Partners Health Management

2025-2026 Provider Operations Manual



Provider Operations Manual

The Partners' Provider Operations Manual is divided into three (3) sections:

1. General Partners Health Management Information
2. BH/IDD Tailored Plan Information
3. PIHP/Medicaid Direct Information

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SECTION: General Information

INTRODUCTION and WELCOME

Welcome

Welcome to Partners Health Management (Partners)! Thank you for being part of our network of participating behavioral health, intellectual/developmental disabilities, substance use disorder, physicians, hospitals, and other healthcare professionals. Members and recipients in Partners' BH/IDD Tailored Plan (TP), Prepaid Inpatient Health Plan (PIHP), and State Funded will have access to a comprehensive network of providers to meet their integrated, whole-person health care needs.

We have partnered with Carolina Complete Health, Inc. (CCH) to expand TP members' access and choice when seeking a physical health (PH) care provider and CVS to develop our pharmacy network. CCH's network is the only Standard Plan network that is led by doctors from the North Carolina Medical Society and the North Carolina Community Health Center Association. This provider-focused approach closely aligns with Partners' commitment to provider-led, locally based strategies and solutions.

About Us

Formed in 2012 through the merger of three legacy area programs that provided decades of service to individuals with severe behavioral health needs and those with intellectual/developmental disabilities, Partners is built on a foundation of service to members and communities.

Since being awarded our LME/MCO contract in 2013, Partners has operated a successful and well-regarded model that focuses on the five words reflected in our logo: Partners. Improving Lives. Strengthening Communities. The words are embedded into our culture and represent our overall approach to serving Tailored Plan members. Partners believes that people, communities, partnerships and integrated care matter most.

Partners manages publicly funded BH/IDD TP, PIHP (Medicaid Direct), and State funded services for a regional catchment area in the central and western sections of North Carolina. It administers local, state and federal (Medicaid, and State funded) services and funds for mental health, physical health, pharmacy, intellectual/developmental disabilities and substance use services in Burke, Cabarrus, Catawba, Cleveland, Davidson, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union and Yadkin counties to be referred to as catchment or service area throughout the remainder of this manual. The corporate office of the organization is located at 901 South New Hope Road in Gastonia, North Carolina. Regional offices are located in Elkin and Hickory.

Business hours are 8 a.m. to 5 p.m., Monday through Friday.

Partners recognizes the following holidays.

New Year's Day	Martin Luther King Jr. Day
Good Friday	Memorial Day
Independence Day	Labor Day
Veterans Day	Thanksgiving Day (and the day after)
Christmas Day (and day before and after)	

Mission

Partners' mission is Improving Lives. Strengthening Communities.®

We believe in delivering a superior BH/IDD Tailored Plan, PIHP, State Funded experience to providers and members that are funded by federal, state and local taxpayer dollars. We ensure all individuals who are eligible for our programs have access to quality providers and effective services. We improve lives and strengthen our communities by focusing on positive outcomes and the proper use of funds entrusted to us. We envision a high-quality, accessible care system that integrates physical and behavioral health in a community of hope, support and acceptance.

Access and Updates to this Manual

Partners' BH/IDD Tailored Plan/PIHP/State Funded Provider Operations Manual is available on the Provider Knowledge Base at http://providers.partnersbhm.org. Providers may request a printed copy by contacting their assigned provider account specialist. It is the responsibility of contracted providers to be familiar with and adhere to the policies and procedures outlined in this manual. Additionally, Partners shares new information and procedural changes to providers on an ongoing basis so that providers are up-to-date and understand revised expectations as they happen. This information is distributed via electronic mail through Provider Communication Bulletins monthly and Provider Alerts as needed. Changes are incorporated and published in revised editions of this BH/IDD Tailored Plan/PIHP/State Funded Provider Operations Manual periodically but no more frequently than one time per quarter in the event that substantive changes updates or revisions that impact either BH/IDD Tailored Plan and/or Medicaid Direct providers as needed and at least annually, with the annual submission due on July 1 each year, or upon request by the NCDHHS.

Partners may update the provider manual once per quarter in the event of substantive updates or revisions that impact providers or BH/IDD Tailored Plan/PIHP/State Funded business. Unless directed by the Department, Partners shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by Partners during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

Partners will ensure that changes reflect the application of federal and state laws, rules and regulations, NCDHHS or Partners' policies, procedures, bulletins, guidelines, manuals, or Partners' business processes as applicable. Within the Provider Manual, the BH/IDD Tailored Plan/PIHP/State Funded shall track and maintain a list of revisions made to the manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed. Partners shall submit the provider manual to NCDHHS for approval within fifteen (15) calendar days of making substantive updates or revisions. Partners shall have five (5) Calendar Days to return an updated version of the provider manual if any revisions are

requested by the Department during the review and approval process. Partners will not post, print or enforce the updates until the NCDHHS has approved the manual. It is important to refer to Provider Communications Bulletins and periodic updates on the Provider Knowledge Base and ProviderCONNECT for the most current information. The BH/IDD Tailored Plan/PIHP/State Funded Provider Orientation Toolkit is also available and provides links to forms, manuals and documents that will assist providers in becoming acquainted and conducting business with Partners. Partners shall correct errors in the electronic version of the BH/IDD Tailored Plan/PIHP/State Funded Provider Operations Manual or make revisions as requested by the NCDHHS within fifteen (15) calendar days of notification or request by NCDHHS. Corrections or revisions to the printed version must be included in the next printing. Partners shall make the redlined Provider Operations Manual available, within five (5) calendar days of approval from NCDHHS, in an electronic version accessible via www.partnersbhm.org, ProviderCONNECT, and in writing upon request of the contracted provider. Partners shall submit Provider Manual to Department for approval thirty (30) Calendar Days after Contract Award. Partners shall not use or distribute the Provider Manual prior to approval by Department.

This manual applies to all Tailored plan, State Funded, PIHP (Medicaid Direct) Network Providers of Partners Health Management unless otherwise specified in a particular provider type or provider contract language.

Governance

Partners' BH/IDD Tailored Plan/PIHP/State Funded current governance structure meets all required provisions of Chapter 122C of the N.C. General Statutes regarding composition, meeting schedule, training, compensation, support of the Consumer and Family Advisory Committee (CFAC) and required advisory board. Our Board of Directors (BOD) consists of 23 members consisting of 21 voting members and two non-voting members (President of the LME/MCO Provider Council or designee and one administrator of a hospital providing mental health, I/DD or substance abuse services). While not required by statute, Partners underscores its commitment to local engagement by ensuring every county in our catchment area is represented by a County Commissioner or their designee serving on the BOD. Members of the BOD may serve up to two 3-year terms and the group meets 10 times per year. Board of Directors members share Partners' vision for serving members, recipients and families, improving members' access to care and improving the communities in which they live. While all counties are represented on the board, each member serves all of Partners' covered counties. Our board members are particularly collaborative without territorial or geographic biases. Our BOD is the driving force behind Partners' member/recipient-first focus and board members support and value our partnerships within the community. Their passion is the impetus of the commitment to continuous learning, collaboration and innovation that Partners demonstrates while serving its members/recipients and communities every day. The BOD is focused on supporting Partners' company culture by ensuring employees have positive work experiences and receive all of the resources and training they need to deliver superior member and recipient care. Partners' BOD oversees and advises on all aspects of our operations. The BOD has created and adopted a set of guidelines to steer its governance and operations. The BOD approaches its task of governing the organization in a manner that emphasizes strategy, leadership, clear distinction of BOD and staff roles and strategic planning. The BOD directs, influences and inspires the organization through careful deliberation and establishment of policies. The BOD establishes annual organizational goals and outcomes and reviews progress toward those goals regularly throughout the year.

The BOD has established five subcommittees and one advisory board to execute its responsibilities. Each of the following committees reports to the full BOD.

- Executive Committee: The Executive Committee is comprised of the BOD Chair, the Immediate Past Chair, Vice-Chair, Treasurer and two other BOD members appointed by the Chair. The Executive Committee orients new BOD members, provides strategic guidance, informs on legislative and policy issues and oversees Partners' performance in meeting company goals and regulatory requirements.
- Finance Committee: The Finance Committee is chaired by the board treasurer and meets monthly, with additional meetings as needed. The Finance Committee has an audit function and fiscal oversight reports and recommendations are standing agenda items for the board.
- Human Rights Committee (HRC): HRC is comprised of two members/families from each county we serve as well as three Partners BOD members, underscoring how meaningful and integrated our leadership is with our members. This committee meets quarterly to ensure Partners' policies and practices protect members and recipients rights, approves grievances/complaints and appeals policies and reviews identified incidents. Members of the HRC are sometimes enlisted by management to discuss member engagement and grievance/complaint matters.
- Nominating Committee: The Nominating Committee meets as necessary to recommend nominees to replace board officers whose terms expire at the end of each fiscal year.
- Regulatory Compliance Committee (RCC): Separate but related RCCs are required by federal law at both the board and senior management level. The Board RCC (RCCb) is comprised of the entire board; a "committee of the whole." The RCCb has the duty to oversee Partners' compliance program and compliance with requirements under its Medicaid Managed Care contract. It has a direct line, as needed, to the senior-management level RCC (RCCm) of Partners via the RCCm, to our chief compliance officer.
- County Commissioner Advisory Board (CCAB): The CCAB is required by state statute to ensure county commissioners have a voice in the leadership of their LME/MCO, even if advisory. However, by bylaws, Partners already has every county represented by a commissioner or designee on the full board. To comply with the law and facilitate insights from the county commissioners/designees, Partners CCAB was created and is a standing agenda item in every board meeting. Partners' unique structure allows the entire BOD to remain fully engaged and connected with local healthcare issues and developments that impact our catchment area.

DISASTER OR EMERGENCY RELATED PLANNING

A disaster or emergency situation that can result in a major failure or disruption in care, includes but is not limited to fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic.

Members with high risk levels that need support during a disaster or emergency situation include high-risk pregnant women, dialysis patients, medically frail, hemophiliacs, long-term care population, individuals receiving Medication Assisted Treatment (MAT).

REGULATORY REFERENCES

Section V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations.

Section V.a.2.a.vi Business Continuity for Medicaid and State-funded Services.

PROCEDURES

Partners will comply with any additional requirements released by the NCDHHS to ensure continuity of care during an epidemic or pandemic, including those related to care coordination, care management and supports to address their Unmet Health-Related Resource Needs.

Pre-Emergency

Care Managers will incorporate disaster and emergency planning in the care planning process. As an integral part of Partners Care Management Program, care plan development will include crisis planning. The care plan will address member-specific needs and may include:

Location of where the member plans to go in an emergency.

Registration with special needs shelters and transportation to the shelter (as

information is made available).

Identification of family or other representative able to care for member.

Plans for obtaining additional medications, oxygen or other items.

Identification of medications and special equipment that requires refrigeration and/or

power supply.

Increase outreach to ensure that members and recipients have adequate shelter, access to support to address their unmet health related resource needs, access to back-up equipment and/or caretaker training if equipment fails or arrange for evacuation if the member is unable to safely shelter in place (for Medicaid members only).

During Emergency

Care managers will conduct outreach to high-risk members in a timeframe appropriate to an emergency (for example, a tornado requires an immediate response).

Care managers will continue to check-in on high-risk members and recipients at a frequency based on the member/recipient's needs to ensure they are sheltering safely and they have access to supports to address their unmet health-related resource needs.

If it is safe to do so, the care manager will arrange for transportation for members, if needed.

Post Emergency

Care managers will check-in on high-risk members to ensure they weathered the disaster safely and identify additional behavioral, medical or unmet health-related resource needs. If the member has newly identified needs, the care manager will update the care plan, as appropriate.

PROVIDER NETWORK RELATIONSHIP AND ENGAGEMENT MANAGEMENT

PROVIDER NETWORK RELATIONSHIP AND ENGAGEMENT MANAGEMENT

Partners Health Management is committed to supporting the provider network through a qualified provider relationship and engagement team that ensures ongoing accessibility to quality supports and coordinates cross-functional assistance for providers. Provider relationships and engagements are essential to working with all providers in the Partners Health Management network. The Partners Provider Network department is designed around the goal of making your experience as a network provider a positive one by being your advocate within Partners. Upon contracting with Partners Health Management, providers have access to Provider Account Specialists within the Provider Network Department that can assist with any questions providers may have. For more information around Provider Contracting click here: https://providers.partnersbhm.org/provider-contracts/

Provider Orientation

New provider training is conducted through Partners Training Resources and Collaborative (TRAC). Partners-contracted providers have convenient opportunities to receive orientation and training through online training modules. Partners offers a Provider Open House via Zoom on a quarterly basis. The open house allows providers to address questions and concerns in a live format with subject matter experts. Partners also offers monthly Office Hours sessions to provide an overview of the health plan to our new physical health providers. Providers register for both online modules, open house, and office hours through Partners Training Resources and Collaborative (TRAC).

Supplementing our new provider orientation, the orientation toolkit provides links to forms, manuals and documents that assist providers in becoming acquainted with and conducting business with Partners. This one-stop resource includes information important to providers such as benefits and covered services, utilization management, the provider portal (ProviderCONNECT), how to file a grievance/complaint, provider disputes, compliance and our provider operations manual.

Providers can find all operational information and forms on ProviderCONNECT, our provider portal, as well as on our provider knowledge base, a website dedicated to informing providers. The website includes a host of information to help providers succeed, improve members' health and well-being, and stay up to date with information. Partners Training Resource and Collaborative (TRAC) offers important training opportunities for providers, such as evidence-based practices, Due Process, Ethics, Clinical Coverage Policies, Cultural Competency, Person-Centered Thinking, and Person-Centered Planning. For more training and educational information click here Partners | Training Academy - Behavioral Health Training.

