. Available at https://files.nc.gov/ncdhhs/Opioid_Overdose_Factsheet_FINAL_06_27_17.pdf.

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- **Division of State Operated Health Care Facilities (DSOHF).** The division that oversees and manages state-operated health care facilities that treat adults and children with mental illness, SUDs, intellectual and developmental disabilities (I/DDs) and neuro-medical needs.

Current SUD Delivery System

Today, North Carolina Medicaid contracts with seven local management entities—managed care organizations (LME-MCOs), which are prepaid inpatient health plans, to provide mental health, substance use, and I/DD services for Medicaid enrollees located within their catchment areas. Medicaid enrollees obtain physical health services, pharmacy, and most long-term services and support (LTSS) through Medicaid fee-for-service. Additionally, DMH/DD/SAS contracts with the LME-MCOs to manage state and federal block grant-funded mental health, I/DD and SUD services to serve the uninsured and underinsured populations living within their catchment areas. Certain populations that are excluded from LME-MCO enrollment, such as NC Health Choice or legal aliens, receive SUD services through Medicaid fee-for-service. NC Medicaid contracts with a vendor to perform utilization management functions for fee-for-service behavioral health services.

Medicaid Delivery System Transformation

In September 2015, the North Carolina General Assembly (General Assembly) enacted North Carolina Session Law 2015-245, which was amended by Session Laws 2016-121, 2017-57 and 2018-48, directing the transition of North Carolina’s Medicaid program from a predominantly fee-for-service model to managed care beginning in 2019. Consistent with best practices, the Department will create integrated managed care products that cover the full spectrum of physical health, behavioral health, LTSS and pharmacy services for all enrollees. North Carolina will permit two types of prepaid health plan (PHPs) products: standard plans and behavioral health and intellectual and developmental disability (BH I/DD) tailored plans. The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower-intensity behavioral health needs, will receive integrated physical health, behavioral health and pharmacy services through standard plans when managed care launches in November 2019. Individuals with significant behavioral health disorders, I/DDs, or traumatic brain injury (TBI) will be enrolled by July 2021 in BH I/DD tailored plans, which will be specialized managed care products that target the needs of these populations.

Both standard plans and BH I/DD tailored plans will cover SUD treatment and withdrawal management services, but the BH I/DD tailored plans will cover a more expansive set of SUD services targeting individuals with significant SUD needs. LME-MCOs will continue to provide all covered SUD treatment services for Medicaid enrollees in the period following approval of the state’s 1115 demonstration until standard plan implementation in November 2019. Upon standard plan implementation and until the anticipated launch of BH I/DD tailored plans in July 2021, LME-MCOs will provide SUD services for Medicaid enrollees who are eligible to enroll in the BH I/DD tailored plans or who are delayed or excluded from managed care. Throughout the managed care transition and afterward, the Department will continue to provide the complete array of Medicaid-covered SUD treatment and withdrawal

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services in fee-for-service for populations that will phase into managed care in later years of implementation or that will be exempt or excluded from managed care.³

³ Federally recognized tribal members may choose to remain in the fee-for-service system and are not mandated to participate in managed care at any point, unless the mandate is for an Indian Managed Care Entity (IMCE).

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Milestone 1: Access to Critical Levels of Care for SUD

North Carolina’s Medicaid State Plan covers a wide range of SUD services for enrollees across outpatient, residential and inpatient care settings. While North Carolina’s Medicaid program currently covers most services in the ASAM continuum of care, the state seeks to complete its coverage of the ASAM continuum by adding ASAM levels 3.1 (clinically managed low-intensity residential treatment services), 3.3 (clinically managed population-specific high-intensity residential programs), 2-WM (ambulatory withdrawal management with extended on-site monitoring) and 3.2-WM (clinically managed residential withdrawal management) to its State Plan, and expanding coverage of existing services such as ASAM levels 3.5 (clinically managed high-intensity residential services) and 3.7 (medically monitored intensive inpatient services) to include adolescents. The table below provides an overview of North Carolina Medicaid coverage for each ASAM level of care, as well as proposed changes.

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
0.5	Early intervention	Screening, brief intervention and referral for treatment (SBIRT)	Physicians and physician extenders only	Currently covered for all	Expansion of providers that are eligible for reimbursement	Fee-for service, standard plans and BH I/DD tailored plans
1	Outpatient services	Psychiatric and biopsychosocial assessment; medication management; individual, group and family therapies; psychotherapy for crisis; and psychological testing for eligible enrollees based on clinical severity and function Service includes assisting the individual to achieve changes in	Direct-enrolled licensed behavioral health providers	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		his or her substance use or addictive behaviors, serving as a step down from a more intensive level of care, care for an individual in the early stages of change, and care for ongoing monitoring and disease management				
2.1	Intensive outpatient services (substance abuse intensive outpatient program)	Structured program delivering 9–19 hours of services per week to meet complex needs of people with addiction and co-occurring conditions	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service and BH I/DD tailored plans
2.5	Partial hospitalization services (substance abuse comprehensive outpatient treatment)	Structured program delivering 20 or more hours of clinically intensive programming per week, with a planned format of individualized services	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
3.1	Clinically managed low-intensity residential treatment services	SUD halfway-house services; supportive living environment with 24-hour staff and integration with clinical services; at least five hours of low-intensity treatment per week or more intensive outpatient care as indicated	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
3.3	Clinically managed population-specific high-intensity residential programs	Clinically managed high-intensity SUD residential service for adults with cognitive impairment, including developmental delays, provided in a structured recovery environment	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.5	Clinically managed high-intensity residential services (substance abuse non-medical community residential treatment)	Clinically managed high-intensity SUD residential services provided in a structured recovery environment	DHSR-licensed facilities	Currently covered for pregnant and parenting women	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.7	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)	Medically monitored SUD inpatient treatment service with a structured regimen of 24-hour physician-directed evaluation, observation, medical monitoring and addiction treatment	DHSR-licensed specialty units in a community or psychiatric hospital	Currently covered for adult enrollees meeting medical necessity criteria	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
4	Medically managed intensive inpatient services (inpatient behavioral health services)	Medically managed intensive inpatient services with 24-hour nursing care and daily physician care for severe, unstable problems in ASAM dimension: (1) acute intoxication and/or withdrawal potential; (2)	DHSR-licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		<p>biomedical conditions and complications; or (3) emotional, behavioral or cognitive conditions and complications</p> <p>Counseling services also available</p>				
OTP	Opioid treatment program (outpatient opioid treatment)	Service includes methadone or buprenorphine administration for treatment or maintenance; NC Medicaid is exploring creating an integrated service package that includes counseling and case management and other supportive services such as lab work in addition to methadone or buprenorphine	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
1-WM	Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification)	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat mild withdrawal symptoms	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
2-WM	Ambulatory withdrawal management with extended on-site monitoring	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat moderate withdrawal symptoms with extended on-site monitoring	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans
3.2-WM	Clinically managed residential withdrawal	An organized, clinically managed residential withdrawal management service for individuals who are experiencing moderate withdrawal symptoms and who require 24-hour supervision, observation and support; uses physician-approved protocols to identify individuals who require medical services beyond the capacity of the facility and to transfer these individuals to the appropriate levels of care	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans
3.7-WM	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)	An organized, medically monitored inpatient withdrawal management service under the supervision of a physician that provides 24-hour observation, monitoring and treatment for individuals who are experiencing severe withdrawal symptoms and require 24-hour nursing care	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
n/a	Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization	An organized, medically monitored withdrawal management service under the supervision of a physician that provides 24 hour supervision in a permanent facility with inpatient beds; individuals served are often in crisis due to co-occurring severe mental disorders and in need of short term, intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation	DHSR-licensed facilities	Currently covered for adult beneficiaries meeting medical necessity criteria	Will be incorporated into ASAM 4.0-WM	Fee-for service, standard plans and BH I/DD tailored plans
4-WM	Medically managed intensive inpatient withdrawal (inpatient behavioral health services)	An organized, medically managed inpatient service under the supervision of a physician that provides 24-hour, medically directed evaluation and withdrawal management for individuals who are experiencing severe, unstable withdrawal and require an acute care setting	Licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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The current North Carolina Medicaid coverage of ASAM-level SUD services, proposed changes and an implementation timeline are described in detail below. LME-MCOs currently are required to follow the Department's service definitions as described in the state's clinical coverage policies. Following managed care implementation, standard plans and BH I/DD tailored plans will be subject to these provisions in the clinical coverage policies when they launch on November 1, 2019, and July 1, 2021, respectively. The Department's service definitions will continue to apply to fee-for-service populations following the managed care transition.

Federal law prohibits federal financial participation (FFP) for services delivered to individuals ages 21 to 64 residing in IMDs. An IMD is defined as a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care or related services. One of the primary goals of the SUD-related portion of the 1115 demonstration is to waive this restriction and expand access to SUD treatment for individuals residing in IMDs. As detailed below, providers delivering the following types of services may be considered IMDs:

- ASAM level 3.1: Clinically managed low-intensity residential treatment services
- ASAM level 3.3: Clinically managed population-specific high-intensity residential programs
- ASAM level 3.5: Clinically managed high-intensity residential services
- ASAM level 3.7: Medically monitored intensive inpatient services
- ASAM level 4: Medically managed intensive inpatient services
- ASAM level 3.2-WM: Clinically managed residential withdrawal
- ASAM level 3.7-WM: Medically monitored inpatient withdrawal management
- Medically supervised or ADATC detoxification crisis stabilization
- ASAM level 4-WM: Medically managed intensive inpatient withdrawal

In addition, North Carolina has obtained approval to obtain FFP upon approval of this SUD Implementation Plan Protocol for the following non-residential services delivered to individuals residing in IMDs.

- ASAM level 2.1: Substance abuse intensive outpatient program
- ASAM level 2.5: Substance abuse comprehensive outpatient treatment program
- Opioid treatment program
- Office-based opioid treatment program

Level of Care: 0.5 (Early Intervention)

Current State

The Department provides coverage for several individual services around early intervention, including smoking cessation counseling and SBIRT. Physicians and physician extenders are the only providers who can currently bill LME-MCOs or Medicaid fee-for-service for these services. These services are available to all Medicaid-eligible enrollees without prior authorization.

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Future State

North Carolina's Medicaid program plans to expand the types of providers that can bill this service to include direct-enrolled licensed behavioral health providers by updating the state's Medicaid management information system (MMIS) to add the taxonomies of the providers who would be eligible to bill these CPT codes. Additionally, NC Medicaid will post a Medicaid Bulletin informing the behavioral health providers of this change and any relevant clinical and billing criteria.

