



Provider Onboarding: Orientation

This training is under review, pending approval, and subject to change by the
North Carolina Department of Health and Human Services

Welcome to the Alliance Provider Network

- **Mission**

Our mission is to improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

- **Vision**

Our vision is to be a leader in transforming the delivery of whole-person care in North Carolina's public sector.

Providers are essential partners in our System of Care, providing evidence-based practices that achieve meaningful life outcomes for the citizens we serve.

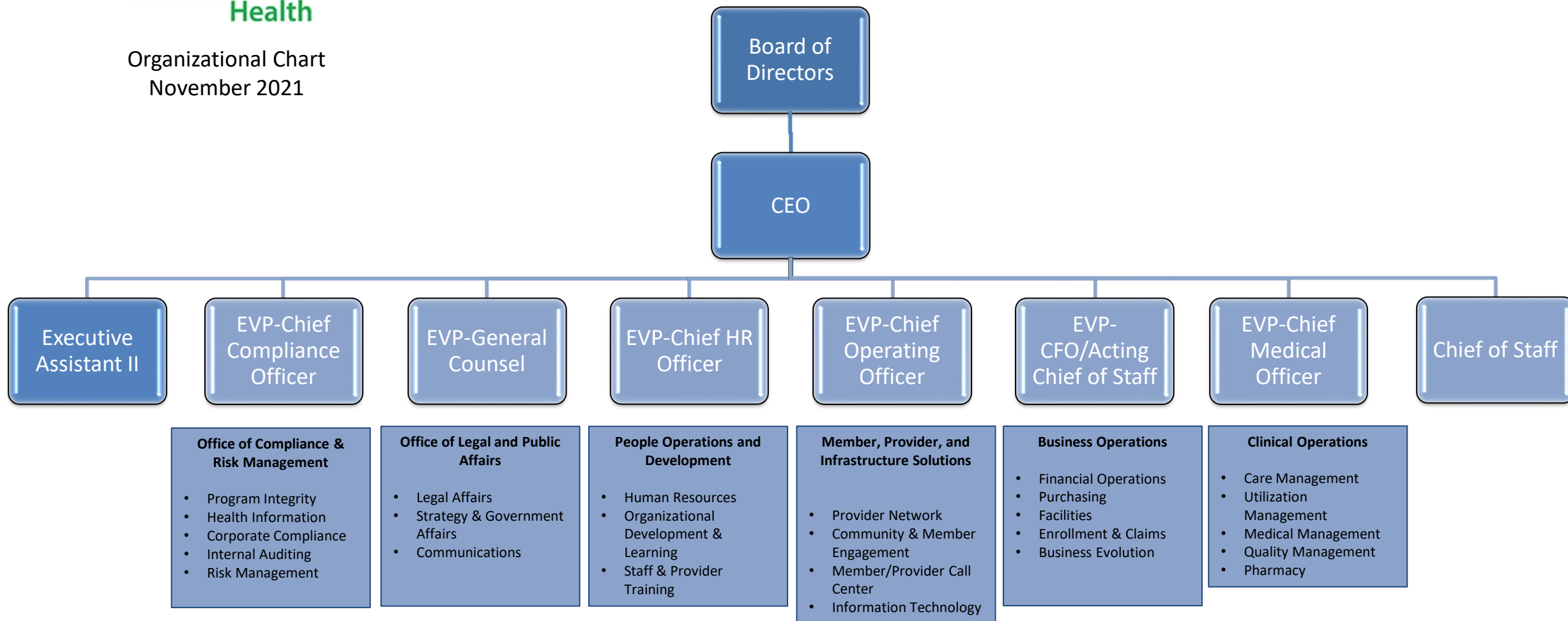
- Alliance's goal is to manage a comprehensive provider network that is integrated and responsive.
- We seek to maintain an environment in which providers can be successful both clinically and financially.
- We are committed to flexible, accessible, high-quality, recovery oriented and family-centered services which honor the dignity, respect the rights, and maximize the potential of the individual.

Orientation Topics

- Alliance Organization Chart
 - Medicaid Managed Care
 - Tailored Plan Quality Strategy
 - Tailored Care Management Overview
 - Provider Manual Overview
 - Advanced Directives
 - Medical Necessity Criteria
 - Clinical Practice Guidelines
 - Screening Tools
 - Claims System and Claims Resources Overview
 - Website Overview
 - Training Calendar
 - Benefit Plan
 - Value Added Services
 - Enrollment (State funds only)
 - Grievances and Appeals
 - Submitting Prior Auth Requests
 - Provider Helpdesk
 - Roles of Provider Relations Specialist
 - SDOH/NCCARES 360
 - Housing Resources
 - Better at Home
 - Value-Based Programs
 - Cultural Competency Plan
 - Disease Management
 - Fraud, Waste and Abuse
- (Orientation for Medicaid and State-Funded Services and training material will be available through the Alliance Provider Portal)

