Alliance Health

All Provider Meeting

October 19, 2023

AGENDA

Introductions: Lynn Widener
Questions can be taken during the webinar through the chat box function for those accessing the webinar through their computers.
Alliance Updates

- **Welcome- Lynn Widener**
- **Medicaid Expansion- Sara Wilson**
- **Legislative Updates- Brian Perkins**
- **Tailored Care Management for Non CMA/AMH+ Providers- Myca Jeter and Krisan Walker**
- **Person-Centered Plan Template update- Damali Alston**
- **Provider Updates- Lynn Widener**
- **Reminders- Cathy Estes Downs**

Recording of this meeting will be posted on the Alliance Website by October 25th

Next currently scheduled All Provider Meeting is TBD due to Holidays in December

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Medicaid Expansion Update

Medicaid Expansion

- NC received federal approval to launch Medicaid Expansion on December 1, 2023.
- Medicaid Expansion increases eligible population to all adults aged 19-64 who have incomes up to 138% of the Federal Poverty Level
- Same ways of getting care as existing Medicaid.
- Same comprehensive benefits and copays as other non-disabled adults in Medicaid

By the Numbers

More than 600,000 individuals are estimated to be covered under Medicaid Expansion by the end of the second year, including:

300,000 expansion enrollees moved from Family Planning benefit by the end of the first year

100,000 beneficiaries who may have lost full Medicaid coverage during recertification in absence of expansion

200,000 expansion eligible individuals not currently enrolled in Medicaid statewide expected to enroll in the first two years

Medicaid Expansion Website and Tool Kit

North Carolina Expands Medicaid | NC Medicaid (ncdhhs.gov)

Medicaid Expansion Flyer

Family Planning Medicaid Flyer

Medicaid Essentials PowerPoint

Navigating ePASS (video) / Guide to Providing Application Assistance

Social Media Toolkit

Newsletter Template

FAQ: Questions and Answers about Medicaid Expansion | NC Medicaid (ncdhhs.gov)

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Legislative Updates

Recap – 2023 Long Session

- North Carolina Medicaid Expansion
  - Access to Healthcare Options (HB 76)
- North Carolina State Budget
  - 2023 Appropriations Act (HB 259)
- Behavioral Healthcare Investments
  - Gov. Cooper's $1 Billion Behavioral Health Roadmap
  - Strengthening Care for Families and Children (HB 855)

NC Medicaid Expansion

- Access to Healthcare Options (HB 76) signed into law March 27
- Allows for an estimated 600,000 more people to have access to Medicaid coverage
- Authorizes a billion-dollar+ federal “signing bonus” for NC
- Medicaid expansion could not go into effect until state budget is passed

NC Medicaid Expansion

- With new state budget becoming law, Expansion will launch on Dec. 1, 2023
- New beneficiaries will receive care the same way as existing Medicaid beneficiaries

North Carolina State Budget

- 2023 Appropriations Act (HB 258)
- Budget for State Fiscal Years 2023-25
- Became law on Oct. 3 without Gov. Cooper’s signature
- Will spend $60 billion across 2 years
- Prioritizes behavioral healthcare

State Budget

Tailored Plan Launch

- TP Launch Date – No later than July 1, 2024
- TP Initial Contract Term – 4 years

State Budget

Public System Updates (re: LME/MCOs / Tailored Plans)

- LME/MCO Catchment Area Minimum Population – 1.5M people
- LME/MCO Consolidation – DHHS directed to reduce the number of LME/MCOs in the state
  - No more than 5 and at least 4
  - DHHS shall redefine catchment areas as needed
  - Changes to effective by Jan. 1, 2024 (90 days after budget became law)

State Budget

State Single Stream Funding

- Budget contains no cuts to single stream funding
- State funding to provide access to behavioral health services for North Carolinians who are uninsured and do not qualify for Medicaid

State Budget

Children and Families Specialty Plan (aka foster care specialty plan)

- DHHS shall procure a single statewide CFSP to begin no later than Dec. 1, 2024
- One or more LME/MCOs may jointly form a consortium for the purpose of responding to procurements issued by DHHS

State Budget

Access to Healthcare Services

- Rate increases for Medicaid behavioral health services ($130M)
- Innovations Waiver slots – 350 new slots ($20M)
- Wage increases for direct care workers serving Innovations recipients ($120M)

State Budget

Healthcare Workforce Recruitment/Retention

- New workforce training center for public behavioral health providers ($17.9M)
- Loan repayment program for licensed BH providers ($20M)
- Loan forgiveness program for psychiatrists in underserved counties ($16M)
- Sign-on and retention bonuses for BH workforce at state healthcare facilities ($40M)

Behavioral Healthcare Investments

Approximately three-quarters of Governor's $1B Behavioral Health Roadmap funded in budget

- Medicaid BH Service Rates
- I/DD & Traumatic Brain Injury Supports
- Workforce Investments (direct care worker wages, loan forgiveness)
- Justice-Involved (diversion, re-entry, capacity restoration)
- Crisis System (BH urgent care, facility-based crisis, mobile crisis, respite, non-law enforcement transportation)
- Child Well-Being (youth crisis stabilization beds, family peers)

Tailored Care Management

What is Tailored Care Management?

