



Odds & Ends about the webinar:

- ▶ Beth Lackey, Provider Network Director, is your moderator for today's webinar.
- ▶ The audience is in "listen only mode." You can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ▶ You may submit questions from today's webinar to:
questions@partnersbhm.org



Odds & Ends continued...

- Today's webinar is recorded and will be posted to the Partners BHM web page under the Provider Knowledge tab. Handouts will be uploaded to this page as well. Previous webinars are also on this page for your viewing pleasure!
- We have a very full agenda today with a wealth of information to share from various departments within Partners. Thank-you for joining us!





Welcome & Announcements

Annual Performance Reviews

- ▶ Currently updating the tool for annual provider performance reviews
- ▶ The new draft tool has additional questions i.e., National Accreditation verification for required services
- ▶ More provider training will be forthcoming prior to implementation
- ▶ Questions on the tool have been aligned with categories that are aligned with the Medicare MIPS system.



Provider Performance Reporting Items

- ▶ Data included for each provider:
 - Total number of unduplicated consumers served
 - Service-specific criteria (billing present for each type of service offered)
 - Claims/Authorization approval rate, NC TOPPs reporting, Monitoring, Fidelity Review, Ambulatory follow-up, Continuous Quality Improvement (CQI) and ACORN tool participation are meeting PBHM standards
 - Total number of grievances/complaints
 - Sanction/Plan of Corrections (POCs) practices are meeting PBHM standards
 - Quality of Care (QOC) practices are meeting PBHM standards
 - National Accreditation requirements and compliance
 - Electronic Health Record (EHR) & NC HealthConnex connectivity are meeting PBHM standards
 - Patient-centered Behavioral Health Model implemented
- ▶ Data will be updated annually.
- ▶ Additional data will be available as the reporting tool continues to develop.



9/13/2018

7

Draft Performance Category Scoring

Draft Performance Categories – items on the tool has been assigned to categories.

The categories are as follows:

- Quality (example, meets fidelity if required, National accreditation if required)
- Promoting Interoperability (example, Electronic Health Record)
- Clinical Practice Improvement (example, NC TOPPs, if application)
- Resource Use (example, claims approval rate)



Training will be forthcoming....Still in DRAFT format – More to Come!



9/13/2018

8

Important Information for Therapeutic Foster Care Providers

In an effort to improve the network and referral system of Therapeutic Foster Care services within our community, Partners Behavioral Health Management (PBHM) is **requiring** all contracted providers to complete a mandatory training that will teach attendees how to use the Rapid Resource for Families database. The purpose of this database is to improve referral responses and provide outcomes that will enhance the delivery of the therapeutic foster care services.

As this is a **mandatory** training, PBHM is offering two training dates for TFC providers, September 18, 2018 and September 24, 2018. Both trainings will begin promptly at 9:00 AM and end at 3:00 PM.

Please note: It is not required for providers to attend both trainings; however, a representative from your agency **must** attend one of these dates.

Please use the links below to register:

Delivery of TFC Training (for providers and MCO staff)

- September 18, 2018
- 9:00 a.m. – 3:00 p.m.
- [Registration Link](#)

Delivery of TFC Training (for providers and MCO staff)

- September 24, 2018
- 9:00 a.m. – 3:00 p.m.
- [Registration Link](#)



9/13/2018

9

Provider Network RFP

Request for Proposals (RFP) #0918-008 Residential Treatment Level III-Problem Sexual Behavior

- ▶ Partners Behavioral Health Management (Partners) is initiating **this RFP to identify** appropriately qualified organizations for the provision of *Residential Treatment Level III services with a specialty for problem sexual behavior*. The location for services is within Partners catchment area. **The organization providing services must have the capability and capacity to provide the needed services as well as demonstrate use of evidenced based practices and a strong system for outcomes measurement.** As described in [NC DMA Clinical Coverage Policy 8 D2](#); "Residential Treatment Level III service is responsive to the need for intensive, active therapeutic intervention, which requires a staff secure treatment setting in order to be successfully implemented. This setting has a higher level of consultative and direct service from psychologists, psychiatrists, medical professionals, etc. Staff are awake during sleep hours and supervision is continuous."
- ▶ The RFP offers an overview of Partners, the requirements to submit a proposal, and links for additional resources. Please review the RFP and if you are interested in being considered for provision of these services with Partners, you must register to attend the Mandatory Bidder's Conference to be held on **Monday, September 17, 2018, from 3:00 pm to 5:00 pm at Partners Behavioral Health Management, 1985 Tate Blvd SE, Multipurpose Room-Basement, Hickory, NC.**
- ▶ To view this RFP, please visit <https://providers.partnersbhm.org/request-for-services/>.
 - To be considered for provision of this service, you must
 - attend the Mandatory Bidders Conference,
 - follow the required RFP format and
 - submit your proposal to the RFP by Wednesday, October 10, 2018, by 5 p.m.
 - *Issuance of an RFI or RFP does not guarantee a financial award, nor does it indicate a commitment on the part of the issuer to pursue further contractual relationship*



9/13/2018

10

Important Provider Reminders

Attention Innovations Providers: Joint Communication Bulletin #J297 LME-MCO, LS v *Wos Instruction*

- ▶ On or after July 25, 2018, NC DHHS published online [#J297 LME-MCO, LS v *Wos Instruction*](#), regarding the State's settlement in December 2014 as to primarily Innovations Waiver utilization management and care coordination practices and communications.
- ▶ The bulletin indicates that DHHS will share it with Innovations beneficiaries and asks LME/MCOs to likewise share the bulletin with Innovations providers. While Partners has asked for some clarifications and edits, and a revised version of JCB297 might at some time issue in the future, the current version is substantially no different than what Partners' practices have been for many years—education without discouragement, ensuring consumers request what they feel are medically necessary, ensuring SIS scores and Base Budgets under Resource Allocation are guidelines only while medical necessity remains the standard for service request authorizations, etc.
- ▶ Innovations providers should review the bulletin as a reminder of these best practices.



9/13/2018 11

Important Provider Reminders (continued)

Attention IDD Providers: NC-SNAP

- ▶ Partners has received many calls concerning the NC-SNAP and who can complete one. An NC-SNAP is required for individuals with Intellectual and/or Developmental Disabilities receiving services funded by State funds (IPRS), B3, ICF-IID, and state developmental centers who do not have a Supports Intensity Scale (SIS) Assessment completed.
- ▶ **Completion of the NC-SNAP is the responsibility of the IDD agencies providing services.** Partners does not have the ability to complete NC-SNAPs on behalf of provider agencies. Agencies should have a certified NC-SNAP Examiner on staff. If your agency does not have a certified NC-SNAP Examiner on staff, Partners encourages you to work with other agencies to get NC-SNAPs updated annually as required.
- ▶ NC-SNAP trainings are offered monthly. Each agency should ensure that employees are registered for the next available NC-SNAP Certification training. The NC DHHS MH/DD/SAS website includes information about NC-SNAP Registration Procedures. To view the site, visit <https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile>.
- ▶ **NC-SNAP Training Registration Procedures:** Regularly scheduled NC-SNAP examiner training is held monthly on Dorothea Dix campus in Raleigh via DMH/DD/SAS. Trainings scheduled for the rest of the calendar year are listed below.
- ▶ All persons, except Developmental Center staff, are required to register through the area LME/MCO Training Coordinator. Developmental Center staff should register through your Developmental Center Training Coordinator.
- ▶ Training is provided free of charge and only to those referred by the LME/MCO or Developmental Centers (i.e., all persons referred for NC-SNAP training should have been assigned responsibility for the NC-SNAP by the LME/MCO, Developmental Center, or private provider).
- ▶ Contact information for DMH/DD/SAS training staff and for Partners' Training Coordinator is listed on the next slide.



9/13/2018 12

More NC SNAP Reminders

2018 NC-SNAP Examiner Certification Schedule: NC-SNAP certification is available to professional intellectual disabilities/developmental disabilities (ID/DD) staff responsible for completing or reviewing NC-SNAP assessments as part of their job responsibilities. To facilitate the registration process, staff responsible for completing the NC-SNAP should email their LME/MCO's Training Coordinator for assistance completing registration. **The Qualified Professional is not registered for scheduled certification training until he or she has received a confirmation letter.**

Upcoming Trainings:

Date	Time	Location	Contact
August			
8/20/2018 Class Full	1:00 – 4:00 p.m.	Dorothea Dix Hospital Brown Building, Room 104 801 Biggs Drive Raleigh, NC 27603	Registration requests for NC-SNAP examiner certification training should be directed to your LME-MCO training coordinator.
September			
9/24/2018	1:00 – 4:00 p.m.	Dorothea Dix Hospital Brown Building, Room 104 801 Biggs Drive Raleigh, NC 27603	Registration requests for NC-SNAP examiner certification training should be directed to your LME-MCO training coordinator.
October			
10/15/2018	1:00 – 4:00 p.m.	Dorothea Dix Hospital Brown Building, Room 104 801 Biggs Drive Raleigh, NC 27603	Registration requests for NC-SNAP examiner certification training should be directed to your LME-MCO training coordinator.
November			
11/19/2018	1:00 – 4:00 p.m.	Dorothea Dix Hospital Brown Building, Room 104 801 Biggs Drive Raleigh, NC 27603	Registration requests for NC-SNAP examiner certification training should be directed to your LME-MCO training coordinator.
December			
12/03/2018	1:00 – 4:00 p.m.	Dorothea Dix Hospital Brown Building, Room 104 801 Biggs Drive Raleigh, NC 27603	Registration requests for NC-SNAP examiner certification training should be directed to your LME-MCO training coordinator.

- The NCDHHS NC-SNAP point of contact and Lead instructor is Rachel Noell, noell@dhhs.nc.gov, 919-715-1294
- Partners Training Coordinator is Kali Sbalbi, Training@PartnersBHM.org, 704-884-2669

For additional information, visit: <https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile>.



9/13/2018

13

One Last NC SNAP Reminder

- An NC-SNAP is valid for one year. Authorization periods must be covered by a valid NC-SNAP. A gap in NC-SNAP coverage dates could result in recoupment of claims.
- A NC-SNAP Update must be completed if the consumer is transferred to another IDD service provider, is discharged, or will no longer receive any IDD services (including transitioning to non-IDD services). An update is done by completing the NC-SNAP Summary Report & Supplemental Information form (cover sheet), marking the Change in DD Support Status, and indicating the changes on the form.
- Fax updates to **704-884-2690** AND upload into AlphaMCS. Providers must do both to be in compliance.
 - All complete NC-SNAPs and updates must be faxed to **704-884-2690**; Attention: Laura Reisinger and Roxann Revels. These are entered into the North Carolina NC-SNAP Database.
 - Complete NC-SNAPs (all pages) and updates must be uploaded into AlphaMCS.
- If you have questions you may contact **Laura Reisinger** by email at lreisinger@partnersbhm.org; by phone at **704-884-2645** or fax to **704-884-2690**.



9/13/2018

14

Regional Individual Placement and Support (IPS) Coalition Meeting—Registration Now Open

The Institute for Best Practices, UNC Center for Excellence in Community Mental Health is hosting a regional Individual Placement and Support (IPS) Coalition meeting on Thursday, September 13 from 10 a.m.-3 p.m. in Benson, NC and Marion, NC.

During the meeting, the group will discuss the mission of the IPS Coalition, brainstorm solutions to implementation barriers, provide updates, and plan for the Coalition's future.

Who should attend? IPS Team members, provider agency leadership, and employees from LME/MCOs, Vocational Rehabilitation, and the Division of Mental Health/Developmental Disabilities/Substance Use Services.