Provider Account Specialists: Supported by a team of experts, provider account specialists will serve as points of contact to address questions, issues, recommendations, and contract concerns that providers may have or be experiencing. These specialists are trained to assist with any questions providers may have. They will work directly with providers, and as liaisons with other departments to ensure a positive provider experience. Some examples of what the specialists will assist with include the following but are not limited to:

- Facilitate provider meetings upon request
- Rate/Funding review and mitigation
- Contract questions
- Technical Assistance
- Build relationships and support providers
- Provide cross functional support with other departments such as Authorizations, Claims, Enrollment, and Information Technology support
- Provide support through various committees and collaboratives
- Provider orientation
- Provide education and training as needed for providers

Your primary point of contact for all things as a provider starts with our Provider Services Line. The Provider support service line offers timely assistance with eligibility, benefits, prior authorization, and claims inquiries. They will utilize Provider account specialists for more complex issues. This line is available Monday – Saturday from 7a.m. – 6p.m. You will have the option to speak directly with a provider services line representative by pressing "0" or choose an option that best fits your needs.

- **Provider Services Line Representatives - 877-398-4145:**

For written questions related to provider accounts, you can also contact the Provider Account Specialist team through email. Behavioral Health (BH) providers can reach out to the Behavioral Health Provider Account Specialist team at **pas@partnersbhm.org**. Physical Health (PH) providers may contact the Physical Health Provider Account Specialist team at **phpas@partnersbhm.org**. These contacts are available to assist with provider account inquiries, updates, and related support needs.

In addition to the Provider Account Specialists, there are other Provider resources that Provider Network Relationship and Engagement uses to assist with your needs:

- **Claims and payment Liaisons:** Highly skilled staff that support the provider account specialist by investigating, researching and resolving complex inquiries regarding claims billing, adjudication and payment.
- **Provider Network Performance Specialists**: Specially trained staff who support the provider network account specialist team and providers in optimizing their practices and improving performance under value-based payment (VBP) arrangements.
- **Provider Network Contracts Specialists**: These staff are available to support any contract-related questions or needs that are more complex in nature.
- **Provider Enrollment and Credentialing Specialists**: Support complex needs around enrollment or state credentialing issues or questions.
- **Indian Health Care Provider (IHCP) Support:** We offer the support of our tribal provider contracting specialist, who will serve as a primary point of contact and collaborate with the Eastern Band of Cherokee Indians to provide education about Partners' provider processes and services.

Partners' goal is to furnish you and your staff with the necessary resources and tools to provide the highest quality of health care possible to Partners' members/recipients. You can access more information about Partners Provider information by visiting the Provider Knowledge Base here: Partners Health Management - Provider Knowledge Base - Partners Provider Knowledge Base.

CREDENTIALING AND RECREDENTIALING

In accordance with 42 C.F.R.§ 438.214, the requirements specified in Partners' BH/IDD Tailored Plan/PIHP/State Funded contract and the Uniform Credentialing and Recredentialing Policy for Medicaid, and State-funded providers, Partners has established the following procedures for the selection and retention of acute care, primary care, mental health, substance use disorder (SUD), intellectual/developmental disability (I/DD), traumatic brain injury (TBI), pharmacy services and long-term services, and supports (LTSS) providers in Partners' BH/IDD Tailored Plan/PIHP/State Funded provider network.

1. Partners ensures that providers are credentialed and recredentialed no less than every three years (3) in accordance with 42 C.F.R. § 438.206(b)(6) **through acceptance of provider credentialing and verified information from the North Carolina Department of Health and Human Services (NCDHHS).** Partners will not request any additional credentialing information from the provider without the NCDHHS approval.

2. Partners has identified standards and established a documented process for making network contracting decisions as outlined in this policy. Partners will use NCDHHS' Objective Quality Standards for participation as a Medicaid-enrolled provider or State-funded Services provider and quality standards included in this policy to assess each applicable provider type's ability to deliver care. Partners, in conjunction with Carolina Complete Health, will comply with network contracting decisions as specified in this policy.

3. Partners does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment per 42 C.F.R. § 438.214(c)

4. Partners does not discriminate 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 based on that license or certification per 42 C.F.R. § 438.12

5. Partners does not 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.

6. Partners does not contract with providers who are not enrolled with NCDHHS as NC Medicaid providers or State-funded Service providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.

7. As part of the contracting process, when Partners requires a provider to submit additional information, Partners will include a description of all such information.

8. For Pharmacy Services, it is the policy of Partners Health Management (Partners) to assure the ongoing adequacy and integrity of the pharmacy provider network which is subcontracted to the Pharmacy Benefits Manager (PBM). As a basis for contract consideration, the PBM will accept credentialing from North Carolina Department of Health and Human Services' (NCDHHS) Centralized Credentialing and Recredentialing Process (CCRP) currently performed through NCTracks and make contracting decisions based on the PEF file received from the state. PBM pharmacy network providers are periodically recredentialed by the Department. The contracting process is executed by the PBM and supervised by Partners.

I. Independent Contractors: The PBM contracts with local network pharmacies, which are independent contractors, to provide prescription drugs and related products and services with respect to the plan. This network is available to Tailored Plan members enrolled with Partners. The PBM partner will add pharmacy providers to the PBM provider network as needed to meet network adequacy standards. Additions to the existing network occur as new pharmacies open, and solicitations for non-network pharmacies are considered at the request of Partners or members. Through our partnerships with the PBM, Partners will contract with any willing pharmacy service provider in good faith, regardless of the provider or its affiliation with Partners or another Tailored Plan, who meets the stated criteria below.

II. Contractor Enrollment Process To contract with the PBM, an independent retail pharmacy must complete the Membership Enrollment Form and comply with all data and licensing requirements. The Membership Enrollment Form includes the pharmacy's demographic and ownership information. In addition, the following documentation must be returned by the pharmacy:

- A signed Provider contract
- A completed Provider Service Levels Form
- A copy of the State Provider License and DEA certificate
- A copy of the Liability Insurance Policy

To enroll a new chain store, the PBM must receive a request from the chain headquarters. The PBM does not require hard copies of insurance policy, and state license certificates for members of a chain pharmacy upon enrollment. The chain headquarters is responsible for ensuring that each store has this information.

As a minimum standard, network pharmacies must be enrolled and credentialed as a NC Medicaid pharmacy provider and comply with the PBM's terms and conditions applicable to participation in the retail pharmacy network, including periodic audits. The PBM will maintain a database of in-network pharmacies so that members, providers, and Partners staff may locate a Network pharmacy using the Partners pharmacy locater on the Partners /the PBM's Web site. (Reference: Pharmacy Program Provider Network Audit Program Plan)

Recredentialing

Partners ensures that providers are credentialed and recredentialed at least every three years in accordance with 42 C.F.R. § 438.206(b)(6) **through acceptance of provider credentialing and verified information from the North Carolina Department of Health and Human Services (NCDHHS).** Partners will not request any additional credentialing information from the provider without the NCDHHS approval.

Credentialing and Re-Credentialing Procedure

1. All providers seeking to join the Partners' BH/IDD Tailored Plan/PIHP/State Funded network and providers who wish to be contracted with Partners' network must be approved through NCDHHS Centralized Credentialing and Recredentialing Process (CCRP) and must also be enrolled in NCTracks. Information from the CCRP will be gathered and presented to the PNPC for both initial and recredentialing providers.

2. Partners will make network contracting decisions for 90% of providers within 30 calendar days of receipt of complete Medicaid-enrolled provider data from NCDHHS or its vendor for consideration and for 100% of providers within 45 calendar days. For providers of physical health and pharmacy services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor; and for providers of BH, I/DD, and TBI services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor and complete information requested by the Tailored Plan for network contracting decisions for providers of BH, I/DD, and TBI services for consideration.

Applications to Re-Enter the Network

Providers applying to re-enter the Partners' network who are under a sanction, under Program Integrity investigation, have an outstanding Medicaid or State overpayment, or are under a monitoring plan of correction (POC) at the time of their termination from the network will have their request to re-enter the network and the circumstances around their previous termination will be reviewed by the PNPC.

Existing Providers adding Sites/Services/Practitioners

The addition of new sites, service additions or practitioner additions must be done through NCDHHS CCRP and NCTracks.

Quality Standards

Partners will adopt the NCDHHS Objective Quality Standards for participation as a BH/IDD Tailored Plan/PIHP/State Funded Services provider in Partners' provider network. BH/IDD Tailored Plan/PIHP/State Funded providers of behavioral health, I/DD and TBI services will be reviewed against the following established quality standards:

Assessing Provider Compliance

1. Availability of public funds (State-Funded Services are not an entitlement and are subject to limited availability of state funds).

2. The provider offers and demonstrates availability of a service that is identified as necessary within the Partners' Network Access/Development Plan or supported by the Network Adequacy and Availability (needs assessment/gap) analysis.

3. The provider has demonstrated compliance with the terms and conditions of the Partners' provider contract(s) (including any applicable scope of work), and applicable state and federal laws, rules and regulations.

4. The provider has demonstrated compliance with the Partners Provider Operations Manual, Partners Provider Communication Bulletins, and bulletins and manuals issued by NCDHHS.

5. The provider has demonstrated the ability to ensure that members meet medical necessity requirements for all services provided. Specifically, the provider must have an authorization approval rate on service requests at or above 75% in any identified time period.

6. The provider demonstrates efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes.

7. The provider has an acceptable agency Cultural Competency Plan that includes a commitment to provide culturally competent services and ensure the cultural sensitivity of staff members.

8. The provider has established an adequate emergency response system that complies with the services being provided; including the implementation of measures to respond to emergencies on weekends and evenings for members served by the network provider.

9. The provider demonstrates member friendly services and attitude by ensuring good communication with members and families as evidenced by a review of member grievances/complaints.

10. The provider delivers services in accordance with all applicable state and federal laws, rules, regulations, the NC State Plan for Medical Assistance, the Waiver, State Service Definitions, and/or Clinical Coverage Policies.

11. The provider meets Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) access standards and appointment wait times.

12. The provider implements a no-reject policy for clinically appropriate members referred by Partners.

13. The provider cooperates and complies with discharge and transfer requirements to ensure a smooth transfer for any member that desires to change providers, or because the network provider cannot meet his/her special needs.

14. The provider meets all documentation requirements as set forth in Medicaid Clinical Coverage Policies, state service definitions, and/or the Records Management and Documentation Manual.

15. The provider cooperates and participates with all Partners program integrity activities (including but not limited to investigations, pre/post-payment reviews and resolution of overpayments), utilization review/management, quality management, compliance, and appeal and grievance/complaint procedures.

16. The provider meets recredentialing criteria as determined by (NCDHHS CCRP).

17. The provider participates in member satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements, as requested, or as appropriate.

18. The provider has demonstrated financial stability as evidenced by the provider must have a claims approval rate at or above 80% in each quarter of the fiscal year per funding source (applies to provider specific denial reasons, not Local Management Entity/Managed Care Organization [LME/MCO] issues).

19. The provider has an acceptable Quality Management Plan with evidence of strategies and goals being implemented by the network provider.

20. The provider has adequate clinical leadership according to the disability and services being provided by the network provider with a sufficient supervision structure.

21. The provider has demonstrated HIPAA-compliant Electronic Medical Record (EMR) system, which supports management of authorizations and billing functions, and compliance with the Federal Meaningful Use Standards.

22. The provider has an acceptable liability insurance history: no history of liability claims for the last five years. An unacceptable liability history is defined as: within the five-year period immediately preceding the date of the agencies' application, one or more legal actions resulted in (i) at least one judgment; (ii) one settlement in an amount over $50,000 or more; or (iii) two or more settlements in an aggregate amount of $50,000 or more.

23. The provider has a valid and current facility license and national accreditation (if required).

Assessing Provider Non-Compliance

24. The network provider is not in compliance with applicable federal or state laws, rules or regulations, or is in breach of any provision of its current contract with Partners, including but not limited to the scope of work or requirements concerning clients' rights, confidentiality and records retention.

25. The network provider has not billed for each type of service contained in their current contract as documented by a paid claim(s) for service(s) delivered during the most recent 60-day period. Note -an additional 60 days must be allowed for timely filing considerations. Service types without associated billing will be removed from the renewal contract. Note -Exceptions may be made at Partners' sole discretion for necessary, but infrequently used services such as crisis respite or a provider of specialty or out-of-catchment area services that are delivered infrequently.

26. Partners has issued two or more consecutive plans of correction against the network provider for the same or substantially similar findings within the three-year credentialing and/or recredentialing cycle.

27. The network provider has failed to implement a plan of correction issued by Partners, and the time for doing so has expired.

28. Partners has issued two or more sanctions or administrative actions against the network provider in a consecutive time period.

29. The network provider has failed to remit an identified overpayment to or entered into an approved payment plan with Partners within the designated timeframe.

30. Partners has logged quality of care concerns or other serious grievances/complaints about the network provider that have not been satisfactorily resolved in required timelines.

31. The network provider has had a consistent and high volume of claim denials despite technical assistance or training offered by Partners. Specifically, the provider must have an overall claims approval rate of 80% in any identified time period per funding sources – This assessment applies to provider specific denial reasons, not LME/MCO issues. Exceptions may be made at Partners' sole discretion for essential providers/services excluded by this item with the successful implementation of a plan of correction.