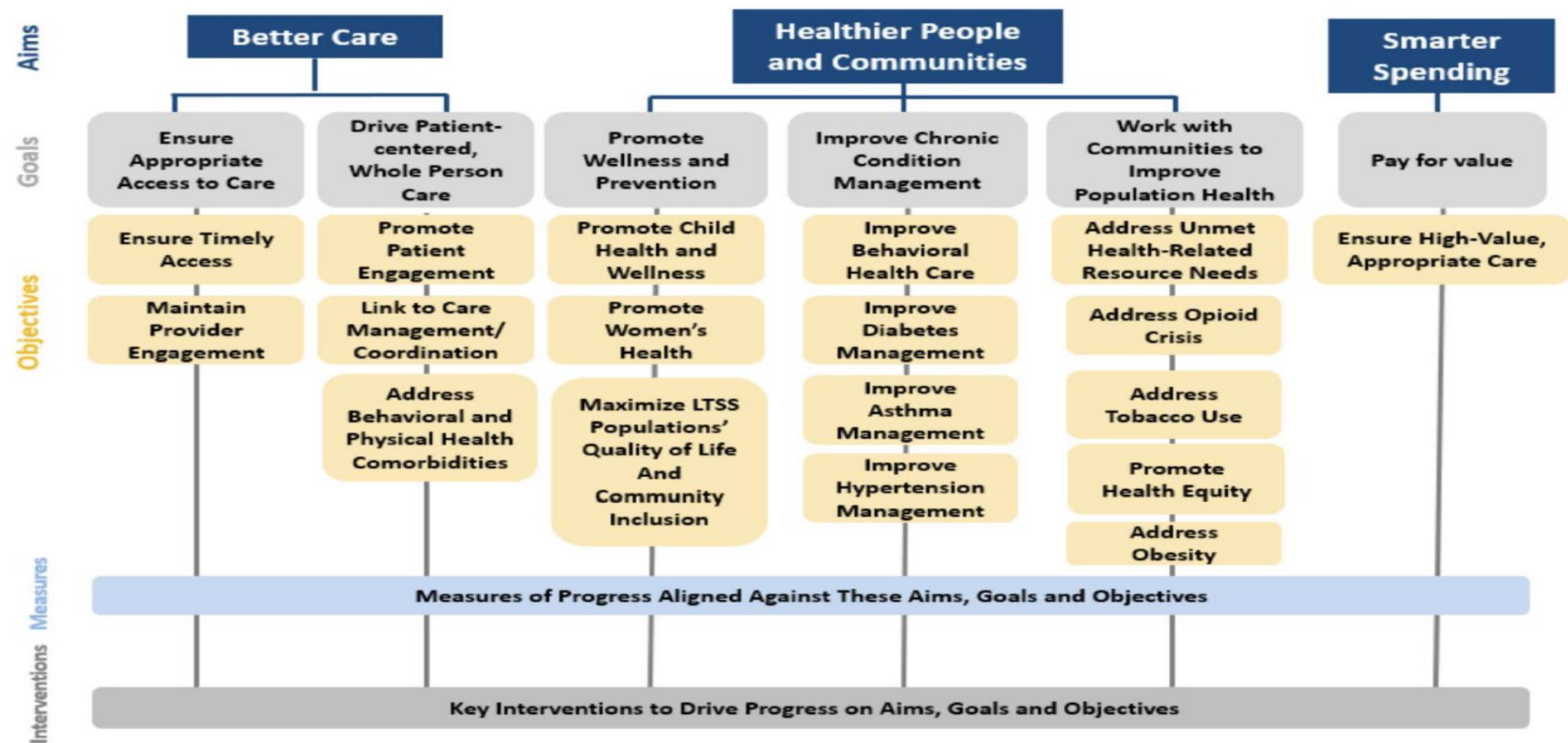


Organizational Chart
November 2021



Orientation: Tailored Plan Quality Strategy

Overview of the Quality Framework



Orientation: Tailored Plan Quality Strategy

- Each of the areas of focus are included in the state's population health programs.
- Practice Transformation Team will provide technical assistance in working with your agency to meet Alliance and State aims, goals and objectives.

NC Medicaid Managed Care Information

Type of Managed Care Plans

- **Standard Plans** – Prepaid Health Plans offering integrated behavioral health and physical health services. Serves most Medicaid members
- **BH I/DD Tailored Plans** – Managed Care Plans targeted for people with specialized behavioral health and I/DD needs. Offers integrated behavioral health and physical health services
- **Medicaid Direct** – fee for service model
- **EBCI Tribal Option-** Primary care case management entity created by the Cherokee Indian Hospital Authority. Available to members of a federally recognized tribe or people eligible for Indian Health Services within designated tribal option counties.
- **Children and Families Specialty Plan (CFSP)** – to be developed – statewide managed care plan for children in foster care

Population Mapping to Medicaid Plans

Plan	Population Served
Standard Plan	Most Individuals with Family & Children's Medicaid, NC Health Choice, Pregnant Women, NonMedicare Aged, Blind, Disabled.
Medicaid Direct	Medicaid/Medicare Dual Eligible CAP/C CAP/DA Waiver or Medically Needy People in DSOF/VA Homes or Long-stay Nursing Facilities Health Insurance Premium Program (HIPP)
BH I/DD Tailored Plan	People meeting Tailored Plan Eligibility Criteria People in Intermediate Care Facilities, Transitions to Community Living, State Funded Residential Facilities People on the Innovations or TBI Waiver

Children in Foster Care and ECBI eligible members can opt into Standard or Tailored Plans if eligible for Tailored Plan

BH I/DD Tailored Plans will also serve individuals requiring state-funded services

Tailored Plan Eligibility

- Enrolled in the Innovations or TBI waiver or on the waiting list
- Enrolled in the Transition to Community Living Initiative (TCLI)
- Have used a Medicaid service that will only be available through the BH I/DD Tailored Plan
- Children with Complex Needs, as defined in the 2016 settlement agreement

Tailored Plan Eligibility

- Have a qualifying I/DD diagnosis code
- Have a qualifying SMI, SED, SUD or suicide attempt diagnosis code and used a Medicaid covered service during the look back period
- Have an admission to a state psychiatric or ADATC facility
- Have had 2 or more admissions to an emergency department for a behavioral health concern, 2 or more behavioral health crisis services or 2 or more psychiatric admissions or readmissions within 18 months

Orientation: Tailored Care Management

- Embedded in the design of the Tailored Plans.
- Fully integrated – behavioral health, physical health, I/DD, TBI, LTSS< pharmacy and unmet health related resources.
- Available to all Tailored plan members throughout their enrollment
- Requires certification as an Advanced Medical Home + (AMH+) or a Care Management Agency (CMA).
- Can be provided by CMA, AMH+ or Alliance.
 - Goal is for 50% of care management to be provider-led during Year 1 of the Alliance Tailored Plan contract.
- NC DHHS Tailored Care Management Manual and other Tailored Care Management information available at [Tailored Care Management | NC Medicaid \(ncdhhs.gov\)](https://www.ncdhhs.gov/tailored-care-management).

Orientation: Provider Manual Overview

Includes:

- Alliance Mission and Values; Clinical Model, treatment philosophy and Community standards of practice
- Behavioral Health Benefits
- Pharmacy
- Medical
- Medicaid Waiver
- NC Innovations Waiver
- Other publicly funded services
- [Provider Manual](#)

Orientation: Provider Manual Overview

Provider responsibilities and Involvement	Credentialing and recredentialing
Alliance responsibilities	Selection criteria
Sufficiency of the provider network	Retention Criteria
Network provider types and specialties	Applying for different sites of services
Cultural competency	Reporting changes and leave of absence
Nondiscrimination and no reject requirements	Monitoring and evaluation
After hours coverage	Quality improvement
Quality of care	Documentation and confidentiality requirements
Provider communication and training	Records retention and disposition

Orientation: Provider Responsibilities

Stay updated and current with people we serve	Comply with Provider Network and contracting requirements
Be active, engaged and culturally competent members of System of Care	Comply with billing and claims processing requirements
Comply with Clinical, Utilization Management and Authorization requirements	Comply with documentation requirements and participate in all reviews and audits
Have a Business Continuity Plan and participate in community disaster response and recovery efforts	Obtain Member Advance Directives
Participate in Fraud, Waste and Abuse training and detection	Ensure Member and Recipient Rights, HIPAA and Privacy

Orientation: Advance Directives

- NC Medicaid provides information for Advanced Directives [here](#).
- Psychiatric Advance Directive or the Advanced Directive for Mental Health Care is a legal document that states the instructions for mental health treatment that an individual would want to receive if they are in a crisis and unable to make a decision for themselves at the time. Providers and care managers can assist individuals to develop this document.
 - Advanced Directives are active until cancelled by the individual.
 - Providers are expected to inquire about the existence of Advance Directives.
 - Advance Directives can be filed with the Secretary of State at: [North Carolina Secretary of State Advance Health Care Directives Advance Health Care Directives \(sosnc.gov\)](#).

Orientation: Medical Necessity Criteria

- Uses nationally recognized review criteria based on sound scientific medical advice.
- Physicians with unrestricted license (NC) and professional knowledge and/or clinical expertise related health care specialty participate in the discussion, adoption, application and annual review of all utilization decision-making criteria.
- Medically Necessary or Medical Necessity means Medically Necessary Covered Services and supplies as determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a Medically Necessary service may not be experimental in nature.