To learn more or register, click on the location where you plan to attend:

East IPS Coalition, Benson:

Benson Conference Center
303 W. Church Street
Benson, NC 27504

West IPS Coalition, Marion:

McDowell Technical Community College
54 College Drive
William Harold Smith Building, Room 113
Marion, NC 28752



9/13/2018 15

Did you know, you can offer appointments through our AlphaMCS slot scheduler?

Providers offering appointments through the AlphaMCS Slot Scheduler need to ensure that appointments are scheduled correctly. Please make sure that your appointments account for the:

correct operating hours over holidays and vacations.

type of funding and clients served (Medicaid or State).

Providers should upload appointments for the next month at least two weeks prior to the beginning of the month. In addition, please inform Access to Care if you are adjusting hours due to operational changes.

If you have any questions, please contact Access to Care at **1-888-235-4673**.



9/13/2018 16

Partners Provider Council

Partners Provider Council: Partners Provider Council will meet on Friday, September 28, 2018 at Partners Hickory Office, Basement Multipurpose Room. Providers meet from 9:30-10:30 a.m., and Partners employees join the meeting from 10:30 a.m.-12 p.m.

- The Partners Provider Council is a professional representative and advocate for all service providers in the Partners' catchment area. The Council facilitates an open exchange of ideas and brings forward concerns and solutions while promoting collaboration and mutual accountability among providers. All providers are welcome to attend Provider Council meetings. To learn more, please visit <https://providers.partnersbhm.org/provider-council/>.
- *In addition, the IDD Sub-Committee* will resume meetings in September, directly after the Provider Council meeting. The sub-committee is also scheduled to meet in December, March, and June.



9/13/2018 17



**Let's see what's new in
the Provider Operations
Manual..**



**Roanna Newton
Provider Network
Development Specialist**

**Provider Operations Manual
Changes**

**This PPT reflects primary
changes only to the Provider
Operations Manual with
the version effective
August 15, 2018.**



Provider Operations Manual Changes

- ▶ **Information Technology**-update to Provider Profile Information section, page 24
- ▶ **Grievance and Complaint Process**-Legal Department manages grievances/complaints, page 15
- ▶ **Multiple Sections**-Quality Management conducts monitoring and site visits
- ▶ **Incident Monitoring**-Quality Management receives verbal notification of deaths and level III incidents. page 17



9/13/2018 21

Provider Operations Manual Changes

- ▶ **Plans of Correction**-update to plan of action section, page 55
- ▶ **Relative/Legal Guardians as Direct Support Employee**-updates services to Community Living and Supports, page 61
- ▶ **IDD Care Coordination**-Specific Requirements for Providers of North Carolina Innovations section updated to reflect change in services to Community Living and Supports, page 77



9/13/2018 22

Provider Operations Manual Changes

Credentialing, pages 39-48:

- ▶ Denials of Requests for Nomination or Changes result in a phone call followed by a letter of notification
- ▶ Providers have 10 business days to respond to requests for additional information to complete an application
- ▶ Credentialing and Recredentialing of Hospitals and/or Health Systems section updated



9/13/2018 23

Provider Operations Manual Changes

Credentialing, pages 39-48:

- ▶ Recredentialing updated
- ▶ Verifications and Good Standing updated
- ▶ Continuous Monitoring of Credentials Updated
- ▶ Consumer Safety Credentialing Investigation updated



9/13/2018 24

Provider Operations Manual Changes

- ▶ **Utilization Management**-Added section named Post Stabilization Services, page 101
- ▶ **Decisions to Deny/Reduce/Suspend/Terminate a Medicaid Service**-Continuation of Benefits Section update to “the Reconsideration involves the termination, suspension or reduction of a *previously* authorized service” page 106



9/13/2018 25

Provider Operations Manual Changes

- ▶ **Decisions to Deny/Reduce/Suspend/Terminate a Medicaid Service**-Appeals filed after February 1, 2013 updated to reflect change to 120 days to file an appeal, page 112
- ▶ **Medicaid Claims Filing Requirement**- Added section for Provider Billing of Patients Who are Medicaid Recipients, pages 140-141
- ▶ **Helpful Websites**-added resource links, page 166



9/13/2018 26

Provider Operations Manual

Providers are responsible for all information contained in the Provider Operations Manual and should review all sections.



9/13/2018 27



A Quick Reminder: NC Health Connex

REMINDER

NC HealthConnex

All providers must be enrolled or have a State approved extension by June 1, 2019

If you don't, you won't get paid.



- ▶ Handouts with information pertaining to NC Health Connex will be uploaded to the Partners BHM webpage under the webinar tab.
- ▶ Link for Provider webinar:
- ▶ <https://providers.partnersbhm.org/provider-webinars-forums/>





Up Next: The Cures Act Beth Lackey for Barbara Hallisey

9/13/2018 1



Cures Act Funding Year Two

21st Century Cures Act

First year (May 2017 – April 2018)

NC received more than \$15.5 million, served 5,704 people with OUD

20% for Prevention:

Two additional Partners' counties received full-time position
 Surry & Yadkin (Burke, Cleveland, Gaston, Iredell)
 Additional Naloxone purchases

80% for Treatment

Primary focus on Medication Assisted Treatment (MAT) as the
 best Evidence-Based Practice —established IPRS contracts
 with Opioid Treatment Providers (OTP) and Office-Based
 Opioid Treatment (OBOTs -Suboxone providers)



9/13/2018 33

Partners Cures Funding FY19

Funding Source	Funding Type	Funding Amount	Purpose
ASOUD	UCR	\$1,212,066	Opioid Treatment Services
Opioid STR	NonUCR	\$100,000	Peer Support in OTPs
ASOUD	UCR	\$291,667	Opioid Treatment Services
State Special Categorical	NonUCR	\$171,667	OD Response Teams; Meds & Testing
Prevention	NonUCR	\$216,243	Surry & Yadkin; and mentoring
		\$1,991,643	Total allocation

Continue to restrict ASOUD Target Population to a small number of providers

Allocations focused primarily on Medication Assisted Treatment (MAT)

State removed FBC/Detox from service array 7/1/18



9/13/2018 34

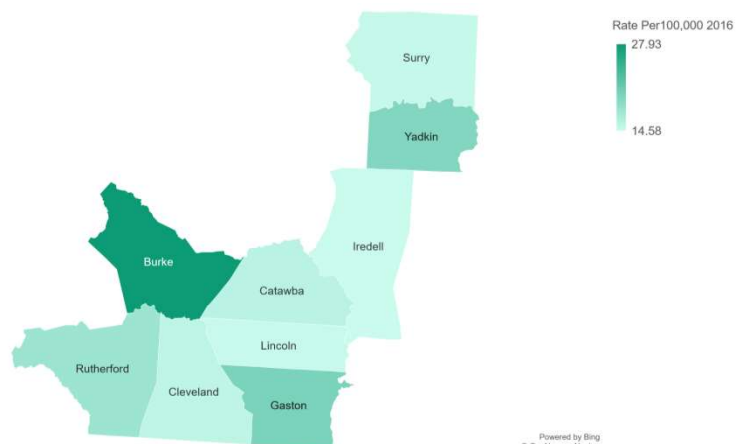
NC Award runs 5/1/17 – 4/30/19

- ▶ Prevention (20% of funding)
 - Expansion of Partnership For Success (PFS) grants
 - **Surry** and **Yadkin** now have Prevention Coordinators through Insight Human Services
 - 3 of our existing PFS grants received funding to provide technical assistance to the new recipients
- ▶ Treatment and Recovery Services (80%)
 - Increasing the number served with Medication Assisted Treatment (MAT)
 - Must serve 1,520 for 2nd year (statewide)

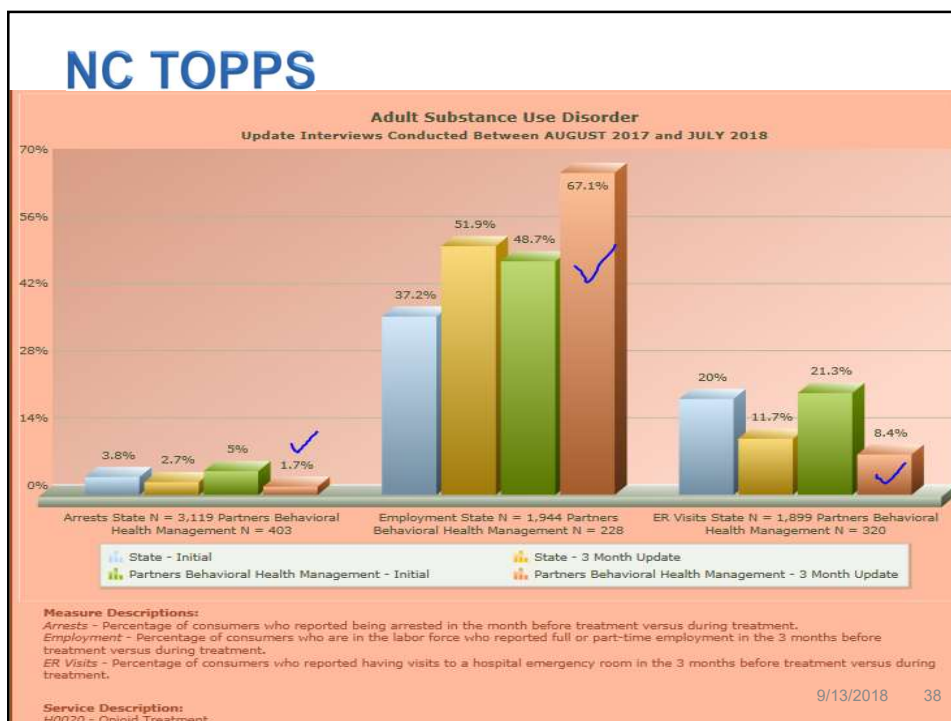
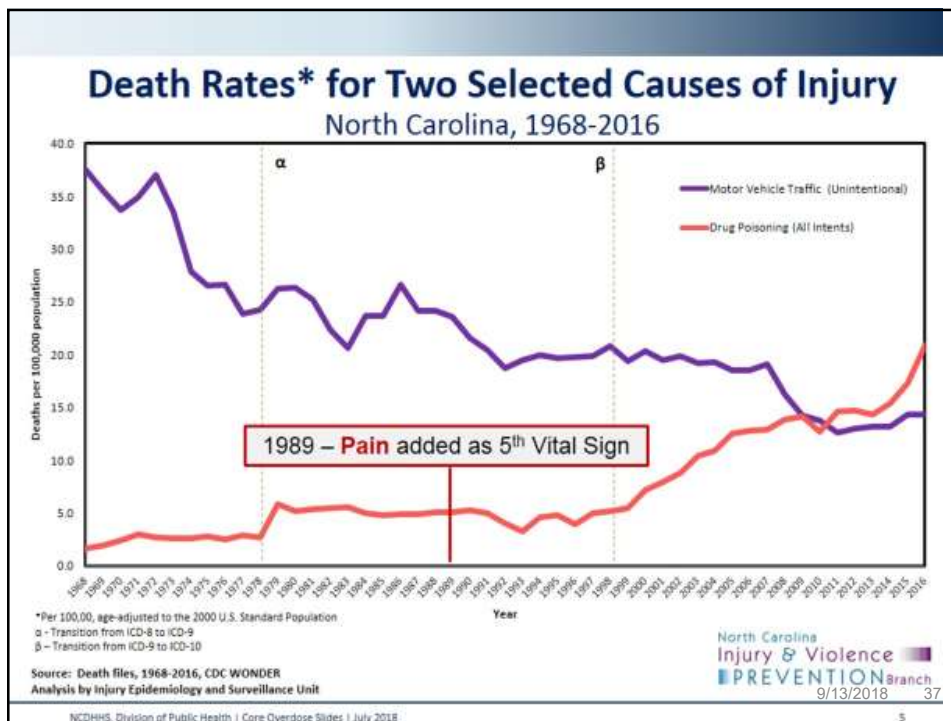


