



All Provider Meeting
September 21, 2022

All Provider Meeting

June 15, 2022 1:00pm – 3:00 pm

AGENDA

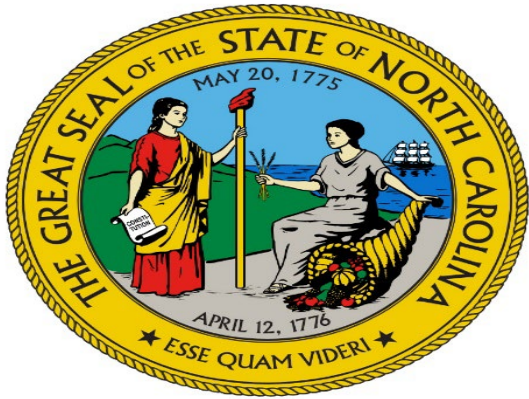
- **Welcome- Cathy Estes Downs**
- **Legislative Updates- Brian Perkins**
- **TBI Waiver Overview- Melissa Hall**
- **IDD Provider Attestation- Matt Ruppel**
- **Tailored Care Management- Myca Jeter and Dana Frakes**
- **TP Training requirement- Lynn Widener**
- **JCB 408 – State Funded Residential Supports Service and Supportive Living** **Update- Lynn Widener**
- **FY23 Contracts and TP and Medicaid Direct contracts-Cathy Estes Downs**
- **NC Child and Family Improvement Initiative – Kate Peterson**
- **Alliance Updates- Sean Schreiber**
- **Questions**

Recording of this meeting will be posted on the Alliance Website by September 28, 2022

Next currently scheduled All Provider Meeting is December 21, 2022



Legislative Updates



NC Traumatic Brain Injury Waiver Overview

- Alliance All Provider Meeting
- September 21, 2022 - 1:00 – 3:00pm

TBI Waiver Counties

Alliance Catchment Counties	Alliance Catchment Counties with Current TBI Waiver	Alliance Catchment Counties – CMS Approval Pending (December 2022/early 2023)
Cumberland	✓	
Durham	✓	
Johnston	✓	
Wake	✓	
Orange		✓
Mecklenburg		✓



WHO IS NC's TBI WAIVER FOR?

- Currently being offered in Wake, Durham, Johnston and Cumberland Counties
- Set to Expand into Orange and Mecklenburg Counties December 2022/early 2023
- The TBI Waiver is an ADULT only Waiver
- CMS has approved Age of injury to Change to 18 and older- 4/1/2022.
 - If an individual has sustained their injury on their 18th birthday or later, they may apply for TBI Waiver effective 4/1/2022





Types of Eligibility

Type of eligibility	Description	Lessons Learned
FINANCIAL	<p>Must qualify for Medicaid and understand and accept terms of deductible payment</p> <p>*financial eligibility has been expanded to 300% with waiver renewal</p>	<p>24% of applicants to Alliance pilots who expressed interest, did not qualify for Medicaid due to income level/assets, declined due to Medicaid enrollment requirements, or declined due to deductible being too high</p>
DIAGNOSTIC	<p>Must have sustained a traumatic brain injury on or after their 18th birthday</p> <p>*age reduced to 18 after onset of waiver renewal 2022</p>	<p>Documentation only indicates TBI by self report or doesn't document age of injury for diagnostic eligibility verification.</p> <p>Multiple injuries should be reviewed and most current considered for waiver enrollment. Members with injuries prior to age 18 with no secondary injury documents, are eligible for Innovations waiver</p>
LEVEL OF CARE	<p>Must meet level of care typically seen in Skilled Nursing and/or Acute Rehab settings</p>	<p>Members with older injuries will likely require neuropsychological evaluations to measure current level of care needed. Recommend completing these assessments prior to Medicaid application as this may help with disability determination process</p>

What is Not Covered?

(Non- Traumatic Brain Injury)

- Often referred to as Acquired Brain Injury (ABI)
- Non- Traumatic Brain Injuries cause damage to the brain by internal factors
- Examples: Lack of Oxygen, Overdose, Stroke, Exposure to Toxins, Pressure from a Brain Tumor



TBI WAIVER

Array of Services:

Cognitive Rehabilitation

Supported Living

Life Skills Training

Day Supports

Residential Supports

Respite

Crisis Services

Community Networking

*Resource Facilitation (going away with Tailored Plan)

Remote Supports

Supported Employment

Natural Supports Education

Specialized Consultative Services

Personal Care

*Speech/OT/PT (*payor of last resort)

Community Networking

TBI SUPPORTS



**Please call Alliance's
24/7 Access & Information Line**





Access and Information Center



800-510-9132

Relay: 711 or 800-735-2962

Provider Support



855-759-9700



ENSURE FAMILIES KNOW THEY WILL RECEIVE A HELPING HAND!