32. The network provider has not responded to requests for data or other information necessary for Partners to respond to requests from NCDHHS.

33. The network provider fails to provide proof of insurance as required under the terms and conditions of their contract.

34. The network provider has failed to meet routine monitoring requirements.

35. Partners has issued an RFP or RFI for the service(s) delivered by the network provider and the RFP/RFI clearly indicates a response is required to continue providing services in the network.

Termination

Partners provides written notice to the Network provider of the decision to terminate the provider. The notice includes at minimum: The reason for Partners' decision, the effective date of termination, the provider's right to Appeal the decision, and how to request an appeal.

When a practitioner or practice group is terminated from the network, Partners identifies members who received his or her primary care from the provider or who received services in the previous 6 months from the terminated provider. For non-PCP/non-AMH providers, Partners notifies the identified members of the termination within 15 calendar days after the provider receives Partners' termination. For PCP/AMH Partners, notifies the identified members of the termination within 7 calendar days after the provider receives Partners' termination. All member notifications include:

1. The practitioner group or name.
2. The effective termination date.
3. Procedures for selecting another practitioner or group.
4. Procedures for selecting or being auto-assigned a new PCP, if the provider was a PCP.
5. Description of efforts to support transition of care for the member to the new provider.
6. Assist impacted members with transition of care for terminated specialty providers.
7. Notifications are distributed to members by mail.

Partners will provide a report on the number of providers terminated by provider type in a form and with the frequency as described in Tailored Plan contract Section VII. Attachment J. Reporting Requirements for Medicaid and in the PIHP contract Section VI. Attachment I. If a Waiver provider has been terminated due to

HCBS issues, the Tailored Plan shall notify NCDHHS Waiver administrators.

If a pharmacy provider is terminated, CVS and Partners will coordinate to ensure each impacted member is connected to a new pharmacy provider of their choosing to avoid disruption in services. Each member who received a prescription in the last 12 months from the terminated pharmacy will receive written notice within 15 calendar days of the termination.

PARTNERS WEBSITES AND INFORMATION TECHNOLOGY

Partners Website: https://www.partnersbhm.org/

Partners' websites are essential elements in how Partners and the provider network communicate and conduct business with each other.

Secure Provider Portal – ProviderCONNECT

Providers can find all operational information and forms on ProviderCONNECT, our secure provider portal, as well as in our Provider Knowledge Base, our provider-dedicated website.

Provider Knowledge Base: https://providers.partnersbhm.org/

Partners' Provider Knowledge Base includes information to help providers succeed, improve members/recipients' health and well-being and stay up to dat. Providers will find clinical guidelines, operational forms and information concerning contracting, utilization management, and claims. This site also hosts publications such as Provider Communication Bulletins and Provider Alerts.

Partners Training Resource and Collaborative (TRAC): https://www.partnerstraining.org/

Partners offers a variety of training opportunities to educate and inform those in our communities, our network of providers and internal staff. Our training site supports our philosophy that the key to creating healthy communities is education and resources.

Member/Recipient information: https://www.partnersbhm.org/member-education/

Member and recipient information is available on our website to provide information about behavioral health (mental health and substance use disorders), Intellectual/developmental disabilities, physical health, pharmacy, non-eme available services, how to get services and many other helpful topics and resources.

Members/recipients can also access our provider directory that includes information for behavioral and physical health, Long Term Services and Supports (LTSS), I/DD, TBI and pharmacy network providers. Our provider directory is easy to understand and meets language and format requirements in accordance with 42 C.F.R. § 438.10 and the contract as specified by NCDHHS. Members, recipients, and providers can access the directory through our website. We also provide paper copies upon request.

Member/Recipient Portal:

Members/recipients can access our secure member portal, MemberCONNECT, at the top right of the Partners website. We encourage members/recipients to create an account and utilize MemberCONNECT to stay connected with Partners and have easy access to request a change to their primary care provider or tailored

care management agency, request a new Medicaid ID card and more

. Members/recipients can access the portal from any computer or mobile phone to:

- Change their Primary Care Provider (PCP).
- Request or Change a Tailored Care Manager (TCM).
- Private message Partners staff.
- View and download Care Plans, Individual Support Plans (ISPs)
- Learn how to access Teledoc Health (scheduling an online medical appointment)
- Find resources such as Member Handbooks, Partners Health Library, and Member and Family online trainings
- Find a provider.
- Take a health screening.
- Understand their rights and responsibilities.
- Stay connected to information and updates.

Provider Communications

Want to be in the know? Register for emails from Partners at https://www.partnersbhm.org/subscribe/

Providers can sign up on the provider portal to receive email alerts and notifications of interest to providers. Providers signing up for email communications need to contact their company's information technology department to ensure they can receive messages via Constant Contact.

Opportunities to stay up to date with Partners

Provider webinar documents: Partners hosts Provider webinars quarterly. Materials from the webinars are posted to the Provider Knowledge Base site under Provider News.

- Provider Communication Bulletin: Partners issues Provider Communication Bulletins at least monthly. The Provider Communication Bulletin contains operational information, notices and updates. Providers should review this document for information pertaining to conducting business with Partners. Provider Communication Bulletins are available on the Provider Knowledge Base.
- Provider Alerts: There are times when Partners needs to communicate time-sensitive information. Provider Alerts are used to communicate this information. They are sent to all email subscribers that have selected to be informed of provider communications through our subscription system.
- Check Partners out on social media! Partners posts on Facebook, Instagram, LinkedIn, X (formerly Twitter) and YouTube. Our social media posts are designed to provide general Partners information, as well as specific events and other relevant information about behavioral and physical health, substance use disorders, I/DD, etc. and behavioral health information, guide readers to relevant events and have a little fun to encourage redirection and reflection. Share posts with friends and family. Comments and discussions are encouraged. Please refer to the general information section in the page info for the full comment policy/user agreement. Visit Partners social media pages often.
    - Facebook: https://www.facebook.com/PartnersHealthMgmt/
    - Instagram: https://www.instagram.com/partnershealthmgmt/
    - LinkedIn: https://www.linkedin.com/company/partners-health-management
    - X (formerly Twitter): https://x.com/partnershm

- YouTube: https://www.youtube.com/channel/UC-GGQEndDVeekalrZtV1q8Q/%2520
- Want to be in the know? Be sure to subscribe to Partners' email communications. To subscribe, click here or go to our website and select the Subscribe button.

Information Technology

The Partners Information Technology department and its systems must support both members/recipients and providers while ensuring confidentiality and privacy. This is done by maintaining secure software systems and email.

ZixMail

Partners uses ZixMail, a desktop email encryption solution that offers a high level of email security. ZixMail lets users encrypt and decrypt emails and attachments with a single click, rendering any hacked or stolen information indecipherable to anyone outside of the Partners Provider Network. ZixMail not only helps safeguard information but also assists in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

All email sent from Partners is encrypted. To view encrypted email, individuals and providers should set up their individual profile in the **Zixmail Portal**.

Note: It is important to save email received via ZixMail as an attachment as the email and information is not retrievable after 90 days. Refer to the link in this section for more information and instructions.

To receive full instructions on setting up ZixMail web portal, visit https://providers.partnersbhm.org/Alpha+-zixmail-sign/.

NCTracks

Individual Medicaid Eligibility Verification

Providers are responsible for monitoring and verifying Medicaid eligibility for their members. This can be completed through NCTracks. Providers employees who are responsible for this function need an NCTracks unique login and password.

For more information about getting started with NCTracks, go to: https://www.nctracks.nc.gov/content/public/providers/getting-started.html.

Provider Profile Information

Notification of Changes in Address

Partners BH/IDD Tailored Plan/PIHP Providers are responsible for ensuring profile information in NCTracks is accurate and current this includes licensure, addresses, insurance, NPI, taxonomy and availability. Providers of Medicaid services may correct and update information in their provider profiles by completing a manage change request (MCR) through their website. Partners is required to ensure that all provider information loaded in Alpha+ matches the information loaded in NCTracks for the purpose of claims processing. This

includes individual clinicians as well as provider agencies and hospitals. If the information in NCTracks has lapsed, expired, been terminated or if the site/address information for an agency, hospital or for an individual clinician is not included in NCTracks, then we are unable to load it in Alpha+. Claims cannot be processed until this is rectified. Please note that the site/address where a clinician will be providing services must be listed in the "name/address" section of NCTracks and not simply in the "affiliation" section. If a clinician works at multiple sites for the same provider or at multiple locations with multiple providers, all those site addresses must be loaded in the "name/address" section of NCTracks.

In situations where the information in NCTracks does not match the request Partners receives from you, then you will receive an enrollment status letter from Partners' enrollment staff. The enrollment status letter will identify the NCTracks enrollment issues that are impacting your enrollment with Partners. You will be instructed to make the correction in NCTracks first, then notify Partners once the change has been made in NCTracks so that it may be verified and your enrollment finalized with Partners. We understand that providers may have already submitted a MCR through NCTracks to update the information with them. Unfortunately, we are unable to update the information based on the MCR until we can verify the change inside NCTracks. Claims cannot be processed until this is rectified. Once your MCR has been processed with NCTracks, you should receive a notification from them. Partners does not receive that notification from NCTracks, so providers should contact the enrollment group at enrollment@partnersbhm.org as instructed in the enrollment status letter as soon as you are notified that the update has been completed with NCTracks. At that point, Partners will verify the information and update Alpha+.

Licensure Requirements

Please note that some license types expire/renew on June 30 each year as a matter of routine. Those license types include Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Clinical Social Worker (LCSW). We will not be able to update the license for those clinicians inside Alpha+ until those licenses are updated inside NCTracks. Please notify us at enrollment@partnersbhm.org as soon as the license update is complete and can be verified inside of NCTracks.

Follow the link for more information on how to maintain provider information:

https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-manage-change-requests.html.

Alpha+

Partners Health Management uses Alpha+ for its managed care operations. More details regarding Alpha+ are available on the Provider Knowledge Base, here https://providers.partnersbhm.org/transitioning-to-Alpha+/.

Alpha+ Provider Setup

The following details how to establish a provider within the Alpha+ software used by Partners.

Entities that transmit or receive HIPAA compliant X12 electronic transactions must mail an original, completed and signed trading partner agreement (TPA) to:

Partners Health Management
Attn: PartnersLOGIC
901 South New Hope Road
Gastonia, N.C. 28054

Allow 72 hours for processing.

Complete Electronic Data Interchange (EDI) Format Testing

Providers need to submit a test 837 file by uploading it to Partners secure file transfer protocol (FTP) site. Once the format testing is complete, providers are given their login credentials for a permanent FTP site inside of Alpha+. Instructions for completing this testing are included within the TPA document.

Request Individual/Unique Partners Alpha+ Logins for Staff

Each staff member will need his or her unique Alpha+ provider portal login and must complete online training prior to receiving the login. To obtain an Alpha+ login or to schedule Alpha+ provider portal online training, call the PartnersLOGIC service desk at 704-842-6431.

Adding Users for Third-Party Billers

1. Call the PartnersLOGIC service desk at 704-842-6431, Monday – Friday, 8 a.m. – 5 p.m. to request an Alpha+ login.
2. A letter from the requesting contract provider agency must be mailed to the Partners HIPAA Security Officer granting permission for this user to access their individual information through Partners Alpha+ to submit claims. A third-party login will not be issued until the letter has been received and reviewed. Send letters to:

   Partners Health Management
   Attn: HIPAA Security Officer
   901 South New Hope Road
   Gastonia, N.C. 28054

Important information to keep in mind:

Staff terminations, resignations or changes must be reported to servicedesk@partnersbhm.org so Alpha+ login access may be inactivated. Include staff name, agency name and effective date of request.

Provider portal trainings may be requested on an individual basis by emailing servicedesk@partnersbhm.org.

Information and updates related to Alpha+ are posted routinely to the Provider Knowledge Base and can be found here, https://providers.partnersbhm.org/Alpha+-zixmail-sign/.

Partners' Responsibilities to Providers

- Alpha+ is hosted at Alpha, not at Partners. However, Partners still supports the software, as well as provider issues, and escalates those issues when appropriate.

- Provider service desk technical assistance to support provider interface Monday through Friday, 8 a.m. to 5 p.m. Providers can contact the service desk by calling 704-842-6431.

Providers' Responsibilities

- Ensure and maintain high-speed internet connectivity.
- Provide complete and accurate data in all submissions to Partners.
- Follow technical support procedures as identified by Partners.
- Use and maintain a corporate e-mail address.
- Notify Partners when clinical staff terminate employment, so Alpha+ logins can be withdrawn.

STAKEHOLDER ENGAGEMENT AND COMMUNITY PARTNERSHIPS

Partners BH/IDD Tailored Plan/PIHP/State Funded Plan has a strong commitment to community engagement. We believe in active participation, collaboration, and innovative approaches to achieve individualized goals within each of our communities. Our Community Engagement department works with a multitude of community partners and providers through a variety of outreach methods to promote awareness of the special populations we serve and address their unique needs. We believe that by working together, we can collectively create the most focused, positive impact for our members and our communities.