Orientation: Medical Necessity Criteria

- The determination of whether a Covered Service is Medically Necessary requires compliance with the requirements established in North Carolina Administrative Code, 10A NCAC 25A.0201, Alliance's agreement with the Department of Health and Human Services and EPSDT requirements as outlined in 42 U.S.C. § 1396d(r) and 42 C.F.R. § 441.50-62 for Medicaid members under 21 years of age.
- In accordance with 42 CFR 440.230, each Medically Necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

Orientation: Clinical Practice Guidelines

- Clinical Practice Guidelines clearly and concisely document what is known and what is not known about a condition or disorder for the treatment of patients with the ultimate goal of improving care. These guidelines reflect evidence based treatment, but are not intended to be service definitions, or medical necessity criteria, though they may overlap.
- Alliance utilizes Clinical Guidelines that have been nationally and internationally developed by expert sources. When national guidelines are unavailable, Alliance creates workgroups consistent of staff, network providers and experts in their field. All guidelines are adopted by the Alliance Provider Quality Committee and are intended to aid providers and members in the clinical decision making process.
- *Clinical Practice Guidelines* adopted by Alliance Health (Medicaid) are at: [Alliance Clinical Guidelines » Alliance Health \(alliancehealthplan.org\)](https://alliancehealthplan.org/alliance-clinical-guidelines)

Orientation: Screening Tools

- Screening instruments available at the following link have been reviewed by Alliance Health's Committee on Provider Quality for use. This committee consists of network provider representatives, network clinicians, and internal Alliance Health employees. Screening instruments are evidenced-based and/or considered best practices. The committee reviews and updates this screening program at least annually, and as needed when new research, evidence, and/or information becomes available.
- <https://www.alliancehealthplan.org/providers/network/program-resources/co-occurring-mh-sud-diagnoses-screening-program/>

Orientation: Alliance Claims System Overview and Claims Resources

Topics:

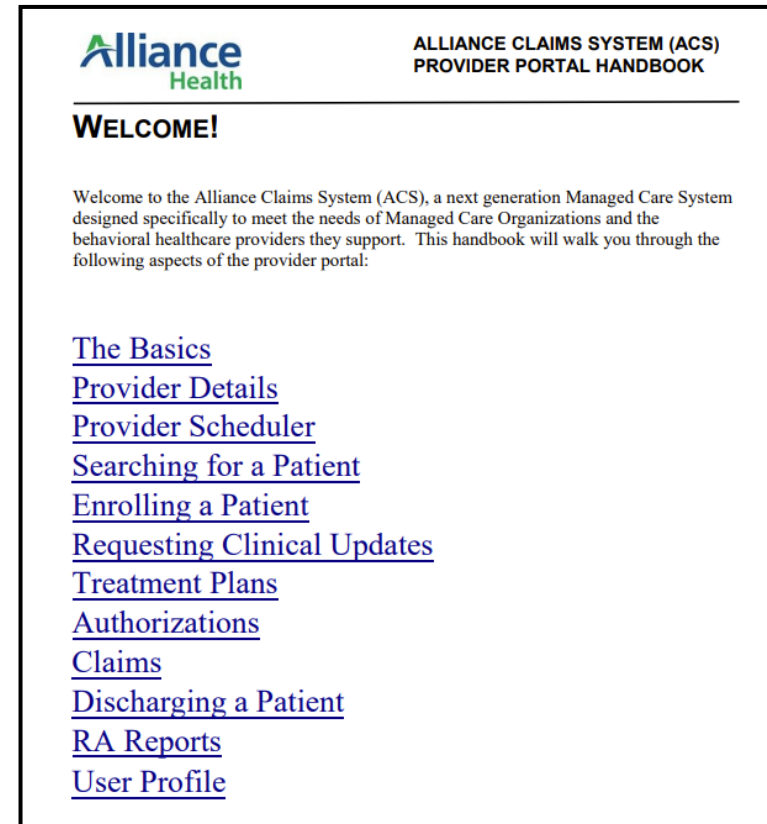
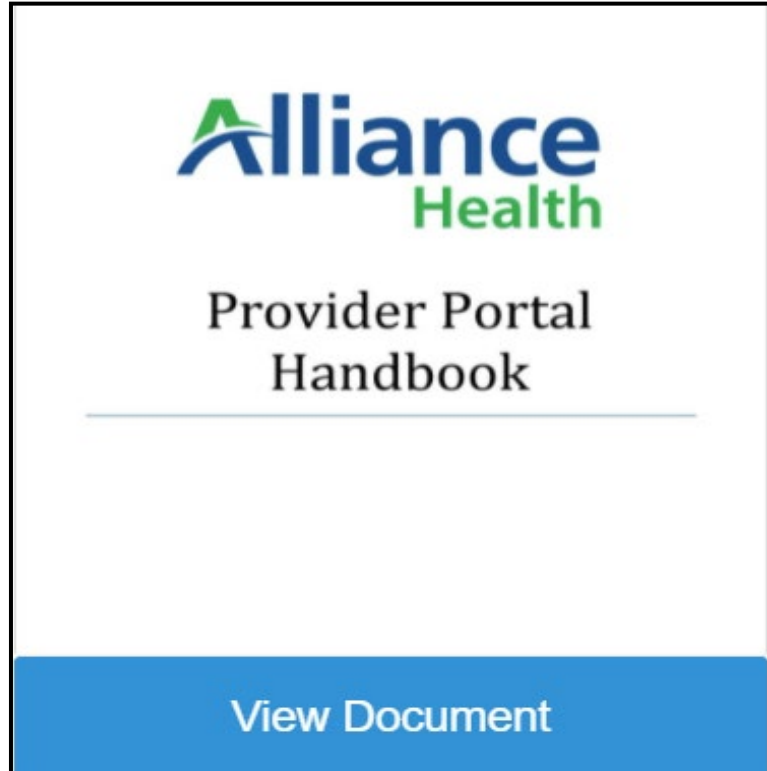
- ACS overview
- Claims Submission
- Timely Filing
- Claims Resources
- Checkwrite Schedule

Alliance Claims System

Provider Portal: <https://alliancehealth.okta.com>

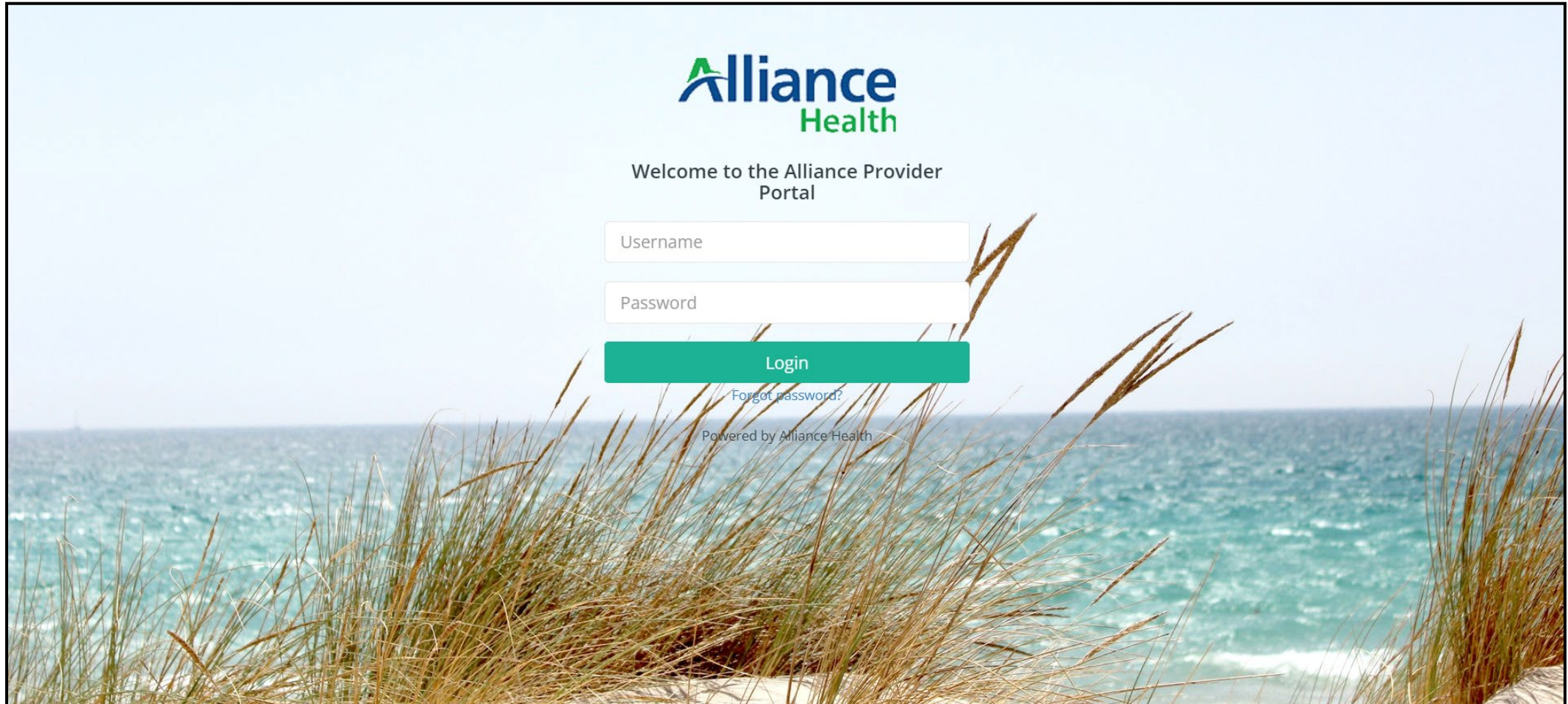
Provider may submit claims in ACS Provider Portal without any fees.

