All Provider Meeting
March 20, 2019
1-3 pm
Welcome

Alliance Updates

Legislative Updates (Brian Perkins)
Medicaid Transformation Updates and Discussion (Sara Wilson)
HIE Updates (Cathy Estes Downs)
IDD Updates (Jarret Stone)
Provider Network Updates
  - Provider Maintenance Portal
    a. Referral Status Portal
    b. Accreditation Portal

Powerpoint will be posted on the Alliance Website by March 29
https://www.alliancebhc.org/providers/provider-resources/all-provider-meetings/

Next meeting: Wednesday, June 19, 2019
Legislative Updates

Brian Perkins, Senior Vice President, Strategy & Government Relations
Current State of Play

• NC General Assembly’s legislative long session in full swing
• Governor released his budget proposal for FY 2019-21
• Appropriations subcommittees meeting multiple times a week
• Policy committees considering bills
Governor’s FY19-21 Budget Proposal

Governor Cooper’s recommended general fund budget by function, 2019-20
Image source: Governor’s office
Governor’s FY19-21 Budget Proposal

• His third budget proposal, but first where he does not face a veto-proof majority

• $25.2 billion plan (5.4% more than the 2018-19 budget)

• Medicaid expansion a central provision
  o Expand Medicaid eligibility to cover 626,000 additional individuals
  o Non-federal share of expansion costs provided through hospital assessments and premium taxes on Prepaid Health Plans
Some Bills We’re Monitoring

• H 70 – Delay NC Health Connex for Certain Providers
• H 75 – School Mental Health Screening Study
• H 320/S 212 – Suspend Child Welfare/Aging Component of NC FAST
• S 144 – Modify Intent/Gross Premiums Tax/PHPs
• H 291 – Continue Social Services Regional Supervision and Collaboration Working Group
HB 70:
Delay NC Health Connex for Certain Providers

• NC Health Connex is the Health Information Exchange (HIE) for electronic health records data

• Would extend deadline for most providers to connect to the HIE through June 1, 2020

• Would extend connection deadline for psychiatrists until June 1, 2021

• Would allow Innovations and other I/DD providers to voluntarily participate in the HIE
HB 70: Delay NC Health Connex for Certain Providers

• Would authorize DHHS to grant hardship exemptions from HIE participation to qualifying providers

• Current status: Approved by House Health Committee and scheduled for vote in the House
H 75: School Mental Health Screening Study

• DHHS and the Department of Public Instruction required to conduct a study and report findings next year

• Study will examine whether the State should require a mental health screen to identify school-aged children at risk of harming themselves or others
H 75: School Mental Health Screening Study

• DHHS and DPI directed to make recommendations on several issues, including:
  o Type of screening
  o Who may conduct the screening
  o Behaviors/diagnoses that initiate need for a screening
  o Confidentiality issues
  o Procedure for parents to opt in to screening

• Current status: Passed House unanimously on March 6
H 320/S 212: Suspend Child Welfare/Aging Component of NC FAST

• DHHS has been working to build out the functions of NC FAST, the IT system for the State social services eligibility system

• Bill would postpone work to expand the NC FAST capacity to include case management for social services and aging

• Current status: Approved by Senate Health Committee today
S 144: Modify Intent/Gross Premiums Tax/PHPs

- Prepaid Health Plans that will be administering the four statewide Standard Plan contracts and the Provider-Led Entity contract will be treated as other health plans and insurers regarding premium taxes

- PHPs will apply the premium tax to their capitation beginning June 30, 2019

- Current status: Passed Senate on March 12
H 291: Continue the Social Services Regional Supervision and Collaboration Working Group

• Working group comprised of representatives from State and local social services, legislators, judges and other stakeholders completed two reports

• Concluded that the regionalization of local social services should not be mandatory, among other items
H 291: Continue the Social Services Regional Supervision and Collaboration Working Group

• Bill would continue their deliberations to:
  - Further consider the relationship between State and local social services
  - Consider the interagency collaboration needed between counties

• Current status: Referred to House Health Committee for consideration
Medicaid Transformation Update
Sara Wilson, Government Relations Director

All Provider Meeting
March 20, 2019
HB 403: Medicaid and BH Modifications

• June 15 – NC General Assembly passed HB403 (unanimous votes in both House and Senate)