- Tailored Care Management is the primary care management model for Tailored Plans
  - The TCM team utilizes a whole person approach in addressing behavioral health, I/DD and/or TBI needs in addition to physical health and unmet health-related resource needs.
- Tailored Care Management is community based and 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, but may still receive Care Coordination from the Tailored Plans

Transition to Tailored Care Management

Before Dec. 2022	Tailored Care Management
LME-MCOs coordinate BH, I/DD and TBI services **CCNC coordinates physical health services** *LME-MCO care coordination is only available to a subset of the population served by LME-MCOs* 	*Tailored Care Management will be available to all enrollees unless they are obtaining duplicative services* **Tailored Plans will provide integrated, whole-person care management** *(Since Dec .2022)* 

Options for Tailored Care Management

Three options for care management:

- Advanced Medical Home+ (AMH+)
- Care Management Agency (CMA)
- Tailored Plan

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

Alliance has **39 organizations** that are **CMAs or AMH+**'s *(List on Next Slide)*

- All 6 of Alliance's counties and all populations are covered
- CMA / AMH+ have specific populations and counties they are certified to serve.
- Alliance Health CMs will also be providing TCM for specific populations and members as assigned

Reminder:

- Members cannot be referred to Tailor Care Management.
- Members are assigned once eligibility is established by DHB through a pre-approved assignment logic.

Current CMA/AMH+ Certified Agencies in ALLIANCE Network

Alexander Youth Network	Family Preservation Services of North Carolina, LLC	S&H Youth and Adult Services, Inc.
Autism Society of North Carolina, Inc.	Fellowship Health Resources, Inc.	Sigma Health Services, LLC
B&D Integrated Health Services	Fernandez Community Center, LLC	Southlight Healthcare
Carolina Outreach, LLC	Freedom House Recovery Center, Inc.	SPARC Services & Programs, LLC
Community Alternatives, Inc dba Community Choices	Hope Services, LLC	Sunrise Clinical Associates, PLLC
Community Partnerships, Inc.	InReach	Support Incorporated
Cumberland County CommuniCare, Inc.	Monarch	The Arc of North Carolina, Inc.
Daymark Recovery Services, Inc.	Pathways Human Services of North Carolina, LLC dba Access Family Services	Threshold, Inc.
Duke Children's Primary Care - Brier Creek	Pinnacle Family Services of North Carolina, LLC	TLC Operations, Inc. dba Tammy Lynn Center for Developmental Disabilities
Duke Children's Primary Care - North Durham	Pivotal Health Solutions	Triangle Comprehensive Health Services, Inc.
Duke Pediatrics - South Durham	PQA Healthcare	UNC - Center for Excellence in Community Mental Health
Duke General Internal Medicine (Duke Med Pediatrics)	Primary Care Solutions, Inc.	VOCA Corporation of North Carolina dba Community Alternatives North Carolina
Duke Family Medicine	Primary Health Choice, Inc.	VOICE Therapeutic Solutions, PLLC
Duke Medical Outpatient Clinic	Renew Counseling Center of NC, LLC	Yelverton's Enrichment Services, Inc.
Easter Seals UCP North Carolina & Virginia, Inc.	RHA Behavioral Health NC LLC	

Service Providers NOT CMA/AMH+

Roles & Responsibilities

- Provide consultation and support for individuals engaged in care management
- 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 when necessary
- Make sure your organization is updated and active in NCCARE360

After Hours/Crisis Coverage

- CMA /AMH+ agencies are required to have 24/7 coverage
  - They are **not** considered the **1st responder** for members
    - The **primary service provider** is **considered the 1st Responder** for After Hours/Crisis needs
  - TCM staff will be available to share information and help to coordinate care with the primary care 1st responder as needed

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 and/or Considered Duplicative to 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)
- CAP C and CAP/DA programs
- Primary Care Case Management (PCCM)
- Critical Time Intervention

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1915(b)(3) and 1915(i) Services Update

CMA/AMH+ 1915(i) Workflow

The member's assigned Care Manager will schedule and complete the required face-to-face Independent Assessment in order avoid service disruption. (*The Independent Assessment will also be completed as part of the of a member's annual care management comprehensive reassessment.)

