Alliance Health

All Provider Meeting

January 24, 2024

AGENDA

Introductions: Lynn Widener

Please submit any questions during the webinar in the chat (for those accessing the webinar via computers).

Alliance Updates

- **Welcome –** Lynn Widener
- **Medicaid Expansion -** Lynn Widener
- **What to Expect at a Community Inclusion Planning Meeting -** Tiffany Brown and Warren Gibbs
- **1915i Updates –** Lynn Widener and Katie Penree
- **Appendix K Flexibilities Update –** Melissa Hall
- **Provider Updates -** Lynn Widener and Jill Osborne
  - **Innovations Direct Care Worker Wage Increase Attestation & Acknowledgement Form**
  - **--Notice of Change reminders**
  - **-- Harnett County Consolidation**

A recording of this meeting will be posted on the Alliance Health website by January 30, 2024.

The next All Provider Meeting is scheduled for March 13, 2024.

Alliance Health

Medicaid Expansion

Lynn Widener

Director of Provider Network Operations

Medicaid Expansion Updates

Beginning December 1, more than 600,000 North Carolinians will be able to get NC Medicaid under new eligibility rules. Nearly half have already been automatically enrolled because they previously had limited benefits through Family Planning Medicaid and are now eligible for full Medicaid. On December 1, 5611 Alliance members became enrolled in full Medicaid for the first time.

Medicaid Expansion Updates

- It is every contracted provider's responsibility to work with any members, receiving state-funded services and who don't already have Medicaid, to apply for Medicaid. This should be ***active assistance and not just referring a member to a website***. As a provider, you should familiarize yourself with the Medicaid Expansion website and all of the resources available for assisting members – https://medicaid.ncdhhs.gov/north-carolina-expands-medicaid.

Medicaid Expansion Updates

- If a member becomes Medicaid eligible and has a current authorization for services in place, a new authorization does not need to be submitted as long as the service code remains the same.

Medicaid Expansion Updates

NC Medicaid reminds providers that **prescriptions written by non-Medicaid enrolled providers will not be reimbursable by NC Medicaid due to federal requirements**. NC Medicaid requires that all providers whose NPI will be used on a pharmacy claim be enrolled with NC Medicaid. There are no exceptions to this requirement.

Medicaid Expansion Updates

Please ensure that all prescribers are enrolled in NC Tracks/NC Medicaid. This bulletin applies to NC Medicaid Direct and NC Managed Care. Requirements for Filling Prescriptions for Medicaid Beneficiaries: Reminder for the Expansion Population

Medicaid Expansion Updates

- Registration Open for **Medicaid Expansion Regional Education Sessions**
- Medicaid expansion regional trainings are a collaborative effort of Care Share Health Alliance, the NC Community Health Center Association and the NC Navigator Consortium. They will be offered in two parts.
- Part 1 is offered in-person in Raleigh and virtually. Part 2 will be available in six locations across the state.
- These trainings are free to attend.

Medicaid Expansion Updates

- Medicaid Expansion Regional Education Sessions overview:

- **Part 1: Medicaid 101**
  - ❑ This training will be offered twice and will include the same content:
    - Medicaid 101 and Managed Care Structure
    - Immigrant Eligibility for Medicaid
    - How to Apply and Next Steps After Applying
    - NC Medicaid Ombudsman
    - Dental Coverage for Medicaid Beneficiaries
  - ❑ Locations:
    - In-person at the McKimmon Center in Raleigh, NC on January 31, 2024
    - Virtually via Zoom on February 7, 2024
  - ❑ Register for part 1 here: Part 1 Registration Form

Medicaid Expansion Updates

- **Part 2: Medicaid Expansion Outreach, Education, and Enrollment**
  - ❑ This training will be offered six times, in-person, in locations across the state. Content at every session includes:
    - Progress and Roadblocks since Expansion Launch
    - Medicaid Expansion Workflows
    - Messaging Guidelines for Medicaid Expansion
    - Outreach Considerations for Special Populations
    - Application and Enrollment Considerations for Special Populations
    - Overview of Medicaid Expansion Tools
  - ❑ Locations:
    - February 1 in Raleigh
    - February 8 in Mooresville
    - February 13 in Greenville
    - February 21 in Winston-Salem
    - February 27 in Fayetteville
    - March 5 in Waynesville
  - ❑ Register for Part 2 here: Part 2 Registration Form

Medicaid Expansion Updates

- For effective ongoing communication between your agency and Alliance, who at your agency is leading these efforts and will be the best point of contact (POC)?

