Alliance Health Tailored Plan/PIHP Provider Manual

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Alliance Health

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A. Introduction

Welcome to the Alliance provider network. As a member of our network you join a select, progressive group of providers who are dedicated to providing quality care for the Individuals of publicly-funded health services in Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. As a provider, you represent the network to the people we serve, and join us in our mission to help people with disabilities and special needs improve the quality of their lives.

As a contracted provider with Alliance Health, it is your responsibility to be familiar and comply with all federal and state laws, rules and regulations governing the provision of services and the processes outlined in this manual. Failure to comply with this manual may constitute a material breach of your contract with Alliance and could result in sanction or administrative action by Alliance, up to and including termination from the network. This manual documents information about Alliance including our purpose, mission, vision and core values and describes our processes related to participating in the provider network including obtaining referrals and authorizations, submitting claims and resolving many issues or problems. We have also included a glossary of frequently used terms for your reference and links to necessary forms. Your compliance with the requirements of this manual will assist Alliance in providing you with timely service authorizations and claims reimbursement.

Please note that this manual will change over time in response to changes in Alliance practices, federal and state law, rules, regulations and Department of Health and Human Services (DHHS) directives. In order to ensure high quality care, Alliance reserves the right to adopt more restrictive processes, policies and procedures than are required by state and federal rules and regulations. Alliance will strive to provide 30 days' advance notice of any material changes to this manual.

Nothing in this manual is intended, or should be construed, to create any enforceable rights, expectations or cause of action against Alliance for any provider or individual.

All timelines in this document refer to calendar days unless otherwise specified. A business or working day refers to a day on which Alliance is officially open for business.

We thank you for your participation in our network, and look forward to a long and rewarding partnership as we work together to provide quality treatment to the individuals we all serve.

Message From The Alliance Chief Executive Officer

Dear providers,

Since the inception of the North Carolina State Mental Health Plan of 2001, Alliance Health has evolved from a treatment provider, a Local Management Entity/Managed Care Organization (LME/MCO) to a fully integrated Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan designed to serve the whole-person care needs of individuals with serious mental illness, intellectual and developmental disabilities, substance used disorders and traumatic brain injuries. We employ a System of Care framework focusing on best-practice service delivery through a multi-county provider network.

Contracts between Alliance and its providers create reciprocal partnerships designed to ensure an integrated system of quality services and supports is available to Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake County residents. All contracts between Alliance and providers contain requirements that promote person and family-centered treatment, sound clinical and business practices, and delivery of high-quality services within Alliance's System of Care.

It is Alliance's goal to manage a comprehensive provider network that is integrated and responsive. We seek to maintain an environment in which providers can be successful both clinically and financially.

Alliance network providers must be mission-driven, willing to work cooperatively on behalf of individuals and their family members, and be active participants within Alliance's System of Care. Medicaid is the payer of last resort, and Alliance network providers are expected to maximize other sources of funding and to extend public funding as far as possible.

Alliance recognizes that a comprehensive, community-wide System of Care requires multiple providers working together in collaborative relationships to serve individuals in the most effective and efficient manner possible. While these relationships sometimes prove challenging, they are the foundation on which we create and maintain the System of Care the individuals we serve and our community deserve. Alliance is interested in your perception of our operations as well. To evaluate performance, we will measure the satisfaction of your experience with Alliance as well as your experiences with other providers. We believe this information is important and will lead to continuous improvement in both quality and efficiency.

As the system evolves, Alliance will use performance indicators, outcome measures and other factors to determine selection and retention of providers in our closed network, but individuals' access to care will remain the primary determining factor. Alliance will always strive to maintain an appropriate balance between individual choice and our responsibility to effectively and efficiently manage publicly-funded whole person care.

We welcome you as our partner in Alliance's System of Care, providing services that use evidence-based practices to achieve meaningful life outcomes for the citizens we work together every day to serve.

Sincerely,
Rob Robinson
Chief Executive Officer Alliance Health

Who We Are

Alliance Health is a prepaid health plan (PHP) operating a Behavioral Health I/DD Tailored Plan on a capitated risk basis for behavioral health and physical health services for the Tailored Plan population. A PHP is a type of Managed Care Organization (MCO) as described in 42 CFR Part 438. Capitation means that Alliance receives funding on a per-member-per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid network population in the four Alliance counties. Capitation supports the type of creative flexibility necessary in an individual-driven system of care. Additionally, Alliance is a Local Management Entity (LME), established and operating in accordance with Chapter 122C of the North Carolina General Statutes and receives a limited allocation from the North Carolina Department of Health and Human Services for state-funded MH/SUD/IDD services, and some competitive grant funding.

Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of state, federal and Medicaid-funded MH/SUD/IDD services and Medicaid funded primary care, medical specialist care, inpatient, pharmacy and ancillary care in Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. Alliance receives funding from multiple federal, state and county sources. The financing provides for coordination and blending of funding resources, collaboration with out-of-system resources, appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care.

Alliance Mission, Vision and Values

Our Mission

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

Our Vision

To be a leader in transforming the delivery of whole-person care in the public sector.

Our Values

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

Innovation: We challenge the way it's always been done. We learn from experience to shape a better future.

Purpose of this Provider Manual

This provider manual is intended for Alliance Health-contracted (participating) providers providing health care services to enrolled Alliance Health members and service recipients. This manual serves as a guide to the policies and procedures governing the administration of Alliance Health's Tailored Plan and is an extension of and supplements the provider contract between Alliance Health and health care providers.

The manual is available on Alliance Health's website. A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative.

In accordance with the policies and procedures clause of the provider contract, participating Alliance Health providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to Alliance Health's policies and procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other period of time as necessary for Alliance Health to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by Alliance Health in the form of provider bulletins and will be incorporated into subsequent versions of this manual. Provider bulletins that are state-specific may override the policies and procedures in this manual.

Per Alliance's contract with DHHS; this manual will

1. Be submitted to the department for approval 90 calendar days after contract award. Alliance shall not use or distribute the manual prior to approval by the department.
2. Be regularly reviewed and updated annually, with submission due on July 1, or upon request of the department to reflect changes to applicable federal and state laws, rules and regulations, department or Alliance policies, procedures, bulletins, guidelines or manuals, or Alliance business processes as necessary. Within the provider manual, Alliance shall track and maintain a list of revisions made to manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.
3. Be submitted to the department for approval within 15 calendar days of making substantive updates or revisions. Alliance shall not post, print or enforce the updates until the Alliance has received approval from the department.
4. Reflect corrected errors in the electronic version or reflect revisions as requested by the department within 15 calendar days of notification or request by department. Corrections or revisions to the printed version must be included in the next printing.
5. Be regularly reviewed and updated annually, with submission due July, or upon request by the department to reflect changes to applicable federal and state laws, rules and regulations, department or Tailored Plan/PIHP policies, procedures, bulletins, guidelines or manuals, or TP/PIHP business processes as necessary.
6. May be updated once per quarter in the event of substantive updates or revisions that impact providers or Tailored Plan/PIHP business. Unless directed by the department, the Tailored Plan/PIHP shall not update the provider manual more than once per quarter during the contract year. Submissions of the provider manual to the department by the PIHP during the contract year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

7. Return an updated version of the provider manual within 15 calendar days if any revisions are requested by the department during the review and approval process. Alliance shall make the provider manual available, within 5 calendar days of approval from the department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

8. Make the redline provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal only.

American Recovery and Reinvestment Act of 2009

Alliance Health may not impose enrollment fees, premiums, or similar charges on Indians serviced by an Indian health care provider; Indian Health Service; and Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Copayment Provision

If copayments are waived as an expanded benefit for Medicaid members, providers must not charge Members copayments for covered services. If copayments are not waived, the amount paid to providers by Alliance Health will be the contracted amount, less any applicable copayments. Members under age 21, pregnant women and qualified Medicare beneficiaries are not required to pay copayments.

B. Clinical Practice Standards and UM Program

Alliance's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations while providing members access to high-quality, cost-effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within Section 12: Definitions of this manual or both.

Alliance's UM program includes components of prior authorization and prospective, concurrent and retrospective review activities. Each component is designed to evaluate the extent and appropriateness of services based on the member's benefits.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required
- Providing access to medically appropriate, cost-effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership
- Facilitating communication and partnerships among members, families, providers, delegated entities and Alliance in an effort to enhance cooperation and appropriate utilization of health care services
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services

Medically Necessary Services

The determination of whether a covered service is medically necessary requires compliance with the requirements established in North Carolina Administrative Code, 10A NCAC 25A.0201, Alliance's agreement with the Department of Health and Human Services and EPSDT requirements as outlined in 42 U.S.C. § 1396d(r) and 42 C.F.R. § 441.50-62 for Medicaid members under 21 years of age.

Medically necessary or medical necessity means medically necessary covered services and supplies as determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

In accordance with 42 CFR 440.230, each medically necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

Alliance's UM program includes components of prior authorization and prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on Alliance's members' coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to providers of care.

Alliance does not reward its associates or any practitioners, physicians or other individuals or entities performing UM activities for issuing denials of coverage, services or care. Alliance does not provide financial incentives to encourage or promote underutilization.

Criteria for UM Decisions

Alliance's UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the state of North Carolina and professional knowledge and/or clinical expertise in the related

health care specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information including the following when making coverage determinations:

- Milliman Care Guidelines (MCG)
- Alliance clinical coverage guidelines
- Medical necessity
- State Medicaid contract
- North Carolina clinical coverage policies and approved in lieu of service definitions
- State provider handbooks, as appropriate
- Local and federal statutes and laws
- Child and Adolescent Needs and Strengths (CANS)
- American Society of Addiction Medicine (ASAM) criteria
- NC Support Needs Assessment (NC SNAP)
- Supports Intensity Scale (SIS)
- State of North Carolina MH/DD/SAS service definitions
- Target populations as defined by the State of North Carolina
- Clinical judgment based on prevailing local practice standards, to include:
    - Age
    - Co-morbidity
    - Progress of treatment
    - Complications
    - Psychosocial setting
    - Home environment
    - Cultural and/or ethnic group beliefs and values

The clinical reviewer and/or medical director involved in the UM process applies medical necessity criteria in context with the member's individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the providers upon request and are posted on Alliance's website at AllianceHealthPlan.org. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the provider support at 855-759-9700 between Monday-Saturday from 7 am-6 pm.

The UM program follows EPSDT criteria for EPSDT service requests defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 for Medicaid members under 21 years of age. The specific EPSDT criteria may be found in the North Carolina EPSDT Policy Instructions at EPSDT Policy Instructions. EPSDT service requests must meet the following criteria:

- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/ investigational.
- Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

Utilization Management Process

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by either National Committee for Quality Assurance (NCQA) requirements, contractual requirements or a combination of both.

Alliance's forms for the submission of notifications and authorization requests can be found in the Provider Portal for electronic service authorization requests.

Notification

To the extent possible, Alliance limits the number of notification requests that are required to be sent to Alliance. Notifications are communications to Alliance with information related to certain services rendered to a member or a member's admission to a facility. Notification is required for:

- **A Member's admission to a hospital:** Alliance uses these alerts to support transitional care management. Providers offering Tailored Care Management must have a system in place to receive and respond to ED and inpatient admissions within "real-time."
- **Child Residential Services**: Admission notification is required based upon the level of child residential placement.

Referrals

Alliance does not require referrals for emergency services. Behavioral health services the initial mental health or substance dependence assessment completed in 12 months will not require a referral.

Prior Authorization

Prior authorization allows for efficient use of covered services and ensures that members receive the most appropriate level of care, within the most appropriate setting. Prior authorization may be requested by the member's PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity
- Appropriateness of rendering provider
- Appropriateness of setting
- Case and disease management considerations

Prior authorization is required for select elective or non-emergency services as designated by Alliance. Guidelines for prior authorization requirements by service type may be found on our website at AllianceHealthPlan.org or by calling Alliance.

Some prior authorization guidelines to note are:

1. The prior authorization request should include the diagnosis to be treated and the CPT® code describing the anticipated procedure.
2. An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.
3. Failure to obtain authorization prior to an elective or non-emergency service is grounds for denial of a post-service authorization request or claim submission.

The process for obtaining this authorization is as follows:

1. The provider submits an authorization request via the electronic Provider Portal.
2. The request will be routed to a qualified UM reviewer.

3. The UM reviewer will review the request against the benefit plan and the clinical criteria.

4. If services meet the benefit plan and/or the appropriate criteria, the service will be authorized and the Provider will be notified electronically through the provider portal.

5. If not met, the request will be sent to the medical director or other appropriate peer reviewer for review of medical necessity. Prior to sending the request to the medical director, reasonable efforts will be made to obtain additional information that may be missing from the request.

6. If medical director or other peer reviewer approves the request, the service will be authorized and provider will be notified electronically through the provider portal.

7. If the medical director or other peer reviewer denies the request, the provider will be notified and a Notice of Adverse Benefit Determination (denial letter) will be sent to the member and provider.

Providers are not required to obtain prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid members under 21 years of age. However, providers may be required to obtain prior authorization for other diagnostic and treatment products and services provided under EPSDT. Providers are required to obtain authorization of any medically necessary EPSDT service for members under the age of 21 years when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule; is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds coverage limitations.

Provider documentation for EPSDT prior authorization requests must show how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the member's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems. If the service, product or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does not eliminate the requirement for prior approval. EPSDT does not apply to NCHC beneficiaries.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. Refer to the Alliance Benefit Plan located on our website at AllianceHealthPlan.org for services requiring prior authorization.

Concurrent Review

Concurrent review activities involve the evaluation of medical appropriateness of continued treatment or stay for a service that require prior approval beyond what was previously authorized. The UM clinician follows the clinical status of the Member by reviewing continued stay requests submitted through the provider portal and communication with the attending physician, hospital UM, care management staff or hospital clinical staff involved in the member's care.

Reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on nationally recognized criteria (e.g., Milliman Care Guidelines (MCG), InterQual® or Clinical Coverage Policies) for appropriateness of a continued stay to:

1. Ensure that services are provided in a timely and efficient manner
2. Make certain that established standards of quality care are met
3. Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate
4. Complete timely and effective discharge planning
5. Identify cases appropriate for care management or care coordination

The concurrent review process incorporates the use of nationally recognized criteria (e.g., MCG) or Alliance-adopted clinical coverage guidelines to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians under the direction of Alliance's medical director.

To ensure the review is completed timely, providers must submit continued stay request and clinical information on or before the last day of the previously authorized date of service.

Failure to submit a timely request and necessary documentation for concurrent review may result in nonpayment.

Facilities can submit clinical chart information for review for continued stay appropriateness and discharge planning through the electronic Provider Portal. Links to the applicable provider portal are located in the Service Code Look-up tool located on our website at AllianceHealthPlan.org.

Retrospective Review

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews that Alliance may perform:

- Retrospective review initiated by Alliance
  - Alliance requires periodic documentation including, but not limited to, the medical record (UB and/or itemized bill) to complete an audit of the provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Alliance to support accurate coding and claims submission.
- Retrospective or post-service medical necessity reviews initiated by providers
  - Alliance will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the member was not eligible and became eligible with Alliance retroactively, or, in cases of emergency treatment, the payer was not known at the time of service. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member's needs at the time of service. Alliance will also identify quality issues, utilization issues and the rationale behind failure to follow Alliance's prior authorization/pre-certification guidelines.

The member or provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Utilization Management Department.

Peer-to-Peer Conversation of Adverse Benefit Determination

In the event medical necessity is not established, a peer-to-peer conversation is offered to the attending or ordering physician. The peer-to-peer review may be conducted prior to rendering a medical necessity decision, or in the event of an adverse determination, following a medical necessity review, offered to the treating physician. The attending or ordering physician is provided a scheduled time to discuss the case no more than 3 business days from the decision date.

Services Requiring No Authorization

Alliance has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of members including:

- Certain diagnostic tests and procedures considered by Alliance to routinely be part of an office visit
- Refugee health assessments do not require prior approval when provided through local health departments
- Additional services for which a pass-through or unmanaged benefit is referenced as part of the Alliance Medicaid Direct Benefit Plan.

All services performed without prior authorization are subject to retrospective review by Alliance.

Alliance Notice of Adverse Benefit Determination

An adverse benefit determination is an action taken by Alliance to deny a request for services. In the event of an adverse benefit determination, Alliance will notify the member and the requesting provider in writing of the determination. The notice will contain the following:

- The action taken or intends to take
- The reason for the action
- Sufficient details that inform members of the decision, which will provide them with information necessary to determine if they wish to appeal.
- The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action
- The member's right to file an appeal including information on exhausting Alliance's level appeal and the right to request a state Fair Hearing if the adverse action is upheld.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

In accordance with North Carolina Prepaid Health Plan Services contract Statute 641.51, the member may elect to have a second opinion provided by a non-contracted provider. Alliance will pay the amount of all charges that are usual, reasonable and customary in the community for second opinion services performed by a physician not under contract with Alliance.

Alliance may require that any tests deemed necessary by a non-contracted provider be conducted by a participating Alliance provider.

Service Authorization Decisions

Type of Request	Decision	Extension
Standard	14 calendar days	14 calendar days
Expedited	72 hours	14 calendar days
Retrospective	30 calendar days unless a more restrictive requirement is issued by NC Medicaid or accrediting bodies	N/A

Standard Service Authorization

Alliance will provide a service authorization decision as expeditiously as the member's health condition requires and within state-established time frame, which will not exceed 14 calendar days. An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension, or if Alliance justifies a need for additional information and the extension is in the member's best interest.

Expedited Service Authorization

If the provider indicates, or Alliance determines, that following the standard time frame could seriously jeopardize the member's life or health, Alliance will make an expedited authorization determination and provide notice within 72 hours of the request. An extension of 14 days may be granted if the member or the provider requests an extension, or if Alliance justifies a need for additional information and the extension is in the member's best interest.

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to prior authorization requirements and are available to members 24 hours a day, 7 days a week. Urgent care services should be provided within one day.

Post-stabilization services are services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve, or resolve the member's condition.

Emergency service providers shall make a reasonable attempt to notify Alliance within 24 hours of the member's presenting for emergency behavioral health services.

Mobile crisis assessment and intervention for members in the community may be provided in lieu of emergency behavioral health care.

Authorization Request Forms

Alliance requests providers submit their request through the secure provider portal and use the standardized authorization request forms.

To ensure timely and appropriate claims payment, all forms must:

- Have all required fields completed
- Be typed or printed in black ink for ease of review
- Contain a clinical summary or have supporting clinical information attached

Incomplete forms are not processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid. All forms can be located at AllianceHealthPlan.org and should be submitted as listed on the form.

In no instance may the limitations or exclusions imposed by Alliance be more stringent than those specified in the North Carolina Medicaid rules, policies and handbooks.

Delegated Entities

Alliance Health delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Alliance Health and the delegated entities. The agreement must be approved by NCDHHS prior to implementation.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that Alliance Health's delegation requirements are met. These requirements include:

- A written description of the specific utilization management delegated activities
- Semi-annual reporting requirements
- Evaluation mechanisms
- Remedies available to Alliance Health if the delegated entity does not fulfill its obligations

On an annual basis, or more frequently as needed, audits of the delegated entity are performed to ensure compliance with Alliance Health's delegation requirements.

C. Covered Services

- Please refer to the list of NC Medicaid program Covered Services & Clinical Coverage Policies located in Section VII. Attachment B. Table 1 of the Behavioral Health I/DD Tailored Plan/PIHP contract.
- Please refer to the list of Behavioral Health, I/DD, and TBI Services Covered located in Section IV.F.1. Table1 of the PIHP contract.

As of the date of publication of this manual, the following core benefits and services (covered services) are provided to Alliance Medicaid Direct members.

Covered services listed are no less in amount, duration and scope of such services in the Medicaid state plan fee-for-service program.

[1] North Carolina's Medicaid state plan is available here: https://medicaid.ncdhhs.gov/document/state-plan-under-title-xix-social-security-act-medical-assistance-program. Medicaid clinical coverage policies are available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

[2] The department reserves the right to update the clinical coverage policies for covered benefits.

Covered Behavioral Health, I/DD, and TBI Services
Inpatient BH services
Outpatient BH emergency room services
Outpatient BH services provided by direct-enrolled providers
Psychological services in health departments and school-based health centers sponsored by health departments
Peer supports
Partial hospitalization
Mobile crisis management
Facility-based crisis services for children and adolescents
Professional treatment services in facility-based crisis program
Outpatient opioid treatment[8]
Ambulatory detoxification
Research-based BH treatment for autism spectrum disorder (ASD)
Diagnostic assessment
Non-hospital medical detoxification

Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
Residential treatment facility services
Child and adolescent day treatment services
Intensive in-home services
Multi-systemic therapy services
Psychiatric residential treatment facilities (PRTFs)
Assertive community treatment (ACT)
Community support team (CST)[9]
Psychosocial rehabilitation
Substance abuse non-medical community residential treatment
Substance abuse medically monitored residential treatment
Substance abuse intensive outpatient program (SAIOP)
Substance abuse comprehensive outpatient treatment program (SACOT)
Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
Early and periodic screening, diagnostic and treatment (EPSDT) services
Supported employment*
Individual transition and support*
Respite*
Community living and supports*
Community transition*

*North Carolina is currently in the process of developing a SPA to CMS to cover these services through 1915(i) authority.

[8]BH I/DD Tailored Plans will also be required to cover OBOT services as detailed in Section VII. First Revised and Restated Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies

[9]CST includes tenancy supports.

State -Funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
All-Disability	1. Diagnostic assessment[1] 2. Facility based crisis for adults[2] 3. Inpatient BH services, including 3-way contract beds 4. Mobile crisis management 5. Outpatient services[3]	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	Assertive community treatment (ACT)[4] Assertive engagement Case management[5] Community support team (CST) Peer supports[6] Psychosocial rehabilitation Mental health recovery residential services[7] Individual placement and support-supported employment (IPS-SE)[8] Transition management service	1. Partial hospitalization
Child Mental Health	1. High fidelity wraparound (HFW)[9] 2. Respite	1. Intensive in-home 2. Mental health day treatment 3. Multi-systemic therapy
I/DD and TBI [10]	1. Meaningful day and prevocational services[11] 2. Residential services[12] 3. TBI long term residential rehabilitation services 4. Supported employment[13] 5. Respite	N/A

Disability Group	Core Services	Non-Core Services
Substance Use Disorder	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[14] 4. Clinically managed population specific high intensity residential services[15] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[16] 8. Substance use residential services and supports[17] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment)	1. Social setting detoxification services

[1] Diagnostic assessment may be provided through Telehealth.

[2] This service is referred to as professional treatment services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

[3] The Behavioral Health I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

[4] The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

[5] This service may include critical time intervention, case management, and resource intensive case management (RICM).

[6] Peer supports include individual and group services.

[7] This category of services may include group living and supervised living among other services.

[8] The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364

[9] The department intends allocate funding for slots for HFW services.

[10] I/DD and TBI care management will be only be provided by the Behavioral Health I/DD Tailored Plan.

[11] This category of services may include day supports, adult developmental vocational program, personal assistance and developmental day among other services.

[12] This category of services may include group living, family living, and supervised living among other services.

[13] This service may include long-term vocational supports.

[14] This service may include critical time intervention, case management, and RICCM.

[15] The department is working to add this service to its array by Behavioral Health I/DD Tailored Plan launch. The Behavioral Health I/DD Tailored Plan will be required to cover this service upon notification from the department.

[16] Peer supports include individual and group services.

[17] This category of services will be covered an interim basis until the department completes its implementation of the 1115 SUD waiver and updates to the service definitions for SUD services to completely align with the ASAM criteria.

Pharmacy Services

Alliance Health Plan is contracted with Navitus Health Solutions pharmacy benefit manager (PBM) to provide outpatient pharmacy benefits at point of sale (POS) to Tailored Plan-eligible members. Alliance Health has adopted the NC Medicaid Preferred Drug List (PDL) and associated NC Medicaid Outpatient Pharmacy Clinical Coverage Policies.

The PDL provides a list of all preferred and non-preferred medications in drug classes managed by NCDHHS. Some therapeutic classes are not managed by NCDHHS, and therefore not included on the PDL. These medications are covered and considered preferred unless explicitly excluded from coverage by state or federal law. The NC Medicaid PDL is a published prescribing reference of prescription drug products selected by the NC Medicaid Pharmacy and Therapeutics (P&T) committee which is an advisory board to the Division of Health Benefits (DHB). The DHB brings the recommended PDL to the P&T committee for review and advice, and then to the public PDL panel meeting. All NC Managed Medicaid Plans, including Alliance Health Plan, provide coverage for all prescription drugs listed in the PDL. Medications are selected based on their efficacy data, safety profile, published clinical literature, and cost effectiveness.

Medication Specific Limits

The NC Medicaid P&T committee may impose medication specific limits to optimize medication safety and promote cost-effective care.

- **Prior authorization** or coverage determination reviews ensure appropriate use of select preferred and nonpreferred medications. Medications requiring prior authorization typically are high risk, have a high potential for misuse, or are high cost.

- **Step therapy** programs ensure that an adequate trial of a safe and cost-effective therapy is attempted before utilization of a more expensive option. First line preferred medications have been evaluated by the P&T committee and are considered safe, effective, and economical.
- **Quantity limits** ensure that medications are used in a manner consistent with Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits also help prevent billing errors.
- **Age limits** ensure safety consistent with FDA approved dosing guidelines.

Prescribers may request exceptions to medication specific limits and submit prior authorization requests via one of the following options:

- Log into the Navitus Provider Portal and submit a request electronically
- Download and fax completed prior authorization (PA) forms to Navitus at 855-668-8553
- Call the Navitus Pharmacy and Provider Services Line at 855-759-9300 between the hours of 7 a.m. and 6 p.m. EST, Monday through Saturday

Links to the Navitus prescriber portal, PA forms, a PDL lookup tool, a pharmacy finder and other pharmacy related information for providers including how members can obtain an emergency supply can be found at: AllianceHealthPlan.org/tp/prescribers/pharmacy-guidance-for-providers.

Alliance Member and Recipient Services is also available to respond to member questions and concerns about pharmacy benefits at 800-510-9132 Monday through Saturday, 7 a.m. to 6 p.m. EST.

Vision Services

The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames, is carved out and not included in Alliance's benefit plan:

- The agency pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, per year for children ages 0 through 20.
- The agency pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, every two years for adults ages 21 and older.
- Providers who supply eye exams and eyeglasses in their office must also provide NC Medicaid program eye exams and fee-for-service eyeglasses to members.

Alliance covered services shall include:

- Routine eye exams
- Medically necessary contact lenses
- Fitting and dispensing visual aids
- Providers obtain NC Medicaid program fee-for- service eyeglasses through the traditional NCDHHS process and bill Alliance for the dispensing fees, after the fee-for-service eyeglasses are dispensed to the Member.

For the most up-to-date information on covered services, refer to the Department of Health and Human Services website at www.ncdhhs.gov.