• October 19- CMS approved the 1115 Waiver
Types of NC Managed Care Plans

• Standard Plans
  o Serve most Medicaid enrollees, including adults and children
  o Provide integrated physical health, behavioral health, and pharmacy services at launch of Medicaid managed care program

• Tailored Plans
  o Specifically designed to serve special populations with unique health care needs
  o Provide integrated physical health, behavioral health, and pharmacy services
Structure of the Managed Care System

• There will be 4 statewide Standard Plans
• DHHS capping number of regional Provider-Led Entities (PLEs) at 10
• Establishes the number of Tailored Plans that may operate – No more than 7 and no fewer than five 5
• Prohibits a statewide BH I/DD Tailored Plan
Contracts for Tailored Plans

- Initial contract term is four years
- LME/MCOs are the only entities that may operate a Tailored Plan during the initial term
- Subsequent contracts to be competitive bid among nonprofit Prepaid Health Plans (PHPs) and LME/MCOs operating the initial contracts
LME/MCO Contracts with Partnering Entities

• LME/MCOs operating Tailored Plans must contract with an entity that:
  o Holds a Prepaid Health Plan (PHP) license
  o Covers the services required under Standard Plans

• DHHS recommends that this partnering entity be one of the Standard Plans
Medicaid Transformation Timeline

• Aug. 2018 – DHHS released Standard Plan RFP
• Feb. 2019 – DHHS awarded Standard Plan contracts
• Nov. 2019 – Standard Plans launch in Phase 1 regions
• Feb. 2020 – Standard Plans launch in Phase 2 regions
• Mid-year 2020 - Tailored Plan Readiness Reviews (projected)
• Tailored Plan Go-Live – July 2021
Standard Plan Contracts

• Statewide PHP contracts were awarded to:
  o AmeriHealth Caritas North Carolina, Inc.
  o Blue Cross and Blue Shield of North Carolina
  o UnitedHealthcare of North Carolina, Inc.
  o WellCare of North Carolina, Inc.

• PHP contract awarded to Carolina Complete Health, a provider-led entity (PLE), to operate in Regions 3 and 5
NC Medicaid Managed Care Regions

REGION 1
FEB. 2020

REGION 2
NOV. 2019

REGION 3
FEB. 2020

REGION 4
NOV. 2019

REGION 5
FEB. 2020

REGION 6
FEB. 2020
BH/IDD Eligibility and Enrollment

Behavioral Health and Intellectual/Developmental Disability Tailored Plan
Eligibility and Enrollment

North Carolina Department of Health and Human Services
March 18, 2019

*The Department reserves the right to amend or update policy as needed.

Tailored Plan Eligible Populations

- Enrolled in the Innovations Waiver or on the Innovations waitlist
- Enrolled in the TBI Waiver or on the TBI waitlist
- Enrolled in the Transition to Community Living Initiative (TCLI)
- Have used a Medicaid service that will only be available through a Behavioral Health I/DD Tailored Plan
- Have used a behavioral health, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds
Tailored Plan Eligible Populations

• Children with complex needs (as defined by the 2016 settlement agreement between the Department and Disability Rights of NC)
• Have a qualifying I/DD diagnosis code
• Have a qualifying SMI or SED diagnosis code who used a Medicaid-covered enhanced behavioral health service during the look back period
• Have a qualifying SUD diagnosis code who used a Medicaid-covered enhanced behavioral health service during the look back period
Tailored Plan Eligible Populations

• Have had two or more psychiatric hospitalizations or readmissions within 18 months;
• Have had an admission to a State psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode in a State-owned facility;
• Have had two or more visits to the emergency department for a psychiatric problem within 18 months.
• Have had two or more episodes using behavioral health crisis services within 18 months.
Foster Care Population

- At BH I/DD Tailored Plan launch, the following individuals can choose between a Specialized Foster Care Plan, if available, a Standard Plan, and a Behavioral Health I/DD Tailored Plan (if they meet the eligibility criteria):
  - Medicaid only beneficiaries in foster care under 21
  - Children in adoptive placements (i.e. receiving adoption assistance)
  - Former foster youth who have aged out of care up to age 26