Summary of Actions Needed

- Implement MMIS modifications: September 2018 – April 2020

Level of Care: 1 (Outpatient Services)

Current State

The Department covers Medicaid-funded outpatient behavioral health services provided by direct-enrolled providers. These services are intended to determine an enrollee's SUD treatment needs and to provide the necessary treatment. Services focus on reducing symptoms of SUD and other BH disorders in order to improve the enrollee's functioning in familial, social, educational or occupational domains. Outpatient behavioral health services are available to eligible enrollees and often involve the participation of family members, significant others and legally responsible person(s) as applicable, unless contraindicated. Based on collaboration between the practitioner and the enrollee, and others as needed, the enrollee's needs and preferences determine the treatment goals and frequency, as well as measurable and desirable outcomes. Outpatient behavioral health services include:

- Comprehensive clinical assessment (CCA)
- Medication management
- Individual, group and family therapies
- Psychotherapy for crisis
- Psychological testing

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, located here: https://files.nc.gov/ncdma/documents/files/8C_0.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to ensure a determination of ASAM level of care is included in the assessment information of enrollees diagnosed with SUDs. Enrollees with a SUD need will need to meet ASAM level 1 criteria to obtain this service.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to reflect ASAM criteria: September 2018 – April 2020

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- Submit SPA for 8A Diagnostic Assessment: September 2018 – April 2020

Level of Care: 2.1 (Intensive Outpatient Services)

Current State

The Department provides Medicaid coverage for substance abuse intensive outpatient program (SAIOP) services, which include structured individual and group SUD services that are provided in an outpatient program designed to assist adult and adolescent enrollees in beginning recovery and learning skills for recovery maintenance. The program is offered at least three hours a day, at least three days a week (no more than 19 hours of structured services per week), with no more than two consecutive days between offered services. SAIOP services include a structured program consisting of, but not limited to, the following services: individual, group and family counseling and support; biochemical assays to identify recent drug use; strategies for relapse prevention to include community and social support systems in treatment; life skills training; crisis contingency planning; disease management; and case management activities. Enrollees must meet the ASAM level 2.1 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policy 8-A to include the structured programming time frame of six to 19 hours for adolescents, reflect the 2013 ASAM criteria, require the presence of a full-time licensed professional, and permit this service to be reimbursed for individuals residing in an IMD. DHSR will update licensure rule 10A NCAC 27G .4400.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add parameters for adolescents, require the presence of a full-time licensed professional, and permit the service to be reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

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Level of Care: 2.5 (Partial Hospitalization Services)

Current State

The Department provides Medicaid coverage for substance abuse comprehensive outpatient treatment (SACOT), a time-limited periodic service with a multifaceted treatment approach for adults who require structure and support to achieve and sustain recovery. SACOT is a service that emphasizes the following: reduction in use of substances or continued abstinence; the negative consequences of substance use; the development of a social support network and necessary lifestyle changes; educational skills; vocational skills that focus on substance use as a barrier to employment; social and interpersonal skills; improved family functioning; understanding of addictive disease; and the continued commitment to a recovery and maintenance program. Enrollees must meet the ASAM level 2.5 criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will update the current Medicaid clinical coverage policy 8-A to align with the 2013 ASAM criteria, require the presence of a full-time licensed professional and permit this service to be reimbursed for individuals residing in an IMD. The Department will also work with DHSR to update licensure rule 10A NCAC 27G .4500.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to align with ASAM criteria, require the presence of full-time licensed professional, and permit this service to be reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

Level of Care: 3.1 (Clinically Managed Low-Intensity Residential Treatment Services)

Current State

North Carolina's Medicaid program does not currently cover ASAM level 3.1 clinically managed low-intensity residential treatment services, also called substance abuse halfway-house services. However, DMH/DD/SAS covers substance abuse halfway-house services under ASAM level 3.1 in its state-funded service array. Additionally, North Carolina has a current licensure rule under 10A NCAC 27G .5600 for the services provided in this type of facility.

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Future State

The Department will submit a state plan amendment (SPA) to add substance abuse halfway-house services to its State Plan for all enrollees. North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for substance abuse halfway-house services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy for substance abuse halfway-house services. This service will provide a supportive living environment with 24-hour staff and at least five hours of low-intensity treatment per week (i.e., individual, group and/or family therapies; psycho-education) or a more intensive level of outpatient care such as ASAM 2.1 as medically necessary. Additionally, DHSR will work to create a new stand-alone licensure rule to align with ASAM criteria. Enrollees will need to meet the ASAM level 3.1 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.3 (Clinically Managed Population-Specific High-Intensity Residential Programs)

Current State

The Department does not currently cover ASAM level 3.3 clinically managed population-specific high-intensity residential programs in Medicaid.

Future State

The Department will submit a SPA to add clinically managed population-specific high-intensity residential programs to its State Plan for all enrollees meeting the medical necessity criteria. North Carolina has obtained expenditure authority to deliver the service to individuals receiving the service in facilities that meet the definition of an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed population-specific high-intensity residential services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. These programs will provide clinically managed high-intensity SUD residential services in a structured recovery environment to adults with cognitive impairment, including

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developmental delays. Additionally, working across divisions, the Department will create a licensure rule for this service. Enrollees will need to meet the ASAM level 3.3 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.5 (Clinically Managed High-Intensity Residential Services)

Current State

The Department currently covers ASAM level 3.5 clinically managed high-intensity residential services for pregnant and parenting women at facilities that do not meet the definition of an IMD. Clinically managed high-intensity residential services, also called non-medical community residential treatment (NMCRT), is a 24-hour, professionally supervised residential recovery program that provides trained staff to work intensively with adults with SUDs who provide or have the potential to provide primary care for their minor children.

NMCRT rehabilitation facilities provide planned programs of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with an addiction disorder. These programs include assessment, referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, medication monitoring and self-management of symptoms, after-care, follow-up, access to preventive and primary healthcare including psychiatric care, and case management activities. NMCRT facilities do not provide 24-hour medical nursing or monitoring. Enrollees must meet the ASAM level 3.5 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to reimburse NMCRT provided to Medicaid enrollees in IMDs.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community. Working across divisions, the Department will revise the licensure rules 10A NCAC 27G .4100 and 10A NCAC 27G .4300 and create a new licensure rule for both adults and

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adolescents. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add adolescents as a population eligible to receive service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise existing licensure rules and create new licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.7 (Medically Monitored Intensive Inpatient Services)

Current State

The Department currently covers ASAM level 3.7 medically monitored intensive inpatient services for adults only at facilities that do not meet the definition of an IMD. Medically monitored intensive inpatient service providers, also called medically monitored community residential treatment (MMCRT) providers, are non-hospital rehabilitation facilities for adults, with 24-hour medical or nursing monitoring, that provide a planned program of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with alcohol and other drug problems or addiction. Enrollees must meet the ASAM level 3.7 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for MMCRT delivered to individuals residing in IMDs. North Carolina is planning to make these services available to both adolescents and adults who demonstrate medical necessity.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service and add IMDs as eligible service providers. Working across divisions, the Department will create a new

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licensure rule for this level of care that aligns with the ASAM criteria. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, add adolescents as a population eligible to receive service, and include IMDs as eligible service providers: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise and create licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 4 (Medically Managed Intensive Inpatient Services)

Current State

Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered in an IMD in lieu of settings covered by the NC State Plan.

North Carolina Medicaid currently provides coverage for ASAM level 4 medically managed intensive inpatient services at facilities that do not meet the definition of an IMD. Medically managed intensive inpatient services are behavioral health services provided in a hospital setting 24 hours a day along with supportive nursing and medical care provided under the supervision of a psychiatrist or a physician. These services are designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. They are appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees who are admitted with an SUD must meet the ASAM level 4 criteria to demonstrate medical necessity for these services.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here: <https://files.nc.gov/ncdma/documents/files/8B.pdf>.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient services delivered to individuals residing in IMDs.

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The Department will revise the current Medicaid clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers for SUD treatment. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule to align with ASAM criteria.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers for SUD treatment: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: OTP (Opioid Treatment Programs)

Current State

The Department currently covers office-based opioid treatment and opioid treatment programs at the ASAM OTP level of care.

Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone

The clinical coverage policy 1A-41 for office-based opioid treatment outlines the requirements for providers who prescribe buprenorphine and the buprenorphine-naloxone combination product for the treatment of opioid use disorders (OUDs) in office-based settings. The Drug Addiction Treatment Act of 2000 (DATA 2000) permits providers who meet certain qualifications to dispense or prescribe narcotic medications that have a lower risk of abuse, such as buprenorphine and the buprenorphine-naloxone combination product, and that are approved by the Food and Drug Administration (FDA) for OUDs in settings other than an OTP, such as a provider's office. This program allows enrollees who need the opioid agonist treatment to receive this treatment in a qualified provider's office, provided certain conditions are met.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone, located here: https://files.nc.gov/ncdma/documents/files/1A-41_4.pdf?ANpMLgJ7MIhEyt4r38bYvXinBFTk1h23.

Outpatient Opioid Treatment

Outpatient opioid treatment is a service designed to offer the enrollee an opportunity to effect constructive changes in his or her lifestyle by receiving, via a licensed OTP, methadone or other drugs approved by the FDA for the treatment of an OUD, in conjunction with rehabilitation and medical services. North Carolina Medicaid covers methadone- and buprenorphine-assisted treatment at this service level. Enrollees must meet the ASAM OTP criteria to demonstrate medical necessity for this service.

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Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhance Mental Health and Substance Use Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect that the 2013 ASAM criteria, permit this service to be reimbursed in an IMD, and to develop an integrated service model for outpatient opioid treatment that includes medication, medication administration, counseling, laboratory tests and case management activities. Working across divisions, the Department will revise the 10A NCAC 27G .3600 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, permit service to be reimbursed in an IMD, and create integrated service model: September 2018 – April 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – April 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – April 2020
- Revise LME-MCO contracts: September 2018 – April 2020

Level of Care: 1-WM (Ambulatory Withdrawal Management Without Extended On-Site Monitoring)

Current State

The Department currently provides coverage for ASAM level 1-WM ambulatory withdrawal management without extended on-site monitoring. Ambulatory detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services in regularly scheduled sessions. The services are designed to treat the enrollee's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and to effectively facilitate the enrollee's transition into ongoing treatment and recovery. Enrollees must meet the ASAM level 1-WM criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here:

https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will need to submit a SPA for 1-WM ambulatory withdrawal management services to reflect the proposed changes to the service based on the ASAM criteria. The Department will

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promulgate a new Medicaid clinical coverage policy that will reflect the ASAM criteria for this level of care and will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule

Summary of Actions Needed

- Develop new Medicaid clinical coverage policy to align with ASAM criteria: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rules: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 2-WM (Ambulatory Withdrawal Management With Extended On-Site Monitoring)

Current State

The Department does not currently provide coverage for ASAM level 2-WM ambulatory withdrawal management with extended on-site monitoring.

Future State

The Department will need to submit a SPA for ambulatory withdrawal management services to reflect that, going forward, the state will cover ambulatory withdrawal management with extended on-site monitoring for all enrollees who meet the medical necessity criteria. The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. This service will provide enrollees with an organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat moderate withdrawal symptoms with extended on-site monitoring. Enrollees must meet the ASAM level 2-WM criteria to demonstrate medical necessity for this service. Additionally, NC Medicaid will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule to include ambulatory withdrawal management with extended on-site monitoring.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

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Level of Care: 3.2-WM (Clinically Managed Residential Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64.

North Carolina Medicaid does not currently provide coverage for ASAM level 3.2-WM clinically managed residential withdrawal.

Future State

The Department will submit a SPA to add clinically managed residential withdrawal services to its State Plan. North Carolina is also seeking expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed residential withdrawal services, also called social setting detoxification services, that are delivered to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care and include IMDs as eligible providers. This policy will provide adults with an organized clinically managed residential withdrawal service that offers 24-hour supervision, observation and support for enrollees who are experiencing moderate withdrawal symptoms and who require 24-hour support utilizing physician-approved protocols. Enrollees must meet the ASAM level 3.2-WM criteria to demonstrate medical necessity for this service.