9/13/2018 35

Continue to have high death rates



9/13/2018 36



Lessons Learned

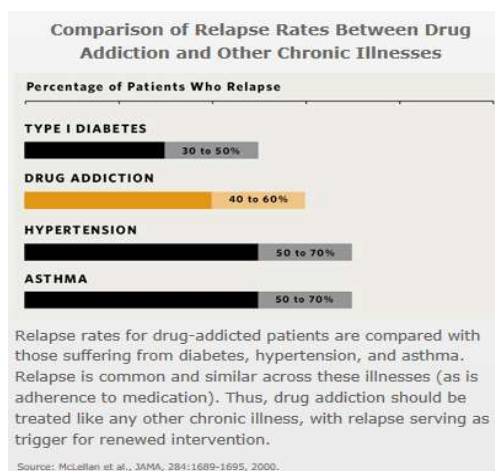
- Peers have a very positive impact on engagement
- Great deal of prejudice & stigma still exists against what the clinical evidence shows as the most effective treatment for OUD – Medication Assisted Recovery (MAT)
- Detox increases the risk of overdose death and turns people off from treatment
- Treatments must be recovery-focused and long-term



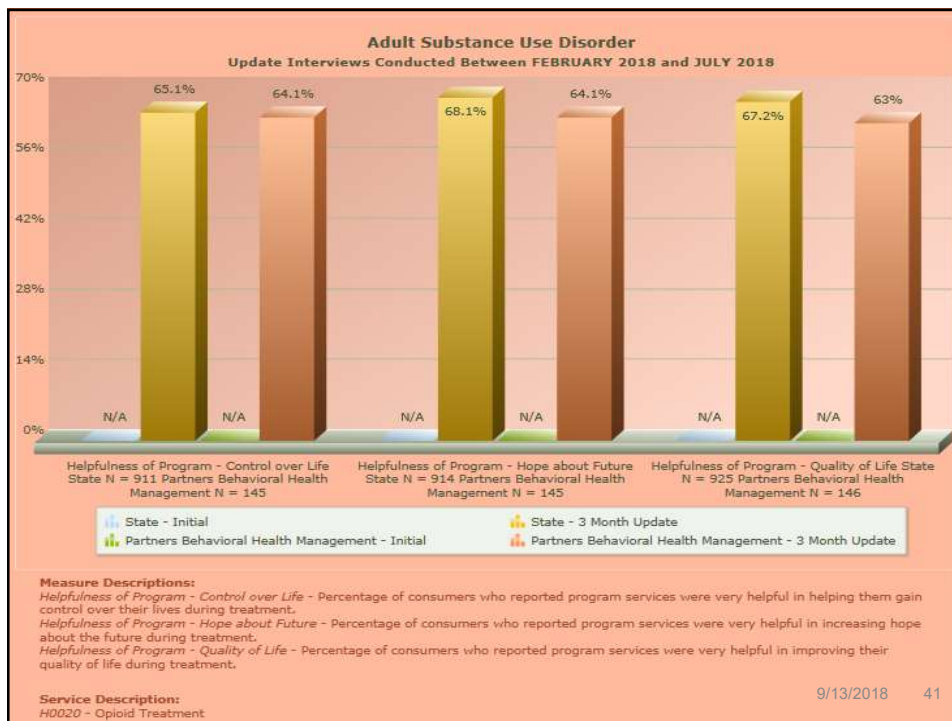
9/13/2018 39

Relapse is not unique to addiction

Typical in any chronic disease. Maintaining changes takes work and focus; people are human.



9/13/2018 40



Recovery

Home, Health, Purpose & Community

A process of change
through which individuals
improve their health and wellness,
live a self-directed life,
and strive to reach their full potential.

The Right Fix

Medication Assisted Treatment (MAT) is gold standard

- Includes medication and psychosocial treatments
- Bulk of Cures funding goes to this modality

Overdose Response Teams

- Rapid engagement of survivors for harm reduction & treatment
- Using Certified Peer Support Specialists
- Staying connected to individuals for up to 3 months

Recovery-Focused Peer Support Services

- Embedded CPSS staff into all four of the OTPs
- First in the state to pull off this collaboration



9/13/2018 43

Contact Information

Barbara Hallisey, MSW, LCSW

(704) 842-6418

bhallisey@partnersbhm.org



9/13/2018 44



Next, Everyone's favorite: NC Tracks Reverification



**NC Tracks Reverification
Beth Lackey
Provider Network Director**

NC TRACKS Reverification Overview

What is this about?

The Affordable Care Act mandates that all Medicaid Providers must be revalidated every 5 years. This is to ensure that provider information is accurate and current. As part of this process, the provider's credentials and qualifications will be evaluated to ensure they meet the professional requirements and are in good standing. The re-credentialing process also includes a criminal background check on all owners and managing relationships associated with this provider record.



9/13/2018 47

NC TRACKS Reverification Overview (continued)

► Is it Re-credentialing or Re-verification?

The terms re-credentialing and re-verification are used interchangeably in NCTracks. Either is acceptable.

► How will I know if I need to complete the Re-credentialing application?

You will receive a re-credentialing/re-verification invitation via their NCTracks secure portal, when you are scheduled to begin the re-credentialing process.

Note: Providers cannot access the re-credentialing application until they receive an invitation to begin the process.

► Is there a fee required?

A \$100 NC Application Fee is required from individual providers and \$100 NC Application Fee is also required per tax ID from organizations and atypical organizations if active in Medicaid and/or NCHC.

► How Much Time do I have to complete the Re-credentialing process?

Effective April 29, 2018, the provider is given 70 days from the notification date to complete the re-verification application. If the application is not completed within that time frame, the provider record will be suspended and claims will not be paid. The provider will receive a suspension letter via regular mail to the correspondence address on record as well as via the NCTracks message center. If suspended for failure to complete the re-verification/re-credentialing application, the provider will be notified of the date to submit the application by to avoid termination, which will be 50 days after suspension. To continue participation in the North Carolina DHHS program, the provider must complete the re-credentialing application by that date or NCTracks will terminate the DMA and DPH health plans. (The entire record is terminated only if all health plans are terminated.)

► What happens if I don't complete the Re-credentialing application?

Your enrollment will be terminated, and you will be required to submit a re-enrollment application if you wish to continue to render services with NC – Medicaid.



9/13/2018 48

How long do I have to update my accreditations/credentials/licenses in NC TRACKS?

- ▶ Providers must update their expiring licenses, certifications, and accreditations through a Manage Change Request (MCR) if their records are not up to date. The system suspends and terminates providers who fail to respond within the specified time limits for accreditations/credentials/licenses updates as well.
- ▶ Effective April 29, 2018, provider notifications to renew or update licensure, accreditation and/or certification are sent 60 days prior to the date of expiration of the license, certification, or accreditation on file. If the provider fails to renew update by the expiration date, the provider's participation will be suspended for 60 days.
- ▶ If the provider fails to renew during the 60-day suspension period, the taxonomy code(s) for which the license is required are terminated. Please note that if the license number on file (printed on the letter) is correct, and it is a NC Medical Board MD/PA/AA license, it will be updated automatically. Clinical Laboratory Improvement Amendments (CLIA) certifications will also be updated automatically. Licenses, certifications, and accreditations must be up to date to complete a re-verification/re-credentialing application.



9/13/2018 49

NC TRACKS Reverification FAQ Link – Important Information to Understand

- ▶ <https://www.nctracks.nc.gov/content/public/providers/provider-recredentialing/faqs-for-re-credentialing.html>



9/13/2018 50



What do I need to do for Credentialing?



Fielding Yelverton, Credentialing Supervisor

Credentialing Potpourri

- ▶ CAQH
- ▶ Re-credentialing/Contract Notices/Application Deadlines
- ▶ Credentialing vs. Enrollment
- ▶ National Plan and Provider Enumeration System (NPPES)/NC Tracks/Alpha
- ▶ Fair Credit Reporting Act (FCRA) release for background checks



9/13/2018 53

CAQH

- ▶ All clinicians must ensure that their CAQH information is up-to-date
 - You **must** complete *and upload* a state release/authorization specific to Partners in CAQH
 - This form can be found in CAQH
- ▶ Partners uses the contact information contained in your CAQH application as primary contact for clinician credentialing.



9/13/2018 54

Re-Credentialing/Contract Notices

- Six Months prior to the expiration of credentialing each provider (clinicians, LIPs as well as agencies) receives a re-credentialing notification.
 - The notice to associated clinicians and LIPs goes to the e-mail address on the clinicians' CAQH application.
 - The notice for agency re-credentialing goes to the agency credentialing contact via e-mail as well as to the CEO via certified mail.
- If Partners has not received a **complete** application 90 days prior to credentialing expiration then providers receive another e-mail notification.
 - Agencies and LIP's also receive a **contract warning** notice via certified mail at this point.
- No further notification is sent to associated clinicians. If an application is not received prior to the expiration date of credentials then the clinician is removed from the network.
- If Partners has not received a **complete** re-credentialing application from LIPs and agencies **60 days prior to credentialing expiration** then Partners issues a **contract non-renewal letter** via certified mail ending your participation in Partners' network effective the date of the credentialing expiration. Partners is required to begin notifying consumers that the provider is no longer eligible to offer services in the network at this point.



9/13/2018 55

Application Deadlines (cont)

- ▶ Please note that **receiving** the application will **not** stop the clock
- ▶ The application must be **complete** in order to avoid or stop the contract non-renewal process
- ▶ Also note that submitting the application on the deadline date does not allow time for review and could potentially result in contract non-renewal notification being issued in error. We ask that you allow ten (10) business days for your application to be reviewed.
- ▶ **Please remember: the contract non-renewal process can be avoided entirely by submitting your complete re-credentialing application in advance of the deadline specified in the notification(s) you receive from us.**



9/13/2018 56

Credentialing vs. Enrollment

- ▶ Credentialing and enrollment are two different processes within Partners
- ▶ Partners enrollment is separate from NC Tracks enrollment
- ▶ Application for enrollment with NC Tracks should be completed first (for providers who are new to Partners)
- ▶ While this application is being processed, the provider should apply for credentialing with Partners.
- ▶ The **credentialing** application process with **Partners CAN** be completed while enrollment with **NC Tracks** is still **pending**.
- ▶ **Enrollment** (in Alpha) with **Partners CANNOT** be completed until enrollment with **NC Tracks** is **completed**



9/13/2018 57

Credentialing vs. Enrollment (cont)

- ▶ In sum:
 - A provider CAN be **credentialled** with Partners BEFORE being **enrolled** with NC Tracks OR Partners
 - A provider CANNOT be **enrolled** with Partners before being BOTH **enrolled** in NC Tracks AND **credentialled** with Partners
- ▶ Recommendation: There is a PowerPoint presentation on Partners' Provider website that addresses the differences between credentialing and enrollment in depth.



9/13/2018 58

NPPES

- ▶ Addresses, taxonomies, NPI numbers must all match in:
 - NC Tracks
 - NPPES
 - Alpha
- ▶ Inconsistencies among these databases will not stop your credentialing application from being processed but will prevent you from billing
- ▶ For practices with multiple site addresses:
 - Partners staff can only see the first site address in NPPES.
 - You will need to print screen shots for all other site addresses and submit them along with your application materials



9/13/2018 59

NPPES – Making Changes to Information

- ▶ How to make changes to information in NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - Ask for “**role request**” to gain access to NPI information
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (**I&A**)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call.
 - Partners cannot process your credentialing application until your current practice site address (associated with your organizational NPI) is entered in NPPES



9/13/2018 60

FCRA form – from whom required

- ▶ In addition to the verifications and monitoring we are required to perform on clinician applicants, Partners is required to perform background checks and exclusions monitoring on:
 - Owners
 - Directors, and
 - Managing employees
- ▶ The FCRA form included in the re-/credentialing application materials is the release allowing us to perform the required background check



9/13/2018 61

Questions?