- Please send the name of your POC and any additional questions you may have to NetworkRelations@alliancehealthplan.org.

Alliance Health

Community Inclusion Planning Meetings Overview

Tiffany Brown and Warren Gibbs

Community Inclusion Planning Coordinators

Community Inclusion

…providing members with severe mental illness “the opportunity to live in the community, and be valued for one’s uniqueness and abilities, like *everyone else*”

Family life Gainful employment Social connections

Civic activity Recreational pursuits Staying fit

Baron, R.C. (2018). Jump-Starting Community Living and Participation.

What are Community Inclusion Planning Meetings?

- **Tailored** for the member receiving services
- Support the **whole** person
- Provide the **right resources** at the **right time**
- Include a variety of **members** that can **contribute** to the member being able to access resources in his/her home or community setting (including peers)

Purpose of Community Inclusion Planning Meetings

- Identify additional services/supports to support the member with meeting his/her goals
- Develop new resources/combine resources to fill gaps
- Build relationships and provide opportunities for better outcomes
- Put System of Care values and principles into practice
- Address member needs
- Partner and provide support to connect the member with resources and/or community supports
- Peer Support throughout the Process

How Can I Submit a Referral?

- For Mecklenburg County specific questions contact Tiffany Brown at tibrown@alliancehealthplan.org.

- For Counties Cumberland, Wake, Durham, Johnston, Orange, and Harnett, contact Warren Gibbs at wgibbs@alliancehealthplan.org.

Alliance Health

Provider Network 1915(i) Service Updates

Lynn Widener
Director of Provider Network Operations

Katie Penree
Manager of Community Care Management

1915(i) Services

Effective 1/5/2024, 1915(i) service codes were loaded into providers' ACS contract details using the following logic:

- If a service provider was offering any of the impacted services, including Community Living and Support, the 1915(i) services were added into provider ACS contract details
- Contract amendments are not being sent out to individual providers – if you identify an error in ACS, please contact your Network Relations Specialist

1915(i) Services – Codes and Rates

Procedure Code	Modifier	Service Description	Billing Unit	Rate effective January 1, 2024
H0043	U4 22	One time transition - MH	1 time	$ 2,500.00
H0045	U4	Respite B3 Individual Child	15 minutes	$ 6.67
H0045	HQ U4	Respite B3 Group Child	15 minutes	$ 3.84
H0045	HB U4	Respite B3 Individual Adult	15 minutes	$ 6.67
H0045	HQ HB U4	Respite B3 Group Adult	15 minutes	$ 3.84
H2023	U4	Initial Individual Supported Employment - I/DD	15 minutes	$ 12.88
H2023	HQ U4	Initial Group Supported Employment - I/DD	15 minutes	$ 3.37
H2026	U4	Maintenance Individual Supported Employment - I/DD	15 minutes	$ 12.88
H2026	HQ U4	Maintenance Group Supported Employment - I/DD	15 minutes	$ 2.11
T1019	U4	Individual Support (subject to EVV)	15 minutes	$ 19.21
T1019	U4 TS	Individual Support (non-EVV, only in the community)	15 minutes	$ 19.21
T2012	U4	Community Living and Supports Individual (non-EVV, only in the community)	15 minutes	$ 6.93
T2012	GC U4	Community Living and Supports relative as provider lives in home (non-EVV)	15 minutes	$ 6.93
T2013	TF HQ U4	Community Living and Supports Group (subject to EVV)	15 minutes	$ 4.86
T2013	TF U4	Community Living and Supports Individual (subject to EVV)	15 minutes	$ 6.93