Working across divisions, the Department will revise the 10A NCAC 27G .3200 licensure rule.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 3.7-WM (Medically Monitored Inpatient Withdrawal Management)

Current State

The Department currently covers ASAM level 3.7-WM medically monitored inpatient withdrawal management services at facilities that do not meet the definition of an IMD. Non-hospital medical detoxification, the Department's name for this service, is an organized service delivered by medical and nursing professionals, which provides 24-hour, medically supervised evaluation and withdrawal

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management in a permanent facility affiliated with a hospital or in a free-standing facility. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Enrollees must meet the ASAM level 3.7-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically monitored inpatient withdrawal management services delivered to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-A to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .3100 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: Medically Supervised or ADATC Detoxification Crisis Stabilization

Current State

The Department currently covers medically supervised or ADATC detoxification crisis stabilization services. Medically supervised or ADATC detoxification crisis stabilization is an organized service, delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a licensed permanent facility with 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Beneficiaries are often in crisis due to co-occurring severe substance related mental disorders (e.g. acutely suicidal or severe mental health problems and co-occurring SUD) and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.

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Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically supervised or ADATC detoxification crisis stabilization services delivered to individuals residing in IMDs.

Coverage for detoxification services delivered in ADATCs will be incorporated into the Medicaid and Health Choice Clinical Coverage Policy 8-B for Inpatient Behavioral Health Services, which will be updated to align with 2013 ASAM level 4.0-WM criteria and include IMDs as eligible service providers. .

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019

Level of Care: 4-WM (Medically Managed Intensive Inpatient Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for medically managed intensive inpatient withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64. Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered to individuals residing in an IMD in lieu of services or settings covered by the Medicaid State Plan.

The Department currently provides Medicaid coverage for ASAM level 4-WM medically managed intensive inpatient withdrawal services at facilities that do not meet the definition of an IMD. Inpatient behavioral health services provide treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. It is appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees must meet the ASAM level 4-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here: <https://files.nc.gov/ncdma/documents/files/8B.pdf>.

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Future State

North Carolina has obtained expenditure authority to deliver this service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient withdrawal services to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

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Summary of Actions Needed Across All Service Levels

Action	Implementation Timeline
Current Services⁴	
Revise Medicaid clinical coverage policies to reflect 2013 ASAM criteria and expand coverage to adolescents, as indicated	September 2018 – October 2020
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise licensure rules to align with ASAM criteria	September 2018 – October 2022
Implement MMIS modifications	September 2018 – October 2020
Submit SPAs, as necessary	September 2018 – October 2020
Revise LME-MCO contracts	September 2018 – October 2020
New Services	
Standard and BH I/DD Tailored Plan Services	
Develop Medicaid clinical coverage policies	September 2018 – July 2020
Develop a licensure rule waiver process	September 2018 – July 2020
Create licensure rules	September 2018 – October 2022
Implement MMIS modifications	September 2018 – July 2020
Submit SPAs	September 2018 – July 2020
Revise LME-MCO contracts	September 2018 – July 2020
BH I/DD Tailored Plan Services Only	
Develop Medicaid clinical coverage policies	September 2019 – October 2020
Create licensure rules	September 2020 – October 2020
Implement MMIS modifications	September 2019 – October 2020
Submit SPAs	September 2019 – October 2020

Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria

North Carolina has robust, evidence-based policies in place to ensure that enrollees have access to appropriate SUD services according to their diagnosis and ASAM level of care determination. Over the course of the 1115 demonstration, North Carolina will strengthen its assessment and person-centered planning policies, which are prerequisites for obtaining most SUD services, by requiring that all SUD providers conducting assessments document their training with respect to the ASAM criteria.

Enrollee Assessments

Current State

As part of its Medicaid 8-A and 8-C clinical coverage policies, NC Medicaid requires behavioral health providers to complete an assessment before an enrollee can receive behavioral health services, except for selected crisis services. Providers use their clinical expertise to choose between two types of assessments:

⁴ For some services, actions will be complete prior to October 2020 as detailed earlier in this section.

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1. **Diagnostic assessments:** NC Medicaid requires that a team of at least two licensed professionals interview and assess an enrollee and, based on the assessment, write a joint report recommending the services appropriate for the enrollee. For enrollees with SUDs, at a minimum this team must include (1) a certified clinical supervisor or licensed clinical addiction specialist; and (2) a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), physician assistant (PA) or licensed psychologist. The clinical coverage policy for diagnostic assessments recommends a level of placement using the ASAM criteria for enrollees with SUD diagnoses, but does not require its use.
2. **Comprehensive clinical assessments (CCA):** Licensed professionals perform the CCA, a clinical evaluation that provides the necessary data and recommendations that form the basis of the enrollee's treatment or person-centered plan, as described in the next section. NC Medicaid does not have a prescribed format for the CCA; providers can tailor the CCA based on the enrollee's clinical presentation.

Diagnostic assessments and CCAs must include the following elements:

- Description of the presenting problems, including source of distress, precipitating events, and the associated problems or symptoms.
- Chronological general health and behavioral health history (including both mental health and substance abuse) of the enrollee's symptoms, treatment and treatment response.
- Current medications (for both physical and psychiatric treatment).
- A review of the biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs and risks in each area.
- Evidence of the enrollee's and the legally responsible person's (if applicable) participation in the assessment.
- Analysis and interpretation of the assessment information with an appropriate case formulation.
- DSM-5 diagnosis, including mental health, SUDs or intellectual/developmental disabilities, as well as physical health conditions and functional impairment.
- Recommendations for additional assessments, services, support or treatment based on the results of the CCA.
- Signature of the licensed professional completing the assessment and the date.

Future State

The Department will update clinical coverage policies 8-A and 8-C to require an ASAM determination as part of the diagnostic assessment and CCA. The Department will require all professionals administering diagnostic assessments and CCAs to obtain training in the ASAM criteria.

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C.

Summary of Actions Needed

- Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or

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assessments document their training with respect to the ASAM criteria: September 2018 – April 2020

- Contractually require standard plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: September 2018- July 2021

Person-Centered Plan

Current State

Person-centered planning is a guiding principle that must be embraced by all who are involved in the SUD service delivery system. Person-centered thinking and individualized service planning are the hallmarks of the provision of high-quality services in meeting the unique needs of each person served. Each plan is driven by the individual, utilizing the results and recommendations of a comprehensive clinical assessment, and is individually tailored to the preferences, strengths and needs of the person seeking services.

As detailed in the clinical coverage policies for behavioral health services, a person-centered plan is required in order for an enrollee to receive the covered SUD treatment services listed in Milestone 1, with the exception of all detoxification services, outpatient treatment and early intervention services. When a person-centered plan is not required, a plan of care, service plan or treatment plan, consistent with and supportive of the service provided and within professional standards of practice, is required on or before the day the service is delivered. The person-centered plan must be developed and written by a qualified professional or a licensed professional according to the requirements of the specific policy and in collaboration with the individual receiving services, family members (when applicable) and other service providers, in order to maximize unified planning. The person responsible for developing the person-centered plan should present the results and recommendations of the plan as an integral part of the person-centered planning discussions and should incorporate them into the plan as appropriate and as agreed upon by the individual and/or his or her legally responsible person.

The person-centered plan is effective for the 12-month period following the date the qualified or licensed professional signs it, unless there is a change that requires an updated plan. The person-centered plan includes service orders for behavioral health services other than ASAM level 1.0 (outpatient services) that demonstrate medical necessity and are based on an assessment of each enrollee's needs. Service orders are valid for one year from the date of the person-centered plan. At least annually, the LME-MCOs must review medical necessity for the services, and providers must issue a new service order for services to continue. An event such as a hospitalization may trigger a new assessment and a person-centered plan revision.

Future State

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the person-centered planning provisions included in current Medicaid clinical

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coverage policies prior to authorizing SUD services. As noted above, the Medicaid clinical coverage policies will continue to apply to SUD services delivered through fee-for-service. This means that the process described above related to the development and use of the person-centered plan will continue to occur as it does today.

Summary of Actions Needed

- Contractually require standard plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: September 2018-July 2021

Utilization Management

Current State

NC Medicaid requires LME-MCOs to establish a utilization management program that includes a written plan that addresses procedures used by LME-MCOs to review and approve requests for medical services, and that identifies the clinical criteria used by LME-MCOs to evaluate the medical necessity of the service being requested. Additionally, LME-MCOs are required to ensure consistent application of the review criteria and consult with requesting providers when appropriate. LME-MCOs must conduct an annual appraisal that assesses adherence to the utilization management plan and identifies the need for changes. LME-MCOs are permitted to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. NC Medicaid requires LME-MCOs to use the ASAM criteria to determine medical necessity of SUD services.

NC Medicaid requires providers, except those in outpatient, SAIOP and SACOT programs, to obtain prior approval from an enrollee's LME-MCO before providing certain SUD services. For all services, the LME-MCOs performs utilization management. The LME-MCOs follow the requirements listed below, although they have the flexibility to establish their own utilization management criteria, provided they are not more restrictive than the requirements listed below.

For populations receiving SUD services through fee-for-service, the NC Medicaid's behavioral health vendor performs utilization management, which includes prior authorization for selected services, in accordance with NC Medicaid's clinical coverage policy requirements detailed below. The vendor does not have the flexibility to establish its own utilization management criteria.

Medicaid clinical coverage policies:

- **ASAM Level 1: Outpatient services.** For children and adolescents under the age of 21, initial coverage is limited to 16 unmanaged outpatient visits per year, with additional visits requiring prior authorization. For adult enrollees, coverage is limited to eight unmanaged outpatient visits per year, with additional visits requiring prior authorization.
- **ASAM Level 2.1: SAIOP.** The initial 30 calendar days of treatment do not require a prior authorization. Services provided after this initial 30-day "pass-through" period require

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authorization from the LME-MCO or the Department's approved behavioral health vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SAIOP services must be included in an enrollee's authorized person-centered plan. Services may not be delivered less frequently than noted in the structured program set forth in the service description described in Milestone 1. Reauthorization shall not exceed 60 calendar days. Under exceptional circumstances, one additional reauthorization up to two weeks can be approved. All utilization review activity shall be documented in the enrollee's person-centered plan.

- **ASAM Level 2.5: SACOT.** The initial 60 calendar days of treatment do not require a prior authorization. Services provided after this initial 60-day pass-through period require authorization from the LME-MCO or the Department's approved behavioral health vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SACOT services, as well as all utilization review activities, must be included in an enrollee's authorized person-centered plan. Reauthorization shall not exceed 60 calendar days.
- **ASAM Levels 3.5 and 3.7: NMCRT and MMCRT.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days, and reauthorization shall not exceed 10 days. This service and all utilization review activity shall be included in the enrollee's person-centered plan. Utilization management must be performed by the LME-MCO or the Department's approved behavioral health vendor.
- **ASAM Level 4: Medically managed intensive inpatient services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.
- **Outpatient opioid treatment.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **ASAM Level 1-WM: Ambulatory detoxification.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven days. Reauthorization is limited to three days, as there is a 10-day maximum for this service. This service must be included in an enrollee's person-centered plan.
- **ASAM Level 3.7-WM: Medically monitored inpatient withdrawal management.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. This service must be included in an enrollee's person-centered plan. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **Medically supervised or ADATC detoxification crisis stabilization.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 5 days. This is a short-term service that cannot be billed for more than 30 days in a 12-month period. All utilization review activity shall be included in an enrollee's person-centered plan.
- **ASAM Level 4-WM: Medically managed withdrawal management services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.