- Members on the TBI Waiver *Registry of Interest* will receive initial outreach from our Alliance's **TBI WAIVER TEAM**
- TBI Waiver Team will assist members through the Screening and Eligibility Process. (*Example, document inventory*)
- We currently have 55 members actively enrolled in the waiver





Interested in Learning More?

Search TBI on Alliance Health Main web Page or follow this link

<https://www.alliancehealthplan.org/consumers-families/traumatic-brain-injury-tbi/>



BEYOND ALLIANCE

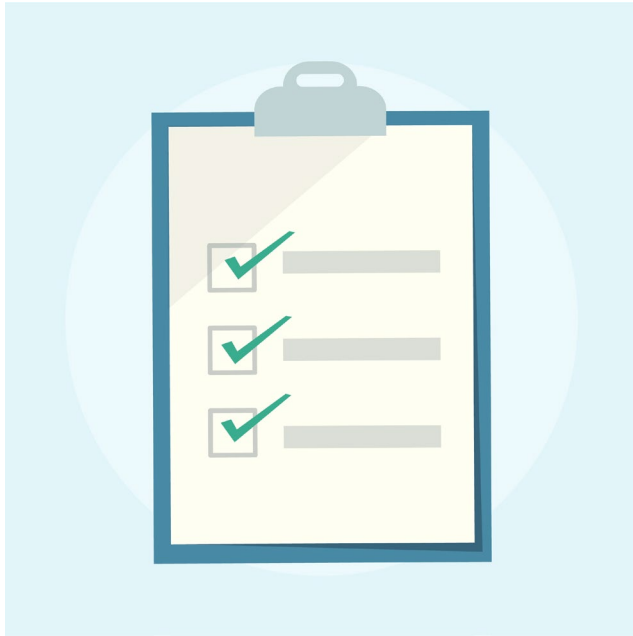


<http://www.bianc.net>

What can BIANC do for you?

BIANC is the leading resource for brain injury survivors, families and providers familiarize

Next Steps



- ✓ Review The Centers for Medicare & Medicaid Services (CMS) TBI Approved Waiver
 - https://files.nc.gov/ncdma/documents/GetInvolved/Public_Notices/TBI-Waiver-and-Public-Comment.pdf
- ✓ Monitor Provider News
 - <https://www.alliancehealthplan.org/provider-updates/provider-news-service-email-sign-up/>
- ✓ Acquaint your agency with training, supports and services offered by BIANC
- ✓ Begin assessing staff training needs



THANK YOU FOR YOUR TIME

Q&A

✓ Questions? Email us at TBlinfo@AllianceHealthPlan.org



IDD Provider Subcontractor Attestation

All Provider Meeting 9/21/22

Background

- The Network Provider Contract:
 - requires providers to seek approval from Alliance before subcontracting covered services
 - legally and contractually subjects providers and their subcontractors to Alliance's oversight authority
- Providers maintain ultimate responsibility for subcontractors' compliance with Alliance's Network Provider Contract

Purpose of Attestation

- Alternative Family Living (AFL); licensed, unlicensed
- Disclose what covered services are subcontracted
- Identify all existing subcontractors providing covered services (separate form)
- Ensure providers commit to carrying out clinical and regulatory compliance oversight of subcontractors

Purpose of Attestation

- Ensure all subcontractors comply with:
 - Terms of the Alliance Network Provider contract
 - State and federal laws and rules
 - NCGS §122C
 - Applicable Clinical Coverage Policies
 - 1915(c) Home- and Community-Based Services (HCBS) Waiver
 - Business Associate requirements
 - Non-discrimination
 - Alliance provider manual
 - Health and safety

Process

- Attestation delivered through DocuSign within 1-2 weeks
- 14 days to respond
- If subcontracting:
 - Submit Subcontractor Identification form (Excel) to:
Compliance@AllianceHealthPlan.org
 - Due date: 10/31/22
- Questions: Provider Support 855-759-9700



Tailored Care Management: Part 2

Objectives

- Provide a brief review of:
 - Medicaid Transformation
 - Tailored Plans and Tailored Care Management
 - Member Choice
- Explain how Medicaid Transformation affects all providers
- Provide guidance on how providers engage with Tailored Care Management providers
- Discuss services excluded from TCM and how to transition members

