

The Alliance Health Plan

INDIVIDUAL and FAMILY Handbook

Alliance Health

Home Office
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

This handbook is available in Spanish and in alternate formats. If you need a larger-print version or have limited reading ability, call Alliance Health at 800-510-9132.
The current edition of this handbook is available on the Alliance website at AllianceHealthPlan.org.

Si necesita información en español, llámenos al 800-510-9132.

Inside you will find:

- Where to call when you need help
- A list of your rights and responsibilities
- How to get services
- How to voice a grievance

Services described in this handbook are available only to qualified residents of Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties in the State of North Carolina.

Mail your comments and suggestions to:

Office of Community and Member Engagement
Alliance Health
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

How to Contact Alliance

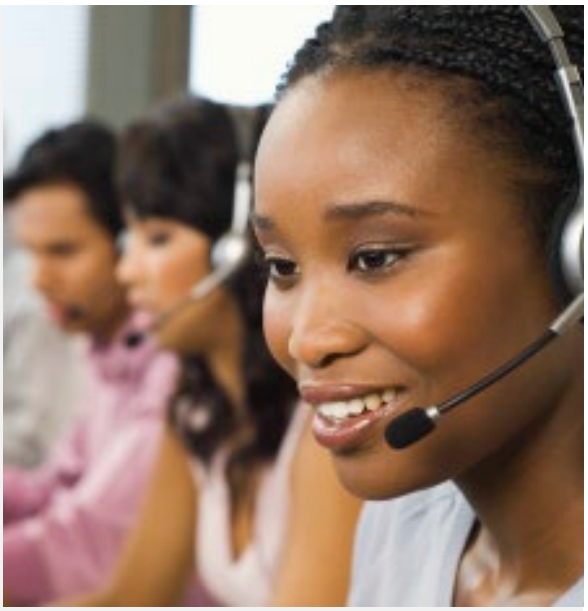
Member and Recipient Services

800-510-9132

Monday-Saturday, 6 a.m.-7 p.m.

Our Member and Recipient Services team can conduct a telephone screening and offer a referral to your choice of appropriate service providers.

They can also provide help for people dealing with a behavioral health crisis and offer information on other resources available in your community.



Relay Calls: 711 or 800-735-2962

Relay is the confidential, transparent link between callers who are hearing and callers who are deaf, hard of hearing, deaf-blind, or speech-impaired. The Relay operator verbally communicates to voice users and types the conversation to TTY users.

Relay is available anytime and anyplace and there is no extra charge. You can reach Relay by dialing 711 or toll-free at 800-735-2962. There is no restriction on when you can use Relay and no time limit on the length of the call, but there may be a delay in answering when call volume is high. Spanish and English languages are offered at this time.

If you are a hearing member or a member who is hard-of-hearing or deaf, dial 711 or 800-735-2962 to reach a Relay operator. Once reaching the Relay operator, give them the number and extension you are trying to reach and they will dial it for you. The Relay operator will type to the TTY user and/or speak to a hearing member. Relay operators are not part of the conversation and cannot make any judgments about the conversation.

Assistance in Languages Other Than English

The Alliance Member and Recipient Services team can connect to a translation service for many different languages. This is a free service, available on any call. You may have to wait briefly for the conference call with the interpreter to begin.

If you are experiencing a medical emergency, dial 911.



A Message from
Rob Robinson
Chief Executive Officer

To Members of the Alliance Health Plan:

I want to welcome you to the Alliance Health system of care. Alliance is a public behavioral health managed care organization that oversees funds for mental health, intellectual/ developmental disabilities and substance use/addiction services. We are the insurance plan for people with Medicaid and for people that are uninsured or underinsured who are eligible and live in the Alliance region. This region includes Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. This handbook provides information to help you obtain the care that you or your family member needs.

Our goal is to offer the same respect and high-quality care that you would expect from a private insurance plan. Alliance does not provide services. Our responsibility is to manage public funds to serve the citizens of the Alliance region. We do this by working with high-quality providers to deliver the services that you need, and by ensuring that you have a choice of providers whenever possible. We have high standards for providers in our network and we work very hard to make sure that these standards are met.

I hope that you find our system easy to use and that you are pleased with the quality of services you receive. We welcome your feedback, whether positive or negative. Knowing about any problems you experience helps us make improvements, and knowing about good experiences gives us important information about provider performance. You are encouraged to call Member and Recipient Services with your thoughts, concerns, or reports of fraud, waste or abuse.

We are very proud to help you find solutions that will make a difference in your life or the life of your loved one!



Rob Robinson, CEO

My Personal Healthcare Contacts

Use the following spaces to write the names and numbers of the people working with you for your mental health, substance use or intellectual/developmental disability services.

My behavioral healthcare provider's name	_____
My behavioral healthcare provider's phone number	_____
My Alliance Care Manager's name	_____
My Alliance Care Manager's phone number	_____
Alliance 24/7 toll-free Behavioral Health Crisis Line	_____
Mobile crisis services number for my county	_____
The name of the closest hospital for medical needs	_____

Use the following spaces to write the names and numbers of other important healthcare contacts, such as your doctor, dentist, or other medical specialist.

_____	_____
_____	_____
_____	_____
_____	_____

Keep this handbook where you can easily find it for future reference.

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Section 1: Welcome to Alliance

In this section:

- Who is Alliance?
- How is Alliance governed?
- How can I get involved?
- What is Alliance's position on discrimination?

Welcome to Alliance Health!

Alliance is a government agency that manages Medicaid, block grant, state and local funding for mental health, intellectual and/or developmental disabilities (IDD) and substance use disorder (MH/IDD/SUD) services. We manage services in Cumberland, Durham, Johnston, Mecklenburg and Orange counties. Our mission is to improve the health and wellbeing of the people we serve by ensuring highly effective, community-based support and care.

Who is Alliance?

Alliance is dedicated to the promotion of recovery, self-direction and a person-centered approach to individual strengths, hope and choice. We work to make sure our members receive the right type of care, in the right amount, at the right time. We effectively manage the system of care by providing:

- Access to a variety of services to meet your individual needs.
- 24-hour access to care, including crisis services.
- Clinical reviews to make sure your care is medically necessary and best meets your needs.
- A network of healthcare providers.
- Management of the network of providers to make sure that quality services are available locally.
- Receipt and resolution of all concerns, grievances and requests for appeals in a timely manner.
- Community education programs and trainings.
- Access to care for individuals leaving hospitals, jails, state residential facilities and treatment centers.

Alliance is responsible for efficiently managing the limited public resources available for our services. We believe it is important to work in partnership with individuals, families, and community stakeholders, like departments of social services, health departments, federally qualified health centers and local hospitals, to meet the needs of people in our region. We have a proven track record of significant savings to taxpayers and positive results for our members by contracting with high-quality service providers.

Members of our provider network must undergo a rigorous credentialing review and are continuously monitored to ensure quality. We are NCQA and URAC accredited in the areas of Health Call Center, Health Network and Health Utilization Management. Alliance is a

Medicaid managed care organization. The NC Department of Health and Human Services (DHHS) contracts with us to operate the NC Medicaid combined 1915(b)/(c) Waiver in our region, also known as our catchment area.

For more information about Alliance, call our toll-free Member and Recipient Services team and 800-510-9132 or visit our website at AllianceHealthPlan.org. You may request a printed copy of our Individual and Family Handbook by calling Member and Recipient Services.

How is Alliance governed?

Alliance is governed by a Board of Directors that includes at least one county commissioner, individuals with specific healthcare, social services, insurance, hospital administration and mental health expertise, and members of the Alliance Consumer and Family Advisory Committee (CFAC). These community stakeholders are appointed by their respective county commissioners. Service providers cannot serve as board members.

We also have a County Commissioner Advisory Board (CCAB) that meets quarterly. This board includes a representative from each of the boards of county commissioners in the counties we serve. It is an advisory group and provides feedback to Alliance about service needs in our local communities.

How can I get involved?

As a member of the Alliance Health Plan, you can participate in our CFAC (Consumer and Family Advisory Committee). The CFAC includes people who receive or have received MH/IDD/SUD services and their relatives or guardians. The CFAC is a self-governing advisory committee that operates under its own bylaws. One CFAC member also serves as a voting member on our Board of Directors. Under state law, the CFAC has the following certain responsibilities:

- Review, comment on and monitor implementation of the local business plan.
- Identify service gaps and underserved populations and make recommendations about needed services.
- Review and comment on our annual budget.
- Participate in quality improvement activities.
- Submit recommendations to the state CFAC about ways to improve service delivery.

The CFAC helps ensure that people receiving services are involved in our oversight, planning and operational committees. For more information on the Alliance CFAC, call us toll-free at 800-510-9132.

We also have a Human Rights Committee (HRC) that protects the rights of people receiving services. The HRC is responsible for reviewing complaints about violations of member rights, including privacy concerns. Most of the people on this committee either receive services or are a family member of someone who receives services. The HRC reviews potential rights violations and monitors trends in the use of restrictive interventions, abuse, neglect and exploitation, deaths and medication errors. The board provides valuable feedback on potential improvements and overall trends.

The HRC meets at least once quarterly and reports to the Alliance Board of Directors, the Alliance Continuous Quality Improvement Committee and state authorities. For more information on the HRC, call 800-510-9132.

What is Alliance's position on discrimination?

Alliance complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex. Alliance and its contracted providers also do not discriminate based on ethnicity, religion, creed, gender identity, sexual orientation, marital status, family/parental status, genetic information, income derived from a public assistance program, political beliefs, or any other category protected under federal or state law.

Alliance provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large-print, audio, accessible electronic formats and other formats).

Alliance also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Alliance Health at 800-510-9132. Hearing impaired resources are available through NC Relay TTD/TYY by first calling 711 or 800-735-2962.

If you believe that Alliance has failed to provide these services or you have experienced discrimination in how services were authorized or provided to you on the basis of race, color, national origin, age, disability, or sex, please let us know. You may call Member and Recipient Services toll-free 800-510-9132 or learn how to file a grievance at AllianceHealthPlan.org/consumers-families/consumer-rights/filing-a-complaint/.

If you prefer to contact someone other than Alliance, please call the NC DHHS Customer Service Center at 800-662-7030. This number is monitored by an external, third-party vendor, and your call will be completely anonymous if you choose. You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201, or by phone at 800-368-1019 or 800-537-7697 (TDD).

Section 2: What is the Medicaid Waiver?

In this section:

- What is the Medicaid 1915(b)/(c) Waiver?
  - Goals of the Medicaid 1915(b)/(c) Waiver
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- What if I have insurance other than Medicaid?

What is the Medicaid Waiver?

Alliance operates under a Medicaid 1915(b)/(c) Waiver. This allows some federal Medicaid requirements to be waived to provide alternatives to the traditional service delivery system. If you receive Medicaid from any of the counties in the Alliance area, you are a member of the Alliance Medicaid 1915(b)/(c) Waiver.

Goals of the Medicaid 1915(b)/(c) Waiver are:

- To improve access to care.
- To improve quality of services.
- To promote cost efficiencies.

Benefits of the Medicaid 1915(b)/(c) Waiver are that:

- You have choice of provider.
- Medically necessary needs are met.
- There is a process for grievance resolution.
- You have the opportunity to get second opinions.

Requirements for Alliance under the Medicaid Waiver are to:

- Provide telephone contact 24 hours a day, 7 days a week.
- Provide emergency referrals 24 hours a day, 7 days a week, within two hours of the request for services.
- Provide urgent care within 48 hours of the request for services.
- Provide routine care within14 calendars days of the request for services.
- Have qualified staff to evaluate services requested by providers.
- Offer a qualified provider network with choice of at least two providers where available, except for crisis services.
- Provide written material explaining the benefit plan, how to access services and member rights.

What is the 1915(b) Waiver?

North Carolina's 1915(b)/(c) Medicaid Waiver is approved by the federal Centers for Medicare and Medicaid Services (CMS). It is really two separate waivers combined into one. The 1915(b) Waiver, called the NC MH/DD/SA Health Plan, is a managed care/freedom of choice waiver that covers all Medicaid beneficiaries in our catchment area. It is called a "waiver" because some requirements of the federal Social Security Act are waived:

- Waives state-wideness – Allows North Carolina to have behavioral health managed care plans in specific areas of the state, such as our four-county region.
- Waives comparability of services – Lets North Carolina provide different benefits to people enrolled in the managed care system.
- Waives freedom of choice – Allows Alliance to have a closed network and require Health Plan members to choose from providers within that network, with some exceptions.

The NC MH/DD/SA Health Plan is designed to:

- Better coordinate the system of care for individuals, families and providers.
- Manage resources better so that service dollars can be directed to those most in need.
- Develop a more complete range of services and supports in the community so that more people can receive services in their community, with as little disruption to their lives as possible.
- Create new, optional (b)(3) services funded with savings Alliance achieves by managing care more effectively. These (b)(3) services are only available for people with Medicaid and are identified by reviewing what kind of practices work best and listening to feedback from members and families.

Alliance ensures there is an array of services and providers in the counties served. Individuals ages three years and older with Medicaid coverage from one of our counties are eligible to receive mental health, substance use and intellectual/developmental disability (IDD) services. The services available include those covered by the current North Carolina Medicaid Plan. The 1915(b) Waiver allows services to be added that may not be included in the current North Carolina Medicaid service options. The addition of any new services will be based on best practices. New services added will involve input from members and families.

Alliance's provider network is developed to make sure evidence-based practice services are available. Evidence-based services integrate research, clinical expertise, and patient value into the decision-making process for member care. You can choose from any provider in Alliance's network who is eligible to provide the approved service. You will receive information and education to help choose providers by calling Member and Recipient Services at 800-510-9132.

What is the 1915(c) Innovations Waiver?

The Innovations Waiver is a home and community-based services waiver for people with intellectual and/or developmental disabilities (IDD). Alliance manages this Waiver in our four counties. The Innovations Waiver serves individuals of any age and allows long-term care services to be provided in home and community-based settings for people with an IDD who meet institutional level of care criteria. Participation in the Innovations Waiver is limited to the number of

individuals approved by the federal Centers for Medicare and Medicaid Services (CMS) each year of the Waiver and the funding approved by the NC General Assembly.

The Innovations Waiver offers individuals and families two levels of control and responsibility:

- Provider-directed services.
- Individual and family-directed supports options (which includes the Agency with Choice and Employer of Record models). Under this option, individuals or families have greater control of all or part of the supports in their individual support plan.

What is the Registry of Unmet Needs?

The Registry of Unmet Needs is a first-come, first-served list maintained by Alliance to keep track of people waiting for IDD services. We strongly encourage parents of children who have an IDD and may need Innovations services in the future to call us so that you can add your child to the registry now. To learn more about the Innovations Waiver or the Registry of Unmet Needs, call Member and Recipient Services toll-free at 800-510-9132.

How do I know if I am eligible for services under the Alliance Health Plan?

The Alliance Health Plan is for individuals who are already on Medicaid. To be eligible for Medicaid coverage in the Alliance region you must:

- Be a U.S. citizen or provide proof of eligible immigration status,
- Be a resident of North Carolina,
- Have a Social Security number or have applied for one,
- Apply and be approved for Medicaid at your local Department of Social Services (DSS) office, and
- Be in one of the Medicaid aid categories that qualifies you under the Alliance Health Plan.

If you are currently receiving Supplemental Security Income (SSI), Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled, you are automatically eligible for Medicaid and do not have to apply at DSS.

Alliance does not allow co-payments, deductibles, or other forms of cost-sharing for Medicaid members for Medicaid services per the contract with the NC Department of Health Benefits. In addition, members are not required to pay for missed appointments. Co-pays may be required for medications or physical health services.

Your Medicaid card serves as your Alliance Health Plan membership card. If your county of Medicaid eligibility is one of the counties we serve, Alliance's name and toll-free Member and Recipient Services telephone number are printed on your card.

What if I have insurance other than Medicaid?

You should tell both Alliance and your provider if you have insurance other than Medicaid. This could include Medicare or private insurance. Federal regulations require Medicaid to be the "payor of last resort." Medicaid pays for services after your other insurance (including Medicare) has processed the claim and made a payment determination.

Section 3: How Do I Access Care?

In this section:

- How do I access care?
- When should I call Alliance?
- What happens when I call Alliance?
- What if I am hearing-impaired?
- How can I get assistance in languages other than English?
- How are my needs assessed?
- Can I get help with transportation to appointments?

How do I access care?

Alliance will help you access (get) care. However, you can access care directly from any provider in the Alliance network. You can go directly to a network provider of your choice. The provider will help you get enrolled in services. You do not need to call Alliance first. You may schedule your appointment directly with the provider or walk into their office.

You may call Alliance toll-free, at 800-510-9132 to access services. Trained professionals who answer will help you with the following:

- Enroll in the Alliance Health Plan
- Complete a brief telephone screening to determine urgency (or need)
- Schedule an appointment for an assessment with a network provider
- Provide information on community resources that may be helpful to you
- Arrange for face-to-face crisis intervention services
- Access peer support services.

You can also access services by walking into or contacting one of the Alliance-approved assessment sites or independent practitioners. Information about providers and available services are located on the Alliance website at AllianceHealthPlan.org.

