All Provider Meeting
March 16, 2022  1:00pm – 3:00 pm

AGENDA

Welcome: Kate Peterson
Questions can be taken during the webinar through the chat box function for those accessing the webinar through their computers.

Alliance Updates

- Self Audits – Matt Ruppel
- Utilization Management Updates - Rob Bell
- Provider Accreditation and Referral tool demo - Jeff Guthrie
- COVID Flexibilities Update - Lynn Widener
- Provider Network Updates - Cathy Estes Downs
- Questions

Recording of this meeting will be posted on the Alliance Website by March 23, 2023

https://www.alliancehealthplan.org/providers/all-provider-meetings/
Audit Requirements

Provider Medicaid Contract
• Article II – Obligations of the Participating Provider states “Provider understands and agrees that self-audits are encouraged by the LME/MCO.”

Provider Operations Manual
• Providers are required to have a Compliance Plan that includes provisions for internal monitoring and auditing.

Medicaid Program Integrity Provisions (42 USC § 1320d)
• Within 60 days of identifying an overpayment, it must be reported and returned by the provider.
• Providers must document and include the reason for the overpayment when it is reported.
Why conduct self-audits and report overpayments?

• Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with an external investigation and litigation.
• Audits increase the perception of detection, thus minimizing the risk of noncompliant practices by your employees.
• Findings allow providers to implement controls to prevent future noncompliance.
• Overpayments result in less funding for other necessary services.
When should self-audits be conducted?

Ad Hoc
• Any time you receive an allegation that or you suspect services billed did not meet requirements, your investigation should include an audit of claims related to the allegation.

Routine
• Every provider should be conducting random audits on a routine basis.
• Focused audit examples include:
  • Services provided by new employees to ensure proper service administration and documentation.
  • Services that do not require prior authorization.
  • Records for members that do not seem to miss any appointments.
  • Services that are frequently unbundled, such as family or group therapy.
How to Report Self-Audits and Overpayments

The following templates are available in the Document Library on the Alliance web site

Provider Self-Audit Template
• The tool has one tab for the audit findings and one for the plan of correction

Provider Payment Election Form
• This form needs to be completed and submitted with self-audit

Provider Self-Audit Submission Instructions
• This document provides details on how to submit results to Alliance.
Utilization Management

• There has been change to the format of both the Alliance Medicaid and Non-Medicaid Benefit Plans

• The tool to look up Benefit Plan information is now named the Benefit Plan Service Details tool

• Both the PDF version of the Benefit Plans as well as Benefit Plan Service Details tool are still currently available. The PDF versions of the Benefit Plans will no longer be available after 4/1/2022
The Benefit Plan Service Detail tool has all the information that was previously on the PDF version of the Alliance Benefit Plans plus additional features.

- It is an easier way to search for information. A user can search by Service Name/Common Abbreviation or Service Code.
- Now includes the Clinical Coverage Policies, SOWs, In-Lieu of Service Definitions, and State-Funded Service Definitions.
- Includes any required forms such as a Discharge Transition Form (Residential Level III/IV), Certificate of Need (Inpatient and PRTF), and Level of Care Form (ICF).
Where can I find the Benefit Plan Service Details tool

https://www.alliancehealthplan.org/providers/network/benefits-and-services/
Benefit Plan Service Details tool

Search by service name or procedure code

Filter by: Coverage  Diagnosis Group  Age Range

119 items found  Sort by: Alphabetical  Last Updated

Enter Service Name or Service Code
Benefit Plan Service Details tool

“Searched H0040” Search Results

Filter by: Coverage ▼ Diagnosis Group ▼ Age Range ▼

2 Items found | Sort by: Alphabetical Last Updated Relevance

Search for: "Actt" x

Medicaid B - Assertive Community Treatment Team (ACTT)

- **Coverage:** Medicaid B
- **Diagnosis Group:** Mental Health, Substance Use
- **Age Range:** 18-20, Adult, Child

Learn More ➔

Non Medicaid - Assertive Community Treatment Team (ACTT)

- **Coverage:** State
- **Diagnosis Group:** Mental Health, Substance Use
- **Age Range:** 18-20, Adult

Learn More ➔
Benefit Plan Service Details tool

Information included: Coverage (Medicaid or Non-Medicaid, TBI, and Innovations), Reference Documents (hyperlinks and thumbnails included as well), Submission Requirements, Service Definition Authorization Parameters, COVID Prior Approval Flexibilities, Authorization Guidelines (LOCUS, CALOCUS, ASAM), Service Codes, and link to ACS
Provider Accreditation and Referrals Update: Move to ACS
Referrals

- Alliance will continue to require providers to enter and then update or confirm their referral information.