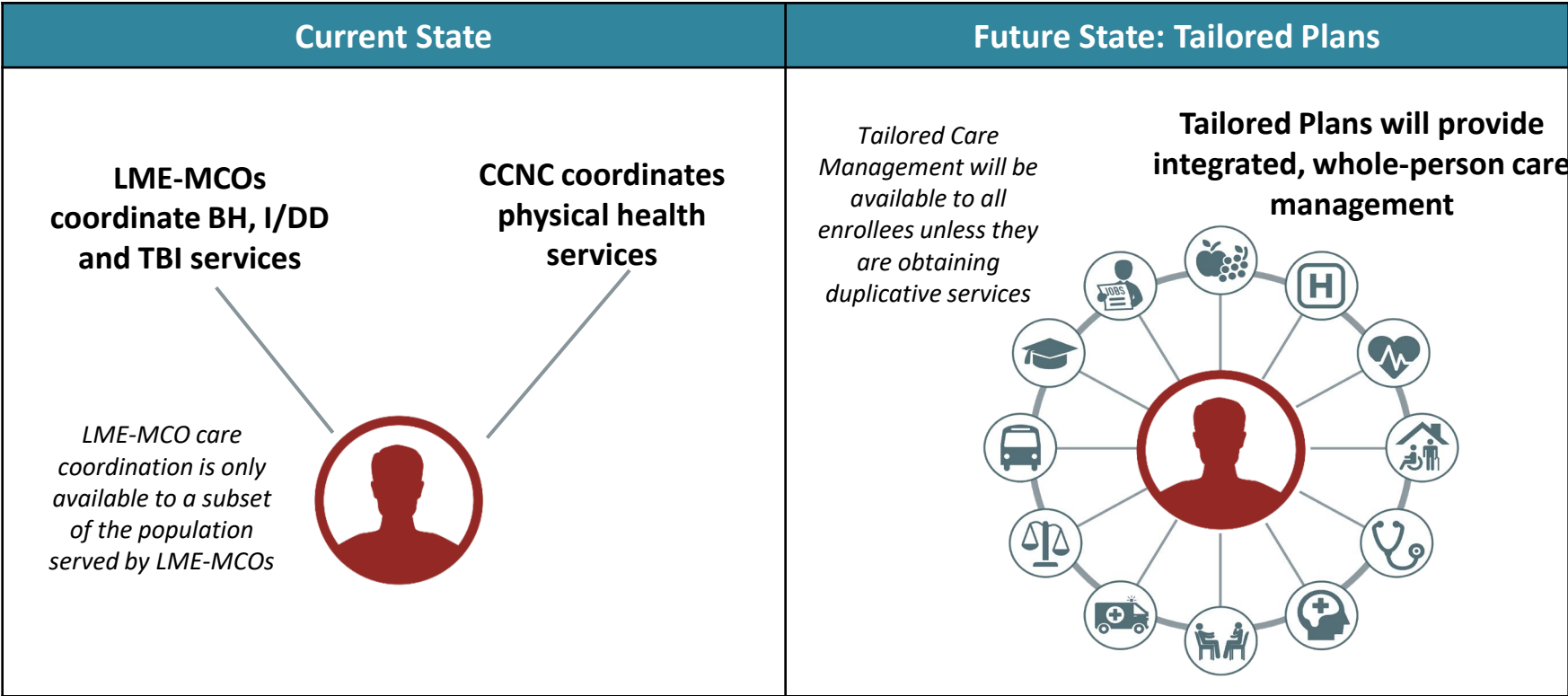


Medicaid Transformation

- Shifts from fee-for-service to a value-based system
- Designed to manage members' comprehensive needs through care management for better health outcomes
- Brings together Mental Health, Substance Use Disorders (SUD), Intellectual Developmental Disorders (IDD) and physical health care for a **whole person, integrated care environment**



Shift to Tailored Care Management



What is Tailored Care Management and how is it different?

- Tailored Care Management is the primary care management model for Tailored Plans
- A single Care Manager takes a whole-person approach with expertise/training in addressing behavioral health, I/DD and/or TBI needs in addition to physical health and unmet health-related resource needs
- Incorporates Person and Family-Centered Planning, considering the unique needs of the member/family system, with family members and caregivers serving as part of the member's care team

Members receiving ACTT, ICF, High Fidelity Wraparound, or Care Management for at Risk Children (CMARC) are not eligible for Tailored Care Management

Provider-Led Care Management (CMAs/AMH+s)

- Alliance has 42 organizations that are in the process of becoming CMAs or AMH+'s.
- All 6 of Alliance's counties and all populations are covered
- Alliance will publish a list of certified and contracted CMAs and AMH+'s prior to go-live.

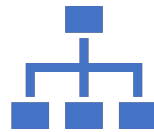
Reminder: Members are not referred to care management entities, they are assigned by Alliance through a pre-approved assignment logic.