1915(i) Services – Providers Needing a Service Added

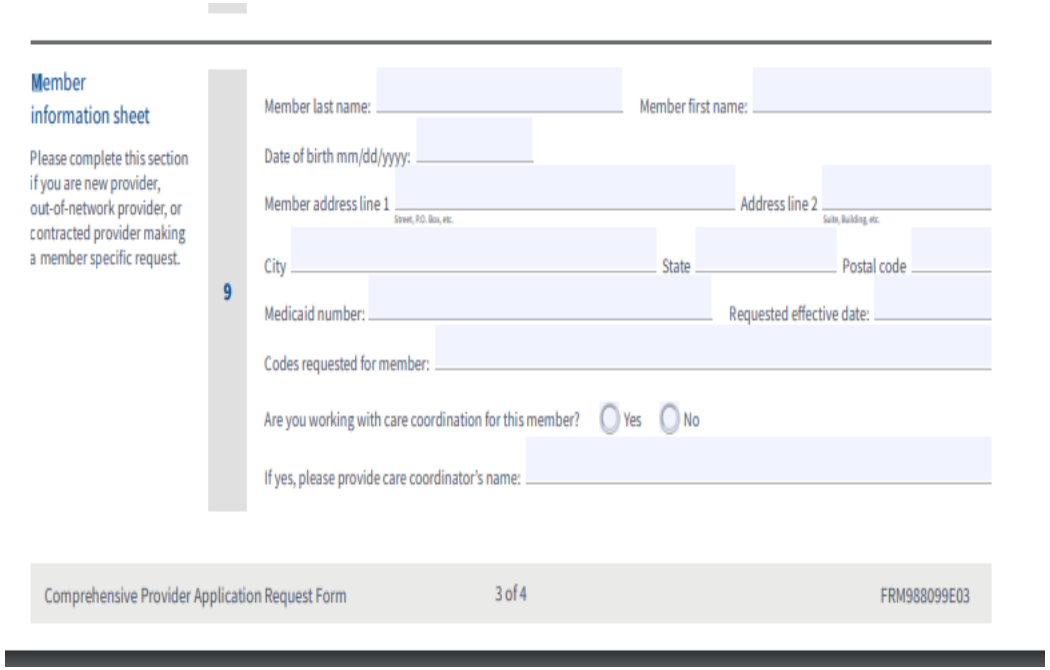
- If a contracted, In-Network service provider needs to have a 1915(i) service added to their contract in ACS, the Care Manager (Alliance/PLE) will send a request to enrollment to add the service.
- The service will be ***fully added*** to the contract (not member specific).

1915(i) Services – Providers Requesting a Service be Added

- If a ***non-contracted, Out of Network*** service provider needs to add a 1915(i) service not currently available to them in ACS, the provider should submit a Complete Provider Application Request (CPAR)
- The CPAR can be found on the Alliance website at this link
  - https://www.alliancehealthplan.org/document-library/61119
- Requests to add a 1915(i) service to contract should be related to a ***specific member*** needing service at the request of a Care Manager (Alliance staff, PLE)

1915(i) Services – Providers Requesting a Service be Added

- It is critical that the service provider complete the Member Information Sheet including the name/agency of the Care Manager. Failure to include this information will result in the CPAR being returned.



Member information sheet

Please complete this section if you are new provider, out-of-network provider, or contracted provider making a member specific request.

9

Member last name: _____ Member first name: _____

Date of birth mm/dd/yyyy: _____

Member address line 1 _____ Address line 2 _____

Street, P.O. Box, etc. Suite, Building, etc.

City _____ State _____ Postal code _____

Medicaid number: _____ Requested effective date: _____

Codes requested for member: _____

Are you working with care coordination for this member? ○ Yes ○ No

If yes, please provide care coordinator's name: _____

Comprehensive Provider Application Request Form 3 of 4 FRM988099E03

How Do Service Providers Get Referrals?