- ▶ Fielding Yelverton, Credentialing Supervisor
 - (704) 884-2505
 - fyelverton@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org



9/13/2018 62



What's this 1115 Waiver Thing?

Vision for North Carolina's Medicaid Managed Care Program

- August 9, 2018 the RFP for the Medicaid Managed Care Prepaid Health plans was released
- In 2015, the General Assembly directed the transition of Medicaid to a managed care structure.
- In managed care, DHHS will oversee all aspects of the Medicaid and NC Health Choice programs. However, PHPs will directly manage certain health services, assume financial risk and contract with providers to provide services for beneficiaries.
- This RFP reflects three years of collaboration with and extensive feedback from beneficiaries, clinicians, hospitals, counties, health plans, elected officials, advocates and other stakeholders to design the managed care program.
- DHHS hosted listening sessions across the state, reviewed more than one thousand written public comments and released 15 policy papers on different aspects of the program.
- This RFP is the largest procurement in DHHS history. It clearly communicates DHHS' requirements and defines the standards that PHPs must adhere to in contracting with DHHS. All plans will be subject to rigorous oversight by DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers among aspects of a successful managed care program.



Medicaid Managed Care

Among the innovations in this RFP for the North Carolina Medicaid managed care program are:

- The integration of physical health, behavioral health and pharmacy services so all managed care beneficiaries will have one insurance card and one health plan managing their care.
- An Advanced Medical Home (AMH) program that will preserve broad access to primary care services for Medicaid enrollees while strengthening the role of primary care in local care management, care coordination and quality improvement.
- Encouraging smart investments in areas that impact health outside of health care services, known as Opportunities for Health, in the domains of housing, food, transportation, employment and interpersonal safety, to build on work already being done in communities.
- This procurement is only for the Standard Plans in which most Medicaid managed care beneficiaries will be enrolled.
- DHHS will accept proposals from potential PHPs until Oct. 12, 2018. Both DHHS and the federal Centers for Medicare & Medicaid Services will have to approve the contract awards, which are anticipated to be announced on Feb. 4, 2019.

For more information about Medicaid managed care, visit the Medicaid Transformation website at <https://www.ncdhhs.gov/medicaid-transformation>.



9/13/2018 65

Goal of Medicaid Managed Care: Create an Innovative, Integrated and Well-Coordinated System of Care

- This RFP procures Standard Benefit Plans, which will provide integrated physical health, behavioral health and pharmacy services to the majority of Medicaid and NC Health Choice beneficiaries with lower intensity behavioral health needs.
- Beginning in 2021, most individuals with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability or a traumatic brain injury will receive integrated physical health, behavioral health, pharmacy services and I/DD services through Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), an integrated specialized managed care product.
- BH I/DD Tailored Plans will be procured later through a separate process, and this population will continue receiving benefits through a combination of Medicaid Fee-for-Service and LME-MCOs as they do today until BH I/DD Tailored Plans begin.



9/13/2018 66

Implement a groundbreaking Advanced Medical Home (AMH) program

- Building on the success of NC's current medical home model, the AMH program will preserve broad access to primary care services for Medicaid enrollees while strengthening the role of primary care in local care management, care coordination and quality improvement.
- The AMH program keeps the current Carolina ACCESS program payments to practices while also introducing new performance incentives for practices to become more focused on cost and quality outcomes over time by aligning payments for practices to specified measures, including total cost of care and health outcomes measures—which in turn links to PHPs' quality incentives set by DHHS.
- DHHS understands that payment reform takes time and that it is essential to preserve the strengths of today's system in the transition to managed care, and the AMH program introduces changes to payment models with sufficient time for clinicians to prepare. DHHS will support clinicians in the transition.



9/13/2018 67

Make smart investments in “Opportunities for Health”

- Research shows that overall health is driven by many things outside the four walls of a hospital or clinic.
- To ensure the most efficient managed care program and to build on work already being done by pediatricians, family physicians, community-based organizations and others, DHHS has identified five priority domains for making smart investments in Opportunities for Health: housing, food, transportation, employment and interpersonal safety.
- PHPs will offer screening and navigation support within these domains through their care management programs, quality standards, value-based payment strategies and the provision of *in lieu of* services.
- PHPs also are encouraged to voluntarily contribute to health-related resources targeted toward high-impact initiatives that improve health outcomes and cost-effective delivery of care in the regions and communities they serve.
- Additionally, PHPs will play a key role in DHHS' enhanced case management pilot with the goal of improving health and reducing health care costs.
- Subject to final negotiations of North Carolina's 1115 waiver application, the pilot will enroll a subset of high-need Medicaid beneficiaries that can most benefit from evidenced-based healthy opportunity interventions.



9/13/2018 68

Mitigate Clinician Administrative Burden whenever possible...

- DHHS is dedicated to maintaining broad clinician participation in Medicaid by reducing or mitigating clinician administrative burden whenever feasible. PHPs will be required to comply with DHHS efforts to ease clinician administrative burden, which include:
 - Standardizing and simplifying processes and standards across PHPs wherever appropriate
 - Incorporating a centralized, streamlined enrollment and credentialing process
 - Ensuring transparent payments for PHPs and fair contracting and payments for clinicians
 - Establishing a single statewide preferred drug list that all PHPs will be required to utilize
 - Requiring PHPs to cover the same services as Medicaid Fee-For-Service (with exception of services carved out of Medicaid managed care)
 - Requiring all PHPs to use DHHS' definition of "medical necessity" when making coverage decisions
 - Standardizing quality measures across PHPs



9/13/2018 69

Preserve strong clinician participation and fair payments to providers of care...

Under Section 5.(6)d. of Session Law 2015-245, PHPs must include all willing providers in their networks (except when the provider fails to meet objective quality standards or refuses to accept network rates) and must contract with all essential providers in their region, unless an alternative arrangement for members to access those services is approved by DHHS.



9/13/2018 70

Preserve strong clinician participation and fair payments to providers of care...

PHPs must pay all in-network primary and specialty care physicians and physician extenders no less than 100 percent of the current Medicaid Fee-For-Service rate. This rate floor will apply to in-network hospitals and nursing facilities for the first few years of the new managed care system (see later in this document for additional details on the hospital reimbursement methodology). To encourage innovation related to value-based payments, PHPs and clinicians may mutually agree to alternative reimbursement arrangements. Generally, PHPs must pay, deny or pend a claim within 30 calendar days of receipt (14 days for a pharmacy claim), or pay interest and a late payment penalty to the provider.



9/13/2018 71

Ensure PHPs maintain strong networks...

- The RFP contains specific standards around network adequacy, including time and distance and appointment wait time standards. In addition, Medicaid beneficiaries will receive adequate and timely coverage of out-
- of-network services (that have been pre-approved) if the PHP is unable to provide coverage within network on a timely basis.
- DHHS will closely monitor PHP Network Access Plans, which must demonstrate that the PHP has a network with the capacity to serve the expected enrollment.
- The Access Plan will be submitted annually and whenever there are substantial changes.
- To assist members in obtaining covered services from network care providers, PHPs will produce, monitor, and maintain consumer facing network care provider directories that are compliant with content requirements outlined in the RFP.



9/13/2018 72

Next Steps

RFP evaluation and award:

- DHHS will accept proposals from potential PHPs until October 12, 2018, at 2 p.m. EST.
- DHHS will first review offers to determine that they are in the proper form and include all required documents. The Evaluation Committee will then screen the offers to determine if the minimum qualifications have been met.
- The Evaluation Committee will evaluate proposals meeting the minimum qualifications and develop consensus ratings, ultimately developing an award selection that is aligned with state law, and will provide supporting documentation for their selection.
- DHHS will submit the contracts to the Federal Centers for Medicare & Medicaid Services for its approval.
- PHP contract awards are anticipated to be announced in February 2019.



9/13/2018 73

Anticipated Timelines

Now and ongoing. Care providers may be contacted by potential PHPs who wish to initiate contract discussions.

- **February 2019.** NC will award contracts to the selected health plans to be PHPs in managed care.
- **Summer 2019.** PHPs must have contracted with enough care providers for their network to meet DHHS standards.
- **July 2019.** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **July-September 2019.** Managed care will start in two phases. For regions of the state in Phase 1, this will be the window in which beneficiaries select a PHP.
- **November 2019.** The Medicaid managed care program will launch in regions in Phase 1.
- **October-December 2019.** For regions of the state in Phase 2, this will be the window in which beneficiaries select a PHP.
- **February 2020.** The Medicaid managed care program will launch in regions in Phase 2.



For more information as this transition occurs, please see this website:
<https://www.ncdhhs.gov/medicaid-transformation>

9/13/2018 74



Partners Vision and the 1115 Waiver Transition

Partners Vision: Culture of Collaboration

The Partners approach fosters strong collaboration and delivers quality care.

We believe in and are committed to:

- ✓ Maintaining collaboration
- ✓ Enhancing our collaboration as we seek participation of the best thinkers at all levels of the system to achieve effective care and raise the level of healthcare for all populations served
- ✓ Focus on specific outcomes, network accountability and re-investment in our providers and communities

1115 Transformation is a new lever that allows enhancement of our culture to improve performance of provider organizations and ultimately, population health.

Partners Vision & 1115 Waiver: Key Components

Partners is well positioned for the State's system transition and is actively evaluating and designing our role in preparation for the transformation.

Value Based Payment

Improved outcomes
Improved cost
Leveraging our provider's expertise and innovation
Improving the total network -raise all boats

Innovation

Whole Person Care
Evidence Based
Collaborative Care with Peers and Social Determinants of Health (SDOH)

Population Health

Provide network solutions that support population health across the full continuum of care

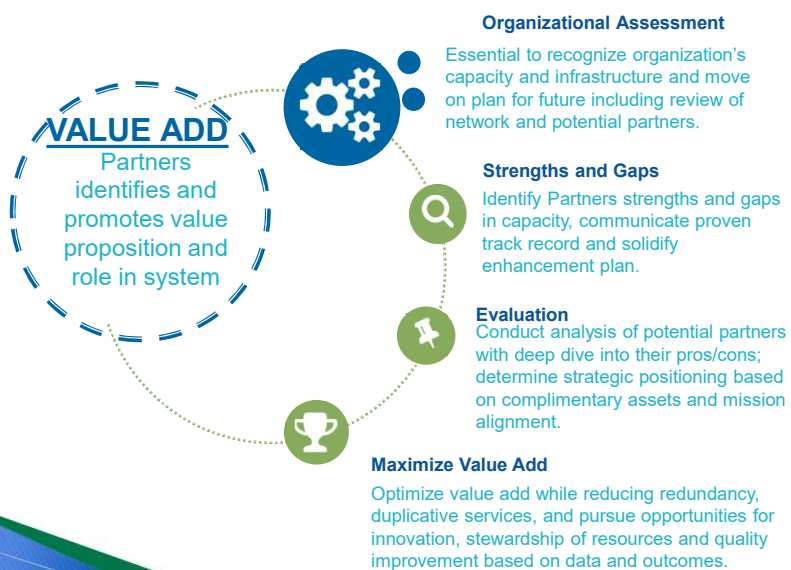
Health Plan Partner

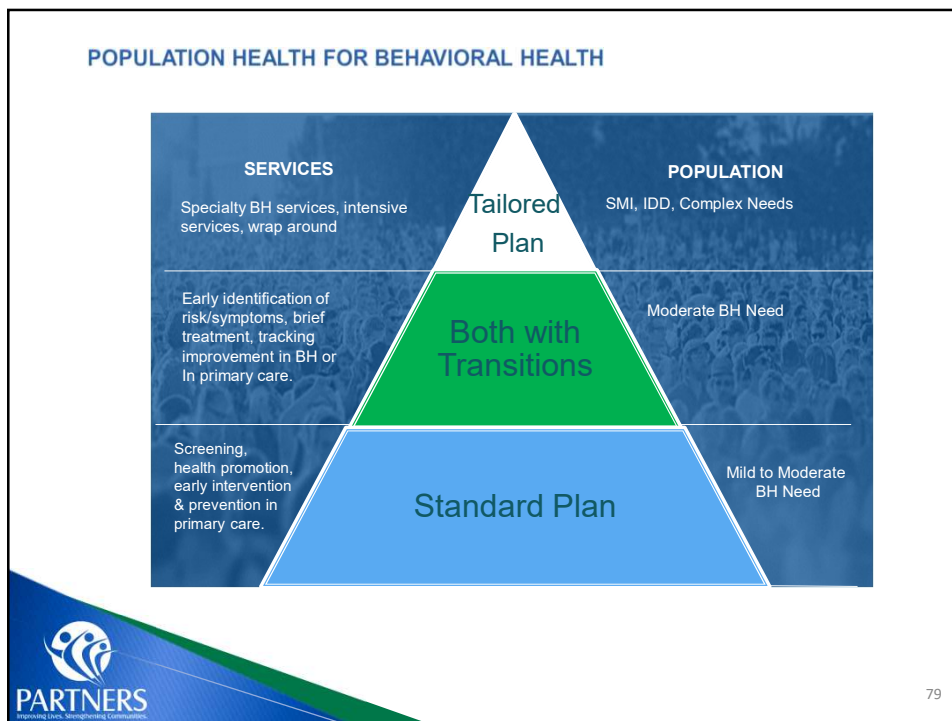
Shares mission and values
Believes in collaborative approach
Offers infrastructure to enhance current models and system of care