- Prior to launch of Behavioral Health I/DD Tailored Plans, these beneficiaries will continue to be covered in the current system.
## Covered Services

### Behavioral Health, I/DD and TBI Services

<table>
<thead>
<tr>
<th>Covered by Both SPs and Behavioral Health I/DD Tailored Plans</th>
<th>Covered Exclusively by Behavioral Health I/DD Tailored Plans (or LME-MCOs Prior To Launch)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Plan Behavioral Health and I/DD Services</strong></td>
<td><strong>State Plan Behavioral Health and I/DD Services</strong></td>
</tr>
<tr>
<td>• Inpatient behavioral health services</td>
<td>• Residential treatment facility services for children and adolescents</td>
</tr>
<tr>
<td>• Outpatient behavioral health emergency room services</td>
<td>• Child and adolescent day treatment services</td>
</tr>
<tr>
<td>• Outpatient behavioral health services provided by direct-enrolled providers</td>
<td>• Intensive in-home services</td>
</tr>
<tr>
<td>• Partial hospitalization</td>
<td>• Multi-systemic therapy services</td>
</tr>
<tr>
<td>• Mobile crisis management</td>
<td>• Psychiatric residential treatment facilities</td>
</tr>
<tr>
<td>• Facility-based crisis services for children and adolescents</td>
<td>• Assertive community treatment</td>
</tr>
<tr>
<td>• Professional treatment services in facility-based crisis program</td>
<td>• Community support team</td>
</tr>
<tr>
<td>• Peer supports</td>
<td>• Psychosocial rehabilitation</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse non-medical community residential treatment</td>
</tr>
</tbody>
</table>
# Covered Services

## Behavioral Health, I/DD and TBI Services

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</tr>
</thead>
<tbody>
<tr>
<td>- Outpatient opioid treatment</td>
<td>- Substance abuse medically monitored residential treatment</td>
</tr>
<tr>
<td>- Ambulatory detoxification</td>
<td>- Clinically managed low-intensity residential treatment services</td>
</tr>
<tr>
<td>- Substance abuse comprehensive outpatient treatment program (SACOT)</td>
<td>- Clinically managed population-specific high-intensity residential programs</td>
</tr>
<tr>
<td>- Substance abuse intensive outpatient program (SAIOP)</td>
<td>- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)</td>
</tr>
<tr>
<td>- Clinically managed residential withdrawal (social setting detoxification services)</td>
<td></td>
</tr>
<tr>
<td>- Research-based intensive behavioral health treatment</td>
<td>- <strong>Waiver Services</strong></td>
</tr>
<tr>
<td>- Diagnostic assessment</td>
<td>- Innovations Waiver services</td>
</tr>
<tr>
<td>- Early and periodic screening, diagnostic and treatment (EPSDT) services</td>
<td>- TBI Waiver services</td>
</tr>
<tr>
<td>- Non-hospital medical detoxification</td>
<td>- 1915(b)(3) services</td>
</tr>
<tr>
<td>- Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization</td>
<td></td>
</tr>
</tbody>
</table>

**State-Funded Behavioral Health and I/DD Services**

**State-Funded TBI Services**
Medicaid Managed Care Updates
What beneficiaries can expect
Understanding MC Impacts to Beneficiaries

What’s New
1. Beneficiaries will be able to choose their own health care plan
2. Most, but not all, people will be in Medicaid Managed Care
3. An enrollment broker will assist with choice

What’s Staying the Same
1. Eligibility rules will stay the same
2. Same health services/treatments/supplies will be covered
3. The beneficiary Medicaid Co-Pays, if any, will stay the same
4. Beneficiaries report changes to local DSS
Beneficiary Experience – Auto Assignment

Beneficiaries who don’t choose a health plan will be assigned one automatically, consistent with the following components in this order:

1. Where the beneficiary lives.
2. Whether the beneficiary is a member of a special population (e.g. member of federally recognized tribes or BH I/DD Tailored Plan eligible).
3. If the beneficiary has a historic relationship with a particular PCP/AMH.
4. Plan assignments of other family members.
5. If the beneficiary has a historic relationship with a particular PHP in the previous twelve (12) months (e.g., “churned” off/into Medicaid Managed Care).
Member Timeline – Phase 1