[ACS Provider Portal Handbook](#)



Alliance Claims System

Alliance Claims System (ACS)

The image shows a login portal for Alliance Health. The background is a scenic view of a beach with tall, golden-brown grass in the foreground and a blue ocean under a clear sky. The Alliance Health logo is centered at the top. Below it, the text 'Welcome to the Alliance Provider Portal' is displayed. There are two input fields for 'Username' and 'Password'. A green 'Login' button is positioned below the password field. A link for 'Forgot password?' is located below the login button. At the bottom, it says 'Powered by Alliance Health'.

Orientation: Claims Submission

- **Before Submitting a Claim**
 - Ensure that your provider entity is set up accurately in ACS
 - Review the contract section to ensure all contracted codes are reflected for the appropriate sites where services are rendered/billed
 - Review the clinician section to ensure that all credentialed clinicians are reflected with accurate license/NPI/taxonomy information
 - Review any provider-specific rates that may need to be applied to claims based on provider contract or Single Case Agreements

Orientation: Claims Submission

- **Determine your method of claim submission**
 - If submitting claims via paper forms, ensure that the required Alliance approval form has been received and approved. **If not approved, paper claims will be returned, unprocessed.**
 - **Address:** Alliance Health, ATTN: Claims Dept., 5200 W Paramount Parkway Ste 200, Morrisville, NC 27560
 - If submitting claims via ACS Provider Portal by direct keying into portal, ensure that your ACS login is working and not shared with any other user
 - If submitting claims electronically using EDI files, be sure your entity is EDI certified with Alliance
 - Ensure that the TPA is current and accurate and that the appropriate clearinghouse is reflected, if applicable
 - Work with the Alliance EDI team to conduct file testing
 - Alliance EDI Payor ID: 23071
 - The sFTP for Trading Partners to submit 837 files and receive their response files, 835's, and daily dump files will be acsftp.alliancehealthplan.org. The providers will use the same credentials (username and password) to access the sFTP that they use in ACS. The sFTP will use the same port (22) that is used for sFTP connections.
 - The location of the file share to submit files to ACS (in) or pick-up files produced by ACS (out) is: \\itcfs01-p\\AllianceFS\\Incoming and \\itcfs01-p\\AllianceFS\\Outgoing
- **Ensure that required EFT information has been received and processed by the Alliance Accounts Payable Team**

Orientation: Claims Submission

- Alliance Health uses ACS (Alliance Claim System) to process provider claims. Providers should routinely review their agency's information in the ACS system to ensure that all contact information and contract information is up to date. To access the system, providers must submit an ACS Access Request form to acssupport@alliancehealthplan.org.
- **Submission:** Claims can be submitted electronically using EDI 837 files OR they can be manually keyed into the ACS Provider Portal.
 - Electronic submission requires EDI certification, an Electronic Claim Submission Agreement (ECS), Trading Partner Agreement (TPA, and file testing with our EDI Specialist. You can contact the EDI Specialist with questions or support at: EDInotifications@alliancehealthplan.org
 - Portal submission requires that providers be set up with individual ACS (Alliance Claim System) login information. You can request access and/or ask questions about the ACS Provider Portal by calling 919-651-8500, option 2 for IT issues or by emailing: acssupport@alliancehealthplan.org
- If additional documentation is needed for claims processing, the documents can be uploaded through the ACS Provider Portal or send electronically on a 275 file.

Orientation: Additional Documentation Needed

- Claims requiring manual pricing or administrative/clinical review, will pend for manual processing. Additionally high dollar claims will pend for manual review. Claims that reach a high dollar threshold will also pend for further review. The high dollar thresholds are: Hospital Inpatient- \$250K; Hospital Outpatient- \$75K; Professional- \$25K.
- When a claim is pended for manual review, Claims Research Analysts will review the claim and identify required documentation. If required documentation is not present at time of claim processing, the claim will deny with the appropriate denial reason specifying the documentation type not received. If the required documentation is present at time of the claim processing, the Claims Research Analyst will continue to process claim. The claims status will appear on 835 response files, in the provider portal, and on remittance advice reports for providers to identify if further submission is needed. If additional documentation is needed, the documents can be uploaded through the ACS Provider Portal or sent via electronic 275 file.
- When Manually processed claims are denied due to documentation or information not received, the denial is communicated via 837 response file, Provider Portal, and Remittance Advice Report. Providers may submit a new claim with the required documentation within the appropriate filing timelines for the claim.

Orientation: Additional Documentation Needed

- **Ambulance Services-** processing requires validation of pick up and drop off codes as well as county. If information not provided on the claim, claim will deny for “Ground Mileage Not Payable for County Transportation and/or Ambulance Trip Information Missing or Invalid.”
- **Hearing Aid Services-** (specific codes: G5014, V5050, V5060, V5130, V5264, V5267, and V5274)- processing requires review of invoice. If required documentation not present at time of adjudication, claim will deny for “Service Requires Invoice for Processing.”
- **Physician Administered Drug Program (PADP)-** services require invoice for processing. If required documentation not present at time of adjudication, claim will deny for “Service Requires Invoice for Processing.”
- **High Dollar Threshold Claims-** high dollar claims require validation via itemized statements. If required documentation is not present at time of adjudication, claim will deny for “Medical Records/Itemized Statement is not Included with Claim.”
- **Modifier 66 Services-** if a claim is received with a service code appended with modifier 66, processing requires documentation reflecting all surgeons information that performed the service. If required documentation is not present at time of adjudication, claim will deny for “Documentation Indicating All Surgeons on Modifier 66 Not Received.”
- **Therapeutic Abortion-** services require signed consent form to be reviewed. If required documentation is not present at time of adjudication, claim will deny for “Abortion Consent Statement Missing or Incomplete.”
- **Sterilization-** services required signed consent form to be reviewed. If required documentation is not present at time of adjudication, claim will deny for “Consent Statement Missing or Incomplete.”
- **Child Medical Exam (CME)-** services require CME Checklist. If required documentation is not present at time of adjudication, claim will deny for “CME Checklist Missing or Incomplete.”