Once the documents are received, Alliance Health forwards the Independent Evaluation report to Carelon.

Once **received**, Carelon will review and determine eligibility for 1915(i) services. Eligibility determinations are provided by letter to the member and to the Care Manager/Practice Transformation by email.

Care Managers will complete and submit a Care Plan/ISP within 60 calendar days of 1915(i) eligibility, but an interim plan can be developed with full plan developed within 60 calendar days.

1915(b)(3) & 1915(i) Update

Providers of currently Authorized 1915 (b)(3) services may continue to submit for reauthorization.

- 1915 (b)(3) Services are available for new members seeking services.
- Tailor Care Managers may reach out to providers to engage members and to obtain current contact information.
- Since the 1915(b)(3) services are ending, when individuals are started on 1915(b)(3) services, plans should be working concurrently with the TCM or care coordinator to complete the assessment and start those individuals on 1915(i) services. *Please note, this direction is subject to change based on feedback from CMS*

<u>Please cooperate/respond</u> when a TCM attempts to contact you, as they are attempting to ensure there is no disruption in current services. For members seeking new 1915(b)(3) services, Service Providers will be responsible for the Service Authorization request, TCM providers are responsible for Independent Assessments and Care Plans/ISP for 1915 (i) services. Once services are cross walked, TCM providers will also be responsible for service authorization request.

Services Transitioning to 1915(i)

As part of the transition to 1915(i), the Department is either retaining benefits in their current form or expanding the scope of existing benefits, such as making some benefits available to additional populations.

Current 1915(b)(3) Service		Future 1915(i) Services
In-Home Skill Building	➤	Community Living and Support
One-time Transitional Costs	➤	Community Transition
Individual Support	➤	**Individual and Transitional Support** *Integrates existing Individual Support, Transitional Living Skills, and Intensive Recovery Supports into one service*
Transitional Living Skills		
Intensive Recovery Supports*		
Respite	➤	Respite
Supported Employment	➤	Supported Employment

The Department will release clinical coverage policies for the new 1915(i) services.

*North Carolina is planning to update its State Plan Amendment (SPA) to incorporate intensive recovery supports.

Beneficiary Eligibility for 1915(i) Services

Eligibility for 1915(i) services varies on a benefit-by-benefit basis. Eligible populations include beneficiaries with an I/DD, TBI, serious mental illness (SMI), serious emotional disturbance (SED), or severe substance use disorder (SUD) who meet need-based criteria set by the Department.*

	I/DD	SED	SMI	SUD	TBI
Community Living and Support	✓				✓
Community Transition	✓		✓	✓	✓
Individual and Transitional Support		✓ *ages 16-21*	✓ *ages 18+*	✓	
Respite	✓	✓ *ages 3-20*		✓ *ages 3-20*	✓
Supported Employment	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*

Needs-Based Criteria
• Have a functional deficit • Can benefit from skill acquisition (e.g., self-determination, independent living) ***or*** • Can benefit from assistance in monitoring a health condition/living skills
• Moving to own community living arrangement and need initial set-up expenses/items
• At least one deficit in an instrumental activity of daily living (e.g., meal preparation)
• Unable to care for themselves in the absence of their primary caregiver
• Express the desire to work • Has a pattern of under/unemployment ***or*** • Have educational goals that relate to employment goals

*Beneficiaries are not required to meet an institutional level of care to be eligible for 1915(i) benefits.

NC Medicaid Managed Care Information and Resources

- Providers are encouraged to remain informed of NC Medicaid Managed Care Transformation through the following resources:
  - Medicaid Managed Care Provider Playbook. Trending Data: Interim Reports to assist providers with verifying their record and PHP contracted information continue to be updated.
  - Fact Sheets: NC Transition of 1915(b)(3) Benefits to 1915(I) is a new fact sheet available under NC Medicaid Programs and Services.
  - Health Plans Webpage – Contact information for all health plans, as well as health plan contract requirements and information.
  - NC Medicaid Managed Care County Playbook – The playbook includes fact sheets on various community partner topics and notices received by beneficiaries transitioning to managed care.
  - Financial and Statistical Reports – Contains a variety of dashboards and reports related NC Medicaid activities.

