All Provider Meeting
October 17, 2018
1:00pm – 3:00pm
4600 Emperor Boulevard, Durham, NC
Rooms 104-105
AGENDA

Welcome and Introductions (Cathy Estes Downs)
APAC Update (Ali Swiller)
Alliance Updates
Legislative Updates (Sara Wilson)
Needs and Gaps Survey 2018 (Carlyle Johnson)
Network Adequacy Survey (Carlyle Johnson)
Incident Reporting – (Wes Knepper)
IDD Updates (Jarret Stone)
Provider Network Updates (Cathy Estes Downs)
(referral status portal, clinician site and specialty portal, contact information, review of site change, NCTracks enrollment and HIE)

Powerpoint will be posted on the Alliance Website by October 26
https://www.alliancebhc.org/providers/provider-resources/all-provider-meetings/

Next meeting: Wednesday, December 19, 2018
HB 403: Medicaid and BH Modifications

• June 15 – NC General Assembly passed HB403 (unanimous votes in both House and Senate)

• June 22 – Governor Cooper signs measure into law

• June 22 – NC DHHS issues report on BH I/DD Tailored Plan implementation
What Does HB 403 Do?

• Amends NC’s Medicaid Transformation law by authorizing:
  - Integration of behavioral health services into Standard Plans
  - Creation of BH I/DD Tailored Plans

• Defines and solidifies the future role of LME/MCOs in Medicaid Transformation
Types of NC Managed Care Plans

• Standard Plans
  o Serve most Medicaid enrollees, including adults and children
  o Provide integrated physical health, behavioral health, and pharmacy services at launch of Medicaid managed care program

• Tailored Plans
  o Specifically designed to serve special populations with unique health care needs
  o Provide integrated physical health, behavioral health, and pharmacy services
Medicaid Transformation Timeline

- August 9, 2018 - DHHS released SP RFP
- February, 2019 - DHHS will award SP contracts
- Nov. 2019 – Standard Plans launch in Phase 1 regions
- Feb. 2020 – Standard Plans launch in Phase 2 regions
- Tailored Plan Readiness Reviews – projected mid-year 2020
- Tailored Plan Go-Live – July 2021
HB 403 – Key Points

• Establishes Tailored Plans to be operated by LME/MCOs that meet a readiness review as determined by DHHS

• Moves Medicaid recipients with “mild-to-moderate” behavioral health needs under the Standard Plans

• DHHS required to negotiate actuarial sound capitation rates for LME/MCOs based on their new consumer population
Structure of the Managed Care System

- Increases number of statewide Standard Plans from 3 to 4
- DHHS capping number of regional provider-led entities (PLEs)
- Establishes the number of Tailored Plans that may operate – no more than 7 and no fewer than five
- Prohibits a statewide Tailored Plan
- Entities operating Tailored Plans shall utilized closed provider networks only for BH, IDD and TBI services
Populations Covered by Tailored Plans

• Targeted toward individuals with:
  o Significant behavioral health needs (including mental health and substance use disorders)
  o Intellectual/developmental disabilities (I/DDs)
  o Traumatic brain injuries (TBIs)
## Medicaid Services Under SPs and TPs

<table>
<thead>
<tr>
<th>Inpatient behavioral health</th>
<th>Outpatient ER</th>
<th>Outpatient BH by direct-enrolled providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile crisis</td>
<td>Facility-based crisis for children/adolescents</td>
<td>Outpatient opioid treatment service</td>
</tr>
<tr>
<td>Ambulatory detox</td>
<td>Non-hospital medical detox</td>
<td>Partial hospital</td>
</tr>
<tr>
<td>Medically supervised or ADATC detox</td>
<td>Research-based intensive behavioral health</td>
<td>Diagnostic and assessment services</td>
</tr>
<tr>
<td>EPSDT</td>
<td></td>
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</tr>
</tbody>
</table>
Services Covered Only by Tailored Plans

• All behavioral health, IDD and TBI services not already listed on previous slide

• Non-Medicaid behavioral health services funded with federal, State and local dollars
Contracts for Tailored Plans

• Initial contract term is four years

• LME/MCOs are the only entities that may operate a Tailored Plan during the initial term

• Subsequent contracts to be competitive bid among nonprofit Prepaid Health Plans (PHPs) and LME/MCOs operating the initial contracts
LME/MCO Contracts with Partnering Entities

- LME/MCOs operating Tailored Plans must contract with an entity that:
  - Holds a PHP license
  - Covers the services required under Standard Plans