Orientation: Claims Timelines

- **Claims Submission Timelines:**

- State Benefit Plan claims must be received (accepted into ACS) within **ninety (90)** calendar days of the date of service. Replacement claims are possible, but must be received within the **same 90-day** window from date of service.
- Medicaid Benefit Plan claims must be received (accepted into ACS) one hundred eighty (180) calendar days of the date of service. Replacement claims can be submitted within the same 180-day window from date of service.
- Coordination of Benefits is required. Secondary claims will be accepted within one hundred eighty (180) days of date of service.

Orientation: Claims Timelines

- **ACS Claims Processing Timelines:**

- The daily cutoff for nightly adjudication in ACS is 5 p.m.
- Claims status is updated in the provider portal (via the Download Queue) each business day.
- Remittance Advice Reports are available in the provider portal the week following processing.
- Check write Cycles are weekly. The current schedule is available on the website: www.alliancehealthplan.org .
Navigate to the “Providers” tab and then the “Finance and Claims Resources.”

- **Medical Claims Adjudication and Payment Timelines:**

- Received claims have an initial adjudication within 18 days of receipt of claim.
- Approved claims have a payment within 30 days of approved adjudication. Pended claims are paid or denied within 30 days of receiving the requested additional information. Approved claims paid outside the timeline are subject to interest and penalty payments to the provider. Late payments will bear interest at the annual rate of 18% beginning on the date following the day on which the claim should have been paid. Penalties equal to 1% of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid.
- There is no right to appeal for claims denying for untimely filing. However, there is a Reconsideration Review process outlined in the Billing & Enrollment manual for situations where timely submission of claims was not possible due to a system issue or other extenuating circumstances as deemed reasonable by the Reconsideration Review team.

Orientation: Claims Coordination of Benefits

- **Coordination of Benefits:**

- Effective 01/01/16, the Provider must submit a secondary claim within 180 days of the date of service to be within the timely filing deadline. If the claim is submitted via Provider Portal, the primary Explanation of Benefits (EOB) must be uploaded to the patient portal at time of claim submission. To upload the EOB within Patient Maintenance: Locate the patient, click on the row to expand and then click on the 'Details' button to go into the details. On the Base Tab, there is an option for 'Clinical Docs' which is where you will upload the EOB. Please choose the 'Clinical Doc Type' as 'EOB'. The effective and end dates should be the dates of service included on the document not the date of the upload.
- Audits are completed monthly for EOB uploads, claims will be recouped if an appropriate EOB is not uploaded at time of claim submission.
- Documentation from the Primary Payer must be uploaded and/or submitted to Enrollment team in order to add or terminate primary coverage in the ACS system and NC Tracks.

Orientation: Secondary Claims

Submitting Secondary Claims and uploading Documents:

Submission of secondary claims via the Provider Portal will require that the related EOB are uploaded into ACS. Providers should upload the EOBs at the time of claim submission. When keying secondary claims you must enter the information needed from the primary EOB as highlighted below. “Coordination of Benefits (COB) amount” refers to the value paid by primary insurer and “COB Allowable Amount” refers to the value the primary insurance allows for the service billed and “Patient Responsibility” refers to the value the primary insurance applies to the patient. You must also include a **valid** “COB Reason” in order for the claim to be recognized as a secondary claim.

Submission of secondary claims via electronic 837 file do not require uploaded EOB, but COB fields must be complete.

For approved Secondary claims, Alliance Health will either:

1. Pay the difference up to the Medicaid contracted amount, or
2. Not pay any additional amount if primary pays more than Medicaid allowed amount.

Orientation: Claims Resources

- **Alliance Health website:** [Publications, Forms and Documents - Alliance Health \(www.alliancehealthplan.org\)](https://www.alliancehealthplan.org) – this will allow providers to download the Billing & Enrollment Manual, ACS Provider Portal Handbook, Fee Schedules, Benefit Plan detail, and other useful documents, forms, and publications.
- **ACS University:** once a provider logs into the ACS Provider Portal, they can link to ACS University which will provide links to webinars and guides to specific modules within ACS.
- Alliance Health offers Technical Assistance via in-person and remote technical support. This can be arranged by contacting claims@alliancehealthplan.org
- **Direct Link to Billing & Enrollment Guide:** [Billing & Enrollment Manual Fiscal Year 2022 \(www.alliancehealthplan.org\)](https://www.alliancehealthplan.org)
- **Claims Manager:** Tina Everett, teverett@alliancehealthplan.org or 919-651-8817
- **Claims Supervisors:**
 - Marilyn Madison, mmadison@alliancehealthplan.org or 919-651-8450
 - Michelle Evans, mevans@alliancehealthplan.org or 919-651-8736

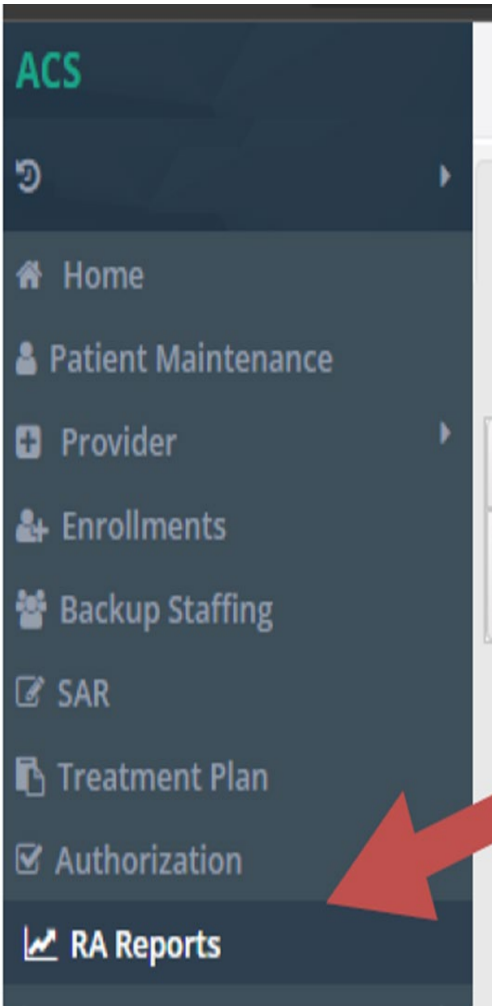
Orientation: Checkwrite Schedule

- Checkwrite Cycles are weekly.
- The current schedule is available on the website:
www.alliancehealthplan.org/document-library/75179/

Orientation: Checking Claim Status

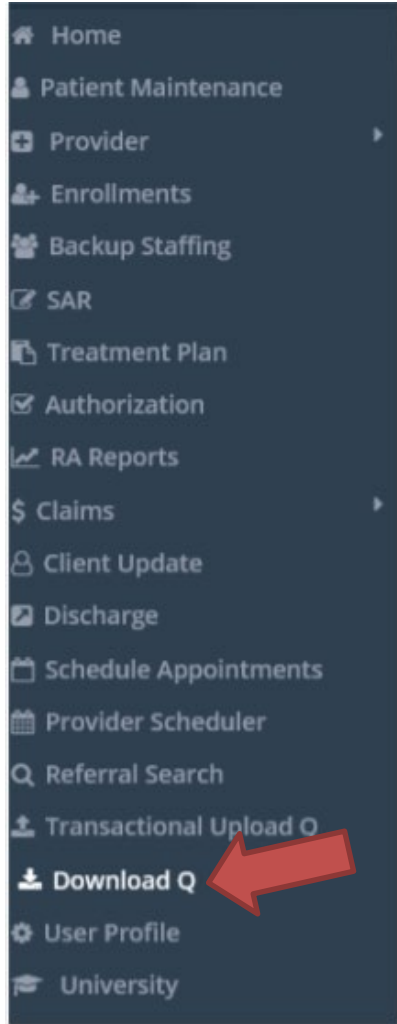
- After Claim submission, you can check your claim status by either pulling your Remittance Advice or utilizing the Download Queue in the Alliance Claims System
- The Remittance Advice will be available following every checkwrite date.
- The Download Queue updates daily to show all claims submitted within the last 6 months.