Tribal Engagement Plan

a. The Eastern Band of Cherokee Indians (EBCI) Tribal Option is a health plan managed by the Cherokee Indian Hospital Authority (CIHA) to meet the primary care coordination needs of federally recognized tribal members and others eligible for services through Indian Health Service (IHS). Only IHS-eligible beneficiaries associated with the EBCI can participate in this health plan. The EBCI Tribal Option will build on the Tribe's strong medical model and deliver high-quality care at the local level. The EBCI Tribal Option offers care coordination and management of Medicaid medical, behavioral health, pharmacy, and support services to address the health needs of American Indian/Alaskan Native Medicaid beneficiaries. The EBCI Tribal Option is primarily offered in five counties: Cherokee, Graham, Haywood, Jackson, and Swain. Eligible beneficiaries in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania.
b. Partners has developed a Tribal Engagement Strategy that will address the needs of federally recognized tribal members and their families. Approaches the PHP will take to address tribal needs which may be different and outside of the traditional safety-net system, such as family safety (child welfare and adult protective services), energy assistance programs and commodities.

Local Community Collaboration and Engagement Strategy

Engagement with community and county organization implementation and engagement at a variety of levels:

To fully understand each community's strengths, needs and goals, we engage stakeholders at all levels of the community. We work with our network of providers to help address the needs and gaps in the communities we serve. We mobilize a team of regional directors and community engagement specialists to interact with stakeholders at all levels, serving as liaison between Partners, our communities, and our treatment providers.

This creates an efficient system for community problem-solving and solution development.

Each county is assigned a regional director and community engagement specialist. Each of these team members have extensive working knowledge of their respective communities and serve as a point of contact for stakeholders looking for resources, having service needs, or seeking to develop programs and services in their communities.

Community Collaborative groups, hosted by the Community Engagement team, are a great way for Providers to network with representatives from community agencies and organizations such as non-profits, faith-based organizations, PHP regional managers, CFAC members, local education agency representation, social services, law enforcement, families, cultural groups and members. Each group focuses on the needs of adults and children. Each meeting is held monthly with the purpose of sharing ideas, resources, identifying gaps and needs within the service continuum as well as social determinants of health needs.

Additionally, all staff within the Community Engagement department work with internal staff and agencies to ensure members have access to treatment. They work with community agencies to identify needs, barriers, and develop ways to overcome obstacles that impede initiating treatment, staying engaged and achieving positive outcomes.

In addition to our Community Collaborative groups, the Community Engagement team hosts a monthly Community Café discussion. The Community Café discussions are held virtually and cover a wide range of topics that are of interest to our stakeholders. Topics include things like specialty courts and diversion programs, community resources, and innovative approaches to addressing social determinants of health.

Local Community Crisis Services Plan

In accordance with N.C. General Statute 122C-202.2, Partners collaborates with local law enforcement, emergency personnel, psychiatric facilities and/or medical facilities, magistrates, health plans and other community organizations to develop local comprehensive crisis service plans. Each plan is developed based on a thorough review of the community's available resources, input from the stakeholders identified above and member needs. Plans are unique to each county served within Partners catchment area and includes information related to involuntary commitment transportation, identification of facilities contracted with Partners to provide health screenings, first examinations and training for law enforcement personnel and other people designated or required to provide transportation and custody of involuntary commitment respondents. The local community crisis service plan is updated every two years or earlier if changes dictate a need for revision.

The coordination and facilitation of the local community crisis collaboratives and service plans are assigned to Partners' Community Engagement team. Meetings are held on a quarterly basis throughout Partners' service area.

Community Training

Community training at the stakeholder level is provided by both system of care/community training coordinators and our Health Education and Resource Team (HEART), formerly known as the Geriatric Adult Specialty Team (GAST). These trainings are free and open to community members and providers alike. Our trainings are designed to increase awareness on healthcare-related issues, as well as create connections to resources.

Non-Emergency Medical Transportation (NEMT) and Non-Emergency Ambulance Transportation (NEAT)

Partners offers NEMT and NEAT services for our Tailored Plan members . We maintain a robust network of transportation providers throughout our service area to accommodate our members' needs. Partners offers in-person, virtual, and on demand trainings related to NEMT/NEAT services and how to access and schedule rides. Our members have access to a transportation app to schedule trips in advance and receive notification regarding the status of their ride. Partners has transportation information and forms easily accessible on our website. Partners also has designated staff to escalate any concerns or needs to our transportation vendor, assist with removing barriers to transportation, and provide personal instruction to our members and stakeholders as needed.

- System of care/community training coordinators develop, coordinate and implement staff and community-based trainings in concert with the guiding principles of the system of care philosophy and practice principles. They offer a variety of curricula and modalities to meet the needs of the treatment providers, law enforcement, stakeholders, and community members. Topics include Crisis Intervention Training (CIT), Mental Health First Aid (adult and youth), Community Resiliency Model (CRM), Buffering Toxic Stress and many more. Multiple training courses are offered monthly and are tailored to meet the needs of the specific audience. While most trainings are face to face, accommodations have been made to provide live webinars for members, community agency staff, and citizens. All training is offered for free except for purchasing requirement materials (notebooks). Locations are accommodating to the stakeholders.
- The HEART team provides free information, education and training to people working with older adults in long-term care facilities and the community. The skills provided by HEART help to increase a caregiver's understanding of mental health issues and how they relate to older adults. Multiple training courses are offered monthly and are held at facilities in which members reside or at various community agencies. While most trainings are face to face, accommodations can be made to provide live webinars for community agency staff as well as tailored trainings for members and caregivers. Training topics include assisting individuals living with Alzheimer's disease and dementia, respectful communication with dementia and mental illness, and many more
- Partners has robust community engagement practice. We truly believe in partnering with our stakeholders to build strong communities and enhance the well-being of our members. By collaborating and building on the strengths of our community partners, we can implement new initiatives and programs that enhance the lives of those we serve as well as the entire community.

CULTURAL AND LINGUISTIC COMPETENCY

Ensuring Provider Cultural Competency

Partners understand that some cultural groups are more likely to be underserved and receive differential treatment outcomes. Accordingly, we have adapted our provider training and tools to improve health care services for culturally and linguistically diverse groups. Through training, contract requirements and ongoing monitoring, providers are expected to deliver care that is culturally relevant for members/recipients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities and regardless of gender, sexual orientation or gender identity.

Partners is dedicated to training on and following the guidance in The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) developed by the U.S. Health and Human Services Office of Minority Health. The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality and help eliminate health care disparities by providing a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services. Partners TRAC staff continuously evaluates, designs and reviews training to ensure they maintain a focus on cultural sensitivity and competence, equality and a person-first perspective.

Cultural competency within Partners is defined as the willingness and ability of a system to value the

importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective that values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems of practices among providers and staff to ensure that services are delivered in a culturally competent manner. Partners is committed to the development, strengthening and sustaining of healthy provider/member/recipient relationships. Members and recipients are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members and recipients are at risk for sub-optimal care. Members/recipients may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. As part of its contracting, Partners will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members/recipients understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the race/ethnicity and language and its impact/influence on the member/recipient's health or illness.
- Office staff that routinely interact with members/recipients have access to and participate in cultural competency training and development.
- Office staff that are responsible for data collection make reasonable attempts to collect race and language-specific member/recipient information. Staff will also explain race/ethnicity categories to a beneficiary so that the member/recipient is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the member/recipient's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and if required by Department of Health and Human Services, any other required non-English language.

Partners' Cultural Competency Plan is reviewed for ongoing development with input from the Partners Provider Council.

Partners is committed to:

- Outlining a Cultural Competence initiative for Partners and network providers.
- Employing strategies for recruiting, hiring and maintaining a culturally diverse workforce at all levels of staffing.
- Providing technical assistance and training for network providers.

Providers are required to develop a Cultural Competence Plan. The provider's Cultural Competence Plan should be consistent with Partners' most current Cultural Competence Provider Plan posted on the Partners website. The provider shall develop procedures for the implementation of systems to evaluate and/or measure adherence to their Cultural Competence Plan, ensure that all staff are trained, and have training available for review by Partners' Quality Management Monitoring Teams.

NETWORK DEVELOPMENT AND MAINTENANCE

Partners will ensure the provision of covered services as specified by the State of North Carolina. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the network adequacy requirements for the Tailored Plan and PIHP networks. Partners will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the behavioral health and medical needs of its members/recipients, both adults and children, without excessive travel requirements, and that is in compliance with Partners' access and availability requirements. For Tailored Plan covered members, Partners offers a network of primary care providers to ensure every member has access to a medical home within the required travel distance standards (30 minutes or 30 miles for at least 95% of members in rural regions; and 30 minutes or 10 miles for at least 95% of members in urban regions). Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, nurse practitioners, and physician assistants. (More information on Primary Care Physicians and their responsibilities can be found in this manual.

In addition, Partners will have available, at a minimum, the following specialists for Tailored Plan covered members on at least a referral basis:

Allergy/Immunology	Gastroenterology
Dermatology	Hematology
Anesthesiology	Gynecology
Hematology	Pain Management (Board Certified)
Cardiology	Infectious Disease
Endocrinology	Nephrology
Ophthalmology	Pulmonology

Optometry	Rheumatology
Orthopedic Surgery	Neurology
ENT/Otolaryngology	Radiology
Urology	Psychiatry
Oncology	

In the event Partners network is unable to provide medically necessary services required under the contract, Partners shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a Partners member for physical health purposes, please contact our Provider Line at 877-398-4145 and a provider will be identified to make the necessary referral.

Non-Discrimination

Partners does not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discrimination laws. Furthermore, we do not have and have never had a policy of terminating any provider who:

- Advocated on behalf of a member or recipient.
- Filed a complaint against Partners.
- Appealed a decision of Partners.

If a provider believes that Partners has discriminated against them, they should file a formal complaint following the process outlined in the Grievance/Complaint Process section of this manual. If the grievance/complaint resolution process does not resolve the issue to the provider's satisfaction, they should notify the NCDHHS of the incident utilizing the process outlined on the DHHS website located at https://www.NCDHHS.gov/.

Tertiary Care

Partners offers a network of tertiary care providers, including level one and level two trauma centers, burn centers, neonatal intensive care units, perinatology services, rehabilitation facilities, comprehensive cancer services, comprehensive cardiac services and medical sub specialists available 24 hours per day in the geographical service area. In the event Partners' network is unable to provide the necessary tertiary care services required, Partners shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

Network Adequacy and Access Standards (includes standards for both BH/IDD Tailored Plan providers and for PIHP/Medicaid Direct)

Partners, along with network evaluators and the Network Management Committee, will regularly assess network adequacy through quantifiable and measurable processes to ensure access to care and contract compliance. Partners will continue to monitor our network to ensure all covered services are available and accessible in a timely manner. Partners will conduct formal quarterly assessments to make sure our Network Access Plan is moving forward and meets adequacy and Department quality assurance standards. Partners will contract with a network that complies with the following standards and will reassess the adequacy of the network at least quarterly to ensure on an ongoing basis that members/recipients have appropriate access to care. In order to ensure that all Members/recipients have timely access to all covered health care services, Partners will ensure its network meets the following time and distance standards as measured from the Member/Recipient' residence for adult and pediatric providers separately through geo-access mapping at least annually.

For purposes of network adequacy standards for physical health providers/services, except as otherwise noted, adult services are those provided to a Member who is 21 years of age or older and pediatric (child/children) services are those provided to a Member who is less than 21 years of age.

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a Member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a Member who is less than 18 years of age.

In the table below "urban" is defined as non-rural counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties." "Rural" is defined as a county with an average population density of less than 250 people per square mile.

Tailored Plan Time/Distance Standards Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care	≥ 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

3	Hospitals*	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital 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 (1) – *measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN requirements.*	≥ 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 members	≥ 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 Outpatient Program, and Outpatient Opioid Treatment (OTP) ≥ 2 providers of each service within 45 minutes or 45 miles residence for at least 95% members Child and Adolescent Day Treatment Services: Not subject to standard
9	Crisis Services	Professional treatment services in facility-based crisis program: The greater of: • 2+ facilities within each Tailored Plan/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 Tailored Plan/PIHP Region • Medically Monitored Inpatient Withdrawal Services:(non-hospital medical detoxification) ≥ 2 Providers within each BH I/DD Tailored Plan/PIHP Region • Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification), Ambulatory Withdrawal Management with Extended On-Site Monitoring, Clinically Managed Residential Withdrawal services (social setting detoxification), Mobile Crisis Management: ≥ 2 Providers of each crisis service within each BH I/DD Tailored Plan Region, ≥ 1 Provider of each crisis service within each PIHP Plan Region, •	
10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan/PIHP/PHP/ 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 BH I/DD Tailored Plan/PIHP/ Region. Each county in BH I/DD Tailored Plan/PIHP/ 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.	