An approved assessment site or independent practitioner is able to provide a comprehensive assessment and, in some cases, follow-up care to individuals covered by the Alliance Health Plan. There is at least one approved assessment site and several independent practitioners located in each county within the Alliance region.

Important: If you have a medical or life-threatening emergency, call 911 or go to a hospital emergency department. You do not need to call Alliance first. A life-threatening emergency is when you or another responsible person thinks you need care immediately so that you or someone else does not get hurt. If you have Medicaid, you will not be responsible for payment of services in the event of an emergency. You also do not have to go to a provider or facility in the Alliance network for emergency treatment.

When should I call Alliance?

You should call Alliance if you:

- Worry about an emotional, learning, or behavioral problem.
- Worry about a drug or alcohol problem.
- Need a provider or want to change providers.
- Are having trouble finding a provider to meet your needs.
- Feel afraid of thoughts, mood or emotions.
- Feel depressed or anxious or are experiencing prolonged sadness, sleeping more or unable to concentrate.
- Are looking for behavioral health services for your child.
- Are a parent or guardian of a child who has been diagnosed with an IDD and need services/supports to help you meet the needs of your child.
- Believe your child has excessive complaints of physical ailments, cannot cope with daily problems or has sudden changes in sleeping or eating habits.
- Notice your child has self-inflicted injuries or other injuries that can't be explained.
- Are worried about an alcohol or drug problem.
- Are afraid of the thoughts, moods and emotions you are having.
- Experience hallucinations (seeing or hearing things) or worry the government or aliens are controlling you.
- Have recurring thoughts of death or suicide.
- Feel like each day is worse than the day before or don't take pleasure in former interests.
- Have a trusted person, like a friend, family member, teacher, counselor or doctor who thinks that you need help.
- Want information about Alliance Health Plan benefits.
- Have questions about changes in the Waiver, your benefits or your services.
- Want to file a complaint or grievance, or you need help filing an appeal.
- Need to be connected to your assigned care manager or another Alliance staff person
- Would like more information about mental health, IDD or substance use resources.

Alliance can connect you to a provider that will meet your needs. You will be offered a choice of appropriate providers. You can choose the one you think will best meet your needs. Alliance will schedule an appointment with the network provider you choose.

What happens when I call Alliance?

A trained Alliance professional will listen to you and ask you questions. We have licensed clinicians available 24 hours a day, seven days a week. Please be as clear as possible in explaining your needs. If you already have a provider, we will try to contact members of your treatment team. If you don't have a treating provider, that's okay. We will help you make an appointment for an evaluation and intake. First, we will make a referral for help according to our assessment of your needs and the severity of the problem.

We want to help link you to the best services for your needs. Many times, we will be able to connect you with the right provider the first time you call. When referring callers for services, we will try to offer provider choices that best match your requests and needs.

What if I am hearing-impaired?

To access Relay calls, call 711 or 800-735-2962. Relay is the confidential, transparent link between callers who are hearing and callers who are deaf, hard-of-hearing, deaf-blind or speech-impaired. The Relay operator verbally communicates to voice users and types the conversation to TTY users.

Relay is available anytime and anyplace, and there is no extra charge. There is no restriction on when you can use Relay and no time limit on the length of the call, but there may be a delay in answering when call volume is high. Spanish and English languages are offered at this time.

If you are a hearing member or a member who is hard-of-hearing or deaf, dial 711 or 800-735-2962 to reach a Relay operator. Once reaching the Relay operator, give him or her the number and extension you are trying to reach, and he or she will dial it for you. The Relay operator will type to the TTY user and/or speak to a hearing member. Relay operators are not part of the conversation and cannot make any judgments about the conversation.

How can I get assistance in languages other than English?

Alliance staff can connect you to an interpretation service for languages other than English. This is a free service to you, and available on any call. You may have to wait briefly for the conference call with the interpreter to begin. Free interpretive service is available when working with Alliance providers as well.

Alliance can also translate this member handbook, forms and brochures into other languages in addition to English and Spanish. Please call the Access and Information Center at 800-510-9132 to request translation of materials into other languages.

How are my needs assessed?

People with the same diagnosis can have very different strengths and abilities. Alliance will evaluate you using nationally recognized assessment tools that measure your level of functioning. Assessment tools are a standardized set of guidelines used by clinicians to perform the initial assessment of your needs. This assessment will be shared with the provider before your appointment. This information sharing will prevent duplicate services and will allow services to begin in a timely manner. That means you can start the recovery process sooner.

Alliance will triage (assign a level of urgency) your needs into one of three categories: emergent, urgent or routine. What you share with Alliance will determine which category under which your needs fall.

Mobile crisis services are available in all counties that Alliance serves. For more information about alternatives to hospital emergency departments, please see Section 4 of this handbook. For urgent and routine needs, we will help you set up an appointment.

CATEGORIES OF NEED

If you have an **EMERGENT NEED** (2 HOURS)	If you have an **URGENT NEED** (48 HOURS)	If you have a **ROUTINE NEED** (14 DAYS)
This means you: • Are suicidal • Are homicidal • Are at risk of harm without supervision • Are actively psychotic (bizarre thought processes) with impaired self-care • Report hallucinations and delusions that may result in self-harm or harm to others • Are severely incapacitated • Are experiencing significant distress related to substance use (tremors, sweats, etc.)	**This means you:** • Are not actively suicidal or homicidal (deny having a plan) • Report significant depression or anxiety but no plan for harm • Display mild to moderate symptoms • Recently experienced hallucinations or delusions but none currently • Could rapidly worsen or progress to emergent need without immediate intervention	**This means you:** • Report no risk of harm to self or others • Can care for yourself on a daily basis • Are experiencing distress that is not incapacitating
What will happen? • We will arrange face-to-face care from an emergency services provider within two hours after the request for emergent care is started, or immediately for life-threatening emergencies. Callers with emergent needs may receive a referral anytime, 24 hours a day, and can expect a return call within one hour.	**What will happen?** • We will make an appointment for you to receive a face-to-face service assessment and/or treatment from an Alliance network provider within two calendar days of the request for care.	**What will happen?** • We will make an appointment for you to receive face-to-face care for service assessment and/or treatment within 14 calendar days of the request for care.

Can I get help with transportation to appointments?

If you receive Medicaid, you can use the Medicaid Transportation Service for trips to and from the doctor's office, the pharmacy, the hospital, or another medical office for Medicaid-approved care. This is offered through your local Department of Social Services (DSS).

This service is available in counties Alliance serves. Contact your local DSS office to find out how to use this service. You can also call Alliance at 800-510-9132 for help on contacting your local DSS office. There is no fee for people enrolled in Medicaid. For people not enrolled in Medicaid, transportation depends on available space and may cost from $1 to $2 each way.

Local DSS contact information:

Cumberland – 910-323-1540
Durham – 919-560-8000
Harnett – 910-893-7500
Johnston – 919-989-5300
Mecklenburg – 704-336-3000
Orange – 919-245-2800
Wake – 919-212-7000

You can request that your initial appointment be in your home if transportation is an issue. You and your provider can make a plan for transportation to future appointments.

Section 4: How Do I Get Help in a Crisis?

In this section:

- How do I get help in a crisis?
- What is a behavioral health crisis?
- Should I call my provider if I am in crisis?
- Are there other ways to get help in a crisis?
- Where are crisis and assessment centers located?
- How do I access walk-in services?
- What are mobile crisis teams?
- How do I access mobile crisis services?

How do I get help in a crisis?

In a crisis, you should seek help, especially if you feel concerned about your safety or the safety of someone you know. The phone number you call first will depend on the type of crisis or emergency and when it happens. If you have a life-threatening emergency, call 911. ***You may also go to the nearest emergency department.*** You do not need to call Alliance before calling 911 or before going to the emergency department. Emergency care does not require prior approval or authorization from Alliance. Alliance does not define what an emergency is. This may include situations where a person has caused severe physical harm to himself/herself or others. If this is a behavioral health crisis and you are not in need of medical intervention you may seek help at one of our crisis centers rather than going to the emergency department.

Post-stabilization services are the services provided immediately following emergency treatment and are intended to keep your condition from getting worse and requiring further emergency treatment. You are entitled to post-stabilization services after treatment for an emergency medical condition or crisis. Post-stabilization services are provided at the same location you received your emergency medical treatment. This includes hospital emergency departments, crisis centers, or your provider. If you have additional questions about post-stabilization services, including where you can receive post-stabilization services, please call Alliance at 800-510-9132.

What is a behavioral health crisis?

A behavioral health crisis exists when a person shows symptoms of severe mental illness or substance use disorder, such as:

- Suicidal, homicidal or other violent thoughts or actions.
- Psychosis: partial or complete loss of the ability to know what is real and what is not (such as hallucinations, delusions, paranoia).
- Inability to provide basic self-care.
- Uncontrollable outbursts or aggressive actions that place a person with an IDD or their environment at risk of harm.
- Physical symptoms of withdrawal from drugs or alcohol or a realization that you need immediate help with an alcohol or drug problem.

Should I call my provider if I am in crisis?

Mental health emergencies are serious, but they do not always require a visit to the emergency department. Most mental health emergencies can be handled by calling your provider. If you are having a behavioral health crisis, your current treatment provider should speak to you immediately. Your provider should listen to your concerns and either give you guidance on what to do or arrange for you to receive emergency or crisis care. Your provider may refer you to a mobile crisis team.

Providers will also assist with post-stabilization services following the emergency and at the same location as the emergency services occurred. Post-stabilization services do not require pre-authorization, and Alliance helps ensure you receive the services you need.

If you do not have a life-threatening situation, you may also call your primary care doctor, Member and Recipient Services, or your local Mobile Crisis Management (MCM) team.

Are there other ways to get help in a crisis?

Alliance offers several alternatives to seeking treatment in a hospital emergency department:

- Crisis and Assessment Centers – These are centers where a clinician will meet with you and help assess your treatment needs. If immediate services are needed, staff from the center will work with you and Alliance to find an appropriate treatment setting prior to you leaving the center.
- Facility-based crisis centers – These are licensed facilities in Cumberland, Durham, Mecklenburg, Orange and Wake counties that are alternatives to an inpatient hospital setting. They can provide stabilization services to individuals experiencing a mental health or substance use crisis.
- Mobile crisis services – This is a 24/7 assessment and evaluation service in which helping professionals go into the community to conduct assessments for service need and provide some crisis stabilization services.

Where are Crisis and Assessment Centers located?

You may be assessed and, if needed, provided with mental health crisis and post-stabilization services and detoxification from drugs and/or alcohol in a safe environment at the following in-network Crisis and Assessment Centers. You can walk-in or call 800-510-9132.

Durham Recovery Response Center
309 Crutchfield Street
Durham, NC 27704
(24 hours a day)

Community Mental Health Center
at Cape Fear Valley Hospital
1724 Roxie Avenue
Fayetteville, NC 28304
(7 days a week, 8:00am-10:00pm)

UNC Hospitals at WakeBrook
107 Sunnybrook Road
Raleigh, NC 27610
(24 hours a day)

Mental Health Division,
Johnston County Health Department
521 North Brightleaf Boulevard
Smithfield, NC 27577
(Monday-Friday, 8:00am-5:00pm)

SECU Youth Crisis Center, A Monarch Program
1810 Back Creek Drive
Charlotte, NC 28213
(24 hours a day)

How do I access walk-in services?

Individuals may walk into any crisis and assessment center for an assessment during the operating hours listed above. Staff will work with you to determine the level of care needed to address your needs. A determination will be made about what type, how much and how quickly care is needed.

You should go to a crisis and assessment center if you:

- Feel that you want to hurt others or yourself,
- Are hearing voices or are told that you are talking to yourself,
- Are intoxicated but have someone to safely bring you to a center, or
- Are depressed or too sad to take care of yourself/others.

What are mobile crisis teams?

Mobile crisis services provide face-to-face counseling and supportive services during a crisis and can offer help for intoxication, drug withdrawal, impaired judgment, suicidal thoughts or other behavioral health crisis issues. Mobile crisis is not limited to Medicaid beneficiaries and is available to anyone in our four-county region. Our contracted mobile crisis teams provide evaluation, treatment, and referral for safe transfer to ensure appropriate support and services.

How do I access mobile crisis services?

You may also directly contact the mobile crisis team nearest you. Mobile crisis services can offer you face-to-face counseling and supportive services at the time of a crisis, 24 hours a day, every day of the year, at no cost to you. Mobile crisis teams work for network providers who contract with Alliance.

Mobile crisis teams are made up of experienced clinical staff well-trained in crisis prevention and stabilization techniques. If you experience a behavioral health crisis, a member of the mobile crisis team will respond and meet you wherever it may be – at home, at school, at work or in the community. Mobile crisis services:

- Can be accessed by calling the 24-hour, toll-free Alliance Behavioral Health Crisis Line at 877-223-4617.
- Provide evaluation, treatment and referral to safely transfer a person to appropriate supports and services.
- Can offer help for intoxication, substance use withdrawal, impaired judgment, or suicidal thoughts.

Alliance oversees mobile crisis services in each of the counties it serves.

If you are experiencing a medical emergency,
call 911 and/or go to an emergency room at your local hospital.

Section 5: What Services and Supports are Available?

In this section:

- What services and supports are available?
- Am I eligible for Medicaid services?
- Are there limitations to Medicaid eligibility I should know about?
- Will I be required to pay a co-pay?
- Where do I obtain a Medicaid identification card?
- What if I have private insurance?
- What levels of services are available?
  - Basic benefit services
  - Enhanced benefit services
  - Residential services
- How can I get care for children and adults without Medicaid?
- Am I eligible for non-Medicaid services?
- How do I know about significant changes to programs and services?
- What is EPSDT?

What services and supports are available?

Alliance covers most publicly funded services for mental health, substance use and intellectual and/or developmental disabilities (IDD). If you get a qualifying category of Medicaid from Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange or Wake counties, you are automatically a member of the Alliance 1915(b) Health Plan. Medicaid beneficiaries approved for an Innovations Waiver slot are members of Alliance 1915(c) Health Plan.

In general, we do not cover services for physical health needs. If you have Medicaid and you have questions about what services are available to meet your physical health needs, such as diabetes or high blood pressure, please call the NC Department of Health and Human Services Customer Service Center (8:00am-5:00pm, Monday through Friday) at 800-662-7030. Operators who speak Spanish are available. If you are assigned an Alliance Care Manager, they can help connect you with a primary care provider.

We are not responsible for services available through Medicare or TRICARE. If you have Medicare, call MEDICARE at 800-633-4227 or visit Medicare.gov for more information. If you are a veteran or family member with access to TRICARE, call TRICARE's Northern Regional Contractor, Health Net Federal Services, LLC, at 877-TRICARE or 877-874-2273 or visit tricare.mil or hnfs.com.

The State of North Carolina and our six counties also provide limited funding so that Alliance can pay for some people who cannot afford care to access certain services. If you are not eligible for Medicaid, you may be eligible to access our non-Medicaid health plan. Adult services begin at age 18 for non-Medicaid services and at age 21 for Medicaid-funded services, with few exceptions.

Behavioral health and IDD crisis services are provided at no cost to any person. This includes individuals who have private insurance. If you have questions about services and your eligibility for them, call Member and Recipient Services at 800-510-9132.

Available services are based on the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the NC Division of Health Benefits (DHB) service listings for Behavioral Health and Developmental Disabilities Services. Some services are available to all residents, regardless of insurance or Medicaid eligibility.

Am I eligible for Medicaid services?

Waiver services are available to individuals who receive Medicaid. To be eligible for Medicaid, you must:

- Be a U.S. citizen or provide proof of eligible immigration status (if you need emergency services, you are not required to provide documentation of immigration status),
- Be a resident of North Carolina and provide proof of residency,
- Have a Social Security number or have applied for one,
- Apply and be approved for Medicaid at your local Department of Social Services (DSS) office, and
- Be in one of the Medicaid aid categories that qualifies you under the Alliance Health Plan.

For Medicaid services, your local DSS decides Medicaid eligibility and any co-payment or deductibles. If you are unable to apply in person, you may print and mail your completed Medicaid application to your local DSS office. If you are currently receiving Social Security Insurance (SSI), Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled, you are automatically eligible for Medicaid and do not need to apply for Medicaid separately.

Are there limitations to Medicaid eligibility I should know about?

Yes. Some Medicaid categories of aid are not covered under the Alliance Health Plan and remain under the NC Division of Health Benefits (DHB). DHB is the NC state agency responsible for managing the Medicaid program. Also, Medicaid regulations do not allow us to pay for services delivered to inmates of public correctional institutions or people in facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs).

This may include some adult care home and family care home settings. Call the Member and Recipient Services 800-510-9132 if you have additional questions about Medicaid eligibility. You should also know that federal regulations require Medicaid to be the “payor of last resort.” This means that any claim for your services must be filed with third-party insurance policies, including Medicare and private health insurance, before Medicaid processes a claim. Your provider must report any other insurance payments for claims when filing for Medicaid payment.

Will I be required to pay a co-pay?

If you are a Medicaid beneficiary, you cannot be charged a co-pay for any of the services managed by Alliance. However, you may be charged a co-pay for services managed by the NC Division of Health Benefits. For example, non-pregnant adults over age 21 may be charged a $3 co-pay for prescriptions. In addition, if you receive non-Medicaid services, your provider can charge a fee based on your income.