Orientation: Remittance Advice



- RA Reports will be available following every checkwrite date. Providers can select RAs by date range according to check date or claim processing date.
- The user can search by a specific check number, check date or claim processing date. The RA will appear in the box below for the user to retrieve. The user can choose a Standard or Expanded view. Expanded view is for institutional claim data.
- The RA is grouped by four adjudication decisions: Approved claims, Denied claims, Sub-Capitated claims and then by Recoupments (Credit Memos).
- From within each adjudication group, there are sub-groups broken down by funding source (State or Medicaid).
- From within the funding source grouping, it is then sub-grouped by consumer.
- Lastly with in the consumer grouping, claims are in order by date of service, with subtotals under each grouping.

Orientation: Download Queue



- To access the ACS Provider Portal Download Queue you will need an FTP Password.
- If you are a provider who is EDI Certified, but do not use a clearing house, your download queue will contain Response Files, Submitter Reports, Provider Dump files and 835s
- If you do use a clearing house, you can request to receive a copy of your 835s that are sent to your vendor.
- The “Current_Claims” file will show current claim status up to 6 months from claims submission, this file is updated daily

Orientation: Claims Reprocessing

- All reprocessed claims will appear on your Remittance Advice and/or Download Queue
- A few reasons for claims reprocessing includes:
 - Retro Medicaid
 - Authorization change
 - Contract change
 - Miscellaneous system updates

Orientation: Claims Issues

- Any significant claim issues and changes that affect provider payment cycles will be announced through our Provider News. Known system issues will also be published on the website.
- Support for individual provider-identified claims issues is available by using the PN Helpdesk phone queue, Claims phone queue, Claims email queue, or direct outreach to Claims Research Analysts.

← → ↻ alliancehealthplan.org/provider-updates/

Looking for information on the Alliance Health Tailored Plan? Visit AllianceTailoredPlan.org.

24/7 Access & Information Line: **800-510-9132** Español 🌐

Alliance Health

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Home / Provider Updates

Provider Updates

These updates support providers by highlighting new classes, trainings, resources, chats, procedures, and programs. You will also find advice and guidance for providers. [Subscribe to updates](#) or [See Alliance News](#)

Subscribe ✉

Orientation: Alliance Website Overview

- The Alliance website contains useful information that will help you work efficiently with Alliance and provides resources for assisting our members.
- In addition to publicly available information, the Alliance website provides a link to our [Provider Portal](#) that contains several useful applications, and other helpful resources designed to simplify your work with Alliance.
- Applications available through the Portal
 - ACS (Claims/UM system)
 - Grievance and Appeal submission
 - Jiva Portal
 - Provider Information Update Tool (report provider accreditation and changes regarding ability to accept referrals)
 - Provider Resources
 - Training and Event Calendar

Alliance Provider Portal Information

- Alliance uses a unified provider portal that allows providers to access tools and applications through a single sign-on function.
- Once a user logs into the Alliance Provider Portal, the user will have access to applications based on requested permissions
- To request access to the Alliance Provider Portal please email acssupport@alliancehealthplan.org
- To access the portal user guide: [71742 \(alliancehealthplan.org\)](#)
- To access the portal: [Alliance Health - Sign In \(okta.com\)](#)

Orientation: Alliance Website Overview

Other Important Weblinks (additional topics related to physical health management and oversight as they are developed)

Note: Links are not currently active. Links will be updated to direct to TP website.

- [Benefit Plans](#)
- Provider Updates and Support
- Provider Training Resources
- Shared Decision Making Tools
- Provider Practice Transformation
- Electronic Visit Verification (EVV)
- Provider Network Assignments

Orientation: Benefit Plan

- **Benefit Plans** – needs further development
 - Several plans being setup in ACS – Sean Schreiber
- Link to Benefit Plan: <https://www.alliancehealthplan.org/services/>

Orientation: Benefit Plan

Alliance's website will provide Clinical resources to include approved clinical coverage policies, process for submitting prior approval, forms and a look-up tool to inform providers if the procedure code requires prior approval. If the service does require PA, the tool will inform the provider where to submit for authorization.

Orientation: Value-Added Services

- Alliance offers our Medicaid eligible Tailored Plan Members a number of Value-Added Services aimed at improving and supporting overall health and recovery
- Members can access these benefits by contacting Alliance member and Recipient Services or through their care manager
- Providers can assist members in accessing these benefits by coordinating with Member care managers.
- Alliance offers the following Value-Added Services (Detailed information and eligibility requirements will be published on our website)
 - Carpet Cleaning/Vacuum and HEPA Filters/Window and Portal Air Conditioning Unit
 - GED and Literacy classes
 - Healthy Cooking Classes/Tobacco Cessation Assistance
 - Free smartphones, talk, text and data plans
 - Youth Camps

Orientation: Enrollments (State Funds Only)

- **Medicaid** recipients are **automatically enrolled** in ACS.
- Enrollments are used to request **State funding** for a consumer who **does not** have insurance. (Medicaid, Medicare or Private Insurance)
- Enrollments **require** a compatible diagnosis and NCTracks Benefit Plan to indicate the disability they are receiving services for.
- Alliance **does not** accept enrollment requests for **Medicaid** recipients unless they are receiving a service that is **not covered** by Medicaid. In this case, please **indicate** the **procedure code** being provided in the comment section for review.

Orientation: Enrollments

- Client updates are used to add or update any information in a consumers record who have State funding.
- Please be advised, you can not request state funding using a Client Update request.
- Enrollments and Client Update requests are subject to review by Alliance's Eligibility & Enrollment Staff.
- All requests are reviewed for completeness, eligibility, residency and household income.

Eligibility For Enrollment in State-Funded Services

For Behavioral Health Services:

- Income at or below 300% of poverty and
- Insurance Status/Other Finance Resources:
 - **Uninsured or insured with third-party insurance (including Medicaid) that:**
 - Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage or
 - Covers the State-funded substance use disorder service, but associated cost sharing is unaffordable

Eligibility For Enrollment in State-Funded Services

Intellectual and Developmental Disabilities (I/DD) and Traumatic Brain Injury (TBI) Services

- No income limits
- Insurance Status/Other Finance Resources:
 - **Uninsured or insured with third-party insurance (including Medicaid) that:**
 - Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage and
 - Applies for Medicaid coverage

Orientation: Enrollment Resources

- **Enrollment Instructions:**
<https://www.alliancehealthplan.org/?s=Enrollent+Guidelines&submit=Search>
- **NC Tracks Benefit Plan Descriptions:**
<https://www.alliancehealthplan.org/document-library/59459>
- **DMH NC Tracks Benefit Plan, Diagnosis and Service Arrays:**
<https://www.ncdhhs.gov/providers/provider-info/health-care/nctracks/fy2021documents>
- **E&E Staff 919-651-8500 option 3 or**
eligibilityconfirmation@alliancehealthplan.org
- **E&E Supervisor, Tasha Jennings** tjennings@alliancehealthplan.org

Orientation: Filing Grievance and Appeals

- Alliance offers a provider appeals system that is distinct from the members appeal process.
- Providers may submit an appeal through the provider web portal, certified US Mail, email, or in person at an Alliance office. The appeal will be accepted when it is accompanied by a completed Provider Request for Reconsideration form and is received within thirty (30) calendar days of when the provider received the notification of the decision or when Alliance should have taken a required action and failed to do so.