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New Person-Centered Planning Template Implementation

NC DHHS Person-Centered Planning

New PCP template effective November 1, 2023

- NC DHHS hosted several trainings in Spring 2023
- The Person-Centered Planning training, From Theory to Practice: Person-Centered Planning in NC is housed on the UNC Behavioral Health Springboards website at www.bhs.unc.edu and is free of charge
- Links to the new PCP Template, PCP Guidance Document, PCP Training FAQ, and the Crisis Plan Template can be found on the NC DHHS Person-Centered Planning page on their website

NC DHHS Person-Centered Planning

- This training meets the requirements for “Person-Centered Thinking” and “Person-Centered Plan Instructional Elements”.
- All provider staff who are responsible for developing a person-centered plan must take this training.
  - Any PCP completed on or after 11/01/2023 must be completed on the new template by a qualified staff person who has completed the training. All PCP training certificates must be maintained in staff personnel files.
- This training is owned by the State and cannot be reproduced. Providers can continue to facilitate ‘inhouse’ trainings on person-centered planning, but those trainings cannot take the place of this training.

NC DHHS Person-Centered Planning

Alliance will require that the new Person-Centered Plan template be implemented as follows:

- All authorizations and reauthorizations with an effective date on or after 11/01/23.
- Any new services started on or after 11/01/23, even if prior authorization is not required.
- Any time there is a need for a new service order on or after 11/01/23 the new PCP template must be used.

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Provider Network Updates

Clinician Updates

- All rendering clinicians must be enrolled in NC Tracks and affiliated with each organization and site where they will be providing services
- Providers should no longer submit a Request to Add form to Alliance requesting to link a clinician in ACS - this information now comes to us from NCT.
- All needed updates should be submitted directly in NC Tracks

Tailored Plan Trainings Available

Alliance has informative trainings available for all providers as we prepare for Tailored Plan

The trainings are located here:
https://www.alliancehealthplan.org/providers/tp/training/

Providers may register here:

https://www.alliancehealthplan.org/providers/tp/training/registration/

Tailored Plan Trainings Available cont.

Of particular importance for providers serving children, please note the following trainings:

- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT):** Overview/Background of EPSDT; EPSDT, The American Academy of Pediatrics Recommendations for Preventative Pediatric Care
- **Into the Mouth of Babes (IMB):** Into the Mouth of Babes (IMB) program training overview-How to access IMB Toolkit

Tailored Plan Trainings Available cont.

Other available trainings include:

- Fraud, Waste, Abuse
- Population Health
- Infection Prevention and Control
- Tobacco Cessation/Tobacco-Free Campus

Reminder: Claims Documentation Required

As a reminder, Providers are required to maintain supporting documentation when submitting claims

Per the DHHS Records Management and Documentation Manual:

- For all periodic services, the frequency requirements for entering service notes is per event, or at least per date of service, when the service is provided. When a periodic service is provided, it shall be documented for the date on which the service was provided by the individual who provided the service on a full service note.

Reminder: Claims Documentation Required cont.

- If a service note or grid is written or dictated any time after twenty-four hours of the date of service or close of the service period, it is classified as a late entry. All late entries must be marked as such and must include a dated signature.
- For any service note [or grid when permitted] to meet reimbursement requirements, the documentation to support the service provider must be written or dictated within seven calendar days from the date of service [or from the closing date of the service period for some day/night and twenty-four hour services]. When a service note or grid is entered after twenty-four hours of the date of service, or after twenty-four hours of the close of the service period, but within seven calendar days that the staff member was on duty as previously described, then it is considered a late entry, but it is still billable for reimbursement. The note or grid shall be identified as a late entry and must include a dated signature.

Reminder: Claims Documentation Required cont.

- Service notes are expected to be written or dictated within the seven-day time frame, not only to meet reimbursement requirements, but also to ensure that the description of the service provided is accurate. There should be very few occasions for a service note to be written or dictated after the seven-day period, as the possibility for the accuracy and detail depicted in the note to be compromised increases with time. When a service note or grid is written or dictated after the seven-day period has lapsed, it is classified as a late entry, must be indicated as such, and a dated signature is required, but it may not be billed.
- https://www.ncdhhs.gov/rmanddm-3rd-edition-9-1-16/download