Vision

Avesis will provide the full spectrum of Medicaid covered vision services through an integrated delivery system of eye care services. Avesis will provide a vision network for Alliance Health Tailored Plan members and will be responsible for contracting, provider relations, and network development. On behalf of Alliance, Avesis will administer comprehensive routine and eye medical vision care benefits.

Phone: 1-800-843-0558
(Note: This phone number will be active when Tailored Plan goes live)
Fax: UM Authorization Fax #: 1-855-591-3566; Appeals and Grievance Fax #: 1-855-691-3243
Provider Portal: https://www.avesis.com/
Main Page: https://www.avesis.com/

Durable Medical Equipment (DME)

Alliance and Northwood have entered into a partnership to ensure access to quality, cost-effective durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for Alliance Tailored Plan members. Authorization requests by Northwood contracted DMEPOS providers shall be requested using Northwood's online provider portal at https://providerportal.northwoodinc.com. To request access to Northwood's provider portal, contact Northwood's provider relations or visit https://northwoodinc.com. Authorization requests from non-Northwood contracted providers may be requested by phone or fax. Items under $500 do not require an authorization for claim consideration. Urgent/emergent requests greater than $500 do not require prior authorization but need to request within 2 business days for the claim to be considered for payment.

Phone: 877-403-6164
(Note: This phone number will be active when Tailored Plan goes live)
Fax: 877-552-6551

D. Eligibility for State-Funded Services, Including Federal Funding Restrictions and Requirements

All enrollment requests submitted to Alliance are reviewed by eligibility and enrollment specialists.

The provider will complete an enrollment through the Alliance Provider Portal within 14 calendar days of the assessment.

Eligibility and enrollment specialists review enrollment requests that were submitted to Alliance through the Alliance Provider Portal within 2 business days.

Eligibility and enrollment specialists review for completeness and verify that the individual lives within the Alliance coverage area and reviews household income and family size information to verify financial eligibility which is 300% below poverty level.

Third Party Liability for State-Funded Services

1. Alliance requires that state-funded providers have policies and procedures acknowledging and ensuring that state funds are the payer of last resort.
2. Alliance requires that providers identify and bill responsible first and third parties before billing Alliance for state-funded services, including Medicaid-funded services and the Division of Vocational Rehabilitation (DVRS) for supported employment.
    a. Alliance will coordinate benefits for recipients who have third party coverage.
    b. ACS includes edits to ensure proper adjudication of state-funded claims for recipients who have first- and third-party payers.
    c. Alliance will monitor provider compliance with first- and third-party requirements.

If enrollment request is missing information, the enrollment request is returned to the provider within 2 business days and the reason for the return is documented in the comment section which is viewable to the provider through the Alliance Provider Portal.

Eligibility and enrollment specialists will check NCT for Medicaid coverage and Medicaid category of aid, Medicare, and third-party liability (TPL). If the individual has a category of aid not covered under the 1915 (b) waiver, the specialist will ask the provider what service is being requested. If the service is exclusively a state funded service, the enrollment will be approved.

If the service is covered by both Medicaid and state funds, the enrollment will be denied.

If all other enrollment information is complete, residency is verified by the requirements stated above and the individual meets financial eligibility criteria, the enrollment is approved.

When an individual is referred to, presents as a walk-in or is brought to an Alliance-designated crisis facility on involuntary commitment, the individual will be eligible for an assessment/evaluation regardless of financial and residency eligibility requirements. If Alliance refers an individual to a state-funded service provider, Alliance will pay for the initial assessment when there is no other payer source, regardless of financial eligibility.

The provider will complete an enrollment through the Alliance Provider Portal within 14 calendar days of the assessment.

If the individual meets residency and financial eligibility, the enrollment request is approved by Alliance and the provider is eligible for reimbursement through Alliance.

If it is determined through the enrollment process that the individual does not meet residency and/or financial eligibility, the enrollment is only approved to cover the date of the assessment. When an

individual is referred to, presents as a walk-in or is brought to an Alliance network non-Medicaid inpatient facility, excluding those under the 3-way contract, the provider must complete an enrollment through the Alliance Provider Portal within 30 calendar days of the discharge date.

E. Care Management Delivered through the Tailored Plans/ PIHP

All Alliance members will receive a member welcome packet upon enrollment with Alliance. This packet will include educational information about care management and a form where members can indicate a preference for care manager, or if they wish to opt out of receiving care management. Members who are not engaged in duplicative services, which are Assertive Community Treatment (ACT), High Fidelity Wrap Around, Intermediate Care Facilities (ICF) or Care Management for At Risk Children (CMARC), may choose to receive Tailored Plan/PIHP care management. Medicaid Direct members who are eligible may also receive care management. If no specific member preferences are indicated and if there is no duplication of care management through a service which includes care management, a member will be assigned to a Care Management Agency (CMA), Advanced Medical Home Plus (AMH+), or an Alliance care manager based on member behavioral and medical health acuity, existing relationships with the CMA or AMH+, CMA or AMH+ capacity to accept new referrals, and geographic location. Members in the Innovations and TBI waivers may choose to continue with their current care manager prior to assignment. CMA and AMH+ organizations are responsible for informing Alliance of their ongoing ability to accept new members for care management.

Members in the Innovations or TBI Waiver or Medicaid Direct who opt out of care management will still receive care coordination as required under the waiver through Alliance. Members may choose to opt back into Tailored Plan/PIHP care management at any time by contacting the Member and Recipient Service Line.

Members may choose to change their care manager or the care management organization they are assigned to twice a year without cause and at any time with cause. The member and Recipient Service Line will assist members with changing their care management organization. Care managers shall assist Members who wish to change care manager or care management organization with the reassignment process.

Alliance will share all required member data and risk stratification information through an application programming interface (API). For CMAs or AMH+s who choose to use the Alliance care management platform, JIVA, member data and risk stratification will also be integrated in the JIVA Provider Portal.

Within 30 days of enrollment with Alliance Health, the selected care management organizations will assign a care manager, with the appropriate qualifications and experience to meet the member's needs. A separate mailing will be sent to the member identifying their care manager and including their contact information.

Care managers will address language, communication, and cultural preferences with members to ensure that care management is conducted in a manner that meets the member's communication and cultural needs. Initial contacts may be made telephonically, through two-way real-time audio or visual conferencing or in-person. Care management organizations shall inform Alliance on a monthly basis through API of members with whom they were not able to connect. Care management organizations that choose to use JIVA can inform Alliance by closing the care management episode for the member.

Care Management Comprehensive Assessment (CMCA)

The Care Management Comprehensive Assessment serves as the federally required initial care needs screening. The CMCA must address all the elements required by the state. For CMA and AMH+ organizations that choose to use JIVA, the Alliance care management platform, Alliance will ensure that the CMCA assessment including state required unmet health-related resource needs questions available in the Provider Portal meet the state's requirements.

The care manager is responsible for conducting the CMCA and shall make best efforts to conduct the CMCA in person and at a location that meets the Member's needs. The care manager shall make best efforts to conduct the CMCA within the following timelines.

- In Contract Year 1, within 45 days and no longer than 60 days after Tailored Plan/PIHP enrollment for Members stratified as high acuity.
- In Contract Year 1 within 90 days after Tailored Plan/PIHP enrollment for Members stratified as medium/low acuity.
- Thereafter, within 60 days after Tailored Plan/PIHP enrollment.

Best effort is defined as at least 3 documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, if the first attempt is unsuccessful.

The care manager is responsible for conducting reassessments:

- At least annually
- Whenever the member's circumstances, needs or health status changes significantly
- After significant changes in scores on department approved level of care instruments or screening tools
- At the member's request

After triggering events including inpatient hospitalization, two ED visits, involuntary treatment, BH crisis services, arrest or other law enforcement involvement, becoming pregnant and/or giving birth, a change in circumstance that affects need for care, loss of housing or foster care involvement.

Reassessment shall be conducted within 30 days of detecting the change in circumstances or event. If an assessment was recently completed, reassessment may be done as an addendum or update to the previous assessment.

Care Plans/Individual Support Plans

Care management organizations shall develop care plans for members with behavioral health needs and individual support plans (ISP) for members with I/DD or TBI needs incorporating the results of the CMCA, member information from claims analysis and risk scoring, available medical records, screening and level of care tools and input from the care team. Care managers shall use the principles of person-centered planning and member engagement in developing care plans/ISPs. Care plans shall be individualized, personalized and developed collaboratively with members and their families, as appropriate, in a manner understandable to the member, taking into consideration their reading level and alternate formats. Care planning meetings shall be held at a location, place and time convenient for the Member and their chosen participants. For members ages 3 – 21, with a mental health or SUD disorder, a member of the child and family team shall be involved in care planning.

Care managers will make best efforts to complete care plans/ISPs within 30 days of CMCA completion. Best effort is defined as at least 3 documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, if the first attempt is unsuccessful. Care plan/ISP development shall not delay provision of services in a timely manner. Care plans/ISPs must be updated at least annually, when members' circumstances or needs change significantly, at Member's request or within 30 days of reassessment.

Care plans/ISPs must include all elements required by the state. ISPs for members on the Innovations or TBI waiver, must also include all elements required under the waiver. For care management organizations who choose to use JIVA, JIVA develops recommended plans of care based on the assessment. Care managers shall engage members and their chosen participants in understanding recommended care plans and shall individualize plans through member choice of goals and interventions to address. Care plans/ISPs can be further personalized by addition of member-chosen goals. Alliance will ensure that care plans/ISPs include all elements required by the state.

Care managers shall document store and make the care plan/ISP available to members and the following representatives within 14 days of care plan/ISP completion.

- Care team members including member's primary care provider, other physical health, BH, I/DD, TBI and LTSS providers
- Other providers delivering care to the member
- The member's legal representative (as appropriate)
- The member's caregiver (as appropriate, with consent)
- Social service providers (as appropriate, with consent)
- Other individuals identified and authorized by the member

Care managers shall establish a multi-disciplinary care team for each member. As applicable, based on the member's needs, the care team shall consist of the following members:

- The member
- Caretaker(s)/legal guardians
- The member's care manager
- Supervising care manager
- PCP
- BH provider(s)
- I/DD and/or TBI providers
- Other specialists
- Nutritionists
- Pharmacists and pharmacy techs
- The member's obstetrician/gynecologist (for pregnant women)
- Peer support specialist
- In-reach and/or transition staff
- Other providers, as determined by the care manager and member

For members ages 3–21 with mental health or SUD, child and family team shall be incorporated in the care team.

Care managers shall work with the member and members of the care team to meet the member's goals and address the member's behavioral, medical and unmet health-resource needs. For Medicaid Direct members care managers will coordinate care with health care providers to ensure that medical needs are addresses. Care managers shall work with the member and members of the care team to support the member's self-management skills and address barriers to community inclusion.

Women's Health Specialists

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for covered services related to this type of routine and preventive care. Alliance (Medicaid) members have the right to obtain family planning services from any participating Medicaid provider without prior authorization.

Foster Care Youth

Care managers working with youth and families involved in the child welfare system will coordinate with county child welfare workers and with the Alliance foster care point of contact to ensure that all state requirements are met including, but not limited to, engagement, assessment, identification of health care services and health-related services, coordination of services, coordination of transitions or crisis events, and involvement in and reporting to regular meetings with county child welfare workers.

i. In-reach

In-reach activities are conducted with the goal of identifying and engaging members and recipients in a variety of inpatient settings (e.g., hospitals, skilled nursing facilities, neonatal intensive care units, psychiatric residential facilities, intermediate care facilities for individuals with intellectual disabilities, facility-based crisis facilities, residential programs and adult care homes).

Coordination of in-reach activities for state psychiatric hospitals is organized using the ready for discharge reports provided by NCDHHS and for adult care homes is coordinated by the community health worker II supervisors.

All population groups will receive timely initiation of in-reach activities. In-reach shall begin within 7 days of admission and, at minimum, at least weekly thereafter to begin and sustain efforts for discharge/ transition planning. In-reach activities shall include but are not limited to:

- Educational activities and review of materials with members and recipients that are of appropriate level of health literacy
- Scheduling, facilitating, and accompanying family members and recipients and guardians in identifying community-based programs which match member needs
- Assess and work to address barriers to community transition including housing, food, and transportation access
- For Alliance-led care management, inclusion of a family partner or peer mentor to engage peer to peer discussions about transition needs
- Regular opportunities to review transition opportunities for those members and recipients who decline moving forward with transition activities
- For Transition to Community Living members and recipients, referral to a transition coordinator; for Alliance-led care management, this is an integrated health consultant I

ii. Transition Management

Transition activities are conducted with the goal of (a) facilitating the relocation of a member receiving services in a variety of inpatient settings to a community setting, (b) assisting the member to identify an alternative provider or (c) transitioning the member to a Standard Plan, while ensuring the appropriate level of services and supports that the member requires.

- Provider Change
  - In the event a member requests to receive services from an alternative provider, Alliance care management will support the member to identify and transition to a new provider, an Alliance care manager will work with the member to coordinate a transition of care to a new provider. The care manager will educate the member about available network options to assist the member in selecting a new provider that will meet the member's needs. The care manager will review all medical records and treatment plans that will be transferred to the new provider with the member and ensure that all medical records or treatment plans are transferred to the new provider prior to the member's first appointment with the new provider.

- Facility to Community
  - The following activities are completed by Alliance care management to support members to transition from an institution to a community setting include:
    - Receive referral including any current assessments or plans developed with member or recipient, guardian, and respective in-reach team members. This assessment will include assessment of the safety and appropriateness of the setting to which the member or recipient is transitioning.
    - Collaborate with facility and relevant team members and recipients regarding timeline and needed supports for member's discharge.
    - If member had an established community-based primary care physician (PCP) and community- based behavioral health providers, support member to relink with their professionals. If member did not have an established PCP or other specialists, provide education about community-based options which can address medical needs of the member.
    - Schedule post-discharge appointments with member for critical services within 7 days of anticipated discharge date.
    - If warranted, make referrals to NC START or other crisis prevention supports.
    - Education and link member to other community-based social resources in the community to which they will be moving. These include, but are not limited to transportation, housing, and food access. For children, this will include a Child and Family Team meeting which includes planning for reconnection with educational services.
    - Ensure that member and member's identified family, guardians, or other identified persons of choice (if consent is provided) have received any training or updates on aftercare needs for member.
    - Coordinate any aftercare benefits initiation with local Department of Social Services, including, but not limited to, initiation of in-home aide, special assistance benefits.
    - Within 3 business days of anticipated discharge date, secure all discharge orders including prescriptions, supply and equipment orders.
    - Develop and finalize a 90-day post discharge plan with member, community-based providers, and natural supports. For members and recipients discharging from state developmental centers, request an extension of the memorandum of agreement in writing prior to actual discharge.
    - On the day of discharge, obtain copies of discharge plan, review with member, providers and natural supports. Communicate and coordinate all admission, medication, and personal effects "move-in" logistics with residential providers, if applicable.
    - Coordinate and facilitate discharge follow up meetings within 30 days to ensure follow up appointments, provider linkage, engagement, adequate personal effects including income (may include community living allowance (CLA), community living tools (working phone, utilities are turned on, member has identified places to shop for groceries, has adequate transportation to medical and non-medical appointments, and access and scheduled socially inclusive events post discharge).
    - For members and recipients leaving excluded services lines (e.g., ICF-IID), initiate tailored plan/PIHP care management assignment process. For members and recipients initiating services which include care management (eg ICF-IID, High Fidelity Wraparound, Assertive Community Treatment Team,

Care Management for At Risk Children, Community Alternatives Program for Disabled Adults, Program for All-Inclusive Care for the Elderly, or Community Alternatives Program for Children, establish linkage and document care management points of contact.

- Tailored Plan to Standard Plan
  For members who meet criteria to return to the Standard Plan a request to move form would be completed by the member or provider. The request to move form would be submitted to the enrollment broker. Once the enrollment broker has approved the transition the member would return to the Standard Plan. A warm handoff summary form and a warm handoff would be completed for this member. All member files will be sent to the Standard Plan via IT file exchange.

iii. Diversion

Diversion activities are conducted with the goal of preventing admission to restrictive treatment settings when a less restrictive/community based treatment option can meet member health and safety needs. Diversion includes assessment of member needs, education of home and community based services (HCBS), linkage to HCBS providers, and monitoring for successful engagement with HCBS providers.

Through Alliance care management, integrated health consultant I, and integrated health consultant II team members complete diversion related interventions including:

i. Providing assessment (RSVP) and engagement with members identified as potentially eligible for TCL. IHC-II supervisors will review the targeted diversion population list provided by NCDHHS and log all activities specific to eligible members in the TCLD system

ii. Outreach for individuals requesting consideration for emergency reserve slot enrollment for Innovations and those in hospital emergency departments who may quality for short term residential stabilization

iii. Consideration of all community-based options and combinations of services covered through EPDST for children at risk for out of home placement. Alliance integrated health consultants and care managers will incorporate all system of care related recommendations for treatment

F. Provider Responsibilities

This section is an overview of guidelines for which all participating Alliance Health Medicaid providers are accountable. Please refer to the provider contract or contact a Provider Relations representative for clarification of any of the following.

Participating Alliance Health providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Agree to cooperate with Alliance Health in its efforts to monitor compliance and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to Alliance Health members as required by state and federal laws.
- Provide covered services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii).].
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct member care within the scope or practice established by the rules and regulations of approved NCDHHS and Alliance Health guidelines.

- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- Clearly identify physician extender titles (examples: ARNP, PA) to members and to other health care professionals.
- Honor at all times any member request to be seen by a physician rather than a physician extender.
- Administer, within the scope of practice, treatment for any member in need of health care services.
- Maintain the confidentiality of member information and records.
- Ensure all documentation regarding services provided is timely, accurate, and complete.
- Allow Alliance Health to use provider performance data for quality improvement activities.
- Respond promptly to Alliance Health's requests for medical records in order to comply with regulatory requirements.
- Maintain accurate medical records and adhere to all Alliance Health policies governing content and confidentiality of medical records as outlined in Section: Department-required Documentation Requirements and Section: Provider Program Integrity Requirements.
- Ensure that:
  - All employed physicians and other providers comply with the terms and conditions of the provider contract.
  - To the extent the contracted provider maintains written agreements with employed physicians and other providers, such agreements are consistent with, and require adherence to, contracted provider's agreement with Alliance Health.
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
- Communicate timely clinical information between providers. Communication will be reviewed during medical/chart review. Upon request, provide timely transfer of clinical information to Alliance Health, the Member or the requesting party at no charge, unless otherwise agreed.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between Alliance Health members and non-Alliance Health members, based on a person's:
  - Race, mental or physical disability, source of payment, cost of treatment, participation in benefit plans, genetic information, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin.
- Ensure that the hours of operation offered to Alliance Health members are no less than those offered to commercial members.
- Not deny, limit or condition the furnishing of treatment to any Alliance Health member on the basis of any factor that is related to health status, including, but not limited to, the following:
  - Medical condition, including mental and physical illness
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability
  - Including conditions arising out of acts of domestic violence, or disability
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on member's behalf for member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are covered services.

- Identify members who need services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation. If indicated, mroviders must refer members to Alliance Health-sponsored or community-based programs.
- Must document the referral to Alliance Health-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

Advanced Medical Home Program

Alliance supports the North Carolina Advanced Medical Home (AMH) program, a primary care program, and the state-designated AMH practices to provide local care management services in the primary care setting. Primary care providers participating in the Advanced Medical Home program will be classified or tiered by NC DHHS and this classification will drive the value of all AMH tier payments. Key responsibilities include but are not limited to:

- Accepting members and being listed as a primary care provider in the plan's member-facing materials for the purpose of providing care to members and managing their health care needs
- Providing primary care and patient care coordination services to each member, in accordance with plan policies
- Providing or arranging for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, 7 days per week
- Providing preventive services
- Maintaining a unified patient medical record for each member following the plan's medical record documentation guidelines
- Promptly arranging referrals for medically necessary health care services that are not provided directly and documenting referrals for specialty care in the medical record
- Authorizing care for the member or providing care for the member based on the standards of appointment availability as defined by the plan's network adequacy standards
- Referring for a second opinion as requested by the member, based on DHHS guidelines and plan standards
- Reviewing and using member utilization and cost reports provided by the plan for the purpose of AMH level utilization management and advising the plan of errors, omissions or discrepancies if they are discovered
- Reviewing and using the monthly enrollment report provided by the plan for the purpose of participating in plan or practice-based population health or care management activities
- Coordinating care with care management entities that are providing Tailored Care Management to AMH enrollees

Copayment Provision

If copayments are waived as an expanded benefit, the provider must not charge members copayments for covered services; and if copayments are not waived as an expanded benefit, the amount paid to providers by Alliance Health will be the contracted amount, less any applicable copayments.

Medicaid cost-sharing does not apply to certain subsets of the population, including children under age 21, pregnant women, individuals receiving hospice care, federally recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, qualified Medicare beneficiaries, disabled children under Family Opportunity Act, and individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than that required for personal needs.

Excluded or Prohibited Services

Providers must verify patient eligibility and enrollment prior to service delivery. Alliance Health is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as specific transplant services, are administered outside of the managed care program.

For Medicaid, excluded services are defined as those services that members may obtain through other applicable Medicaid programs, including the NC Medicaid fee for service system, and for which Alliance Health is not financially responsible. These services may be paid for by the Department of Health and Human Services (DHHS) on a fee for service basis or other basis. Providers are required to determine eligibility and covered services prior to rendering services. In the event the service is excluded, providers must file a claim for reimbursement directly to the DHHS. In the event the service(s) is (are) prohibited, neither Alliance Health nor the DHHS is (are) financially responsible.

Identification and Reporting of Abuse, Neglect and Exploitation of Children and Vulnerable Adults

Providers are responsible for the screening and identification of children and vulnerable adults for abuse, neglect or exploitation. Information on mandatory reporting in NC can be found at: www.nccasa.org/resources/mandatory-reporting/.

To report suspected abuse, neglect or exploitation of children or vulnerable adults, providers should contact the local Department of Social Services. A list of offices is online at www.ncdhhs.gov/divisions/dss/local-county-social-services-offices. If a provider sees a child or vulnerable adult in immediate danger, the provider should call **911**.

Providers must report suspected cases of abuse, neglect and/or exploitation to the agency's Department of Social Services.

- If the suspected activity involves a parent, guardian, or caretaker:
  - **Children:** Report what you know to the local Department of Social Services and more information can be found at: https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/child-protective-services/about-child-abuse-and-child-neglect.
  - **Adults:** Report what you know to the local Department of Social Services and more information can be found at: https://www.ncdhhs.gov/assistance/adult-services/adult-protective- services.
  - **Elders:** Report what you know to the local Department of Social Services and more information can be found at: https://www.nia.nih.gov/health/elder-abuse.
- If the suspected activity does not involve a parent, guardian or caretaker, report what you know to the local law enforcement authorities.
- If the suspected activity involves personnel engaged in providing health care services, report what you know to the NC Health Care Personnel Registry (HCPR). More information can be found at https://info.ncdhhs.gov/dhsr/hcpr/flohcinv.html.
- Adult protective services (APS) are services designed to protect elders and vulnerable adults from abuse, neglect or exploitation. The Department of Aging and Adult Services and APS have defined processes for ensuring elderly victims of abuse, neglect or exploitation in need of home and community-based services are referred to the aging network, tracked and served in a timely manner. Requirements for serving children and elderly victims of abuse, neglect and exploitation can be found in G.S. 108A Article 6 and G.S. 7B Article 3 and 10A NCAC 27G .0610.
- Providers may be asked to cooperate with Alliance Health to provide services or arrange for the member receive services at an alternate location. Training regarding abuse, neglect and exploitation is available on Alliance Health's website at AllianceHealthPlan.org.

Responsibilities of All Providers

The following is a summary of responsibilities specific to all providers who render services to Alliance Health members and recipients. These are intended to supplement the terms of the provider contract, not replace them. In the event of a conflict between this provider manual and the provider contract, the provider contract shall govern

Provider Identifiers

All participating providers are required to have a National Provider Identifier (NPI). Providers who are not already enrolled, and who perform services for Alliance Health's Medicaid and state funded members, must enroll in NCTracks. The NPI associated to a provider's North Carolina Medicaid enrollment is used to submit a claim or encounter data for the services rendered under Alliance Health. It is the provider's responsibility to enroll and maintain successful enrollment in NCTracks for the services/sites they are billing for and ensure the billing/rendering NPI and taxonomy codes billed on a claim or encounter match how the provider is enrolled with NCTracks.

Advance Directives

Members and recipients have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states.

Each Alliance Health member and recipient (age 18 years or older and of sound mind) should receive information regarding living wills and advance directives. This allows the member/recipient to designate another person to make a decision should the member/recipient become mentally or physically unable to do so. Alliance Health provides information on advance directives in the member and recipient handbooks.

Information regarding living wills and advance directives should be made available in provider offices and discussed with the members/recipients. Completed forms should be documented and filed in the member's medical record.

A provider shall not, as a condition of treatment, require a member/recipient to execute or waive an advance directive.

Provider Termination

In addition to the provider termination information included in the provider contract, providers must adhere to the following terms:

- Any contracted provider must give at least 90 days prior written notice to Alliance Health before terminating their relationship with Alliance Health "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to Alliance Health members/recipients regarding the provider's participation status with Alliance Health. Please refer to the provider contract for the details regarding the specific required days for providing termination notice, as the Provider may be required by contract to give different notice than listed above.
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.
- Members/recipients in active treatment may continue to receive care when such care is medically necessary, through the completion of treatment for which the member/recipient was receiving at the time of the termination, or until the member/recipient selects another treating provider, for a minimum of 60 days, is not to exceed 6 months after the provider termination. For pregnant members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation of care shall be provided until the completion of postpartum care.

Please note that Alliance Health will notify in writing all members prior to the termination effective date of a participating primary care provider (PCP), hospital, specialist or significant ancillary provider within the service area as required by North Carolina Medicaid requirements and/or regulations and statutes.

Out-of-Area Member Transfers

Providers should assist Alliance Health in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Alliance Health provider and the out-of-network attending physician/provider.

Responsibilities of Primary Care Providers (PCPs)

The following is a summary of responsibilities specific to PCPs who render services to Alliance Health members. These are intended to supplement the terms of the provider contract, not replace them.

- Coordinate, monitor and supervise the delivery of primary care services to each member.
- See members for an initial office visit and assessment within the first 90 days of enrollment in Alliance Health.
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under the age of 21.
- Ensure each time a referral is made of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance, that copies of the referral are provided to the member and kept in the Member's medical record.
- Ensure members are aware of the availability of public transportation where available.
- Provide access to Alliance Health or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office.
- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Healthcare Effectiveness Data and Information Set) service.
- Submit encounters. For more information on encounters, refer to Section 5: Claims.
- Ensure members use network providers. If unable to locate a participating Alliance Health Medicaid provider for services required, contact Clinical Services for assistance. Refer to the Quick Reference Guide on Alliance Health's website at AllianceHealthPlan.org.
- Comply with and participate in corrective action and performance improvement plan(s).