77

VISION: Achieving Vision Means Strong Network Through Collaboration and Accountability





Are you ready?

- ▶ The National Council of Behavioral Health has a great readiness assessment tool that is relevant in 1115 waiver planning.
- ▶ As an organization, assessing your strengths and weaknesses can assist in your focus and planning efforts.

https://www.thenationalcouncil.org/dl.php?file=/var/www/vhosts/thenationalcouncil.org/public_html/wp-content/uploads/2013/01/Provider-Readiness-Assessment.pdf

1115 Waiver Planning

- ▶ Partners has constituted a CEO Roundtable Discussion regarding 1115 waiver planning
- ▶ This Roundtable connects directly to the Provider Council as the chair of the Provider Council sits on this group
- ▶ The roundtable consists of large and small providers, across all disabilities, local, regional and statewide provider representation
- ▶ The purpose is to gain stakeholder input and planning to prepare for an 1115 waiver transition



9/13/2018 81



Does your Program have Integrity??



Documentation for Reimbursement

Provider Forum Webinar, September 12, 2018
Teresa Shirley, Program Integrity Lead Auditor

Purpose of this training...

- ▶ To briefly discuss NC Medicaid and Health Choice Clinical Coverage 8C section 7.3.5: Service Note and Progress Notes requirements
- ▶ Records Management and Documentation Manual APSM 45-2 section 8-5: Service Notes and Service Grids
- ▶ To assure services are well documented to support paid claims



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84

Documentation and reimbursement in a clinical setting:

Regulatory issues and reimbursement mechanisms have an enormous impact on the quality of care, the introduction to the latest technology, utilization of products and services, patient access to care and the actual outcomes of care delivered.



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85

Service and Procedure Codes

Clinical Coverage Policy 8C § 7.3.5 Service Notes and Progress Notes:

There must be a progress note for each treatment encounter that documents the following information:

- ☐ Date of service;
- ☐ Name of the service provided (e.g., Outpatient Therapy – Individual);
- ☐ Type of contact (face-to-face, phone call, collateral)
- ☐ Purpose of the contact (tied to the specific goals in the plan);



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86

Service and Procedure Codes Cont.

- ❑ Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary's plan;
- ❑ Effectiveness of the intervention(s) and the beneficiary's response or progress toward goal(s);
- ❑ The duration of the service (e.g., length of the assessment or treatment in minutes);
- ❑ Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and
- ❑ Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.



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87

FYI

The provider submitting the claim is responsible for providing upon request all pertinent information and records needed to support the services billed.



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88

An accurate record of the services or event should be depicted...

- Be specific to the consumer
- Be specific to the situation at the time of the encounter
- Accurately reflect the service performed
- Support the necessity of the services
- Clearly identify who performed the services and assessments documented clearly



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89

Record Management and Documentation Manual APSM 45-2 § 8.5 Contents of a Service Note

While there are no specific required formats for the documentation of service delivery, all services which require a service note must contain certain required elements. Service notes shall include, but are not limited to the following on every service note page:

- ▶ Name of the individual receiving the service
- ▶ Service record number of the individual
- ▶ Medicaid Identification Number for services reimbursed by Medicaid



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90

Contents of a Service Note cont.:

- ▶ Medicaid Identification Number for services reimbursed by Medicaid [on every service note page]
- ▶ Full date the service was provided [month/day/year]
- ▶ Name of the service provided [e.g., Community Support – Individual]
- ▶ Type of Contact [face to face, phone call, collateral]
- ▶ Place of service [when required by the service definition]
- ▶ Purpose of the contact [tied to specific goal(s) in the service plan]



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91

Contents of a Service Note cont.:

- ▶ Description of the intervention(s)/treatment/support provided. Interventions must include active engagement of the individual and relate to the goals and strategies outlined on the individual's PCP or service plan. NOTE: The interventions described in the service note, whether for periodic, day/night, or twenty-four hour services, must accurately reflect treatment for the duration of time indicated.
- ▶ Total amount of time spent performing the service [required for periodic services, unless the periodic service is billed on a per event basis, and any other service as required by the service definition, Medicaid Clinical Coverage Policies, or the Medicaid State Plan]. Some of the services for which the provider must record the amount of time spent performing the interventions are listed on the Service Duration Table in Appendix F of APSM 45-2.



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92

Contents of a Service Note cont.:

- ▶ Effectiveness of the intervention(s) and the individual's response/progress toward goal(s).
- ▶ For professionals: Signature, with credentials, degree, or licensure of clinician who provided the service. For licensed professionals, the full signature denotes the clinician's licensure and/or certification; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and should also include the individual's professional status [e.g., QP or AP], and any other certifications the person may hold [e.g., CSAC]. The signature must be handwritten; however, the credentials, degree, or licensure may be typed, printed or stamped.



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93

Finally...

The provider is responsible for staying abreast of the requirements for delivering the services that they are credentialed and contracted to provide in the Partners' closed Network.



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94

Helpful Links...

- ▶ Records Management and Documentation Manual:
<http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf>
- ▶ DMA Clinical Coverage Policies:
<http://www.ncdhhs.gov/dma/mp/>
- ▶ DHSR Mental Health Licensure Section:
<http://www.ncdhhs.gov/dhsr/mhlcs/mhpage.html>



August 9, 2018

95

Contact Information

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August 9, 2018

96



SAMHSA Update



Brief Overview of Partners NC System of Care Expansion Grant



Promotion, Prevention & Intervention

- ▶ Address SDOH
- ▶ Sustainable Plan
- ▶ Comprehensive Services
- ▶ Family and Youth Voice
- ▶ Improved Service Integration with successful engagement



99

Partners' SOC Expansion Grant builds upon two Partners' initiatives

- System of Care, a nationally-known program that brings child and family serving agencies together with the family to develop and implement services in the child's best interest; and
- Partners' innovative Whole Person Integrated Care model, which combines behavioral care, physical care, and peer support in one setting

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Population to be Served

Age Range	Diagnostic Criteria	Additional Criteria	Severity
Children and youth ages birth to 21, and their families	Criteria #1a: - Emotional, socio-emotional, behavioral, or mental disorder - diagnosable under the current DSM-4 or the ICD-9 equivalents or the DC: 0-3R if under age three OR Criteria 1b: is experiencing/at serious risk of first episode psychosis (FEP).	Criteria #2a -TWO or MORE of the following <u>additional criteria</u>: (1) trauma history (abuse, neglect, trafficking), (2) co-occurring substance use disorder, (3) Autism Spectrum Disorder; (4) two or more MH/SA hospitalizations; (5) an episode of care in a psychiatric residential facility; (6)currently involved with child welfare (e.g. in foster care); or, (7) currently involved with the Department of Juvenile Justice.	Criteria #2b: The combination and severity of additional criteria is assessed at high, medium or low severity: - If Criteria #1a OR #1b is YES, the Child and Adolescent Needs & Strengths tool (CANS) is administered with a clinical interview. - The results of this screening and assessment process are determined to be high, moderate or low severity in total (per CANS process)

Flow of Care - continued

Behaviorist provides Child and Adolescent Needs Assessment/CANS to identify level of care needed

- **Level 1 highest level of care:** High Fidelity Wraparound with access to all interventions available in the community • WPIC services to support the family and address social determinants, o continued healthcare access, o MH/SA individualized services from a whole person/whole family perspective, o linkage to a Medical Home of choice, • Triple P parenting training and support • Buffering Toxic Stress training, Transition to Independence (older youth)

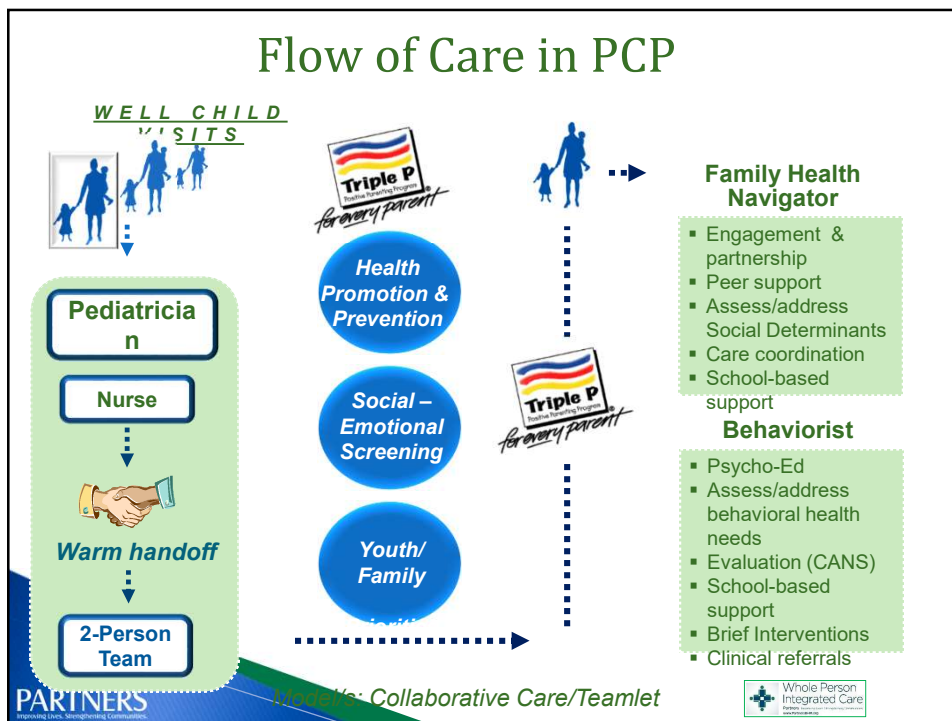
STEP DOWN TO LEVEL 2

- **Level 2 > high risk:** WPIC, o linkage to a Medical Home, • Triple P • Care Management • Triple P Level 3 services to support the parents on targeted behavioral issues • Care Coordination and access to all community resources • Buffering Toxic Stress training, • Transition to Independence (older youth)

STEP DOWN TO LEVEL 3

- **Level 3 at risk:** • normal targeted array of services delivered with a strengths-based focus, honoring youth and parent priorities, with access to • Buffering Toxic Stress training • Transition to Independence (older youth)

All children/youth are continuously monitored for potential change in need that may elevate them to Levels 1 or 2.