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Future State

For all newly added SUD services—halfway house for individuals with an SUD, clinically managed population-specific high-intensity residential services, ambulatory detoxification services with extended on-site monitoring, and social setting detoxification services—the Department will establish prior authorization and utilization management requirements consistent with ASAM standards of care to ensure the appropriateness of patient placement. The clinical coverage policies for these new services will include these prior authorization and utilization management requirements. As described in Milestone 1, the Department will submit SPAs to add these four services to its Medicaid State Plan.

Following the managed care transition in November 2019, and consistent with its utilization management approach for LME-MCOs, the Department will permit standard plans and BH I/DD tailored plans (beginning at their launch in July 2021) to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. Standard plans and BH I/DD tailored plans will be required to use the ASAM criteria to review the medical necessity of SUD services versus a “fail first” approach and will ensure that patient placements are appropriate as detailed in the LME-MCO and PHP contracts.

Approximately one to two years following BH I/DD tailored plan launch, the Department will solicit feedback from enrollees and providers, as well as standard plans and BH I/DD tailored plans, on utilization management approaches for SUD services, to determine whether to allow plans greater flexibility to establish their own utilization management approach. The clinical coverage policies will continue to apply to the fee-for-service population.

The Department understands the importance of ensuring that the length of SUD treatment authorized is aligned with an individual’s specific needs. The National Institute on Drug Abuse (NIDA) notes that a program of fewer than 90 days of residential or outpatient treatment has shown limited or no effectiveness and recommends a 12-month minimum length of treatment for methadone maintenance.⁵ Individuals with SUDs may require treatment that continues over a period of years and for multiple episodes. Client retention and engagement in treatment are critical components of recovery.

Summary of Actions Needed

Action	Implementation Timeline
Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document their training with respect to the ASAM criteria	September 2018 – April 2020
Submit SPAs as needed to reflect updated utilization management requirements	September 2018 – October 2020
Update LME-MCO contracts, as necessary	September 2018 – October 2020

⁵ National Institute on Drug Abuse. (n.d.). 7: Duration of treatment. Retrieved April 12, 2018, from <https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment>.

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Require standard plans to follow clinical coverage policies 8-A and 8-C	Completed
Require BH I/DD tailored plans to follow clinical coverage policies 8-A and 8-C	September 2018 – July 2021

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

DHSR licenses and regulates outpatient, residential and inpatient SUD providers. The current licensure rules for SUD treatment providers include standards around the services that must be offered, program hours and staff credentials. Today, the degree of alignment between licensure rules for SUD providers and the ASAM criteria varies across provider type. The Department, through cross-division collaboration, intends to update nearly all of the licensure rules for SUD providers to align with the 2013 ASAM criteria and ensure that residential treatment providers either provide medication-assisted treatment (MAT) on-site or facilitate access to off-site MAT providers within a specified distance. The Department will also conduct more robust monitoring of SUD treatment providers to ensure compliance with the ASAM criteria.

Provider Licensure

Current State

Today, DHSR’s Mental Health Licensure & Certification Section (MHLC) licenses and regulates non-acute residential facilities and outpatient programs pursuant to NC General Statute 122C. DHSR’s Acute and Home Care Section licenses and regulates hospitals and psychiatric hospitals that provide acute inpatient and withdrawal management services. Four outpatient services and five residential services that provide an ASAM level of care are considered to be non-acute residential facilities and outpatient programs. With the exception of ASAM level 2.1 (substance abuse intensive outpatient program) and 2.5 (substance abuse comprehensive outpatient program) providers, none of the licensure rules for covered SUD treatment providers, including residential treatment providers, were written to reflect the ASAM criteria. The table below displays the SUD outpatient programs and the residential and inpatient services that North Carolina Medicaid covers today or intends to add to the State Plan; North Carolina’s administrative rule that applies to each service; and the alignment between the current provider qualifications and the ASAM criteria.

The licensing standards for each covered service are memorialized in the 10 NCAC 27G Administrative Code, located here: <http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.pdf>.

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ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
Outpatient Services				
2.1	Intensive outpatient services	Substance abuse intensive outpatient program	.4400	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment	.4500	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
OTP	Opioid treatment program	Outpatient opioid treatment	.3600	Do not reflect ASAM criteria
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Outpatient detoxification for substance abuse	.3300	Do not reflect ASAM criteria
2-WM	Ambulatory withdrawal management with extended on-site monitoring	N/A	N/A	New service; will require revision of the .3300 licensure rule
Residential Services				
3.1	Clinically managed low-intensity residential treatment services	Supervised-living halfway house	.5600	Will require new stand-alone licensure rule
3.2-WM	Clinically managed residential withdrawal	Social setting detoxification for substance abuse	.3200	Do not reflect ASAM criteria
3.3	Clinically managed population-specific high-intensity residential programs	N/A	N/A	New service; will require new licensure rule

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ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
3.5	Clinically managed high-intensity residential services	Residential recovery programs for individuals with substance abuse disorders and their children	.4100	Do not reflect ASAM criteria
		Therapeutic community	.4300	Do not reflect ASAM criteria
		Non-medical community residential treatment services (adults and adolescents)	N/A	New service; will require new licensure rule
3.7	Medically monitored intensive inpatient services	Residential treatment for individuals with substance abuse disorders	.3400	Do not reflect ASAM criteria
3.7-WM	Medically managed inpatient withdrawal	Non-hospital medical detoxification	.3100	Do not reflect ASAM criteria
N/A	Medically supervised or ADATC detoxification crisis stabilization	N/A	N/A	Do not reflect ASAM criteria
Inpatient Services				
4	Medically managed intensive inpatient services	Psychiatric hospital	.6000	Do not reflect ASAM criteria
		Psychiatric unit, hospital	10A NCAC 13B .5200	
4-WM	Medically managed intensive inpatient withdrawal	Psychiatric hospital	.6000 10A NCAC 13B	Do not reflect ASAM criteria

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ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
		Psychiatric unit, hospital		

Future State

DHSR, in collaboration with other divisions of the Department, will develop a licensure rule waiver process to expedite the process of aligning its provider qualifications for SUD outpatient programs and residential treatment services with ASAM criteria within the next 24 months. DHSR will also leverage the state’s administrative rulemaking process to update its licensure rules for SUD outpatient programs and residential treatment services to align with the ASAM criteria. DHSR will continue to evaluate whether it needs to revise its licensure rules for inpatient services to align with ASAM criteria. When developing licensure rules for new services or new populations that will be able to access a service (e.g., adolescents), DHSR will ensure that they reflect ASAM’s specifications regarding service definitions, hours of clinical care provided and program staff credentialing.

Summary of Actions Needed

- Develop a licensure rule waiver process to incorporate ASAM criteria:
September 2018 – October 2020
- Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria:
September 2018 – October 2022

Monitoring of SUD Treatment Providers

Current State

To ensure that high-quality SUD treatment services are delivered in accordance with state licensure rules, DHSR regularly monitors outpatient OTPs and residential treatment providers. DHSR’s monitoring of residential and OTP providers includes annual surveys, complaint investigations and follow-up surveys to determine compliance with the North Carolina administrative rules regarding services offered, hours of clinical care and program staffing. DHSR does not conduct annual surveys of outpatient treatment providers other than OTPs, but investigates complaints and conducts follow-up surveys to ensure that the provider has addressed the cited deficiencies.

Future State

DHSR will incorporate questions assessing compliance with the ASAM criteria, as memorialized in the state’s updated licensure rules, into its annual surveys of licensed SUD treatment providers. In addition, DHSR will begin surveying ASAM level 2.1, 2.5 and 1-WM providers annually for compliance with the licensure rules. DHSR, in collaboration with other divisions of the Department, will train its inspectors to ensure they are equipped on how to monitor providers for compliance with ASAM standards. As part of these education efforts, DHSR will also revise its Survey Process Guide, which includes written

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instructions for surveyors regarding how to consistently assess compliance with administrative rules. These actions are expected to be completed by October 2020.

Summary of Actions Needed

- Revise DHR MHLIC's annual survey process to provide the ability to assess compliance with 2013 ASAM standards: September 2018 – October 2020

Requirement That Residential Treatment Providers Offer MAT On-Site or Facilitate Access to Off-Site Providers

Current State

DMH/DD/SAS currently requires state-funded ASAM level 3.5 (clinically managed high-intensity residential services) providers, many of which may be Medicaid providers as well, to provide MAT on-site or coordinate care with a licensed OTP or office-based opioid treatment (OBOT) provider. ASAM level 3.7 (medically monitored intensive inpatient services) providers are not subject to a similar requirement, although some ASAM 3.7 providers may offer MAT on-site if the individual was receiving MAT prior to seeking care at the residential facility and/or if the physicians at the facility have completed buprenorphine training required under DATA 2000.

To ensure that all residential treatment providers either offer MAT on-site or facilitate access to MAT off-site, North Carolina is conducting two different assessments of MAT capacity. First, the state is working to identify which residential treatment providers offer MAT on-site today. Second, the state is plotting the locations of licensed OBOT providers and OTPs that currently provide MAT services and comparing them to the locations of residential treatment providers to understand access to OBOT and OTP.

Future State

The Department will require residential treatment providers that do not provide MAT on-site to have the ability to link individuals to a licensed OBOT or OTP located within a minimum number of miles or minutes. The Department will develop this requirement based on the results of its analysis of the geographic locations of residential treatment providers compared with OBOT providers and OTPs. This standard may vary for residential treatment facilities located in urban and rural areas of the state. To ensure provider compliance with this requirement, the Department will conduct outreach and additional training, as well as provide technical assistance to residential treatment providers.

Summary of Actions Needed

- Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes: September 2018 – October 2020

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Summary of Actions Needed

Action	Implementation Timeline
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria	September 2018 – October 2022
Revise DHSR MHLC’s annual survey process to provide the ability to assess compliance with 2013 ASAM standards	September 2018 – October 2020
Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes	September 2018 – October 2020

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, Including for Medication-Assisted Treatment for OUD

Today, LME-MCOs manage SUD provider networks and are required to comply with NC Medicaid choice and time and distance standards for all covered Medicaid services. Rural areas, in particular, face ongoing staffing shortages at critical levels of SUD care, including with respect to OTPs and residential treatment services. To ensure that Medicaid enrollees, whether they receive services through the LME-MCOs or fee-for-service, have access to SUD treatment providers at critical levels of care, the Department will conduct an assessment of all Medicaid-enrolled providers. As part of this assessment, the Department will identify providers that are accepting new patients. The Department will use the results of the assessment to target network development efforts for LME-MCOs, standard plans and BH I/DD tailored plans.