Advanced Medical Home Program

Alliance supports the North Carolina Advanced Medical Home (AMH) program, a primary care program, and the state-designated AMH practices to provide local care management services in the primary care setting. Primary care providers participating in the Advanced Medical Home program will be classified or tiered by NC DHHS and this classification will drive the value of all AMH tier payments. Key responsibilities include:

- Accepting members and being listed as a primary care provider in the plan's member-facing materials for the purpose of providing care to members and managing their health care needs,
- Providing primary care and patient care coordination services to each member, in accordance with plan policies,
- Providing or arranging for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, 7 days per week.

- Providing preventive services.
- Maintaining a unified patient medical record for each member following the plan's medical record documentation guidelines.
- Promptly arranging referrals for medically necessary health care services that are not provided directly and documenting referrals for specialty care in the medical record.
- Authorizing care for the member or providing care for the member based on the standards of appointment availability as defined by the plan's network adequacy standards.
- Referring for a second opinion as requested by the member, based on DHHS guidelines and plan standards.
- Reviewing and using member utilization and cost reports provided by the plan for the purpose of AMH level utilization management and advising the plan of errors, omissions or discrepancies if they are discovered.
- Reviewing and using the monthly enrollment report provided by the plan for the purpose of participating in plan or practice-based population health or care management activities.
- Coordinate care with care management entities that are providing Tailored Care Management to AMH enrollees.

Vaccines for Children Program

Providers must participate in the Vaccines for Children Program (VFC). The VFC is administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments (CHDs) for immunizations. Alliance Health covers and reimburses participating providers for immunizations covered by Medicaid, but not provided through VFC. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health care and medical treatment. Alliance providers offer or arrange for the full range of preventive and treatment services available within the federal EPSDT benefit.

Preventive (wellness) services are offered without copays or other charges, on a periodic schedule established by the state of North Carolina. Early periodic screening services include physical exams, up to date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices. Medically necessary care and treatment to "correct or ameliorate" health problems must be provided directly or arranged by referral, even when a Medicaid coverable service is not available under the state Medicaid plan. Our pediatric primary care goal is to improve the health of Medicaid members from birth to age 21 by increasing participation in comprehensive early periodic screening (wellness) visits. EPSDT claims are paid by Medicaid as the primary payer; Alliance will seek recovery from any liable third party for these claims.

When conducting early periodic screenings, providers will adhere to best practice guidelines published by the American Academy of Pediatrics in their Bright Futures publication.

Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services are responsible for:

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with federal regulation 42 U.S.C. § 1396d(r)(5); NC State Contract Section V.C.2.i.iii; and as recommended and updated by the American Academy of Pediatrics (AAP)

"Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents" for all members under the age of 21; including:

- Screening for developmental delay at each visit through the fifth year.
- Screening for autistic spectrum disorders per AAP guidelines.
- Comprehensive, unclothed physical examination.
- All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
- Laboratory testing (including blood lead screening appropriate for age and risk factors).

- Health education and anticipatory guidance for both the child and caregiver perform, during preventive visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under 21 years of age in accordance with the Department's Oral Health Periodicity Schedule; and,
  - Refer infant Medicaid members to a dentist or a dental professional working under the supervision of a dentist at age 1, per requirements of the Department's Oral Health Periodicity Schedule.
    - Services provided by a dentist are carved out of Medicaid Managed Care and should be billed to the NC Medicaid Fee for Service programs.
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Providing vaccinations in conjunction with EPSDT/well-child visits.
- Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) program for Medicaid children younger than the age of 19.
- Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits.
- Requesting prior authorization, if applicable, for special services resulting from an EPSDT visit, in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62; and the particular needs of the member, are not otherwise covered under NC Medicaid.
  - Prior authorization of preventive care (early and periodic screens/wellness visits) for Medicaid members less than 21 years of age is NOT required.
- Coordinating with behavioral health (BH) Providers and specialists when conducting (EPSDT) screenings.
- Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with members to ensure they receive the necessary medical services.
- Referring the member to an out-of-network provider for treatment if the follow-up service is not available within Alliance's network
- Monitoring, tracking and following up with members:
  - Who have not had a health assessment screening.
  - Who miss appointments to assist them in obtaining an appointment.
- Assisting members with transition to other appropriate care for children who age out of EPSDT services.

For more information on EPSDT covered services, refer to Section 1: Welcome to Alliance. For more information on the NC Medicaid EPSDT periodicity schedule, refer to the DHHS website at https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents. For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx.

Primary Care Offices

PCPs provide comprehensive primary care services to Alliance members. Primary care offices participating in Alliance's provider network have access to the following services:

- Support of the provider relations, provider services, clinical services, and as well as the tools and resources at AllianceHealthPlan.org
- Information on Alliance's network providers for the purposes of referral management and discharge planning

Closing of Physician Panel

When requesting closure of the provider's panel to new and/or transferring Alliance Members, PCPs must:

- Submit the request in writing at least 60 days (or such other period stated in the provider contract) prior to the effective date of closing the panel
- Maintain the panel to all Alliance members who were provided services before the closing of the panel
- Submit written notice of the reopening of the panel, including a specific effective date

Covering Physicians/Providers

If participating providers are temporarily unavailable to provide care or referral services to Alliance members, providers should make arrangements with another Alliance contracted (participating) and credentialed provider to provide services on their behalf, except in cases of emergency care.

In non-emergency cases, if a provider has a covering physician/provider who is not contracted and credentialed, he or she should contact Alliance for approval.

Domestic Violence and Substance Use Disorder Screening

PCPs should identify indicators of substance use disorder or domestic violence and offer referral services to applicable community agencies. PCPs can make referrals to NCCare360 as applicable or contact Alliance member services to refer for SUD services. Sample screening tools for domestic violence and substance use disorder are located on Alliance Health's website.

Opioid Misuse Prevention and Treatment Program

The Opioid Misuse Prevention Program contains interventions that support and promote safer prescribing of opioids, management of chronic pain with non-opioid pharmacologic and nonpharmacologic modalities, early detection of opioid misuse and intervention, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and increased access to naloxone and substance use disorder treatment, including medication-assisted treatment (MAT). Providers are encouraged to participate in Alliance training, technical assistance and outreach efforts that focus on best practices for preventing and addressing opioid misuse.

In alignment with NC Gen. Stat. § 108A-68.2, Alliance will implement a member lock-in program that limits over-utilizing members to a single prescriber and a single pharmacy for their controlled substance prescription medication needs for a 24-month period. A North Carolina member shall be locked in to 1 prescriber and 1 pharmacy for controlled substances, categorized as opiates or benzodiazepines and certain anxiolytics, when 1 or more of the following criteria are met:

Member who has at least 1 of the following:

1. Benzodiazepines and certain anxiolytics: more than 6 claims in 2 consecutive months.
2. Opiates: more than 6 claims in 2 consecutive months.
3. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from more than 3 prescribers in 2 consecutive months.

Termination of a Member/Recipient

An Alliance provider may not seek or request to terminate their relationship with a member/recipient, or transfer a member/recipient to another provider of care, based upon the member's medical condition, amount or variety of care required, or the cost of covered services required by Alliance's member/recipient.

Reasonable efforts should always be made to establish a satisfactory provider and member/recipient relationship in accordance with practice standards. The provider should provide adequate documentation in the member's/recipient's medical record to support their efforts to develop and maintain a satisfactory provider and member/recipient relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide care for the Alliance member/recipient until such time that written notification is received from Alliance stating that the member/recipient has been transferred from the provider's practice, and such transfer has occurred.

If a participating provider wants to terminate their relationship with an Alliance member/recipient, the provider should maintain documentation to support that they have attempted to maintain a satisfactory provider and member/recipient relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide care for the Alliance member/recipient until such time that written notification is received from Alliance stating that the member/recipient has been transferred from the provider's practice, and such transfer has occurred.

The provider should complete a "PCP Request for Transfer of Member Form," attach supporting documentation and fax the form to Alliance's member services department. A copy of the form is available at AllianceHealthPlan.org/document-library/77441/.

G. Network Requirements

i. Nondiscrimination

Alliance will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Alliance will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the contracting process. Decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Alliance policies and processes will not discriminate against any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

ii. Cultural and Linguistic Competency Expectations

Cultural and linguistic competency and the delivery of such services should be integrated into the overall fabric of service delivery, linked to quality of care and emphasized in policy, practice, procedures, and resources. Alliance recognizes that becoming culturally competent is an ongoing process in which we gain knowledge about one another and use that knowledge to build trust, break down barriers

and improve the quality of care throughout the network. In network agency and group providers are required to develop and submit to Alliance when requested a cultural competency plan and comply with cultural competency requirements set forth herein. In network LIP solo providers are required to obtain yearly (within each calendar year) cultural competency training and submit appropriate training certificates when requested.

Cultural awareness and sensitivity among Alliance's staff and contracted providers enable us to work effectively with each other in cross-cultural situations. It is our intention to create an environment that protects and preserves the dignity of all by acknowledging cultural differences among us without placing values on those differences.

We encourage our staff and providers to recognize that culture makes us who we are. Culture not only determines how we see the world and each other, but greatly impacts how we experience physical and mental illness. It also shapes the recovery process, affects the types of services that are utilized, impacts diagnosis, influences treatment and the organization and financing of services. We envision that our network includes providers who recognize that there is variation in behaviors, beliefs and values as they assess an individual's wellness or illness and incorporate that awareness in treatment planning with competence and sensitivity. Alliance encourages providers to participate in the provider cultural competency plan, which shall be developed and approved by a Provider Advisory Council composed of individuals of the Alliance provider network with representation across all disability groups.

Language interpretation services shall be made available by telephone or in-person to ensure that members are able to communicate with Alliance and network providers. Providers and Alliance shall make oral interpretation services available free of charge to each member. This applies to non-English languages as specified in 42 C.F.R. § 438.10. TDD (telecommunication devices for the deaf) must also be made available by providers for people who have impaired hearing or a communication disorder.

iii. On-call Coverage

Certain DMH/DD/SAS state service definitions and DMA clinical coverage policies require first responder/crisis be delivered as part of the service definition. Providers contracted for those services are required to designate qualified staff who are available to accept and respond to after-hours calls from individuals or family members or to return the call within one hour. This includes but is not limited to all enhanced benefit service providers.

All providers must provide access to 24-hour coverage for behavioral health emergency services. Those with first responder responsibilities should clearly define in their policy and procedures and PCP crisis plans how to access after-hours crisis calls and make those crisis plans available to their afterhours/on-call staff. If required by the applicable service definition, the designated after-hours on-call provider staff must be the individual's licensed clinician.

Upon receipt of an after-hours telephone call, the after-hours staff will assess the caller's level of need. If the situation is determined to be of an emergent nature, whereby there is concern of imminent risk of harm to self or to others, and the individual does not respond to his/her individualized crisis plan, that professional will contact either the local crisis and assessment center and/or the appropriate community partner (e.g. law enforcement). In situations that call for immediate psychiatric intervention(s), a licensed clinician from the agency or a mobile crisis team may be deployed to make a home or on-site visit to help prevent hospitalization or to alleviate the potential for further decompensation. If the situation is of an urgent or routine nature, that Individual will receive a follow-up contact from his or her licensed clinician or qualified professional on the next working day (or from that staff's supervisor).

The on-call staff shall be responsible for assuring the individual's individual treatment provider (or direct supervisor) is notified of the situation no later than the next business day. Outpatient and other contracted providers who are not required by the applicable service definition to maintain live staff for

after-hours coverage shall provide, or have a written agreement with another entity for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that they are not available to respond to a beneficiary in crisis. This coverage shall include the ability for the beneficiary to speak with the licensed clinician on call either face-to-face or telephonically. Written agreements with another entity must be for the same service.

Providers contracted to serve NC Innovations Waiver participants are also required to respond to emergencies of participants and have a back-up system in place to respond to emergencies/crises on weekends and evenings as outlined in the NC Innovations service definitions. NC Innovations Waiver providers of In-Home Intensive Supports, In-Home Skill Building, Personal Care, and Residential Support services are required to have qualified professional (QP) staff available as Primary Crisis Services providers for emergencies that occur with participants in their care 24 hours per day, 7 days per week or have an arrangement (memorandum of understanding) with a primary crisis services provider.

When an individual presents to a local crisis and assessment center after-hours requesting assistance, the crisis center staff must determine if the individual is enrolled with Alliance and the name of his or her primary provider. Crisis staff will perform an assessment to gather basic presenting information that includes determining the individual's needs and crisis lethality and attempt to contact the primary provider and access the crisis plan to obtain vital information to ensure that a thorough and comprehensive assessment is completed and an appropriate disposition is made.

The primary provider will be contacted for assistance, information, and treatment recommendations. After-hours staff from the primary provider agency must respond telephonically to the local crisis and assessment center and have access to the individual's crisis plans and pertinent clinical information. Specific information regarding demographics, problem summary, diagnosis, substance use history, living situation, supports, health issues, medication regime, safety and security issues, history of suicidal or homicidal ideation/intent, the service delivery plan, and other pertinent details of the crisis plan should be provided. If there is no reason to contact the primary provider after-hours on-call staff, the crisis center staff will contact the primary provider the next business day to alert them of the contact they had with the individual.

This contact should be documented in the individual's record. If the crisis center staff is unable to reach the primary provider's after-hours on-call staff or does not receive a call back within 1 hour, this will be reported to the Alliance Member and Recipient Services immediately for follow-up by the Alliance Quality Management Department and/or the Office of Compliance.

iv. Credentialing and Recredentialing

Overview

Credentialing and recredentialing of all providers is done through the department, or department-designated vendor, via a centralized credentialing and recredentialing process (CCRP). The department, or department-designated vendor, shall collect information and verify credentials for all providers currently enrolled, or seeking to enroll, in North Carolina's Medicaid program, or as a state-funded services provider.

Contracting is the process of determining whether a provider who applies to participate in the Alliance provider network meets the minimum criteria established by Alliance and the Behavioral Health I/DD Tailored Plan/PIHP contract for participation.

Process for consideration for enrollment in the Alliance Network

a. Provider agencies, practices and groups will submit a Provider Application Request

b. Licensed practitioners who are working under a currently contracted agency, practice or group will be added to the provider agency, practice, hospital system or group based on the affiliations in the PEF. All provider types are required to be enrolled in NCTracks and must be included in the PEF (provider enrollment file) from the department in order to be considered for enrollment in the Alliance network.

All providers who have been accepted for consideration for contracting with Alliance will be reviewed for final determination. Providers who meet all criteria for initial or continued participation and whose participation in the NC Medicaid program has been verified by the PEF, will be accepted into the provider network.

Alliance will make determination for physical health providers based solely upon the credentialing information provided by the department on the PEF. For network providers of Medicaid BH, I/DD, and TBI services, Alliance has the authority to maintain a closed network for these services as set forth in Section 4.(10)(a)(1)(IV) of Session Law 2018-48.

Alliance's role and responsibility:

a. Accept verified information from the PEF; Per NC Department of Health and Human Services requirements, Alliance is not permitted to require additional credentialing information from a provider or any other source without the department's written prior approval

b. Collect other information, as approved by the department, from providers for contracting purposes only.

Information collected from the provider for contracting purposes to support claim payment, directories, and data management.

Additional Contracting Data
Provider's website
Primary contact information for QM, and other business functions
Tax (W9)
ACS Provider Portal Request
EFT Authorization
Electronic Connectivity Request
Trading Partner Agreement
Cultural Characteristics Form (Optional)
Has provider completed Cultural Competency training?
PCP panel size

c. Alliance maintains the confidentiality of all information and documentation obtained in the screening, enrollment, and contracting process. Alliance will not use, disclose, or share provider credentialing information for any purpose other than use in Medicaid and/or state-funded services without the express, written consent of the provider and the department.

d. Alliance will follow their credentialing and recredentialing procedures when making a contracting decision for in-state, border (i.e., providers that reside within 40 miles of the North Carolina state line), and out-of-state network providers.

e. Alliance will publish all previous versions of the provider manual with updated credentialing and recredentialing policy and selection and retention policy and effective dates.

Nondiscrimination Statement

Alliance will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Alliance will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the contracting process.

Alliance policies and processes will not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

Contract Processing Timeframes

Alliance will provide written notice of network contracting decisions to providers within 5 business days of determination of the providers status as an enrolled provider.

Provider Disenrollment and Termination

Payment suspension at recredentialing:

a. Alliance will suspend claims payment to any provider for dates of services after the effective date provided by the department in its network within 1 business day of receipt of a notice from the department that provider payment has been suspended for failing to submit recredentialing documentation to the department or otherwise failing to meet department requirements.
b. Alliance will reinstate payment to the provider upon notice that the department has received the requested information from the provider. If the provider does not provide the information with 50 days of suspension, the department will terminate the provider from Medicaid.
c. Alliance is not liable for interest or penalties for payment suspension when directed by the department.

Alliance Provider Termination:

a. Alliance may terminate a Provider from its Medicaid network, Tailored Plan and State Funded Network with or without cause. Any decision to terminate will comply with the requirements of the Contract.
b. Alliance will comply with the program integrity provider termination requirements
c. All terminations require written notification to be sent to the network provider informing them of the effective date of termination, the reason(s) for the decision, the provider's right to an appeal the decision, and how to request an appeal.
d. Alliance shall report data to the department on the number of providers terminated by provider type in the required state format.

Selection and Retention of Providers

The Tailored Plan/PIHP shall develop and implement, as part of its provider manual, written policies and procedures for the selection and retention of network providers. The policy, at a minimum, must:

1. Meet the requirements specified in 42 C.F.R. § 438.214;
2. Meet the requirements specified in this contract;
3. Follow this policy and any applicable requirements from the contract, and address acute, primary, mental health, substance use disorders, and long-term services and supports providers;
4. Establish that the Tailored Plan/PIHP shall accept provider credentialing and verified information from the department and shall not request any additional credentialing information without the department's approval.

5. Establish a documented process for determining if a provider is an active Medicaid enrolled provider or state-funded services provider and therefore eligible for contracting;
6. Prohibit Tailored Plan/PIHP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
8. Prohibit Tailored Plan/PIHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
9. Prohibit contracting with providers who are not enrolled with the department as NC Medicaid providers or state-funded services providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and
10. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH, I/DD, and TBI services. At a minimum, these standards shall assess a provider's ability to deliver care.
11. Identify standards and establish a documented process for making network contracting decisions on state-funded services providers.
12. Describe the information that providers will be requested to submit as part of the contracting process.
13. Describe the process by which the Tailored Plan/PIHP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).
14. If Tailored Plan/PIHP requires a provider to submit additional information as part of its contracting process, the Tailored Plan's/ PIHP's policy shall include a description of all such information.
15. Tailored Plan/PIHP shall make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the appearance of a provider on the daily provider enrollment file and the provider's acceptance of the contracting terms and rates. Tailored Plan/ PIHP shall recredential providers as follows:
    a. The Tailored Plan/PIHP shall evaluate a provider's continued eligibility based on timelines defined in the contract. During the provider credentialing transition period, no less frequently than every 5 years.
    b. After the provider credentialing transition period, no less frequently than every 3 years.
16. Tailored Plan/PIHP shall follow this policy when making a contracting decision for in-state, border (i.e., providers that reside within 40 miles of the NC state line), and out-of-state network providers.
17. Tailored Plan/PIHP shall have discretion to make network contracting decisions consistent with the policy.

- The Tailored Plan/PIHP shall follow the department's uniform credentialing and recredentialing policy.
- The Tailored Plan/PIHP shall follow documented processes and procedures for credentialing and recredentialing network providers. 42 CFR § 438.214.
- The Tailored Plan/PIHP shall accept provider credentialing and verified information from the department, or designated department vendor, and shall not request any additional credentialing information from a provider without the department's written prior approval. The Tailored Plan/PIHP is not prohibited from collecting other information from providers necessary for the Tailored Plan/PIHP's contracting process.
- The Tailored Plan/PIHP shall not solicit or accept provider credentialing or verified information from any source other than the department, or designated department vendor, except as expressly permitted by the department in Section V.B.4. providers of the Tailored Plan contract and Section IV.H. provider of the PIHP contract.

v. Access Requirements

Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within 30 calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within 14 calendar days for member less than 6 months of age Within 30 calendar days for members 6 months or age and older.
2	After-Hours Access– Emergent and Urgent	Care requested after normal business office hours.	Immediately {available 24 hours a day, 365 days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
4	Routine/Check- up without Symptoms	Non-symptomatic visits for routine health check-up.	Within 30 calendar days

Reference Number	Visit Type	Description	Standard
Prenatal Care			
5	Initial Appointment –1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within 14 calendar days
5a	Initial Appointment –high risk pregnancy or 3rd Trimester		Within 5 calendar days
Specialty Care			
6	After-Hours Access– Emergent and Urgent	Care requested after normal business office hours.	Immediately available 24 hours a day, 365 days a year
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
8	Routine/Check- up without Symptoms	Non-symptomatic visits for health check.	Within 30 calendar days

Reference Number	Visit Type	Description	Standard
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Mobile crisis services, for adults and children that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.	Within 2 hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Medicaid crisis service for the purpose of network adequacy standards.	Emergency services available immediately available 24 hours a day, 365 days a year
11	Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait time standards.	Immediately available 24 hours a day, 365 days a year

12	Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.	Immediately available 24 hours a day, 365 days a year
13	Urgent Care Services for Mental Health	1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. 2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.	Within 24 hours

14	Urgent Care Services for SUDs	1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards. 2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/ care for the purposes of the BH appointment wait-time standards.	Within 24 hours
15	Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.	Within 14 calendar days
16	Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.	Within 48 hours

vi. No-reject Requirements

Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity within capacity and parameters of their competency.

vii. Notification of Changes in Address

Prior notice to a provider relations representative or provider services is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and email

Any changes to provider demographic information must be submitted to Alliance and NCTracks.

viii. Licensure Requirements

Providers are required to maintain licensure, accreditation, and credentials sufficient to meet Alliance's network participation requirements pursuant to 25 U.S.C. §§ 1621t and §1647a, Alliance shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the Alliance shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

ix. Insurance Requirements

The provider shall purchase and maintain insurance as listed below from a company, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Should any of the described policies be reduced or canceled before the expiration date thereof, notice will be delivered in accordance with the policy provisions. Any loss of insurance shall be the basis of a payback to Alliance for services billed during this period and may result in the termination of this contract. All insurance requirements of this contract must be fully met unless specifically waived in writing by Alliance. Provider shall provide Alliance upon request with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph and shall provide Alliance with no less than 30 days advance written notice of any modification, cancellation or termination of their insurance. The provider shall purchase and maintain the following minimum coverage:

- Professional liability: Professional liability insurance protecting the Provider and any employee performing work under the contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.
- Comprehensive general liability: Bodily Injury and property damage liability Insurance protecting the provider and any employee performing work under the contract from claims of bodily injury or property damage arising from operations under the contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.
- Automobile liability: If provider transports members automobile bodily injury and property damage liability Insurance covering all owned, non-owned, and hired automobiles for an amount not less than $500,000.00 each person and $500,0000.00 each occurrence. Policies written on a combined single limit basis shall have a minimum limit of $1,000,000.00.

- Workers' compensation and occupational disease insurance, employer's liability insurance: Workers' compensation and occupational disease insurance as required by the statutes of the State of North Carolina. Employer's liability Insurance for an amount not less than bodily injury by accident $100,000.00 each accident/ bodily injury by disease $100,000.00 each employee/bodily injury by disease $500,000.00 policy limit.
- Tail coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) for a period of not less than 3 years after the end of the contract term, or an agreement to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided.
- Any provider utilizing any model for self-directing Innovations services and/or Agency With Choice services for Innovations enrollees shall carry workers compensation insurance in accordance with the requirements of the DHB and Alliance Tailored Plan contract and Innovations Waiver §1915(c) rules.
- Provider shall:
  - Submit new certificate of insurance (COI) no later than 10 business days after the expiration of any listed policy to ensure documentation of continual coverage without demand by Alliance;
  - Notify Alliance in writing at least 30 calendar days' before any coverage is suspended, voided, canceled or reduced;
  - Provide evidence to Alliance of continual coverage at the levels stated above within 2 business days if provider changes insurance carriers during the term of the contract, including tail coverage as required for continual coverage; and
  - All insurance requirements of this contract shall be fully met unless specifically waived in writing by both Alliance and provider.

In accordance with NC law, provider may self-insure provided that provider's self-insurance program is currently licensed/approved by the Department of Insurance of the State of North Carolina and has been actuarially determined sufficient currently to pay the insurance limits required in the contract. Evidence of such self-Insurance may be submitted to Alliance for review and approval in lieu of some or all of the insurance requirements above.

x. Required Availability

Providers shall have the capacity to respond to emergencies for assigned individuals according to state availability standards for emergent needs.

H. Telehealth

Telehealth is a covered plan benefit subject to compliance with state and federal laws and administrative policies, and guidelines. Telehealth is defined as the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations for the purpose of evaluation, diagnosis, or treatment. Telemedicine services provide the member with enhanced health care services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable or unsuitable. Alliance agrees to provide coverage for telehealth services, when appropriate, for services covered under contract, to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner. Alliance also covers virtual patient communications and remote patient monitoring services, when appropriate.

Required Criteria

- Practitioners provide telemedicine services within their scope of practice
- Procedures or services are consistent with symptoms or diagnosis
- Providers ensure that services are safely and effectively delivered
- Providers consider a member's behavioral, physical, and cognitive abilities to participate in services
- Services conform to professional standards of care including those identified by ethical practice, scope of practice, and relevant federal, state, and institutional policies
- Provider obtains and documents verbal or written consent and ensures member privacy is protected
- Members are not required to seek services through telehealth, virtual communications, or remote patient monitoring

Alliance will reimburse for:

- Telehealth office and outpatient visits, inpatient consultation, and hybrid telehealth visits with supporting home visit
- Virtual communications for online digital evaluation and management, telephonic evaluation and management, and interprofessional assessment and management
- Remote patient monitoring including self-measured blood pressure and physiologic monitoring

Providers will submit claims in a manner consistent with guidance provided by Alliance for telehealth services. This may include the addition of a code modifier.

Alliance does not reimburse for:

- Procedures or services that are duplicative
- Procedures or services that are experimental or part of a clinical trial

I. Network Adequacy and Access Standards

Please refer to list of Network Adequacy and Access Standards located in Section VII. First Revised and Restated Attachment F.1. Table 1: Tailored Plan/PIHP Time/Distance Standards for Medicaid, Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid, and Section VII. First Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid of the Tailored Plan Contract.

- Plans should be sure to indicate that the network adequacy standards apply to the adult population separately from the child population as outlined in the preamble to Section VII. First Revised and Restated Attachment F.
- For state-funded specific standards refer to the list located in Section VII. First Revised and Restated Attachment F.1. Table 2 of the Tailored Plan Contract.
- Please refer to list of network adequacy and access standards located in Section VI. Attachment E. Table 1 and Section VI. Attachment E. Table 3: Appointment Wait Time Standards of the PIHP contract.

Access Standards

All providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the member's needs. Alliance will comply with the agency's requirement to have the required participating providers (as required by the state contract), by region, offer after hours appointment availability to Medicaid members.