- The referral process for 1915(i) is Care Manager driven
- Members currently receiving 1915(b)(3) Services will be crosswalked into 1915(i) Services
- Members needing new services will need to choose a provider of service; the Care Manager will assist with referrals

1915(i) Referrals

- At this time, service providers receive all referrals for 1915(i) services by either an Alliance Care Manager or Provider Led Entity (PLE)

- Prior to the referral, the Care Manger/Provider Led Entity is responsible for ensuring that the member has completed an assessment or eligibility determination

- If a new service is being requested for services not originally requested on an Independent Assessment, the Member will require a new Independent Assessment prior to requesting new services

1915(i) Referrals

- The updated 1915(i) Independent Assessment should be maintained in the Member's record and submitted to Utilization Management at the time of the service authorization request

- The updated assessment will not be submitted to Alliance for Carelon approval as Carelon will not accept the new assessment unless the previous assessment is expiring

1915(i) Referrals

- 1915(i) services must be included in the ISP/POC by the Care Manager
- 1915(i) providers are expected to receive a copy of the ISP/POC from the Care Manager
- In some instances, a service provider may receive a request from a Care Manager/PLE for a service not currently on contract

PROCESS FLOW: ACCESSING 1915(i) SERVICES IN TAILORED PLANS

Member Need Identified

Independent Assessment

Independent Evaluation/ Carelon

ISP

Prior Authorization /Submit SAR to UM

Monitor Service Delivery and Ongoing Care Management

DETAILED VIEW: AFTER ELIGIBILITY DETERMINATION: NEW 1915(i) MEMBERS

Appendix K Flexibilities for Innovations and TBI Waiver Services

Permanent Policy Updates

Melissa Hall

Provider Network Developmental Specialist

Flexibilities Update

On Nov. 22, 2023, The Centers for Medicare, and Medicaid Services (CMS) approved North Carolina Medicaid to continue certain Appendix K flexibilities in the 1915(c) Innovations Waiver and Traumatic Brain Injury (TBI) Waiver amendment, effective **March 1, 2024.**

Appendix K

In order to ensure the safety of waiver members in their communities, CMS allowed States to use Appendix K flexibilities during emergency situations.

As circumstances gradually improve, some Appendix K flexibilities will end **Feb. 29, 2024**.

NC Medicaid and Alliance Health will work to support members as they transition from any discontinued Innovations and TBI Waiver Appendix K flexibilities by March 1, 2024.

What Does this Mean for Innovations Waiver Members?

Innovations Waiver members will be able to continue using the Appendix K flexibilities until Feb. 29, 2024.

On March 1, 2024, Innovations Waiver members will be able to use the following approved flexibilities, which will be considered ongoing and included in the approved amendment:

1. Home delivered meals (up to seven meals per week/one per day).

2. Access to real time, **two-way interactive audio, and video telehealth** for the following services:

   - Day Support
   - Specialized Consultative Services
   - Community Living and Supports
   - Supportive Employment
   - Supported Living
   - Community Networking

What Does this Mean for Innovations Waiver Members?

3. Allow members to receive services in alternative locations: hotel, shelter, church or alternative facility-based settings under specific circumstances.

4. Remove the requirement for members to attend a day supports provider once per week. Increase the Innovations waiver cap from $135,000 to *$184,000 per waiver year.

*This is a change from the initial requested increase of $157,000 and takes into account the Innovations Direct Care Worker increase.

What Does this Mean for Innovations Waiver Members?

5. Allow parents of minor children receiving Community Living and Support to provide this service to their child who has been indicated as having extraordinary support needs up to 40 hours/week.

6. Allow Supported Living to be provided by relatives.

7. Allow Relatives as Providers, for adult waiver members, to provide 56 hours/week or more but not exceeding 84 hours/week of Community Living and Supports.

8. Community Navigator service will be available only to members who self-direct one or more of their services through the Agency with Choice or Employer of Record model.

What does this mean for Innovations Services?