2019

Feb 1
- Initial letter sent to beneficiaries in 2 counties
- Address verification letter sent to remaining counties

March
- Flyers posted at DSS
- Address corrections to DSS

April
- 2nd letter to members
- Member Outreach activities
- Public Service Announcements
- PHP marketing materials

May

June 3rd
- EB Call Center Open
- Welcome Packets mailed

July
- Open Enrollment Begins - July 15th

Aug
- Open Enrollment Ends - Sept 13th
- Members auto assigned to PHPs based on algorithm

Sept

Oct
- Member ID cards
- Member Handbooks

Nov 1st
Managed Care Launch - Phase 1

Dec
- Member feedback
- Evaluation of materials, process
Member Timeline - Phase 2

2019

June 3rd
- EB Call Center Open
- Outreach Activities

July
- Flyers posted at DSS
- Address corrections to DSS

Aug
- Letters to members
- Member Outreach activities

Sept 2nd
- Enrollment Welcome Packets

Oct
- Open Enrollment Begins - Oct 14th

Nov

Dec
- Open Enrollment Ends - Dec 13th

2020

Jan
- Member ID cards
- Member Handbooks

Feb 1st
- Managed Care Launch - Phase 2

March
- Member feedback
- Evaluation of materials, process

SOFT LAUNCH
Day 1 - Regions 1, 3, 5 & 6

Managed Care Launch - Phase 2

AllianceHealthPlan.org
What providers can expect
Provider Experience In Managed Care

Addressing Administrative Burden:

• a centralized and streamlined provider enrollment and credentialing process;

• transparent, timely and fair payments for providers;

• a single statewide drug formulary that all PHPs will be required to utilize;

• same services covered in Medicaid managed care and fee-for-service (with exception of services carved out of Medicaid Managed Care)

• Department’s definition of “medical necessity” used by PHPs when making coverage decisions; and

• providers offered some contracting “guardrails”, standard PHP contract language
### Managed Care Impacts on Providers

<table>
<thead>
<tr>
<th>Contract/Payment</th>
<th>Information/Problem Solving</th>
</tr>
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<tbody>
<tr>
<td>• Potential contract with multiple PHPs, CINs</td>
<td>• Build relationships with health plans</td>
</tr>
<tr>
<td>• Opportunity to negotiate rates*</td>
<td>• PHP provider assistance line</td>
</tr>
<tr>
<td>• Understanding contract terms, conditions, payment and reimbursement methodologies</td>
<td>• Provider appeals procedures specified in PHP provider manual</td>
</tr>
<tr>
<td>• Network adequacy and out of networks standards</td>
<td>• DHHS provider ombudsman to assist with problem solving</td>
</tr>
<tr>
<td>• AMH program/tiered payments</td>
<td>• Opportunities to provide feedback</td>
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<tr>
<td></td>
<td>• i.e. AMH TAG</td>
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* rate floors apply
# Provider E&E: Summary of Approach for 2019

Education and engagement will evolve from information dissemination and feedback opportunities early on to higher-intensity, specialized training as go-live approaches.

<table>
<thead>
<tr>
<th>Lower Intensity, Broader Audience</th>
<th>Planned Approach</th>
<th>Summary of Planned Activities (January – November 2019)</th>
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</table>
| Web-Based Resources (e.g., factsheets/FAQs) | • Ongoing updates to FAQs after webinars, office hours, and in response to questions received by email (currently 4 FAQ documents with 158 FAQs)  
• Develop sustainable process for triaging, updating, and maintaining FAQs |                                                                                                                                 |
| Webinars                         | • Approx. 24 topical webinars planned across all content areas  
• Managed Care 101 to kick off in early February, followed by fast-paced series of topical webinars (e.g. Quality/Value overview) |                                                                                                                                 |
| Virtual Office Hours             | • Weekly 2-hour sessions from February through November  
• Identify SMEs and operational process for: staffing; publicizing; compiling questions in advance; running calls; and feeding into FAQs |                                                                                                                                 |
| Provider/PHP “Meet and Greets”   | • 6 in-person regional meetings to be launched by April 2019                      |                                                                                                                                 |
| Partner Communication Channels   | • Approx. 25 provider associations have been identified as outreach channels for targeted presentations; ongoing engagement (e.g. NHCA presentation)  
• Brief presentation by DHB staff followed by open Q&A |                                                                                                                                 |
| Training for Targeted Providers* | • Contracting with AHEC to develop and launch a training plan (e.g. tools, regional training sessions, etc) |                                                                                                                                 |
| Hands-on Technical Assistance for Targeted Providers* | • Contracting with AHEC to develop and launch TA strategy (e.g. identification of high priority practices for training, etc.) |                                                                                                                                 |