- Providers will now do this through the ACS Provider Portal.

- Note the Verify Referrals button. This button is used when you have no changes to make to your referral data.
Referrals (continued)

• Once in your Provider record in ACS, you can navigate to Details to enter both Referrals and Accreditations.

• First, Referrals.

• Go to Sites.

• Expand a Site.

• Click Details.
Referrals (continued)

- Everyone should be familiar with the Site Details page.
- Scroll to Referrals.
- Contracted Services Appear.
- Expand Service.
- Click Update.
Referrals (continued)

- Here you add referral information.
- Accepting Referrals.
- 7 Day Appointment.
- Age Groups.
- Languages.
- Click Save.
Verify Referrals

• Every 3 months, Alliance would like for you to verify that your referral info is correct and edit accordingly.

• You can drill down to Site details for each site and verify/update your referral preferences at any time.

• Once done, just click the Verify Referrals button mentioned earlier.
Accreditations

• Navigate the same way as you did to access Referrals.

• Click the Details button.
Accreditation (continued)

• Click the Accreditations Tab. You click the Add button to create a new record.

• You may or may not see records here. If this is your first time entering an accreditation, the grid will be empty.
Accreditation (continued)

- Click the Add button to create a new accreditation record.

- A blank accreditation form opens. Fill in fields appropriately.

- Required fields are marked with an asterisk

- You must choose either 1 year or less or 2+ years for Accreditation Years.

- No matter how many years or governing body, you always have to add at least one attachment for the accreditation to be accepted.
Accreditation (continued)

- Expand the row in the grid to view the accreditation info.
- View and Update take you to the same formatted page.
  - Update allows you to update information before submitting or when more information is requested
  - View allows you to view the details but does not have a Save or Save and Submit button
Accreditation (continued)

Update

View
Now let’s take a quick look at the functionality in the ACS Provider Portal!
COVID flexibilities ending 3/31/2022
Special Bulletin COVID-19 #234: Update to Permanent Changes Made for PHE Flexibilities and Plan for Sunsetting of Temporary Policies

• The NC Division of Health Benefits (DHB) has published an update on COVID-19 flexibilities that will either be sunsetting on 3/31/2021, ending at the end of the federal Public Health Emergency (PHE) or will be incorporated into permanent policy.

• This presentation focuses on the flexibilities that will be ending on 3/31/2022

• The link to Special Bulletin COVID-19 #234 is SPECIAL BULLETIN COVID-19 #234: UPDATE to Permanent Changes Made for PHE Flexibilities and Plan for Sunsetting of Temporary Policies | NC Medicaid (ncdhhs.gov)
Alliance Key Reminders

- For a service where any flexibility remains in place, then the CR and GT CR modifiers will remain active in ACS.
- The CR and GT CR modifier should be used if a provider is using a flexibility when delivering the service.
- If no flexibility remains, the CR and GT CR modifiers will be ended dated in ACS as of 3/31/2022.
- For services that will no longer have authorization flexibilities, providers may immediately begin submitting Service Authorization Requests (SARs). Providers do not have to wait until 4/1/2022.
Substance Abuse Medically Monitored Community Residential Treatment

The flexibility below ends 3.31.22

- Allow supervision of QP and AP to occur virtually
- Effective 4/1/22 – supervision must be face to face
Community Support Team
The flexibility below ends 3.31.22

- Allow team meetings to occur virtually
- Waive requirement that 75% of the service must be delivered face-to-face and outside of the agency
Mobile Crisis Management

The flexibility below ends 3.31.22

- Waive requirement that 80% of the service must be provided face-to-face
Intensive In-Home Services
The flexibility below ends 3.31.22

• Waive requirement that staff must be dedicated to the team
• Waive requirements that 60% of contacts should be face-to-face and 60% of staff time should be spent outside of the facility
• Waive team-to-family ratio of 1:12
• Allow for supervision by any licensed professional on the team or employed by the provider agency, within scope and training, if Team Lead is sick or unavailable
Multisystemic Therapy
The flexibility below ends 3.31.22

- Waive requirements that 50% of face-to-face contact with beneficiary and family and 60% of staff time should occur outside of facility.
- Waive maximum of 480 units per three months.
Outpatient Opioid Treatment
The flexibility below ends 3.31.22

• Allow seven days of take-home, reduced from policy flexibility of 28 days take-home.
Child and Adolescent Day Treatment
The flexibility below ends 3.31.22