Alliance will ensure members have access to care through an adequate provider network by monitoring travel times and distances between providers and members. In the event a geographic area does not have enough providers to meet the standards listed below, Alliance Health will conduct outreach activities in order to add additional providers to the network.

Network Adequacy Time and Distance Standards

Alliance monitors providers against the standards listed below to ensure members and recipients can obtain needed, covered health services within the acceptable appointment waiting times. Providers not in compliance with these standards will be required to implement corrective actions set forth by Alliance.

Table 1: Tailored Plan Time/Distance Standards for Medicaid

Reference Number	Service Type	Urban Standard	Rural Standard
1	Primary Care[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members

Reference Number	Service Type	Urban Standard	Rural Standard
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics[2]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of member	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based BH treatment for autism spectrum disorder (ASD): Not subject to standard
8	Location-Based Services	• Psychosocial rehabilitation, substance abuse comprehensive outpatient treatment, substance abuse intensive outpatient program, and outpatient opioid treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members child and adolescent day treatment services: Not subject to standard	• Psychosocial rehabilitation, substance abuse comprehensive outpatient, substance abuse intensive outpatient program, and outpatient opioid treatment(OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% members child and adolescent day treatment services: Not subject to standard

Reference Number	Service Type	Urban Standard	Rural Standard

9	Crisis Services	• Professional treatment services in facility-based crisis program: **The greater of:**
		  • 2+ facilities within each Tailored Plan region, OR
		  • 1 facility within each region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates).
		• Facility-based crisis services for children and adolescents: **≥ 1 provider within each Tailored Plan region**
		• Non-hospital medical detoxification: **≥ 2 provider within each BH I/DD Tailored Plan region**
		• Ambulatory detoxification, ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal: **≥ 1 provider of each crisis service within each BH I/DD Tailored Plan region**
		• Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): **Not subject to standard**	

10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each Tailored Plan Region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	Community/ Mobile Services	≥ 2 providers of community/mobile services within each Tailored Plan region. Each county in Tailored Plan region must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities)*	≥ 2 LTSS provider types (Home care providers and home health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	

Reference Number	Service Type	Urban Standard	Rural Standard
15	Residential Treatment Services	• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per Tailored Plan Region, ◦ Substance Abuse Medically Monitored Residential Treatment: Access to ≥ 1 licensed provider per Tailored Plan Region (refer to 10A NCAC 27G.3400) ◦ Substance Abuse Non-Medical Community Residential Treatment: ▪ Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) ▪ Adolescent: Contract with all designated CASPs within the Tailored Plan Region ▪ Women & Children: Contract with all designated CASPs within the Tailored Plan Region ◦ Substance Abuse Halfway House: ▪ Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)3 ▪ Adolescent: Access to ≥1 program per Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard	
16	1915(c) HCBS Waiver Services: NC Innovations	• Community living & support, community navigator, community networking, residential supports, respite, supported employment, supported living: **≥ 2 providers of each Innovations waiver service within each Tailored Plan and PIHP region.** • Crisis intervention & stabilization supports, day supports, financial support services: **≥ 1 provider of each Innovations waiver service within each Tailored Plan and PIHP region.** • Assistive technology equipment and supplies, community transition, home modifications, individual directed goods and services, natural supports education, specialized consultation, vehicle modification: **Not subject to standard**	

Reference Number	Service Type	Urban Standard	Rural Standard
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• Community networking, life skills training, residential supports, resource facilitation, in-home respite, supported employment: ≥ 2 providers of each TBI waiver service within each Tailored Plan region. • Day supports, cognitive rehabilitation, crisis intervention & stabilization supports: ≥ 1 provider of each TBI waiver service within each Tailored Plan region. • Adult day health, assistive technology rquipment and supplies, community transition, home modifications, natural supports education, occupational therapy, physical therapy, speech and language therapy, vehicle modification: N/A	

[1] Nurse practitioners and physician assistants may be included to satisfy primary care access requirements.

[2] Measured on members who are female and age 14 or older. Certified nurse midwives may be included to satisfy OB/GYN access requirements

[3] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid

Reference Number	Service Type	Definition
1	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for autism spectrum disorder (ASD)
2	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance abuse comprehensive outpatient treatment • Substance abuse intensive outpatient program • Outpatient opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4	Inpatient BH Services	Inpatient Hospital – Adult • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds Inpatient Hospital – Adolescent / Children • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds

Reference Number	Service Type	Definition
5	Partial Hospitalization	• Partial hospitalization (adults and children)
6	Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:
7	Community/ Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer supports • Diagnostic assessment
8	1915(i) HCBS (Medicaid Direct Only)	• Supported Employment • Individual Support • Respite • Community Living and Support • Community Transition

Reference Number	Service Type	Definition
9	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

Table 3: Appointment Wait Time Standards for Tailored Plan			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within 30 calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within 14 calendar days for member less than 6 months of age. Within 30 calendar days for members 6 months or age and older.
2	After-Hours Access–Emergent and Urgent	Care requested after normal business office hours.	Immediately available 24 hours a day, 365 days a year
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within 30 calendar days
Prenatal Care			
5	Initial Appointment –1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within 14 calendar days
5a	Initial Appointment –high risk pregnancy or 3rd Trimester		Within 5 calendar days

Reference Number	Visit Type	Description	Standard
Specialty Care			
6	After-Hours Access –Emergent and Urgent	Care requested after normal business office hours.	Immediately available 24 hours a day, 365 days a year
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within 24 hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within 30 calendar days
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.	Within 2 hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Medicaid crisis service for the purpose of network adequacy standards.	Emergency Services available immediately available 24 hours a day, 365 days a year

Reference Number	Visit Type	Description	Standard
Behavioral Health, I/DD, and TBI Services			
11	Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait time standards.	Immediately available 24 hours a day, 365 days a year
12	Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.	Immediately available 24 hours a day, 365 days a year

Reference Number	Visit Type	Description	Standard
Behavioral Health, I/DD, and TBI Services			
13	Urgent Care Services for Mental Health	1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. 2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.	Within 24 hours

Reference Number	Visit Type	Description	Standard
Behavioral Health, I/DD, and TBI Services			
14	Urgent Care Services for SUDs	1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards. 2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/ care for the purposes of the BH appointment wait-time standards.	Within 24 hours
15	Routine Services For Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.	Within 14 calendar days

Reference Number	Visit Type	Description	Standard
Behavioral Health, I/DD, and TBI Services			
16	Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.	Within 48 hours

Table 4: Specialty Care Providers for Tailored Plan	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

Table 5: BH I/DD Time or Distance Standards for State-Funded Services			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[1]	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services	• Psychosocial rehabilitation, substance abuse comprehensive outpatient, substance abuse intensive outpatient program, outpatient opioid treatment (OTP): **≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients** • Child and adolescent day treatment services: **Not subject to standard**	• Psychosocial rehabilitation, substance abuse comprehensive outpatient, substance abuse intensive outpatient program, outpatient opioid treatment (OTP): **≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients** • Child and adolescent day treatment services: **Not subject to standard**

3	Crisis Services	• Facility based crisis for adults: **The greater of:**
		  • 2+ facilities within each Tailored Plan region, OR
		  • 1 facility within each region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available).
		• Non-hospital medical detoxification: **≥ 2 provider within each Tailored Plan region**
		• Ambulatory detoxification and BH urgent care: **≥ 1 provider of each crisis service within each Tailored Plan region**	

4	Inpatient BH Services	≥ 1 provider within each Tailored Plan region	

Reference Number	Service Type	Urban Standard	Rural Standard
5	Community/ Mobile Services	Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each Tailored Plan Region. Each county in Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. High Fidelity Wraparound ≥ 2 provider within one hour	
		Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients2	Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients

6	Residential Treatment Services	• Residential treatment facility services: **Access to ≥ 1 licensed provider per Tailored Plan region**
		• Substance abuse halfway house:
		  • Adult: **Access to ≥ 1 male and ≥1 female program per Tailored Plan region (Refer to 10A NCAC 27G.5600E)[3]**
		  • Adolescent: **Access to ≥1 program per Tailored Plan region (Refer to 10A NCAC 27G.5600E)**
		• Substance abuse medically monitored community residential treatment: **Access to ≥1 licensed provider**
		• Substance abuse non-medical community residential treatment:
		  • Adult: **Access to ≥ 1 licensed provider per Tailored Plan region (refer to licensure requirements to be determined by the Department)**
		  • Adolescent: **Contract with all designated CASPs within the Tailored Plan's region**
		  • Women & Children: **Contract with all designated CASPs within the Tailored Plan's region**
		• Substance use residential supports & mental health recovery residential services: **To be determined**	

Reference Number	Service Type	Urban Standard	Rural Standard
7	Employment and Housing Services	• Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use): **100% of eligible recipients must have a choice of 2 provider agencies within each Tailored Plan Region.** • Individual Placement and Support-Supported Employment (Adult MH): **100% of eligible individuals must have a choice of 2 provider agencies within each Tailored Plan Region. Each county in Tailored Plan Region must have access to ≥1 provider that is accepting new patients.** • I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services, IDD Supported Employment: **100% of eligible recipients must have access to ≥1 provider agency within each Tailored Plan Region.** • Clinically Managed Population-specific High Intensity Residential Programs: **To be determined** • TBI long-term residential rehabilitation services: **To be determined**	

[1] The department defines recipients for the purposes of network adequacy as those who received state-funded services in the previous year.

[2] The department defines recipients for the purposes of network adequacy as those who received state-funded services in the previous year.

[3] Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Table 6: Classifications of Service Category for Behavioral Health Time or Distance Standards (State-funded Services)							
Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
1	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
		Assertive Engagement		Y			
2	Location-Based Services^	Psychosocial Rehabilitation				Y	
		Substance Abuse Comprehensive Outpatient				Y	Y
		Substance Abuse Intensive Outpatient Program				Y	
		Outpatient Opioid Therapy				Y	
3	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y	
		Ambulatory Detoxification				Y	
4	Inpatient BH Services	Inpatient Hospital (including Three- way Contract Bed)	Y	Y	Y	Y	Y

Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
5	Residential Treatment Services	Substance Abuse Halfway House				Y	Y
		Substance Abuse Medically Monitored Residential Treatment				Y	
		Substance Abuse Non-Medical Community Residential Treatment				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			
		Clinically managed population specific high intensity residential services				Y	

Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
6	Community/ Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	
		Transition Management Service		Y			
		High Fidelity Wraparound			Y		Y
		Intensive In-home			Y		Y
		Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y

Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
7	Employment and Housing Services	I/DD & TBI Day Supports	Y				
		Community Living & Support	Y				
		I/DD & TBI Residential Services	Y				
		Supported Employment	Y				
		Residential Supports	Y	Y			
		Respite Services	Y		Y		Y
		Individual Placement and Supports (IPS)- Supported Employment		Y		Y	
		TBI Long-term Residential Rehabilitation Services	Y				
		Clinically Managed Population- specific High Intensity Residential Programs				Y	

Table 7: Appointment Wait Time Standards for State-Funded Services			
Reference Number	**Visit Type**	**Description**	**Standard**
BH Care/I/DD			
1	Mobile Crisis Management Services	Mobile crisis services, for adults and children that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.	Within 2 hours
2	Facility-Based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	A crisis service for the purpose of network adequacy standards.	Immediately available 24 hours a day, 365 days a year.
3	Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.	Immediately available 24 hours a day, 365 days a year.
4	Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.	Immediately available 24 hours a day, 365 days a year.

Reference Number	Visit Type	Description	Standard
5	Urgent Care Services for Mental Health	1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. 2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.	Within 24 hours
6	Urgent Care Services for SUDs	1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards. 2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.	Within 24 hours

Reference Number	Visit Type	Description	Standard
7	Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.	Within 14 calendar days
8	Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.	Within 48 hours

Table 8: PIHP Time/Distance Standards for Medicaid Direct			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard
2	Location-Based Services	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard	• Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard

3	Crisis Services	• Professional treatment services in facility-based crisis program: The greater of:
		  2+ facilities within each PIHP Region, OR
		  1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates).
		• Facility-based crisis services for children and adolescents: ≥ 1 provider within each PIHP Region
		• Non-Hospital Medical Detoxification: ≥ 2 provider within each PIHP Region
		• Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:
		≥ 1 provider of each crisis service within each PIHP Region
		• Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard	

4	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP region	
5	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
6	Community/ Mobile Services	≥ 2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to ≥ 1 provider that is accepting new patients.	
7	1915(i) HCBS	Community Living & Support, Individual and Transitional Support, Respite, and Supported Employment (for IDD and MH/SUD): ≥ 2 providers of each (i) Option service within each PIHP Region	

8	Residential Treatment Services	• Residential Treatment Facility Services: **Access to ≥ 1 licensed provider per PIHP Region**
		• Substance Abuse Medically Monitored Residential Treatment: **Access to ≥ 1 licensed provider per PIHP Region (refer to 10A NCAC 27G.3400)**
		• **Substance Abuse Non-Medical Community Residential Treatment:**
		  Adult: Access to ≥ 1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department)
		  Adolescent: Contract with all designated CASPs within the PIHP's Region
		  Women & Children: Contract with all designated CASPs within the PIHP's Region
		• **Substance Abuse Halfway House:**
		  Adult: Access to ≥1 male and ≥1 female program per PIHP Region (Refer to 10A NCAC 27G.5600)6
		  Adolescent: Access to ≥1 program per PIHP Region (Refer to 10A NCAC 27G.5600)
		• Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: **Not subject to standard**

9	1915(c) HCBS Waiver Services: NC Innovations	• Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: **≥ 2 providers of each Innovations waiver service within each PIHP Region.** • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: **≥ 1 provider of each Innovations waiver service within each PIHP Region.** • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: **Not subject to standard**

[6] PIHPs must also ensure that gender non-conforming members have access to substance abuse halfway house services.

Table 9: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid Direct		
Reference Number	**Service Type**	**Definition**
1	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)

4	Inpatient BH Services	Inpatient Hospital – Adult • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds Inpatient Hospital – Adolescent / Children • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance abuse beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5	Partial Hospitalization	• Partial hospitalization (adults and children)
6	Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:
7	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment

8	1915(i) HCBS	• Supported Employment • Individual Support • Respite • Community Living and Support • Community Transition
9	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

Table 10: Appointment Wait Time Standards for Medicaid Direct			
Reference Number	**Visit Type**	**Description**	**Standard**
Behavioral Health and I/DD Services			
1	Mobile Crisis Management Services	Mobile crisis services, for adults and children that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.	Within 2 hours
2	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Medicaid crisis service for the purpose of network adequacy standards.	Emergency Services available immediately available 24 hours a day, 365 days a year
3	Emergency Services for Mental Health	Services to treat a life- threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/ or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait time standards.	Immediately available 24 hours a day, 365 days a year
4	Emergency Services for SUDs	Services to treat a life- threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic	Immediately available 24 hours a day, 365 days a year

Reference Number	Visit Type	Description	Standard
5	Urgent Care Services for Mental Health	1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. 2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.	Within 24 hours
6	Urgent Care Services for SUDs	1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards. 2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.	Within 24 hours

Reference Number	Visit Type	Description	Standard
7	Routine Services For Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.	Within 14 calendar days
8	Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.	Within 48 hours

All members and recipients receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, which includes the specific time, date, place, and name of the provider to be seen, prior to discharge. The outpatient treatment must occur within 7 days from the date of discharge and should include medication monitoring, if needed.

In the event that a member/recipient misses an appointment, the behavioral health provider must contact the member within 24 hours to reschedule.

Behavioral health providers are expected to assist members/recipients in accessing emergent, urgent and routine behavioral services as expeditiously as the member's/recipients' condition requires. Members/recipients also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is printed on the member's card and is available on Alliance's website AllianceHealthPlan.org.

Alliance will ensure members have access to care through an adequate provider network by monitoring travel times and distances between providers and members. In the event a geographic area does not have enough providers to meet the standards listed below, Alliance will conduct outreach activities in order to add additional providers to the network.

J. Billing, Claim Editing, SNIP Editing and Clearinghouse Requirements

Claim System Edits

Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), Alliance may deny payment for any claims that fail to meet Alliance's submission requirements for clean claims or that are received after the time limit in the provider contract for filing clean claims.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Alliance
- A provider's electronic submission sheet with all the following identifiers, including patient name, provider name, date of service to match EOB/ claim(s) in question, prior submission bill dates; and Alliance product name or line of business

The following items are not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) rejection letter; or
- A copy of the provider's billing screen.

Additional information regarding reimbursement policies and claims companion guides are located on Alliance's website at AllianceHealthPlan.org/ resources/document-library/?category=8&types=&languages=.

Tax Identification (TIN) and National Provider Identifier (NPI) Requirements

Alliance requires the payer-issued Tax ID and NPI on all claim's submissions. Alliance will reject claims without the Tax ID and NPI. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the CMS website.

Taxonomy

Providers are required to submit claims with the **correct** taxonomy code consistent with the provider's specialty and services being rendered in order for appropriate adjudication. Alliance may reject the claim if the taxonomy code is incorrect or omitted.

National Drug Codes (NDC)

Alliance follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

K. Cultural and Linguistic Competency and Accessibility Requirements

Cultural and linguistic competency and the delivery of such services should be integrated into the overall fabric of service delivery, linked to quality of care and emphasized in policy, practice, procedures, and resources. Alliance recognizes that becoming culturally competent is an ongoing process in which we gain knowledge about one another and use that knowledge to build trust, break down barriers and improve the quality of care throughout the network. In-network agency and group providers are required to develop and submit to Alliance when requested a cultural competency plan and comply with cultural competency requirements set forth herein. In-network LIP solo providers are required to obtain yearly (within each calendar year) cultural competency training and submit appropriate training certificates when requested.

Cultural awareness and sensitivity among Alliance's staff and contracted providers enable us to work effectively with each other in cross-cultural situations. It is our intention to create an environment that protects and preserves the dignity of all by acknowledging cultural differences among us without placing values on those differences.

We encourage our staff and providers to recognize that culture makes us who we are. Culture not only determines how we see the world and each other, but greatly impacts how we experience physical and mental illness. It also shapes the recovery process, affects the types of services that are utilized, impacts diagnosis, influences treatment and the organization and financing of services. We envision that our network includes providers who recognize that there is variation in behaviors, beliefs and values as they assess an individual's wellness or illness and incorporate that awareness in treatment planning with competence and sensitivity. Alliance encourages providers to participate in the provider cultural competency plan, which shall be developed and approved by a Provider Advisory Council composed of individuals of the Alliance provider network with representation across all disability groups.

Language interpretation services shall be made available by telephone or in-person to ensure that members are able to communicate with Alliance and network providers. Providers and Alliance shall make oral interpretation services available free of charge to each member. This applies to non-English languages as specified in 42 C.F.R. § 438.10. TDD (telecommunication devices for the deaf) must also be made available by providers for people who have impaired hearing or a communication disorder.

L. Authorization, utilization review, and care management requirements

Please refer to sections:

B. Clinical Practice Standards and UM Program

E. Care Management Delivered through the BH I/DD Tailored Plans/PIHP

M. Care coordination and discharge planning requirements

Please refer to Sections E. Tailored Care Management Delivered through the BH IDD Tailored Plan/PIHP.

N. Department-required Documentation Requirements

Member medical records must be maintained by being available, legible, detailed, organized and protected to permit effective and confidential patient care, coordination of care and quality review. A complete medical record includes medications, allergies, documentation of inpatient admissions and discharges, specialty consults, authorizations for treatment and release of information, and other documentation necessary to provide effective care, referrals, and treatment. The medical record must also reflect the quantity, quality, appropriateness, and timeliness of services provided under the contract. Documentation contained in the medical record shall be signed and dated by the person who provided the service.

Confidentiality of member information must be maintained at all times. Records are to be properly safeguarded and maintained with access granted to authorized personnel only. Access to and copies of records shall be granted to Alliance or its representatives at no charge. This includes fees charged by copy services. Providers shall have procedures in place to permit the timely access and submission of medical records to Alliance upon request. This includes medical, personnel and financial records. Provider shall maintain the records as required by state and/or federal retention time periods and as outlined in the provider contract. For more information regarding confidentiality of member information and release of records, refer to Section 8: Compliance.

The member's original medical record is the property of the provider who creates the record. The provider bears the responsibility for the record including the maintenance and retention for these records at their own expense. The original medical record shall not be relinquished to another provider. However, each member (or legal representative) is entitled to one free copy of their medical record unless there is a reason for denial under §164.524(a) or North Carolina General Statute § 122C-53. Copies made for transfer to another provider shall not incur a charge and shall be done as a professional courtesy. Members must be made aware in advance, of any fees that may be imposed for copying their record.

Each provider is required to maintain a primary medical record for each member that contains sufficient medical information from all providers involved in the member's care to ensure continuity of care. Documentation shall, at a minimum, require:

- Member name/patient medical record number on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race, ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name, and telephone numbers of emergency contacts (if no phone, contact name), consent forms, languages spoken and guardianship information
- Service notes or grids with required information. Late entries should include date and time of occurrence and date and time of documentation. For providers of behavioral health services, any note not written or dictated within 24 hours of the service or the close of the service period is classified as a late entry. All late entries shall be noted as such and must include a dated signature. Any notes not written or documented within 7 calendar days from the date of service are not billable.
- Provider identification by name and profession of the rendering provider (e.g., M.D., D.O., O.D LCSW, LCAS, etc.)
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location
- Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chicken pox)
- Identification of current problems
- The consultation, laboratory and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review

- A current list of immunizations pursuant to 42 CFR 456
- Identification and history of nicotine, alcohol use or substance use disorder
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department of Public Health pursuant to 42 CFR 456 and North Carolina General Statutes §130A
- Follow-up visits provided secondary to reports of emergency room care
- Hospital admission and discharge summaries, history and physicals
- Advance medical directives, for adults
- Documentation that member has received the provider's office policy regarding office practices compliant to HIPAA
- Documentation regarding permission to share protected health information with specific individuals has been obtained
- Log of releases and disclosures of confidential information (accounting of disclosure)
- Legal Information: Copies of any relevant papers, such as guardianship/legally responsible person designation
- Copies of any consent or attestation form used, or the court order for prescribed psychotherapeutic medication for a child younger than 13 years
- Include the following items for services provided through telemedicine:
    - A brief explanation of the use of telemedicine in each progress note
    - Documentation of telemedicine equipment used for the particular covered services provided
    - A signed statement from the member or the member's representative indicating the member's choice to receive services through telemedicine. This statement may be for a set period of treatment or one time visit, as applicable to the service(s) provided
    - A review of telemedicine should be included in Alliance's fraud and abuse detection activities
    - Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer

A member's medical record shall include the following minimal detail for individual clinical encounters:

- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening (EPSDT) services are addressed from previous visits
- Plan of treatment including:
    - Medication history, current medications prescribed, including the strength, amount and directions for use and refills
    - Therapies and other prescribed regimen
    - Follow-up plans including consultation and referrals and directions, including time to return
- Education and instructions whether verbal, written or via telephone

OB/GYN Medical Records

Medical records requirements and guidelines per current American College of Obstetrics and Gynecology standards:

The maternity chart will contain documentation of the following:

- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities
- Nutritional assessment and counseling for all pregnant members that includes:
    - Promotion of breastfeeding and the use of breast milk substitutes to ensure the provision of safe and adequate nutrition for infants
    - Offering a mid-level nutrition assessment as directed by clinical presentation

- Member education (childbirth/maternal care)
- Postpartum care within 56 days of delivery
- Family planning counseling and services for all pregnant women and mothers
- HIV testing/counseling is offered at the initial prenatal care visit and again at 28 weeks and 32 weeks
- Screening for Hepatitis B:

- Providers must screen all pregnant members during their first prenatal visit for Hepatitis B and again between 28 weeks and 32 weeks for members who test negative and are considered high-risk for Hepatitis B
  - Providers refer all pregnant, breastfeeding and postpartum women to the local Women, Infants, and Children (WIC) office:
    - Providers provide a completed North Carolina WIC program medical referral form with the current height or length and weight (taken within sixty (60) calendar days of the WIC appointment)
    - Hemoglobin or hematocrit (H&H)
    - Any identified medical/nutritional problems
    - Give a copy of the completed form to the member
    - Retain a copy of the completed form in the member's medical record

Behavioral Health Providers

Medical records for behavioral health providers are required to have the following information in their medical records per APSM 45-2 Records Management and Documentation Manual and Clinical Coverage Policies.

- Consents and releases: (completed fully, then signed, dated and witnessed).
- Informed written consent for treatment (must grant permission to seek emergency care from a hospital or physician).
- Written consent to release information.
- Documentation of written notice given to the individual/legally responsible person upon admission that disclosure may be made of pertinent confidential information without their expressed consent in accordance with G.S. § 122C-52 through 122C-56.
- Documentation of communicating the notice to patients of federal confidentiality requirements upon admission to a part 2 program in accordance with 42 CFR Part 2 §2.22.
- Acknowledgement of receipt of client rights information according to 10A NCAC 27D 0201, and as specified in GS §122C, Article 3.
- Emergency information for each member which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and name, address, and telephone number of the individual's preferred physician; and hospital preference.
- Third-party release (to include private insurance carrier, public benefits and entitlements).
- Informed written consent for planned use of a Restrictive Intervention (as applicable).
- Informed written consent for participation in research projects (as applicable).
- Informed written consent or agreement for proposed treatment and plan development required on the individual's person-centered plan (PCP) or service plan, or a written statement by the provider stating why such consent could not be obtained.
- Documentation that client rights were explained to the individual/legally responsible person.
- NC-TOPPS (as required for state and Medicaid funded MH and SA). Additional information can be found at: https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/reports/nc-topps-reports/nc-treatment-outcomes-and-program-performance-system-nc-topps.

- Person-centered plan if an enhanced service or as required per the state benefit plan or an individual support plan (ISP for consumers receiving Innovations).
- NC SNAP and/or SIS for consumers with a I/DD diagnosis.
- ASAM score for consumers with a SUD diagnosis.
- Documentation of mental illness, intellectual/ developmental disabilities or substance abuse.
- Diagnosis coded according to the DSM-V (or its successors) and documentation of physical disorders according to the ICD-10, including subsequent amendments and editions.
- Screening-shall include assessment of presenting problem/needs, whether or not the agency can provide services that can address the individual's needs, and disposition, including recommendations and referrals.
- Admissions/clinical assessment(s) that contain the elements of a Comprehensive Clinical Assessment (CCA) as described in Chapter 3 of APSM 45-2 for enhanced services and as required by Clinical Coverage Policies. Some services require completion of additional instruments in conjunction with the CCA.
- Applicable service order: for all services to be provided, signed by the appropriate professional.
- Note: Each community provider is responsible for obtaining the appropriate diagnoses and a physician's order for billing Medicaid-covered services that it is planning to provide.
- Referral information sent or received.
- Service authorizations. As applicable; reauthorization requests, denial appeals, service end-date reporting.
- Discharge plans/summaries.
- Other elements may be required or clinically relevant depending upon the services received (e.g. crisis plans, medication administration record, documentation of allergies, etc.).