Community Resources & Support

Each participating PCP is supported through their county's Community Collaborative, to assist with:

- Access to community partners
- Assistance in accessing resources
- An array of child/youth/family services

Grant Activity

- ▶ Contract with Piedmont Adult and Pediatric Medicine Associates
- ▶ Provided Triple P Training to 20 individuals from all 4 counties
- ▶ Upcoming Train the Trainer on Buffering Toxic Stress
- ▶ Connecting with NAMI and Youth Moves to increase family/child voice



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SAMHSA SOC Expansion Grant

Lachelle Freeman, Project Director

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Shikeena Pope, Social Marketing Communication Lead

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ECHO/Perception of Care Study



Tamikka Woods
QA/QI Section Manager

- ▶ Allows the North Carolinas Department of Health and Human Services (DHHS) and LME/MCO's to identify key opportunities for improving members' experiences
- ▶ Helps identifying strengths and weaknesses in quality of care and services
- ▶ Provides data necessary to assess where resources can best be allocated
- ▶ Provides a way to see the effects of improvement efforts over time

PURPOSE



9/13/2018

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Experience of Care and Health Outcomes Survey (ECHO)

- ▶ Survey administered directly to consumers by the Carolina Center for Medical Excellence, a contracted agency with DMA
- ▶ The survey types include:
 - Child
 - Adult



9/13/2018

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Mental Health/Substance Abuse Consumer Perception of Care Survey

- ▶ Is the perception of individuals and families who received MH and/or SU services
- ▶ Administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and distributed by LME/MCO's annually
- ▶ Survey-type:
 - Adult
 - Youth
 - Child Family-Parents of children under 11 years of age



9/13/2018

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How did we do?



9/13/2018

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Results of ECHO Survey

- ▶ Child Domains has 4 Composites
 - Getting Treatment Quickly- 61.8%
 - How Well Clinicians Communicate- 91.8%
 - Getting Treatment and Information from the Plan- 43.6%
 - Perceived Improvement- 63.7%
- ▶ Adult Domains has 5 Composites
 - Getting Treatment Quickly- 65.6%
 - How Well Clinicians Communicate- 82.3%
 - Getting Treatment Information from the Plan- 29.7%
 - Perceived Improvement- 54.4%
 - Information about Treatment Options- 55.2%



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Results for Perception of Care Survey

- ▶ 8 Perception of Care Domains regarding consumers' services:
 - Access to Services
 - Quality and Appropriateness
 - Outcomes
 - Treatment Planning
 - General Satisfaction
 - Social Connectedness
 - Functioning
 - Cultural Sensitivity



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11
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Summation/Key Strengths

- ▶ Partners' highest domain scores were Quality and Appropriateness for Adult Survey, and Cultural Sensitivity for the Youth and Child Family Survey.
- ▶ There were no domain scores that below 60% for all three survey types.
- ▶ Partners' lowest domain scores across all three(3) surveys was for the Outcome domain.
- ▶ **Quality Appropriateness**
 - Adult- 95%
- ▶ **General Satisfaction**
 - Adult- 91%
- ▶ **Cultural Sensitivity**
 - Youth- 90%
 - Child Family- 96%
- ▶ **First Service within timeframe that met needs**
 - Child Family- 91%



9/13/2018

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Opportunities

- ▶ **Outcomes**
 - Better at handling daily life- 66%
 - Getting along better with family- 67%
 - Better able to cope when things go wrong- 59%
 - Getting along better with friends, others- 65%
 - Satisfied with family life- 55%
- ▶ **LME/MCO Network**
 - Received Consumer Handbook in 14days- 46%
 - Knows how to make a complaint- 60%
 - Given choice of providers- 64%
- ▶ **Adult Physical Health**
 - Received routine physical exam in past year- 61%
 - Received dental care in past year- 40%
 - Smokes or use tobacco/nicotine products every/some days- 64%



9/13/2018

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In Conclusion...

- ▶ Partners' is invested in overall continued quality improvement.
- ▶ The ECHO and Perception of Care Survey results data serve as tools to assess both the network and LME/MCO functions in an effort to providing high quality customer service and services to consumers and families.
- ▶ We need your feedback about strategies to address the areas of opportunity identified in addition to continuation of improving in the areas of strength.

Tamikka Woods, MBA/HCM
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(704) 884-2568



9/13/2018

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Benefit Plan Changes



Presented by
Janet Reading, UM Child/Adolescent Services Supervisor
Jessie Green, UM Adult Services Supervisor

Inpatient Requests

Inpatient Requests (Medicaid and Non-Medicaid)

- ❖ [Provider Bulletin #82](#) June 20, 2018
- ❖ Based on feedback from providers (effective with June 20, 2018 start Date of Service), Partners has made changes to inpatient authorizations processes for:
- ❖ Authorizations that span a weekend day; allowing extension of end date to Sunday
- ❖ Authorizations for Involuntary Commitments (IVC); allowing up to 3 days for initial evaluation/authorization



9/13/2018

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Facility Based Crisis Children & Adolescents

Facility Based Crisis for Children and Adolescents

- ❖ Partners will allow initial authorizations for FBC to be submitted within 48 hours from admission date.
- ❖ Documentation is required to be submitted with the request within 48 hours.
- ❖ There is no grace period for concurrent authorization requests.



9/13/2018

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Adult Services

Adult Services

- ❖ Documentation of consumer's symptoms within PCP or clinical information: UM recommends to include the frequency, intensity, and severity of each behavior.
- ❖ Include information about how the symptom/behavior impacts functional impairment.



9/13/2018

12
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Adult Services Assessments & Intake Codes

Assessment/Intake:

- ❖ 90791-90792 GT; DJ; TK
- ❖ 90875 (Interactive complexity add-on code)

- ❖ No Authorization for first 4 visits, per year
- ❖ 4 Visits do not count against unmanaged visits per year
- ❖ Authorization required on the 5th visit



9/13/2018

12
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Adult Service PSR

Psychosocial Rehabilitation

Documentation Requirements:

Concurrent Request:

- ❖ Updated Person-Centered Plan
- ❖ Service order



9/13/2018

12
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Adult Services CTI

Critical Time Intervention

Phase I: Benefit Limit

- ❖ 12 units weekly
- ❖ 155 units per 3 months

Documentation Requirements: Phase I

- ❖ Comprehensive Clinical Assessment
- ❖ CTI Phase Plan
- ❖ Service Order



9/13/2018

12
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UM Contact Information

Utilization Management Contact Information:

CONTACT INFORMATION

UM STAFF

<u>MH/SA UM Workgroup</u>	X 6436	Direct In-dial Number	1-704-842-6436
<u>IDD/Innovations Workgroup</u>	X 2605	Direct In-dial Number	1-704-884-2605
<u>Inpatient Reviewers Workgroup</u>	X 6434	Direct In-dial Number	1-704-842-6434
<u>Appeals Department Workgroup</u>	X 2650	Direct In-dial Number	1-704-884-2650

UM Fax/ Phone Numbers

UM MH/SA Faxcore: 704-884-2701
 Inpatient Faxcore: 704-884-2703
 Gastonia: 704-866-7727
 Hickory: 828-325-9826
 UM Appeals Faxcore: 704-884-2720
 UM IDD Faxcore: 704-884-2690
 PBHM Service Desk-704-842-6431



9/13/2018

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We need your help!

9/13/2018¹²₇



**Traumatic Brain Injury
(TBI)**

The CDC reports that 2% of the population has sustained a TBI. In North Carolina that means that approximately 208,000 individuals are living a TBI.

There are several individuals whom we are serving who has suffered a Traumatic Brain Injury within Partners catchment area.

I am attempting to identify as many as possible.

In order for me to be successful in identifying them. I need your help!



9/13/2018

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Traumatic Brain Injury (TBI)

► What is a Traumatic Brain Injury?

- An injury to the brain that was caused by an external force such as hitting your head or other types of blunt force trauma. The most common causes of TBI include slips and falls, motor vehicle accidents and struck by or against events.
- The injury can cause cognitive, physical, emotional and behavioral changes.
- A TBI can happen at any age....



9/13/2018

13
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Partners is

► Identifying individuals who sustained a diagnosed TBI

- Prior to and/or after their 22nd Birthday



9/13/2018

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How can you help?

- **Identify** enrolled members through your agency who have sustained a possible brain and/or TBI.
- **Notify** me by emailing the following info:
 - Name
 - Date of Birth
 - Patient ID#
 - Date and Cause of Injury (Supporting documentation required)

Please put the initials- **TBI** in the **subject line** of the email!



9/13/2018

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Contact

Tammy Wellman
IDD System Manager
twellman@partnersbhm.org

Call @
980-223-4471



9/13/2018 13
3





Organizational Highlights

Mary Costner, MA, EdS
Administrator- Gastonia



RHA Mission Statement

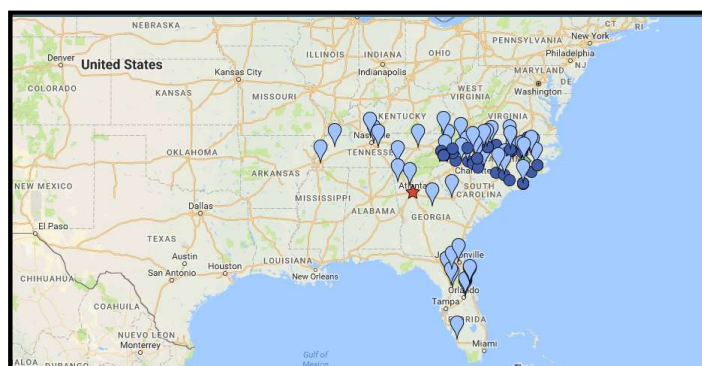
“ To provide a safe and healthy environment, while creating opportunities for personal outcomes.”

People are at the center of all we do...





RHA's Footprint



RHA Expansion

- New ICF Services in Florida and TN
- New Services in TN for supported employment-
Employment and Community First Choices (ECF) Choices



IC-New Services



RHA is expanding our substance abuse services specifically to help with **Opioid epidemic** impacting our community in North Carolina.

Services include

- Substance Abuse Intensive Outpatient Services (SAIOP) for anyone struggling with addiction to substances such as alcohol, cocaine, heroin, and opioids.
- Substance Abuse Comprehensive Outpatient Programs (SACOT), which includes therapeutic and educational groups, individual sessions, recreational therapy assessment and intervention, and a higher level of involvement from medical professionals.

Learn more at <https://rhahealthservices.org/substance-abuse-opioid-treatment/specialized-opioid-treatment/>



RHA- Statesville

Partnership with Partners Behavioral Health

- ▶ 4-bed home designed to support children who are at risk of institutionalization.
- ▶ Currently 2 children are receiving Money Follows the Person and the other 2 children are receiving Innovation Waiver Funding.
- ▶ Transition to the community has been successful whereas they were previously supported in a PRTF in South Carolina, Broughton and Murdoch Center.



RHA-Community Connections

- Community Hub for Meals on Wheels
- Volunteering at Habitat at Humanity- ReStore
- Active member of community resources
- Community Continued Education
- Kindness Rock Project
- Partnerships in Community Gardens
- Meaningful employment



People do not live in an organization, they live in a community.



RHA-Empowering People

Repurposing Clock-In Tablets to increase access to technology.

STRATEGIC MISSION: To empower people to live independently and strengthen their desired relationships through increased access to technology. A part of our societal fabric; technology leverages the opportunities for community and personal engagement, cultivates creativity and the ability to experience common bond and equality.



RHA- Technology Initiative

81% of non-disabled population in the United States have internet access compared to 54% of disabled individuals.

Such disparities can create additional barriers for people living with an intellectual disability including:

- Financial
- Societal attitudes
- Inclusion
- Policy and governmental support
- Education and training.