Current State

The Department tasks the LME-MCOs with overseeing the development and management of a qualified SUD provider network in accordance with community needs. LME-MCOs are responsible for the enrollment, disenrollment, credentialing, and assessment of qualifications and competencies of providers, in accordance with applicable state and federal regulations. The LME-MCOs are subject to the following network adequacy standards for Medicaid covered behavioral health services:

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Provider Type	Urban Standard	Rural Standard ⁶
Outpatient Services ⁷	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services ⁸	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services ⁹	≥ 1 provider of each crisis service within each LME-MCO region	
Specialized Services ¹⁰	≥ 1 provider of each service within each LME-MCO region	
Inpatient Services	≥ 1 provider of each service within each LME-MCO region	

LME-MCOs endeavor to ensure that enrollees have a choice of providers within time and distance requirements set forth by the Department. LME-MCOs must ensure a provider directory is made available to the enrollees to support their selection of a provider. In the event of limited services, LME-MCOs may request an exception for a specific access-to-care gap. The Department determines whether to grant an exception by examining service utilization, provider availability and the LME-MCO’s plan for ensuring enrollees have access to the required service. In addition, the LME-MCO must have a plan for meeting the network adequacy requirement in the future.

Each LME-MCO is required to conduct an annual gap analysis and needs assessment of its provider network that incorporates data analysis of access to and choice of providers, as well as input from enrollees, family members, providers and other stakeholders. LME-MCOs review all services, identify service gaps, and prioritize strategies to address any gaps or weaknesses identified. The assessment takes into consideration the characteristics of the population in the entire catchment area and includes input from individuals receiving services and their family members, the provider community, local public agencies, and other local system stakeholders. Each LME-MCO assesses the adequacy, accessibility, and availability of its current provider network and creates a network development plan to meet identified community needs, following the Department’s published gap analysis requirements.

Notwithstanding the LME-MCOs’ robust time and distance standards, there are gaps in provider access in rural areas of North Carolina across all ASAM levels. Recent gap analyses have

⁶ For the purposes of the state’s network adequacy standards, “urban” is defined as “non-rural counties,” or counties with an average population density of 250 or more people per square mile. This includes 20 counties categorized by the North Carolina Rural Economic Development Center (the Rural Center) as “regional cities or suburban counties” or “urban counties.” These 20 counties include 59% of the state’s population. “Rural” is defined as counties with a population density below 250 people per square mile. Per the Rural Center, 80 counties in North Carolina meet this definition; these counties are home to 41% of the state’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

⁷ Outpatient services include behavioral health services provided by direct enrolled providers such as psychiatrists.

⁸ Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.

⁹ Detoxification services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, each LME-MCO is required to contract with all three ADATCs in the state.

¹⁰ Specialized services include ASAM levels 3.5 (NMCRT) and 3.7 (MMCRT).

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highlighted gaps in access to OTPs, ASAM level 2.5 (SACOT) providers, residential treatment programs and withdrawal management services.

To ensure that enrollees in fee-for-service have sufficient access to services, NC Medicaid enrolls any willing provider, reviews the adequacy of its network on a service-level basis, and collaborates with stakeholders to expand its network for services where shortages exist.

Future State

Within 12 months of the demonstration approval, the Department will complete its statewide assessment of the availability of enrolled Medicaid and state-funded providers, which will include identifying those who are accepting new patients at the critical levels of care. This assessment will also identify providers delivering state-funded services at ASAM level 3.1 (substance abuse halfway house) and ASAM level 3.2-WM (social setting detoxification services), which will be added to the Medicaid service array.

Summary of Actions Needed

- Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care: September 2018 – October 2019

Network Adequacy Standards for LME-MCOs, Standard Plans and BH I/DD Tailored Plans

As described above, LME-MCOs are subject to a strong set of SUD network adequacy standards today. Standard plans and BH I/DD tailored plans will also be expected to maintain and monitor a robust network of SUD providers beginning at their launches in November 2019 and July 2021, respectively.

The Department will develop a monitoring system to ensure compliance with all applicable network adequacy standards for LME-MCOs, standard plans and BH I/DD tailored plans. In alignment with the final federal Medicaid managed care rule, the Department will monitor the following indicators from the report “Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability.” North Carolina will also use consumer experience to verify and monitor access to care and adjust time and distance standards, if necessary. The state will monitor appropriate service use through performance measure indicators that align with HEDIS measures.

Indicators of Provider Network Adequacy and Service Availability

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	Timely Access to Care	Cultural Competency & Operating Hours	Customer Service	Appropriate Service Use
Number of providers accepting new Medicaid enrollees	Percentage of consumers living within 30 minutes/30 miles for urban and 45 minutes/45 miles for rural areas	Availability and delivery of services in a culturally competent manner regardless of cultural and ethnic backgrounds;	Consumer perception of care surveys Number of appeals,	Critical performance indicators: Follow-up after care

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Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	Timely Access to Care	Cultural Competency & Operating Hours	Customer Service	Appropriate Service Use
	Percentage of consumers able to be seen within maximum wait time for emergent, urgent and routine care	disabilities; and gender, sexual orientation or gender identity	grievances and complaints	Readmissions Initiation and engagement Physical healthcare visits

As part of its managed care design process, the Department has developed the following time and distance standards for proposed SUD services that will be covered by standard plans. These services include one of the new services at ASAM level 2-WM (ambulatory detoxification with extended on-site monitoring). The Department will develop network adequacy standards for BH I/DD tailored plans in the coming year.

Standard Plan Network Adequacy Standards for Behavioral Health Services

Provider Type	Urban Standard	Rural Standard
Outpatient Services ¹¹	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services ¹²	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services ¹³	≥ 1 provider of each crisis service within each standard plan region	
Inpatient Services	≥ 1 provider of each crisis service within each standard plan region	

Building Capacity for New Services

The state intends to support LME-MCOs, standard plans and BH I/DD tailored plans in building network capacity for new or expanded services that will be covered through fee-for-service as well.

¹¹ Outpatient services include behavioral health services provided by direct-enrolled providers such as psychiatrists.

¹² Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.

¹³ Crisis services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), 2-WM (ambulatory detoxification with extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, the standard plan will be required to contract with all three ADATCs in the state.

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- **Expand service offerings to include ASAM level 2-WM.** The Department plans to work with the LME-MCOs to encourage their ASAM level 1-WM providers to expand their service offerings to include ASAM level 2-WM.
- **Leverage state-funded networks for ASAM levels 3.1, 3.7 and 3.2-WM.** The Department plans to work with LME-MCOs to enroll in Medicaid their current state-funded providers for ASAM levels 3.1 and 3.2-WM, in order to build Medicaid provider networks for these services. In addition, the state will work with LME-MCOs to enroll in Medicaid their state-funded providers serving adolescents for ASAM level 3.7 (medically monitored community residential treatment).
- **Engage with stakeholders for ASAM level 3.3.** To build sufficient networks for ASAM level 3.3 (clinically managed population-specific high-intensity residential programs), the state will engage with disability advocates representing individuals with TBI or I/DD as well as LME-MCOs, in order to identify providers that may be interested in offering this service.
- **Provide training for new Medicaid SUD providers.** The Department will educate and require the LME-MCOs, standard plans and BH I/DD tailored plans to provide training for new Medicaid SUD providers, to orient them to Medicaid and managed care, including topics such as utilization management, credentialing and billing.

Strategies to Ensure Adequate Capacity Post-Managed Care Transition

While standard plans and BH I/DD tailored plans will be required to meet minimum standards set by the Department, they will be given sufficient flexibility to innovate to improve quality and efficiency of care. In the event a service gap is identified, the standard plan or BH I/DD tailored plan may request an exception for a specific access-to-care gap in a specific region, consistent with current LME-MCO practice. The Department will determine if an exception is granted by looking at service utilization, the availability of providers, history of complaints, and the plan's short- and long-term plans for meeting ASAM level of care needs.

Standard plans and BH I/DD tailored plans will be allowed to develop their own telemedicine policies to ensure access to needed services, consistent with departmental guidance and approval. However, plans will not be permitted to use telemedicine to meet the state's network adequacy standards (unless the state has approved a request for an exception that involves telemedicine). When a Medicaid enrollee requires a medically necessary service that is not available within a standard plan's or BH I/DD tailored plan's network, the plan may offer the service, if applicable and clinically appropriate, through telemedicine, in addition to providing access to an out-of-network provider of the needed service. In these instances, the enrollee will have a choice between out-of-network provider and telemedicine and will not be forced to receive services through telemedicine. Medicaid enrollees receiving services through fee-for-service will be able to access telemedicine services consistent with the Department's clinical coverage policies. The Department is also exploring additional ways to leverage telemedicine for SUD treatment. As discussed in greater detail in Milestone 5 below, the state is supporting an expansion of Project Extension for Community Healthcare Outcomes (ECHO) to expand access to MAT in underserved and rural communities.

Standard plans and BH I/DD tailored plans will be required to submit an Access Plan annually to the Department, which will be reviewed and monitored by department staff. The Access Plan will

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demonstrate that the plans have the capacity to serve the expected enrollment in their service area in accordance with the Department's network requirements and network adequacy standards. NC Medicaid will review each Access Plan to ensure the standard plan or BH I/DD tailored plan meets all the expectations and requirements and provides a reasonable approach to a plan's oversight and management of its providers and networks.

NC Medicaid will continue to ensure that it has an adequate network of SUD providers in its fee-for-service program.

Expanding Access to MAT

The state has identified approximately 800 certified OBOT providers across North Carolina, and is working to determine the composition of active and non-active MAT prescribers. A robust network of active OBOT providers can complement the growing network of 65 OTPs licensed across the state. To build the network of active OBOT providers, the state intends to provide ongoing training programs and technical support to prescribers on the following:

- Implementing safe prescribing practices.
- Collaborating with pharmacists as part of a care team.
- Incorporating component services including counseling into the practice.
- Billing the PHP for component services (e.g., prescription, laboratory and counseling services).

Summary of Actions Needed

Action	Implementation Timeline
Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care	September 2018 – October 2019
Work to build Medicaid provider networks for new Medicaid levels of care	September 2018 – October 2020
Develop BH I/DD tailored plan network adequacy standards for SUD treatment services, taking into account results of provider assessment	September 2018 – October 2019

Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

North Carolina has intensified its efforts over the past year to address the opioid crisis. As described below, the state developed and is making progress on an Opioid Action Plan outlining statewide goals and priorities for tackling the epidemic. Recent state legislation implementing opioid prescribing guidelines and expanding access to naloxone, Medicaid pharmacy program initiatives, the state's requirements for PHPs and a federal 21st Century Cures Act grant of \$31 million have also bolstered North Carolina's efforts.

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The North Carolina Opioid Action Plan

In June 2017, North Carolina announced [North Carolina's Opioid Action Plan](#), which outlines the key actions the state and its partners are taking to combat the epidemic and calls for measuring and assessing the effectiveness of the strategies. The Opioid Action Plan was developed through collaboration among state agencies and various health, law enforcement, education, business, nonprofit and government partners. It aims to reduce opioid addiction and overdose deaths in the period from 2017 to 2021 by implementing the following key strategies:

- Create a coordinated infrastructure between the state, stakeholders and local coalitions.
- Reduce oversupply of prescription opioids.
- Reduce diversion of prescription drugs and flow of illicit drugs.
- Increase community awareness and prevention.
- Make naloxone widely available, and link overdose survivors to care.
- Expand treatment and recovery-oriented systems of care.
- Measure impact and revise strategies based on results.