Member Choice Period

August 15th – October 14th



Members will receive a letter notifying them of their assigned care management agency



The member can choose to keep the care manager, request a different care manager, or decline care management



Member will notify agency or Tailored Plan of choice

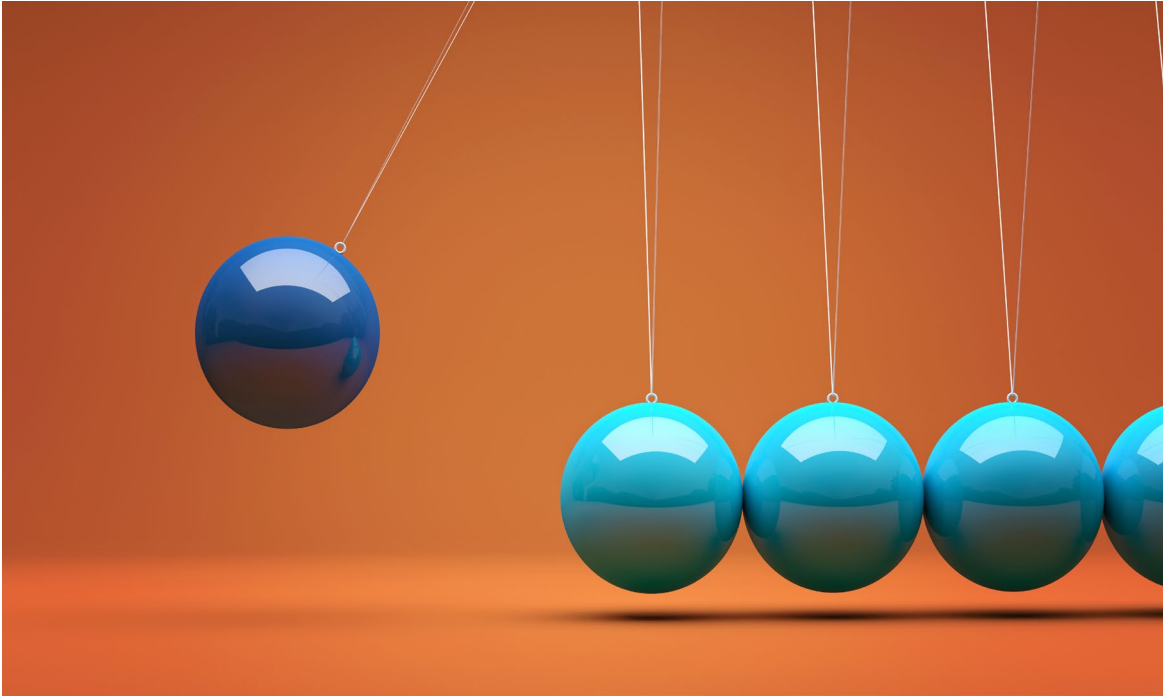


Document the choice of the member



If member wants a new care manager, Tailored Plan will reassign

How will this impact you?



The Tailored Care Management model impacts all service deliveries provided by agencies.

Regardless of whether or not your agency will be a CMA or AMH+, Tailored Care Management WILL affect you.

Service Provider Roles & Responsibilities

- Provide consultation and support for individuals engaged in care
- Accept referrals from Care Team
- Participate in Plan of Care development for individuals engaged in care
- Collaborate with members' care management entities and other providers, especially during transitions
- Assist members with choosing and/or changing their care management entity
- Make sure your organization is updated and active in NCCARE360

Crisis Coverage / First Responder

- Tailored Care Management agencies are required to arrange 24/7 crisis coverage. This includes coordinating care and sharing information
- If a member is receiving Tailored Care Management, **the primary service provider** is still considered the first responder after-hours and during crisis episodes.

Assisting Members with changing their CMA/AMH+

All agencies who provide services to members are responsible for assisting members if/when they want to change CMAs/AMH+.

- Members may change their CMA/AMH+ twice per year without cause
- Members may change their CMA/AMH+ anytime with cause
 - The organization or Care manager has not provided services to which the member is entitled
 - The organization or Care manager is unable to accommodate the member's needs
 - There is a change in the accessibility or availability of the organization or care manager (e.g., new locations, new hours)
 - The member and the organization/care manager agree that a change is in the member's best interest
 - The assigned organization leaves the Tailored Plan Network, is no longer certified, or is excluded from participation in federal health care programs
 - The member's care manager is no longer employed by the organization to which the member is assigned

To assist members with changing their CMA/AMH+, call Alliance Member Access line at 1-800-510-9132.

As a service provider, members will ask YOU questions about this process!