Note: This is not a complete list of all required record elements. The full list can be accessed at: http://www.ncdhhs.gov/document/apsm-45-2-records-management-and- documentation-manuals. Additional requirements may be listed in each Clinical Coverage Policy related to the service being provided as well as the NCMMIS Provider Claims and Billing Assistance Guide (formally known as the Basic Medicaid Billing Guide): https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html. Providers are expected to adhere to all, minimum and service specific, requirements.

O. Provider Appeals and Grievance Process

Medicaid Provider Appeals Process

Alliance Health has a provider appeals system distinct from that offered to members that is designed to handle appeals promptly, consistently, and fairly. The system is in compliance with state, federal, and department requirements. Providers must exhaust the Alliance appeals process before seeking recourse under any other process permitted by contract or law. Alliance will not discriminate or retaliate against a provider for filing an appeal of an Alliance decision.

Provider notifications of Alliance decisions that are subject to appeal include a description of the provider's right to appeal and the methods for submitting an appeal, the deadline for the appeal, and how to request an extension. Provider notifications will also include contact information for the provider complaint, grievance, and appeal coordinator for technical assistance.

Providers may submit an appeal through the provider web portal, certified US Mail, email, or in person at an Alliance office. The appeal will be accepted when it is accompanied by a completed Provider Request for Appeal of an Action form and is received within 30 calendar days of when the

provider received the notification of the decision or when Alliance should have taken a required action and failed to do so. The Provider Request for Appeal of an Action form is posted on the Alliance website and serves as a cover page to the provider appeal. Alliance will acknowledge receipt of appeals within 5 calendar days of the request. Appeals received after the 30 calendar day deadline will be denied. If a provider believes an appeal denied for timely filing was submitted within the appropriate time frame, the provider may submit documentation showing evidence of timely filing.

Providers may request an extension of the appeal deadline of up to 30 calendar days for good cause. A request for an extension must be submitted in writing using the Provider Request for Appeal Extension form via the provider web portal, certified US Mail, email or in person at the Alliance home office no later than 20 calendar days of when the provider received the notification of the decision. Extension requests are reviewed by Alliance to determine if good cause exists. Good cause includes voluminous nature of required evidence/supporting documentation, natural disasters, states of emergency, absence of crucial provider employee(s) and/or audits/investigations by other entities. Alliance will inform the provider of the decision to approve or deny the request to extend deadline within 3 calendar days of receipt.

Decisions that are not appealed by the provider by the aforementioned deadline or by the approved deadline extension are considered final by Alliance.

Network providers have the right to appeal certain actions taken by Alliance. The appeal process is available to network providers for the following reasons:

a. Finding of or recovery of an overpayment by Alliance;
b. Withhold or suspension of a payment related to waste or abuse concerns;
c. Contract termination for cause or finding of contract violation;
d. Corrective action by Alliance;
e. Determination to downgrade or de-certify an AMH+ or CMA

Out-of-network providers may appeal the following:

a. An out-of-network payment arrangement
b. Finding of waste or abuse by Alliance and
c. Finding or recovery of an overpayment by Alliance

Provider appeals are reviewed by the Provider Appeals Committee consisting of at least 3 qualified individuals at senior management level with representation from clinical, business, and network operations that were not involved in the original decision, action, or inaction that gave rise to the appeal.

Alliance will notify the provider in writing of the appeal outcome within 30 calendar days of receipt of a complete appeal request, or within 30 calendar days of receipt of all evidence when an extension has been granted. Previously approved and paid claims associated with overturned decisions will not be reversed for recovery. Appeal decisions regarding actions related to conduct or competence that impact network status and/or objective quality standards for state-funded services will describe further appeal rights.

Appeals of an Alliance decision to suspend or withhold provider payment will be limited to whether Alliance had good cause to initiate the withhold or suspension of payment and will not address findings of fraud or abuse. The provider will be offered the opportunity to participate in person or by telephone when the provider has appealed whether Alliance had good cause to withhold or suspend payment to the provider. The appeal will be scheduled and a written decision will be issued within 15 business days of receipt of the appeal request.

Member

For a member appeal, the member, member's representative or a provider acting on behalf of the member and with the member's written consent, may file an appeal request verbally or in writing with the Appeals Department as indicated on the adverse benefit determination letter. All requests must be submitted within 60 calendar days from the date on the Adverse Benefit Determination letter. Alliance shall acknowledge requests for standard appeals in writing within 1 business day of receipt of appeal and shall acknowledge requests for expedited appeals in writing within 24 hours of receipt of appeal.

Medicaid beneficiaries have the right to appeal whenever they do not agree with an adverse benefit determination made by Alliance regarding a request for services. An appeal is the request for review of an adverse benefit determination.

An adverse benefit determination as defined in federal law, means any of the following:

- 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
- The failure of Alliance to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. Grievances are not appealable outside of Alliance.

Alliance ensures that decision makers on appeals were not involved in previous levels of review or decision-making. When deciding any of the following: (a) an appeal of a denial based on lack of medical necessity, (b) a grievance regarding denial of expedited resolution of an appeal, or (c) a grievance or appeal involving clinical issues, the appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

Alliance must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following time frames:

- Expedited request: 2 calendar days
- Standard (pre-service and retrospective request): 30 calendar days

If the member's request for appeal is submitted after 60 calendar days from the date on the adverse benefit determination letter, then good cause must be shown in order for Alliance to accept the late request.

Examples of good cause include, but are not limited to, the following:

- The member did not personally receive the notice of adverse benefit determination or received the notice late
- The member was seriously ill, which prevented a timely appeal
- A death or serious illness in the member's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The member had incorrect or incomplete information concerning the appeal process

Alliance shall provide members and/or authorized representative the member's complete case file upon request, including medical records, other documents, and records, and any new or additional evidence to be considered, relied upon or generated by Alliance (or at the direction of Alliance) in connection with the appeal. Information shall be provided free of charge and in advance of the appeal resolution timeframe.

Expedited Appeals Process

To request an expedited appeal, a member or a provider acting on behalf of the member and with the member's written consent, must submit a verbal or written request directly to the appeals department. A request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which Alliance makes a less than fully favorable decision to the member.

Members who verbally request an expedited appeal are not required to submit a written appeal request.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The time frame to submit additional information for an expedited appeal is limited due to the short time frame to process the file. members may also review a copy of their case file any time during and/or after the completion of the appeal review.

Denial of an Expedited Request

Alliance will make reasonable efforts to provide the member with prompt verbal notification of the decision being made regarding the denial of an expedited appeal and the member's rights, and will subsequently mail to the member within 2 calendar days of the verbal notification, a written letter that explains that Alliance will automatically transfer and process the request using the 30 calendar-day time frame for standard Appeals beginning on the date Alliance received the original request and;

- The member's right to file an expedited grievance if she or he disagrees with the organization's decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames.

Resolution of an Expedited Appeal

Upon an expedited appeal of an adverse determination, Alliance will complete the expedited appeal and give the member written notice of its decision as expeditiously as the member's health condition requires, but no later than 2 calendar days after receiving a valid complete request for appeal.

Reversal of Denial of an Expedited Appeal

If Alliance overturns its initial action and/or the denial, it will issue an authorization to cover the requested service and notify the member verbally by end of business the day the decision is made, followed by written notification of the appeal decision.

Affirmation of Denial of an Expedited Appeal

If Alliance affirms its initial action and/or denial (in whole or in part), it will:

- Verbally notify the member of the decision within 2 calendar days.
- Provide written notification of the decision being upheld, including the specific reason for the appeal decision, in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Inform the Member:
  - Of their right to request a State Fair Hearing within 120 calendar days of receipt of the notice of appeal resolution and how to do so
  - Of their right to representation
  - Of their right to continue to receive benefits pending a Medicaid fair hearing

Provider

Providers may file a grievance orally or in writing or dispute over any aspects of the operations, activities, or behavior of the plan except for any dispute over for which the provider has appeal rights. A provider may file a grievance by mailing or faxing a Complaint Request Form with supporting documentation to Alliance's Grievance Department.

Providers must file their grievance no later than 30 calendar days from the date the provider becomes aware of the issue generating the complaint.

A written provider grievance shall be mailed directly to Alliance's Grievance Department. For more information on the Grievance Department, refer to: AllianceHealthPlan.org/consumers-families/consumer-rights/filing-a-complaint/.

When acting as the member's representative, a provider may not file a grievance on behalf of the member without written consent from the member.

Alliance will give all providers written notice of the provider grievance procedures at the time they enter into contract.

Other than member out-of-pocket costs as established by the member's benefit plan, providers may not bill North Carolina Medicaid members for services covered by Alliance.

For more information, see the Grievance Submission section.

Office of the Provider Ombudsman

Providers may contact the NCDHHS Ombudsman Program established to assist providers with submitting a complaint about Alliance providers may call the Medicaid Managed Care Provider Ombudsman Program at **866-304-7062**. Providers can also find more information about the Medicaid Managed Care Provider Ombudsman Program and how to submit a complaint via: Email Medicaid.ProviderOmbudsman@dhhs.nc.gov.

Member

The member, or member's representative acting on the member's behalf, may file a grievance.

Examples of grievances that can be submitted include:

- Provider service including, but not limited to:
  - Rudeness by provider or office staff
  - Failure to respect the member's rights
  - Quality of care/services provided
  - Refusal to see member (other than in the case of patient discharge from office)
  - Office conditions
- Services provided by Alliance including, but not limited to:
  - Hold time on telephone
  - Rudeness of staff
  - Involuntary disenrollment from Alliance
  - Unfulfilled requests
- Access availability including, but not limited to:
  - Difficulty getting an appointment
  - Wait time in excess of one hour
  - Handicap accessibility
  - Violation of confidentiality

A member's representative or any provider acting on behalf of the member with written consent, may file a grievance at any time.

Alliance will ensure that no punitive action is taken against a provider who, as an authorized representative, files a grievance on behalf of a member, or supports a grievance filed by a member.

P. Complaint or Grievance Investigation and Resolution Procedures

Grievance Submission

A provider may not violate or obstruct the rights of an individual to make a grievance and must not take or allow staff to take any punitive action whatsoever against an individual who exercises this right.

The provider must have a grievance policy and procedure to address any concerns of the individual and the individual's family related to the services provided. The procedure to file a grievance shall be posted in the individual waiting area. Instruction about the provider's grievance process must be provided in writing to all individuals and families of individuals upon admission and upon request. The provider's written materials on grievances must advise individuals and families that they may contact Alliance directly at 800-510-9132 or at Complaints@AllianceHealthPlan.org about any complaints or grievances.

The provider must keep documentation on all grievances received including date received, points of grievances, and resolution information. At its request Alliance has the right to review provider documentation on grievances. Any unresolved complaints or grievances must be referred to Alliance. Alliance contact information 800-510-9132 and the toll-free telephone number for Disability Rights of North Carolina 877-235-4210 must be published, posted and made available to the individual and family individuals.

Any individual, legally responsible person and/or provider is encouraged to contact Alliance if they feel that services being provided to an individual are unsatisfactory or if the individual's emotional or physical well-being is being endangered by such services. A grievance may be submitted as follows:

- The individual may call the Member and Recipient Services Line at 800-510-9132 or TTY at 800-735-2962.
- A written statement of the concern may be faxed to 919-651-8687.
- A written statement of the concern may be emailed to Complaints@AllianceHealthPlan.org.
- The complainant may deliver their verbal or written grievance in person at the Alliance Home Office, located at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or any of the Alliance community site locations, which are posted on the Alliance website (AllianceHealthPlan.org).

Grievances will be designated by Alliance as Medicaid related or non-Medicaid related grievances depending on individual eligibility.

For Medicaid Related Grievances

Alliance will acknowledge standard Medicaid grievances in writing within 5 business days from the date the grievance is received by Alliance. Upon the grievance resolution, a letter will be mailed to the member within 30 calendar days, from the date the standard grievance is received by Alliance. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent. Then one letter shall be sent which includes the acknowledgement and the decision of the grievance.

Alliance may extend the timeframe by up to 14 calendar days if (i) the individual requests extension or (ii) there is a need for additional information and the delay is in the best interest of the individual. Any extension granted shall be communicated to the individual within 1 business day either verbally or in writing. Verbal notifications shall be followed up in writing to the individual.

The acknowledgement letter includes:

- Name and telephone number of the grievance coordinator
- Request for any additional information, if needed to investigate the issue

The resolution letter includes:

- The results/findings of the resolution
- A statement of the grievance outcomes
- All information considered in the investigation of the grievance
- Date(s) of review of information related to the complaint
- The date of the grievance resolution
- Instructions for filing an appeal if the grievant does not agree with the resolution
- Information regarding the right to file an appeal and filing a complaint with NC DHHS

A grievant who does not agree with the resolution of their grievance can submit an appeal to the CEO as indicated in the resolution letter contact Member and Recipient Services for assistance as indicated in the resolution letter.

Non-Medicaid Related Grievances

1. Alliance will acknowledge the non-Medicaid grievance and notify the grievant in writing by US mail within 5 working days of receiving the grievance.
2. Alliance will resolve non-Medicaid grievances expeditiously and provide a written resolution to the grievant no later than 15 working days of the date Alliance received the grievance.
3. Upon completion of the complaint investigation Alliance will notify the grievant and provide a written resolution summary via US Mail. The resolution letter sent to the grievant complainant will include:
    - The results/findings of the resolution
    - All information considered in the investigation of the grievance
    - The date of the grievance resolution
    - Instructions for filing an appeal if the grievant does not agree with the resolution

Q. Performance Improvement Procedures

Alliance's Quality Management and Improvement Program (QMIP) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities implemented in response to findings. The QMIP addresses the quality of clinical care and nonclinical aspects of service with a focus on key areas that include, but are not limited to:

- Quantitative and qualitative improvement in Member outcomes
- Coordination and continuity of care with seamless transitions across health care settings/ services
- Cultural competency
- Quality of care/service
- Preventive health
- Service utilization
- Complaints/grievances
- Network adequacy
- Appropriate service utilization
- Disease and care management
- Member and provider satisfaction
- Components of operational service
- Regulatory/federal/state/accreditation requirements

The QMIP activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, other subset population data sets and metrics, and/or medical record audits. The Continuous Quality Improvement (CQI) Committee is responsible for approving specific QI activities, including monitoring and evaluating outcomes, overall effectiveness of the QMIP and initiating corrective actions plans when appropriate, when the results are less than desired or when areas needing improvement are identified.

Provider Participation in the Quality Management and Improvement Program

Participating providers are contractually required to cooperate with quality improvement activities. Providers are invited to participate in the QMIP. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys.

Information regarding the QMIP, available upon request, includes a description of the QMIP and the annual evaluation of progress toward goal. Alliance evaluates the effectiveness of the QMIP on an annual basis. An annual report summarizes a review of completed and continuing QI activities that address the quality of clinical care and service, trending of measures to assess performance in quality of clinical care and quality of service, any corrective actions implemented, corrective actions that are recommended or in progress, and any modifications to the program. This report is available as a written document.

Preventive Guidelines

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents, and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap smears and mammograms

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the member's needs.

Prevention improvement activities are reviewed and approved by the Provider Quality Committee which reports to Continuous Quality Improvement (CQI) Committee. Improvement activities include distribution of information to members and providers, member and provider incentives, and telephonic outreach to members with gaps in care. While Alliance can and does implement activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention adherence.

i. Member Satisfaction Surveys

On an annual basis, the NCDHHS Division of Health Benefits conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality and access is evaluated. The results are compared to Alliance's performance goals, and improvement action plans are developed to address any areas not meeting standards.

ii. Clinical Studies

Performance Improvement Projects (PIPs) are a critical component of the Quality Management and Improvement Program (QMIP) and adheres to a structured approach in conducting quality improvement projects by applying the Plan Do Study Act (PDSA) principles. The PIPs are determined based on state and accreditation requirements and identified areas of need within Alliance with the purpose of improving overall operational performance and clinical outcomes. Topics for PIPs can range from diabetes control and follow-up after mental health discharges, to transitions to community living, and antidepressant medication management, depending on requirements and identified needs. All PIPs are approved, reviewed, and monitored by Alliance's quality management committees – the Global Quality Management Committee (an Alliance Board subcommittee) and the Continuous Quality Improvement Committee.

Within the Quality Management division, the Quality Improvement Team supports the PIPs by leading cross-functional Project Advisory Teams (PATs) through the quality improvement process. These PATs can consist of representatives from Community Health and Well-Being, Care Management, Practice Transformation, Claims, Pharmacy, Provider Network and several other units within Alliance. Through regularly scheduled meetings, the PAT conducts root cause analysis, challenges and barriers assessments, and other processing exercises to target opportunities for improvement and implementation of viable interventions. Results are collected to determine the impact and effectiveness of interventions. Effective interventions are then expanded and incorporated into standard operational procedures as best practices, where applicable.

iii. Incident Reporting

Monitoring of Incidents

An incident is an event at a facility or in a service/support that is likely to lead to adverse effects upon an individual. Incidents are classified into several categories according to the severity of the incident. Providers are required to develop and maintain a system to collect documentation on any incident that occurs in relation to an individual. This includes all state reporting regulations in relation to the documentation and reporting of critical incidents. In addition, providers must submit all Level II and Level III incident reports in the state's Incident Response Improvement System (IRIS) and a summary of all Level I incidents must be submitted quarterly.

Providers must implement procedures that ensure the review, investigation, and follow up for each incident that occurs through the providers' internal quality management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns.
- Strategies aimed at the reduction/elimination of trends/patterns.
- Documentation of the efforts toward improvement as well as an evaluation of ongoing progress.
- Internal root cause analyses on any deaths that occur.
- Mandatory reporting requirements are followed.
- Entering Level II and III incidents into the state's Incident Response Improvement System (IRIS).

There are specific state laws governing the reporting of abuse, neglect or exploitation of individuals. It is important that the provider's procedures include all of these requirements. If a report alleges the involvement of a provider's staff in an incident of abuse, neglect or exploitation, the provider must ensure that Individuals are protected from involvement with that staff person until the allegation is proved or disproved. The agency must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

Alliance Incident Review Process

Alliance is required to monitor certain types of incidents that occur with network providers, as well as providers who are not in the network but operate services in the Alliance catchment area. Alliance is also required to monitor the state IRIS system.

Upon receipt, the Alliance Quality Management Department reviews all incidents for completeness, appropriateness of interventions and achievement of short and long-term follow up both for the individual as well as the provider's service system. If questions or concerns are noted when reviewing the incident report the QM staff will work with the provider to resolve these.

If concerns are raised related to an individual's care, services, or the provider's response to an incident, an onsite review of the provider may be arranged. If deficiencies are found during the review process, the provider will be required to submit and implement a plan of correction.

Alliance will provide technical assistance as needed and appropriate to assist the provider to address the areas of deficiency and implement the plan.

Monitoring to Ensure Quality of Care

Alliance is charged with conducting compliance reviews and audits of medical records, administrative files, physical environment, and other areas of service including cultural competency reviews. Alliance is also charged with reviewing critical incidents, death reports, and restrictive interventions to assure the protection of rights and the health and safety of individuals.

Alliance will review the incidents reported and determine whether any follow up is needed and may conduct investigations of incidents reported directly by providers on incident reports, as well as reports provided by individuals, families and the community.

iv. Outcomes Requirements

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of health plans to measure performance on important dimensions of care and service. Annual HEDIS reporting is required by the state Medicaid programs and the health plan accreditation agencies. The tool comprises a wide variety of measures across 6 domains of care, including:

1. Effectiveness of care
2. Access/availability of care
3. Experience of Care
4. Utilization and risk adjusted utilization
5. Health plan descriptive information
6. Measures collected using electronic clinical data systems

A key element in our partnership is the evaluation of the quality of care and services delivered to our members. One of the most important ways we measure that quality is through the HEDIS; the quality measures are based on the specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures.

All HEDIS data reported is audited and certified by an NCQA-designated auditing firm as required by accreditation bodies, our state partners, and the Centers for Medicare & Medicaid Services (CMS). This HEDIS audit is a standard part of the NCQA HEDIS data collection process and NCQA accreditation standards.

As part of the HEDIS audit, we may contact providers for patient records to review according to HEDIS clinical documentation standards. In compliance with the HEDIS standards, we request medical records annually for certain measures to collect information that typically cannot be found in a claim or an encounter. Alliance will contact the provider's office to schedule medical record collection for member charts because we have identified that you are either the assigned or previous PCP of the member or have submitted a claim or encounter that relates to a HEDIS measure.

The requirement of an audit is also part of your provider contract with Alliance, which requires that you submit needed records at no charge within 3 business days of the request or as otherwise stated. Please refer to your contract for more information.

Web Resources

Alliance periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the Alliance website. Please check Alliance's website frequently for the latest news at AllianceHealthPlan.org/provider-updates/.

R. Compensation and Claims Processing Requirements

This section of the Provider Operations Manual provides general information related to the submission of claims and the reimbursement for services. Providers should refer to the Billing and Enrollment Manual for further details.

The focus of Alliance's Claims and Enrollment Department is to process claims in a timely manner. Alliance has established toll-free telephone numbers for providers to access representatives. For more information, refer to the Alliance Billing and Enrollment Manual which will be found on Alliance's website at AllianceHealthPlan.org/document-library/59347.

For providers who are unaccustomed to submitting claims, Alliance provides detailed claims submission procedures on Alliance Claims System (ACS) Provider Portal and in the Billing and Enrollment Manual.

Consumer Enrollment and Eligibility Process ACS Provider Portal

Alliance Claims System (ACS) is a secure, web-based system that can be used by Network Providers to:

- Submit service authorization requests (SAR)
- Key and submit professional and inpatient claims
- Reverse and replace claims
- Inquire about a member's eligibility
- Inquire about the status of a claim or SAR
- Obtain weekly report on submitted claims
- Obtain weekly remittance advices (RA)

Each provider will be contacted and provided with the user ID and password upon execution of a network contract. Providers are required to notify the Alliance Provider Helpdesk when their employees that have access to Alliance ACS Provider Portal terminate employment so that the logins can be disabled.

Eligibility Determination

If consumers are enrolled with Medicaid, they are financially eligible for Medicaid reimbursable services from Alliance that are not covered by other insurance or third-party payer.

It is the provider's responsibility to verify a consumer's eligibility for Medicaid coverage, state funding, and other third-party insurance coverage, or if any other payer is involved such as worker's compensation, or other liable parties. Coordination of benefits is required.

Consumers in certain circumstances may be eligible for state funding of services. The provider must determine if:

- The consumer does not have Medicaid; or if consumer does have Medicaid but requires contracted services that are not billable to Medicaid.
- The consumer does not have Medicare, other insurance or other third-party coverage that will pay for required services.

Consumers who have their services paid in whole or in part by Alliance must be registered by the provider with Alliance. Consumers with applicable Medicaid coverage through the Alliance area are automatically enrolled with Alliance and do not require enrollment by the provider. If the consumer is not yet registered or no longer active in the system, the provider must enroll the consumer or update consumer information through the ACS Provider Portal. Alliance reviews and must approve all enrollments.

Once the consumer is enrolled, an Alliance Consumer Identification Number is assigned and viewable to the provider in the ACS Provider Portal. This number can be used for submitting claims to Alliance. Instructions for how to register/enroll a consumer are available in the Provider Central section of the Alliance website.

Consumer Confidentiality

Providers are responsible for securing a consent to treatment and informing consumers that their protected health information (PHI) will be used to obtain payment from Alliance. Providers should never send a consumer's PHI through unencrypted/unsecured email. PHI can be sent by fax or through the Alliance's secure ZixMail system.

Member ID

The Alliance Client ID number is assigned by the ACS once a consumer is enrolled as a member. To obtain this number, the consumer must be confirmed as eligible and registered/enrolled with Alliance. Claims are denied if submitted with an incorrect Alliance Client ID number, or with a valid number that is not registered or active to the provider on the date of service billed.

The 6-digit Alliance Client ID number is required to identify a consumer in the care coordination information system (CCIS) and to bill claims through the online direct data entry (DDE) system. Claims submitted by HIPAA compliant 837 transaction files may identify recipients of service with their Alliance Client ID number or their active Medicaid ID number.

Key Data to Capture During Enrollment

All providers are required to ensure the consumer is an enrolled member and demographic data is up-to-date and accurate in the ACS consumer profile. If enrollment is not complete prior to service provision, authorizations, and claims payment may be affected. This could include denials of authorizations and claims for these services. When furnishing services to consumers without Medicaid, or a consumer who is not enrolled with Alliance, the provider must complete an electronic enrollment request within 14 days of the consumer's intake appointment.

To complete registration/enrollment, providers need to confirm consumer's identity and register them with their legal name, birth date, Social Security number, or Medicaid identification number. Additional information may be required including:

- Consumer's maiden name, when applicable, to determine if the consumer has already been registered under another name.
- Insurance information for any policy that may cover services including: insurance company name, policy name and or group number, effective dates, and name of policy holder.

Other demographic information may be required for Alliance to report enrollment information to the Consumer Data Warehouse (CDW) as required by the NC Division of MH/DD/SAS.

Claims Submission Requirements

Alliance requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. Alliance requires all diagnosis coding to be ICD-10-CM, or its successor, as mandated by CMS. Refer to the Compliance section for additional information. In addition, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory, and radiology procedures. When coding, the provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

Alliance tracks billing codes and providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as part of the retrospective review process. Should a provider continue to repeat the inappropriate coding practice, the Provider will be subject to an adverse action.

When presenting a claim for payment to Alliance, the provider is indicating an understanding that have an affirmative duty to:

- Supervise the provision of, and be responsible for, the services provided;

- Supervise and be responsible for preparation and submission of the claim; and
- Present a claim that is true and accurate and that is for Alliance covered services that:
    - Have actually been furnished to the member by the provider prior to submitting the claims; and
    - Are medically necessary.

Providers using electronic submission shall submit all claims to Alliance or its designee, as applicable, using the HIPAA-compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses and/or non-covered services.

Authorization Number and Effective Dates

Each authorization has a unique number, a start date, and an end date. Only dates of service within the specified effective dates of the authorization are paid. Service dates outside these parameters are denied. The authorization number is not required on the claim to process.

Service Categories or Specific Services

Each authorization indicates specific services that have been authorized or, in some cases, categories of services or service groups. Each procedure code billed is validated against the authorization. Claims must reference the specific procedure code or revenue code for the service rendered.

Units of Service

Each authorization indicates the maximum number of units of service allowed. The claim adjudication system checks to make sure that the units being claimed fall within the units of services authorized, and any established daily, weekly, monthly, or other period of delivery limitations. If the number of units billed exceed the authorized number of units remaining, this system cuts back the units paid to the remaining authorized unit limit. Claims submitted after all of the authorized units for the period have been fully utilized are denied. Providers need to establish internal procedures to monitor their utilization of authorized units and obtain additional authorization to ensure payment for services delivered.