15	Residential Treatment Services	• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan/PIHP Region, • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): Access to ≥ 1 licensed provider per BH I/DD Tailored/PIHP Plan Region (refer to 10A NCAC 27G.3400) • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): o Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan/PIHP Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established o Adolescent: Contract with all designated CASPs statewide o Women & Children: Contract with all designated CASPs statewide • Clinically Managed Population-Specific High-Intensity Residential Program: contract with all designated CASPs • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): o Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan/PIHP Region (Refer to 10A NCAC 27G.5600E)3 o Adolescent: Access to ≥1 program per BH I/DD Tailored Plan/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 • Medically monitored intensive inpatient services (once policy is added) •

16	Employment and Housing	• "• Individual Placement and Supports (IPS) – Supported Employment (Adult MH): Eligible individuals shall have the choice of at least two (2) provider agencies within each PIHP Region. Each county in BH I/DD Tailored Plan/PIHP Region must have access to ≥1 provider that is accepting new patients • Region."
17	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/PIHP Region. • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each Tailored Plan/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. •

18	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/PIHP Region. • Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each Tailored Plan/PIHP Region. • Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification: N/A
19	1915(i) HCBS Services	• Community Living and Supports, Individual and Transitional Supports, Out of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) Service within each Tailored Plan/PIHP Region. • In-Home Respite: ≥ 2 providers within 45 minutes of the Member's residence. Community Transition: Not subject to standard

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) • Diagnostic Assessment
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 withdrawal management without extended on-site monitoring (Ambulatory detoxification)Medically monitored inpatient withdrawal services (Non-hospital medical detoxification) (adult)Ambulatory withdrawal management with extended onsite monitoring • Mobile Crisis Management • Clinically managed residential withdrawal services (social setting detoxification)

4	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Medically managed intensive inpatient service (Inpatient Behavioral Health)Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds) *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds •

		• Acute care hospitals with child inpatient psychiatric beds • • Medically managed intensive inpatient services (Acute care hospitals with adolescent inpatient substance use beds
5	Partial Hospitalization	• Partial Hospitalization (adults and children)
6	Residential Treatment Services	• Mental Health Recovery and Residential Services • Residential treatment facility services • Substance Abuse Halfway House Adult Male • Substance Abuse Halfway House Adult Female • Substance Abuse Medically Monitored Community Residential Treatment • Substance Abuse Non-Medical Community Residential Treatment • Substance Use Residential Services & Supports • Mental Health Recovery Residential Services • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID • Clinically managed population specific high intensity residential services
7	Community/Mobile Services	• Assertive Community Treatment • Community Support Team • Intensive in-home services • Multi-systemic therapy services • Peer Supports • Transition Management Service • Assertive Engagement • High-fidelity Wraparound • Case Management
8	Employment and Housing Services	• Residential Services (I/DD and TBI) • Respite Services • Individual Placement and Support-Supported Employment (Adult MH) • Supported Employment for I/DD and TBI • I/DD & TBI Day Supports • Community Living and Supports

9	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Navigator • 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

10	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Crisis Intervention and Stabilization Supports • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Residential Supports • Resource Facilitation • In Home Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Vehicle Modifications
11	1915(i) HCBS	• Community Living and Support • Individual and Transitional Support • Respite • Individual Placement and Support (Supported Employment) (For MH/SUD) • Supported Employment (For IDD/TBI) • Community Transition

Partners uses the following provider types as “specialty care” providers for purposes of meeting the requirements for Network Adequacy.

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

Medicaid Direct Contract Section VI. Attachment E. Table 1: PIHP Time/Distance Standards			
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 Behavioral Health 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 Behavioral Health 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 st	
4	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan/PIHP/PHP/ 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 and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) Service within each Standard Plan Region. • In-Home Respite: ≥ 2 providers within 45 minutes of the Member's residence. • Community Transition: Not subject to standard	

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 PIHPs 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)[1] ○ 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 Navigator, 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
10	Employment and Housing Services	• Individual Placement and Supports (IPS) – Supported Employment (Adult MH): Eligible individuals shall have the choice of at least two (2) provider agencies within each PIHP Region. Each county in PIHP Region must have access to ≥1 provider that is accepting new patients

Medicaid Direct Section VI. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD) • Diagnostic Assessment

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	• Professional treatment services in a facility-based crisis program (adult) • Facility-based crisis services for children and adolescents • Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification) • Medically monitored inpatient withdrawal services (Non-hospital medical detoxification) (adult) • Ambulatory withdrawal management with extended on-site monitoring • Mobile Crisis Management Clinically managed residential withdrawal services (social setting detoxification)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Medically managed intensive inpatient service (Inpatient Behavioral Health) Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds) *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with child inpatient psychiatric beds • Medically managed intensive inpatient services (Acute care hospitals with adolescent inpatient substance use 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 (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports •
8.	Residential Treatment Services	• Residential treatment facility services • Substance Abuse Medically Monitored Community Residential Treatment • Substance Abuse Non-Medical Community Residential Treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID
9.	Employment and Housing Services	• Individual Placement and Support-Supported Employment (Adult MH) • Supported Employment for I/DD and TBI
10.	1915(i) HCBS	• Community Living and Support • Individual Support • Respite • Individual Placement and Support (Supported Employment) (For MH/SUD) • Supported Employment (For IDD/TBI) • Community Transition

11.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Navigator • 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
12.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Residential Supports • Resource Facilitation • In Home Respite • Supported Employment • Crisis intervention and stabilization supports • Speech and Language Therapy • Vehicle Modification • Specialized Consultation

To ensure compliance with BH/IDD Tailored Plan/PIHP Network Adequacy reporting, Partners will:

- Generate provider counts as of a particular date and the number of members/recipients served, including timeframes.
- Generate counts of members/recipients who lived in the regional catchment area during the identified timeframe. When determining if Medicaid members have choice of or access to providers, count only

provider agencies with current (as of identified date) contracts with Partners and who are actively accepting new referrals. When determining recipient choice of or access to providers for State-funded requirements, count only provider agencies with current (as of identified date) contracts with Partners to provide non-Medicaid-funded services.

Partners will overlay this data with the requirements for the services to ensure access standards and choice standards are met, or to close those identified gaps.

To describe and demonstrate our approach, we have provided eight tables that cover the following:

- Tailored Plan/PIHP Provider Network Access Standards (Geographic, Specialty, Service) - Tailored Plan Time/Distance Standards for Medicaid
- Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid
- Appointment Wait Time Standards for Medicaid
- Specialty Care Provider Types
- Tailored Plan Time and Distance Standards – state-funded
- Classification of Service Category for Behavioral Health Time and Distance Standards
- BH I/DD Appointment Wait Times – state-funded
- Process for Assuring Compliance with Access

These tables can be found in the Network Access Plan in ProviderCONNECT.

Network requirements*:*

Partners has established the following procedures for the selection and retention of acute, primary, mental health, substance use disorders, intellectual/developmental disability and long-term services and supports providers in the Tailored Plan/PIHP provider network.

- Partners ensures that providers are credentialed in accordance with 42 C.F.R. § 438.206(b)(6) through acceptance of provider credentialing and verified information from the NCDHHS. Partners shall not request any additional credentialing information from the provider without the NCDHHS approval.
- Partners has identified standards and established a documented process for making network contracting decisions as outlined in this policy. Partners does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Partners does not discriminate 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.
- Partners does not 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.

- Partners does not contract with providers who are not enrolled with the NCDHHS 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.
- As part of the contracting process, when Partners requires a provider to submit additional information, Partners will include a description of all such information.
- Network providers seeking to add a site or service to a network contract should submit the appropriate change form located on the Enrollment page of the Partners website. If a need for the additional site or service has not been identified, the Provider Network department may reject the request or may gather information related to service capacity and needs and present the request to the PNPC for consideration.
- If the request is approved, the request will be reviewed to ensure that network providers seeking to add a new site location or service to their existing contract meet applicable contracting requirements and are in good standing with established quality standards.
- Network providers may link additional licensed practitioners without applying to add a new site or service so long as the additional licensed practitioners will be working out of existing site locations enrolled in NCTracks and contracted with Partners. All licensed practitioners are required to meet credentialing requirements in accordance with NCDHHS CCRP and must be enrolled in NCTracks prior to enrollment with Partners

Quality Standards

Partners will adopt the NCDHHS Objective Quality Standards for participation as a Medicaid Enrolled provider or State-Funded Services provider. Medicaid and State-funded providers will be reviewed against the following established quality standards:

1. Availability of public funds (State-Funded Services are not an entitlement and are subject to limited availability of state funds).
2. Provision of a service that is identified as necessary within the Partners Network Access/Development Plan or supported by the Network Adequacy and Availability (needs assessment/gap) analysis.
3. Demonstrated compliance with the terms and conditions of the Partners Provider Contract(s) (including any applicable scope of work), and applicable state and federal laws, rules and regulations.
4. Demonstrated compliance with the Partners Provider Operations Manual as amended or supplemented, Partners Provider Communication Bulletins, and bulletins and manuals issued by the NCDHHS.
5. Demonstrated ability of a network provider to ensure that members meet medical necessity requirements for all services provided. Specifically, provider must have an authorization approval rate on service requests at or above 75% in any identified time period.
6. Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes.
7. Demonstrate an acceptable agency Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members.

8. Provide an adequate emergency response system that complies with the services being provided, including the implementation of measures to respond to emergencies on weekends and evenings for members served by the Network Provider.
9. Demonstrates member-friendly services and attitude by implementing a system that ensures good communication with members and families as evidenced by a review of member grievances/complaints.
10. Provision of services in accordance with all applicable state and federal laws, rules, regulations, the NC State Plan for Medical Assistance, the Waiver, State Service Definitions, and/or Clinical Coverage Policies.
11. Meet Division of Mental Health/Developmental Disabilities/Substance Use Services (DMHDDSAS) access standards and appointment wait times.
12. Implementation of a no-reject policy for clinically appropriate member referred by Partners.
13. Cooperation and compliance with discharge and transfer requirements to ensure a smooth transfer for any member that desires to change providers, or because the Network Provider cannot meet his/her special needs.
14. Meeting all documentation requirements as set forth in Medicaid Clinical Coverage Policies, State Service Definitions, and/or the Records Management and Documentation Manual.pdf.
15. Cooperation and participation with all Partners Program Integrity activities (including but not limited to investigations, audits, and prepayment and post-payment reviews), utilization review/management, quality management, compliance, and appeal and grievance/complaint procedures.
16. Ability of the network provider to meet re-credentialing criteria as determined by NCDHHS CCRP.
17. Participation in member satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements, as requested, or as appropriate.
18. Demonstrated financial stability as evidenced by the provider must have a claims approval rate at or above 80% in each quarter of the fiscal year per funding source (applies to provider specific denial reasons, not Local Management Entity/Managed Care Organization [LME/MCO] issues).
19. An acceptable Quality Management Plan with evidence of strategies and goals being implemented by the network provider.
20. Adequate clinical leadership according to the disability and services being provided by the network provider with a sufficient supervision structure.
21. Demonstrated HIPAA-compliant Electronic Medical Record (EMR) system which supports management of authorizations and billing functions and compliance with the Federal Meaningful Use Standards.
22. An acceptable liability history: no history of liability claims for the last five years. An unacceptable liability history is defined as: Within the five-year period immediately preceding the date of the agencies' application, one or more legal actions resulted in: (i) At least one judgment; (ii) One settlement in an amount over $50,000 or more; or (iii) two or more settlements in an aggregate amount of $50,000 or more.
23. A valid and current facility license and national accreditation (if required).
24. The network provider is not in compliance with applicable federal or state laws, rules or regulations, or is in breach of any provision of its current contract with Partners, including but not limited to the scope of work or requirements concerning clients' rights, confidentiality and records retention.

25. The network provider has not billed for each type of service contained in the current contract as documented by a paid claim for service delivered during the most recent 60-day period (must allow another 60 days for timely filing considerations). Service types without billing will be removed from the renewal contract. (Exceptions may be made at Partners sole discretion for necessary, but infrequently used services such as crisis respite or a provider of specialty or out-of-catchment area services that are delivered infrequently.)
26. Partners has issued two or more consecutive plans of correction against the network provider for the same or substantially similar findings within the three-year credentialing and/or recredentialing cycle.
27. The network provider has failed to implement a Plan of Correction issued by Partners and the time for doing so has expired.
28. Partners has issued two or more sanctions or administrative actions against the network provider in a consecutive period of time.
29. The network provider has failed to remit an identified overpayment to or enter into an approved payment plan with Partners within the designated timeframe.
30. Partners has logged quality of care concerns or other serious grievances/complaints about the network provider that have not been satisfactorily resolved in required timelines.
31. The network provider has had a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Partners; (specifically, the provider must have an overall approval rate for claims at 80% in any identified time period per funding sources (applies to provider specific denial reasons, not LME/MCO issues; exceptions may be made at Partners sole discretion for essential providers/services excluded by this item with the successful implementation of a plan of correction).
32. The network provider has not responded to requests for data or other information necessary for Partners to respond to requests from the state.
33. The network provider fails to provide proof of insurance as required under the terms and conditions of the contract.
34. The network provider has failed to meet routine monitoring requirements.
35. Partners has issued an RFP or RFI for the service(s) delivered by the network provider and the RFP/RFI clearly indicates a response is required to continue providing services in the Network.
36. Partners has identified excess capacity for the service(s) delivered by the network provider or has determined that the network provider's service delivery does not fit within the priorities for network development as identified in the Network Development plan and/or the needs assessment/gap analysis.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a

condition identified by screening," even if the service is not covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

Partners TP/PIHP provides coverage for a full range of childhood services, as defined in the NCDHHS policies and procedures. Coverage complies with the American Academy of Pediatrics (AAP) and Bright Futures periodicity schedule for screenings and the Center for Disease Control & Prevention's Advisory Council on Immunization Practices Recommended Immunization Periodicity Schedule. The EPSDT program facilitates age-appropriate, comprehensive preventive services for Partners' members from birth through age 20 (covering services through the month of a member's 21st birthday), as outlined by the AAP. The program emphasizes early detection and treatment to improve overall health, including behavioral health (BH). EPSDT resources and toolkits are available in ProviderCONNECT.

Partners' medical necessity determination process includes consideration of each member's specific circumstances and needs. We adhere to applicable state and federal requirements specific to EPSDT, as defined in 42 U.S.C. § 1396d(r) and 42 C.F.R.§§ 441.50-62 and the application of professionally recognized standards of care.

We maximize health outcomes by ensuring members receive consistent, high-quality care delivered in the most appropriate setting, in the most economic mode and according to nationally recognized, evidence-based clinical decision criteria, including InterQual® criteria and applicable EPSDT guidelines. We will not require prior authorization (PA) for preventive care including early and periodic screens and wellness visits for members under 21 with Medicaid.