*DPH will be responsible for providing high-intensity training and technical assistance for LHDs re: Care Management Programs; PHPs will be required to participate in AHEC training when launched, and provide their own detailed training plan.
• Questions?
• Feedback?
Currently the requirement remains for providers to be connected to the NC HealthConnex by June 1, 2019.

According the NC HIEA website: https://hiea.nc.gov/providers/extension-process there is a process to receive an extension. If you are a provider and have not submitted your Participation Agreement to NC HIEA- please review the above link in order to complete this process.

It is strongly encouraged that providers have a signed participation agreement in place with HIE by June 1, 2019

Legislation has been introduced with House Bill 70, which includes extending deadlines that certain providers are required to connect to and participate in the HIE

The State has asked us to share that “Providers who have not connected with NC HealthConnex by June 1, 2019 will continue to be eligible to receive Medicaid funds. DHB/NC Medicaid will not impose penalties or sanctions on these providers.”
IDD Services Updates

Jarret Stone, IDD Clinical Director
Overview

• Research-Based Behavioral Health Treatment for Individuals with Autism Spectrum Disorders (RB-BHT)
  • Clinical Coverage Policy 8F
  • New CPT Codes
• Specialized Consultative Services
• HCBS Validation Process
RB-BHT for ASD

- RB-BHT (more commonly referenced as Applied Behavior Analysis or ABA) now has a Clinical Coverage Policy up for public comment
  
  - Public Comment period expires April 20, 2019
    - Submit comments to dma.webmedpolicy@dhhs.nc.gov
  
  - Link to proposed policy:

NC Medicaid has delayed the effective date of these codes in NCTRACKS (and subsequently with LME/MCOs) until July 1, 2019.

These changes reduce the total number of service codes and standardize the unit of service.
Crosswalk: New CPT Codes for RB-BHT
Current Go Live date projected 7.1.19

<table>
<thead>
<tr>
<th>Existing Code</th>
<th>Existing Unit of Service</th>
<th>New Code</th>
<th>New Unit of Service</th>
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<tbody>
<tr>
<td>0359T</td>
<td>Event</td>
<td>97151</td>
<td>15 minutes</td>
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<tr>
<td>0360T</td>
<td>30 minutes</td>
<td>97152</td>
<td>15 minutes</td>
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<td>0361T</td>
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<td>0371T</td>
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</table>
Specialized Consultative Services

- Recent correspondence received from Alliance indicated there may be some confusion or misunderstanding about what activities are included in this service. Following slide identifies covered activities (summary based on “covered activities” within CCP 8P).

- This service continues to be an identified Network Need-qualified providers that are interested in adding this to their contract please check our website at https://www.alliancehealthplan.org/providers/current-service-needs/ to review required qualifications and how to submit a request to add this service.
Specialized Consultative Services (Cont’d)

a. Observing the individual to determine needs;

b. Assessing any current interventions for effectiveness;

c. Developing a written intervention plan (including preventative measures, equipment and environmental modifications)

e. Training and technical assistance of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan;

f. Observe, record data and monitor implementation of therapeutic interventions/support strategies;

g. Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan;

h. Revision of the intervention plan as needed to assure progress toward achievement of outcomes

i. Participating in team meetings; and/or

j. Tele-consultation through use of two-way, real time-interactive audio and video to provide behavioral and psychological care when distance separates the care from the individual.
HCBS Validation