- DHHS recommends that this partnering entity be one of the Standard Plans
Preparing for Medicaid Transformation

Nov. 2017 – Alliance created the Advancing NC Whole Health Coalition with Trillium Health Resources and Vaya Health

- Unified voice in advocating for the public BH healthcare system in Medicaid Transformation
- Enhanced statewide presence to preserve stability and continuity of care for consumers
- Establish a combined statewide provider network
- Greater negotiating position with strategic partners
Direct contracts

DHHS

Standard Plan

CP/PLE

Agreements for BH

Advancing NC Whole Heath Coalition

Alliance

VayaHealth

Trillium Health Resources

AllianceBHC.org
Tailored Plan

DHHS

Direct contract

Alliance BEHAVIORAL HEALTHCARE

Co-management

PH Partner

Physical healthcare
Evaluating Physical Health Partners

• Expertise – Experience delivering physical health and pharmacy services under Medicaid

• Infrastructure – Established local physical health and pharmacy networks

• Innovation – Advanced data analytics and technology-enabled health services

• Competitive Advantage – Strong chance of winning Standard Plan contract
Next Steps

• Standard Plan procurement process continues
• Finalize agreements with PH partners
• Continue developing internal integrated care talent/expertise
• Continue dialogue with DHHS regarding Tailored Plan implementation and readiness reviews
Next Steps

• Ongoing training/education of staff, Board, CFAC, providers and other stakeholders

• Continue workgroup meetings with experts from Coalition and PH partners
2018 Community Needs Assessment

Alliance All-Provider Meeting

October 17, 2018
2018 Community Needs Assessment

• Change in breadth and focus of assessment
  • New CMS rules for *network adequacy*
  • NC Medicaid transformation
  • Preparation for standard and tailored plans

• Examples of DHHS change in emphasis
  • DHHS feedback about 2017 Community Needs Assessment
  • DHHS Concept Paper: *Network Adequacy & Accessibility Standards*
  • Name change of report: *2018 Network Adequacy and Accessibility Analysis Report*
DHHS Concept Paper

• Access to Care: historically measured by sufficiency / number of providers and geographic access (choice of providers within 30 minutes/miles)

• Shift to multifaceted approach:
  • **Availability**: number of providers, *willingness to accept new referrals*, ability to offer timely appointments
  • **Accessibility**: geographic accessibility, physical access (e.g., handicapped accessible), non-English access
  • **Accommodation**: operating hours, appointment policies, language and cultural competency
  • **Realized Access**: actual use of services by enrollees
Network Adequacy Questions

• Are there enough providers of each service type?
• Does the network have enough providers within a reasonable distance who are accepting referrals?
• Are appointments available in a timely manner?
• Does the MCO address the needs of all beneficiaries, including those with limited English proficiency or literacy.

• Are services culturally competent for those with:
  • Diverse cultural and ethnic backgrounds
  • Disabilities
  • Diversity in gender, sexual orientation or gender identity
Scope of Network Adequacy Report

• Access and Choice of providers (geomaps)
• Population demographics
• Methodology for obtaining feedback
• Results of analysis:
  • Underserved populations
  • Identified needs and gaps
  • Barriers to accessibility
• Network Access Plan
  • Progress on addressing gaps from last year
  • Identified priorities for upcoming year
  • Strategies for addressing needs and gaps
Sources of Information

- Demographic information
- Service geomapping
- Service utilization data
- Alliance CFAC and local CFAC feedback
- APAC and local PAC input
- On-line surveys of consumers, family members, stakeholders, providers, staff
- Focus groups
- Other sources of data as available
Community Survey Enhancements

• Improved survey format to reduce completion time and highlight priorities
  • Reduced estimated completion time from 26 minutes to 8 minutes
• Added ‘virtual focus group’ option
• Added Spanish version in both electronic and hard copy versions
• New survey: Provider capacity and accessibility survey
Community Survey

• Access to needed services
• Barriers to accessing services
• Populations with limited access or difficulty accessing services
• Linguistic access
• Specific services not available within each community
• Network strengths
Provider Capacity and Accessibility Survey