Providers can submit prior authorization requests, review progress and access adverse decision letters via ProviderCONNECT. For services that require review, Partners ensures the determination process does not delay service delivery. We may recommend alternative services to meet the child's needs, including referral assistance for a non-medical treatment that is not covered. Federal EPSDT criteria will be considered and documented during service authorization review. We will not make an adverse benefit determination for a child until the request is reviewed per EPSDT criteria.

Partners contractually requires all network providers to offer EPSDT preventative health services to their eligible members according to the AAP periodicity schedule. EPSDT services include routine physical examinations, screenings for developmental delays, screenings for autism spectrum disorder, appropriately scheduled immunizations, oral health assessments, dental counseling, lab testing and health education for children and caregivers.

Partners has developed a comprehensive EPSDT curriculum for all network providers for whom EPSDT is relevant. Training topics include:

- EPSDT benefits and screening components.
- Medical necessity review standards and processes.
- Bright Futures periodicity schedule sponsored by the American Academy of Pediatrics.
- Documentation requirements.

- Immunizations.
- Laboratory tests.
- Medical transportation services.
- Partners EPSDT outreach activities.
- EPSDT documentation required for reimbursement.
- Into the Mouths of Babes/Physical Fluoride Varnish Program.

We provide EPSDT education to all pregnancy management programs, FQHCs, prenatal clinics and OB providers who offer prenatal or EPSDT services through:

- New provider orientation.
- In-person site visits.
- Webinars and regional seminars.
- Partners' website and ProviderCONNECT.
- Provider Manual and provider newsletters.
- Ongoing provider training sessions.

Partners routinely audits providers who deliver EPSDT services. This audit is highly effective in determining a provider's understanding of EPSDT protocols. It includes a review of the timeliness and frequency of services provided and type of care delivered. We give feedback and specialized education through individualized meetings, provider forums or webinars.

EMERGENCY CARE SERVICES

Partners TP/PIHP defines an emergency medical condition as a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairments of bodily functions.
3. Serious dysfunction of any bodily organ or part; Serious harm to self or others due to an alcohol or drug abuse emergency.
2. Injury to self or bodily harm to others.
3. With respect to a pregnant woman having contractions: that there is inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn.

Beneficiaries may access emergency services at any time without prior authorization or prior contact with Partners. If beneficiaries are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Partners Health 24-hour Nurse Triage Line for assistance; however, this is not a requirement to access emergency services.

Partners contracts with emergency services providers as well as non-emergency providers who can address the beneficiary's nonemergency care issues occurring after regular business hours or on weekends. Emergency services are covered by Partners when furnished by a qualified provider, including non-network providers, and will be covered until the beneficiary is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Partners. Emergency services are covered and reimbursed regardless of whether the provider is in Partners provider network as long as the provider is located within the United States. Emergency services obtained outside the United States are not covered by the state or Partners.

Payment will not be denied for treatment obtained within the United States under either of the following circumstances:

1. A beneficiary had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition.
2. A representative from the plan instructs the beneficiary to seek emergency services. Once the beneficiary's emergency medical condition is stabilized, Partners requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this handbook.

Providers serving Medicaid Direct members will bill NC TRACKS directly. https://providers.partnersbhm.org/

After-Hours Coverage and Crisis Plan Requirements

As a member of the Partners' provider network, you have a responsibility to ensure clinical coverage for members after hours. This will help reduce unnecessary visits to the emergency department (ED) for behavioral health concerns that could better be managed by your clinical teams. To ensure compliance with this requirement, Partners periodically engages in "mystery shopping" calls to verify after-hours protocols; we also conduct crisis plan audits.

Please review Partners' network provider requirements below and as outlined in the Partners' Provider Operations Manual as well as service definitions and NC Department of Health and Human Services clinical coverage policies.

Below are guidelines and requirements for your after-hours protocol and a sample script for voice mail messages.

Providers must:

1. Have a clinical backup system in place to respond to all crises/emergencies for members receiving services. This includes:
2. Crisis plans that are available to the providers' clinicians, members and their natural supports, and Partners' Access to Care Department
3. Information and directions on how to seek assistance in a crisis/emergency:
4. Posted office hours, weekends, evenings and holidays for all members being served
5. Voicemail systems updated and monitored

6. Voicemail message specifies mental health, substance use, or psychiatric crisis for after-hours coverage phone number
7. Have a 24/7/365 telephone number for members to contact you in the case of an MH/DD/SA crisis or emergency.
   - This contact may NOT be:
     - 911 (unless specified for medical emergencies)
     - Directing the member to the emergency department for non-medical crisis
     - **PartnersACCESS BH Crisis Line**
     - A hospital or Mobile Crisis Team (unless a contracted arrangement exists)
   - This contact is:
     - An agency staff or subcontracted backup contact person who has the qualifications, training and capacity to navigate the range of MH/DD/SA crisis scenarios a member may experience
     - Staff who assists the member and assists in the coordination of care during the crisis
     - Staff available telephonically or in-person if the situation requires
     - Has immediate access to crisis plans for members who have them
     - Sample script for voice mail messages for after-hours coverage:

"You have reached [Provider Name] [Provided Service]'s after-hours first responder line. If this is a medical emergency, please hang up and dial 911. If you, or your family member, are currently receiving [Service Type] services and need immediate assistance, please press [Designated Key or Number Sequence] to speak with a member of our team. For all non-emergency mental health or substance use service-related calls, please press [Designated Key or Number Sequence] to leave a voice mail that will be answered the next business day. Thank you for calling [Provider Name] [Provided Service]'s after-hours first responder line."

PartnersACCESS Call Center

PartnersACCESS provides customer service lines for providers and members to access information about Partners Medicaid Direct and Tailored Plans. Partners Member Services Department provides oversight of the PartnersACCESS/Call Center and Member Engagement Department.
PartnersACCESS Service Lines Partners offers multiple customer service lines for providers and members:

Provider Services **877-398-4145** operates Monday through Saturday 7 a.m. to 6 p.m.

MENU OPTIONS	DESCRIPTION/SUBMENUS

Option 1	Partners IT Help Desk
Option 2	Provider Claims
Option 3	Partners Utilization Management submenu
	UM Option 1 Tailored Plan/Physical Health/DME Option 2 I/DD and TBI Option 3 Behavioral Health Outpatient Option 4 Behavioral Health Inpatient
Option 4	Contracts & Credentialing
Option 5	Behavioral Health Provider Account Specialist
Option 6	TP Transportation Provider Sub Menu
Sub Menu 1	Facility Transportation Assistance
Sub Menu 2	Provider Transportation Assistance
Option 7	TP Pharmacy
Option 8	TP Vision
Option 9	TP Radiology
Option 0	"For all other Provider issues" live agent queue

CLOSED MENU OPTIONS	DESCRIPTION/SUBMENUS
Option 1	Tailored Plan NEMT Transportation sub- menu
	option 1 NEMT Facility
	option 2 NEMT Provider
Option 2	CVS Pharmacy Provider line
Option 3	TP Vision
Option 4	TP Radiology
Option 5	Provider Line Voice Mail

Member and Recipient Services **888-235-4673** operates Monday through Saturday 7 a.m. to 6 p.m.

Assistance for Partners Medicaid members and State-funded recipients' general questions and connection to services. Callers may leave a voicemail and receive a return call within 24 hours.

Provider and Member Non-Emergent Medical Transportation Lines: Modivcare is our vendor that manages transportation for Tailored Plan members. Modivcare will schedule rides for Tailored Plan members to/from medical appointments, pharmacy to pick up medications, and rides for members being discharged from the

hospital.

Rescheduling in the event of no-shows. The Modivcare agents will assist in rescheduling the ride and attempt to arrange transportation for the same day. The agents can call the provider/medical office with

member to determine if they can be seen later that day or if the appointment needs to be rescheduled Modivcare requires at least a 2 day notice but can schedule Urgent Trip requests if needed.

1. If a member has family member or friend who can transport the member to their appointment, then they can request mileage reimbursement from Modivcare.

For NEMT Providers- 855-397-3604

Partners vendor, Modivcare, is committed to providing a high level of support and value to our members and providers. Visit the Transportation Portal https://www.modivcare.com/who-we-serve/transportation-provider-driver/ for questions on:

- Billing and claims
- Ride reservations
- Book a driver safety training course

Nurse Advice Line (Member Only)-888-369-2452

The Nurse Advise Line is only for Partners Medicaid Tailored Plan members. Centene nursing staff manage general medical benefits questions. Prior to warm transferring any caller to the Nurse Advise line, staff must verify in NCTracks their Medicaid plan is Partners TP and that the caller needs assistance with the following:

- Triage for medical symptoms
  - Emergent
  - Non-emergent
- Medication inquiries
  - Side Effects
  - General knowledge
- Health Topics
  - Newly diagnosed
  - Audio library and Health materials

Helpful information to understand about the Nurse Advise Line

1. The Nurse Advise line operates 24/7/365.
2. Every call is live answered by a Customer Care Professional (CCP)
3. They field calls for emergent and non-emergent medical symptoms
4. Answer questions about Medications, side effects, and general knowledge
5. Educate members on Health topics and has audio library.

Partners Pharmacy Line-866-453-7196

CVS Caremark, is Partners Prescription Benefit Manager for members and providers. Members should note that this does NOT mean members have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a very large pharmacy network.

NC Medicaid has a drug list for prescription drugs that is a closed formulary. Under a closed formulary, certain drugs are not covered. Please note that there is an exception process available to providers who believe that, based on medical necessity, it is in the member's best interest to remain on a non-covered drug(s).

Basic services provided:

1. Lines are staffed 24/7/365
2. Processing pharmacy claims
3. Creating and administering retail pharmacy networks
4. Ensuring clinically appropriate drug use at network retail pharmacies
5. Helping members understand the best use of pharmacy benefits
6. NOTE: Calls from Providers about PADP-Physician Administered Drug Program-any injections for drugs administered at a medical provider's office-will be warm transferred to the Partners UM Physical health number.

Radiology Line-800-327-0639 or RadMD.com

Evolent Radiology is the Provider delegated Radiology Benefit Manager. Medicaid Providers requiring eligibility validation, claim status, or other questions use this line.

Vision Line-833-224-0516

Envolve Vision is the delegated manager for eye exams and eyewear. Providers call for prior authorizations for these services.

Providers can send an email to –visioncustomerserviceL2@envovlehealth.com and is responded to the next business day.

Behavioral Health Crisis line-833-353-2093

This line is live answered by licensed clinicians and operates 24 hours a day, seven days a week for access to crisis and services available to all members and recipients regardless of beneficiaries' funding source. The BH Crisis line provides access to behavioral health screening/triage/referral service for all regional catchment area individuals to determine eligibility, the level of acuity, and provider preference.

Partners BH Crisis line licensed clinicians screen and triage each caller to determine the level of acuity and need for behavioral health crisis services. The screening and/or enrollment guides the subsequent referral to emergent, or urgent services. For any screening that meets routine level of acuity, a referral will be made to an appropriate provider for routine community-based services.

After the initial triage, those who are eligible for State-funded urgent or routine services are offered a choice, when available, of at least two appropriate providers and are referred for an intake assessment. Information on clinical specialties of providers, locations, hours of operation and services provided are available to assist the caller/member with determining choice. Partners also maintains a comprehensive list of hospital and inpatient facilities located across North Carolina.

Licensed staff offer referral or walk-in information to each eligible caller/member with the provider of choice. Choice is determined by:

- Availability of Service.
- Proximity to member.
- Caller/member's desire for the services the provider offers.

In an emergent situation, staff facilitates an immediate Mobile Crisis face-to-face assessment and/or a referral to an appropriate crisis provider then follows up with all emergent and urgent referrals to ensure the safety of the member and to determine whether the member has engaged in services. **Once a provider acknowledges (accepts) a routine referral made by Partners, the provider is expected to follow up with the referral that was made to their agency to remind the member of the scheduled appointment, reschedule the appointment, and/or assertively reach out to those members who do not show for their initial appointments. Providers are to ensure that a routinely referred member is assessed within 14 calendar days.**

The PartnersACCESS department, along with the Quality Management department, conducts internal quality assurance reviews designed to assure that Partners' members receive timely access to services based on the state's timely access requirements for emergent, urgent or routine care.

Appointment Accessibility Standards

Partners follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Partners monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency department utilization. **Providers who fail to comply with published appointment standards may be subject to corrective action.**

Visit Type	Standard
Emergent	Immediately
Urgent	Within 24 hours
Routine	Within 14 calendar days

Funding Sources Accepted

Eligibility and Enrollment staff enrolls (when appropriate) and/or schedules eligible individuals with the following funding sources.

- Indigent/uninsured residents of Burke, Cabarrus, Catawba, Cleveland, Davidson, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union and Yadkin counties.
- Standard health plan Medicaid-B members will be warm transferred to their health plan behavioral health provider.

Regardless of payer source, PartnersACCESS department will assist all callers triaged as emergent by ensuring that the emergent individual receives a face-to-face service within two hours by offering a Mobile Crisis service, refer to Facility Based Crisis, referring to EMS/911 dispatch or directing the individual to a local hospital emergency department. Please see the section titled "Additional Funding Source Information" for instructions regarding enrollment for non-Medicare covered services.

Accessing Urgent Services

An Urgent member is any individual who presents *with moderate risk or incapacitation* in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SUD problems.