Where do I obtain a Medicaid identification card?

Your Medicaid identification card will be issued with Alliance's name and phone number printed on it. This Medicaid identification card is your Alliance member card. Your local county DSS office will continue to issue your Medicaid card annually. The NC Division of Health Benefits is the North Carolina state agency responsible for Medicaid.

What if I have private insurance?

You should tell your provider if you have insurance other than Medicaid. This could include Medicare or private insurance. Federal regulations require Medicaid to be the "payor of last resort." This means that Medicaid pays for authorized services after your other insurance has processed the claim and made a payment determination. If the Medicaid allowed amount is more than the third-party payment, Medicaid will pay the difference. If the insurance payment is more than the Medicaid allowed amount, Medicaid will not pay the additional amount.

What levels of services are available?

Providers will work with each individual to determine what types of services to provide. The services must be medically necessary, in the Alliance benefit plan and either on the non-Medicaid-funded or Medicaid plan for the State of North Carolina. Three levels of service are available to individuals with eligible Medicaid that are based on need, treatment history and the state's definition of medical necessity. The levels of service are:

Basic Benefit Services

Basic benefit services are healthcare services designed to provide interventions for people with less severe mental health or substance use treatment needs. These services:

- Reflect the least restrictive level of care
- Provide brief interventions for acute (immediate but short-term) needs
- Are available through a simple referral from a provider in the Alliance network or through Member and Recipient Services 800-510-9132.
- Require no prior authorization, unless you need more than the number of visits allowed under the applicable benefit plan
- Are not typically assigned to an Alliance Care Manager.

Examples of basic services include assessments, outpatient medication management and individual or group therapy.

Enhanced Benefit Services

Enhanced benefit services are intended to provide a range of services and supports that are appropriate if you are seeking to recover from more acute forms of mental illness or substance use or to address your needs if you have an IDD. These services:

- Include intensive services designed to help keep individuals in their home environment
- Are accessed through the member's person-centered planning process
- Require prior authorization
- Are highly coordinated to ensure you receive proper services without duplicating (copying) services.

Examples of enhanced services include assertive community treatment (ACT) team, substance abuse intensive outpatient program, community support team (CST), day treatment, intensive in-home (IIH) and psychosocial rehabilitation. A care manager may be assigned depending on member need/presentation to crisis or emergency services.

Residential Services

Residential services are:

- Provided to individuals who require treatment outside of their homes.
- Always require prior authorization.
- Accessed through the person-centered planning process.
- Provided in the least restrictive community setting (typically one to six beds).
- Are highly coordinated and may include a care manager based upon the setting and member need.
- May be time-limited or longer-term.

How can I get care for adults and children without Medicaid?

Alliance offers a range of behavioral health services available to individuals without Medicaid coverage who meet certain requirements. A list of available non-Medicaid services can be found on our website at AllianceHealthPlan.org. Most non-Medicaid (state-funded) services require prior authorization by Alliance and can be accessed by contacting Member and Recipient Services at 800-510-9132. Part of the non-Medicaid service eligibility process is based on the income of the individual or family in addition to clinical needs.

The Alliance counties also fund some services that are available to residents of those counties, including crisis and outpatient clinics. There are some crisis services available to individuals within the Alliance region that are available regardless of residency or an individual's ability to pay.

Am I eligible for non-Medicaid services?

Every individual enrolled with Alliance is evaluated to determine his or her ability to pay for non-Medicaid services. The combination of an individual's adjusted gross income and the number of dependents will show if they have the ability to pay. An individual meets financial eligibility if the

individual's household income is at or below 300% of the federal poverty level and he or she has no assets or third-party funding or insurance available to pay for services. If an individual's income exceeds this amount, he or she will be required to pay 100% of the cost for the non-Medicaid services provided to him or her.

To become eligible for non-Medicaid services, your provider must enroll you by calling the Alliance Access and Information Center at 800-510-9132. Eligibility for non-Medicaid services is based on income, citizenship and availability of other insurance and is limited to the services offered in the non-Medicaid benefit plan. If you request non-Medicaid services, your provider will ask you to share information about your annual household income to determine if you are eligible.

Non-Medicaid services are not an entitlement, and availability is based on funding Alliance receives from the state. Many of the services available through Medicaid are not covered under the non-Medicaid benefit plan, including residential treatment for children. Non-Medicaid funds cannot be used to pay for co-payments or deductibles under your primary insurance.

At times, individuals seeking non-Medicaid-funded services may be placed on waiting list when:

- Demand for service exceeds available resources (non-Medicaid funds only), or
- Service capacity is reached and there is no available provider for the non-Medicaid-funded service

The Alliance Utilization Management (UM) Department is notified when providers report openings in service capacity or funding for services becomes available. The department then works with providers to identify potential individuals from their waiting list. The provider and Alliance UM staff will consider the following factors when selecting individuals on waitlists for services:

- Service need (individual meets medical necessity for service)
- Risk factors such as health and/or safety issues
- Risk of hospitalization or a higher level of care if the need is not addressed
- Whether the resources identified are adequate to meet the individual's needs
- If other funding sources are available to meet the individual's needs
- Length of time the individual has been waiting

To find out if you may be eligible for non-Medicaid services, contact your provider or call the Member and Recipient Services at 800-510-9132.

How do I know about significant changes to programs and services?

When a significant change to the Alliance Health Plan is made, the appropriate department, working with the Director of Individual and Family Affairs and the Director of Communications, will draft a written notification and will send notice to individuals of the change at least 30 days prior to the effective date of change.

What is EPSDT?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a part of the federal Medicaid law that requires Medicaid to pay for regular screenings and certain services for children and youths under age 21, even if the services are not included in the State Plan for Medical Assistance or the 1915(b) Waiver. In North Carolina, the screening part of this program is known as “Health Check.”

Medicaid pays for services under EPSDT only if they are medically necessary to correct or ameliorate a defect, physical or mental illness or condition identified through the screening. The term “ameliorate” means “to improve or maintain the consumer’s health in the best condition possible, to compensate for a health problem to prevent it from getting worse or to prevent the development of additional health problems.” The request must meet certain criteria for Alliance to approve it under EPSDT:

- The request must fall within a category of services listed at Section 1905(a) of the Social Security Act. This means that most Innovations Waiver services are not covered under EPSDT.
- The request must be determined to be medical in nature.
- The request must be generally recognized as an accepted method of medical practice or treatment.
- The request must not be experimental or investigational.
- The request must be safe and effective.

Requirements for prior approval apply to EPSDT services. If you are under age 21 or the parent of a child under age 21, services may be available to you or your child even if they are not covered under the Alliance Health Plan. Limits that apply to adult services do not apply to services under EPSDT.

If you or your child has Medicaid, please talk to your provider or pediatrician to find out if the services needed may be covered under EPSDT. If your provider is not familiar with EPSDT or has questions, ask him or her to call Member and Recipient Services 800-510-9132.

If you or your provider want to request a service under EPSDT that is not covered in the NC MH/DD/SA Health Plan and cannot be requested electronically through the Alliance Claim System (ACS), please call 800-510-9132, and a care manager can help you with your request.

If Alliance decides that a service requested for your Medicaid-eligible child does not meet EPSDT criteria, you will receive a formal written notice and appeal form with instructions. See Section 10 of this handbook for more information about your appeal rights.

Section 6: How Does Alliance Coordinate/Manage My Care?

In this section:

- What is a System of Care?
- What is care coordination/care management?
- What are special needs populations?
- What is Transitions to Community Living (TCL)?
- What is a behavioral health home?
- What is a Person-Centered Plan?
- What is an Individual Support Plan?

What is a System of Care?

A System of Care (SOC) is a continuum of effective, community-based services and supports for individuals, children and families who have mental health issues and other life challenges. These services and supports are organized into a coordinated network and built on partnerships and collaboration. The core values of a SOC require services to be:

- Culturally competent, with agencies, programs and services that are sensitive and responsive to the cultural, racial and ethnic differences of the populations they serve.
- Community-based, with the focus of services, as well as the management and decision-making responsibility, resting at the community level.
- Person-directed and family-focused, with the strengths and needs of the individual, child and family determining the types and mix of services.
- Evidence-based to help ensure positive treatment outcomes.

The Child and Family Team is an essential part of System of Care. The Child and Family Team:

- Is selected by the family.
- Is made up of professionals, family members, friends, and community supports who are committed to supporting the goals of the child and family.
- Meets regularly and as needed to monitor the progress with the treatment plan.

If you or someone you know wants to learn more about System of Care, please call Member and Recipient Services toll-free at 800-510-9132 and ask to speak to the SOC coordinator in your area.

What is care coordination/care management?

Care coordination/care management is a service offered to eligible members with special needs. Care coordination/care management helps ensure that people with complex mental health, substance use or IDD needs receive appropriate assessments and integrated treatment planning and are linked to the right services. Care managers work with you, your family and providers to:

- Identify members who are eligible for care coordination/care management through referrals and reports.
- Assist members who are at high risk for hospitalization or institutionalization.
- Assist members returning to the community who have been living in an institution, hospital or residential setting.
- Manage your services across the continuum of care and link you to appropriate treatment.
- Ensure that you receive appropriate clinical assessments and evaluations and have access to clinical and medical specialists.
- Check on the health and safety of Innovations Waiver participants.
- Develop a care plan.

Care managers also work to involve everyone in your treatment team to ensure you receive integrated care planning. This includes:

- Providers you need to meet your treatment or habilitative goals, including your doctor, dentist or other healthcare specialists that provide or support your care.
- Representatives from county DSS or Juvenile Justice Agencies or other people you identify who are working with you and your family.
- People who will support you even after certain services stop. These should be people you trust and call when you need help in your daily life who do not receive payment for their support.

What are special needs populations?

Special needs populations are made up of individuals with needs who require specialized services or higher levels of care. An individual is designated to have special health are needs based on a combination of their diagnosis and service needs determined in part through the use of standardized level of care tools like ASAM criteria, the, the LOCUS and the CALOCUS. ASAM stands for the American Society of Addiction Medicine. LOCUS is the Level of Care utilization system, and CALOCUS is the Child and Adolescent Level of Care utilization system. Both of these were developed by the American Association of Community Psychiatrists.

These tools, which help explore the severity of need, the effects of co-occurring health issues and strengths and supports, help Alliance determine the appropriate service level and eligibility for care coordination/care management.

LOCUS© and CALOCUS© Tools

The LOCUS© (designed for adults 18 and older) and CALOCUS© (for children ages 7 to 17) are assessment and placement tools developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child and Adolescent Psychiatry (AACAP).

These tools focus on an individual's level of functioning, rather than just on a diagnosis. The higher the score, the more supports a person needs. A CALOCUS© is not validated for an adult with an IDD. However, it can be used for a child with an IDD.

CANS Assessment

The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment is an open domain tool that addresses the mental health of children, adolescents, and their families to support care planning and decision making. Alliance requires use of the current CANS for children ages three through six. Staff members who administer the CANS are not required to be licensed clinicians but must complete the online training and pass the training test. Providers should maintain certificates of training completion for staff responsible for administering the CANS. Annual retraining is not required.

ASAM Criteria

The ASAM are criteria developed by the American Society of Addiction Medicine to make level of care decisions for people with addiction and co-occurring conditions. Like the LOCUS© or CALOCUS©, it focuses on a person's level of functioning versus just a diagnosis. The higher the score, the more supports are indicated as necessary.

IDD Tools

The Supports Intensity Scale® (SIS®) is a needs assessment tool designed to evaluate the practical support requirements of a person with an IDD through a lengthy assessment. Use of the SIS® is required by DHB for participants in the Innovations Waiver.

The NC Support Needs Assessment Tool (NC-SNAP) is a needs assessment tool that measures an individual's level of intensity of need for IDD supports and services. Individuals with an IDD diagnosis who receive non-Medicaid funded supports or are placed on the waiting list to receive non-Medicaid supports must have the SNAP administered annually.

Designated special needs populations for IDD care coordination/care management include the following:

- Individuals enrolled in NC Innovations or who are Medicaid-eligible and on the Registry of Unmet Needs.
- Individuals with an IDD who are functionally eligible for the ICF-IID level of care but are NOT enrolled in NC Innovations or an ICF-IID facility.
- Individuals with an IDD who are currently in, or have been in within the past 30 days, a facility operated by the Department of Corrections (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom Alliance has received notification of discharge.

Designated special needs populations for mental health and/or substance use care coordination/care management include the following:

- Adults with severe and persistent mental illness and current LOCUS Level of VI.
- Children with severe emotional disturbance or current CALOCUS level of VI or are currently in, or have been in within the past 30 days, a facility operated by the DOC or DJJDP for whom Alliance has received notification of discharge. Individuals who have a substance use diagnosis and current ASAM Level of III.7 or II.2D or higher.

- Individuals with an opioid use disorder diagnosis who have reported to have used drugs by injection within the past 30 days.
- Individuals with both a mental illness diagnosis and a substance use diagnosis and current LOCUS/CALCUS of V or higher, or a current ASAM PPC Level of III.5 or higher.
- Individuals with both a mental illness diagnosis and a IDD diagnosis and a current LOCUS/CALOCUS of IV or higher.
- Individuals with both an IDD diagnosis and a substance use diagnosis and a current ASAM PPC Level of III.3 or higher.
- Individuals identified in the U.S. Department of Justice Transitions to Community Living settlement who have serious and persistent mental illness and are transitioning out of an institutional-type residential setting to a community setting.

What is Transitions to Community Living (TCL)?

The State of North Carolina entered into a settlement agreement with the U.S. Department of Justice (DOJ) in 2012. The purpose of this agreement was to make sure that people with mental illness are able to live in their communities in the least restrictive settings of their choice. The N.C. Department of Health and Human Services (DHHS) has implemented the agreement through the Transitions to Community Living (TCL).

What are the components of TCL?

- In-Reach: Certified peer support specialists go into facilities and build relationships with individuals to discuss community-based mental health services and potential housing resources.
- Diversion: Referral Screening Verification Process (RSVP) will replace Pre-Admission Screening Resident Review (PASRR) for Adult Care Homes, providing a more streamlined and effective process to screen Transition to Community Living (TCL) target populations prior to any admission into an adult care home to determine if the candidate has mental illness.
- Transition planning: Once an individual is identified by in-reach as interested in community-based mental health or housing services, he or she is assigned to a transition coordinator. The transition coordinator helps develop a plan to transition an individual into the community.
- Available services:
    - Housing slots with financial rental assistance.
    - Tenancy support to help with moving, setting up household supplies and furniture and explaining what to do in an emergency.
    - Individual placement and supported employment service (for individuals with mental health and substance use disorders) to obtain competitive employment in an integrated work setting. Work Incentives Planning and Assistance (WIPA) for individuals with disabilities who receive Social Security benefits to help acquire, retain and increase meaningful employment with the goal of improving financial independence.

- Special assistance-in home provides cash supplement to help low-income adults who are at risk of placement in a licensed residential care setting to reside in a private living setting.

Who is potentially eligible for TCL?

As part of the DOJ settlement, DHHS has determined that the following members are potentially eligible for inclusion in the TCL. Approval for inclusion in the TCL program comes from DHHS and is not determined by Alliance.

- Individuals with severe and persistent mental illness (SPMI) who reside in adult care homes that are determined to be Institutes of Mental Disease (IMD).
- Individuals with SPMI who reside in adult care homes licensed for at least 50 beds, and in which 25 percent or more of the population has a mental illness.
- Individuals with SPMI who reside in adult care homes licensed for 20-49 beds, and in which 40 percent or more of the population has a mental illness.
- Individuals with SPMI who are or will be discharged from a state psychiatric hospital, and who are homeless or have unstable housing.
- Individuals diverted from entry into adult care homes pursuant to the pre-admission screening and diversion.

For more information, please visit ncdhhs.gov/transitions-community-living-initiative.

What is a behavioral health home?

A behavioral health home is the agency, determined by the primary service provider for the member, which will assist in development of a person-centered plan, provide case management, and coordinate all other services.

What is a person-centered plan?

Person-centered planning is a tool of the Alliance Health Plan that helps members exercise choice and responsibility in the development and implementation of their care plans. It helps define what is important to the person and it allows individuals to have real and honest discussions with their clinical teams about their desires, needs and supports. It can occur annually or anytime an individual experiences significant life changes.

The person-centered plan (PCP) helps individuals reach their potential by:

- Ensuring that the individual has maximum social participation and inclusion in the community.
- Providing an opportunity for members to guide their care plans, with assistance from family, friends, and professional service providers. Incorporating a variety of supports, including training, therapy, treatment and other services needed to achieve the individual's personal goals.
- Drawing upon a diverse mix of resources, including paid and natural supports, to best meet the individual's goals.

The PCP should clearly express the voice of the person. All PCPs:

- Are respectful of the person and those who support the person.
- Are easy to read and understand and use everyday language.
- Are constructed so that information is located easily.
- Use complete thoughts but not necessarily complete sentences.
- Have enough detail and/or enough examples to be easily understood by someone who has not known the individual for very long.