- Services closed to new admissions
- Reasons for not accepting new referrals
- Strategies for improving access to care
- Services available for non-English speaking
- Programs for specific populations
- Wait times for appointments
- Use of Alliance slot scheduler
- Barriers to timely access
<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid</th>
<th>State</th>
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<tbody>
<tr>
<td>Outpatient</td>
<td>Two (2) within 30 miles or minutes (m/m)</td>
<td>Two (2) within 30 m/m</td>
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<tr>
<td>Location-Based</td>
<td>Two (2) within 30 m/m</td>
<td>One (1) within 30 m/m</td>
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<tr>
<td>Community / Mobile</td>
<td>Two (2) within ABH catchment (ABHC)</td>
<td>One (1) within ABHC</td>
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<td>Crisis</td>
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<td>One (1) within ABHC</td>
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<tr>
<td>Inpatient</td>
<td>One (1) within ABHC</td>
<td>One (1) within ABHC</td>
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<tr>
<td>Specialized</td>
<td>Two (2) in NC</td>
<td>One (1) in NC</td>
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<tr>
<td>C-Waiver-Group 1</td>
<td>Two (2) within ABHC</td>
<td>N/A</td>
</tr>
<tr>
<td>C-Waiver-Group 2</td>
<td>One (1) within ABHC</td>
<td>N/A</td>
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</table>
Geographic Access Results

Areas in full compliance with geographic access requirements:

- Outpatient
- Community-based / mobile
- Crisis
- Inpatient
- C-Waiver
Geographic Access Gaps

• Location-based
  • Child & Adolescent Day Treatment (M,S)
  • SACOT (S)
  • Opioid Treatment (M)*
  • Day Supports (S)

• Specialized Services
  • Medicaid: (b)(3) I/DD Facility-Based Respite
  • State: PRTF, Residential Treatment, IDD Supported Living, ICF/IDD

*State-funded opioid treatment no longer available due to depletion of funds
# Community Survey Responses

<table>
<thead>
<tr>
<th></th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>Consumers &amp; Family members</td>
<td>35</td>
<td>13</td>
<td>10</td>
<td>86</td>
<td>148</td>
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<tr>
<td>Providers</td>
<td>51</td>
<td>120</td>
<td>65</td>
<td>141</td>
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<tr>
<td>Stakeholders</td>
<td>10</td>
<td>29</td>
<td>10</td>
<td>60</td>
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<tr>
<td>ABH Staff</td>
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<td>182</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>96</strong></td>
<td><strong>162</strong></td>
<td><strong>85</strong></td>
<td><strong>287</strong></td>
<td><strong>691</strong></td>
</tr>
</tbody>
</table>
Access Barriers

- Lack of reliable transportation
- Homeless/housing issues
- Lack of insurance
- Limited information about how to obtain services
- Services not available nearby
- Wait too long for appointments
- Cost of medication
- Availability of qualified staff
- Language barrier
Populations with Limited Access

• Homeless/ those with unstable housing
• People with transportation barriers
• Court-involved or in jails/prisons
• Dually diagnosed (IDD/MI & SUD/MI)
• Non-English speaking
• Uninsured and underinsured
• Individuals with I/DD who are not on Innovations waiver
• Traumatic Brain Injuries
Service Gaps

- Residential treatment
- Relief for primary caretakers
- Housing
- Social networks / community connections
- Services to develop daily living skills
- Daily structured programs
- Vocational and educational services
- Crisis continuum
- Improvement in timely access
- Services to promote independence
Provider Access Survey Results

• 135 responses
• 87% accepting Medicaid referrals
• 56% accepting Non-Medicaid referrals
• Primary reasons for not accepting referrals were “service at capacity” and “staffing shortage”
• Only 14% of respondents use Alliance slot scheduler
• Primary reasons for not using slot scheduler include:
  • Administrative burden / duplication of provider efforts
  • Lack of familiarity with scheduler
  • Does not fit with agency service types
• Primary barriers to access include transportation, staff shortages/turnover, administrative burdens
FY18 Network Development Plan Updates

1. Crisis Continuum
   • Enhanced Mobile Crisis Pilot in Wake
   • Implemented Behavioral Health Urgent Care in Durham; expansion to Wake in process
   • Recovery-oriented system of care
   • Facility-Based Crisis for children

2. Engagement & Self-Management
   • Remote Monitoring Pilot Home to promote independent living for individuals with I/DD
   • Self-management pilot initiatives: WHAM training, member cards, shared decision-making tools
FY18 Network Development Plan Updates

3. Youth & Adults with Complex Needs
   - Expanded Trauma-informed Therapeutic Foster Care
   - Implemented Intensive Wrap-Around for children and transition age youth
   - Therapeutic Foster Care EBP implementation
   - Integrated physical/behavioral healthcare expansion
   - Tiered Case Management initiatives
   - Day Treatment expansion in Cumberland
   - Transitioning PSR programs to evidence-based psychiatric rehabilitation models
FY18 Network Development Plan Updates