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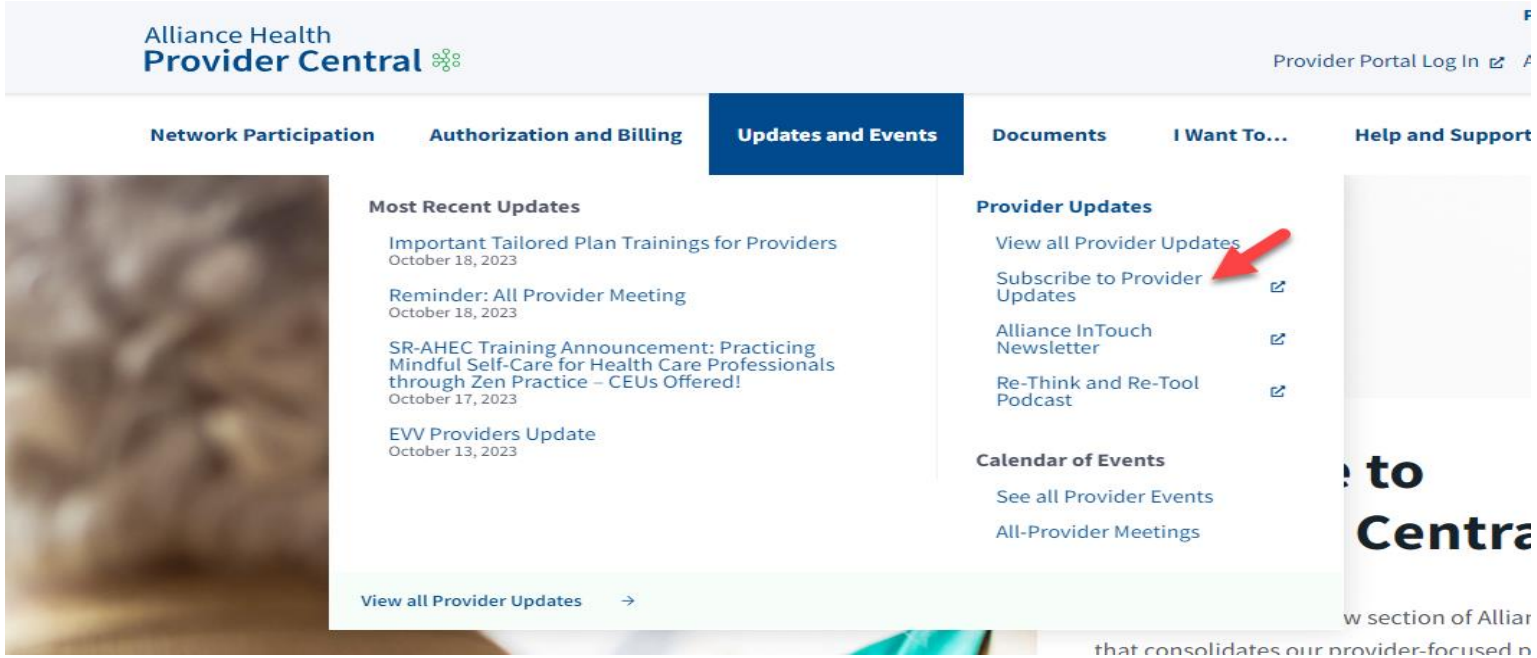
Reminders

Provider News

Providers continue to be encouraged to sign up for Provider News as this is the mechanism that Alliance communicates information and important changes that may affect provider service delivery and operations.



Provider Responsibility Reminder

***** Providers are reminded that they are responsible for ensuring that any service that they provide under their Alliance contract is delivered according to the requirements that are in NC Medicaid Clinical Coverage Policy(s), Scopes of Work(SOW) and any In Lieu Of or Alternative Service Definitions.**

For example: Certain services require National Accreditation i.e. Innovation Services and Enhanced Services. If a provider submits claims and are paid for these services *and* the provider is not accredited - the provider is at risk for recoupment and possible sanctions

Keep NCTracks Provider Records Current

Medicaid Managed Care health plans, as well as the NC Medicaid Provider and Health Plan Lookup Tool must use information from the NCTracks provider record for their directories. For this reason, and because NC Medicaid recently announced a Provider Data Management/Credentialing Verification Organization Solution Coming in 2024, it is essential for providers to ensure all data in each active NCTracks provider record is accurate.

Provider Reverification

Providers for whom recredentialing/reverification was delayed are being notified of their requirement to complete the reverification process. Notifications are sent to the NCTracks Message Center Inbox on the secure Provider Portal. Failure to respond will result in suspension and subsequent termination of the provider record. A list of providers due for reverification through December 2023 is available on the Provider Enrollment Recredentialing webpage

Medicaid Managed Care Webinars

Visit the AHEC Medicaid Managed Care webpage for additional information and registration for upcoming webinars, as well as recordings, slides and transcripts from previous webinars.
The latest schedule, registration and information on previous webinars, including the recording, slides, and transcript are available on the AHEC Medicaid Managed Care website.

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 for general questions and they can also assist with identifying your Network Specialist for more detailed assistance.