The phases of completing the PCP are:

- Gathering information/assessment.
- Organizing the information for team review/team meeting.
- Developing the PCP.
- Requesting approval of services within the PCP.
- Implementing the PCP.

Alliance believes that you will have more success at recovery and staying healthy if you take responsibility for your own treatment and help your providers know what works for you.
In developing a PCP, you should consider:

- What has been happening in your life over the past year?
- What do you want your life to look like?
- Do you want to volunteer or work at a paid job?
- Where do you want to live and with whom?
- What would make where and how you live better?
- What supports do you need to maintain the important things in your life?
- What would you change about your life if you could?
- What part of the day do you like best and why?
- Do you have enough money to pay for all the activities you would like to do?
- What kind of person makes the best support person for you?
- How is your health? Do you have concerns about your general health?

What is an individual support plan (ISP)?

If you are an Innovations Waiver participant, you will develop an ISP with your assigned care coordinator/care manager who will help manage your care, link you to needed services and supports and perform regular visits to make sure you are healthy and safe. The ISP packet describes you as a person, your likes, your dislikes, what is important to you, your goals and the services and supports you need to live an integrated life in the community of your choice. The ISP process:

- The care plan covers up to a 12-month period that runs from the first day of the month following the participant's birth month to the last day of the month of the birth month. Your care manager will contact you to schedule a planning meeting in the weeks prior to your birth month.
- During the planning process, your care manager will explain the different services to you and the benefit limits and requirements in the Innovations Waiver for those services.

- Your care manager will work with you, your natural supports and your provider to develop a care plan that includes the services you want to request, for the length of time you want to request them.
- The care plan should be used to plan for the entire year and include any services you expect to need at any point during the year.
- If you wish to change or add services during the plan year, you may ask your care manager to help you request the change by writing an update to your care plan at any time.
- Your care manager will draft the care plan based on your wishes and needs, review the plan with you before you sign it, answer any questions you have and make any changes to the plan that you request before you are asked to sign it.
- Your care manager will never ask you to sign a plan that does not contain the level or type of services that you want. If you think you will need the services for the entire plan year, you will not be asked to sign a care plan that does not request those services for the entire plan year.
- You or your legally responsible person (referred to as an LRP) must sign the care plan once it is complete. You must have a signed care plan to receive services through the Innovations Waiver. This means that you need to sign a plan containing the level of services that you want to request, which may be different than what Alliance approves.
- A medical necessity review of the services and supports requested in your care plan packet is done by Alliance Utilization Management Department, which will make a decision within 14 days, unless more information is needed. That department is separate from Alliance care coordination/care management. Your care manager does not make the decision about whether the services you request are medically necessary.
- If any service requested in your care plan packet is not fully approved, you will receive a written explanation of that decision and information about how you can appeal.

Section 7: How Do I Find a Provider for My Care?

In this section:

- How do I choose a provider?
- How do I change providers?
- How does Alliance ensure quality services?
- What types of providers are available in the Alliance network?
- Where are providers located?
- How do I pay for my care?
- What is the Human Rights Committee?
- What is cultural competency?

How do I choose a provider?

When you call Alliance to access services, you will be offered a choice of at least two providers. In most cases, we can provide information to help you choose a provider.

- Provider name.
- Provider address/locations.
- Telephone numbers.
- The services the provider provides (type or category).
- Provider qualifications.
- If the provider is accepting new patients (sometimes listed as “referrals accepted”).
- Insurance type accepted (Medicaid or non-Medicaid).
- Provider specialty (such as mental health, etc.).
- Special accommodations provided, such as wheelchair access, assistance for hearing impaired and languages spoken or translators available.
- Availability within 30 miles or 45 miles, based on whether you live in an urban area (like a town or city) or rural areas (such as unincorporated areas outside of city limits in the “country”).
- Cultural diversity training completed by the provider.

Ask friends, relatives, doctors, and others you trust about whom they would recommend as therapists or service providers. Building a relationship with your provider enhances the quality of care. Providers should treat you as an individual, not as a diagnosis. You deserve a meaningful therapeutic relationship and good quality care. Some suggestions regarding choosing a provider are:

- Select a provider when you are feeling well and are able to communicate your needs effectively.
- Look for willingness to answer your questions.
- Search for a provider who is aware of the secondary conditions you may have, such as diabetes, lung conditions, hepatitis, or heart disease.
- Try to find a professional who is willing to be part of a team to work with you to be as healthy as you can be.

Once you choose a provider, take the following with you to your first appointment:

- A list of your medications (prescribed and over the counter).
- A list of your hospitalizations and a list of programs you have attended (along with if you remember them).
- A copy of your Medicaid ID card and, if applicable, other insurance card.
- A list of any secondary conditions like those listed above.

Most appointments with a doctor or psychiatrist will only last 15 to 20 minutes. You can request a longer appointment if you are having particular concerns.

Alliance works to maintain an up-to-date electronic listing of providers and makes this available on our website by clicking “Find a Provider” at the top of any page. You can also access the Alliance Provider Directory or Clinician Directory or call Alliance at 800-510-9132 and ask for a copy to be mailed to you.

A provider who has met the established criteria for enrollment and provides services within the counties Alliance covers is eligible to be part of the provider network and is considered an in-network provider. A network provider has a contract with us to provide services. Alliance does not offer any physician incentive plans to members of its provider network.

How do I change providers?

Within our provider network, you have the right to change providers. You have the right to consider providers you are currently using and request a change if needed by calling 800-510-9132 or speaking to your care manager. Alliance strives to have enough providers enrolled in the network to offer choices to members.

When a provider leaves the network (either by choice or otherwise), Alliance will contact all members currently in treatment with the provider. Alliance will make every effort to notify each member in writing 30 days prior to the provider leaving the network.

How does Alliance ensure quality services?

We believe it is our responsibility to closely monitor providers who deliver your services and supports. All providers in the Alliance network must complete a comprehensive application process including credentialing, confirmation with the NC Division of Health Benefits (DHB) on any existing provider issues and onsite visits. We also conduct complaint investigations, focused monitoring, and post-payment reviews of providers in our network to ensure quality care and prevent fraud and abuse of public funds.

Our Quality Management incidents and grievances team investigates all complaints received about providers in our network, whether those complaints come from you, family members, community stakeholders or our staff. If we substantiate a complaint, the provider may be asked to implement a plan of correction. Or we may take action against the provider, up to and including termination from our provider network. We also monitor critical incidents filed by our contracted providers in the NC Incident Response Improvement System (IRIS).We also have a Special Investigations Unit made up of certified investigators who investigate allegations of fraud, waste

and abuse in our Medicaid managed care program. This team identifies and recovers overpayments made to providers in our network and refers allegations of fraud to the Medicaid Investigations Division of the NC Attorney General's Office. These investigations are confidential.

We are committed to a robust quality management (QM) program that ensures access to care, a well-qualified provider network and a comprehensive array of clinically appropriate behavioral health and IDD services that meet quality standards. This program helps make sure your services are high-quality, including services provided in outpatient, inpatient/hospital, residential and community-based settings. Our Quality Improvement Committee explores ways we can improve with projects to address access to care, quality of care and network provider performance.

What types of providers are in the Alliance network?

Agencies

An agency-based provider is a business (for-profit or not-for-profit) that provides mental health, IDD and/or substance use services. Employees of the agency provide the service to the member, and agency management assures the employees meet the qualifications to provide services and meet all other requirements of the contract between Alliance and the agency-based provider. Employees who are licensed practitioners must be credentialed by Alliance.

State-Operated Healthcare Facilities

The State of North Carolina oversees and manages 14 state-operated healthcare facilities that treat adults and children with mental illness, IDD, substance use disorders and neuro-medical needs.

Licensed Independent Practitioners and Group Practices

Licensed independent practitioners (LIPs) and group practices include:

- Medical doctors.
- Practicing psychologists (PhD).
- Licensed psychological associates (LPA).
- Licensed clinical social workers (LCSW).
- Licensed marriage and family therapists (LMFT).
- Licensed professional counselors (LPC).
- Licensed clinical addiction specialists (LCAS).
- Advanced practice clinical nurse specialists.
- Psychiatric nurse practitioners.
- Licensed physician assistants.

These practitioners and group practices contract with Alliance and are part of the Alliance network. Group practices are groups of practitioners who have created a corporate entity for billing purposes. These practitioners usually share office space and offer only outpatient therapy services.

Hospital Facilities

Hospitals with inpatient psychiatric facilities and/or outpatient psychiatric programs are also enrolled in the network. Hospitals that provide emergency services to members with a behavioral health discharge diagnosis are paid for these services under an out-of-network agreement.

Most services will be available within 30 miles from your home through in-network providers. However, some specialty providers may be located in another county. Alliance will assist you in locating a provider that can meet your needs, as close to your home as possible.

You have the right to access emergency services and post-stabilization care at any location that provides emergency care without prior authorization from Alliance. If inpatient hospitalization is needed, your care will routinely be reviewed for medical necessity.

Can I receive services from an out-of-network provider?

Alliance has network providers and out-of-network providers that can be in the Alliance area, out of the Alliance area, or even out of state.

Emergency Services

There is no special process for you to obtain emergency services from any provider, regardless of the provider's location.

Non-Emergency Services from Out of Network Providers

You may be responsible for payment of services if you go to an out-of-network provider for non-emergency services that have not been pre-authorized by Alliance. The out of network provider will be responsible for contacting Alliance to go through the out of network process and set up the necessary paperwork to receive payment. To receive pre-authorization, call the Alliance Access and Information Center at 800-510-9132 for more information.

How do I pay for my care?

For services to be paid in whole or in part by Alliance, you must be enrolled in the Alliance system. If you have any questions about eligibility, please call Member and Recipient Services at 800-510-9132. Some non-Medicaid services (state-funded, mobile crisis management, etc.) are provided at no cost.

What is the Human Rights Committee?

The Alliance Human Rights Committee protects the rights of people receiving services. The committee is made up of members, family members and board members. Your provider should also have a human rights committee as required by their contract with Alliance. Call your provider for more information. You can also call Alliance for more information.

Providers must have a process that lets you submit complaints and grievances about your services. Providers must document all complaints received and must refer any unresolved concerns or complaints to Alliance. Providers must share their complaint and grievance process

with you when you first start receiving services or whenever you request a copy. They also must inform you of your rights and responsibilities.

What is cultural competency?

We want our service system to reflect the uniqueness of our local communities, improve the quality of services and allow members to shape the choices available. Cultural competency means "the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds." Alliance encourages our provider network to develop cultural competency to provide the highest quality of care to all people.

We want our providers to achieve the following goals related to cultural competency:

- Providers will become more involved in the community of people served. This may include participating in community events, focus groups and community advisory councils.
- Providers and their staff will become more aware of ethnic, racial, regional and cultural differences to help develop a respectful service delivery free of offensive practices or conditions.
- Providers and their staff will become better educated on how best to deliver services to culturally and ethnically diverse people and on how to eliminate barriers to treatment, such as language and interpretation.

If you believe staff serving you does not understand your language or your religious, cultural, educational or social background, you have the right to ask about changing staff to better meet your needs.

Section 8: How Does Alliance Make Decisions About My Care?

In this section:

- What is prior authorization?
- How long does it take Alliance to make a decision about my request?
- What is medical necessity?
- What other guidelines does Alliance follow?
- What is peer review?
- What happens if the service I need is not available?
- Can I request a new treatment or service?

Federal Medicaid regulations require us to review authorization requests and make decisions about whether the services your provider is asking for are medically necessary. This process helps us keep track of the type and amount of services and how often they are used. Our Utilization Management Department is staffed by experienced clinicians who review requests for services. They make decisions to ensure you get the right care, in the right amount, at the right time.

Alliance does not offer incentives that would discourage requests or approval of service requests. We do not offer incentives for utilization management staff or contractors to deny, reduce, terminate, suspend, limit or discontinue medically necessary services to any member. We also do not offer physician incentive plans.

Our decision-making is based on your eligibility, your needs, your treatment history and whether the requested service is medically necessary and meets the requirements of applicable rules. These rules include the NC State Plan for Medical Assistance, 1915(b)/(c) Waiver criteria, clinical coverage policies, service definitions, benefit plan restrictions and clinical practice guidelines. For Medicaid beneficiaries under age 21, we also review requests against Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria. EPSDT is explained in Section 5.

Clinical coverage policies and service definitions are issued by the NC Division of Health Benefits (DHB) and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). They are not created by Alliance and are subject to change with relatively short notice. Each service definition lists the criteria, limits and exclusions for that service that Alliance must follow when reviewing requests for authorization.

For more information about the NC State Plan for Medical Assistance or NC Medicaid Clinical Coverage Policies, visit the DHB website at dma.ncdhhs.gov. For questions about limits or exclusions on services, call Member and Recipient Services at 800-510-9132.

What is prior authorization?

Medicaid requires that we review and authorize some services before they are provided. Authorization covers the dates and amounts of services provided. Prior authorization is generally required for all Alliance Health Plan covered services, with the following exceptions:

Basic Services

- Basic services: 24 medically necessary outpatient sessions do not require authorization. The provider must submit an authorization request to Alliance if you need additional sessions.
- Psychiatric evaluation and ongoing psychiatric treatment.
- Group therapy (up to 52 sessions annually).

Emergency and Crisis Services

Crisis services are always provided in an emergency. Alliance will reimburse providers for documented emergency or crisis services at any time without regard to prior authorization or whether the provider is enrolled in the Alliance network. Members with Medicaid who receive emergency or crisis services will be enrolled in the Alliance Health Plan as soon as possible.

The date of enrollment will become the date the emergency or crisis services were provided. You must be enrolled in our system before you can receive additional, non-emergency services. Your provider should know which services require prior authorization, or you can call Member and Recipient Services at 800-510-9132 for more information.

Providers request services by completing a Service Authorization Request (SAR) form via the electronic Alliance Claim System (ACS). Your provider is responsible for including documentation to show that the service is necessary for you.

Remember that it is important to attend your appointments within the authorization timeframe. Once you are past the dates for your authorization, you will need to get additional authorizations for services from Alliance even if you did not use all the services that were authorized.

How long does Alliance take to make a decision about my request?

Timeframe for Completion of the Clinical Review
Urgent – 72 hours
Non-urgent – 14 calendar days
For urgent and non-urgent cases, Alliance may extend this period one time for up to 14 calendar days and may be requested by a member or a provider in writing: • If Alliance determines an extension is necessary because of matters beyond its control, • If Alliance notifies the member prior to the expiration of the initial 14 calendar-day period of the circumstances requiring the extension and the date when the plan expects to make a decision, and • If a provider agency fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the provider agency must be given at least 14 calendar days from receipt of notice to respond to the plan request for more information.

What is medical necessity?

People receiving care must meet medical necessity criteria for the amount and duration of the service requested to address their specific condition. Individuals without Medicaid who are eligible and meet medical necessity criteria will receive services to the extent that funding for non-Medicaid services is available.

We use medical necessity criteria when determining appropriate care for Alliance Health Plan members. Medically necessary treatment includes procedures, products and services that are:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative or restorative treatment of a mental health or substance use condition.
- Necessary to address areas of difficulties such as self-care, communication, mobility, decision-making, independent living, and financial self-sufficiency.
- Consistent with Medicaid clinical coverage policies and national or evidence-based standards, bulletins, standards, or other guidance issued by the Centers for Medicare and Medicaid Services (CMS), the NC Department of Health and Human Services (DHHS) or its divisions or verified by independent clinical experts at the time the procedures, products and the services are provided.
- Provided in the most cost-effective, least restrictive environment that is consistent with good clinical standards of care.
- Not provided solely for the convenience of you, your family, caregiver or provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- Furnished by or under the supervision of practitioners licensed under state law in the specialty for which they are providing services and in accordance with the NC State Plan for Medical Assistance, the North Carolina Administrative Code, Medicaid clinical coverage policies and other applicable federal and state laws, rules, regulations and directives.
- Sufficient in amount, duration and scope to reasonably achieve their purpose.
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity and duration of service and treatment settings.

Medically necessary treatment is designed to:

- Be provided along with a person-centered plan based upon a comprehensive assessment and developed with you or with a child, the child's family (or legal guardian) and community team.
- Be provided along with an individual support plan.
- Conform to any advance directive that you have prepared.
- Respond to the unique needs of linguistic and cultural minorities.
- Prevent the need for involuntary treatment or institutionalization.

You do not need to "fail" at a lower level of care to be eligible for a higher one.

What other guidelines does Alliance follow?

Our UM Department uses clinical practice guidelines, clinical decision support tools (such as the LOCUS©, CALOCUS©, CANS, ASAM, SIS® and NC-SNAP) and other clinical standards to

evaluate whether care is effective and appropriate. Providers use these guidelines as a road map for effective evidence-based care.

We also encourage you to use these guidelines to help make choices about treatment decisions. Practice guidelines are meant to improve care by helping you and your provider make good clinical decisions. They are based on research, published by well-known organizations, such as the American Psychiatric Association, and have been shown to help people with their problems. The guidelines we use are approved by a local committee of people receiving services, family members, staff, and clinical professionals.