Exceptions to Authorization Rule

Certain Medicaid and state-funded services are paid without an authorization during the initial period of unmanaged care each fiscal year (July-June). These services are limited in scope to basic services and are limited to the total number of encounters allowed for the consumer with any provider without authorization. Once the unmanaged limit has been reached for a consumer, all services without an authorization are denied, regardless of the provider of the service. Once prior approval is on file for the recipient, the system considers the unmanaged count as fully utilized for that fiscal year, regardless of the amount of previous services provided. Providers must be constantly aware of this issue in order to avoid denied claims.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

Alliance uses ICD for diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

All providers must submit HIPAA-compliant diagnoses codes in ICD-10-CM code structure. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Information on the ICD-10 transition and codes can also be found at www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists.

Electronic Claims Submissions

Alliance accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Alliance must be in the ANSI ASC X12N format, version 5010A or its successor. For more information on EDI implementation with Alliance, refer to the Alliance Health Companion Guides, which may be found on Alliance's website at AllianceHealthPlan.org/resources/document-library/?category=52.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a Alliance contracted clearinghouse, to establish EDI with Alliance. For a list of Alliance contracted clearinghouse(s), for information on the unique Alliance Payer Identification (Payer ID) numbers used to identify Alliance on electronic claims submissions, or to contact Alliance's EDI team, refer to the Provider Resource Guide, which may be found on Alliance's website at AllianceHealthPlan.org/providers/medicaid-transformation/.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as Alliance, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA-designated content and format.

Specific Alliance requirements for claims and encounter transactions, code sets and SNIP validation are described as follows: To promote consistency and efficiency for all claims and encounter submissions to Alliance, it is Alliance's policy that these requirements also apply to all paper and DDE transactions.

For more information on EDI implementation with Alliance, refer to the Alliance Companion Guides on Alliance's website at AllianceHealthPlan.org/resources/document-library/?category=8&types=&languages=.

Paper Claims Submissions

Paper claims are not accepted by Alliance Health unless prior approval is requested via the "Paper Claims Request" form prior to submission of the claims and the request is approved. If Alliance Health receives paper claims for an in-network provider, the claim will be mailed back to sender.
For timelier processing of claims, providers are required to submit claims electronically. For assistance in creating an EDI process, contact Alliance's EDI team by referring to the Alliance website at AllianceHealthPlan.org/providers/medicaid-transformation/.

i. Requirement of Electronic Formats

Use of Electronic Data Interchange (EDI) allows for faster, more efficient and cost-effective claim submission for providers and reduces administrative costs. Providers will need to submit the Trading Partner Agreement (TPA) and Connectivity Form that will be used for submissions of 837 files. Providers will receive a TPA with their contract. The TPA can be used for both state and Medicaid claims. The agreement needs to be signed only once for the fiscal year. It will be in effect for the entire fiscal year or until the provider makes changes to addresses, contacts, etc. Additionally, the Alliance Notice of Change form must be completed when such changes occur. Providers should verify their EDI Certification in the ACS Provider Portal. Providers can do this by navigating to the main menu, choosing "Provider Details" and clicking on the line to expand the view. If the "Certified for EDI" box is checked, the agency is certified and 837 files sent can be processed. If the provider does not see the certification box checked, they should contact the Alliance EDI specialist for assistance.

ii. Mandated Timelines

Effective Date of Registration/Enrollment

Consumer registration or enrollment into the Alliance system must be completed prior to providing services beyond the initial assessment except in emergency situations. Crisis services provided in an emergency situation are an exception to this rule. It is the provider's responsibility to submit required registration or case activation information within 14 days of initial contact, and to obtain authorization prior to service delivery when required. In crisis cases, the provider must still enroll the consumer within 5 days and indicate the date of enrollment as the date that the emergency services were provided. The enrollment date entered on registration forms must be on or before the date of any billed service, but can be no more than 14 business days from date of submission. Service dates prior to an enrollment or activation date are denied.

Reporting of Third-Party Payments

Providers are required to record on the claim either the payment or denial information from a third-party payer. Copies of the RA or EOB from the insurance company should be uploaded into ACS and accompany the claim when submitted by the provider. Claims with third party liability showing a zero paid amount by insurance company must be submitted into the ACS with documentation. Alliance members with third-party liability, must ensure copies of the insurance company's RA or EOB showing the denial reason codes.

Providers must bill any third-party insurance coverage including worker's compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time to obtain a response from the insurance company. However, it is important that providers not exceed the 90-day rule before submitting claims. If an insurance company pays after a claim has been submitted to Alliance, the provider must submit a replacement claim reflecting the updated COB information within 30 calendar days of other insurance payment and contact Alliance Health at claims@AllianceHealthPlan.org to report that the replacement claim requires processing.

Timeframe for Claim Submission

Claims must be submitted to Alliance Health within the prescribed calendar days from the date services were rendered (or the date of discharge for inpatient admissions). Please allow for normal processing time before re-submitting a claim either through the EDI, ACS portal, or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim.

	Before Tailored Plan Implementation	After Tailored Plan Implementation
Medicaid	180 days from date of service	365 days from date of service
State	60 days from date of service	90 days from date of service

Claims are not considered received under timely filing guidelines if they are rejected for missing or invalid provider or member data.

Submitting Claims Outside of Filing Period

If a claim is submitted outside of the contractual timeframes, proper documentation supporting the reason for late filing must be attached and submitted for consideration with a paper claim form.

Acceptable proof of timely filing includes:

- Documentation of the cause of the delay in submitting a claim to Alliance when the provider experiences exceptional circumstances beyond their control.
- Copy of the remittance advice or evidence of benefits from the primary payer indicating the date of resolution (payment, denial, or notice) when the claim was denied for timely filing.
- Evidence of retroactive Medicaid eligibility.

The information can be submitted to the director of claims via secured email or regular mail as shown at AllianceHealthPlan.org/contact. The information will be reviewed within 5 business days for acceptance or denial of filing outside of the timely filing deadline.

Process for Submitting Claims to Alliance

Providers are required to submit claims electronically via the web-based ACS Provider Portal and/or a HIPAA compliant 837 transaction set.

837 Claim Submissions

Detailed instructions are provided in the Alliance 837 Companion Guides located at AllianceHealthPlan.org/document-library/60160. The companion guides are NOT intended to be used as stand-alone requirements. The ASC X12 version 5010 Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction.

Claim Receipt Verification

Alliance acknowledges receipt of 837 transaction file by providing the 997 X12 file available for download from the online system. Providers, billing services or clearinghouses wishing to submit claims to Alliance by HIPAA compliant 837 transaction file must complete a Trading Partner Agreement with Alliance and submit a test file for format compliance approval prior to submitting 837 files for payment. Instructions for 837 testing can be found in the Companion Guides.

Submitting Voided Claims and Replacing a Paid Claim

Providers may submit a replacement claim for a previously paid claim within 180 calendar days post service date. Replacement claims submitted past 180 calendar days are denied for exceeding the timely filing requirements. Voided or Replacement claims may be submitted electronically through the ACS Provider Portal or via an 837 transaction set. Detailed instructions can be found in the Claims Manual or 837 Companion Guides. Providers may void a previously paid claim within the fiscal year. If a claim must be voided outside the fiscal year, the request to void should be submitted via the self-audit/overpayment process through the Alliance Health Compliance Department.

Claim Inquiries

The status of a claim can be obtained through the ACS Provider Portal through the download queue. This is available to providers submitting 837s as well. For additional claim inquiries, Providers can email claims@AllianceHealthCare.org or call the Alliance Provider Helpdesk at 919-651-8500 Monday through Friday between the hours of 8:30 am and 5:15 pm. When requesting the status of a claim, the caller must identify themself and provide the following information:

- Provider name
- Recipient's name
- Recipient's identification number

- Date of birth of recipient
- Date of service of recipient
- Billed services

Claim Processing Time

Alliance will follow the Prompt Pay Guidelines which requires that all clean claims are processed within 18 days and payment is made within 30 days of adjudication.

Response to Claims

- Remittance advice (RA): An RA is available for providers electronically to download on the ACS Provider Portal. The RA will include paid, denied, and adjusted claims. Instructions on resolving denied claims can be found in the ACS claim adjudication codes document located at AllianceHealthPlan.org/document-library/59425.
- Electronic remittance advice (ERA): Providers may also request an 835 electronic transaction in addition to the explanation of benefits (EOB). The 835 returns information for paid and denied claims in a standard HIPAA compliant format.

Reimbursement Rates

Provider contracts include a listing of eligible sites and services for which the provider is eligible to be reimbursed. All providers are reimbursed at the Alliance published standard rates for the service rendered unless otherwise stated in their contract.

Providers must only bill the service codes in their contract or reimbursement is denied as non-contracted services. If the billed rate is higher than the Alliance contracted rate, only the published or contracted rate will be paid. If a provider submits a service claim for less than the published rate, the lower rate is paid unless a mandated rate floor is in place for the service being billed. Any change in the published fee schedule rates will be announced in the Alliance provider feed and on the Provider News page on the Alliance website at AllianceHealthPlan.org/provider-updates/ at least 30 days in advance of the new rate effective date. It is the provider's responsibility to monitor the published rates and make necessary changes to their billing systems.

The published rates can be found at AllianceHealthPlan.org/resources/document-library/?category=52.

Definition of a Clean Claim

A clean claim is defined as a claim that has all of the required data elements, is submitted in the correct format, requires no other documentation for payment, and meets the terms of the contract between Alliance and the provider for the billed service. Additionally, federal Medicaid regulations define a clean claim as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Coordination of Services

Alliance is the payer of last resort. Providers are required to collect all third-party funds prior to submitting claims to Alliance for reimbursement. Third-party payers are any other funding sources that are liable to pay for the services provided. This can include worker's compensation, disability insurance, Medicare or other health insurance coverage.

All claims must include original EOB and identify the amounts collected by third parties, and only request payment for any remaining reimbursable amount. Only the remaining amount of the consumer responsibility under their insurance policy is reimbursable by Alliance when Medicaid is secondary coverage.

Financial Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a client enters the delivery system. The eligibility determination should include whether a person has private insurance, is Medicaid or Medicare-eligible, or has another payer source. Periodically (no less than quarterly) the provider should update its eligibility information to determine if there are any changes to first or third party liability for this consumer. It is the provider's responsibility to monitor this information and to adjust billing accordingly. Changes in income or family size affecting first party liability, changes to third party insurance information should be added to the consumer's record in the system. Determination of financial eligibility by the provider is not required for Medicaid recipients.

Obligation to Collect

Providers must make good faith efforts to collect all first and third party funds prior to billing Alliance. First party charges must be shown on the claim whether they were collected or not. The Alliance Claims Adjudication System has the ability to validate third party payer liability and will deny a claim that is missing required coordination of benefits information.

Eligibility for Benefit Determination

All non-Medicaid consumers must be evaluated at the time of enrollment for their ability to pay. This determination should be updated at least annually to ensure that a family must be at or below 300% of the federal poverty level based on income and household size to be eligible for non-Medicaid funded services.

Any changes in information related to the consumer's family size and income should be updated in the client's profile in ACS as necessary.

Process to Establish Eligibility

It is the responsibility of the service provider to ensure consumer financial eligibility for state and county funded services prior to enrolling consumer with Alliance. The combination of a consumer's adjusted gross monthly income and the number of dependents determines eligibility for services.

Providers should use the Division of MH/DD/SAS published definitions for family size and family income for this determination.

If a consumer does not meet eligibility guidelines they should pay 100% of the services being provided. In this case, the consumer should not be registered in the ACS system and claims should not be submitted to Alliance for reimbursement. Cost sharing is not permitted for Medicaid consumers.

Management of Accounts Receivable – Provider Responsibility

Providers are responsible for maintaining their consumer accounts receivable. Alliance will produce an 835 electronic remittance advice for 837 submitters, and a remittance advice (RA), for those submitting CMS 1500/UB04 claims, for each check write. The RA and/or 835 can be accessed through the ACS Provider Portal. Providers can export reports from their user outbox into Excel documents to sort and manage billings, payments, and denials.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process Useful information about EFT payments

- All providers will receive an email notification from the Accounts Payable staff (accountspayable@alliancehealthplan.org) of their upcoming payment (deposit).
- One email address per provider can be added to receive the payment (deposit) notification.
- Depending on when AP processes the payment file you will receive the email notification, however, the deposit of funds will be in accordance with the published checkwrite schedule for the respective year (for example, you receive the notification on Friday, however, the payment won't be deposited until the following Tuesday based on the checkwrite schedule).
- The email notification is sent unencrypted with the EFT stub attached detailing the paid invoice information.
    - If it not received, check with your IT department to ensure @alliancehealthplan.org is included for emails containing unencrypted attachments.

Email updated email address or banking info for EFT to VendorSetup@AllianceHealthPlan.org if your email or banking information changes.

iii. Transition of Care Obligations

Alliance Health will honor existing and active prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the first 90 days after Tailored Plan/PIHP implementation to ensure continuity of care for members. For the first 90 days after Tailored Plan/PIHP launch, Alliance Health shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network providers equal to that of in-network providers.

iv. Coordination of Benefits

Coordination of benefits (COB) should occur when applicable. In such instances, the provider should include the COB information on the claim at time of submission to Alliance Health. This includes COB paid amount, COB allowable amount, and COB reason. COB information is reviewed on a routine basis.

S. Interest and Penalty Provisions for Late or Under-payment by the Tailored Plan/ PIHP

Alliance will follow state guidance on prompt payment of clean claims and will apply interest and penalties in conjunction with the state's corresponding interest and penalty rate for claims processed beyond prompt pay guidelines.

Clean claim payments that are not made in accordance with the prompt pay guidelines shall bear interest at the annual percentage rate of 18% beginning on the date following the day on which the claim should have been paid. In addition to the interest on late payments required, Alliance of North Carolina will pay a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid. If additional information was requested by Alliance of North Carolina, interest on health benefit claim payments shall begin to accrue on the 31st day after Alliance receives the additional information. A payment is considered made on the date upon which a check or draft is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment

T. Member Rights and Responsibilities

Members of Alliance Health have certain rights and responsibilities. Alliance Health respects member rights and the ability for members to exercise those rights. Additionally, Alliance Heath will make information available to members on their responsibilities as a member of Alliance Health. For a full list of rights and responsibilities as a member of Alliance Health, visit our website at AllianceHealthPlan.org/utility/individual-rights-and-responsibilities/ or a request for a hard copy can be requested by contacting Member and Recipient Services.

Member Handbook

The member handbook is the member's guide to health and wellness services and your benefits. All newly enrolled members and recipients can access the member or recipient handbook(s) on the Alliance website at AllianceHealthPlan.org and may request a hard copy of the handbook by contacting Member and Recipient Services at 800-510-9132.

Member Medicaid Identification Cards

Member identification cards are intended to identify the type of plan they have to facilitate their interactions with healthcare providers. The Medicaid ID card is mailed directly to the member. The mailing address on the card is the same as the address on file for the member at their local DSS office. The Medicaid ID card has:

- The member's primary care provider's (PCP's) name and phone number
- The member's Medicaid Identification Number
- Other important contact information

If anything is wrong on the Medicaid ID card or if the card is lost, the local DSS office should be called right away. A list of DSS locations can be found here: https://ncdhhs.gov/localdss. Members should always carry their Medicaid ID card with them. Members will need to show it each time they go for care.

Member Engagement

Alliance utilizes a number of engagement strategies to establish relationships with members and offer information that supports member engagement.

- Alliance operates a Member and Recipient Services Line that offers members resources and supports, connects them with behavioral health, specialty providers and community resources. Alliance also operates a Behavioral Health Crisis Line that is available to members to address immediate behavioral health concerns.
- Alliance uses its website, social media, texting campaigns and community outreach to offer information on a variety of topics. The Alliance website offers information on how to access care, whole person health needs, prevention and population health programs, Medicaid Managed Care and other topics. Alliance utilizes social media and text messaging to market targeted campaigns and offers community outreach to engage members in the community.
- Alliance engages enrolled members through its member portal that will allow access to their account information, care plans, and assessments.

To communicate with members in their preferred language, Alliance uses Transperfect International, Inc for interpretation and has hired Spanish speaking staff for member service lines. Alliance Handbooks and written materials are available in all of the 20 most frequent languages used in the Alliance catchment area.

Choosing a Primary Care Provider

A PCP is a doctor, nurse practitioner or physician assistant who will:

- Care for the member's physical health when they are well and sick
- Help the member get referrals for specialized services if they need them (like a cardiologist)

As a Medicaid beneficiary, the member has an opportunity to choose their own PCP. The member can find their PCP's name and contact information on their Medicaid ID card. If they do not choose a PCP, NC Medicaid may choose one for them based on their past health care.

Changing Primary Care Providers

Members can change their PCP for any reason twice per year and are allowed to change their PCP with cause at any time. Members of federally recognized tribes may change their PCP without cause at any time. If the member has any questions about choosing or changing their PCP, they should reference their handbook for the appropriate entity to request a change.

U. Member Cost Share Requirements

Alliance shall ensure that any member enrolling into the Tailored Plan/PIHP is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.

Alliance shall impose the same cost sharing amounts as specified in North Carolina's Medicaid program which are displayed Medicaid Managed Care Cost Sharing Table below.

Alliance shall not require members to pay for any covered services other than the copayment amounts required under the state plans.

Alliance shall not hold members responsible for any of the following:

1. Alliance Health's debts in the event of Alliance Health insolvency;
2. Covered services provided to the member for which:
    i. The Department does not pay Alliance Health, or
    ii. The Department, or Alliance Health, does not pay the health care provider that furnished the services under a contractual referral or other arrangement.
3. Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Alliance Health covered the services directly. 42 C.F.R. § 438.106.

Exceptions for cost sharing:

1. Pursuant to 42 C.F.R. § 457.505(d)(1), all all NC Medicaid program members receive well-child visits and age-appropriate immunizations at no cost to their families.
2. Consistent with 42 C.F.R. § 447.56, Medicaid cost sharing does not apply to a subset of the population including children under age 21, pregnant women, individuals receiving hospice care, federally-recognized American Indians/ Alaska Natives, BCCCP beneficiaries, foster children, qualified Medicare beneficiaries, disabled children under Family Opportunity Act, 1915(c) waiver beneficiaries, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
3. Alliance Health shall not impose cost sharing on Medicaid and NC Medicaid program BH, I/DD and TBI services, as defined by the department.

Medicaid Managed Care Cost Sharing			
Income Level	**Annual Enrollment Fee**	**Service**	**Copay**
Medicaid			
All Medicaid beneficiaries	None	Physician services	$4/visit
		Outpatient services	$4/visit
		Podiatrists	$4/visit
		Generic and brand prescriptions	$4/script
		Chiropractic services	$4/visit
		Optical services/supplies	$4/visit
		Optometrists	$4/visit
		Non-emergency ER visit	$4/visit
NC Medicaid			
NC Medicaid program beneficiari es with family incomes <159% FPL	None	Office visits	$0/visit
		Generic prescriptions	$1/script
		Brand prescriptions when no generics available	$1/script
		Brand prescriptions when generics available	$3/script
		Over-the-counter medications	$1/script
		Non-emergency ER visit	$10/visit
NC Medicaid program beneficiari es with family incomes >159% and <211% FPL	$50 per child or $100 maximum for two or more children[16]	Office visits	$5/visit
		Outpatient hospital visits	$5/visit
		Generic prescriptions	$1/script
		Brand prescriptions when no generics available	$1/script
		Brand prescriptions when generics available	$10/script
		Over-the-counter medications	$1/script
		Non-emergency ER visit	$25/visit

[16] The NC Medicaid program annual fee is collected by the counties. Not by the Tailored Plan/PIHP.

V. Provider Program Integrity Requirements

Alliance Program Integrity Functions

As part of our compliance program, we operate a proactive and reactive system of controls to prevent, detect, investigate and mitigate fraud, waste and abuse (FWA). The Program Integrity Department focuses on activities to prevent and detect FWA by providers, members and recipients, vendors, and any other applicable external parties. The results of the department's efforts allow recovery of improper payments and enforce compliance with rules and regulations throughout the provider network.

We have established FWA prevention, detection, and investigation procedures that demonstrate our commitment to delivering high-quality care while achieving overall savings and recoveries across all lines of business. Our tools include processes to identify patterns of unbundling, upcoding, overutilization, billing for services not rendered, and excessive billing. Our tools and techniques are updated and adapted based on experience, training, and health care FWA trends.

Alliance strives to process claims and payments consistently and in accordance with best practice standards per the American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), the Food and Drug Administration (FDA), and NCDHHS guidelines. Edits are in place to identify unbundled procedures, misuse of modifiers, medically unlikely procedures, procedure to procedure exclusions, duplicate claims, frequency limits, other coverage and prior authorization requirements. High dollar claims, inpatient claims, and emergency room claims are audited by claims auditors. Providers will be notified of the adjudication status of their claims, including the determination that a claim was not compliant with the above stated guidelines. Providers are encouraged to review remittance advice to identify claims that have been identified as noncompliant based on edits and seek guidance from Alliance as needed.

Allegations of suspected fraud and abuse are investigated by the Alliance Special Investigations Unit (SIU). Investigation findings are reported to NCDHHS and are subject to further investigation by federal and state regulatory agencies and law enforcement. Intentionally billing for services not rendered is a clear example of fraud, but providers are cautioned that other billing activities intended to increase reimbursement through code manipulation, such as unbundling and upcoding, can be considered a misrepresentation of the services provided and could result in significant fines, penalties, and/or civil and/or criminal prosecution.

Investigation findings that are not considered for further investigation by other authorities may result in one or more of the following actions by Alliance:

- Exclusion from participation in network
- Limiting referrals
- Moratorium on the expansion of sites or services
- Payment suspension
- Plan of correction/corrective action plan
- Probation
- Recovery or recoupment of identified overpayments
- Site or service specific termination
- Suspension from network
- Suspension of neferrals
- Termination from network
- Warning

Alliance may require providers to undergo prepayment claims review to ensure that claims presented for payment meet the requirements of federal and state laws and regulations and medical necessity criteria. Grounds for being placed on prepayment claims review include, but are not limited to, when an allegation of fraud against a provider has been determined to be credible by NCDHHS, identification of aberrant billing practices through an Alliance investigation or data analysis, failure by the provider to respond timely to a request for documentation made by Alliance, or other grounds as defined by the department in rule.

Confidentiality of Member and Recipient Information and Release of Records

Medical records shall be maintained in a manner designed to protect the confidentiality, availability, security and integrity of such information and in accordance with applicable state and federal laws, rules, and regulations. Providers shall develop policies and procedures that address how information will be recorded, stored, retrieved, maintained and disseminated as well as how this information will be protected against loss, theft, destruction, unauthorized access, and natural disasters. All conversations involving the member or recipient or their information shall be conducted discreetly and professionally. All provider personnel shall be trained on the North Carolina General Statutes and Administrative Code regarding confidentiality, 42 CFR Part 2 that governs alcohol and drug abuse records, and HIPAA privacy and security regulations before access to confidential information is granted and at a minimum, annually. Providers shall also ensure that their employees follow policies and procedures at all times. Policies and procedures are required for how a member/legally responsible person can obtain a copy of their records or how they will ensure appropriate authorization is received from members to release information where required by applicable state and federal law.

Policies and procedures shall include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI, and how breach notification will occur when necessary.

Providers are required to provide members with information regarding their privacy practices as spelled out in their notice of privacy practices (NPP). The NPP advises members how the provider may use and disclose a member's PHI and how a member can exercise their health privacy rights. HIPAA and the North Carolina General Statutes allows for the release of member medical records to Alliance Health for payment purposes and/or health plan operations with the exception of records protected under 42 CFR Part 2. Records governed under 42 CFR Part 2 require a release of information for treatment and payment purposes. For purposes of audit and evaluation, a release is not required for providers to disclose records governed under Part 2. HIPAA regulations require each covered entity, such as health care providers, to provide a NPP to each new patient or member. Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information include:

- Medical records
- Communication between a member and a provider regarding the member's medical and behavioral health care treatment
- All personal and/or protected health information (PHI), regardless of the format, as defined under the federal HIPAA privacy regulations, and/or other state or federal laws
- Any communication with other clinicians involved in the member's health, medical and behavioral care (i.e., diagnosis, treatment, and any identifying information such as name, address, Social Security number (SSN), etc.
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral or psychiatric problem

i. How to Report Suspected Fraud

Providers, including Provider employees and/or Provider subcontractors, must report to Alliance any suspected FWA, misconduct or criminal acts by Alliance, or any Provider, including Provider employees and/or Provider subcontractors, or by Alliance Members and/or Recipients. Reports may be made anonymously through the Compliance Hotline at 1-855-727-6721. Suspected Medicaid fraud and/or abuse can also be reported to the Medicaid Fraud, Waste and Program Abuse Tip Line at 877-362-8471.

ii. Waste and Abuse

Definitions of Fraud, Waste and Abuse (FWA)

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member/recipient practices that result in unnecessary cost to the Medicaid program. This definition applies to all funding sources managed by Alliance: Medicaid, state and local funding.

Waste: Misuse, underutilization or overutilization of services or other inappropriate billing or medical practices that add to health care or unexplained variation in care that results in no discernible differences in health or patient outcomes.

Providers are required to ensure that billing practices are consistent with the International Classification of Diseases (ICD-10), Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual. In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims.

Providers are accountable for ensuring that Medicaid and state funds are not used in association with excluded individuals by checking the State Excluded Provider List, the U.S. Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities (LEIE), the System of Award Management (SAM), the Social Security Administration Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES) and the Office of Foreign Assets Control (OFAC). Providers are required to report to Alliance the name and employment dates of any employee, including contract employees, that has been excluded within 2 business days of identification.

Providers are required to ensure that all employees, including contracted employees, meet annual compliance and education training requirements with respect to FWA. Providers and their employees must complete an annual FWA training program. The FWA training program shall cover at a minimum the False Claims Act, the North Carolina False Claims Act, the Anti- Kickback Statute and North Carolina Medical Assistance Provider Fraud as well as the associated penalties and fines associated with these laws.

- Fraud, waste and abuse training
- Definitions and examples of fraud, waste and abuse
- Laws and regulations related to fraud, waste and abuse, specifically covering the False Claims Act and the Anti-Kickback Statute
- Policies and procedures to address fraud, waste and abuse
- Mechanisms for reporting suspected fraud, waste, and abuse
- Non-retaliation and protections for employees and subcontractors who report suspected fraud, waste and abuse in good faith

iii. Compliance with Other State and Federal Requirements

All providers, including provider employees and provider sub-contractors and their employees, are required to comply with Alliance's Corporate Compliance Program requirements, which are designed to promote legal and ethical conduct in all of Alliance's operations. Providers must have written policies, procedures and standards of conduct that articulate commitment to comply with all applicable federal and state standards. Providers must ensure that the following areas are addressed in policies and procedures and have effective methods for communicating these requirements to all employees and sub-contractors.