The Department has thus far conducted numerous activities in support of the Opioid Action Plan. In October 2017, the Department purchased nearly 40,000 units of nasal naloxone to make the overdose reversal drug more widely available and thus help reduce the number of unintentional opioid-related deaths. The naloxone has been distributed to partners across the state that work with individuals at high risk of opioid overdose, including OTPs and other treatment providers, EMS agencies, Oxford House, and other community partners. The Department established a North Carolina Payers Council to bring together healthcare payers across the state to partner on benefit design, member services, and pharmacy policies to reduce opioid overuse and overdose. The Department also made important changes to the Medicaid program in order to increase access to treatment by removing prior-approval requirements for suboxone.

Strengthen Opioid Misuse Prevention Act

In June 2017, North Carolina's General Assembly passed and Governor Roy Cooper signed the STOP Act, North Carolina Session Law 2017-57, Senate Bill 257. The STOP Act seeks to reduce drug addiction and overdoses through smarter prescribing practices by doctors and dentists, restrictions on pharmacies dispensing opioids, expanding the availability of naloxone, and strengthening the state's Controlled Substance Reporting System (CSRS). STOP Act provisions apply broadly across the state; they are not specific to the Medicaid program.¹⁴ North Carolina will require standard plans and BH I/DD tailored plans to incorporate STOP Act requirements into their opioid misuse programs. Key provisions, most of which became effective immediately, include:

Prescriber Provisions

- **Reduce unused, misused and diverted pills with five-day limit on initial prescriptions for acute pain.** A prescriber may not prescribe more than a five-day supply of a controlled substance (or a

¹⁴ [STOP Act, https://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2017&BillID=H243](https://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2017&BillID=H243).

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seven-day supply after surgery) when first treating a patient for acute pain, effective January 1, 2018.¹⁵

- **Reduce doctor shopping and improve care with required scan of state prescription database.** Before prescribing controlled substances, a doctor, dentist or other prescriber must check the CSRS to learn of a patient’s other prescriptions, effective upon completion of certain upgrades to the CSRS.¹⁶
- **Reduce fraud through e-prescribing.** A prescriber must electronically prescribe controlled substances to reduce fraud stemming from stolen prescription pads or forged prescriptions—except for drugs administered by the prescriber or drugs administered in a healthcare or residential facility, effective January 1, 2020.
- **Reduce diversion of veterinary drugs.** Veterinarians who dispense controlled substances must register and report to CSRS to enable detection of drug diversion by pet owners, effective January 1, 2019.
- **Tighter supervision.** PAs and NPs must consult their supervising physicians the first time they prescribe controlled substances and every 90 days thereafter, effective July 1, 2017.

Pharmacy Provisions

- **Implement universal registration and reporting.** All pharmacies dispensing controlled substances must register for and report to CSRS—consistent with the current practice of most pharmacies.
- **Enable near-time reporting to detect and stop doctor-shopping.** Pharmacies dispensing controlled substances must report to CSRS within 24 hours of each transaction—down from the current requirement of 72 hours but consistent with the current practice of many pharmacies, effective September 1, 2017.
- **Detect fraud, misuse and diversion.** Pharmacies must consult the CSRS before dispensing a controlled substance when there is reason to suspect fraud, misuse or diversion, and must consult the prescriber when there is reason to believe the prescription is fraudulent or duplicative. Pharmacies are required to remedy missing or incomplete data upon request, effective upon completion of certain upgrades to the CSRS.

Provisions Expanding Access to Community-Based Treatment and Naloxone

- **Improve health and save money by investing in local treatment and recovery services.** The STOP Act appropriates \$10 million for FY 2017-18 and \$10 million for FY 2018-19 for community-based treatment and recovery services for substance use disorders, including MAT.
- **Reverse overdoses and save lives.** The STOP Act facilitates wider distribution of the overdose-reversal drug naloxone by clarifying that standing orders cover not only individuals at risk, family members, law enforcement and local health departments, but also community health groups. In addition, the act underscores that no state funds may be used to support needle exchange programs, but that does not preclude a local government from supporting such a program in its community.

Other Provisions

¹⁵ This requirement does not apply to cancer care, palliative care, hospice care or MAT for substance use disorders.

¹⁶ This scan is allowed but not required for cancer treatment, palliative care, hospice care, drugs administered in a healthcare or residential facility, or prescriptions for five or fewer days (or seven or fewer days after surgery).

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- **Stronger oversight.** The Department will audit doctor, dentist and other prescriber use of the CSRS and will report violations to the appropriate licensing boards, effective upon completion of certain upgrades to the CSRS.
- **Better data use.** The STOP Act expands use of data to detect and prevent fraud and misuse.
- **More secure funding.** The STOP Act creates a non-reverting special revenue fund to support the CSRS.

Medicaid Pharmacy Program

The NC Medicaid pharmacy program has worked to (1) update clinical coverage criteria for the use of opioids for pain management based on the Centers for Disease Control and Prevention (CDC) guideline “Prescribing Opioids for Chronic Pain”; (2) align clinical coverage criteria for prescription of opioids with strategies targeted toward reducing the oversupply of prescription opioids available for diversion and misuse; (3) strengthen its enrollee lock-in program; and (4) expand access to suboxone.¹⁷ The Medicaid pharmacy program has also adopted the STOP Act provisions, as applicable.

In 2010, North Carolina established the NC Medicaid Enrollee Lock-In Program to establish a “prescription gatekeeper” for enrollees deemed to have potential for misuse of their prescription benefits.¹⁸ In March 2017, the state strengthened its Medicaid lock-in program by increasing the number of enrollees subject to the lock-in from 200 to 600 per month and by lengthening the duration of enrollment in the program to two years. Next, in May 2017, Medicaid increased the early refill threshold for all opioids and benzodiazepine prescriptions from 75% to 85%, meaning that an enrollee cannot refill a prescription for one of these drugs until less than 15% of his or her current supply remains.

Effective June 1, 2018, NC Medicaid limited the prior authorization threshold for opioids to 90 mg of morphine equivalents per day. In addition, NC Medicaid began to require prior approval for opioid prescriptions exceeding the maximum daily dosage; for opioid prescriptions that are for longer than five or seven days, consistent with the STOP Act; or for any non-preferred opioid product.¹⁹ The state requires opioid prescribers to consult the CSRS, review the CDC chronic pain guidelines for prescribing opioids and, if applicable, explain the need to exceed daily dosage limits prior to prescribing opioids. Finally, the Medicaid program eliminated the prior authorization requirements for suboxone as of November 1, 2017, to provide timely access to opioid withdrawal treatment.

New Medicaid Managed Care Provisions

North Carolina recognizes that a strong partnership with standard plans and BH I/DD tailored plans is necessary to build on its ongoing efforts to combat the opioid epidemic. To that end, the Department

¹⁷ NC Division of Medical Assistance. Outpatient Pharmacy Prior Approval Criteria Opioid Analgesics, available at <https://www.nctracks.nc.gov/content/dam/jcr:45fd795f-2681-4fab-b59c-07b350801d6b/Criteria-Opioid%20Analgesics%2090mme%20and%20III%20and%20IV.pdf>.

¹⁸ Today, the program restricts enrollees who meet at least one of the following criteria to a single prescriber and pharmacy: enrollees with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, NC Medicaid or Community Care of North Carolina (CCNC). NCHC enrollees are not subject to lock-in provisions. Source: [NC Outpatient Pharmacy Clinical Coverage Policy](#).

¹⁹ North Carolina Medicaid Pharmacy Newsletter, June 2017.

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will require its PHPs to implement a comprehensive opioid misuse prevention program. To monitor potential abuse or inappropriate utilization of prescription medications, the Department will give plans the choice of either participating in the NC Medicaid Enrollee Lock-In Program or develop their own lock-in program consistent with state law and subject to Department approval. PHPs will provide care coordination for enrollees in the lock-in program in conjunction with the enrollee's primary care provider. Plans will be required to report to the Department lock-in program outcomes including, but not limited to, changes in emergency department visits and changes in opioid misuse, to inform monitoring efforts and identify the need for further interventions.

Additionally, plans will be required to implement a maximum morphine milligram equivalent dose for opioid prescriptions as point-of-service edits, as well as drug utilization review programs to address opioid misuse.

Opioid Initiatives Supported by the 21st Century Cures Act Grant

North Carolina is using a \$31 million grant received through the 21st Century Cures Act in May 2017 to expand access to prevention, treatment and recovery supports to reduce opioid-related deaths over the next two years.²⁰ It will also be used to purchase 6,600 naloxone kits statewide to be distributed to law enforcement, paramedics and OTPs. The state expects to serve approximately 1,500 individuals annually over the two-year period through the grant as a whole. In addition to expanding treatment services, funding will be available for prevention, education and outreach; screening/triage/referral; recovery supports; and provider education and development. Two specific examples of current projects funded by this grant follow:

- **Project Extension for Community Healthcare Outcomes (ECHO)** The Department is using its 21st Century Cures Act grant to expand training on MAT and associated barriers for providers and interdisciplinary clinical teams through the University of North Carolina's (UNC) research initiative, Project ECHO, in collaboration with the University of New Mexico Project ECHO. The core goals of the UNC ECHO for MAT demonstration project are to (1) increase understanding about how known barriers to the implementation of MAT in primary care can be overcome; (2) evaluate strategies to overcome those barriers; and (3) simultaneously expand access to MAT in rural and underserved counties, reducing the risk of accidental overdose deaths through a multilayered provider and practice engagement strategy. Additional ECHOs may focus on highlighting best practices and evidence-based care, as well as building treatment capacity for pregnant women or mothers, individuals with OUD who are also HIV positive or hepatitis C positive, and/or for individuals with OUD in North Carolina prisons.
- **Training on ASAM Levels of Care.** During March and April 2018, the state used funds from its 21st Century Cures Act grant to offer and subsidize the cost of eight two-day and four one-day trainings on the ASAM criteria, primarily targeting medical professionals and clinical staff employed at OTPs and OBOT programs across the state. The training provided participants with a comprehensive overview of the ASAM criteria, including:
 - Services that are part of the ASAM continuum of care.
 - ASAM's six dimensions used to complete a holistic, biopsychosocial assessment that evaluates an individual's substance use and withdrawal history; health history and

²⁰ Governor Cooper Announces \$31 Million Grant to Fight Opioid Epidemic in NC.

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current physical condition; readiness to change; and emotional, behavioral or cognitive conditions, among others.

- ASAM’s continued stay and discharge criteria for residential SUD services.

North Carolina has been a leader in the fight against the opioid crisis. By deploying these initiatives, the state has made and will continue to make progress in curbing this nationwide epidemic.