IMPORTANT NOTE:

Providers are expected to provide services within the hard limits of the waiver and in accordance to the ISP, inclusive of the sunsetting of Appendix K. Multi-disciplinary teams may need to update ISPs in accordance with service delivery of CCP 8P or the TBI Waiver. Upon review of updated plans/revisions, ISPs will continue to be reviewed against medical necessity.

Innovations Waiver Update

350 Legislated Innovations Waiver Slots Added

**Waiver slots were not part of the Appendix K flexibilities but were added to align with legislative requirements.*

What Does this Mean for TBI Waiver Members?

Traumatic Brain Injury Waiver members will be able to continue using the Appendix K flexibilities until Feb. 29, 2024.

On March 1, 2024, TBI Waiver members will be able to use the following approved flexibilities, which will be considered ongoing and included in the approved amendment:

1. Home Delivered Meals (up to seven meals per week/one per day).

2. Resource Facilitation: The support provided under this service will now be provided under Tailored Care Management.

3. Remove the requirement for beneficiaries to attend a Day Supports program once per week

4. Allow direct care services to be provided in a hotel, shelter, church, or alternative facility-based setting or the home of a direct care worker under specific circumstances

What Does this Mean for TBI Waiver Members?

5. Allow real-time, **two-way interactive audio and video telehealth** for the following services:

   - Cognitive Rehabilitation
   - Specialized Consultative Services
   - Life Skills Training
   - Day Supports
   - Supported Employment
   - Supported Living
   - Community Networking

6. Allow relatives of TBI Waiver members to provide up to 40 hours/per week

   - Life Skills Training and/or
   - Personal Care

What Does this Mean for TBI Waiver Services?

IMPORTANT NOTE:

Authorization requirements should be followed per *CMS Approved TBI Waiver

*No CCP released yet

Telehealth Guidance

*Telehealth **is not** intended to supplant full meaningful day, but rather to complement it.*

Services that support community integration are not eligible for 100% telehealth delivery.

The provider shall also document that any platform used to conduct telehealth activities are in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

The use of telehealth shall not exceed 25% of the authorized service hours per week. (i.e. if an individual is authorized 40 hours a week, the individual may use the real time two-way interactive audio and video telehealth 10 hours/week).

Services Not Approved for Telehealth Per CMS

Services that will **not** have telehealth after 2.29.24 are below
(This also would include any modifiers attached to these codes for the 1915c waivers)

- H2011 Primary Crisis Response
- H2016 Residential Supports Level 1
- H2016 Residential Supports Level 4
- S5150 Respite Care - Community Individual
- T1005 Respite Care Nursing -
- T2014 Residential Supports Level 2
- T2020 Residential Supports Level 3
- T2025 U1 EOR Management of Funds
- T2027 22 Developmental Day
- T2034 Out of Home Crisis
- T2038 Community Transition Supports
- T2041 Community Navigator

Alliance Health

Provider Network Updates

Lynn Widener
Director of Provider Network Operations

Jill Osborne
Credentialing and Enrollment Manager

Innovations Direct Care Worker Wage Increase
Attestation & Acknowledgement Form

- On November 22, 2023, NC Medicaid announced Innovations Waiver provider rate increases so that Innovations services providers can in turn raise the hourly wages of the direct care workers (DCW) they employ. The rate increases will be effective retroactive to July 1, 2023. LME/MCOs are required to adjust rates for services covered in their plans that were delivered on or after July 1, 2023, and reprocess any affected claims, as applicable.
- Alliance activated the July 1st rates in the Alliance Claim System (ACS) on November 30, 2023.

- Per the legislation, Innovations waiver services providers must document to LME/MCOs their commitment to and use of the rate increases "to the benefit of its Innovations direct care workers, including in the form of an increase in hourly wage, benefits, or associated payroll costs." This will be done using an upcoming attestation template. The template will be sent to the providers for signature and return to Alliance. Upon receipt of the signed template, Alliance will reprocess previously paid applicable claims within **30** calendar days.

- Claims submitted and paid as of the date of the template submission will be reprocessed with the new rates. Any claims after that date will be the responsibility of the provider to resubmit. All information will be contained on the Remittance Advice or through the provider's 835. No additional information will be provided.