Orientation: Filing Grievance and Appeals

- Providers may request an extension of the appeal deadline of up to thirty (30) calendar days for good cause. A request for an extension must be submitted in writing using the Provider Request for Reconsideration Extension form via the provider web portal, certified US Mail, email, or in person at the Alliance home office no later than twenty (20) calendar days of when the provider received the notification of the decision. Extension requests are reviewed by Alliance to determine if good cause exists.

Orientation: Filing Grievance and Appeals

- Appeals of an Alliance decision to suspend or withhold provider payment will be limited to whether Alliance had good cause to initiate the withhold or suspension of payment and will not address findings of fraud or abuse.
- The provider will be offered the opportunity to participate in person or by telephone when the provider has appealed whether Alliance had good cause to withhold or suspend payment to the provider.
- The appeal will be scheduled, and a written decision will be issued within fifteen (15) business days of receipt of the appeal request.
- Grievances will be resolved in a timely manner. The Provider Grievances process includes those that are received when remedial action is not requested.

Orientation: Submitting Prior Authorization Requests

- Providers submit Alliance Service Authorization Request (SAR) through the Provider Portal.
- Utilization Management (UM) uses the information on the form to make clinical determination for the member's needs.
- If the SAR is not complete, this will delay the approval process
- Alliance monitors providers for accuracy and completeness in submitting SARs.
- Please check Alliance's [UM webpage](#) for more information.

Orientation: Accessing the Provider Helpline

- The **Alliance Provider Helpdesk** is available to help find answers to provider questions about contracting, authorization, billing, claims, enrollment and credentialing/enrollment, ACS, or other issues
- **The Helpdesk is available:**
 - Monday-Saturday
 - 7:00 a.m. to 6:00 p.m.
 - 1-855-759-9700
- **Email:** providernetwork@AllianceHealthPlan.org

Orientation: Role of the Provider Network Relationship Specialist

- All Alliance network providers are assigned a Provider Network Relationship Specialist
- Provider Network Relationship Specialists assist providers through all aspects of enrollment and contracting
- Provider Network Relationship Specialists help orient and onboard providers into the Alliance Network and ensure providers have access to needed tools and resources
- Serve as a single point of contact who is trained to research and resolve provider inquiries
- Your Provider Network Relationship Specialist will contact you either monthly or quarterly

Orientation: Social Drivers of Health

- Alliance assesses members for Unmet Health related needs.
- CMAs and AMH+ will also assess members for Unmet Health Related needs.
- The Unmet Health-related Needs is captured during the Care Management Comprehensive Assessment.
- Both Alliance Care Managers and Provider –led Care Managers will address members unmet health-related needs.
- Use the state recommended questions.

Orientation: NCCare360

- To facilitate referrals for members to meet their unmet health-related needs, Alliance recommends using NCCare360.
- NCCare360 is a statewide coordinated care network used to connect individuals to local services and resources.
- If you are not using NCCare360, please go [here](#).

Orientation: Housing Resources

- Providers can find housing resources [here](#).
- Housing resources include:
 - Independent Living Initiative
 - Restoring Hope Initiative
 - Permanent Housing Support
 - Transitions to Community Living
 - DASH Program
 - Better at Home

Alliance also does work with local landlords.

Orientation: Better At Home

Housing is an important social driver of health and argumentatively the leverage point for all other whole-person interventions. Yet the complex systems of homelessness, housing, and healthcare can be difficult to navigate. Our Better at Home campaign aims to help increase provider competency surrounding community living and tenancy supports through monthly trainings. People are *Better at Home*.

- Alliance offers monthly trainings for Providers for our Better At Home Program. The Better at Home.
- The monthly trainings can be found [here](#).

Better at Home Training Topics

✓ Applying for Independent Living Initiative Funding	✓ Olmstead, More than a Mandate
✓ First things First: Understanding Housing First/ Permanent Supportive Housing	✓ Budgeting with Little Income
✓ Finding the Way Home: Housing Search 101	✓ Housing Search Strategies
✓ Fair Housing: It's the Law	✓ Myths about Tobacco Use
✓ How it's Written Matters: Reasonable Accommodations	✓ Lawful Removal: The Eviction Process
✓ Opportunities to Contribute: Community Inclusion	✓ Affordable Housing Options
✓ Housing Inspections are an Intervention	✓ What's in Your Lease?
✓ What Gets in the Way? Tenant and Landlord Rights and Responsibilities	✓ Keeping the Voucher: Understanding Subsidy Administration
✓ What the Difference: Targeted Housing and Public Housing	✓ What to Say and <i>Not to Say</i> : Landlord & Property Manager Engagement
✓ Knock, Knock: Understanding the Homeless Service System	✓ Supportive Housing through Harm Reduction
✓ Developing Housing Goals for Each Stage of Tenancy	✓ Understanding Transition to Community Living (TCLI) Eligibility
✓ Encouraging Supportive Employment	✓ Have a Voucher, Now What?
✓ NC Rental Laws and Statutes	✓ Tobacco Policies
✓ Back to Basic: Finding a New Home	✓ Landlord Tenant Disputes

Orientation: Value-Based Programs

- Alliance offers an array of Value-Based Payment (VBP) models aimed at improving health outcomes for our members and promoting efficient clinical care
- Our VBPs align with the Health Care Payment Learning and Action Framework, with each including quality targets
- Models are available to an array of behavioral health providers, including providers of residential services, psychiatric inpatient services, peer support, supported employment, child in-home treatment services and ACTT and CST providers that support members that are part of the Transition to Community Living Initiative
- Alliance has developed a pay for performance model to promote Alliance and State quality aims that is specifically designed for Care Management entities and primary care providers.

Orientation: Cultural Competency Plan

- Alliance is committed to ensuring that every individual in our community receives H= high-quality and equitable care.
- Alliance's Cultural Competency Plan can be found [here](#).
- Alliance priorities include:
 - Achieving quality improvement and innovation on our diversity tactics.
 - Promoting an ideal organizational culture
 - Providing opportunities for leadership engagement and visibility
 - Reinforcing Alliance's zero tolerance policy for discriminatory behaviors.



Orientation: Cultural Competency Plan

- Alliance requires cultural and linguistic competency in delivery of services, linked to quality of care and emphasized in policy, practice, procedures, and resources.
- Providers are required to develop and submit a Cultural Competency Plan and comply with cultural competency requirements set forth.
- Alliance requires Licensed Individual Practitioners (LIP) take a Cultural Competency training annually.

Orientation: Disease Management Programs

Disease management programs are structured treatment plans that aim to help people better manage chronic disease and reduce healthcare service use and cost related to avoidable complications as well as maintain and improve quality of life. Alliance offers the several disease management programs to help our members better manage certain chronic conditions:

- Asthma Management
- Hypertension Management
- Diabetes Management

Asthma

Program Objective: To decrease the number of Members who experience exacerbation of asthma symptoms, e.g. mild to severe wheezing, cough, and potential emergency room visits that may result in inpatient admissions.

Program Description: Our program will focus on educating Members on their asthma triggers, for example, pollen, mold, or tobacco smoke. Asthma is one of the most frequent causes of hospitalizations among children in the State. In the 10 most urban counties the prevalence rate was 11.7%. Thirteen percent of children (0-14 years of age) on Medicaid identified by claims data had an indication of asthma. CDC data (2020) for adults in the state reported 645,784 or 7.8% had a diagnosis of or were treated for asthma. Etiology is linked to genetic, environment, or occupation. It is important to note that Blacks and Native Americans have the highest prevalence in the state.