In turn, access to the internet increases expressed identity, reduces stigma, self-determination, self advocacy and reduces inequalities



RHA-Integrated Health Campaign

1. RHA is seeking opportunities to engage with AHEC Healthcare Provider Learning sessions.

Education will be provided on IDD and additional resources when supporting someone with an intellectual disability in their practice.

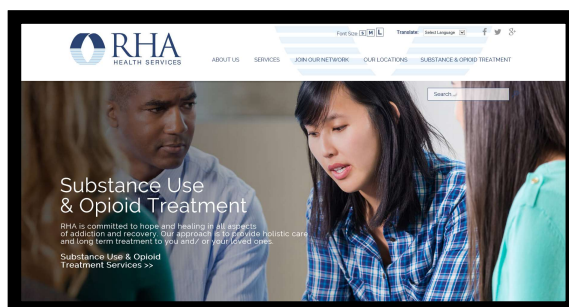
2. Organizational Learning Initiatives which will launch in 2019.

Content for Learning Initiatives will be based on the framework of Integrated care including wellness, healthcare campaigns, financial, relationships, etc. The Learning Campaigns will maintain scope with our audience including People, Health Providers, Family and Support Staff.



For more information

<https://rhahealthservices.org/>





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Improving Lives. Strengthening Communities.

Skill Creations, Inc. Lindy Davis

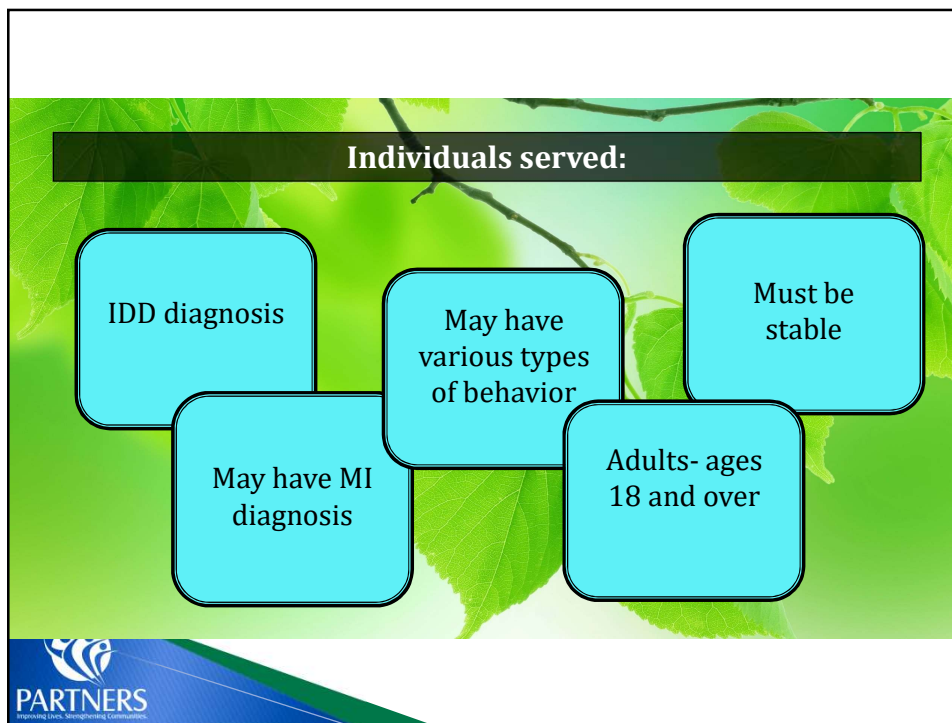
9/13/2018¹⁴
7

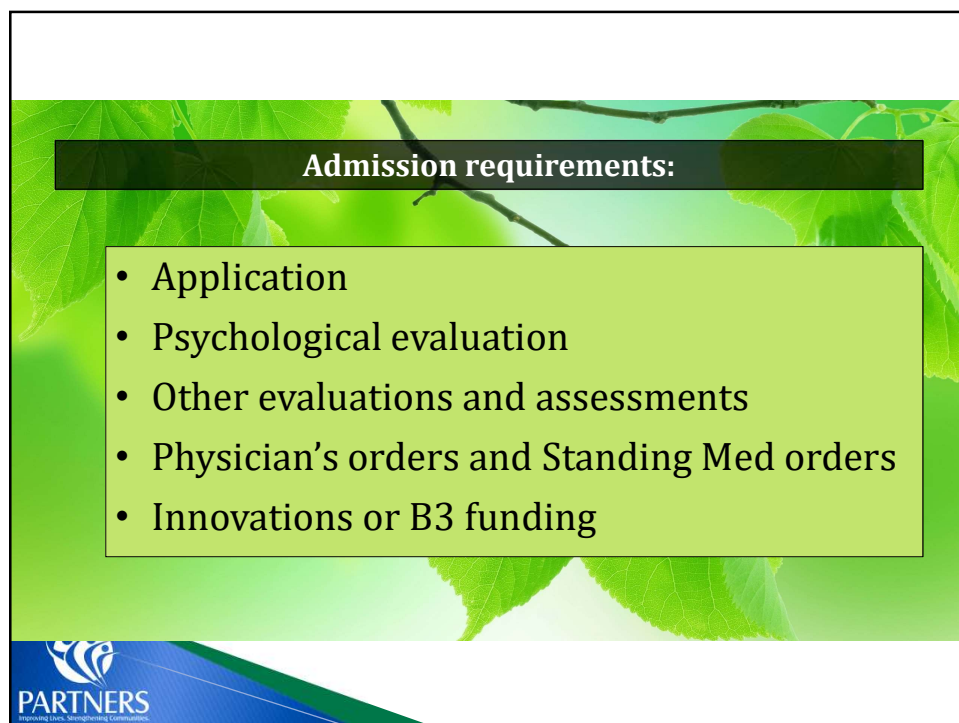
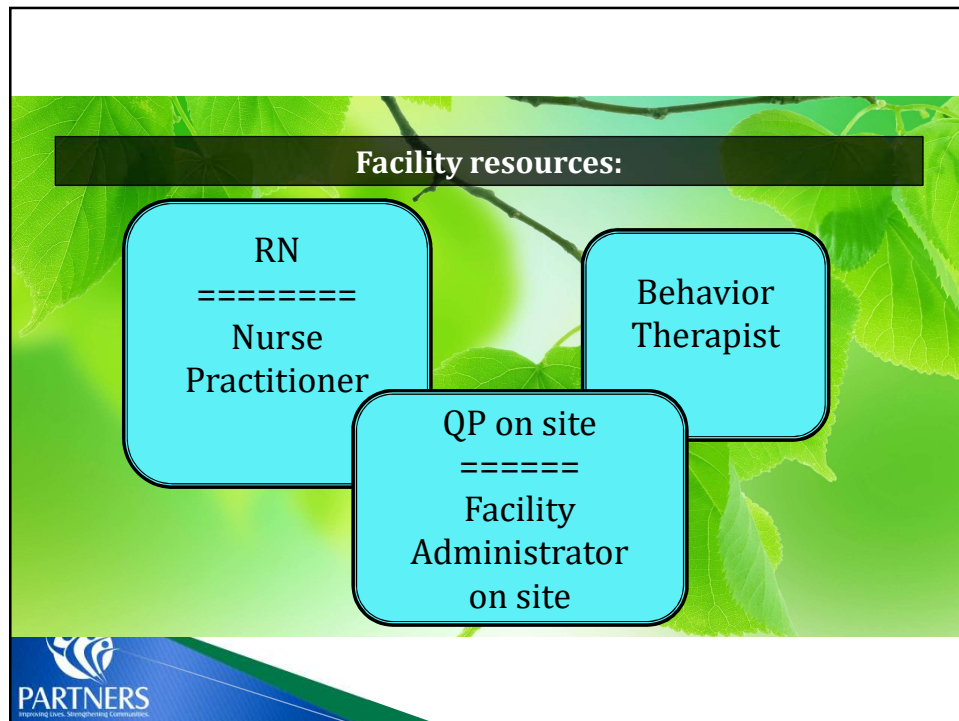


Skill Creations, Inc. Emergent Need Respite Facility

Morganton, NC









Contact information:

Lindy Davis
828-394-4983
lindy.davis@skillcreations.com



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**Provider Council
Chair, Julie Walker**

PBHM Provider Council Updates:

- ▶ Provider Council meets the 4th Friday of every month from 9:30am to 12pm at Partners Hickory Office (Basement Multipurpose Room)—come out and join us!
- ▶ **Conference in Via phone/computer is available:
- ▶ (704) 842-6305 Extension 5113
- ▶ Participant Code: 0940852
- ▶ Host Code: 1341050
- Or
- ▶ Click this link:
<http://bridge.pbhm.local/conference/0940852>



Updates continued...

- ▶ Committee Updates:
- ▶ *Global CQI Committee—next meeting 9/7 9:30am to 12noon/Partners Hickory location
- ▶ *Credentialing Committee—the committee is in need of a non-managerial licensed staff to join.
- ▶ If you are interested please forward your interest to jwalker@thecogcon.com
- ▶ *IDD Sub Committee will meet in September, December, March and June after Provider Council



9/13/2018

15
6

Resources

- ▶ Helpful 1115 Wavier Resources:
 - ▶ *NCDHHS
 - ▶ *NC Division of Medical Assistance
(<https://dma.ncdhhs.gov/documents/2018-medicaid-bulletin-and-index>)
 - ▶ HIE/NC Tracks Updates—Re-credentialing and NC Health Connex
 - ▶ *PBHM Behavioral Health Focus, Provider Knowledge Website information, Provider Council and Provider Forum



9/13/2018

15
7

Benchmarks Update

- ▶ *Fall/Winter Conferences:
 - ▶ September 18-20, 2018 NC Provider Council Conference (Greensboro NC)
 - ▶ December 5-7, 2018 Pinehurst Conference (Pinehurst NC)



9/13/2018

15
8

Upcoming Trainings:

- ▶ *Sponsor: Lifespan--Person Centered Thinking –September 18-19, 2018/9am to 4pm
- ▶ Contact Lori Jakubowski 336-852-1495, ext. 3427 or ljakubowski@lifespanservices.org
- ▶ *Review PBHM Provider Knowledge training events on their website
- ▶ *NAMI Family to Family Education Program—September 29-November 24, 2018/register at namisouthmoutainsnc@gmail.com (828) 771-6305
- ▶ *Managing Pain in the Age of Opioid Crisis—September 15, 2018 7:30am to 12:30pm/Gaston DHHS (330 Dr. Martin Luther King Jr. Way Gastonia NC)



9/13/2018

15
9

September 2018:Recovery Month Events

- ▶ *Suicide Awareness Month—please take time to share resources within your communities that will help reach out to those affected by suicide, raise awareness and connect individuals with suicidal ideation to treatment services.
- ▶ *Recovery Month Events:
- ▶ Western Regional Recovery Rally—September 8, 2018 10am to 2pm/Lake Junaluska NC
- ▶ REBOUND The Chris Herren Story—September 19, 2018 6:30pm/Catawba Valley Community College/Tarlton Complex (2550 Us Hwy 70 SE Hickory, NC)



9/13/2018

16
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Recovery Month Events Cont'd

- ▶ 3rd Annual Burke Rally for Recovery—September 15, 2018 10am to 2pm/Morganton Historic Courthouse Square (102 East Union St. Morganton, NC)
- ▶ Yadkin County Hope Fest for Recovery—September 15, 2018 10am to 2pm/Lila Swaim Park (121 Delos Martin Drive Jonesville, NC)
- ▶ Facing Addiction with NCADD—September 22, 2018 10:30am to 2:30am/Foothills Higher Education Center Room 147 (2128 S. Sterling Street, Morganton NC)
- ▶ Iredell County Walk for Recovery—September 28, 2018 5pm to 8:30pm/ESC Park (338 North Ave. Troutman NC)



9/13/2018

16
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And last but not least....