- DMH and DHB have recently advised LME/MCO to begin the validation process of HCBS.
- This process does not pose substantial changes since the HCBS final rule implementation began in 2014.
- Reminder – for new sites for Residential, Day Supports, Adult Day Health or Supported Employment
  - Ensure you complete an HCBS provider Self-Assessment for the site prior beginning services
  - [https://www.hcbs.ncdhhs.gov/assessment.html](https://www.hcbs.ncdhhs.gov/assessment.html)
  - More information about HCBS final rule and the validation process can be found at the following link
Questions

Feel free to contact me

Jarret Stone

jstone@alliancehealthplan.org

919.651.8641
Provider Maintenance Portal

Melissa Payne, Provider Network Development Specialist
Melissa Shaffer, Provider Network Evaluator II
We're Changing Our Name

Over the coming weeks you may notice that Alliance Behavioral Healthcare is changing its name to Alliance Health.

We’re doing this to reflect our growing focus on the total health of the people we serve. Please don’t be confused if you see both names for a little while.
Provider Login
Provider Login User Guide

User Roles

There are multiple user roles on the Portal. As a Provider, you can have access to all the applications that are applicable.

Provider Login

- No access to Portal

- If you don't have access to the Portal, you will need to register for the User Account.

- On the Login page, click the Register New Provider User Account link to initially access the Portal.
In the Register New Provider User Account, fill in the appropriate information and select the application to which you are requesting access. Click the Create button to submit your request.

NOTE: Only Supported Employment providers will check the DOJ-Supported Employment site access box. All other providers only need Provider Maintenance.
This will send a request to the Business Owner of the application at the Alliance Health to grant access. Once this has been done initially, Providers can just login to access the application.

You will receive an email when you have been approved for access to the requested application. Once approved, log into the application directly through the Portal.
Access to Portal, however no access to desired application
All Alliance Health applications are accessed through the Portal. If you already have access to the portal for another application, log in using your username and password. On the main screen, click the Request Site Access link in the left side Navigation pane.

Once you do, you will see a list of available applications to which you can request access. Select the specific application you need access to and click Submit.

Access to applications in Portal
Enter your Username and Password. Click on the application to be managed and proceed.
Dashboard

The Dashboard is the initial launching point for all actions you will take in the system. This dashboard will be fluid for the next few months as more new modules are released in the Provider Maintenance application. Initially, only the Accreditation on the dashboard contains data. The Clinician Maintenance section is under construction and there will be future modules under that.
Provider Maintenance-Referrals Module
What is the purpose of the Referrals module?

- This module will allow Alliance Call Center and Care Coordination to make more effective referrals to services by providing staff with real-time information regarding providers’ availability to accept referrals.
- Alliance will be able to use the data in this module to assess the accessibility of specific services.
- In the future, this module will feed the external Provider Search Tool on the Alliance website.
What is the benefit to providers?

- The Referrals module may be used by Alliance staff when making referrals.
- By keeping your information current providers may see an increase in referrals as it allows Alliance staff to have a more efficient way to be able to identify who is currently taking referrals.
- Providers can use this data to assess their own capacity and accessibility.
Instructions for the Referrals Module: Dashboard

The Dashboard is the initial launching point for any and all actions you will take in the system. This dashboard will be fluid for the next few months as more new modules are released in the Provider Maintenance application. Initially, only the Accreditation section on the dashboard contained data. Now, the Referrals section is also being put into use. The Clinician Maintenance section is under construction and there will be future modules after that.

When you first access the dashboard, you may or may not see any data on the page displayed.
Instructions for the Referrals Module: Enter/Verify Referral Status

All site addresses for the Provider will be displayed in a list with each site being collapsible and the first site expanded when the page is accessed. Start with the first site or collapse it and expand a different site.

Note: The checkboxes that are inside the Accepting Referrals and 7 Day Appt column heading cells allow the Provider to select Yes for all of the services in the entire table.
Instructions for the Referrals Module: Selecting Age Groups and Languages

Click the arrow next to the service to expand the additional information for the service:

The Age Groups and Languages tabs are displayed. Click the Add new record tab to add age groups for that service:
A new row is added below, expand that row to select an Age Band from the list of bands provided and then click the Update button.

Repeat this step for each Age Group that this service with this funding source is offered. Notice that there is a choice for All Ages. Click the Update button when complete.
Now you must select the languages that are spoken for this service. Click the Languages tab and then click the Add new record.