Tips for Working with CMAs/AMH+s

- Get to know the CMAs/AMH+s in your area
- Be responsive
- Educate your staff on Tailored Care Management
- Work through crossover functions/responsibilities
- Collaborate
- Be part of the team!



Services excluded from Care Management

There are some services that are excluded from Care Management because they are considered duplicative:

- Assertive Community Treatment Team (ACTT)
- High Fidelity Wraparound (HFD)
- Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-IDD)
- Care Management for At Risk Children (CMARC)
- Skilled Nursing Facilities (with expected stay > 90 days) *(Medicaid Direct only)*
- CAP C and CAP/DA programs *(Medicaid Direct only)*
- Primary Care Case Management (PCCM) *(Medicaid Direct only)*

Transitions to/from excluded services and Care Management

Providers of excluded services must work collaboratively with Care Management entities when a member is transitioning to or from that service.

There is a 30-day period at the beginning and end of services where both services may be provided and billed. This is to allow for Warm Handoffs to occur between the service provide and care management entity.

What is a Warm Handoff?

The NCDHHS defines a warm handoff as “time-sensitive, member-specific planning for Care Managed members or other members identified by either the transferring or receiving entity to ensure continuity of service and care management functions.

Warm Handoffs require collaborate transition planning between both transferring and receiving entities and as possible, occur prior to transition.”



Benefits of a Warm Handoff

- Continuity of Care
- Encourages engagement of family and member; allows them to speak up to team
- Encourages whole person, integrated care
- Builds relationships
- Provides a safety check
- Opportunity to correct or clarify information

Warm Handoff Scenario

Diane is receiving ACTT services. She has been steadily improving and is ready to step down to a lower level of care.

As the ACTT provider, what do you do?

Warm Handoff Scenario

- 1) At least 45 days prior to discharge, talk to Diane about Tailored Care Management options to see if she has a preference as to who her TCM provider will be.
- 2) With Diane present, call Alliance's Access Call Center at 1-800-510-9132 to inform them of the member's upcoming discharge, and that Diane will need to be assigned to a TCM provider (indicate preference, if applicable).
- 3) As soon as you are notified of the assigned TCM provider, reach out to that agency to facilitate the warm handoff (at least 30 days prior to discharge).



Questions?



Tailored Plan Provider Training Update

What you need to Know

- As part of the Tailored Plan, set to go-live on 12.1.2022, all physical and behavioral health providers will be required to take key trainings offered by the Tailored Plan
- Providers will receive notification from Alliance within the next week on how to submit up to 3 names of staff designated to take the required trainings in order for the Provider entity to demonstrate compliance with this requirement at the organizational level
- These identified staff will be set up in the new Alliance training platform called KnowledgePoint and will receive an email from Knowledge Point regarding registration and access to training
- Staff may upload appropriate training certificates if training is taken elsewhere
- Through KnowledgePoint, these staff will be able to complete all the training requirements for the organizational entity
- These trainings are also required for all provider staff working with members- please stay tuned for additional details coming regarding access to training for all provider staff

Required Trainings

Provider Orientation

Population Health

Infection Control and Prevention

NC Tobacco Free Campus

Early Periodic Screening Diagnostic Treatment
(EPSDT)

Into the Mouths of Babies(IMB)