The PartnersACCESS Standard for Urgent Care is to arrange for face-to-face services within 24 hours of contact. PartnersACCESS geographic standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas.

Urgent Referral Process for State Funded Members

A member's clinical need may be considered urgent if, but not limited to the following:

- The member is reporting a substance use-related problem.
- The member is being discharged from an inpatient substance use treatment facility.
- The member seems at risk for continued deterioration in functioning and/or becoming Emergent if not seen face to face within 24-hours.

All callers triaged as Urgent are managed by a PartnersACCESS licensed clinician

The Urgent member is seen face to face within 24 hours of contact if the member is experiencing a slowly evolving crisis and a catastrophic outcome is not imminent. The member may be experiencing or expressing hopelessness, helplessness, or other intense feelings or life stressors. Providing rapid access to care is likely to avert the development of a behavioral health emergency. This level of acuity includes members who are intoxicated or in withdrawal seeking treatment whose motivation for treatment might be enhanced by rapid entry to services.

Members triaged as having Urgent needs are offered choices for face-to-face assessments within 24 hours. If the member can contract for safety, he or she is provided an appointment and choice for Clinical Home in the Partners' Provider Network or offered an opportunity to walk into an Open Access or walk in clinic. An appointment is made with the provider of choice via a phone, PartnersACCESS licensed clinician will warm transfer or coordinate with the caller on the phone an appointment or provide schedule information for walk in hours for clinics with open access. If the member is already active in the Partners' network, every attempt is made to engage and link the member back to his or her own clinical home/first responder, for crisis intervention and resolution.

The PartnersACCESS clinician reminds the member that the PartnersACCESS Center is available 24 hours a day and instructs the member to call the PartnersACCESS number by telephone at any time 24 hours a day, seven days a week, 365 days a year should his or her situation escalate and require immediate attention.

PartnersACCESS department continues to follow–up with any Urgent contact up to three times or until it is ascertained that the member has been able to receive the care that is most appropriate to meet his or her clinical needs. All Urgent referrals are tracked and resolved for attended, no show, reschedule or cancellation by the provider and Partners.

Partners' Network Providers are held to the following standard regarding appointment wait time for Urgent Referrals:

- Scheduled Appointment – one hour
- Walk-in – within two hours

ACCESSING EMERGENT SERVICES

An Emergent member is any individual, *regardless of eligibility or payer source,* who has a moderate or severe risk related to safety or supervision, or

- Member is at moderate or severe risk for substance use withdrawal symptoms.
- Member presents a mild, moderate, or severe risk of harm to self or others.
- Member has severe incapacitation in one or more areas(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SUD problems.

The PartnersACCESS standard for Emergent Services is to arrange for face-to-face services within two hours or immediately for life-threatening emergencies. The geographic PartnersACCESS standard for services is 30 miles or 30 minutes driving time.

EMERGENT REFERRAL PROCESS

- The Emergent member is one who is experiencing an acute behavioral health crisis which requires immediate intervention. The crisis may involve sudden and intense disturbance in thinking, mood, or relationships. There may be imminent danger to the member or others, intense and disturbing delusions, command hallucinations, or a gross inability to care for self. The Emergent member includes those who are intoxicated or in active withdrawal and are or will be at serious risk for self-harm/safety if unable to access services without immediate assistance.
- All calls that are deemed to be Emergent are managed by a PartnersACCESS licensed clinician/or RN. The PartnersACCESS clinician determines through clinical screening whether the member presents an immediate danger to self or others. If the member is an imminent danger to self or others, the PartnersACCESS clinician implements the appropriate crisis intervention procedures as an attempt to stabilize the member. The clinician attempts to determine whether there are any available supports for the caller and when possible, speaks to them directly for assistance.
- The Emergent member is kept on the line without being put "on hold" and the crisis is followed by a PartnersACCESS clinician until the Emergent member is considered safe and has been able to receive the care that is most appropriate to meet their clinical needs.

- Emergent members are seen face-to-face within two hours or directly linked to 911 depending on severity of need, imminent danger, and medical needs so that face to face care is provided

immediately for life-threatening emergencies.

- Members triaged as emergent who are not actively engaged with a Partners' network provider are immediately referred to Mobile Crisis, 911, Facility Based Crisis, emergency services or the nearest emergency department. Those who are already active with a provider are linked back to their Clinical Home agency for first responder crisis intervention and resolution. Mobile Crisis is always available to a first responder for consultation and/or crisis response assistance when appropriate.
- Members are informed of the availability and types of crisis services in the Partners' area through the *Partners' Member Handbook*, various print materials, community collaborative meetings, system of care coordination efforts, website postings and local media.
- The Emergent member is kept on the line without being put "on hold" and the crisis is followed by an PartnersACCESS clinician until the Emergent member is considered safe and has been able to receive the care that is most appropriate to meet his/her clinical needs.

Crisis/First Responder

- Members who are actively engaged with a Partners' network provider are screened for acuity and linked to their Provider/clinical home provider/first responder by telephone. ***All providers, particularly providers of Enhanced Services, are required to provide first responder services for their members.*** NC Innovations providers of Residential Supports, Supported Living and Community Living and Supports are first responders, as providers of Crisis Services – Primary Response. The person-centered plan must include a well-developed crisis plan, identify the Clinical Home, and identify the means *by which the member can access their first responder* and/or a provider contracted by their provider to deliver crisis care after business hours.
- If the member is in crisis, the first responder may initially respond with a phone call. *However, prior to the member accessing a higher level of care or receiving Mobile Crisis, the provider/first responder must respond face-to-face to assess the member and attempt to resolve the crisis.*
- Members triaged as Emergent, require crisis intervention and do not have a service provider, are referred directly to an appropriate crisis service based on their acuity.
- Based on the member 's acuity and present problem, PartnersACCESS staff may:
    - Dispatch Mobile Crisis
    - Request police assistance
    - Contact 911 for immediate assistance
    - Send the member directly to the nearest emergency crisis facility

RIGHTS AND RESPONSIBILITIES

Member Rights & Responsibilities

Rights of Members

Partners understands the importance of protecting and promoting freedom for all individuals to exercise their rights be treated fairly and demonstrate self-determination. We recognize that members/recipients with serious mental illness, SUD and I/DD can be vulnerable to discrimination and abuse/neglect and are at an increased risk for rights violations. Members/recipients are assured rights by law, and Partners expects providers to provide members continual education regarding their rights, as well as support them in exercising their rights to the fullest extent.

Members receive a Welcome Packet upon enrollment in Medicaid, while recipients receive their packets immediately following the scheduling of their first state-funded service. The letter provides members with a phone number to call to request a Member/Recipient Handbook. Additional copies are available by calling (toll-free) 1-888-325-HOPE (4673) or by using the TTY system at (toll-free)1-800-749-6099. In addition, copies may be viewed, printed or saved from Partners website. Upon admission and annually thereafter, Partners notifies each member of the availability of the Partners' Member and Recipient Handbook containing information to help them access services for physical health, behavioral health, intellectual/developmental disabilities, TBI, LTSS and pharmacy. The handbook includes information and instructions for members/recipients regarding:

1. Where to call when they need assistance.
2. A list of rights and responsibilities.
3. How to obtain services.
4. How to make a complaint or grievance.
5. How to contact Partners.

Member/Recipients Rights and Responsibilities

Partners Health Management (Partners) maintains and implements Member Services policies and procedures that address the needs of potential members, members and caregivers specific to all Member Services activities. Partners treats members with dignity and respect, protects their rights, informs them of their responsibilities as members of the Behavioral Health and Intellectual/Developmental Disabilities Tailored Health Plan (Tailored Plan) and the NC Medicaid Direct Plan. Partners ensures each individual is not subjected to any unlawful discrimination in the course of obtaining or receiving health care services from any network provider of the Tailored Plan. It is the policy of Partners to protect the rights of members. Partners has established protocols to ensure the communication of rights and responsibilities within six business days to all individuals enrolled in the Plan. Member rights and responsibilities statements are developed in accordance with state and federal regulations, statutes and laws. Partners engages with members and their authorized representatives to assist with understanding Medicaid managed care, their rights and responsibilities, and accessing available benefits and health care services in person, by telephone, by mail, and online/electronically. 42 C.F.R. § 438.10(b)(7).

I. Notification to Member

A. Partners' Member Handbook is available to each individual who has accessed health care services or enrolled with Medicaid. The handbook was developed to help guide and assist individuals seeking health care services and supports from the Partners Tailored Health Plan.
B. A Member Welcome Packet, including a welcome letter, a Notice of Privacy Practice and a notice of non-discrimination, is mailed to members within seven business days of enrollment or from their first appointment with a Partners contracted provider. The welcome packet includes the Member Handbook and gives information about all health care services and supports. The handbook is posted on Partners' website. It is also mailed to newly enrolled members and to members upon request via calling PartnersACCESS or Member Services.
C. The handbook includes information about how to access specific health care services, person-centered-planning, crisis services, rights and responsibilities of members, and helpful contacts and resources.
D. In addition to general rights and responsibilities, the handbook also outlines the specific rights and responsibilities for those admitted to a residential facility.
E. Rights and responsibilities are written using a sixth-grade reading level.
F. A Spanish version of the handbook is available, as well as large print and Braille upon request.
G. A list of member rights and responsibilities is posted on the Partners' website and included in other member manuals specific to certain programs.
H. Partners Human Rights Committee handles escalated member rights issues. A member of the Quality Management department serves as a liaison to this committee.
I. Partners provides periodic trainings and events to educate members about their rights and responsibilities.

Notification to Partners' Employees and Network Providers

A. Partners provides a copy of the Member Rights and Responsibilities Policy and Procedure to all employees upon hire and annually thereafter.
B. Partners provides a copy of the Member Rights and Responsibilities Policy and Procedure to all network providers in the Provider Operations Manual upon onboarding and through a State-funded specific provider orientation training that is recorded and available on the website.

II. Partners' Member Rights and Responsibilities

Partners provides training and support to advise members of their freedom to exercise their rights and that the exercising of those rights will not adversely affect the way Partners or its providers treats the member. The North Carolina General Statutes and Administrative Code outlines rules and regulations about Member Rights and Responsibilities. Partners expects contracted providers to let members know of their rights and help them understand them.

MEMBER RIGHTS

Partners ensures Medicaid members have the right to:

I. Notification to Member

A. A Member Welcome Packet, including a welcome letter and a Notice of Privacy Practices, is mailed to members within seven business days of enrollment or from their first appointment with a Partners contracted provider. The welcome packet includes the Member Handbook and gives information about all health care services and supports. The handbook is posted on Partners' website. It is also mailed to newly enrolled members and to members upon request via calling PartnersACCESS or Member Services.

B. Partners' Member Handbook is available to each individual who has accessed health care services or is enrolled with Medicaid. The handbook was developed to help guide and assist individuals seeking health care services and supports from the Partners Tailored Plan.

C. The handbook includes information about how to access specific health care services, person-centered planning, crisis services, rights and responsibilities of members, and helpful contacts and resources.

D. In addition to general rights and responsibilities, the handbook also outlines the specific rights and responsibilities for those admitted to a residential facility.

E. Rights and responsibilities are written using a sixth-grade reading level.

F. Versions of the handbook are available in Spanish, large print and Braille and other languages upon request.

G. A list of member rights and responsibilities is posted on the Partners' website and included in other member manuals specific to certain programs (e.g., the Innovations Waiver and residential programs).

H. Partners' Human Rights Committee handles escalated member rights issues. A member of the Quality Management department serves as a liaison to this committee.

I. Partners provides periodic trainings and events to educate members about their rights and responsibilities.

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II. Partners' Member Rights

Partners provides training and support to advise members of their freedom to exercise their rights and that the exercising of those rights will not adversely affect the way Partners or its providers treat the member. The North Carolina General Statutes and Administrative Code outlines rules and regulations about Member Rights and Responsibilities. Partners expects contracted providers to let members know of their rights and help them understand them.

MEMBER RIGHTS

Partners ensures Medicaid members have the right to:

- Receive information about Partners in a way that is easily understood in accordance with 42 C.F.R. § 438.10. The information will include, but not limited to its health care services, its providers and practitioners, and the rights and responsibilities of members, including the right to receive oral interpreter services at no cost.
- Be free to exercise their rights, and that by doing so will not change the way the Contractor, its network providers, or the State Medicaid agency treats the member (42 CFR §438.100).
- Make recommendations about Partners policies and procedures, including the Member Rights and Responsibilities policy.
- Be treated with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity.
- Be treated with respect and with due consideration for his or her dignity and privacy by Partners' staff, network providers and others who are part of their health team.
- Not be subjected to any unlawful discrimination specified in the Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against recipients in the course of obtaining or receiving services from any network provider of the health plan.
- Express freedom of speech and freedom of religious expression.
- Be free of influence, limitations, or any interference with their decision to exercise their rights.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions about their health care, including the right to refuse treatment and advance directives for Medicaid and State-funded services.
- Connect to providers in Partners' network to get the health care services they need.
- Get treatment in the most natural, age-appropriate, and independent setting as possible.
- Receive health care services that meet requirements for timely access and medically necessary coordinated care (42 CFR §438.206 through 42 CFR §438.210).
- Get information about changes in benefits, health care services or providers. Partners will notify members in writing of any important changes to programs or health care services.
- Be furnished, consistent with the scope of services of the Contract, health care services in accordance with

42 C.F.R. §§ 438.206-438.210.

- Be informed of the availability of Medicaid transportation services at no cost.

o Have the transportation policy explained, including how to request or cancel a trip, limitations on transportation, personal conduct, and no-show rules.

o Be transported to medical appointments if unable to arrange or pay for transportation:

 By means appropriate to circumstances.