4. Social Determinants of Health
   
   • Housing initiatives
     
     • Independent Living Initiatives (ILI): $879K in FY18
     • Permanent Supportive Housing: DASH, Home Again Program, TCLI subsidies
     • Capital investments of $750K with developers

   • Social Determinants pilot initiatives
     
     • Transportation pilot to reduce barriers for persons being discharged from hospitals or crisis facilities
     • Implemented use of Virginia Commonwealth Social Needs Assessment
     • WHAM trainings
FY18 Network Development Plan Updates

5. Substance Use Disorder Continuum

- SUD & OTP Collaboratives
- Implementation of service expansion through 21st Century Cures Grant
  - Expanded Opioid Treatment Program (OTP) contracts for uninsured in all counties
  - Increased # of uninsured served by 850%
  - Implemented Office-Based Opioid Treatment (OBOT) in Durham
  - Embedded Peer Support Specialists within OTP programs
  - Social Determinants pilot within OTP programs
  - Pending initiatives to improve engagement and retention
FY18 Network Development Plan Updates

6. System Access & Availability

• Focus on improving timely aftercare engagement through ‘7-day Challenge’
• Multiple Quality Improvement Projects addressing timely access to care
• Enhanced continuum of services for justice-involved individuals (e.g., JJSAMHP & JCPC collaboration, DPS ‘Raise the Age’ preparation, ILI Housing “Restoring Hope Initiative,” Stepping Up initiatives, etc.)
• Ongoing improvement of information through Alliance provider search and web page
• Developing recommendations for non-English access
FY19 Network Access Priorities

- Crisis continuum
- Services/supports for individuals with complex needs
- Recovery-oriented system of care
- Social Determinants of Health
- Public awareness of Alliance and its service array
- Service availability and access
Crisis Continuum

Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities

• Implement Enhanced Mobile Crisis Pilot (Wake)
• Implement Behavioral Health Urgent Care (Tier II Same Day Access, Wake)
• Develop Facility Based Crisis capacity for children
• Improve timely access to aftercare appointments following inpatient, facility-based crisis or non-hospital detoxification treatment
Individuals with Complex Needs

*Increase interventions and supports for individuals with complex needs*

- Continue implementation/expansion of Day Treatment services (Cumberland)
- Evaluate residential treatment service needs
- Evaluate service capacity needs for dually diagnosed and develop recommendations for improving access, reducing barriers and improving systems of care
Recovery-Oriented System of Care

Develop an array of recovery-oriented, individualized and person-centered services that promote community inclusion

- Transition PSR programs to recovery-oriented psychiatric rehabilitation models
- Improve quality and consistency of Peer Support services
- Initiatives to promote independence, social connections, independent living skills, personal care and self-help needs
- Expand vocational and educational services & supports
Social Determinants of Health

Improve service outcomes by addressing social determinants of health

- Housing initiatives, including Supportive Housing and Group Living Step Down projects
- Social Determinants pilot initiatives
- Services to address transportation challenges
- Implement Health Literacy initiatives
Public Awareness of Services

*Improve public awareness of Alliance and its service array*

- Improve availability of information to the public about service availability and access
- Explore use of peer and family navigators and community health workers to assist with system navigation
Improve service availability and access

• Improve access to services for non-English speaking consumers

• Identify and implement strategies for improving access and availability of appointments

• Evaluate barriers to accessing respite service and develop strategies for improving access

• Develop and enhance the continuum of care for individuals with Substance Use Disorders

• Improve access to services for individuals with I/DD who are not on Innovations waiver
Incident Reporting

QM and Late Submissions
October 17, 2018
PURPOSE

• To promptly address late submissions of Level II and Level III Incident Reports into NC-IRIS

• To provide immediate feedback to providers on the accuracy and timely submission of Incident Reports

• To decrease the number of late submissions of Level II and Level III Incident Reports in NC-IRIS
NOTIFICATION STEPS:

1. **Email Notification** for first late submission within the quarter
   - Reminder of timely submission requirements
   - Inform of MCO actions (Executive Leadership Notification) for further late submissions within the quarter
NOTIFICATION STEPS:

2. Certified Letter to Executive Leadership
   • Inform Executive Leadership of 2\textsuperscript{nd} late submission within the quarter
   • Inform of actions (POC) for future late submissions within the quarter
NOTIFICATION STEPS:

3. Referral to Compliance for a POC
   • When a provider
     • Submits 3 late reports within a quarter
     • Receives 2 written warning in two consecutive quarters in the current fiscal year
     • Receives 3 email notifications for 3 consecutive quarters in the fiscal year
I/DD Updates

All Provider Meeting
October 17, 2018
I/DD Updates

Waiting….