Summary of Actions Needed

Action	Implementation Timeline
Continue implementation of the STOP Act provisions on an ongoing basis.	September 2018 – October 2020

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Care Coordination

Current State

Today, LME-MCOs are responsible for providing care coordination for Medicaid enrollees, including those with special healthcare needs and those who meet the state’s definition of being “at risk,” but cannot duplicate case management functions that enrollees receive as part of select behavioral health services. The population with special healthcare needs includes the following individuals with SUDs:

- Individuals with an SUD diagnosis and current ASAM patient placement criteria (PPC) of at least level 3.7 or 3.2-WM.
- Adults who reported use of drugs by injection.
- Children with a mental health or SUD diagnosis, who are currently residing or have resided in the past 30 days in a facility operated by the Department of Juvenile Justice or the Department of Corrections, an inpatient hospital setting, a therapeutic group home, or a psychiatric residential treatment facility.
- Individuals with co-occurring SUD and mental illness or I/DD as follows:
 - Individuals with both a mental illness diagnosis and a substance use diagnosis and a current LOCUS/CALOCUS of V or higher, or current ASAM PPC level of 3.5 or higher.
 - Individuals with both an I/DD and an SUD diagnosis and current ASAM PPC level of 3.3 or higher.

Medicaid defines at-risk individuals as those enrollees who:

- Do not appear for scheduled appointments and are at risk for inpatient or emergency treatment.
- Receive a crisis service as their first service, in order to facilitate engagement with ongoing care.
- Are discharged from an inpatient psychiatric unit or hospital, a psychiatric residential treatment facility, or a facility-based crisis or general hospital unit following admission for a mental health, SUD or I/DD condition.

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LME-MCOs' care coordination responsibilities for the populations listed above include the following:

- Identifying enrollees' clinical needs.
- Determining level of care through case review.
- Arranging assessments.
- Linking enrollees to necessary psychological, behavioral, educational and physical evaluations.
- Engaging in clinical discussions with enrollees' treatment providers.
- Conducting deliberate organization of care activities.
- Facilitating appropriate delivery of healthcare services and connecting enrollees to the appropriate level of care.
- Addressing support services and resources.
- Assisting enrollees with obtaining referrals and arranging appointments.
- Educating enrollees about other available supports as recommended by clinical care coordinators.
- Monitoring enrollees' attendance in treatment.
- Identifying and addressing enrollees' needs and barriers to treatment engagement.
- Developing engagement strategies for individuals with special healthcare needs.
- Coordinating and linking all Medicaid-funded services for the enrollee, as appropriate.
- Assisting with developing a person-centered treatment plan in consultation with the enrollee and his or her primary care provider.

In addition to the care coordination functions performed by the LME-MCOs, case management is provided as part of select SUD services. In particular, SAIOP and SACOT services include case management components to arrange, link, or integrate across multiple types of SUD services and supports.

The state's fee-for-service behavioral health contractor provides care coordination services to populations excluded from the LME-MCOs. Care coordinators provide the following care coordination functions telephonically:

- Information intake;
- Evaluation;
- Referral to inpatient providers or to appropriate level of care;
- Utilization review;
- Quality assurance;
- Discharge and aftercare planning; and
- Monitoring.

Transitions of Care

Current State

Among their care coordination functions, LME-MCOs are required to coordinate and monitor services provided to enrollees during transitions of care. Responsibilities include assisting hospitals, facilities and other institutional providers with discharge planning for short-term and long-term hospital and institutional stays when the admission is primarily based on the enrollee's behavioral health diagnosis.

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Transitional care coordination performed by LME-MCOs cannot duplicate inpatient facilities' requirements for discharge planning. The inpatient facility must involve the patient, family, staff members and referral sources in discharge planning. If a patient is being referred to another facility for further care, appropriate documentation of the patient's current status must be forwarded with the patient within 48 hours of discharge. The discharge summary must include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action recommendations, and activities and procedures used by the patient to maintain and improve functioning.

Future State

Upon their launches in 2019 and 2021, respectively, the standard plans and BH I/DD tailored plans will be responsible for care coordination and care management for enrollees with SUDs, including managing transitions between levels of care. LME-MCOs will continue to manage care coordination and care transitions for certain Medicaid enrollees with SUDs until BH I/DD tailored plans launch. For populations that will remain in fee-for-service, the state will develop care coordination protocols that include transitions of care across service levels. In developing the care coordination and care management approaches for these new managed care products, North Carolina has prioritized the establishment of specific requirements related to serving enrollees with SUDs as described below.

Standard Plans: Care Coordination and Care Management

When standard plans launch in November 2019, they will be responsible for overseeing, funding and organizing all aspects of care management in a way that improves health outcomes and manages the total cost of care for their enrollees. They will be required to complete care needs screenings and to perform claims analysis and risk scoring to identify enrollees at risk; stratify their populations by level of need; perform comprehensive assessments for those identified as part of "priority populations"; and perform localized care management at the site of care, in the home or in the community, where face-to-face interaction is possible.

Standard plans will be required to establish policies and procedures to deliver care to and coordinate services for all enrollees regardless of risk or needs. As part of their care coordination for all enrollees, standard plans will be required to do the following:

- Establish policies and procedures for coordination between physical and behavioral health providers, and between mental health and substance use providers.
- Establish policies and procedures to coordinate enrollee transitions from LME-MCOs or Medicaid fee-for-service into standard plans and from one standard plan to another, or between delivery systems.
- Design an evidence-based tool to conduct a care needs screening that can identify enrollees' behavioral health needs, incorporating the ASAM criteria to screen for opioid usage and other SUDs.
- Make best efforts to conduct a care screening of every enrollee within 90 days of enrollment as required by the managed care rule, to identify enrollees with unmet healthcare needs (including SUDs) who may require a comprehensive assessment for care management.

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Additionally, standard plans will designate enrollees with SUDs as meeting the state’s definition of special healthcare needs, and thereby as a high-priority population for receiving care management.

All care management must include coordination of physical health, behavioral health, pharmacy and social services. In addition, the Department will require that all care managers receive training on integrated and coordinated physical and behavioral healthcare, and care managers serving individuals with behavioral health needs will also receive training on behavioral health crisis response.

Standard Plans: Transitions of Care

Among their care coordination responsibilities for all enrollees, including those with SUDs, standard plans will manage transitions of care for all enrollees moving from one clinical setting to another, to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. Following standard plan contracting, standard plans will be required to share with the Department their transitional care management policies and procedures, the experience and qualifications of care managers performing transitional care management, and how their transitional care management approach relates to the staffing and contracting approach for high-need enrollees’ care management.

In order to identify enrollees in transition who are at risk of readmissions and other poor outcomes, standard plans shall develop a methodology that considers the frequency, duration and acuity of inpatient, skilled nursing facility (SNF), and LTSS admissions or emergency department visits; discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised treatment centers or alcohol drug abuse treatment centers; and neonatal intensive care unit (NICU) discharges. In addition, the standard plan may target enrollees for transitional care management by severity of condition, medications and other factors the standard plan may prioritize.

Standard plans will ensure that the entity conducting transitional care management performs the following functions:

- Conducts outreach to the member’s advanced medical home/primary care provider and all other medical providers.²¹
- Facilitates clinical handoffs, including those to behavioral health providers.
- Obtains a copy of the discharge plan/summary, and verifies that the enrollee’s care manager receives and reviews the discharge plan with the enrollee and the facility.
- Ensures that a follow-up outpatient and/or home visit is scheduled, within a clinically appropriate time window.
- Conducts medication reconciliation and support medication adherence.
- Ensures that a care manager is assigned to manage the transition.
- Rapidly follows up with the enrollee via the assigned care manager following discharge.
- Develop a protocol for determining the appropriate timing and format of such outreach.

²¹ The AMH program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity (e.g., a Clinically Integrated Network)—and receive higher reimbursement for such responsibility—or choose to coordinate with PHPs’ care management approaches.

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BH I/DD Tailored Plans: Care Coordination and Care Management

By design, BH I/DD tailored plans will serve a high-cost population with complex needs. BH I/DD tailored plan enrollees will have a significant need for robust, whole-person care management services that will address their physical health, mental health, substance use, I/DD, TBI, pharmacy, community support and social needs. Specifically, care management for BH I/DD tailored plan enrollees will take into account the following:

- Future BH I/DD tailored plan enrollees are closely engaged with mental health, SUD, I/DD and TBI providers with whom they have frequent interaction and trusting relationships, and conflict-free care management services should be provided at these sites or in primary care settings that have expertise in serving populations with significant BH or I/DD needs to the maximum extent possible.
- Care management services for populations that will enroll in BH I/DD tailored plans, including individuals with SUDs, should generally be more intensive than those provided to the standard plan population and should occur face-to-face for all BH I/DD tailored plan enrollees.
- Care managers serving BH I/DD tailored plan enrollees must have specialized expertise, including training in mental health, SUD, I/DD and/or TBI care; experience managing physical and behavioral healthcare and I/DD co-morbidities; and specialized clinical supervision experience to support the coordination of care between physical and behavioral healthcare.

The BH I/DD tailored plan care management model will meet federal standards for health home services, and North Carolina anticipates submitting a health home SPA prior to the BH I/DD tailored plan launch. Health home funds will flow to BH I/DD tailored plans. Given that BH I/DD tailored plans will not launch until July 2021, the Department is still in the process of establishing the full set of BH I/DD care management requirements.

BH I/DD Tailored Plans: Transitions of Care

Among their care management responsibilities, entities delivering health home care management services will be required to provide comprehensive transitional care management services, including all standard plan transitional care services. Additional responsibilities will include:

- Instituting evidence-based care transition programs directed toward individuals with mental health disorders SUDs and I/DD.
- Developing relationships with local hospitals, nursing homes, SUD residential treatment facilities, SUD rehabilitation providers and inpatient psychiatric facilities to promote smooth care transitions.
- Developing working relationships with the justice system and the Division of Social Services to support transitions back to the community.

The Department recognizes the importance of ensuring that standard plan enrollees who meet the BH I/DD tailored plan level of need or require a service that will only be covered by BH I/DD tailored plans are transitioned as quickly and smoothly as possible. To that end, these enrollees will be able to transfer across standard plans and BH I/DD tailored plans throughout the coverage year.