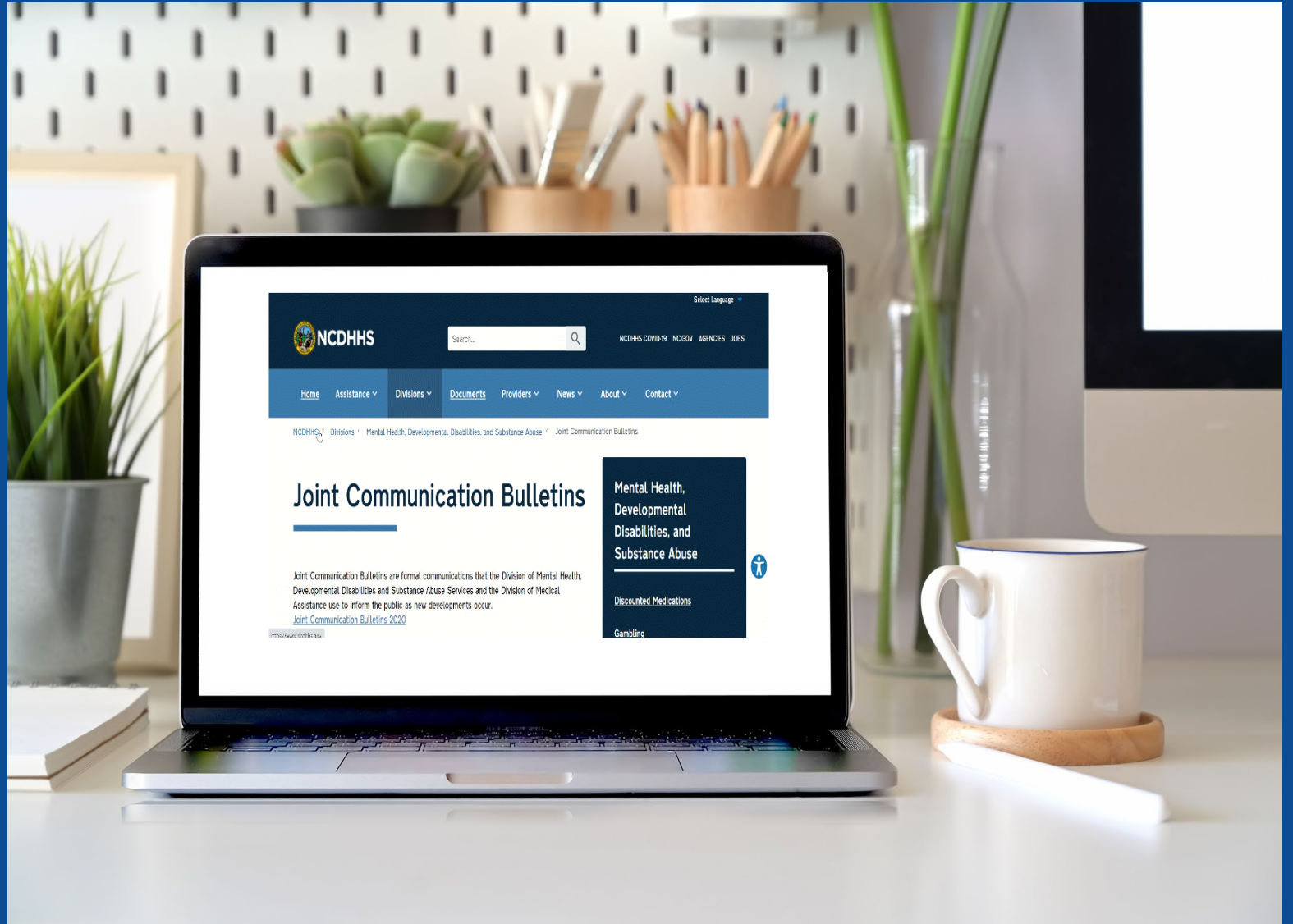
State Funded Residential Supports
and Supported Living
Service Update:

All Provider Meeting: September 21, 2022

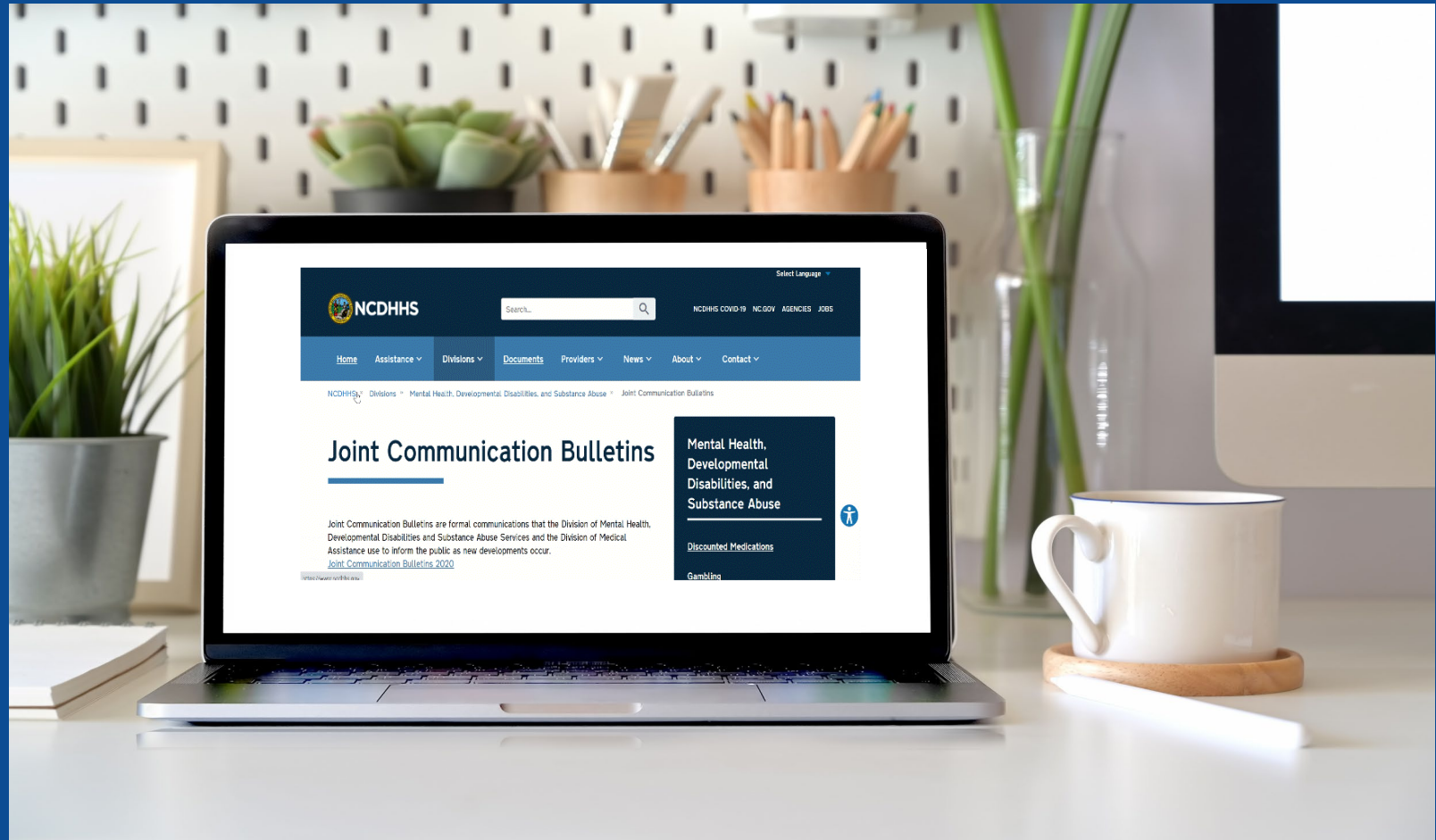
Key Points



Joint Communication Bulletin: J408 / J417- update



They can be
found here



J408: <https://www.ncdhhs.gov/media/15051/download?attachment>
J417: <https://www.ncdhhs.gov/media/15568/download?attachment>

Date to Remember



Providers are to continue submitting Service Authorization Requests (SARs) as they normally would for members who have expiring authorizations with the existing sunseting service. Requests will be authorized until November 30th. December 1st all sunseting services will be removed from NC Tracks and Alliance ACS system.

What codes are impacted?

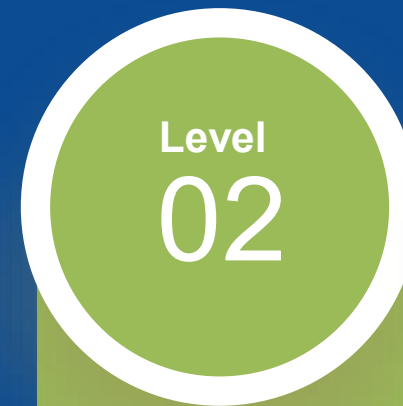


Current NCTracks/ Existing Alliance codes	Service Name/Description
YM850	Residential Supports
YP660	Day Activity
YP610	Developmental Day (Inc. Before/After)
YP020	Personal Assistance- Individual
YP760	Group Living- Low
YP770	Group Living- Moderate
YP780	Group Living- High
YP710	Supervised Living- Low
YM812	Supervised Living, 2 Resident
YM813	Supervised Living, 3 Resident
YM814	Supervised Living, 4 Resident
YM815	Supervised Living, 5 Resident
YM816	Supervised Living, 6 Resident
H2014	Developmental Therapy- Professional
H2014 U1	Developmental Therapy- Paraprofessional Group
H2014 UM	Developmental Therapy- Paraprofessional

New Billing Codes



YM846



YM847



YM848

What is required?



Prior authorization by the LME/MCO is required



Residential Supports and Supported Living services
require NC SNAP assessments.

Additional Information



LME/MCO Responsibilities



- Utilization Management and Care Management are creating a crosswalk and will automatically transition eligible members to the appropriate level of care.
- Eligible members are those with an active authorization and paid claims within the past 90 days.
- If there are no paid claims, that member will not be crosswalked.

LME/MCO Responsibilities



- Our Finance Team is completing the financial analysis to determine rates.



- Our Contracting Team will be adding the necessary codes to provider contracts on the back end. A formal request from providers will not be needed.