Compliance Program

- Compliance personnel and resources
- Policies and procedures and how to access them
- Ensure that policies and procedures are understood
- Code of ethics and conduct
- Direction on the ways suspected violations can be reported
- Non-retaliation policies
- Mitigation of violations through corrective and disciplinary action

Privacy and Security

- Overview of privacy and security requirements in accordance with the federal standards established per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, 42 CFR Part 2 and North Carolina General Statute 122C 52-56.
- Training includes, but is not limited to:
  - Definition of protected health information (PHI)
  - Proper uses and disclosures of PHI
  - Member rights, including notice of privacy practices
  - Physical, administrative, and technical safeguards
  - HIPAA incidents and how to report them

False Claims Act [31 U.S.C. § § 3729-3733 and 18 U.S.C. § 287]

The civil False Claims Act (FCA) protects the government from being overcharged or paying for inferior goods or service. Under this law, it is illegal to submit claims to Alliance that you know or should know are false or fraudulent. Under the civil FCA, no specific intent to defraud is required. "Knowing" is defined as including not only actual knowledge but also instances in which the person acted in deliberate disregard of the truth or falsity of the information. The civil FCA includes a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States government and entitles the individual to a percentage of any recoveries. This is called a Qui Tam action. Penalties for violating the civil FCA include fines of up to 3 times the damages caused plus $11,000 per claim filed.

The criminal FCA makes it illegal to present or make any false, fictitious, or fraudulent claim against agency or department of the United States. To be guilty of a violation of this statute, it must be shown that the perpetrator made or presented a claim that the perpetrator knew was false, fictitious, or fraudulent. The crime is complete when the claim is presented, and payment of the claim is not required to have violated this statute. Penalties for violating the criminal FCA include imprisonment of not more than 5 years per violation and a fine of $250,000.

Medical Assistance Provider False Claims Act [NCGS § 108A-70.10 - § 108A-70.16]

The Medical Assistance Provider False Claims Act makes it unlawful for any Provider of medical assistance under Medicaid to knowingly present or cause to be presented to Medicaid a false or fraudulent claim for payment or approval. It also

prohibits knowingly making, using or causing to made or used a false record or statement to ger a false or fraudulent claim paid or approved by Medicaid. Violations may result in penalties of $5,000 to $10,000 plus 3 times the damages sustained by Medicaid. Providers in violation are also liable for the costs of civil action to recover any penalty or damages plus interest.

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment, offering, soliciting or receipt of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by federal health care programs. Remuneration includes anything of value, including cash, free or reduced rent, gifts and excessive compensation for consultancies. Criminal penalties and administrative sanctions for violating the AKS include fines, prison time and exclusion from participation in federal health care programs. In addition, under the Civil Monetary Penalties Law, physicians who pay or accept kickbacks may be penalized up to $50,000 per kickback and 3 times the amount of the remuneration.

The AKS includes safe harbors, which protect certain payment practices, but to be protected an arrangement must satisfy all the safe harbor requirements.

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, also known as the Stark Law, prohibits physicians from referring patients to receive designated health services payable by Medicaid from entities with which the physician or an immediate family member has a financial relationship, including ownership/investment interests and compensation arrangements. Designated health services are:

- Clinical laboratory services;
- Durable medical equipment (DME) and supplies;
- Home health services;
- Inpatient and outpatient hospital services;
- Outpatient prescription drugs;
- Parenteral and enteral nutrients, equipment, and supplies;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Prosthetics, orthotics, and prosthetic devices and supplies; and
- Radiology and certain other imaging services.

Proof of specific intent to violate this law is not required. Claims resulting from prohibited referrals are subject to the FCA. Violators of this law face fines and exclusion from participation in federal health care programs.

Medical Assistance Provider Fraud [NCGS § 108A-63]

The Medical Assistance Provider Fraud statute has multiple provisions and penalties for violations, several of which are similar to previously described federal and state statutes. Violations of this statute include providers that knowingly and willingly:

- Make or cause to be made false statements about qualifications or conceal facts that make affect continued entitlement to payments;
- Execute or attempt to execute a scheme to defraud the Medicaid program or to obtain government property through false representations;
- Make or cause to be made a false entry in a financial, medical or other record related to provision of a benefit or service with intent to obstruct or delay an investigation into medical assistance by the attorney general's office;
- Solicit, receive, offer or pay any remuneration for referrals for which payment may be made by Medicaid.

W. Sections for Medicaid Providers

i. Clinical Practice Standards

Alliance adopts validated evidence-based clinical practice guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede clinical practice guidelines, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The clinical practice guidelines are based on peer-reviewed medical evidence, are integrated to focus on whole person care, and are relevant to the population served. Approval of the clinical practice guidelines occurs through the Provider Quality Committee which reports to Continuous Quality Improvement Committee. Clinical practice guidelines, to include preventive health guidelines, are at AllianceHealthPlan.org/alliance-clinical-guidelines/.

ii. Authorization, Utilization Review, and Care Management Requirements

Please refer to sections:

- Clinical Practice Standards and UM Program
- Care Management Delivered through the Tailored Plans/PIHP

iii. Care Coordination and Discharge Planning Requirements

Please refer to: Care Management Delivered through the Tailored Plans/PIHP.

iv. Notification of the availability of the Department's Provider Ombudsman Service

Providers may contact the NCDHHS Ombudsman Program established to assist providers with submitting a complaint. Alliance providers may call the Medicaid Managed Care Provider Ombudsman Program at **866-304-7062**. Providers can also find more information about the Medicaid Managed Care Provider Ombudsman Program and how to submit a complaint via: Email Medicaid.ProviderOmbudsman@dhhs.nc.gov.

v. Disaster and Emergency Relief Planning and Response

Alliance network providers must have a business continuity plan and participate in community disaster response and recovery efforts:

- Develop and maintain a plan for continued provider operations in the event of a natural disaster, weather event or other business interruption, including communication(s) with individuals, families and Alliance.
- Work proactively to ensure an individual crisis plan is in place for each individual served by the provider.
- Assist in community disaster response and recovery efforts.
- Licensed professionals are encouraged to participate in the North Carolina Disaster Response Network.

X. Provider Obligations

Provider Obligation to Monitor Activities and Report Overpayments

Providers are required to monitor and audit their own activities to ensure compliance and to prevent and detect potential fraud, waste and abuse. This includes ensuring that all documentation regarding services provided is timely, accurate and complete and that Alliance is the payer of last resort. Provider self-audit tools and payment election forms are posted in the document library on the Alliance web site. Any overpayments identified by a provider must be reported and refunded to Alliance within 60 days of identifying the overpayment per 42 CFR § 401.305. To report an overpayment, providers must submit the audit tool and payment election form to the Alliance Office of Compliance and Risk Management by email to Compliance@AllianceHealthPlan.org or by mail to:

Alliance Health
Office of Compliance and Risk Management
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

The self-audits will be reviewed for accuracy before claims are adjusted per the audit results.

Provider Preventable Conditions

Per 42 C.F.R. § 438.3(g), Providers are required to identify and report provider-preventable conditions. Alliance is prohibited from paying providers for Provider-preventable conditions per 42 C.F.R. §§ 434.6(a)(12) and 447.26. Prohibition on payments shall not result in a loss of access to care or services for Alliance members. Provider-preventable conditions are:

Category 1 - health care-acquired conditions (for any inpatient hospital settings in medicaid):

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma; including fractures, Dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control; including: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) - mediastinitis
  - Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, gaparoscopic gastric restrictive surgery
  - Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions

Category 2 – other provider preventable conditions (for any health care setting):

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
- Any other provider preventable conditions (OPPC) as defined in the North Carolina Medicaid State Plan

Payer of Last Resort

Alliance requires that providers implement a policy recognizing Alliance as the payer of last resort. Providers must identify and bill responsible third parties before billing Alliance. Providers are responsible for notifying and/or confirming with Alliance that a third-party payer exists.

Initial Orientation

Initial orientation of providers shall be performed, in person, at the provider's office or virtually, via recorded webinars or at a mutually agreed upon site within 30 days of placing a newly contracted provider, or provider group, on active status. The orientation can be administered in a variety of settings (e.g., group, seminar, or one-on-one).

Providers are required to complete a comprehensive set of training modules within 30 days of contracting. Providers have the option of completing their training via web modules located on the Provider Portal (with an attestation requirement) or in-person with their provider relations representative. A Provider Visit Information Form is used to document the in-person orientation and outline all topics covered. This form is signed and dated by the provider, along with the names of participants who were present, and any follow-up items.

Evidence of the initial orientation is stored in Alliance's internal customer relationship management system, along with the signed Provider Visit Information Form.

During the orientation, Alliance's Provider Portal is used to navigate the training documents so providers are aware of the various tools and resources available for everyday use. Some of the topics discussed during initial orientation will include:

- Managed care pogram and services
- Eligibility and benefits
- Rights and responsibilities
- Member care and quality
- Authorizations
- Alliance Health's compliance program
- Billing, payment, and encounters (including electronic visit verification (EVV))
- Appeals and grievances
- Alliance Health's policies and procedures
- Telemedicine services
- Model of care
- Timely access requirements
- Record retention requirements
- Continuity of care and transition of care
- Members with special needs
- Review of the provider manual
- Specialized provider education (for certain long term care, serious mental illness specialty plan providers and others as identified by Alliance).

Ongoing Training

Ongoing training shall be provided as deemed necessary and meet the requirements outlined by either Alliance, NC Medicaid contract or the NC MH/SU/DD contract to ensure compliance with program standards. Ongoing monthly webinars are also conducted in adherence with contractual requirements. Ad hoc trainings may be initiated, as necessary, to address identified issues and/or updates as proposed by the plan, State of North Carolina or the provider. Methods of training include group orientations, seminars and summits, one-on-one provider sessions, joint operating committee meetings, webinars, phone calls, emails, etc.

Provider relations representatives are available to provide up-to-date information on trainings provided.

Provider Medical Records

Providers are responsible for compliance with service record documentation, maintenance, and retention of the medical/service record requirements in accordance with the provider contract and other applicable statutes, rules, and regulations. This includes maintaining the records in a secure and confidential manner and until the appropriate retention period has been met. Providers are required to follow 07 NCAC 04M .0510 when deciding on a method of destruction. This applies to paper and electronic records. Destruction logs are required to be maintained permanently. Any records that are subject to an audit or investigation or those that are legally required for ongoing official proceedings must be retained until released from such audits, investigations for official proceedings. When there are multiple schedules, providers shall follow the most stringent requirement.

When a contract is terminated or if the provider closes network operations, but continues to have operations elsewhere in the state, the provider is required to submit either copies of the medical records of members/individuals served under the plan or submit a plan for maintenance and storage of all records for approval by Alliance. Alliance has the sole discretion to approve or disapprove the plan.

Abandonment of records is a serious issue. It is a contractual violation as well as a violation of member rights, the North Carolina General Statutes, and HIPAA. Any abandonment of records shall be reported to the Office of Civil Rights and the NC Medicaid Program Integrity office.

Website Resources

Alliance's website AllianceHealthPlan.org offers a variety of tools to assist Providers and their staff.

Available resources include:

- Provider Manual
- Quick Reference Guide
- Clinical practice guidelines
- Clinical coverage guidelines
- Forms and documents
- Pharmacy and provider look-up (directories)
- Authorization look-up
- Training materials and guides
- Newsletters
- Member rights and responsibilities
- Privacy Statement and Notice of Privacy Practice

Y. List of Revisions

Revision Date Completed	Section Revised	Summary of Revision/s
9/7/2022	O	Added "Corrective Actions by Alliance" as an appealable action. Updated Provider Grievance section related to ways to submit a grievance and timeline for resolution. Updated Resolution Letter components and directions for appealing the resolution.
9/15/2022	O	Updated appealable actions for network and out-of-network providers
9/15/2022	O	Removed appeals of enrollment denials for quality concerns.
9/15/2022	O	Removed two level appeal process.
9/15/2022	O	Removed State Fair Hearing, Hearing Division and Clerk's Office, and Medicaid Specific Inquiries
9/15/2022	L	Updated some abbreviations. No long use LOCUS and CALOCUS
9/15/2022	L	Updated Medical Record definition
9/15/2022	L	Verified all links
9/19/2022	E	Added language to clarify that CM will care coordinate physical health care needs for Medicaid Direct. Also added related to CM responsibilities for Foster Care youth
9/20/2022	R	Corrected wording from "Alliance Information System" to "Alliance Claims System"
9/20/2022	U	Updated copay rates per Lisa's note (change $3 and $2 lines to $4)
9/21/2022	V	Updated list of provider actions
9/21/2022	Appendix A	Added definitions of each provider action
9/23/2022	I	Added network adequacy standards for Medicaid Direct
9/26/2022	T	Removed "Recipient" language and language about physical health and benefits specific to TP. Used language approved by DHHS in Med Dir Handbook

Revision Date Completed	Section Revised	Summary of Revision/s
10/6/2022	B & C	Removed content specific to Tailored Plan benefits only. Added Covered Services per Medicaid Direct Contract. Removed LOCUS/CALOCUS as this is no longer a required LOC. Note: there is still a placeholder for a phone number to Provider Services. Please insert correct contact number.
10/28/2022	R	Replaced information on Professional Services and Institutional Services with the use of EDI.
11/1/2022	Q	Added PIP Review information under Clinical Studies
11/1/2022	G	Updated information regarding LP enrollment
11/1/2022	G	Updated information required for contracting
11/1/2022	G	Moved Access requirements table to v.
11/1/2022	G	Added No- reject requirements
11/1/2022	G	Added licensure requirements
11/1/2022	G	Added required availability
11/1/2022	G	Added on call coverage
11/3/2022	W	Added information for Disaster and Emergency Relief Planning and Response
11/3/2022	W	Reworded the first sentence under Notification of the availability of the Department's provider Ombudsman service
1/8/2023	R	Added information for Paper Claims submissions. Revised link under 837 Claim Submissions. Revised link under Response to Claims. Removed Health Choice under Financial Eligibility Determination Process by Provider. Under iii Transition of Care Obligations, changed from "For the first sixty (60) days" to ninety (90) days.
1/9/2023	N	On 3rd paragraph, added original (The Member's original medical record), removed 'remains the property' on second sentence. Added North Carolina General Statute § 122C-53. Added that members must be made aware 'in advance' of any fees.

Revision Date Completed	Section Revised	Summary of Revision/s
1/10/2023	C	Added Alliance's Pharmacy Services information to include Navitus (PBM) and Medication Specific Limits.
1/13/2023	O	Replaced "reconsideration" with "appeal". Reconsideration is language from LME-MCO process and will be appeal under the TP/MD contracts.
1/13/2023	Appendix A	Removed First Level Panel definition. Replaced Reconsideration Review with Provider Appeal. Removed Second Level Panel definition based on language from LME-MCO contract.
1/11/2023	T	Updated language under Member Handbook, Changing Primary Care Providers. Updated member information rights link. Revised bullet under Member Medicaid Identification Cards. Corrected cost-sharing table copay to $4 for NC Medicaid program beneficiaries with family incomes <159% FPL (Brand prescriptions when generics available).
1/6/2023	O	Replaced Medicaid Managed Care Provider Ombudsman Program number to 866-304-7062
1/6/2023	A	Added and updated numbers 1,2,4,5,6, and 7 under Purpose of this Provider Manual
1/6/2023	A	Added Alliance's vision, mission and values, and Who We Are
1/6/2023	All	Replace references to variations of "Medicaid and NC Health Choice" with NC Medicaid throughout document.
1/12/2023	I	On Table 5: BH I/DD Time or Distance Standards for State-Funded Services removed #5 Reserved n/a row
1/24/2023	All	Updated references as applicable to include PIHP
1/24/2023	G	Added Selection and Retention of Providers heading
1/24/2023	G	Removed duplicative section on credentialing
1/24/2023	C	Added State -Funded BH, I/DD, and TBI Services table
1/24/2023	G	Updated Additional Contracting Data that can be collected
2/17/2023	G	Updated contracting decision language

Revision Date Completed	Section Revised	Summary of Revision/s
2/17/2023	G	Updated Provider Termination language
2/17/2023	G	Updated language to reflect revision of effective dates of credentialing and recredentialing policy and selectin and retention policy
3/3/2023	T	Updated Member Information link
3/23/2023	R	Updated Transition of Care section "For the first 90 days after BH I/DD Tailored Plan/PIHP launch, Alliance Health shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network providers equal to that of in network providers."
4/18/2023	Table of Contents	Updated page numbers on Table of Contents
5/8/2023	A	Updated Purpose of this Provider Manual section to remove link to LME-MCO Manual
5/8/2023	C	Updated Pharmacy Services section "The NC Medicaid PDL is a published prescribing reference of prescription drug products selected by the NC Medicaid Pharmacy and Therapeutics (P&T) committee which is an advisory board to the Division of Health Benefits (DHB). The DHB brings the recommended PDL to the P&T committee for review and advice and then to the public PDL panel meeting."
5/9/2023	R	Updated Reporting of Third-Party Payments section "the Provider must submit a replacement claim reflecting the updated COB information within 30 calendar days of other insurance payment and contact Alliance Health at claims@AllianceHealthPlan.org to inform that the replacement claim requires processing."
5/9/2023	R	Updated Timeframe for Claim Submission section to remove "Providers have an additional 90 days to resubmit corrected claims that were originally denied within the initial timely filing limit.

Revision Date Completed	Section Revised	Summary of Revision/s
5/9/2023	R	Updated Timeframe for Claim Submission section to add "Denied claims may not be replaced. If a billing error caused a denial, the provider must submit a new day claim within the original 180 calendar days of date of service."
5/9/2023	R	Updated Process for Submitting Claims to Alliance section to remove "Paper Claims are not accepted at Alliance."
5/9/2023	R	Updated Submitting Voided Claims and Replacing a Paid Claim section to replace "voided claim" with "replacement claim", remove "or replace a paid claim", and add "Providers may void a previously paid claim within the fiscal year. If a claim must be voided outside the fiscal year, the request to void should be submitted via the self-audit/overpayment process through the Alliance Health Compliance Department."
5/9/2023	R	Updated Claim Processing Time section to replace "approved or denied" with "processed."
5/23/2023	Table of Contents	Updated page numbers on Table of Contents for final submission.
7/19/2023	V	Removed # with DMA and retained (877) 362-8471
7/19/2023	C	Added superscript 8 for Outpatient Opioid treatment, and footnote
7/19/2023	C	Added superscript 9 for Community Support Team (CST), and footnote
7/19/2023	I	Removed duplicate: Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard
7/19/2023	G	Added Tailored Plan under Alliance Provider Termination section
7/19/2023	O	Added space between "acknowledge" and "receipt" under Medicaid Provider Appeals Process section
7/19/2023	O	Space added between "determine" and "if" under Medicaid Provider Appeals Process section

Revision Date Completed	Section Revised	Summary of Revision/s
7/19/2023	F	Updated the link to www.nccasa.org/resources/mandatory-reporting/ under Identification and Reporting of Abuse, Neglect and Exploitation of Children and Vulnerable Adults section
7/19/2023	O	Removed the link https://medicaid.ncdhhs.gov/documents?combine=&field_agency_department_tid_1=2 under Behavioral Health Providers section
7/24/2023	U	Updated language to reflect page 103 of the BH I/DD Tailored Plan Amendment 1 First Revised Restated contract. Update: Members can change their PCP at any time and for any reason twice per year and are allowed to change their PCP with cause at any time. Members of federally recognized tribes may change their PCP without cause at any time. under Changing Primary Care Providers
7/25/2023	R	Updated timelines for submitting claims to show 365 calendar days to match information in the Health Plan Billing Guidance.
7/28/2023	R	Replaced the link www.Alliance.com/North-Carolina/Providers/ICD10-Compliance with www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists
7/28/2023	B	Added #8 Make the redline provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal only under Purpose of ths Provider Manual section.
8/25/2023	G	Updated statement to: Alliance may terminate a Provider from its Medicaid network, Tailored Plan and State Funded Network with or without cause. Any decision to terminate will comply with the requirements of the Contract.
8/25/2023	O	Added a space between 'determine if'
8/25/2023	C	Under Pharmacy Services removed link per State's direction: https://www.nctracks.nc.gov/content/public/providers/pharmacy
9/14/2023	Cover Page, and C	Removed the mention of October 1, 2023, TP Go Live date for the Vision and DME phone numbers.
10/4/2023	Title Page	Updated version date to October 2023.

Revision Date Completed	Section Revised	Summary of Revision/s
1/19/24	Introduction	Added Harnett County.
6/24/2024	C	Changed Avesis Provider Portal URL from https://www.avesis.com/Government3/Provider/Index.aspx to https://www.avesis.com/
6/24/2024	E	Deleted "For Transition to Community Living members and recipients, referral to a Transition Coordinator; For Alliance led care management, this is an Integrated Health Consultant" under In- reach.
6/24/2024	E	Deleted "Integrated Health Consultant I, and Integrated Health Consultant II " and added care management team members related to completing diversion related interventions under Diversion.
6/24/2024	E	Replaced Integrated Health consultants and Care Managers with Care Management Department under Diversion.
5/1/2024	O	Deleted "at Senior Management level with representation from Clinical, Business, and Network operations'
6/24/2024	O	Changed from one (1) business day to five (5) business days for Alliance to acknowledge requests for standard appeals in writing after receipt of Member appeals.
6/24/2024	O	Changed from 2 calendar days to within 72 hours of receiving the expedited request on notification for Member appeal determination.
6/24/2024	O	Deleted "Members who verbally request an expedited appeal are not required to submit a written appeal request."
6/24/2024	O	Denial of an Expedited Request: Changed from within two (2) calendar days to within 72 hours for Alliance to mail the Member the verbal communication related to the decision being made regarding the denial of an expedited appeal.
6/24/2024	O	Resolution of an Expedited Appeal: Changed from within two (2) calendar days to within 72 hours for Alliance give the Member written notice on the expedited appeal.
6/24/2024	O	Affirmation of Denial of an Expedited Appeal: Changed from notifying the Member verbally to notifying the Member in writing.

Revision Date Completed	Section Revised	Summary of Revision/s
6/24/2024	P	For Medicaid Related Grievances: Changed from five (5) business days to five (5) days for Alliance to acknowledge standard Medicaid grievances in writing.
6/24/2024	P	Deleted "This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent: then one letter shall be sent which includes the acknowledgement and the decision of the grievance."
6/24/2024	P	Deleted what was included under Resolution Letter "Instructions for filing an Appeal if the grievant does not agree with the resolution" and "Information regarding the right to file an Appeal and filing a complaint with NC DHHS"
6/24/2024	P	Added "Contact information for the Medicaid Ombudsman if they do not agree with the grievance resolution." under Resolution Letter inclusions.
9/6/2024	T	Updated weblink for Rights and Responsibilities to: AllianceHealthPlan.org/utility/individual-rights-and-responsibilities/
9/9/2024	O	Updated the Denial of an Expedited Request to include “Must mail notice within 2 calendar days.”

Appendix A: Glossary of Terms

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. Web reference: www.medicaid.gov/medicaid/data-systems/index.html
Member and Recipient Services	The toll-free call system established by Alliance to receive all inquiries, respond to crisis situations, and provide quick linkages to qualified providers in the network. This will include information, access to care, emergency and network provider assistance. The 1-800 call system will rely on information systems management software to assist in tracking and responding to calls.
Adjudicate	A determination to pay or reject a claim.
Administrative Review	A review of documentation to determine whether Alliance procedures were followed, and if any additional information provided warrants a change in a previous determination.
ANSI	American National Standards Institute
Advance Directive	A communication given by a competent adult which 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.
Appeal	A request for review of an as adverse benefit determination
Appellant	An individual filing an appeal.
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. An individual requiring enhanced benefit is in need of more than the basic benefit visits in order to maintain or improve their level of functioning. An authorization for the services available in this level will need to be requested through the LME/MCO's utilization management department. Authorization is based on the individual's need and medical necessity criteria for the services requested.

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 the Local Management Entity, through its screening, triage and referral system. Once the referral is made, there are no prior authorization requirements for these services. Referred individuals can access up to 8 visits for adults ages 21 and up and 16 visits for children and adolescents below age 21 from the basic benefit package from any provider enrolled in the LME/MCO's provider network.
Benchmark	A standard by which something can be measured, judged or compared.
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.
Business Associate	A person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity's work force. A business associate can also be a covered (see the HIPAA definition as it appears in 45 CFR 160.103).
CALOCUS (Child and Adolescent Level of Care Utilization System)	A standardized tool that measures level of care needs for children and adolescents. Note: LOCUS is used to assess adults.
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.
Catchment Area	Geographic service area with a defined grouping of counties. Alliance's catchment area includes Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the services or a third party. It does not include a claim under review for medical necessity, or a claim from a provider that is under investigation by a governmental agency for fraud or abuse.
Claim	A request for reimbursement under a benefit plan for services.
Client	As defined in the General Statutes 122C-3 (6).
CMS	Centers for Medicare and Medicaid Services

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, developmental disabilities, and substance abuse services in the four-county region serviced by Alliance.
Critical Access Behavioral Healthcare Agency (CABHA) Providers	A Provider who delivers a comprehensive array of mental health and substance abuse services. This does not include intellectual/developmental disability services, although some CABHAs may provide I/DD services. The role of a CABHA is to ensure that critical services are delivered by a clinically-competent organization with appropriate medical oversight and the ability to deliver a robust array of services. CABHAs ensure individual care is based upon a comprehensive clinical assessment and appropriate array of services for the population served. A CABHA is required to offer the following Core Services: Comprehensive Clinical Assessment, Medication Management and Outpatient Therapy.
Concurrent Review	A review conducted by the LME/MCO during a course of treatment to determine whether services continue to meet medical necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.
Consumer	A person who needs services for treatment of a mental health condition, intellectual and/or developmental disability, or substance use/addiction condition. (Alliance has changed its general reference to “consumer” to “individual.”)
Covered Services	The service which the LME/MCO agrees to provide or arranges to provide to individuals.
Credentialing	The review process to approve the credentials and/or eligibility of a provider who has applied to participate in the LME/MCO metwork of providers.
Crisis Intervention	Unscheduled assessment and treatment for the purpose of resolving an urgent/emergent situation requiring immediate attention.
Crisis Plan	An individualized, written plan developed in conjunction with the individual and the treatment team. The Plan contains clear directive information to assist in de-escalating a crisis, for individual supports, as well as crisis response clinicians or others involved. Crisis plans are developed for individuals at-risk for inpatient treatment, incarceration, or out-of-home placement.

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.
Days	Except as otherwise noted, refers to calendar working or business days.
De-credentialed	The process that occurs when a currently credentialed licensed practitioner is no longer providing services billed under their rendering NPI. The practitioner is eligible to reapply if there is identified network need.
Denial of Service	A determination made by the LME/MCO in response to a network provider's request for approval to provide in-plan services of a specific duration and scope which: • 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 which includes a requirement for a concurrent review by the LME/MCO 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).
Dispute Resolution Process	Alliance process to address administrative actions or sanctions taken against providers in a consistent manner.
Enhanced Services	The enhanced benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent the resources are available, to non-Medicaid individuals meeting priority population criteria.
NC Medicaid	The North Carolina Department of Health and Human Services Division of Health Benefits
DMH/DD/SAS	North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Eligibility	The determination that an individual meets the requirements to receive services as defined by the payor.

Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.
Emergency Services	Covered inpatient and outpatient emergency services are: • Furnished by a provider that is qualified to furnish such services; and • Needed to evaluate or stabilize an emergency medical condition as defined above.
Emergent Need Mental Health	A life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in self harm or harm to others, and/or vegetative signs and is unable to care for themself.
Emergent Need Substance Abuse	A life-threatening condition in which the person is, by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for themself without supervision due to the effects of chronic substance abuse or dependence.
Enhanced Benefit Plan	Includes those services, which will be made available to Medicaid-entitled individuals and non-Medicaid-entitled 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 which are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance abuse and with more complex service and support needs as identified in the person-centered planning process.
Enrollment	Action taken by NC Medicaid to add a Medicaid recipient's name to the monthly enrollment report.
Enrollment Period	The time span during which a recipient in enrolled with the LME/MCO as a Medicaid waiver-eligible recipient.

EPSDT	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal Medicaid benefit that says Medicaid must provide all necessary health care 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 under 21 years of age if the service is listed at 1905 (a) of the Social Security Act and if all EPSDT criteria are met.
Exclusion from Participation in Network	Provider is excluded from participating as in in-network or out-of-network provider, including working for another provider as a licensed or certified professional, managing employee, or other position which is responsible for rendering services directly or indirectly, in whole or in part, payable by Medicaid, State, or other grant or local funding through Alliance.
Facility	Any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of people with mental illness, intellectual/developmental disabilities or substance use disorder, and includes: • Licensed facilities are any 24-hour residential facilities required to be licensed under Chapter 122C of the North Carolina General Statutes, such as psychiatric residential treatment facilities (PRTFs), intermediate care facilities for the developmentally disabled (ICF-DDs), supervised living facilities, residential treatment/rehabilitation facilities for individuals with substance abuse disorders, outpatient opioid treatment facilities, .5600 group homes or other licensed MH/IDD/SU facilities. These facilities may require a certificate of need or letter of support and must meet all applicable state licensure laws and rules, including but not limited to NCG.S. §122C-3 and Title 10A, Subchapter 27C, 27D, 27E, 27F,27G, 26B and 26C. • A state facility, which is a facility that is operated by the secretary. • A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation or rehabilitation of people with mental illness, intellectual/developmental disabilities or substance use disorder.
Fee-For-Service	A payment methodology that associates a unit of service with a specific reimbursement amount.
Fidelity	Adheres to the guidelines as specified in the evidenced based best practice.
Financial Audit	Audit generally performed by a certified public accountant (CPA) in accordance with generally accepted accounting principles to obtain reasonable assurance about whether the general purpose financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. Audits also include assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall general purpose financial statement presentation.

First Responder	A person or personnel of an agency designated as the primary provider by the person-centered plan/crisis plan who will have access to the individual's crisis plan at all times and be knowledgeable of the local crisis response system.
Fiscal Audit	Audit performed by the financial department of the LME/MCO which includes a review of the contractor's evaluation of an individual's income, an individual's determined ability to pay, third party insurance verification, first and third party billing, receipts and denials. A review of COB information will also be conducted to verify support of claimed amounts submitted to the LME/MCO.
Fiscal Agent	An agency that processes and audits provider claims for payment and performs certain other related functions as an agent of DMA and DMH.
Fraud	The misrepresentation or concealment of a material fact made by a person that could result in some unauthorized benefit to self, some other person, or organization. It includes any act that constitutes fraud under applicable federal or state law.
Global Assessment of Functioning (GAF)	This assessment is used to determine the psychological, social, and occupational functioning of a patient.
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination. 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.
Grievance Procedure	The written procedure pursuant to which individuals may express dissatisfaction with the provision of services by Alliance and the methods for resolution of the individual's grievance by Alliance.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
Incident	An unusual occurrence as defined in APSM 30-1. Incidents are reported as Level I, II, or III as defined in APSM 30-1.
Initial Authorization (also called Pre-Authorization)	The initial or first approval by Alliance's Utilization Management Department of a medically necessary service(s) at a given level of care prior to services being rendered.
Intellectual/ Developmental Disabilities (IDD)	Characterized by the following: Impairment of general intellectual functioning and adaptive behavior that occurs before age 22 which: • Limits one (1) or more major life functions; • Is characterized by an IQ of 69 or below; and • Has continued since its origination or can be expected to continue indefinitely.

Least Restrictive Environment	The least intensive/restrictive setting of care sufficient to effectively treat an individual.
Licensed Independent Practitioner	Medical doctors (MDs), practicing psychologists (PhDs) psychologist associates (master's level psychologist [LPAs]), master's level social workers (LCSWs), licensed marriage and family therapists (LMFTs), licensed professional counselors (LPCs), licensed clinical addictions specialists (LCASs), advanced practice psychiatric clinical nurse specialists, psychiatric nurse practitioners, and licensed physician assistants who are eligible to bill under their own license.
Limiting Referrals	A provider is allowed to serve a limited number of new (additional) members/ recipients or allowed to serve new (additional) members/recipients limited to specific services and/or sites.
Local Management Entity (LME)	A local political subdivision of the state of North Carolina as established under General Statute 122C.
LME-MCO (Local Management Entity-Managed Care Organization)	LME that is under contract with the Department to operate the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.
Managed Benefit	Services that require authorization from Utilization Management.
Managed Care Organization (MCO)	The organization providing health benefits to members.
Material Change	A material change in any written instrument is one which changes its legal meaning and effect.
Medicaid Identification (MID) Card:	The medical assistance eligibility certification card issued monthly by DMA to Medicaid recipients.
Medicaid for Infants and Children (MIC)	A program for medical assistance for children under the age of 19 whose countable income falls under a specific percentage of the federal poverty level and who are not already eligible for Medicaid in another category.
Medicaid for Pregnant Women (MPW)	A program for medical assistance for pregnant women whose income falls under a specified percentage of the federal poverty level and who are not already eligible in another category.
Medical Assistance (Medicaid) Program	NC Medicaid's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. se.

Medical Record	A single complete record which documents all healthcare services provided to an individual during any aspect of healthcare delivery. It serves to support decisions made in a Member's care, supports revenue sought from third-party payers and documents the services provided as legal testimony regarding the Member's illness or injury, response to treatment, and caregiver decisions.
Medically Necessary Services	A range of procedures or interventions that is 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, developmental disability or substance abuse condition; and • Necessary for and appropriate to the conditions, symptoms, intervention, diagnosis, or treatment of a mental health, developmental disability or substance abuse condition; and • Within generally accepted standards of medical practice; and • Not primarily for the convenience of a consumer; and • Performed in the least costly setting and manner appropriate to treat the individual's mental health, developmental disability or substance abuse condition.
Mediation	The process of bringing individuals or agencies in conflict together with a neutral third person who assists them in reaching a mutually agreeable solution.
MMIS	Medicaid Management Information System
Moratorium on the Expansion of Sites or Services	The provider may not submit an application to provide additional services or to provide services out of sites not in their contract.
Natural Resource Linking	Processes that maximize the use of family and community support systems to optimize functioning.
NC Innovations	A 1915(c) Home and Community-Based wavier for individuals with intellectual and/or developmental disabilities. 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 the LME/MCO can determine the size and scope of the provider network. This also allows for use of Medicaid funds for alternative services.

NCQA	National Council of Quality Assurance is an independent, 501(c)(3) non-profit organization whose mission is to improve health care quality through the following methodologies: accreditation and recognition programs with a rigorous review of key clinical and administrative processes, the Health Plan Employer Data and Information Set (HEIDS®) which is a tool used to measure performance in key areas, and through a comprehensive member satisfaction survey.
NC-TOPPS	The NC Treatment Outcomes and Program Performance System is a Division web-based system for gathering outcome and performance data on behalf of individuals with mental health and substance abuse concerns in North Carolina's public system of services. The NC-TOPPS system provides reliable information that is used to measure the impact of treatment, and improve services and manage quality throughout the service system.
NCTracks	The new multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.
Network Provider	An appropriately-credentialed provider of MH/IDD/SU services that has entered into a contract for participation in the Alliance network.
Out-of-Plan Services	Health care services, which 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 individuals served by Alliance.
Payment Suspension	The provider may continue to bill for claims, but payments will be suspended (wholly or partially) for a designated time period not to exceed six (6) months, unless payment suspension is required by 42 C.F.R. 455.23, in which case the suspension period remains in effect until the MID completes its investigation or legal proceedings related to the alleged fraud have been completed.
PIHP	Prepaid inpatient health plan.
Plan of Correction/ Corrective Action Plan	This is a written document developed by the provider that specifies how the provider will address each out-of-compliance finding, violation or deficiency identified by Alliance. Alliance will allow a minimum of thirty (30) calendar days for the provider to implement corrective action. Alliance will conduct implementation review(s) to ensure that the plan has been implemented and fully integrated into the provider's operation and that all deficiencies have been corrected and are unlikely to re-occur.
Primary Diagnosis	The most important or significant condition of an individual at any time during the course of treatment in terms of its implications for the individual's health, medical care and need for services.

Priority Populations	People who have the most severe type of mental illness, severe emotional disturbances, or substance abuse disorders with complicating life circumstances conditions, and/or who are in situations which impact their capacity to function, often resulting in high-risk behaviors.
Probation	Provider may be placed on probation with increased monitoring for a specified period of time, not to exceed 1 year.
Protected Health Information (PHI)	Under the U.S. Health Insurance Portability and Accountability Act (HIPAA), any information about health status, provision of health care, or payment for health care that can be linked to a specific individual.
Penetration Rate	The degree to which a defined population is served.
Person-Centered Planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. The person-centered planning process involves families, friends and professionals as the individual desires or requires. The resulting treatment document is the person-centered plan (PCP) or individual service plan (ISP).
Pre-Authorization (also called Initial Authorization)	The initial or first approval by Alliance's Utilization Department of a medically necessary service at a given level of care prior to service delivery.
Primary Clinician	A professional assigned after the initial intake that is ultimately responsible for implementation/coordination of the treatment plan/person-centered plan or treatment plan.
Prior Authorization	The act of authorizing specific services before they are rendered.
Prompt Payment Guidelines	State-mandated timelines that LME/MCOs must follow when adjudicating and paying claims.
Provider Network	The network of credentialed providers that have entered into contracts to furnish services to individuals served by Alliance.
Post-Payment Review (aka Billing Audit)	A review conducted by Alliance to assess the presence of appropriate documentation to support claims submitted for payment by Alliance.
Qualified Professional	Any individual with appropriate training or experience as specified by the North Carolina General Statues or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services in the field of mental health or intellectual/developmental disabilities, or substance abuse treatments or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors and certified counselors (NC General Statute 122C-3).

Recipient	A person who is receiving state-funded behavioral health, substance use disorder or intellectual and developmental disability services.
Provider Appeal	A review of a previous finding or decision by Alliance based on the Provider's Appeal Request and any additional materials presented by the Provider.
Recovery or Recoupment of identified overpayments	Recoupment of funds for all dates of services in which provider was identified to have been under an adverse action penalty, lapse in insurance, loss of accreditation or license, listed on the federal and/or North Carolina exclusions listings, lack of or inadequate documentation or other significant out-of-compliance finding/s.
Recredentialing	The review process to determine if a provider continues to meet the criteria for inclusion as a LME/MCO network provider.
Routine Need – Mental Health	A condition in which the person describes signs and symptoms which are resulting in impairment and functioning of life tasks, impact the person's ability to participate in daily living, and/or have markedly decreased the person's quality of life.
Routine Need – Substance Abuse	A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.
SED (Children with Severe Emotional Disturbances)	Individuals who: • Are age 17 or under • Have mental, behavioral, or emotional disturbance severe enough to substantially interfere with or limit the minor's role or function in family, school, or community activities • Score less than 60 on the Global Assessment of Functioning Scale (GAF).
Service Location	Any location at which an individual may obtain any covered service from a network provider.
Site or Service Specific Termination	One or multiple sites and/or services are terminated from the Network.

SMI (Persons with Severe Mental Illness)	Describes individuals who: • Are age 18 or older • Have substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life • Score less than or equal to 50 on the Global Assessment of Functioning Scale (GAF), or • Have had 1 or more psychiatric hospitalizations or crisis home admissions in the last year.
SNAP	Measurement used for level of care for I/DD. This scale will be replaced by the Supports Intensity Scale (SIS).
Special Needs Population	Population cohorts defined by diagnostic, demographic and behavioral characteristics that are identified in a managed care waiver. The managed care organization responsible for waiver operations must identify and ensure that these individuals receive appropriate assessment and services.
Spend Down	Medicaid term used to indicate the dollar amount of charges an individual with Medicaid must incur before Medicaid coverage begins during a specified period of time. These may also be referred to as Medicaid deductibles.

SPMI (Persons with Severe and Persistent Mental Illness)	Describes individuals who:
	• Are age 18 or older
	• Have a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life
	• Score less than or equal to 30 on the Global Assessment of Functioning Scale (GAF), AND
	• Have had 3 or more psychiatric hospitalizations or crisis home admissions in the last year.
	• Includes all individuals diagnosed with:
	  • Bipolar disorders 296.00-296.96.
	  • Schizophrenia 295.20-295.90.
	  • Major depressive disorders 296.20-296.36.

Support Plan	A component of the person-centered plan that addresses the treatment needs, natural resources, and community resources needed for the individual to achieve personal goals and to live in the least restrictive setting possible.

Suspension from Network	Provider may be suspended from participating in the Alliance Network for a period of time in which all members/recipients are transitioned to other provider/s. Alliance will not reimburse claims for services provided during any period of suspension and the provider is not allowed to serve any new (additional) members/recipients.
Suspension of Referrals	A provider is not allowed to serve any new (additional) members/recipients.
Termination from Network	Provider is terminated from the Network including all sites and services.
The Joint Commission (TJC)	The national accrediting organization that evaluates and certifies hospitals and other health care organizations as meeting certain administrative and operational standards.
Third-Party Billing	Services billed to an insurance company, Medicare or another agency.
Treatment Planning Case Management	A managed care function that ensures that individuals meeting special needs population criteria receive needed assessments and assistance in accessing services. Alliance care coordinators carry out this function working with providers if the individual is already engaged with providers, or assists in connecting and engaging the individual with providers that will provide the necessary services to meet their needs. Activities may include: • Referral for assessment of the eligible individual to determine service needs. • Development of a specific care plan. • Referral and related activities to help the individual obtain needed services. • Monitoring and follow-up.
Unmanaged Benefit	Services that do not require authorization from Utilization Management (UM).
URAC	The national accrediting body under which Alliance Health is accredited.
Urgent Need Mental Health	A condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage, has potential to become actively suicidal or homicidal without immediate intervention, a condition which could rapidly deteriorate without immediate intervention, and/or without diversion and intervention will progress to the need for emergent services and care.
Urgent Need Substance Abuse	A condition in which the person is not imminently at risk of harm to themself or others or unable to adequately care for themself, but by virtue of their substance use is in need of prompt assistance to avoid further deterioration in their condition which could require emergency assistance.

Utilization Review	A formal review of the appropriateness and medical necessity of behavioral health services to determine if the service is appropriate, if the goals are being achieved, or if changes need to be made in the person-centered plan or services and supports provided.
Utilization Management Authorization	The process of evaluating the medical necessity, appropriateness and efficiency of behavioral health care services against established guidelines and criteria and to ensure that the client receives necessary, appropriate, high-quality care in a cost-effective manner.
Utilization Review Manager	LME/MCO qualified professional who reviews an individual's clinical data to determine the clinical necessity of care and authorizes services associated with the plan of care.
Warning	Formal warning letter notifying provider of the potential for increased monitoring/sanctions/possible loss of contract with additional violations in the specified time period. Letter may include references or clarification of expectations per contract, rules, statutes, law, or other standards and best practices.
Waste and Abuse	Incidents or practices that are inconsistent with sound fiscal, business or medical practices that could result in unnecessary costs to Alliance, the state or federal government, or another organization. Waste could also result in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

Appendix B: Commonly Used Acronyms

A	
AA	Alcoholics Anonymous
ABD	Aged Blind and Disabled
ACH	Adult Care Home
ACR	Assignment of Care Responsibility (form)
A-CRA	Adolescent Community Reinforcement Approach
ACTT	Assertive Community Treatment Team
ADA	Americans with Disabilities Act
ADATC	Alcohol and Drug Abuse Treatment Center
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADVP	Adult Developmental Vocational Program
AFL	Alternative Family Living
AMA	American Medical Association
AMH	Adult Mental Health
AMI	Alliance for the Mentally Ill
AOC	Administrative Office of the Courts
AOD	Alcohol and Other Drugs
AP	Associate Professional
APS	Adult Protective Services
ASAM	American Society of Addiction Medicine
ATOD	Alcohol Tobacco and Other Drugs

B	
BCBS	Blue Cross/Blue Shield
BD	Behaviorally Disturbed
BEH	Behaviorally/Emotionally Handicapped
BSH	Broughton State Hospital
C	
CABHA	Critical Access Behavioral Health Agency
CALOCUS	(C & A LOCUS) Child and Adolescent Level of Care Utilization System
CAP	Community Alternative Program
CAP-DA	Community Alternative Program for Disabled Adults
CAP-C	Community Alternative Program for Children
CAP-I/DD MR/ DD	Community Alternative Program for Persons with Intellectual/ Developmental Disabilities
CARF	Commission on Accreditation of Rehabilitation Facilities
CASP	Cross Area Service Program
CBT	Cognitive Behavioral Therapy
CC	Care Coordination
CCA	Comprehensive Clinical Assessment
CCS	Certified Clinical Supervisor (NCSAPPB)
CCIS	Care Coordination Information System
CCNC	Community Care of North Carolina
CDSA	Child Developmental Service Agency
CDW	Client Data Warehouse
CFAC	Consumer and Family Advisory Committee
CFS	Child and Family Services
CFT	Child and Family Team

CG	Community Guide
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Team (Law Enforcement & Fire/Police)
CM	Care Management
CMH	Child Mental Health
CMHREF	Child MH/SA Referral Number (Medicaid clients only)
CMS	Centers for Medicare and Medicaid (formerly HCFA)
CMSED	Child Mental Health Severely Emotionally Disturbed
COA	Council on Accreditation
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget and Reconciliation Act
CPS	Child Protective Services
CPT	Current Procedural Terminology (Reimbursement Codes)
CQI	Continuous Quality Improvement
CQL	Council on Quality and Leadership
CRA	Community Reinforcement Approach
CRE	Case Responsible Entity
CRH	Central Regional Hospital
CRIPA	Civil Rights of Institutionalized Persons Act
CSA	Child Substance Abuse
CSAP	Center for Substance Abuse Prevention (federal)
CST	Community Support Team
CSU	Crisis Stabilization Unit
CT	Cognitive Therapy

D	
D.A.	Diagnostic Assessment
DBA	Doing Business As
DBT	Dialectical Behavioral Therapy
DCI	Description of Clinical Issues (form)
DD	Developmental Disability/Developmentally Delayed
DDE	Direct Data Entry (for claims)
DDS	Disability Determination Services
DEC	Developmental Evaluation Center
DENR	Department of Environment and Natural Resources
DHHS	Department of Health and Human Services
DHSR	Division of Health Services Regulation
DJJ	Division of Juvenile Justice
DHB	Division of Health Benefits
DME	Durable Medical Equipment
DMH/DD/ SAS	Division of Mental Health/Developmental Disabilities/Substance Abuse Services
DOB	Date of Birth
DOC	Department of Corrections
DOE	Department of Education
DOJ	Department of Justice
DOS	Date of Service
DPI	Department of Public Instruction
DPS	Department of Public Safety
DSB	Division of Services for the Blind
DSDHH	Division of Services for the Deaf and Hard of Hearing

DSM-V	Diagnostic and Statistical Manual of Mental Disorders
DSS	(County) Department of Social Services
DWI	Driving While Impaired
Dx	Diagnosis
E	
EBD	Emotionally/Behaviorally Disturbed
EBP	Evidence-Based Practice
ECAC	Exceptional Children’s Assistance Center
ECI	Early Childhood Intervention
ECS	Electronic Claims Submission
ED	Emergency Department
EDI	Electronic Data Interchange
EHA	Education for All Handicapped Children Act
ELP	Essential Lifestyle Plan
ELT	Executive Leadership Team
EMR	Electronic Medical Record
EMTALA	Emergency Medical Treatment Active Labor Act
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ES	Emergency Services
F	
FASD	Fetal Alcohol Spectrum Disorder
F&CS	Family and Children's Services
FC	Foster Care
FCH	Foster Care Home

FDA	Food and Drug Administration
FEM	Frequency and Extent of Monitoring
FNS	Food and Nutrition Services
FPL	Federal Poverty Level
FSN	Family Support Network
FSQ	Family Satisfaction Questionnaire
FY	Fiscal Year
G	
GAAP	Generally Accepted Accounting Principles
GAIN	Global Appraisal of Individual Needs
GAST	Geriatric/Adult Mental Health Specialty Team
GCC	Governor's Crime Commission
GS	General Statutes
H	
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act of 1996
HIPP	Health Insurance Premium Payment
HMO	Health Maintenance Organization HR Human Resources
HUD	U.S. Department of Housing and Urban Development
I	
I&R	Information and Referral
IAC	Interagency Council
ICC	Interagency Coordinating Council

ICD-9	International Statistical Classifications of Diseases (diagnostic codes)
ICD-10	International Statistical Classifications of Diseases (diagnostic codes)
ICF	Intermediate Care Facility
ICF-I//DD	Intermediate Care Facility for Persons with Intellectual/ Developmental Disabilities
I/DD	Intellectual/Developmental Disability
IDEA	Individuals with Disabilities Act
IEP	Individualized Education Program
IFSP	Individual Family Services Plan
IIH	Intensive In-Home Services
ILC	Independent Living Center
IOP	Intensive Outpatient Program (Substance Abuse)
IRIS	Incident Response Improvement System
IRWG	Incident Reporting Work Group
IS	Information Systems
ISP	Individual Service Plan
IVC	Involuntary Commitment
J/K	
JCAHO	The Joint Commission, formerly known as Joint Commission on Accreditation of Healthcare Organizations
JCC	Juvenile Court Counselor
JCPC	Juvenile Crime Prevention Council
JDC	Juvenile Detention Center
JJSAMHP	Juvenile Justice Substance Abuse/Mental
JOBS	Health Partnership Job Opportunities and Basic Skills Program
JTPA	Job Training Partnership Act

L	
LCAS	Licensed Clinical Addictions Specialist
LCSW	Licensed Clinical Social Worker
LEA	Local Education Agency
LIAD	LME Individual Admission and Discharge (form)
LIP	Licensed Independent Practitioner
LME	Local Management Entity
LME/MCO	Local Management Entity/Managed Care Organization
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOCUS	Level of Care Utilization System for Psychiatric Services
LON	Letter of Notification
LP	Licensed Professional
LPA	Licensed Professional Associate
LPC	Licensed Professional Counselor
M	
MCH	Maternal and Child Health
MCM	Mobile Crisis Management
MFP	Money Follows the Person
MHBG	Mental Health Block Grant
MI	Motivational Interviewing
MOE	Maintenance of Effort
MST	Multi-systemic Therapy
MCO	Managed Care Organization
MH	Mental Health

MID	Medicaid Identification Number
MOU	Memorandum of Understanding
MRA	Maximum Reimbursable Amount
MRR	Medicaid Reimbursement Rate
MSW	Master of Social Work
N	
NA	Narcotics Anonymous
NAMI	National Alliance on Mental Illness
NCAC	North Carolina Administrative Code
NCBLPC	North Carolina Board of Licensed Professional Counselors
NCGS	North Carolina General Statute
NCHFA	North Carolina Housing Finance Agency
NCSAPPB	North Carolina Substance Abuse Professional Practice Board
NC SNAP	North Carolina Support Needs Assistance Profile
NC-TOPPS	North Carolina Treatment Outcome Program Performance System
NEA	Notification of Endorsement Action
NIDA	National Institute on Drug Abuse
NIMH	National Institute of Mental Health
NMHA	National Mental Health Association
Non-UCR	Non Unit Cost Reimbursement
NPI	National Provider Identification
NPPES	National Plan and Provider Enumeration System
NREPP	National Registry of Evidence-based Programs and Practices (SAMHSA)

O	
OAH	Office of Administrative Hearings
ODD	Oppositional Defiant Disorder
OJJDP	Office of Juvenile Justice and Delinquency Prevention (national)
OMB	Office of Management and Budget
OPC	Outpatient Commitment
OTC	Over-the-Counter Medication
P	
PACT	Parents and Children Together (or Parent and Children Training)
PAC	Provider Advisory Council
PATH	Projects for Assistance in Transition from Homelessness
PCS	Personal Care Services
PCP	Person-Centered Plan
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PL	Public Law
PMPM	Per Member Per Month
PMT	Provider Monitoring Tool
PNO	Provider Network Operations Department (Alliance)
POC	Plan of Correction
POS	Place of Service
PSA	Public Service Announcement
PRTF	Psychiatric Residential Treatment Facility
PSR	Psychosocial Rehabilitation
PSS	Peer Support Services
PTSD	Post-Traumatic Stress Disorder

Q	
QA	Quality Assurance
QDDP	Qualified Developmental Disability Professional
QI	Quality Improvement
QM	Quality Management
QMHP	Qualified Mental Health Professional
QP	Qualified Professional
QSAP	Qualified Substance Abuse Professional
R	
RA	Remittance Advice
RAD	Reactive Attachment Disorder
RARF	Regional Assessment and Referral Form
RFA	Request for Application
RFP	Request for Proposal
RMDM	Records Management and Documents Manual
S	
SA	Substance Abuse OR Special Assistance
SACOT	Substance Abuse Comprehensive Outpatient Treatment
SAIH	Special Assistance In-Home
SAIOP	Substance Abuse Intensive Outpatient Program
SAMHSA	Substance Abuse Mental Health Services Administration (Federal)
SAPTBG	Substance Abuse Prevention and Treatment Block Grant
SAR	Service Authorization Request
SAS	Substance Abuse Services
SED	Seriously Emotionally Disturbed

SCFAC	State Consumer and Family Advisory Committee
SFY	State Fiscal Year
SIPS	State Information Processing System
SIS	Supports Intensity Scale
SMI	Serious Mental Illness
SPMI	Severe and Persistent Mental Illness
SOC	System of Care
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
STR	Screening, Triage, Referral (form)
SW	Social Worker
T	
TA	Technical Assistance
TASC	Treatment Accountability for Safer Communities
TBI	Traumatic Brain Injury
T/C	Telephone Call
TEACCH	Treatment and Education of Autistic Children and Other Communication Handicaps
TFC	Therapeutic Foster Care
TJC	The Joint Commission, formerly known as Joint Commission on Accreditation of Healthcare Organizations
TP	Target Population (Target Pop)
TPA	Trading Partner Agreement
TPL	Third Party Liability

TTY	Teletext Device Typewriter
Tx	Treatment
U	
UCR	Unit Cost Reimbursement
UM	Utilization Management
UR	Utilization Review
V	
VA	Veterans Administration/Veterans Affairs
VR	Vocational Rehabilitation
W	
WF	Work First
WFFA	Work First Family Assistance (Nationally known as TANF)
WIC	Special Supplemental Food Program for Women, Infants and Children