A new row is added below, expand that row to select a Language from the list of languages provided and then click the Update button.
Important to remember

• Make sure to click on the “Verify Referrals” button when you reviewed or modified the referral status for these sites by each site. Otherwise, the referral information will not be able to be included in referral availability report without this verification.
Provider Maintenance Accreditation Module
Please note: Only providers that are required per NC DMA Clinical Coverages Policies (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies) to be nationally accredited by one of the following accrediting bodies (Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Quality and Leadership (CQL), The Joint Commission, or Council on Accreditation (COA)) are required to inform Alliance of their accreditation status.
Enter an Accreditation

When you first access the dashboard, you may or may not see an Accreditation entry. If you do not see an accreditation then you will need to enter one and submit it for review and acceptance.

From the Dashboard, you can click either the Create/Edit button or click the Accreditation link at the top of the page:

Once on the Accreditation page, you will need to fill out the following information:
1. **Source Name** – choose one of the Governing Body selections from the dropdown menu

![Dropdown menu for Governing Body selections](image)

2. **Effective Date** – select the effective start date of your organization’s accreditation.

![Calendar for selecting effective date](image)
3. **Expiration Date** – select the expiration of your organization’s accreditation

4. **Accreditation Years** – select whether your organization’s accreditation is for two years or more or less than one year
**SPECIAL NOTE** – the system will validate your choice against the dates you selected above. If the period between the dates does not match this choice, you will receive an error message.

5. **Add Documentation** – here you must add any documentation related to your accreditation. If your accreditation is for two years or more, you need only add the official notification from the accreditation body chosen. If your accreditation is for one year or less, you will need to submit all findings the accrediting body provided. These documents must be submitted to the LME/MCO within 30 days of receipt.

Click the Add New Document button.
Click the Select files button and choose a document from your hard drive.

Enter a Description and click Save.
Save or Save & Submit
Once you have completed your entries, you have two options. You can Save or Save & Submit. Below is the result of clicking either button:

Save – clicking the save button saves all of your entries and uploaded documents to the database but does not submit it for review to Alliance.

Save & Submit – clicking save and submit saves all of your entries and uploaded documents to the database, submits them for review and acceptance by Alliance.

NOTE: Navigate back to the Dashboard to see the status of your Accreditation “Submitted”. You will receive an email notification that your submission has been received. You will also receive an email when your Accreditation request is Accepted. Once your request has been accepted you will no longer be able to make edits to it.
Request More Info

At times, after you submit your Accreditation request, Alliance may need additional information before accepting it. In these cases, you will receive an email requesting more information. You must log into Provider Maintenance and provide the requested information.

From the Dashboard, click the Create/Edit Button or the Accreditation link at the top of the page. Note that the Current Status on this page is “Request More Info.”
Review the Feedback Comments and take appropriate action, as instructed. Note that any documents you uploaded prior to submitting can no longer be edited or deleted. Only documents you upload in your current session can be edited or deleted.

When finished, click Save or Save & Submit, as needed.
Enter Next or Future Accreditation

Alliance’s system for tracking Accreditation allows providers to enter their next valid accreditation 30 days prior to the current one expiring. Just like entering your first accreditation, navigate to the accreditation screen and you will see that your current Accreditation is expiring soon.

From this screen, you can view your existing Accreditation or you can create a new one by clicking the corresponding buttons. Enter your accreditation information just like you did originally and submit for Acceptance.

Once you have submitted your next Accreditation request, you will notice that it displays on the Dashboard. You still have an existing Accreditation that is in effect but it is now accessible via the History tab on the Accreditation page. The Dashboard always displays the most current record on file, even if it is for a future entry.
Alliance Health

Links for the user guide:

http://prod.providermain.alliancebhc.org/Documents/Provider_Accreditation_Required.pdf


Confidentiality Notice:
This document (including any attachments) may contain confidential, proprietary and/or privileged information. Any unauthorized disclosure, distribution or use other than its intended purpose is strictly prohibited.
Questions or need technical assistance?

Technical support for the Provider Referral Portal contact:
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mpayne@alliancebhc.org
919-651-8801

Technical support for the Provider Accreditation Portal go to:
Melissa Shaffer, Provider Network Evaluator
mshaffer@alliancebhc.org
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