Asthma Management educational materials available through Healthwise will be available to members through the Alliance member portal. Members will be encouraged to attend American Lung Association programs as well. Alliance is making carpet cleaning, nutrition and weight management services, HEPA filter vacuum cleaner and replacement filters available to its members with respiratory illnesses at no cost.

Alliance will work with Provider practices to promote medication adherence, decrease reliance on asthma rescue medications and encourage the completion of environmental assessments to identify factors that exacerbate symptoms.

Hypertension

Program Objective: To decrease the prevalence of hypertension through proactive healthcare and by supporting Members in lifestyle behavior changes.

- Our program will promote prevention and amelioration of hypertension by addressing obesity, physical activity and tobacco cessation. In 2019, 31% of our adult Members had hypertension, 18.2% had obesity and 26.8% used tobacco. Care Managers will address access to healthy foods, referrals to dietitians, barriers to physical activity, tobacco cessation, and annual primary care visits during their check-ins with Members.
- At a **system level**, Alliance will align with the NC Healthy 2030 and Eat Smart Move More initiatives and coordinate with local departments of public health, community agencies and QuitlineNC to address opportunities for healthy foods, physical activity and tobacco cessation.
- At the **Provider level**, Practice Transformation Specialists will work with primary care practices and behavioral health providers to promote tobacco cessation, referral to nutritionists, prescription of blood pressure cuffs and scales. Encourage.
- Alliance will offer **Members** hypertension prevention and self-management educational material through HealthWise in its Member portal and through the Manage Your Health toolkit on its website. Members who use tobacco will be encouraged to enroll in our tobacco cessation programs and referred to the Quitline.

Diabetes Prevention

Program Objective: To decrease the prevalence of type II diabetes through proactive healthcare and by supporting members in lifestyle behavior changes.

- Our program will promote prevention and amelioration of type II diabetes by addressing obesity, physical activity and metabolic side effects of second-generation antipsychotic medications.
- In 2019, based on claims data, 14.8% of adults in the prospective Tailored Plan population had type II diabetes, 18.2% had obesity diagnoses and 21.9% were prescribed an atypical antipsychotic.
- At a **system level**, Alliance will align with the North Carolina Diabetes Advisory Council's (DAC) recommendations in the *2020 North Carolina's Guide to Diabetes Prevention and Management* and coordinate with community partners to improve access to healthy food and opportunities for physical activity. Through care team planning, care managers and providers will be expected to coordinate treatment for Members with uncontrolled blood sugar. Care Managers will link Members to specialty care, dietitians, and diabetes education programs, as needed, and assist members to address barriers to obtaining healthy food or exercise.
- At a **Provider level**, Practice Transformation Specialists will work with Primary Care and behavioral health providers to promote referral to diabetes prevention and self-management programs and to increase metabolic monitoring of Members prescribed second generation antipsychotics.
- Alliance will educate **Members** about diabetes prevention and self-management through HealthWise information in it's Member portal and through the Manage Your Health toolkit on its website.

Orientation: Fraud, Waste and Abuse

The National Health Care Anti-Fraud Association (NHCAA) estimates that the financial losses due to health care fraud are in the

TENS OF BILLIONS OF DOLLARS EACH YEAR.

A conservative estimate is 3% of total health care expenditures, while some government and law enforcement agencies place the loss as high as 10% of our annual health outlay, which could mean

MORE THAN \$300 BILLION

Orientation: Fraud

- Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person
- Includes any act that constitutes fraud under applicable Federal or State law

Orientation: Abuse

- Provider practices inconsistent with sound fiscal, business or medical practices, resulting in unnecessary cost to the Medicaid program, or in reimbursement for services not medically necessary or that fail to meet professionally recognized standards for health care
- Also includes member/enrollee practices resulting in unnecessary cost to the Medicaid program

Orientation: Waste

- Misuse, underutilization or overutilization of items or services or other inappropriate or unnecessary billing or medical practices that directly or indirectly add to healthcare costs or unwarranted or unexplained variation in care that results in no discernible differences in health or patient outcomes

Orientation: Understanding the Laws



Imposes civil and criminal liability for presenting or conspiring to present a false claim to the government.



CIVIL PENALTIES

not less than \$5000 or more than \$10,000;
plus, three times the amount of damages

CRIMINAL PENALTIES

up to 5 years imprisonment, up to \$250,00
fine, and exclusion from participation in
Federal Programs

Example: A therapist provides services to an individual 1 time per week but bills Medicaid as if the services were provided 2 times weekly and creates service documentation to support the claims for the dates when services were not provided.

Orientation: Understanding the Laws



Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business.



CRIMINAL PENALTIES


Up to \$25,000 fine and/or 5-year prison term per violation

CIVIL PENALTIES

Liable for False Claims Act and Civil Monetary Penalties


Example: Paying a Medicaid enrollee in exchange for the use of their Medicaid information to bill.

Orientation: Understanding the Laws



Prohibits physicians from making referrals for services to entities with which the physician or immediate family member has a financial relationship.

Also prohibits physicians from making a Medicaid referral, Medicaid claim, or compensation arrangement in exchange for payment or reduction in debt.



PENALTIES

Liable for False Claim Act and Civil Monetary Penalties

Fine of up to three times the amount claimed

Exclusion from participation in Federal Programs

Example: A physician refers all their patients to a laboratory owned by their sibling for services.

Orientation: Fraud, Waste and Abuse - Reporting

- **Alliance Confidential Fraud and Abuse Line – (855) 727-6721**
- **Alliance Program Integrity Department – (919) 651-8401**
- **Medicaid Fraud Waste and Program Abuse Tip Line – (877) 362-8471**
- **Office of Inspector General Fraud Line – (800)-HHS-TIPS**
- **State Auditor Waste Line – (800) 730-TIPS**
- **Medicaid Investigations Division – (919) 881-2320**

Delegated Partners



- WellCare is our Standard Plan Partner
 - Specialty UM
 - Transplant Care Management
 - Complex Case Staffing
 - Nurse Advice Line

Services Requiring Prior Authorization Through WellCare

- Imaging (*CT, MR, PET*)
- Cardiac Imaging (*TTE, TEE, Stress Echo, Stress MUGA, CCTA*)
- Radiation Oncology
- Musculoskeletal and Orthopedics
- Complex Labs

Subcontractor: Avesis



Avesis will provide the full spectrum of Medicaid covered vision services through an integrated delivery system of eye care services. Avesis will provide a vision network for Alliance Behavior Health I/DD Tailored Plan members

Phone: 1-800-843-0558

**The Avesis phone number will be active on 4/1/23*

Fax:

UM Authorization Fax #: 1-855-591-3566;

Appeals & Grievance Fax #: 1-855-691-3243

Provider Portal: <https://www.avesis.com/Government3/Provider/Index.aspx>

Main Page: <http://www.avesis.com/>

Subcontractor: Northwood



Northwood access to quality, cost-effective durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for Alliance Tailored Plan Members. Items under \$500 do not require an authorization for claim consideration. Urgent/emergent requests greater than \$500 do not require prior authorization but need to request within two (2) business days in order for the claim to be considered for payment.

Phone: 1-877-403-6164 **The Northwood phone number will be active on 4/1/23*

Fax: 1-877-552-6551

Provider Portal: <https://providerportal.northwoodinc.com>

Main Page: <https://northwoodinc.com>