For a full listing of utilization management criteria, or to request a copy of our Clinical Practice Guidelines, call Member and Recipient Services at 800-510-9132 or visit AllianceHealthPlan.org. If you feel your provider is not following these guidelines, please call 800-510-9132 and let us know about your concerns.

If you don't tell us about your concerns, we cannot improve the care you receive.

What is peer review?

If our care managers determine the requested service does not meet criteria, the request will be reviewed by a licensed psychologist or medical doctor (peer reviewer), who was not involved in the original decision, to make a final decision. Only peer reviewers can decide to deny, reduce or terminate a service requested for you.

In some cases, other levels or kinds of services may be recommended. If Alliance decides to deny, reduce or terminate a service requested for you, we will send you or your guardian a notice in writing with instructions and a form for filing an appeal. Section 10 of this handbook provides detailed information on how to appeal. Our goal is to ensure that people receive the right type and amounts of service at the right time, using the most effective and efficient treatment possible.

What happens if the service I need is not available?

If you have Medicaid, we will try to find an in-network provider for your care. If no in-network provider is available, we will work hard to find an out-of-network provider. It is our job to make sure providers are available for you. We will only place you on a waiting list for services if one of the following applies:

- You are asking for an Innovations Waiver slot and none are available (these slots are allocated by the state, and Alliance has no control over the number of slots available).
- Demand for services exceeds available resources (non-Medicaid funds only).
- There is no provider available for a service (for example, if all residential or inpatient beds are full).

Alliance maintains a waiting list for residential and inpatient services at capacity or non-Medicaid services subject to funding limitations and is notified when providers report openings or funding for services becomes available. The team then identifies potential candidates from the waiting list.

The following factors are considered when selecting people from the waitlist for services:

- Service need.
- Risk factors such as health and/or safety issues.
- Risk of hospitalization or a higher level of care if the need is not addressed.
- Whether the resources identified are adequate to meet your needs.
- If other funding sources are available to meet your needs.
- Length of time you have been waiting.
- For group settings, the compatibility with other people receiving treatment. In some cases, people in residential settings are given choices over preferred housemates (adult services).

You will then be given a list of qualified providers and may select from that list. If the opening is within an identified program, the program receives a list of eligible individuals.

The provider's admissions committee will screen applicants and make a selection based on the factors identified above. Individuals referred from regional developmental centers, state mental health facilities or state substance use facilities will be given equal consideration for community referrals. Bringing people back to the community is a high priority for Alliance.

Can I request a new treatment or service?

Alliance is always interested in learning about new treatments or therapies to determine if they should be covered benefits. We review new behavioral health advances, government studies and peer-reviewed research as they are made available to determine if experts have agreed that new treatments are safe and effective.

New proven therapies and treatments must result in outcomes that are as good as, or better than, covered benefits currently offered by Alliance. You may call your care manager anytime you have a need for a new treatment or service. If you do not have an assigned care manager, you can call 800-510-9132 to ask Alliance to consider a new service. Requests for new treatments are reviewed by our Medical Director.

Section 9: What are My Rights and Responsibilities?

In this section:

- What are my rights?
- If I am a minor, do I have any rights?
- What are my responsibilities?
- Can I recommend changes to Alliance policies and services?
- What are my rights in a 24-hour facility or adult care home?
- What are my rights if I have an IDD?
- What are restricted rights?
- What do I do if I believe my rights have been violated?
- What is informed consent?
- What if I am unable to make a decision about my care?
- Do I lose my rights if I have a guardian?
- Can I have my competency restored?
- What are my privacy rights?

If you get Medicaid from any of the counties in the Alliance region, you are a member of the Alliance Health Plan. As a member of the Alliance Health Plan, you have rights and responsibilities for your care. You are free to exercise your rights and the exercise of those rights shall not adversely affect the way that Alliance or its providers treat you.

What are my rights?

NC General Statutes and Administrative Code outline rules and regulations about human rights you are allowed:

- The right to receive information about Alliance, its services, its providers/practitioners, and member rights and responsibilities presented in a manner appropriate to your ability to understand.
- The right to be treated with respect and recognition of your dignity and right to privacy.
- The right to participate with providers/practitioners in making decisions regarding your health care.
- The right to a candid discussion with service providers/practitioners on appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You may need to decide among relevant treatment options, the risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitation.
- The right to voice grievances about Alliance or the care you receive from providers in the Alliance network.
- The right to appeal any Alliance decision to deny, reduce, suspend or terminate a requested service.

- The right of individuals who live in adult care homes to report any suspected rights violation to the appropriate regulatory authority.
- The right to make recommendations regarding the organization's member rights and responsibilities policy.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The right to refuse treatment.
- The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. If the doctor or therapist determines that this would be detrimental to your physical well-being, you can request that the information be sent to a physician or professional of your choice.
- If you disagree with what is written in your medical records, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SA retention schedule (11 years for adults, 12 years after a minor reaches the age of 18, 15 years for DUI records).
- The right to a second opinion from a qualified health care professional within the network, or Alliance will arrange for the member to obtain one outside the network, at no cost to the member.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences. A treatment plan must be implemented within 30 days after services start.
- The right to take part in the development and periodic review of your treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression.
- The right to equal employment and educational opportunities.
- The right to treatment in the most natural, age-appropriate and least restrictive environment possible.
- The right to ask questions when you do not understand your care or what you are expected to do.
- The right to free oral translation services.
- The right to recommend changes to Alliance policies and services.

Members are free to exercise their rights and the exercise of those rights shall not adversely affect the way that Alliance or its providers treat the member.

If I am a minor, do I have any rights?

Minors have the right to agree to some treatments without the consent of a parent or guardian:

- For treatment of sexually transmitted diseases.
- For services related to pregnancy.
- For services that address alcohol and/or other substance use.
- For services that help with emotional difficulties.

What are my responsibilities?

In addition to your rights as a member of the Alliance Health Plan, you can ensure the best outcomes for yourself by assuming the following responsibilities:

- Seeking help when you need it and calling your provider or Alliance if you are in crisis.
- Supplying all information (to the extent possible), including information about your health problems, that Alliance and its providers need to provide care for you.
- Following the plans and instructions for care that you have agreed to with your providers.
- Understanding your health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible, telling the doctor, nurse, or other service provider about any changes in your health and asking questions when you do not understand your care or what you are expected to do.
- Inviting people who will be helpful and supportive to you to be included in your treatment planning.
- Working on the goals of your person-centered plan.
- Respecting the rights and property of other individuals and of Alliance and provider staff.
- Respecting the privacy and security of other individuals.
- Keeping all the scheduled appointments that you can and being on time for appointments.
- Canceling an appointment at least 24 hours in advance if you are unable to keep it.
- Meeting financial obligations according to your established agreement.
- Informing staff of any medical condition that is contagious.
- Taking medications as they are prescribed for you.
- Telling your doctor if you are having unpleasant side effects from your medications or if your medications do not seem to be working to help you feel better.
- Refrain from “doctor shopping” in an attempt to obtain more prescriptions than you need.
- Telling your doctor or therapist if you do not agree with their recommendations.
- Telling your doctor or therapist if and when you want to end treatment.
- Carrying your Medicaid or other insurance card with you at all times, and not allowing friends, family members or others to use your Medicaid card.
- Cooperating with those trying to help you.
- Following the rules posted in day, evening or 24-hour service programs.
- Being considerate of other individuals and family members.
- Seeking out additional support services in your community.
- Reading, or having read to you, written notices from Alliance about changes in benefits, services or providers.
- When you leave a program, requesting a discharge plan, being sure you understand it and being committed to following it.

Can I recommend changes to Alliance policies and services?

Members have the right to recommend changes to Alliance policies and services. To do so, they may email their recommendations to the Member Inclusion and Outreach Manager, rbranch@AllianceHealthPlan.org or mail to:

Alliance Health Member Inclusion and Outreach Manager
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

What are my rights in a 24-hour facility or adult care home?

If you receive care in a 24-hour facility or adult care home, you have the rights listed above. You also have the right to:

- Receive necessary medical care if you are sick. If your insurance does not cover the cost, then you will be responsible for payment.
- Receive a reasonable response to requests made to facility administrator or staff.
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified when the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by DHHS and the basis on which the provisional license or notice of revocation of license was issued. Your responsible family member or guardian shall also be notified.
- Send and receive unopened mail and have access to writing material, postage and staff assistance if requested.
- Contact and consult with a member advocate.
- Contact and see a lawyer, your own doctor or other private professionals. This will be at your own expense, not at the expense of the facility.
- Contact and consult with your parent or legal guardian at any time if you are under 18 years of age.
- Make and receive confidential (private) telephone calls. All long distance calls will be at your expense, not at the expense of the facility.
- Receive visitors between the hours of 8:00am and 9:00pm. Visiting hours must be available six hours each day. Two of those hours must be after 6:00pm. If you are under the age of 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with you. This may be under supervision if your treatment team feels this is necessary.
- Make visits outside the facility, unless it has been included in your person-centered plan that this is not recommended.
- Be outside daily and access to facilities and/or equipment for physical exercise several times per week.
- Have individual storage space for your private belongings that can be locked and only accessible by you, the administrator or supervisor-in-charge.
- Keep personal possessions and clothing, except those items that are prohibited by law.

- Keep and spend a responsible sum of your own money. If the facility is holding your money for you, you can examine the account at any time.
- Participate in religious worship if you choose.
- Retain a driver's license unless you are not of age or have been prohibited to do so by a court of law.
- Not be transferred or discharged from a facility except for medical reasons, yours or another's welfare, nonpayment or if mandated by state or federal law. You must be given 30 days' notice except in cases of safety to yourself or others. You can appeal a transfer or discharge (according to rules by the Medical Care Commission), and you can stay in the facility until resolution of the appeal.

What are my rights if I have an intellectual or development disability (IDD) diagnosis?

If your primary disability is an IDD, you have the right to continuity of care. If you are discharged from a residential facility and still need residential care, the provider MUST provide you with a 60-day written notice as written into law General Statute 122C-63, "Assurance for Continuity of Care." This gives you time to find a new residence. This right exists as long as you have not committed any illegal acts or are not a safety threat to others.

What are restricted rights?

Your rights can only be restricted for reasons related to your care or treatment by your treatment team. You must be part of your treatment team and the decision-making process. You have the right to have an advocate or someone you trust involved. A restriction of your rights must go through a Human Rights Committee for approval. Any restriction will be documented and kept in your medical record.

What do I do if I believe my rights have been violated?

If your rights have been violated, contact Member and Recipient Services at 800-510-9132. You can file a complaint or grievance in person or by phone. You do not have to give your name. If you feel your protected health information has been violated, you may file a complaint with Alliance by calling Member and Recipient Services.

You may also contact:

NC Division of Health Benefits Privacy Officer
2501 Mail Service Center
Raleigh, NC 27699-2501
Phone: 919-855-4100

Individuals living in adult care homes have the right to report to the NC Division of Health Service Regulation (DHSR) any suspected violation of their member rights.

DHSR Complaint Unit
2711 Mail Service Center
Raleigh, NC 27699-2711
Phone: 800-624-3004 (in NC) or (919) 855-4500
Fax: (919) 715-7724
Hours: 8:30 a.m.-4:00 p.m. M-F

What is informed consent?

You have the right to be informed in advance of the potential risks and benefits of treatment options, including the right to refuse to take part in research studies. You have the right to consent to or refuse any treatment unless one of the following applies:

- It is an emergency situation.
- You are not a voluntary patient.
- Treatment is ordered by a court of law.
- You are under 18 years of age, have not been emancipated and the guardian or conservator gives permission.

What if I am unable to make a decision about my care?

You have the right to make instructions for your treatment in advance. There are three types of advance directives. These legal documents allow you to let your wishes be known in the event you are unable to make decisions for yourself.

These are:

- Psychiatric advance directives or the advance directive for mental health care.
- Health care power of attorney.
- Living will.

Psychiatric Advance Directives

The psychiatric advance directive (PAD), available at medicaid.ncdhhs.gov/documents/advanced-directives, or the Advance Directive for Mental Health Care, is a legal document that states the instructions for mental health treatment you would want to receive if you are in a crisis and unable to make decisions for yourself. Your service provider or care manager should be able to assist you in the development of this document.

The instructions give information about:

- What you think helps calm you.
- How you feel about seclusion or electroconvulsive therapy.
- What medicines you do not want to take.
- Which doctor you want to be in charge of your treatment.

These are decisions you can make in advance of any situation in which you are unable to communicate your wishes about your care and provide specific instructions to be followed by a physician or psychologist. The instructions you include in the PAD will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Your instructions may be overridden if you are being held in accordance with civil commitment law.

If your provider does not agree with any parts of the advance directive (due to a "matter of conscience" or personal objection), they must provide (in writing) why they disagree, include detail from the law that allows the objections, and describe the medical conditions involved. You may choose to see a new provider. Your instructions may also not be followed if you are being held in accordance with civil commitment law.

Health Care Power of Attorney

A health care power of attorney allows you to designate someone who can make decisions for you if you are unable to make your own choices about treatment. This document gives the person you designate as your healthcare agent broad powers to make healthcare decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment and other healthcare decisions with your healthcare agent.

Except to the extent that you express specific limitations or restrictions in this form, your healthcare agent may make any healthcare decision you could make yourself.

Living Will

A living will is a document that tells others what kind of care you want or if you want to die a natural death if you are incurably sick and cannot receive nutrition or breathe on your own.

All three of these documents must be written and signed by you while you are able to understand your condition and treatment choices and are able to make your wishes known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney must be notarized.

Be sure to keep a copy of your advance directives in a safe place and give copies to your family, your treatment team, your doctor, and the hospital where you are likely to receive treatment. You can also have your advance directive filed in a national database or registered with the NC Advanced Health Care Directive Registry, which is part of the Department of the North Carolina Secretary of State (sosnc.gov). There is a $10 fee to register. This includes the registration, a revocation form, registration card and password. You can use the revocation form at any time if you change your mind and your directives.

If your provider does not agree with any parts of the advance directive (due to a "matter of conscience" or personal objection), they must provide (in writing) why they disagree, include detail from the law that allows the objections, and describe the medical conditions involved. You may choose to see a new provider. Your instructions may also not be followed if you are being held in accordance with civil commitment law. Your advance directives are active until you cancel them. You may cancel or change your advance directives at any time unless you have been declared

incompetent. If you cancel or change your advance directives, be sure to communicate the change to anyone who has a copy.

Do I lose my rights if I have a guardian?

People who do not have the ability to make and communicate important decisions about their personal and financial affairs may be declared incompetent by a court and assigned a guardian to help them exercise their rights. If you have been adjudicated incompetent, your guardian is legally appointed by the court to serve as your decision-maker and advocate. However, your guardian must give you the opportunity to take part as fully as possible in all decisions affecting your life.

People who are adjudicated incompetent and who are assigned a court-appointed guardian retain all legal and civil rights, except rights granted to the guardian by the court. You should read the guardianship order carefully. Often it includes language that reserves some of your rights, such as your right to associate with your own friends, make decisions about where you live or make healthcare decisions.

Can I have my competency restored?

If you have been declared incompetent, you can have your guardianship reversed and possibly be restored to competency (decision by a judge about your legal ability to make choices). You, the guardian, or any other interested person can ask the clerk of Superior Court to re-open the case. The request begins by filing a written motion or petition with the clerk in the county where the guardianship is administered.

To be restored to competency, you must prove that you are able to manage your own affairs and make and communicate important decisions. If competency is restored, the guardian is dismissed.

Partial restoration of some rights is also an option. For more information about guardianship, please contact your local Department of Social Services (DSS) office.

What are my privacy rights?

Alliance Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of This Notice: September 23, 2013

Alliance Healthcare (“Alliance”) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at Alliance Health, please contact the Privacy Officer at 800-510-9132 or at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560.

Understanding Your Medical Record/Health Information

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, assessment, diagnosis, treatment plan, and treatment recommendations. These records may also disclose or reveal that you are a recipient of public welfare benefits. This Protected Health Information (PHI), often referred to as your medical record, serves as a basis for planning your treatment, a means to communicate between service providers involved in your care, as a legal document describing your care and services, and verification for you and/or a third party payer that the services billed were provided to you. It can also be used as a source of data to assure that we are continuously monitoring the quality of services and measuring outcomes. Understanding what is in your medical record and how, when and why we use the information helps you make informed decisions when authorizing disclosure to others. Your health information will not be disclosed without your authorization unless required or allowed by state and Federal laws, rules or regulations.

Our Responsibilities

Alliance must protect and secure health information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care. We are only allowed to use and disclose protected health information in the manner described in this Notice. This Notice is posted on our website and we will provide you a paper copy of this Notice upon your request.

How Alliance Health May Use or Disclose Your Health Information

The following categories describe ways that Alliance may use or disclose your health information. Any use or disclosure of your health information will be limited to the minimum information necessary to carry out the purpose of the use or disclosure. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Note that we can only use or disclose alcohol and drug abuse records with your consent or as specifically permitted under federal law. These exceptions are listed on the next page.

Payment Functions

We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. Health information may be shared with other government programs such as Medicare, Medicaid, NC Health Choice, or private insurance to manage your medical necessity of health care services, determine whether a particular treatment is experimental or investigational, or determine whether a treatment is covered under your plan.