- Waive requirement that staff must be dedicated to the team
- Waive requirement that a maximum of 25% of treatment services may be provided outside of the day treatment facility. Waive staff-to-beneficiary ratio if provided outside of the facility
- Waive requirements for staff training within 30 and 90 days of employment and follow-up, and ongoing continuing education requirements for fidelity of clinical models, if unable to be obtained during the state of emergency.
Substance Abuse Intensive Outpatient Program
The flexibility below ends 3.31.22

- Waive reauthorization after the initial 30-day pass through.
- Waive requirement that the CCS or LCAS be on-site 50% of the hours open; but must be available virtually.
- Waive beneficiary-to-staff ratio if provided outside of the facility.
- Waive requirement that CCS or LCAS must be on-site but must be available virtually a minimum of 90% of the hours the service is in operation.
Community Support Team
The flexibility below ends 3.31.22

• Waive Comprehensive Clinical Assessment beyond six months of treatment.
• Waive staff to beneficiary ratio of 1:12.
• Waive monitoring of delivery of service by team leader.
• Waive staff training requirements within 30 and 90 days of employment, if unable to be obtained during the state of emergency.
• Allow functional assessments and crisis interventions to be completed by telehealth or telephonic modalities, as clinically appropriate.
Assertive Community Treatment
The flexibility below ends 3.31.22

- Waive staff training requirements within 120 days of employment, if unable to be obtained during the state of emergency.
- Allow any agency-employed, licensed staff to provide supervision within scope if team lead is sick or unavailable.
- Allow Associate licensed professional to have more than 30 months to become fully licensed.
- Waive requirement that staff must be dedicated to the team.
Outpatient Behavioral Health Services Provided by Direct Enrolled Providers

The flexibility below ends 3.31.22

- Waive initial and reauthorization
- No other flexibilities will remain as a result the CR and GT CR modifiers for OPT codes will end on 3/31/2022
Peer Support Services
The flexibility below ends 3.31.22

- Waive staff-to-beneficiary ratio.
- Waive requirement that telephone time be 20% or less of total service time per individual per year
- Waive staff training requirements unable to be obtained during the state of emergency within 30 and 90 days of employment
- Waive initial authorization and reauthorization
- No other flexibilities will remain as a result the CR and GT CR modifiers for Peer Support codes will end on 3/31/2022
Unsure of Authorization Requirements?
Please utilize the published benefit plan at the link below
https://www.alliancehealthplan.org/providers/network/benefits-and-services/

Need to refresh on Clinical Coverage Policy?
Please utilize the link below or use the link embedded in the published benefit plan
https://medicaid.ncdhhs.gov/blog/2020/01/13/clinical-coverage-policies
Billing and Enrollment Virtual Technical Assistance Trainings

The Billing and Enrollment team at Alliance Health will be offering four virtual technical assistance sessions for claims and enrollment related topics and questions. These sessions are formatted for provider agency staff directly involved in the submission of enrollments and claims and will include group instruction and training, as well as one-to-one provider technical assistance. Training will be held at the following dates and times. RSVP is required as space is limited. Please RSVP to claims@alliancehealthplan.org and indicate your name, agency name, date, and time of training you wish to attend. Providers should attend only one of the four sessions as the content will be the same for each session.

Training Dates:
Tuesday, March 22\textsuperscript{nd} 10 am – 12 pm
Thursday March 24\textsuperscript{th}, 10 am – 12 pm
Tuesday April 19\textsuperscript{th} 10 am – 12 pm
Thursday April 21\textsuperscript{st} 10 am – 12 pm

If you have any questions, please email: claims@alliancehealthplan.org
Updated Medicaid Rate table

Please ensure that you are monitoring the published Medicaid and State Rate tables for updates based on changes in flexibilities and HCBS direct care rate related changes

https://www.alliancehealthplan.org/resources/document-library/
Contracts FY23

Contracts for current MCO/LME services will be completed thru a Contract Extension – these contracts will be valid until the Tailor Plan goes live- December 1, 2022.

There will be new contracts for the Tailored Plan with an effective date of December 1, 2022 – please stay tuned to Provider News regarding this process/requirements.
Please remember that your Provider Network Development Specialist is your “go to” person to assist in answering and/or finding out answers to questions you may have.

Network Staff assignments are able to be found on the website at:
https://www.alliancehealthplan.org/document-library/59359/

Or providers can email providerhelpdesk@alliancehealthplan.org and they will assist with identifying your Network Specialist.