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Summary of Actions Needed

Action	Implementation Timeline
Incorporate care management provisions into standard plan contracts	January 2019 – November 2019
Incorporate care management provisions into BH I/DD tailored plan contracts	January 2021 – July 2021
Submit a health home SPA to authorize the creation of behavioral health homes	July 2019 – March 2020

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SUD HIT Plan: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
1. Enhanced interstate data sharing in order to better track patient-specific prescription data	<ul style="list-style-type: none"> North Carolina’s PDMP, which is called the CSRS, enables practitioners to see patient prescription history of 24 states, Washington DC, Puerto Rico and the Military Health System using National Associations of Boards of Pharmacy’s (NABP) PMP Interconnect (PMPi). The states are: Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Maine, Minnesota, Mississippi, New Jersey, New Mexico, New York, North Dakota, Ohio, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and West Virginia. 	<ul style="list-style-type: none"> The state will update its HIT plan as more states are included in PMPi sharing. By September 2019, 11,250 prescriber and 580 pharmacies will be approved for integration. Two-way data sharing will be established between North Carolina and all other states. 	<ul style="list-style-type: none"> Review necessary steps to join RxCheck. Enhance interstate data sharing (ex. KY) through connection with the RxCheck hub, and continue to reach out to remaining states (provided funds are available). <p>Timeline: September 2018 – April 2020</p>
2. Enhanced “ease of use” for prescribers and other state and federal stakeholders.	<ul style="list-style-type: none"> In order to facilitate ease for prescribers, DMH/DD/SAS successfully updated the CSRS platform in September 2018 North Carolina launched new efforts to integrate CSRS and other states’ PDMP data into clinical workflows in November 2018. At this time, 3,213 prescribers have been approved for integration. 	<ul style="list-style-type: none"> North Carolina has a CSRS integration plan that includes a variety of EHR platforms, including the state’s HIE as an option in the event an EHR vendor is not willing to participate. The state has developed a prioritization matrix based on healthcare entities’ 	<ul style="list-style-type: none"> Continue to approve additional prescribers and pharmacies for integration with the CSRS, as well continue its integration efforts with the HIE. <p>Timeframe: September 2018 - September 2019</p>

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<ul style="list-style-type: none"> ▪ Forty-three pharmacies are currently approved to be integrated. ▪ The state’s Health Information Exchange (HIE), NC HealthConnex, is expected to complete integration by September 2019. ▪ The UNC Health Care System integrated independent of the state’s effort in the Summer of 2018. ▪ Large pharmacy chains, such as CVS (367 stores), Walmart (229), Kroger (125), Kmart (14), Costco (8), Harris Teeter (8) and Walgreens (474) have integrated independently as well. 	<p>geographic location, specialty, past prescribing practices, and overdose rates in their area.</p> <ul style="list-style-type: none"> ▪ Integration goals are 11,250 prescribers and 580 pharmacies by September 2019. ▪ Ultimately, all NC prescribers and dispensers will have CSRS data integrated into their daily workflows (December 2023, contingent on availability of funds). 	
3. Enhanced connectivity between the state’s PDMP and any statewide, regional or local health information exchange.	<ul style="list-style-type: none"> ▪ The Department is working to connect the CSRS with the state’s HIE, known as NC HealthConnex. ▪ In May 2018, the Department executed a contract with a vendor to use PMP Gateway to develop an interface between the CSRS and NC HealthConnex . 	<ul style="list-style-type: none"> ▪ Transmissions between the CSRS and the HIE will be bi-directional and occur in real time. ▪ The interface with NC HealthConnex is expected to be complete in September 2019, following NC HealthConnex’s migration to a new platform. 	<ul style="list-style-type: none"> ▪ Complete the interface with HealthConnex in September 2019. <p>Timeframe: September 2018 - September 2019</p>
4. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also “Use of PDMP” #6, below).	<ul style="list-style-type: none"> ▪ On a quarterly basis, DMH/DD/SAS is providing the NC Medical Board, Nursing Board and Board of Pharmacy with advanced analytics collected through the CSRS, based on criteria established by each board aimed at 	<ul style="list-style-type: none"> ▪ DMH/DD/SAS plans to partner with additional state licensing boards, such as the NC Board of Podiatry Examiners and the NC State Board of Dental Examiners, to 	<ul style="list-style-type: none"> ▪ Continue to partner with Medical, Nursing and Pharmacy Boards to refine reports.

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<p>flagging providers with potentially questionable prescribing patterns.</p> <ul style="list-style-type: none"> ▪ The licensing boards use these reports to identify prescribers for investigation. ▪ In addition to quarterly reports to the licensing boards, the system utilizes threshold reports to notify prescribers directly when a patient has exceeded established thresholds of a number of prescribers and pharmacies visited in a 90-day period. 	<p>identify prescribers with questionable prescribing patterns.</p> <ul style="list-style-type: none"> ▪ DMH/DD/SAS will work with new partners to develop a process for reporting. ▪ Additionally, DMH/DD/SAS will improve reporting sensitivity by improving identity resolution for patients, prescribers and dispensers in the CSRS. ▪ In September 2019, “clinical alerts” will be deployed, which will enable any prescriber to see these threshold alerts when a patient is queried. Current threshold reports are only visible to the practitioner who wrote the prescription. 	<ul style="list-style-type: none"> ▪ Establish partnerships with additional state licensing boards. ▪ Deploy clinical alerts in September 2019. <p>Timeframe: September 2018 - September 2019</p>
Current and Future PDMP Query Capabilities			
<p>5. Facilitate the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the Entity Resolution [ER] strategy with regard to PDMP queries).</p>	<ul style="list-style-type: none"> ▪ The CSRS’ current approach to matching patients with prescriptions to patients in the CSRS involves first examining patients’ first and last names, dates of birth, and street addresses. ▪ Based upon that review, the CSRS identifies cases where records with 	<ul style="list-style-type: none"> ▪ DMH/DD/SAS plans to continue its efforts to improve identity resolution among prescribers, patients and dispensers, including leveraging the HIE’s MPI capabilities. 	<ul style="list-style-type: none"> ▪ Prescriber and dispenser Entity Resolution is moving forward using DEA and NPI data in routine system auditing in addition to the Entity Resolution plan.

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<p>similar names used to fill multiple opioid prescriptions are likely a single patient, or separates records when it identifies that two different patients have used the same identifying information to fill their prescriptions.</p> <ul style="list-style-type: none"> ▪ Since 2017, DMH/DD/SAS has partnered with the state’s Government Data Analytics Center (GDAC) to facilitate data sharing to improve patient, prescriber and dispenser identity resolution. ▪ The CSRS is also using data from the U.S. Drug Enforcement Agency (DEA) to improve identity resolution for patients, prescribers and dispensers. ▪ Finally, DMH/DD/SAS is working to identify additional data sources that can further improve the resolution of patient identity. 		<ul style="list-style-type: none"> ▪ Continue partnership with GDAC and expand scope of work to include making the business case to other state agencies to obtain permissions and consult with GDAC on defining the methodology for patient and prescriber entity resolution. ▪ Begin discussions with the HIE Authority on additional strategies to coordinate NC HealthConnex and CSRS information. <p>Timeframe: September 2018 - September 2021</p>
Use of PDMP – Supporting Clinicians with Changing Office Workflows			
6. Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled	<ul style="list-style-type: none"> ▪ DMH/DD/SAS co-chairs the Department’s Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC), which is focused on implementing the state’s Opioid Action Plan, as described in Milestone 5. ▪ As part of the Opioid Action Plan, the Department aims to expand clinicians’ 	<ul style="list-style-type: none"> ▪ All HCEs using EHRs and PMS will have CSRS data integrated into their workflows 	<ul style="list-style-type: none"> ▪ Continue to collaborate with vendor to integrate EHR/PMS and CSRS data and acquire additional licenses for pharmacies and prescribers. <p>Timeframe: November 2018 - December 2023</p>

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
substance, to address the issues that follow.	<p>access and use of the CSRS as a tool to combat the opioid epidemic.</p> <ul style="list-style-type: none"> ▪ The Department recommends that a patient’s report is queried within 48 hours of a patient’s initial visit. ▪ The CSRS integration plan simplifies providers’ abilities to query the report while a patient is in clinic without interrupting the clinician’s workflow. ▪ For those entities that are not integrated, state law permits delegate access to the system for querying patients’ prescription history on behalf of the practitioner. ▪ Practitioners use the CSRS separate from their EHR and Pharmacy Management Systems (PMS) to acquire patient controlled substance prescription history. ▪ The state is in the process of integrating CSRS and EHR data for individual Healthcare Entities (HCEs) 		(Contingent upon available funds)
7. Develop enhanced supports for clinician review of patient CSRS data prior to prescribing a controlled substance	<ul style="list-style-type: none"> ▪ PDMP users currently use NarxCare analytics, available since September 2018 to review prescription history. ▪ In addition to the information provided in #6, the new CSRS platform includes additional supports for clinical decision-making by providing visualization of the history and overdose risk scores. 	<ul style="list-style-type: none"> ▪ The state will enhance educational resources available to users on effective NarxCare usage 	<ul style="list-style-type: none"> ▪ Extend NarxCare funding to continue availability of NarxCare analytics to CSRS users. <p>Timeline: September 2018 - December 2019</p>

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<ul style="list-style-type: none"> ▪ The SAMHSA MAT locator is embedded in the system along with links to printable Centers for Disease Control and Prevention (CDC) pamphlets to help practitioners discuss topics with their patients. ▪ CSRS also provides a morphine milligram equivalent (MME) or lorazepam milligram equivalent (LME) to assist prescribers in identifying risky behavior. 		
Master Patient Index/Identity Management			
8. Enhance patient and prescriber profiles by leveraging other state databases in support of SUD care delivery.	<ul style="list-style-type: none"> ▪ DMH/DD/SAS is in the early stages of Entity Resolution. ▪ The CSRS' current approach to matching patients is detailed above, under #5, "Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP." 	<ul style="list-style-type: none"> ▪ Collaborate with GDAC to mirror the current database and use other databases (e.g., Division of Motor Vehicles, Department of Public Safety, HIE Authority) that GDAC has access to, with proper permissions, to better link prescriptions and identify patients and prescribers. 	<ul style="list-style-type: none"> ▪ Continue partnership with GDAC and expand scope of work to include making the business case to other state agencies to obtain permissions. ▪ Consult with GDAC on defining the methodology for patient and prescriber Entity Resolution. <p>Timeframe: September 2018 - September 2021</p>
Overall Objective for Enhancing PDMP Functionality & Interoperability			
9. Leverage the above functionalities/capabilities/supports (in concert with any other state	<ul style="list-style-type: none"> ▪ DMH/DD/SAS has started a pilot project with NC Medicaid to minimize the risk of inappropriate opioid overprescribing 	<ul style="list-style-type: none"> ▪ DMH/DD/SAS and NC Medicaid will work to expand the pilots and run reports analyzing all Medicaid claims 	<ul style="list-style-type: none"> ▪ Expand pilots to run reports analyzing all Medicaid claims for

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
<p>health IT, technical assistance or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids.</p>	<p>and to ensure that Medicaid does not inappropriately pay for opioids.</p> <ul style="list-style-type: none"> ▪ Through this pilot, DMH/DD/SAS and NC Medicaid match CSRS data with Medicaid claims data to identify Medicaid prescribers who may be overprescribing opioids, as well as patients who may be at risk of developing or have OUDs. 	<p>for opioid prescriptions on a monthly basis.</p> <ul style="list-style-type: none"> ▪ Following the managed care transition, standard plans (as of November 2019) and BH I/DD tailored plans (as of July 2021) will be required to submit pharmacy encounter data to the Department on a weekly basis. ▪ Once NC Medicaid receives the encounter data, it will clean and process the data to identify opioid prescriptions and share with DMH/DD/SAS to identify (1) prescribers who are overprescribing opioids, and (2) patients who have or may be at risk of developing OUDs. 	<p>opioid prescriptions on monthly basis.</p> <ul style="list-style-type: none"> ▪ DMH/DD/SAS and NC Medicaid will meet to plan for: (1) cleaning and processing data received from standard plans and BH I/DD tailored plans, and (2) sharing information on prescribers who may be overprescribing opioids and patients who have or may be at risk of developing OUDs. <p>Timeframe: September 2018 - July 2021</p>

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10. North Carolina has sufficient health IT infrastructure at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of this demonstration.

11. North Carolina's SUD Health IT Plan is aligned with the State's broader State Medicaid Health IT Plan (SMHP).

12. The Department will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent PHP contract amendments or PHP re-procurements.

Attachment A, Section II—Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Katherine Nichols, Assistant Director, DMH/DD/SAS

Telephone Number: 919-715-2027

Email Address: Katherine.Nichols@dhhs.nc.gov

Attachment A, Section III—Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.