Healthcare Operations

We may use and disclose health information about you to carry out necessary managed care/ insurance-related activities. For example, such activities may include premium rating and other

activities relating to plan coverage, conducting quality assessment and improvement activities such as handling and investigating complaints, submitting claims for stop-loss coverage, conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs, and business planning, management and general administration.

Treatment

Alliance Health is not a provider of treatment but some of our functions require that we make a referral for an assessment or perform other activities which include helping formulate a treatment plan, coordinating appropriate and effective care, treatment and services or setting up an appointment with other behavioral health and health care providers. We may also share your health information with emergency treatment providers when you need emergency services. We may also communicate and share information with other behavioral health service providers who have contracts with Alliance or governmental entities with whom we have business associate agreements. These include hospitals, licensed facilities, licensed practitioners, community-based service providers, and governmental entities such as local jails and schools. When these services are contracted, we may disclose your health information to our contractors so that they can provide you services and bill you or your third-party payer for services rendered. We require the contractor to appropriately safeguard your information. We are required to give you an opportunity to object before we are allowed to share your PHI with another HIPAA Covered Entity such as your primary care physician or another type of physical health type provider. If you wish to object to us sharing your PHI with these types of providers, then there is a form you must sign that will be kept on file and we are required by law to honor your request.

Required by Law

Alliance may use and disclose your health information as required by law. Some examples where we are required by law to share limited information include but are not limited to: PHI related to your care/treatment with your next of kin, family member, or another person that is involved in your care, with organizations such as the Red Cross during an emergency, to report certain type of wounds or other physical injuries, and to the extent necessary to fulfill responsibilities when a consumer is examined or committed for inpatient treatment.

Public Health

Your health information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to preventing or controlling disease, injury or disability, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Health Oversight Activities

We may disclose your health information to health, regulatory and/or oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system. For example, health information may be reviewed by investigators, auditors, accountants or lawyers who make certain that we comply with various laws, or to audit your file to make sure that no information about you was given to someone in a way that violated this notice.

Judicial and Administrative Proceedings

We may disclose your health information in response to a subpoena or court order in the course of any administrative or judicial proceeding, in the course of any administrative or judicial proceeding required by law (such as a licensure action), for payment purposes (such as a collection action), or for purposes of litigation that relates to health care operations where Alliance is a party to the proceeding.

Public Safety/Law Enforcement

We may disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent danger or threat to the health or safety of a particular person or the general public or when there is likelihood of the commission of a felony or violent misdemeanor.

National Security

We may disclose your health information for military, prisoner, and national security.

Worker's Compensation

We may disclose your health information as necessary to comply with worker's compensation or similar laws.

Marketing

We may contact you to give you information about health-related benefits and services that may be of interest to you. If we receive compensation from a third party for providing you with the information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this third party.

Disclosures to Plan Sponsors

We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.

Research

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

Applicability of More Stringent State Laws

Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws or rules that are more stringent than Federal laws or regulations, including disclosures related to mental health and substance abuse, intellectual/developmental disabilities, alcohol and other drug abuse (AODA), and HIV testing.

Use and Disclosure of Health Information without your Authorization

Federal laws require or allow that we share your health information, including alcohol and drug abuse records, with others in specific situations in which you do not have to give consent, authorize or have the opportunity to agree or object to the use and disclosure. Prior to disclosing your health information under one of these exceptions, we will evaluate each request to ensure

that only necessary information will be disclosed. These situations include, but are not limited to the following:

- To a county department of social services or law enforcement to report abuse, neglect or domestic violence,
- To respond to a court order or subpoena,
- To qualified personnel for research, audit, and program evaluation,
- To a health care provider who is providing emergency medical services,
- To appropriate authorities if we learn that you might seriously harm another person or property (including Alliance) in the future or that you intend to commit a crime of violence or that you intend to self-harm,
- For the purpose of internal communications, as outlined above, or
- To qualified service organization agencies when appropriate. (These agencies must agree to abide by the Federal law.)

NC-TOPPS assessments fall under the audit or evaluation exception of federal confidentiality regulations (42 CFR Part 2 and 45 CFR Parts 160 and 164). Consumer identifying information obtained via NC-TOPPS may be disclosed without consumer consent to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and to authorized contractors under the audit and evaluation exception. The DMH/DD/SAS or its authorized contractors may re-disclose any individual consumer-identifying information only to the designated provider facility and to the consumer's assigned LME/MCO for which this information has been submitted.

When Alliance May Not Use or Disclose Your Protected Health Information

Except as described in this notice, Alliance will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, although we will be unable to take back any disclosures we have already made with your permission.

- Your authorization is necessary for most uses and disclosures of psychotherapy notes.
- Your authorization is necessary for any disclosures of health information in which the health plan receives compensation.
- Your authorization is necessary for most uses and disclosures of alcohol and drug abuse records (exceptions are listed above).

Statement of Your Health Information Rights

Although your health information is the physical property of Alliance, the information belongs to you. You have the right to request, in writing, certain uses and disclosures of your health information.

Right to Request Restrictions

You have the right to request a restriction on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request. If you would like

to make a request for restrictions, you must submit your request in writing to the Privacy Officer at the address listed below. We will let you know if we can comply with the restriction or not.

Right to Request Confidential Communications

You have the right to receive your health information through a reasonable alternative means or at an alternate location. To request confidential communications, you must submit your request in writing to the Privacy Officer at the address listed below. We are not required to agree to your request.

Right to Inspect and Copy

You have the right to inspect and receive an electronic or paper copy of your health information that may be used to make decisions about your plan benefits. To inspect and copy information, you must submit your request in writing to the Privacy Officer at the address listed below. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. There are certain situations where we will be unable to grant your request to review records.

Right to Request Amendment

You have a right to request that we amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can appeal the denial.
To request an amendment, you must make your request in writing to the Privacy Officer at the address listed below. You must also provide a reason for your request.

Right to Accounting of Disclosures

You have the right to receive a list or accounting of disclosures of your health information made by us in the past six years, except that we do not have to account for disclosures made for purposes of payment functions, healthcare operations of treatment, or made by you. To request this accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address listed below. We will provide one list or accounting per 12-month period free of charge, we may charge you for additional lists or accountings. We will inform you of the cost and you may choose to withdraw or modify your request before any costs are incurred. There are certain exceptions that apply.

Right to a Copy

You have a right to receive an electronic copy of this notice at any time. To obtain a paper copy of this Notice, send your written request to the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560.You may also access this Notice at AllianceHealthPlan.org/consumers-families/consumer-rights/notice-of-privacy-practices/.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or one of our business associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or by calling 800-510-9132.

Changes to this Notice and Distribution

Alliance Health reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new notice provisions effective for all health information that it maintains. As your health plan, we will provide a copy of our notice upon your enrollment in the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you. The notice is provided and pertains to the named Medicaid beneficiary or other individual enrolled in the plan.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed as well as the rights you have to your health information. If our Notice has a material change, we will post information regarding this change to the website for you to review. In addition, following the date of the material change, we will include a description of the change that occurred and information on how to obtain a copy of the revised notice in any annual mailing required by 42 CFR Part 438.

Complaints

Complaints about this Notice of Privacy practices or about how we handle your health information should be directed to the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or by calling 800-510-9132. Alliance will not retaliate against you in any way for filing a complaint. All complaints to Alliance must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services at hhs.gov/ocr/privacy/hipaa/complaints/ or call 800-368-1019.

Si necesita información en español, llámenos al 800-510-9132.

Alliance Health (Alliance Behavioral Healthcare) History of Notice of Privacy Practices

Original Approval Date: June 2012
Revised: September 23, 2013 (Removed activities including fundraising, genetic information and underwriting, research; added information to Rights to be Notified of a Breach; changes to NCTOPPS; added use or disclosure of substance abuse with consent or as permitted.)
Revised: August 15, 2017 (Added the History of changes to the Notice of Privacy Practices)

Section 10: How Do I Make an Appeal or File a Grievance?

In this section:

- What is an appeal?
- How do I file an appeal of an adverse benefit determination?
- What is a reconsideration request?
- What records should I keep?
- Can I receive services during my reconsideration review?
- Can my reconsideration review request be expedited?
- Can the reconsideration review timeframe be extended?
- What if I disagree with the decision?
- How do I file a formal appeal with the Office of Administrative Hearings?
- Who is responsible for my services while my appeal is pending?
- Can I appeal a decision about non-Medicaid services?
- Can my non-Medicaid reconsideration review request be expedited?
- What if I disagree with the decision?
- What is a grievance?
- How do I file a grievance?
- What is the grievance process?
- What if I'm not satisfied with the response to my Medicaid grievance?
- What if I'm not satisfied with the response to my non-Medicaid grievance?
- What records should I keep?
- Can I get legal assistance?
- How can I file a complaint?
- What does Alliance do when it receives a complaint?
- What if I'm not satisfied with the response to my complaint?

We want you to understand your right to request appeals and file grievances. Medicaid beneficiaries have a constitutional right to due process. Due process means you are entitled to a written notice and an opportunity to be heard. Our Medicaid appeals system is based on this fundamental right to due process.

What is an appeal?

An appeal means "a request for review of an adverse benefit determination." An adverse benefit determination is defined as:

- Alliance denies or partially denies a request for services for you.
- Alliance reduces, suspends (pauses) or terminates (ends) authorization for a service you are currently authorized to receive.
- Alliance denies the whole payment or partial payment for your authorized services.

- Alliance fails to ensure that you receive services in a timely manner, as defined by the state
- Alliance fails to meet the grievance and appeal deadlines described in this section.
- Alliance denies your request to dispute a financial liability (or responsibility), including cost sharing, copayments, premiums, deductibles, coinsurance and other financial liabilities.
- Alliance fails to allow you to get services outside the network, but only if you live in a rural area and there is no network provider available to provide the service.

A Medicaid appeal can be filed by you, your guardian, or a representative, including your provider, who has your written consent (or permission) to act on your behalf. Alliance ensures that punitive action (any kind of punishment) is not taken against you or the provider who either requests or supports a member appeal.

Before the adverse benefit determination is final, you will receive a letter explaining how to appeal the adverse benefit determination. In most cases, if you properly appeal the adverse benefit determination by following the instructions in the letter, your services will continue through the end of the original authorization period.

Alliance ensures members are not discouraged, coerced (forced) or misinformed (given wrong information) regarding the type, amount and duration (length) of services they may request. In addition, Alliance does not discourage, coerce (force) or misinform (give wrong information) to members about the right to appeal the denial, reduction or termination (stopping) of a service.
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Note: If you appeal a denial of a request for a new service, Alliance will not continue to authorize the requested service during an appeal period.

If Alliance reduces, suspends (pauses) or terminates (ends) a current, unexpired service authorization, Alliance must notify you in writing at least 10 calendar days before such adverse benefit determination. If Alliance denies a request for a new service, you will be notified in writing when the denial decision is made. You will be notified in writing of the process to appeal an adverse benefit determination in the adverse benefit determination letter. It is very important for you to follow all instructions given in the notices and letters you receive after Alliance makes an adverse benefit determination.

How do I file an appeal of an adverse benefit determination?

If you wish to appeal an Alliance adverse benefit determination, you must first submit a LME/MCO Level Appeal Form. If you do not like the outcome of the Alliance LME/MCO Level Appeal, you can formally request a State Fair Hearing with the Office of Administrative Hearing (OAH). Instructions for submission are included below.

An appeals coordinator is available to help explain and complete your appeal documentation, if requested by you, your legal guardian, or your authorized representative. We must provide you with reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing auxiliary (assistive) aids and services upon request, such as interpreter services and TTY/TTD capability. You can call Alliance at (919) 651-8641 to speak with the appeals coordinator.

What is a reconsideration request?

An Alliance Reconsideration Review or LME/MCO Local Appeal is a local, independent review of an Alliance adverse benefit determination. When Alliance makes a decision regarding your services, you will receive an adverse benefit determination letter in the mail. Within 60 calendar days of the mailing date of your adverse benefit determination letter, you, your guardian or your authorized representative may request an Alliance reconsideration either by asking for one or in writing. Your written or oral (voiced) request will be on time if Alliance receives the request within the 60-calendar day deadline.

The request for a reconsideration review orally or in writing must be received within 60 calendar days. The LME/MCO Level Appeal Form must be sent to any of the following:

BY FAX: Fax: (919) 651-8682
BY MAIL: Alliance Health Attn: Appeals Department 5200 W. Paramount Parkway, Suite 200 Morrisville, NC 27560
For Assistance Call: (919) 651-8545
IN PERSON: At any of the Alliance offices
ORAL REQUESTS: Call (919) 651-8641

Please remember that your representative must have your written consent to submit a reconsideration review request. We will send you a written acknowledgement within one business day when we receive your request. If you have submitted a request and have not received the acknowledgement, call us and let us know. We will not accept or process requests for reconsideration filed outside the timeline.

A healthcare professional with appropriate clinical expertise in treating your condition (who was not involved in the original decision) will decide your LME/MCO Level Appeal request. It can take up to 30 calendar days to make a decision about your Alliance reconsideration review request.

What records should I keep?

It is important for you to keep good records of written correspondence and telephone conversations. Keep every letter you receive from Alliance, your providers, or the Division of Health Benefits. On a sheet of paper, make a telephone log sheet. Always write down:

- The date and number you called.
- The name of the person with whom you spoke.
- A note about the subject of the call.
- When you can expect a response and from whom, or the name and number of another person for you to contact.

Store your telephone log sheet and letters in a safe place. If you want a copy of your case file, free of charge, please call the appeals coordinator at (919) 651-8545. Please let us know as soon as possible if you want a copy. The case file will include all records considered by Alliance in connection with the decision, including documents submitted by your provider. You can also submit new information at any point during the appeal process. This might include new information from your physician, such as updated assessments.

All appeal records are kept by Alliance for a minimum of five years after resolution. There must be no future litigation or audits for these records to be destroyed.

Can I receive services during my reconsideration review?

Federal law allows you to continue receiving services when you appeal an adverse benefit determination. If you wish for existing services to continue without interruption until the end of the original authorization period while you appeal a Medicaid reduction, suspension (pause), termination (end) or denial, you must request the Alliance LME/MCO Level Appeal within 10 calendar days of the date of the adverse benefit determination letter was mailed.

If you request a LME/MCO Level Appeal 11 to 60 calendar days from the date of the adverse benefit determination letter was mailed, there could be an interruption in your current services. Upon receipt of your Reconsideration Review Request Form, we will reinstate the services.

Federal law explains this in much more detail. It says that if Alliance terminates, suspends or reduces your current Medicaid services before the expiration of the authorization period, you may continue to receive those Medicaid services if you meet all of the following conditions:

- You timely submit a LME/MCO Level Appeal Request Form, meaning on or before the following (whichever is later):
    - Within 10 calendar days of Alliance mailing the adverse benefit determination, or
    - The intended effective date of Alliance's proposed adverse benefit determination,
- The LME/MCO Level Appeal involves the termination, suspension or reduction of currently authorized services,
- The services were ordered by an authorized provider,
- The authorization period for the services has not expired, and
- You timely request (within 10 calendar days) that your services continue.

If all of these conditions are met, you may continue to receive your current services until:

- You withdraw your request for a LME/MCO Level Appeal or State Fair Hearing,
- Ten calendar days after Alliance mails the LME/MCO Level Appeal decision to you, unless you request a State Fair Hearing with the NC Office of Administrative Hearing (OAH) within those 10 calendar days, or
- A State Fair Hearing office issues a hearing decision against you.

Can my reconsideration review request be expedited?

You may request to expedite (speed up) the LME/MCO Level Appeal process if the 30-day timeframe will harm your health and safety. You can request an expedited LME/MCO Level Appeal by asking for one orally (voiced) or in writing. If you make an oral request, it does not have to be followed up with a written request. If we do not expedite your appeal request you have the right to file a grievance if you disagree with our decision.

Alliance will try to notify you by phone and will send a written notice within two calendar days of your request for an expedited review to let you know if this request was accepted as expedited. If the request is accepted as expedited, your appeal will be processed within 72 hours and Alliance will make efforts to inform you of the outcome in a phone call. We will also send you a letter containing the same information. For any expedited appeal, you will be notified of Alliance's decision with 72 hours of submitting the request.

Can the reconsideration review timeframe be extended?

Alliance may extend the timeframes up to 14 calendar days if you request an extension. Alliance may extend timeframes up to 14 calendar days on its own when there is a need for additional information and the extension is in your interest.

When Alliance extends timeframes, but you did not request the extension, Alliance will:

- Provide you with written notice of the reason for the extension within two calendar days.
- Make an effort to provide prompt verbal (by telephone) notification of the delay.
- Resolve the appeal as quickly as your health condition requires and no later than the date the extension expires.
- Notify you of your right to file a grievance if you disagree with the decision to extend the appeal resolution timeframe.

What if I disagree with the decision?

If you do not agree with the outcome of the reconsideration, you can file a formal appeal with the NC Office of Administrative Hearings (OAH) to request a State Fair Hearing. The request for State Fair Hearing must be made to OAH within 120 calendar days of the mailing date of the reconsideration review decision (called the Notice of Resolution letter). Formal appeals are heard by an administrative law judge with OAH. If you have questions, you may call DHHS's toll-free CARELINE Information and Referral Service at 800-662-7030 and ask for the DHB Hearing Office.