- Please be on the lookout for this document. It will be sent via DocuSign to the identified person that is responsible for signing your contract
- ***If the provider does not sign the attestation within the required timeframe that will be identified in DocuSign , Alliance will recoup any claims that were paid at the higher rate***.
- Additional details regarding the services impacted and the base rate assumptions can be found on the NCDHHS website: **NC Medicaid Innovations Waiver Provider Rate Increase**.

Requesting Contract Changes or Notifying Alliance of Administrative Changes

- There are two ways a provider can submit contractual or administrative change requests to Alliance Health
- For contractual requests, providers should submit the Comprehensive Provider Application Request (PAR) as outlined below:

  - ✓ A CONTRACTED provider requesting to add sites or services
  - ✓ A NEW provider requesting to join the Alliance network
  - ✓ A NON-CONTRACTED provider seeking a single case, or member specific contract

Requesting Contract Changes or Notifying Alliance of Administrative Changes, continued

- To notify Alliance of administrative changes, providers should submit a Notice of Change (NOC)

  - ✓ A name change
  - ✓ Service site address change
  - ✓ Change in provider contact information (phone, email, website)
  - ✓ Request to remove a service from contract
  - ✓ Change of Tax ID
  - ✓ Request to withdraw or terminate contract
  - ✓ Other administrative changes

Requesting Contract Changes or Notifying Alliance of Administrative Changes, continued

- Both forms are available on our website:

  Comprehensive Provider Application Request
  https://www.alliancehealthplan.org/document-library/61119

  Notice of Change
  https://www.alliancehealthplan.org/document-library/61147

- Completed forms should be emailed to Enrollment@alliancehealthplan.org

Tips and Reminders for PAR / NOC Submissions

- Providers are required to provide a 30-day notice in advance of any business change (site moves or closures, service terminations, contract withdrawals). Failure to provide advance notice may result in claims denials and/or compliance action.
- All Tax ID's, sites addresses, NPI numbers, Taxonomies, and Health Plan selections must be active in NC Tracks before you submit a request to Alliance

Tips and Reminders for PAR / NOC Submissions

- Because Alliance operates a closed behavioral health network, we do not routinely add services to provider contracts unless the services are identified as areas of need within our network.
- When submitting a request to add services to your contract, please review the **Service Needs List** *prior* to submitting your request. https://www.alliancehealthplan.org/providers/network/service-needs/

Tips and Reminders for PAR / NOC Submissions

- When requesting to add new services be sure to include the title of the service and the service code.
- All services in our benefit plan can be found on our website by searching the Document Library for our most up to date Rate Sheets for Medicaid and Non-Medicaid services.
- From the Document Library you can enter “rate” in the search bar and filter the results by “last updated” https://www.alliancehealthplan.org/providers/document-library/

Reminder for NOC Submissions

- In order to facilitate communication between Alliance and our providers, please remember to submit a **Notice of Change (NOC)** to update your primary email contact whenever there is a change to your primary contact person and/or contact email address

Harnett County Consolidation

- Contracts are actively being sent out to Providers that have billed for Harnett County members in the past year- only services and sites that provided service to these members, based on data we received from Sandhills, are being added.

-Providers that are not currently contracted with Alliance but meet the criteria above have been sent out enrollment/contracting packets- these need to be returned to Alliance to initiate the contract.

- Currently over 50% of Alliance providers that were serving Harnett members do not need any contractual changes due to current contract with Alliance

- We strongly encourage providers to closely review the Alliance benefit plan and Fee schedules for any differences in procedure codes from Sandhills – this will help to reduce any denials that you may receive by billing an incorrect procedure code.

- Any questions regarding your contract please contact your Provider Network Relations Specialist or email NetworkRelations@AllianceHealthplan.org

-Reminder to sign up for Provider News in order to get notifications of any updates or opportunities that may be valuable for your organization

Alliance Health

Thank You

The next meeting will be March 13, 2024