- ▶ Gaston County Recovery Month Celebration and Candlelight Vigil—September 28, 2018 6pm to 9:30pm/Gaston Pavilion (111 N. South St. Gastonia, NC)
- ▶ Catawba Recovery Rally—September 29, 2018 1pm to 3pm/(110 2nd St. Place SE Hickory NC)



9/13/2018

16
2



**Have you heard about
Cost Finding?**



9-12-18

Individualized Rate

Cost Finding Template

Wyatt Bell, IDD CC Manager

Definition of terms

- ▶ Cost Finding: Net Cost per a unit of service, direct and indirect for a specific timeframe.
- ▶ FTE: (Full time equivalent) : a ratio that determines total hours worked divided by the maximum number of compensable hours in a full-time schedule. F/T is determined by your agency.
- ▶ Salary or Contract: overall total earning paid for a specific timeframe before withholdings.
- ▶ Fringe Benefits: forms of compensation provided to employees outside of a stated wage or salary. Common **examples of fringe benefits** include medical and dental insurance, use of a company car, housing allowance, educational assistance, vacation pay, sick pay, and meals.



9/13/2018

16
5

Definition of terms....

- ▶ Units of service produced: 15 mins, hourly, per diem (remember service specific)
- ▶ Program Direct Cost: Cost associated directly with service. Ex: mileage, staff training, behavioral incentive programs.
- ▶ Administrative Overhead: Cost not involved in the development or production of the service. ex: HR, billing, claims payroll
- ▶ Non Billable Staff Time for Direct Service Staff: Cost that are required for providing the service but not directly related to the specific service. Ex: documentation, meetings, supervision.



9/13/2018

16
6

Resources/Needed Information

Gather any and all related cost to complete Cost Finding.

*Remember this is for actual cost not projected or requested cost.

Examples of info that may be needed:

Gross earning per staff

Fringe benefits

Check stubs

Mileage

Program expenditures

Training cost

other



9/13/2018

16
7

Example of Gross vs Net

Rhett Melton		Any Provider, NC		EARNING STATEMENT		
901 S New Hope Road		# 75840				
SSN	PAY PERIOD	PAY DATE	EMPLOYEE ID			
111-222-3333	9/1/18 to 9/8/18	08/27/18	823542			
INCOME	RATE	HOURS	RENT TOTAL	DEDUCTIONS	TOTAL	YTD TOTAL
GROSS EARNINGS	11.47	40	458.80	FICA - MEDICARE	6.65	226.10
				FICA - SOCIAL SECURITY	28.45	967.30
				FEDERAL TAX	53.92	1833.28
				STATE TAX	32.12	1092.08
YTD GROSS	YTD DEDUCTIONS	YTD NET PAY	TOTAL	DEDUCTIONS	NET PAY	
15599.20	4118.76	11480.44	458.80	121.14	3196	



9/13/2018

16
8

Program description

Supported Living

- ▶ 4 Paraprofessional staff
 - 2 staff Monday through Friday
 - 2 staff Saturday and Sunday
- ▶ Fringe Benefits include \$75/month stipend for full time staff only
- ▶ Staff Training cost \$1200
- ▶ 1200 miles driven/reimbursed
- ▶ BSP with incentive



9/13/2018

16
9

Cost Finding

Program/Administrative Info Staffing Cost

Cost Finding									
Complete yellow cells with actual costs, preferably for a 12 month period.		Program's first year in operation?							
Service Description:		Supported Living Level 3		Svc Code:		T2033TF		No	
Provider Name:		Partners BHM		Unit Type:		Per Diem			
Person Completing Form:		Wyatt Bell		Provider Email:		Wbell@partnersbhm.org		Min weekly hrs worked	
Time Period Represented - From:		9/9/2017		To:		9/8/2018		considered full time at agency	
Number of Months in Time Period:		12		LME/MCO		Partners BHM		40	
Counties covered by this program:				Iredell					
Staffing Costs									
Position Classification	Qualification	Annual FTE (FTE=2080÷ working hrs/yr; Full time for 6mos÷ .5FTE)	Salary or Contract Cost	Fringe Benefits	Total	Fringe as % of Salary	Units of Service Produced during Time Period	% of Time Billed	
Direct Support Staff	Paraprofessional	1.00	\$15,599.20	\$900.00	\$16,499.20	6%	260	100%	
Direct Support Staff	Paraprofessional	1.00	\$17,599.50	\$900.00	\$18,499.50	5%		0%	
Direct Support Staff	Paraprofessional	0.40	\$9,855.00	\$0.00	\$9,855.00	0%	104	100%	
Direct Support Staff	Paraprofessional	0.40	\$9,855.00	\$0.00	\$9,855.00	0%		0%	
					\$0.00	0%		0%	
Total		2.80	\$2,908.7	1,800.0	\$4,708.7	3%	364	50%	



9/13/2018

17
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Cost Finding, Program Costs, Admin Overhead and Cost

Program Direct Costs		
Description	Detail	Amount
Staff Training req. by Svc Definition	(include registration and per diem expenses, travel is listed below)	\$1,200.00
Staff Travel		
# of miles:	1,200	Rate per mile: \$0.54 Total: \$648.00
Vehicle/gas Expense (if not per mile)	(describe) Behavioral Incentive	\$2,500.00
Vehicle/gas Expense (if not per mile)	(describe)	
Client Program Costs *	(describe)	
Other Program Costs Not in OH	(describe)	
(List expenses specific to this program)	(describe)	
	(describe)	
	(describe)	
	(describe)	
	(describe)	
	(describe)	
	(describe)	
	(describe)	
Total		\$4,348.00
* Client Program Costs examples include getting client ID, birth certificate, etc.		
Administrative Overhead		
Total		
Administrative Overhead includes HR, OM, Billing, Finance, Medical Records support, Payroll, etc., not included in Program Costs		
Grand Total		\$59,056.70
	Administrative OH as % Program Cost:	0%
Total Units of Service Produced by Staff during Time Period Listed		364
Annual Cost of Program	\$ 59,056.70	Cost Per Unit: \$ 162.24
		Unit Type: Per Diem

Cost Finding, nonbillable staff time

Optional - NonBillable Staff Time for Direct Service Staff	
Function	Estimated Hours per Month per FTE
Travel	
Training	
Receiving Supervision	
Team Meetings regarding Clients	
Administrative Meetings	
Documentation	
Other (specify)	
Total	-

Questions?

Cost Finding									
Complete yellow cells with actual costs, payable for a 12-month period									
Service Description		Supported Living Level 3		Program's first year in operation?		No			
Provider Name		Partners BHM		Svc Code		T203TF			
Person Completing Form		Vign Ball		Unit Type		Per Diem			
Provider Email		Vball@partnersbhm.org		Provider Email		Vball@partnersbhm.org			
Time Period Represented - From		9/1/2017		To		9/30/2018		Missed/leave worked	
Number of Months in Time Period		12		LME/MCO		Partners BHM		40	
Units covered by the program									
Staffing Costs									
Position Classification	Qualification	Annual FTE position	Salary or Contract Cost	Fringe Benefits	Total	Fringe as % of Salary	Units of Service Produced during Time Period	% of Time Billed	
Direct Support Staff	Paraprofessional	1.00	\$16,599.20	\$900.00	\$17,499.20	5%	260	100%	
Direct Support Staff	Paraprofessional	1.00	\$17,599.50	\$900.00	\$18,499.50	5%		0%	
Direct Support Staff	Paraprofessional	0.40	\$3,956.00	\$0.00	\$3,956.00	0%	104	100%	
Direct Support Staff	Paraprofessional	0.40	\$3,956.00	\$0.00	\$3,956.00	0%		0%	
Total		2.80	\$2,908.7	1,800.0	\$4,708.7	30%	364	90%	
Program Direct Costs									
Description	Detail	Amount							
Staff Training req. by Svc	(Includes registration and per diem expenses; travel is listed below)	\$1,200.00							
Staff Travel									
# of miles	1200								
Rate per mile	\$0.54								
Total		\$648.00							
Subsidized Expenses (if not per mile)	Behavioral Incentive	\$2,500.00							
Client Program Costs									
Other Program Costs No									
(All other non-personnel or other expenses)									
Total		\$4,348.00							
*Client Program Costs examples include: getting client ID, birth certificates, etc.									
Administrative Overhead									
Total									
Administrative Overhead includes: HR, GM, Billing, Finance, Medical Records support, Payroll, etc., not included in Program Costs									
Grand Total	Administrative OH as % Program Cost	0%							
Total Units of Service Produced by Staff during Time Period Listed									
364									
Annual Cost of Program	\$	\$9,056.70							
Cost Per Unit	\$	\$24.24							
Unit Type	Per Diem								



9/13/2018

17
3

Show me the Money...





COB Audits & Working Denials

9/13/2018¹⁷
5



Claims Management

Improving Claims Reimbursement

What are you doing to reduce denials?

- Train staff to research information prior to submitting claims
- Track denial rate of claims
- Set up goals to improve the volume of denials
- Always submit claims within the timely filing guidelines



9/13/2018

17
7

- It is the responsibility of all providers to work their claim denials by utilizing their Download Q, Remittance Advice, and 835
- Stay up to date on changes/subscribe to Partners Communication Bulletins and Provider Alerts
- Process management is essential to minimize denials



9/13/2018

17
8

Verify Insurance Coverage

- Providers have the capability to verify a consumers insurance information (First or Third-Party) in NCTracks at <https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP>
- If Medicare or Commercial insurance information needs to be updated in NCTracks, an HMS form can be completed at <https://ncprovider.hms.com/>
- Providers should verify insurance coverage **every time** the consumer comes in for services



9/13/2018

17
9

- ▶ Federal and State regulations require Medicaid to be the “payer of last resort”
- ▶ Providers are required to collect **all first and third-party funds** before submitting Medicaid claims to Partners for reimbursement
- ▶ Third-party payers are any other funding sources that can be billed to pay for the services provided to the consumer
- ▶ Third-party payers, including Medicare and private health insurance carriers, must process the claim before Partners processes a Medicaid claim
- ▶ Providers must report any payments or denial reasons from third-party payers on Medicaid claims filed with MCOs



9/13/2018

18
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- ▶ Partners pays Coordination of Benefit claims according to the “lesser of” methodology:
 - If the Medicaid allowed amount is more than the third-party payment, Partners will pay the difference up to the contracted allowed amount
 - If the other insurance payment is greater than the Partners contracted amount, no additional amount will be paid
- ▶ Partners will **not** pay for any service that could have been paid for by Medicare or other private insurance plans had the beneficiary or provider complied with the plan's requirements.
- ▶ Examples of common private plan non-compliance denials include, but are not limited to:
 - Failure to get an authorization referral from a primary care physician
 - The provider is a “Non-participating provider” in the first and/or third-party plan
 - Failure to obtain prior approval



9/13/2018

18
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- ▶ Providers should **not** bill for covered services provided by clinicians who are non-paneled or not enrolled under the recipient's third-party coverage plans
- ▶ If the provider is not enrolled nor has paneled staff with the primary payment, the provider should refer the consumer to an eligible provider of third-party covered services
- ▶ First-party payers are the client's consumer or their guarantor

* Partners BHM applies the same guidelines when processing claims for State funded services

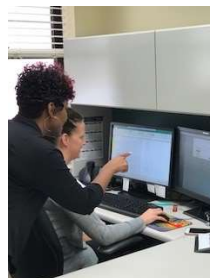
* Providers are not required to bill Medicare/TPL for service codes that are listed on the current bypass list



9/13/2018

18
2

Questions?



Contact information:
ClaimsDepartment@partnersbhm.org
704-842-6486



9/13/2018

18
3



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