How do I file a formal appeal with the Office of Administrative Hearings?

If you wish to request a State Fair Hearing, please mail or fax the State Fair Hearing form you received from Alliance to the addresses or fax numbers listed on the following page:

Agency	Mailing Address	Telephone Number	Fax Number
North Carolina Office of Administrative Hearings (OAH)	Attn: Clerk 6714 Mail Service Center Raleigh, NC 27699-6700	(919) 431-3000	(919) 431-3100
Alliance Health	Attn: Appeals Department 5200 W. Paramount Parkway, Suite 200 Morrisville, NC 27560	(919) 651-8545	(919) 651-8682

After you request a State Fair Hearing, OAH or the Mediation Network of North Carolina will offer you the option to have your case mediated by a mediator. A mediation is an informal meeting to attempt to resolve a formal appeal before it is heard by the administrative law judge. If you accept mediation, it must be completed within 25 days of your formal appeal submission. If you agree to mediation and fail to show up, OAH will dismiss your appeal and it will not proceed to a hearing. If you decline mediation, or you accept mediation and it is unsuccessful, your formal appeal will proceed to a hearing. You will be notified by mail of the date, time and location of the hearing.

During the mediation phase of the appeal, Alliance's Appeals Coordinator is available to provide assistance to explain and complete required appeal documentation if requested by you, your legal guardian or your authorized representative. If mediation resolves the case, the hearing will be dismissed. Services will be provided as specified by the Mediation Network of North Carolina.

You may represent yourself in the hearing process, hire an attorney or ask a relative, friend or other spokesperson to speak on your behalf. We will provide you with all documents we intend to use at the hearing in advance. You can present new evidence at the hearing, although this may result in a delay. At the hearing, both sides can present evidence.

If the formal appeal is not settled at mediation, the matter will be set for a hearing with an administrative law judge. The administrative law judge will make a decision regarding your case. You will receive a written copy of the decision within 90 days from the date you filed your request for reconsideration with Alliance, not including the number of days you took to file for a State Fair Hearing. If you disagree with the administrative law judge's final decision, you may retain an attorney and appeal your case in Superior Court.

Who is responsible for my services while my appeal is pending?

If the final decision is not in your favor Alliance's reduction, suspension, termination, or denial is upheld, then Alliance may elect to recover from you the cost of the services furnished to you during the formal appeal process. Alliance may only seek recovery from the member, the spouse of an adult member or the parent or legal guardian of a minor member. A decision about whether

to seek to recover the cost of such services shall be made by the Alliance CEO or designee, taking into account the following factors:

- The financial ability of the member to reimburse Alliance, and
- The costs to Alliance of recovering such funds, and
- Whether the appeal had no merit, was frivolous or was not filed in good faith.

Can I appeal a decision about non-Medicaid services?

Unlike Medicaid services, state law makes clear that there is not an entitlement to non-Medicaid services, and the appeal rights are different. In general, you may request an appeal if Alliance issues a decision to deny, reduce, terminate or suspend a non-Medicaid service.
Alliance is required to notify you in writing within one day if we make a decision to deny, reduce, suspend or terminate your non-Medicaid services. If you get a letter from us saying some or all of your non-Medicaid services have been reduced, suspended, terminated or denied, you can appeal the decision.

This notice of decision will include an appeal form and information about how to file your Alliance appeal request and all subsequent appeals. You must file an appeal with Alliance before you file an appeal with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

To appeal the reduction, suspension, termination or denial of non-Medicaid benefits, you must complete and return the Non-Medicaid Services Appeal Form (included in the notice of decision mailed to you) to any of the following within 15 business days of the date of your notice of decision. Your provider cannot file the appeal for you. Send the form to:

BY FAX: (919) 651-8682
BY MAIL: Alliance Health Attn: Appeals Department 5200 W. Paramount Parkway, Suite 200 Morrisville, NC 27560
For Assistance Call: (919) 651-8641
IN PERSON: At any of the Alliance offices

An Alliance appeal is an impartial review of the decision to reduce, suspend, terminate or deny your non-Medicaid services. A healthcare professional with appropriate clinical expertise in treating your condition or disorder who was not involved in the original decision will issue the appeal. Alliance will decide your appeal within seven business days of receipt of a valid request. Services will not be authorized during the review.

Can my Non-Medicaid Services Appeal review request be expedited?

You may request to expedite (speed up) the Non-Medicaid Services Appeal process if the 7-day timeframe will harm your health and safety. You can request an expedited Non-Medicaid Services Appeal by asking for one or in writing. If you make an oral request, it does not have to be followed up with a written request (unlike the actual request for Non-Medicaid Services Appeal). We will approve or deny your request to expedite your Non-Medicaid Services Appeal Review Request.

If you request an expedited Non-Medicaid Services Appeal, and Alliance denies it, we will notify you by telephone of the decision NOT to expedite the request. If we agree that it should be expedited, we will complete the expedited review within 72 hours of the request and let you or your provider know our decision by phone. We will send you a written decision no more than three days after that.

What if I disagree with the decision?

If you disagree with the appeal decision, you may file an appeal with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) to request a non-Medicaid appeal hearing within 11 calendar days of the appeal decision letter date. To file an appeal with DMH/DD/SAS, you must mail or fax a completed Non-Medicaid Appeal Request Form to:

BY FAX:
(919) 733-4962

BY MAIL:
DMH/DD/SAS Hearing Office
c/o Customer Service and Community Rights
Mail Service Center 3001
Raleigh, NC 27699-3001

The Non-Medicaid Appeal Request Form is included in the decision letter. Remember that DMH/DD/SAS must receive the request form no later than 11 days from the date of the Alliance appeal decision letter. Appeals are heard by a DMH/DD/SAS hearing officer at an Alliance office location. If you have questions about the DMH appeal process, please call DMH/DD/SAS at (919) 715-3197. Upon receipt of an appeal request, DMH/DD/SAS will:

- Review the appeal to determine your eligibility to appeal.
- Accept or deny the appeal. If the appeal is accepted, the office will contact you to schedule a non-Medicaid appeal hearing (with at least 15 days' notice).
- Request documentation from Alliance used in the initial decision and appeal.

The non-Medicaid appeal hearing:

- Is conducted by a DMH/DD/SAS hearing officer.
- Is conducted in person.
- Is scheduled for two hours.
- Is attended by the appellant (member who filed the appeal) and/or his or her representatives.
- Is attended by one or more Alliance representatives.

Within 60 days of the written request for appeal, the State Fair Hearing officer will issue a written decision that includes findings, decisions and recommendations to you or your legal representative and the Alliance Chief Executive Officer. Within 10 calendar days of receipt of the hearing officer's findings, Alliance will issue and send a written final decision to you or your legal representative.

Alliance ensures members are not discouraged, coerced (forced) or misinformed (given wrong information) regarding the type, amount and duration (length) of services they may request. In addition, Alliance does not discourage, coerce (force) or misinform (give wrong information) members about the right to appeal the denial, reduction, or termination (stopping) of a service.

What is a grievance?

A grievance is defined as any expression(s) of dissatisfaction about any matter other than an adverse benefit determination (see definition below) filed by a member or by an individual who has been authorized in writing to file on behalf of a member.

Your family members, friends, advocates and/or your attorney may also help you file a grievance. You or your network provider that has been authorized in writing to act on your behalf may file requests for grievances.

Adverse benefit determination means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.
- The failure of an LME/MCO (such as Alliance) or Prepaid Inpatient Health Plan (PIHP) to act within the timeframes provided in § 438.408(b).
- The denial of a member's request to exercise his or her right, under § 438.52 (b) (2) (ii), to obtain services outside the network.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financials liabilities.

Examples of grievance matters are:

- Staff not keeping an appointment.
- Staff not being respectful to you.
- Quality of care with a provider.
- Lack of access to services where you live or services that are not allowed on the benefit plan.
- Attitude of Alliance staff and providers.
- Billing and financial issues.
- Quality of your practitioner's office site.

How do I file a grievance?

If you are unhappy with your services, you have the right to file a grievance with Alliance. Members with Medicaid have a constitutional right to due process. Due process means you are entitled to a written notice and an opportunity to be heard. You can file a grievance in any of the following ways:

BY PHONE: 800-510-9132
BY MAIL: Alliance Health Quality Management Department Attn: Complaints and Grievances 5200 W. Paramount Parkway, Suite 200 Morrisville, NC 27560
BY EMAIL: Complaints@AllianceHealthPlan.org
ONLINE: Downloadable form available at AllianceHealthPlan.org/consumers-families/consumer-rights/filing-a-complaint/

If you want to discuss a grievance, you can contact Alliance at 800-510-9132. You may also share your concerns with your provider or care manager directly and ask them to help or advise you. You are not required to discuss your grievance directly with your provider before calling Alliance.

When you call Alliance to discuss your grievance, we will make a written record of it. If your grievance involves health and safety concerns, we will take action immediately. You and/or your

family member have the right to be represented and have support from advocates, personal supporters or a legally responsible person at any meeting held to discuss the grievance. Your provider can assist you with filing a grievance as well. However, if the provider calls to file a grievance on your behalf, the provider must have your written consent.

What is the grievance process?

Once Alliance receives your grievance, we will:

- Make a written record of the grievance.
- Send written acknowledgment of your grievance within five business days.
- Contact you and others involved with the grievance to help resolve your concerns.
- Consult the department that can best address your concerns. If your grievance involves health and safety concerns, we will take action immediately.
- Attempt to mediate your grievance with your provider agency, you are not required to use your service provider's grievance process.

We will discuss the resolution of the grievance with you and send you a formal resolution letter. The notification will specify if your grievance is referred to another agency, such as the state DHSR (if a licensed facility is involved). You will not lose your Medicaid benefits for filing a grievance.

It is Alliance's policy is that all grievances must be resolved within 90 calendar days of receipt. For non-Medicaid grievances, Alliance will seek to resolve grievances as quickly as possible and provide written notice by US mail to all affected parties no later than 15 calendar days of the date Alliance received the grievance. If the grievance is not resolved within 15 business days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

This timeframe can be extended by 14 calendar days if:

- You make the request.
- Alliance demonstrates to the DHB that there is a need for additional information and the delay is in your best interest.

What if I'm not satisfied with the response to my Medicaid grievance?

Please note that you cannot appeal the resolution of a grievance regarding a Medicaid service. There is no right to appeal the resolution of a grievance of a Medicaid service to the state OAH or any other forum.

What if I'm not satisfied with the response to my non-Medicaid grievance?

You can appeal the resolution of grievances regarding non-Medicaid-funded services or other matters by calling Alliance's 24-hour 800-510-9132.

If you are not satisfied with the response you receive from Alliance, you may contact Disability Rights North Carolina at (877) 235-4210. You may also call the Advocacy and Customer Service Section under Customer Service and Community Rights of the NC DMH/DD/SAS at (919) 715-3197.

What records should I keep?

It is important for you to keep good records of written correspondence and telephone conversations. Keep every letter you receive from Alliance, your providers, or the DHB. On a sheet of paper, make a telephone log sheet. Always write down:

- The date and number you called.
- The name of the person with whom you spoke.
- A note about the subject of the call.
- When you can expect a response and from whom, or the name and number of another person for you to contact.

Store your telephone log sheet and letters in a safe place. All grievance records are kept by Alliance for a minimum of five years after resolution. For these records to be destroyed, there must be no future litigation or audits that will occur.

Can I get legal assistance?

To locate a lawyer please call 800-662-7660 for the NC Health Information Project Lawyer Referral Service or 800-662-7407 for the NC State Bar Lawyer Referral Service. You can also call Disability Rights of North Carolina toll-free at (877) 235-4210 or Legal Aid of North Carolina at (866) 219-5262.

How can I file a complaint?

Individuals also have the option to file complaints, which are different from grievances and appeals. A complaint is any expression of dissatisfaction about Alliance or a network provider, initiated by anyone who does not have written consent to file a grievance on a member's behalf.

Examples of complaints are:

- Staff tardiness.
- Staff not being respectful to a member.
- Quality of care or access to services.
- Attitude of Alliance staff and providers.
- Billing and financial issues.
- Quality of a practitioner's office site.

Friends, family members who are not guardians or coworkers may choose to file a complaint with Alliance and may file anonymously (without giving their name). Anyone can file a complaint by using the contact information on the following page:

BY PHONE: 800-510-9132
BY MAIL: Alliance Health Quality Management Department Attn: Complaints and Grievances 5200 W. Paramount Parkway, Suite 200 Morrisville, NC 27560
ONLINE: Downloadable form available at AllianceHealthPlan.org/consumers-families/consumer-rights/filing-a-complaint/

If you want to discuss a complaint, you can contact Alliance at 800-510-9132. When anyone calls Alliance to discuss a complaint, we will make a written record of it. If the complaint involves health and safety concerns Alliance will take action immediately. You and/or your family member have the right to be represented and have support from advocates, personal supporters or a legally responsible person at any meeting held to discuss the complaint.

What does Alliance do when it receives a complaint?

It is Alliance's policy is that all complaints must be resolved within 30 calendar days of receipt. This timeframe can be extended by 14 calendar days if:

- You make the request.
- Alliance demonstrates to the DHB that there is a need for additional information and the delay is in your best interest.

Once Alliance receives your complaint, we will:

- Send written acknowledgment to the person who filed the complaint.
- Contact you and others involved with the complaint to help resolve your concerns.
- Attempt to mediate the complaint with your provider agency.
- Alliance will discuss the resolution of the complaint with you and send you a formal resolution letter.

What if I am not satisfied with the response to my complaint?

All complaints have appeal rights, for both Medicaid and non-Medicaid services. Individuals must file an appeal to the complaint within 21 calendar days from receipt of the investigation report from Alliance. The resolution letter will include information on how to file this appeal.

A decision on the appeal will be mailed back to the complainant within 28 calendar days from receipt of the appeal. This second decision is final, and there are no further appeal rights. All complaint records are kept by Alliance for a minimum of five years after resolution. For these records to be destroyed, there must be no future litigation or audits that will occur.

Section 11: How can I help prevent fraud and abuse?

In this section:

- How can I help prevent fraud and abuse?
- How do I report fraud and abuse?

Alliance is committed to preventing and identifying fraud and abuse in the Medicaid program. You can help by reporting any suspicious billing practices or other activity you think may be fraud or abuse.

Medicaid fraud occurs when a healthcare provider submits a false or fraudulent claim or when a person intentionally lies or conceals income or assets to obtain government benefits. Abuse occurs when a person or healthcare provider engages in activities that result in unreasonable or excessive cost to the Medicaid program, including a Medicaid managed care organization, such as Alliance. The federal government estimates fraud and abuse costs US taxpayers more than $15 billion every year.

Examples of fraud and abuse may include:

- You fail to report all your income or other insurance when applying for Medicaid.
- You let someone else use your Medicaid card to obtain services.
- Someone steals your Medicaid card and uses it without your permission.
- A provider bills Alliance for services or supplies that you never received.
- A provider bills Alliance for services that were not medically necessary, not coded properly or not supported by all required documentation.
- A provider's reported credentials are false.

How can I help prevent fraud and abuse?

Things you SHOULD do:

- DO protect your Medicaid number (on your Medicaid card) and your Social Security Number (on your Social Security card). Treat your Medicaid card like it is a credit card.
- DO ask for a copy of everything you sign and keep all paperwork together.
- DO ask questions. You have a right to know everything about your care and treatment, including costs billed to Alliance by your provider.
- DO use a calendar to record all of your service appointments and treatments. Then check your explanation of benefits carefully to make sure you got each service listed and that all the details are correct. If you spend time in a hospital, make sure the admission date, discharge date and diagnosis are correct.
- DO remain alert for services that were promised to you but never delivered or for unnecessary tests or procedures.
- DO be wary of providers who tell you that the item or service isn't usually covered, but they "know how to bill" so that Alliance or Medicaid will pay.

- DO remember that nothing is ever “free.” Don't accept offers of money or gifts for free medical care.
- DO check your pills before you leave the pharmacy to be sure you got the correct medication, including whether it's a brand or generic and the full amount. If you don’t get your full prescription, report the problem to the pharmacist.
- DO report suspected instances of fraud.

Things you SHOULD NOT do:

- DON'T share your Medicaid card, Medicaid number, Social Security card, or Social Security Number with anyone except your doctor or other authorized provider.
- DON’T let friends, relatives or anyone else “borrow” your Medicaid card.
- DON’T ask your doctor or other health care provider for treatment or care that you do not need or let anyone else persuade you to see a doctor for care or services you don't need.
- DON’T accept gifts or kickbacks from your provider.
- DON’T share medical records or other sensitive information with anyone except Alliance or another insurance company, or a doctor, agency, clinic, hospital or other healthcare provider.
- DON'T accept medical supplies from a door-to-door sales representative. If someone comes to your door claiming to be from Medicare or Medicaid, remember that Medicare and Medicaid don’t send representatives to your home to sell products or services.
- DON’T sign any blank forms.
- DON'T be influenced by certain media advertising about your health. Many internet, television and radio ads don’t have your best interest at heart.