- Innovations Waiver Renewal – Continued
  - Intensive Review Dialogue
- Upcoming Clinical Coverage Policies (RB-BHT and TBI Waiver)
- HCBS….

No longer waiting

- TBI Waiver has begun!
PROVIDER NETWORK UPDATES
Coming soon:

In order to better have more up to date information regarding each provider’s ability to accept referrals. Alliance is developing a system to collect information on each provider’s ability to accept referrals, by site, service, funding source, language and age.
Provider Portals

• The referral status portal will be accessed through the same portal that the current Accreditation and Clinician Maintenance portal utilizes.

• Please monitor Provider News for upcoming information regarding implementation and training
Clinician Maintenance Portal

Attention LIPs, Agencies and Groups Providing Outpatient and Psychiatric Services

To help Alliance enhance its online Provider Search tool it is critical that we collect important information from Licensed Clinicians credentialed by Alliance. All contracted provider entities should follow instructions outlined in the Clinician Maintenance User Guide to access an online portal to provide this information about each of your clinicians. This information includes clinician specialties, languages spoken, and sites at which the clinician provides services. Please help us provide more comprehensive and useful information to people in our communities who use the Provider Search when seeking services.
Accreditation Portal

• In response to LME-MCO Communication #J254 which ended the use of the DHHS Agency (Routine) Monitoring Tool for agencies that are nationally accredited, Alliance is launching a new "Accreditation" tab in the Provider Maintenance Portal to monitor provider accreditation. Please log in to the Provider Maintenance Portal and update your accreditation information. A Provider Maintenance User Guide is available on the Alliance website. Questions may be directed to AccreditationReview@AllianceBHC.org.
How to access the Provider Portal

• [https://portal.alliancebhc.org/Login](https://portal.alliancebhc.org/Login)

• Or via the Alliance website at [www.alliancebhc.org](http://www.alliancebhc.org) – click “For Provider” tab and you will see a button “Access the provider portal” which will bring you directly to that site
The law requires:

- Hospitals as defined by G.S. 131E-176(13), physicians licensed to practice under Article 1 of Chapter 90 of the General Statutes, physician assistants as defined in 21 NCAC 32S .0201, and nurse practitioners as defined in 21 NCAC 36 .0801 who provide Medicaid services and who have an electronic health record system shall connect by June 1, 2018.
- All other providers of Medicaid and state-funded services shall connect by June 1, 2019.
- Prepaid Health Plans (PHPs), as defined in S.L. 2015-245, will be required to connect to the HIE per their contracts with the NC Division of Health Benefits (DHB). Clarifies that PHPs are required to submit encounter and claims data by the commencement of the contract with NC DHB.
- Local Management Entities/Managed Care Organizations (LMEs/MCOs) are required to submit encounter and claims data by June 1, 2020.
NC HIEA

- Additional information on NC HIEA
  - https://hiea.nc.gov/
- NC Medicaid Bulletins
- Upcoming Conferences
  - i2i Center for Integrative Health – Pinehurst-Dec 4-7, 2018
  - North Carolina Providers Council – Greensboro Jan 14-16, 2019
  - Monitor Provider News for any additional HIEA information sessions
Provider Network Reminders

**Site changes**- all site changes require a minimum of a prior 30 day notification using the Notice of Change form. All new sites will need to be enrolled in NCTracks prior to being entered in Alpha. The effective date will be the date indicated on the Notice of Change (the actual date of the move) or the NCTrackseffective date- whichever comes last. Previous sites will be end dated on the date the provider is no longer providing services from that site. Alliance is not required to process retro-active date changes.

Please ensure your enrollment of any new site in NCTracks has an effective date that will not cause a gap as it may result in a gap in contract end and start dates which will result in payment denials.
Provider Network Reminders

• Important: There will be a suspension in a provider's ability to be paid and receive authorizations for site changes that are not yet enrolled in NCTracks.
• Please note any services billed from a site that the provider has indicated they have moved from may result in a recoupment and a compliance referral.
Credentialing Reminders

- **Re-Credentialing** - Please note that at the time of re-credentialing a billing review will be done for each Licensed Practitioner (LP). If there is no billing for the previous 12 months the provider will be decredentialied and unenrolled from the Alliance Network. The LP would be eligible to re-apply to the Network.