Things to Remember



Please note that NC SNAP training may be needed for provider staff

- Trainings are completed by NC DHHS every other month
- They have 2 virtual trainings during those months
 - There are 15 to 20 trainees in each class (registration is first come, first served)
- Lauren Spencer is the new NC SNAP trainer for DHHS- lauren.spencer@dhhs.nc.gov
- The Training schedule can be found here: <https://www.ncdhhs.gov/media/15137/open>



Registration for NC SNAP training is handled by the LME/MCO

- For Alliance, providers are to contact Rachel Porter RPorter@alliancehealthplan.org and submit a registration form

Please monitor Provider News for further updates regarding transition

Next Steps



FY23 Contracts and TP and Medicaid Direct contracts

Contract Update

This is a busy year for contracts. There are 5 potential contracts that providers are in the process of receiving for this FY

FY23 Medicaid Extension

FY23 State Extension

Tailored Plan Medicaid Contract

Tailored Plan State Contract

Medicaid Direct addendum amendment

Please note: FY23 contract extensions that have not been returned will result in a contract suspension which will result in not being able to receive payment until the contract is executed.

Tailored Plan Medicaid and State and Medicaid Direct Contracts are currently in the process of being sent out- if you have not received these contracts by 10/31/22 please contact your Provider Network Relations specialist

<https://www.alliancehealthplan.org/providers/network/provider-network-assignments/>

Reminder regarding NCTracks

Alliance no longer requires initial credentialing or re-credentialing applications from providers, including agencies, LIPs and LP's (associated clinicians). Alliance reviews the provider enrollment information from NCTracks to enroll and contract with providers. This change was effective May 12, 2022 and was made in accordance with NC Department of Health and Human Services, Division of Health Benefits.

Alliance is only able to utilize the information that is in NCTracks to make enrollment decisions and to be considered for a contract. Please ensure that you keep your NCTracks enrollment up to date. If your NPI, Taxonomy or Health Plan is suspended/terminated in NCTracks you will also be suspended/terminated in the Alliance ACS system which will result in claim denials

Clinician affiliations in NCTracks

Please ensure that clinicians are up to date with their affiliation status in NCTracks- if a clinician is not affiliated in NCTracks with the provider group/sites that they are working under claims will deny

How do I request to link a clinician to an existing provider?

Providers will submit a Request to Add Clinician request. <https://www.alliancehealthplan.org/document-library/60094/> **We will be transitioning to using the online tool only by the end of October.** Once that information is received it will be verified in NCTracks and exclusion checks will be completed. Clinicians and Agency staff will receive an enrollment disposition notification within 7 business days. In addition, Alliance no longer requires clinicians to complete applications through CAQH ProView, effective with this change.

****If a clinician is not enrolled in NCTracks you will receive an unable to process enrollment notification**** Please do not submit requests until the clinician is enrolled in NCTracks. Providers will be able to request retro-effective dates based on the NCTracks enrollment dates (for providers new to NCTracks). If a provider does not have a valid taxonomy, health plan or NCTracks is terminated you will also receive an unable to process enrollment notification.

If you have questions about the status of your enrollment with us, please contact us by email at enrollment@alliancehealthplan.org.

Please remember that your Provider Network Relations 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.



NC Child and Family Improvement Initiative

NC Child and Family Improvement Initiative



- Implementing a **statewide model to ensure seamless access to quality care** for youth and families served by the child welfare system regardless of where they live in North Carolina;
- Creating **ease of movement** for children in foster care who relocate throughout the state;
- **Alleviating administrative burdens** on providers who are involved in these movements across counties; and
- **Expanding and improving crisis services** for these children by increasing availability across the state.



Objective 1:

Formalize a **statewide network** to ensure access to care across NC for critical child behavioral health services (including Psychiatric Residential Treatment Facility (PRTF), Level IV, Level III, and Level II group and family).

Objective 4:

Offer **statewide crisis and transitional services** in the continuum of care and increase capacity based on assessed need.

Objective 7:

Adopt a standardized list of child specific **In-Lieu-Of Services** across all LME/MCOs.

Objective 2:

Establish a **standardized Transition of Care Policy** for youth involved with the child welfare system.

Objective 5:

Support coordination between LME/MCOs and Local DSS child welfare workers, including **co-location**, tailoring the approach to meet local DSS needs.

Objective 8:

Develop a **statewide referral system**, including a standardized referral form, for all residential and Therapeutic Foster Care providers.

Objective 3:

Establish a standardized Utilization Management and Review protocol allowing for **pass-through authorization for key services** frequently accessed by youth in foster care.

Objective 6:

Agreement to pay at least **100% of the Medicaid rate for out-of-network community-based behavioral health providers** to strengthen statewide service capacity.

Objective 9:

Establish with local DSSs a **standardized coordinated response framework** to address when and how a case should be escalated and key timeframes.