How do I report fraud and abuse?

You can remain anonymous, but detailed information will help us with our investigation. (In rare cases involving legal proceedings, Alliance may have to reveal who you are.) When you contact us, please provide the name/Medicaid ID number of the Medicaid beneficiary involved, the name of the provider, the date(s) of service, the amount of claims billed or paid and a description of the fraudulent or suspicious activity.

You can report suspected fraud and abuse in any of the following ways:

- Call the 24-hour, toll-free Alliance Fraud and Abuse Line at 888-727-6721. You may remain anonymous
- Call the Medicaid Fraud, Waste and Program Abuse Tip Line at 877-DMA-TIP1 or 877-362-8471
- Call the NC Division of Health Benefits (DHB) Customer Service Center at 800-662-7030
- Call the U.S. Office of Inspector General’s Fraud Line at 800-HHS-TIPS or 800-447-8477
- Call the NC State Auditor at 800-730-TIPS or 800-730-8477.
- Submit a Medicaid fraud and abuse confidential (private) online complaint on the DHB Customer Service website at medicaid.ncdhhs.gov/meetings-and-notices/report-fraud-waste-or-abuse.

Section 12: Advocacy, Recovery and Resilience

In this section:

- What is the Consumer and Family Advisory Committee (CFAC)?
- What is the Human Rights Committee (HRC)?
- How can Alliance help me in my recovery?
- What is resilience?
- Does Alliance offer education or training?
- Does Alliance offer housing support programs?

What is the Consumer and Family Advisory Committee (CFAC)?

The Consumer and Family Advisory Committee consists of individuals who receive mental health, IDD, or substance use services and family members of those individuals. CFAC is a self-governing committee that serves as an advisor to Alliance administration and the Board of Directors.

State statutes charge CFAC with the following responsibilities:

- Review, comment on and monitor the implementation of the local business plan.
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.
- Review and comment on the budget.
- Participate in all quality improvement measures and performance indicators.
- Submit findings and recommendations to the state CFAC regarding ways to improve the delivery of mental health, IDD, and substance use services.

For more information or if you are interested in participating, call toll-free at 800-510-9132 to be put in touch with someone at the Alliance CFAC.

What is the Human Rights Committee?

The Human Rights Committee oversees Alliance's compliance with federal and state rules regarding individual rights, confidentiality and grievances. The HRC is made up of individuals, family members and board members who meet at least once quarterly. It reviews and monitors trends in the use of restrictive interventions, abuse, neglect and exploitation, deaths, and medication errors. The HRC also makes reports to the Board of Directors. Individuals, family members and other stakeholders may submit rights violations to the HRC through the Corporate Compliance Officer or through the usual grievance process.

If you are interested in serving on the HRC, please call 800-510-5132 and ask to speak with a Human Rights Committee liaison.

How can Alliance help me in my recovery?

The National Consensus Statement on Mental Health Recovery states that “Recovery is a journey of healing and transformation enabling a person to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

Alliance believes that everyone is resilient and that people can recover from trauma. Everyone deserves to experience a fulfilling and productive life. We want to help you identify your strengths and reach your goals. We can help you work with your family and your support system to participate more fully in the community of your choice.

We believe that recovery:

- Emerges from hope.
- Is person-driven.
- Occurs through many pathways.
- Is holistic.
- Is supported by peers and allies.
- Is supported through relationships and social networks.
- Is culturally based and influenced.
- Is supported by addressing trauma.
- Involves individual, family and community strengths and responsibility.
- Is based on respect.

Each person’s path to recovery is unique. Through the recovery process, people who experience psychiatric or substance use disorders are empowered to understand that who they are as a whole person – not their diagnosis – is central to their lives.

Alliance strives to support you on your path to recovery by engaging in community collaboration and promoting services that improve the health and wellbeing of those we serve. Our hope is that these programs will help you achieve your recovery goals and empower you to live in a healthy, safe and meaningful way.

What is resilience?

Resilience is the ability to adapt to stress. Resilience is the ability to withstand catastrophe. This means using coping skills to keep going in the face of adversity. Alliance can assist you with getting services and support to help with your situation. Contact Alliance at 800-510-9132 for assistance.

Does Alliance offer education or training?

People who are well informed about their illnesses are better able to manage them and achieve desired results. Alliance provides educational opportunities to our members, families and other community members with helpful information about diagnoses, treatment options and maximizing treatment benefits. More information can be found on our website at AllianceHealthPlan.org or by calling 800-510-9132.

Does Alliance offer housing support programs?

We believe having a safe and stable place to live is an integral part of wellbeing and recovery. There is no entitlement to housing funds through Alliance, other than Transitions to Community Living (TCL). We work with community partners to provide knowledge, resources, and training about housing and residential options. Please call 800-510-9132 for more information.

Appendix A: Summary of the Provisions of this Agreement to be Provided to Members and Providers (Innovations Waiver)

The following statements, which are directed to members and providers, supersede any information contained in this handbook which may be inconsistent with these statements.

- During the planning process, your care manager will explain the different services to you and work with you to develop your Individual Support Plan (ISP) based on the services you wish to request and goals you have chosen. Your care manager will also explain the requirements in the Innovations Waiver around those services.
- Your care manager will assure that your ISP will include the services that you want to request, for the length of time that you want to request them. Your ISP should be used to plan for the entire year, and services that you expect to need at any point during that year.
- You must have a signed ISP in order to receive services through the Innovations Waiver. That means that you need to sign the ISP containing the services that you want to request, which may be different than the services that will be approved. Your care manager will draft the ISP based on your wishes, will review the plan with you before you sign it, will answer any questions you have, and will make any changes to the ISP that you request before you are asked to sign it.
- If you wish to change or add services during the plan year, you may ask your care manager to help you request the change by writing an update/revision to your ISP at any time.
- Resource allocation/individual budgets and the Support Intensities Scale ® (SIS ®) are tools that may be used in the planning process. You may have an assigned individual budget, which is not a limit on the amount of services you can request or have approved. If any of the services that you requested are denied, you will receive written notice with information about how you can appeal that decision.
- During the planning process, your care manager will review your individual budget with you. As mentioned above, your care manager will assure that your ISP includes the services you want to request, for the length of time you want to request them.
- The Utilization Management Department of Alliance will determine whether or not the services you request are medically necessary, not your care manager. A decision on your request for services in your ISP will be made within 14 days unless more information is needed.
- If any service requested in your ISP is not fully approved (for example, a service is denied, or is approved for fewer hours or for a length of time that is less than what you requested), you will receive a written explanation of that decision and information about how you can appeal.
- Alliance will not retaliate against you in any way if you appeal. Your care manager can assist you with the forms needed to file an appeal.

- If some services are approved and some are denied, you can receive the services that were approved while you appeal the services that were denied. You may also make a new request for different services while your appeal is pending, if you wish to do so.

Appendix B: Glossary of Acronyms and Words to Know

Advance directive: A communication given by a competent adult that gives directions or appoints another individual to make decisions concerning an individual's care, custody or medical treatment in the event that the individual is unable to participate in medical treatment decisions

Ability-to-pay determination: The amount an individual is obligated to pay for services. The ability to pay is calculated based on the individual's income and number of dependents. The Federal Government Poverty Guidelines are used to determine the individual's payment amount. See more at cms.hhs.gov/medicaid/eligibiity/default.asp.

Abuse and waste: Incidents or practices that are inconsistent with sound fiscal, business or medical practices that could result in an unnecessary cost to Alliance, the state or federal government or another organization. It could also result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2).

Alliance Health: A multi-county managed care organization (MCO) that manages, authorizes and oversees the provision of waiver services for individuals with mental health, IDD, and substance use needs whose Medicaid originates from Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.

Appeal: A request for review of an action.

Area: Used interchangeably with catchment or region to describe the counties that Alliance operates as an LME/MCO.

Assessment: A procedure for determining the nature and extent of need for which the individual is seeking services.

Authorized service: Medically necessary services pre-approved by the LME/MCO.

Best practices: Recommended practices, including evidenced-based practices that consist of those clinical and administrative practices, that have been proved to consistently produce specific, intended results, as well as emerging practices for which there is preliminary evidence of effectiveness of treatment.

Basic benefit plan: The basic benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services are intended to provide brief

interventions for individuals with acute needs. The basic benefit package is accessed through a simple referral from Alliance through its screening, triage and referral system. Once the referral is made, there are no prior authorization requirements for these services.

Care management: Care management is non-face-to face monitoring of an individual's care and services, including follow-up activities, as well as assistance to individuals in accessing care on non-plan services, including referrals to providers and other community agencies.

Consumer and Family Advisory Committee (CFAC): A formalized group of individuals and family members appointed in accordance with the requirements of NCGS 122-C-170. The purpose of CFAC is to ensure meaningful participation by individuals and families in shaping the development and delivery of public mental health, IDD and substance abuse services in the four-county region serviced by Alliance.

Care Management Department: A division of Alliance that provides outreach and treatment planning case management functions for special, high-impact population of individuals.

Covered services: The service which Alliance agrees to provide or arranges to provide to members.

Cultural competency: The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to identify and value differences, acknowledge the interactive dynamics of cultural differences, continuously expand cultural knowledge and resources with regard to populations served, collaborate with the community regarding service provisions and delivery, and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Centers for Medicare and Medicaid Services (CMMS or CMS): The unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs

County Department of Social Services (DSS): The local (county) public agency that is responsible for determining eligibility for Medicaid benefits and for other assistance programs

Denial of service: A determination made by Alliance in response to a network provider's request for approval to provide in-plan services of a specific duration and scope that disapproves the request completely or approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider, (an approval of a requested services that includes a requirement for a concurrent review by Alliance during the authorized period does not constitute a denial), or disapproves provision of the requested service(s) but approves provision of an alternative service(s).

Division of Health Benefits (DHB): The state agency responsible for Medicaid-funded services and the administration of the NC Innovations and NC MH/DD/SAS Health Plan. The website for North Carolina's Division of Health Benefits is ncdhhs.gov/dma/index.htm.

Department of Health and Human Services (DHHS): The state agency that includes both the Division of Health Benefits and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS). The website for North Carolina's DHHS is ncdhhs.gov/.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS): The state agency that works with DHB in the administration of the NC Innovations and NC MH/DD/SAS Health Plan. The website for North Carolina's DMH/DD/SAS is ncdhhs.gov/mhddsas/.

Enhanced benefit plan: A plan that includes services made available to Medicaid-entitled individuals and non-Medicaid individuals meeting priority population criteria. Enhanced benefit services are accessed through a person-centered planning process. Enhanced benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance use and with more complex service and support needs as identified in the person-centered planning process.

Early and Periodic Screening, Diagnosis and Treatment: Early and Periodic Screening, Diagnosis and Treatment (EPSDT): The federal Medicaid benefit that says Medicaid must provide all necessary healthcare services to Medicaid-eligible children under 21 years of age. Even if the service is not covered under the NC Medicaid State Plan, it can be covered for recipients younger than 21 if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met.

Grievance: An expression of dissatisfaction about any matter other than an action, as action is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME/MCO level and access to the State Fair Hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee and failure to respect the individual's rights.

Individual/member/enrollee: Different names used to describe a person that needs services for treatment of a mental health, IDD or substance use condition.

Least restrictive environment: The least restrictive/intensive setting of care sufficient to effectively and safely support an individual. Supporting an individual in the environment that is least restrictive is considered best practice.

Legal guardian or legally responsible person: A person who has been appointed by a court of law to act as decision maker for an individual deemed unable to make decisions on their own behalf. Parents of children younger than 18 are their children's legally responsible person unless those rights have been taken away by the court. Once a person turns 18, they legally become their own guardian unless the court deems otherwise and appoints a guardian representative (most often a family member or friend unless there is no one available, in which case a public employee is appointed).

Medical record: A single complete record, maintained by the provider of services, which documents all of the treatment plans developed for and behavioral health services received by the member.

Medically necessary services: Procedures or interventions that are appropriate and necessary for the diagnosis, treatment or support in response to an assessment of an individual's condition or need. Medically necessary means services and supplies that are provided for the diagnosis, secondary or tertiary prevention, amelioration, intervention, rehabilitation or care and treatment of a mental health, IDD or substance use condition. The services must be within generally accepted standards of medical practice and not primarily for the convenience of an individual, and the services must be performed in the least costly setting and manner appropriate to treat the individual's mental health, IDD or substance use condition.

Mediation: The process of bringing individuals or agencies in conflict together with a neutral third person who helps them reach a mutually agreeable solution.

Medicare: Medicare is health insurance for people ages 65 or older, under age 65 with certain disabilities and any age with end-stage renal disease (also known as ESRD/permanent kidney failure requiring dialysis or a kidney transplant).

Member and Recipient Services: The toll-free call system established by Alliance to receive all inquiries and provide quick linkages to qualified providers in the network. This will include information, access to care, and network provider assistance. The call system relies on information systems management software to assist in tracking and responding to calls.

Most integrated environment: The least restrictive setting of care sufficient to effectively treat a participant. An integrated environment is one in which a person with a disability participates in the same activities and settings as peers without disabilities.

NC Innovations: A 1915(c) home and community-based waiver for individuals with intellectual and/or developmental disabilities (IDD). This is a waiver of institutional level of care. Funds that could be used to serve a person in an intermediate care facility may be used to serve people in the community.

NC MH/DD/SAS Health Plan: A 1915(b) Medicaid Managed Care Waiver for Mental Health and Substance Abuse allowing for a waiver of freedom of choice of providers so that Alliance can determine the size and scope of the provider network. This also allows for use of Medicaid funds for alternative services.

Natural supports: People who provide support, care and assistance to a person without payment for that support. Natural supports may include parents, siblings, extended family members, neighbors, church members and/or co-workers.

Network provider: An appropriately credentialed provider of mental health, IDD and substance use services that has entered into a contract for participation in the Alliance network.

Out-of-plan services: Healthcare services that the plan is not required to provide under the terms of this contract. The services are Medicaid-covered services reimbursed on a fee-for-service basis.

Out-of-network provider: A practice or agency who has been approved as an out-of-network provider and has executed a single-case agreement with Alliance. The out-of-network provider is not offered as a choice of referral to Alliance members.

Person-centered plan: The document that includes important information about the participant, his or her life goals and the steps that he or she and the planning team need to take to get there. It also identifies support needs and includes a combination of paid supports, natural supports from family and friends and community supports.

Prepaid Inpatient Health Plan (PIHP): Alliance, as do all NC managed care organizations (MCOs), functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, IDD, and substance services are managed and authorized for Medicaid participants in Cumberland, Durham, nburg, Orange and Wake counties.

Provider network: The agencies or professionals under contract with Alliance to provide authorized services to eligible individuals.

Risk support needs assessment: An assessment of factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include health risk (medical conditions that require continuing care and treatment), behavioral risk (behaviors or conditions that might cause harm to the person or others), and personal safety risk, e.g. ability to make safe evacuation independently.

Reconsideration review: A review of a previous finding or decision by Alliance based on the provider's reconsideration request and any additional materials presented by the provider.

Spend-down: Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time.

State plan: The term that refers to the state Medicaid Plan for Medicaid for the State of North Carolina that is approved by the Center for Medicare and Medicaid Services (CMS).

Supplemental Security Income (SSI): Social Security program that pays benefits to adults and children with disabilities who have limited income and resources.

Support services: Services that enable an individual to live in his or her community. These include services that can provide direct assistance to the individual and/or services that provide assistance to the individual's caregivers and/or support staff.

Utilization Management Department (UM): The Alliance department responsible for approving Individual Support Plans and authorizing medically necessary services. Care managers work in the UM Department.

Acronyms

ACTT	Assertive Community Treatment Team
ASAM	American Society of Addiction Medicine
CALOCUS	Child and Adolescence Level of Care Utilization System
CFAC	Consumer and Family Advisory Committee
CST	Community Support Team
DHB	Division of Health Benefits
DHHS	Department of Health and Human Services
DMH/DD/SAS	Division Mental Health/Developmental Disabilities/Substance Abuse Services
DOC	Department of Corrections
DSS	Department of Social Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for individuals with intellectual disabilities
IDD	Intellectual and/or developmental disabilities
LOCUS	Level of Care Utilization System
LME/MCO	Local Management Entity/Managed Care Organization
MH	Mental health
NC-TOPPS	North Carolina Treatment Outcomes and Program Performance System
PAD	Psychiatric Advanced Directive
PCP	Person-Centered Plan
SOC	System of Care
SSI	Supplemental Security Income
SU/SUD	Substance use/substance use disorders
UM	Utilization management
UR	Utilization review

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Record of Review and Revisions

DATE	PAGE/SECTION	DESCRIPTION
November 2018	Entire Document	CFAC, DMA, Interdepartmental Review
November 2019	Entire Document Modifications to Section 4 (help in a crisis), Section 7 (out of network providers), and Section 9 (member rights, and making recommendations to Alliance polices and services)	EQRO revisions
July 2021	pp. 30-31 under heading “What are special needs populations?” Section 10: How Do I Make an Appeal or File a Grievance?	EQRO revisions
October 2022	Entire Document	EQRO and county realignment revisions
February 2024	Entire Document	Add Harnett County references