 To arrive at the medical provider in time for their scheduled appointment.

 Be informed that a member under the age of eighteen (18) does not have to ride alone and that member and/or attendants can ride at no additional cost.

 Request a hearing if the request for transportation assistance is denied.

 Receive assistance in filling out forms or paperwork needed to assure their rights.

- Make suggestions to us about our policies and health care services by calling the toll-free PartnersACCESS Member and Recipient services line at 1-888-235-HOPE (4673) (for deaf or hard of hearing, NC Relay 711; TTY: 1-800-735-2962-English; 1-888-825-6570-Spanish).

o If members would prefer to email their suggestions, they can be sent to the Member Engagement department at memberquestions@partnersbhm.org or by completing our feedback form online at https://www.partnersbhm.org/feedback/.

o Medicaid members may contact the State Medicaid Ombudsman program 1-855-723-7283 to assist, if needed, with resolution of issues and questions about their rights.

 The Ombudsman program provides free and confidential support about the rights and responsibilities members have under NC Medicaid.

 The call center offers free interpretation in over 150 languages.

- Prepare Advance Directives and share with their providers.

- Have an open discussion with service providers or practitioners on appropriate or medically necessary treatment options for their conditions, regardless of cost or what their health benefits cover.

o Members may need to decide among related treatment options, risks, benefits, and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of limits of what their benefits cover.

- Receive health care services from a provider even if they cannot pay required copayment—a fee they pay when they get certain healthcare services or a prescription. There are NO copays for the following members or health care services:

o Under age 21

o Pregnant

o Receiving hospice care

o Federally recognized tribal members

o North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries

o Children in foster care

o People living in an institution who are receiving coverage for cost of care

o For questions on copayments, members may contact the PartnersACCESS service line at 1-888-235-HOPE (4673) (for deaf or hard of hearing, (for deaf or hard of hearing, NC Relay 711; TTY: 1-800-735-2962-English; 1-888-825-6570-Spanish)

• Voice concerns or complaints about us or the care they receive. Members may voice their concerns in a confidential and secure way by filing a grievance in the following ways:

o Telephone: 1-888-235-HOPE (4673).

o Mail: Partners Health Management, c/o Grievances, 901 S. New Hope Road, Gastonia, NC 28054.

o Email: Grievances@partnersbhm.org.

o Online feedback form: https://www.partnersbhm.org/feedback/.

o In person: every employee at Partners can take their grievance or concern.

• Request and receive a copy of their medical records and request a change to it, as specified in 45 C.F.R. §§ 164.524 and 164.526. For medical records and any other health and enrollment information that identifies a particular member, Partners uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable (42 CFR §438.224).

• Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation.

o A member's rights can only be restricted by their treatment team for reasons related to their care or treatment.

o They must be part of their own treatment team and must be involved in making decisions. They have the right to have an advocate or someone they trust involved.

o The Human Rights Committee must approve the plan to restrict their rights.

o Any restriction is documented and kept in their medical record.

• Receive a second opinion from a qualified behavioral health professional, within the Partners' network out of network, at no cost to the member.

• Disagree with what is written in their medical records.

o If members disagree, they have the right to compose a statement to be placed in their file.

However, the original notes will also stay in the record until the time for retention ends, according to the MH/DD/SAS retention schedule (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DUI records).

- Freely exercise their appeal and grievance rights and resolve issues efficiently with minimal burden to them or their authorized representative.

o Receive education on their rights and provide reasonable assistance with understanding and navigating the appeals and grievances process (Utilization Management appeals staff assist with filling out paperwork).

o Request a reconsideration review by Partners staff if they disagree with our decision to deny, reduce, suspend, or terminate a service and receive assistance.

o If the decision is upheld, request a State Fair Hearing to appeal.

o Appoint someone to speak on their behalf (including providers, legal guardian, or other concerned person), with their written consent, including requesting an appeal or filing a grievance on their behalf. 42 C.F.R.§ 438.402.

- Take part in creating a written, health care or person-centered treatment plan that builds on their needs, strengths, and choices.

o A treatment or care plan must be put into action within 30 days after health care services start.

- Ensure that minors, per North Carolina state law, have the right to treatment for the following conditions without the consent of a parent or guardian:

o Sexually transmitted diseases.

o Pregnancy.

o Use of controlled substances or alcohol.

o Emotional disturbances.

Members who live in a 24-hour facility have the right to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, then they will be responsible for payment.

- Send and receive unopened mail and have access to writing materials, postage and staff assistance, if requested.

- Contact and consult with the Grievance/Member Rights Coordinator at 1-888-235-HOPE (4673).

- Contact and see a lawyer, their own doctor and other private professionals. This will be at their own expense, not at the expense of the facility.

- Contact and consult with their parent or legal guardian at any time as indicated.
- Make and receive confidential telephone calls. All long-distance calls will be at their expense, not at the expense of the facility.
- Have visitors between 8 a.m. and 9 p.m. Visiting hours must be available at least six hours each day. Two of those hours must be after 6 p.m. If the member is under the age of 18, visitors cannot interfere with school or treatment.
- Communicate and meet with other individuals. These meetings and communications may be supervised if their treatment team feels it is necessary.
- Make visits outside the facility unless their person-centered plan states otherwise.
- Have access to outside facilities and equipment for physical exercise several times per week.
- Have individual storage space for their private belongings.
- Keep personal possessions and clothing, except items prohibited by law.
- Keep and spend a responsible sum of their own money.
- Participate in religious worship if they choose.
- Retain a driver's license unless they are prohibited from doing so by a court of law.
- If members live in an Adult Care Home or Nursing Home, they have the right to report any suspected violation of their rights to Partners Consumer Rights Officer via email at iris@partnersbhm.org or by calling 704-884-2698. Reports may also be made to the Office of the State Long Term Care Ombudsman that assists residents of long-term care facilities in exercising their rights and attempts to resolve grievances between residents, families and facilities. Members can contact them by phone at 1-919-855-3400. They may also contact the Division of Health Service Regulation, which oversees licensed facilities in North Carolina. Members may contact them by phone at 1-800-624-3004 or 1-919-855-4500.

Additionally, Partners ensures that no referrals to publicly supported health care resources are made to avoid costs for covered benefits and services.

Additional rights for members with an intellectual and/or developmental disability are detailed in the NC Innovations Member Handbook.

MEMBER RESPONSIBILITIES

Members are encouraged to improve their care by taking on the following responsibilities:

- Understanding their health benefits and plan before receiving care.

o Reading, or having read to them, written notices from Partners and their providers about changes in

benefits, health care services or providers.

o Understanding the roles of the service providers and professionals who deliver their health care services or treatment.

o Understanding their health and taking part, as much as they can, in creating treatment goals.

- Always carrying their Medicaid or other insurance card with them.

o Call the numbers on the back of the card when they need health care services or help.

o Contacting their provider or physician when they have a concern or need help.

- Paying for health care services if payment is included in their established agreement.

Sharing the information needed for their care.

o Telling the clinician, doctor or nurse about any changes in their health.

o Following the plans and instructions for care they have agreed to with their providers.

o Asking questions when they do not understand their care or what they are expected to do.

- Keeping all the scheduled appointments, as able.

o Cancelling an appointment at least 24 hours in advance if they cannot keep it.

- Calling their primary care physician (PCP) when they need medical care, even if it is after hours.

o Using emergency room services only for injuries and illnesses that require immediate treatment.

- Inviting people who will be helpful and supportive to be included in creating their treatment plan.

- Seeking additional resources and support services in their community as needed.

- Use available transportation resources appropriately and efficiently.

o Travel to the requested location and receive a Medicaid covered service.

o Make timely requests for transportation assistance.

o Be ready and at the designated place and time for transportation pick up.

o Cancel transportation services that are no longer needed.

o Follow the instructions of the driver.

o Maintain the health and safety of drivers and other passengers.

o Respect and not violate the rights of other passengers or the driver.

o This includes not creating a disturbance or engaging in threatening language or behavior.

- Taking medications as they are prescribed for their care.

o Telling their doctor if they are having unpleasant side effects from their medications, or if their medications are not helping them feel better.

- Telling their provider if they do not agree with their suggestions.

- Telling their provider when or if they want to end treatment.

o Requesting a discharge plan when they leave a provider; making sure they understand it and being committed to following it.

- Respecting the rights, health and property of other members and provider staff.

o Respecting other members' needs for privacy.

o Informing staff of any medical condition that is contagious.

Member Support

Partners' Member Engagement team supports member empowerment through advocacy, education, and navigation of North Carolina's public behavioral health and I/DD health care system. Member Engagement staff are dedicated to building strong partnerships with our internal departments, providers, the North Carolina Department of Health and Human Services (NCDHHS), external stakeholder groups and disability-specific advocacy groups to better serve our members with resource needs and continuity of care. We work with provider-facing teams to educate about Partners' benefits available to members and in support of provider's work with members. These include the following:

- Assist members who are not engaged in Care Management to resolve physical and behavioral health complex issues and grievance resolution.
- Attend community meetings to bring the member perspective to the group as well as identify gaps, needs, and issues and bring those back to partners leadership.
- Identify and coordinate with locations where members and potential members congregate to assist members who can easily fall through the cracks or are difficult to contact with answer questions, assist with navigating the system, connect to additional community resources, and assist connecting to Care Management Services or with staying connected with their assigned Care Manager.
- Involved with Recovery and Mental Health Courts when requested.
- Coordinate with internal departments and external stakeholders to plan member and community focused events including Community Discussions About Suicide in to reduce stigma and offer Question Persuade Refer Suicide Prevention Training following the event.
- Member Cafés-Offered monthly with special topics of interest to members and families and orientation to resources and services offered by Partners' plan and its network. https://www.partnersbhm.org/member-cafe/

- Member-focused trainings for physical health and behavioral health wellness, service overviews, and resources are available either live, virtually by Member Engagement Specialist or the Member Engagement Health Educator and are also offered on partnersbhm.org on the Training Resources and Collaborative (TRAC) link. . All educational opportunities are available in English and Spanish.
- Self-management tools such as member behavioral health and physical health wellness screenings and Pyx Health wellness app on Partnersbhm.org.
- Coordination for members and providers requiring support with transitions of care between health plans (Standard and Tailored plans). Contact via email to toc_partners@partnersbhm.org for assistance.
- Support for members who need to be added to State-Funded Services waiting lists may contact Member and Recipient Services.

We would like to partner with you to help our members make the most of available services, supports, and resources. Encourage each member to register for our Partners' member portal, MemberCONNECT, accessed on the front page of www.partnersbhm.org and to also visit our Member Education page for support and training information for members and families at https://www.partnersbhm.org/member-education/.

You may contact the department at memberquestions@partnersbhm.org or by calling Member and Recipient Services at 888-235-4673.

Value Added Services and Extra Benefits for Members (PartnersGREATDAY Program)

Partners has several value-added benefits available to members and recipients who qualify. Additional value-added services will be available dependent upon funding. For more information call Member and Recipient Services at 888-235-4673 or email PartnersGREATDAY@partnersbhm.org:

- Wellness – **Pyx Health Mobile app** for ages 18 and up to screen for loneliness and depression with connection to call center, referrals to crisis line, and transfer to care team, if needed. Contact www.HiPyx.com .
- Other – **MemberCONNECT** cell phone and SafeLink program for free calls from providers, care managers, pharmacies and important family contacts, as funds available (If ineligible for SafeLink program and based on available funding).
- **Teledoc**-Tailored Plan members and recipients have access to Teladoc Health through Partners Health Management. Speak to a healthcare provider within minutes, avoid waiting rooms and urgent care and feel better faster. Get care for cold, flu, allergies and more. Licensed healthcare professionals are ready to help. Visit https://www.teladochealth.com/benefits/nc-partners to get started, or call 1-800-835-2362, 24 hours a day, 7 days a week.
- **Somethings** (Teen Mentor app) available on the NCDHHS website https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/weathering-storm
- **Living Tobacco Free program** for smoking cessation.
- **Healthy Rewards** (Walmart restricted gift cards)
  - $10 for downloading the Pyx Health application.

- $20 for completing an annual wellness/prevention visit with primary care provider (PCP).

Be Involved-Partners Stakeholder Committees

https://www.partnersbhm.org/be-involved/

Human Rights Committees

The Human Rights Committee (HRC) is a standing committee of Partners Health Management's Board of Directors. The Committee's mission is to protect the human rights of individuals served by providers in the Partners' Network in the delivery of mental health, intellectual and developmental disabilities, and substance use services.

Currently, HRC seeks community stakeholders with the following experience to represent Partners counties who have knowledge of mental health, intellectual and developmental disabilities, substance use disorders, traumatic brain injury and physical health.

Consumer and Family Advisory Committee (CFAC)

The Consumer and Family Advisory Committee (CFAC) is a group of individuals or the family members of individuals who receive services through a Partners Health Management Health Plan. The committee gives a voice to people who receive services for physical health, mental health, substance use disorders, intellectual and developmental disabilities (I/DD) or traumatic brain injuries by providing important input into Partners' business processes. The committee is self-governing and operates under the requirements of North Carolina general statute 122-C-170 (a) Local Community and Family Advisory Committees.

The committee is open to new members for available counties and meets monthly and is open to the public. For more information, please email *CFAC@partnersbhm.org*.

NC Innovations Stakeholder Committee

The Innovations Stakeholder Committee is a group of members, families, providers, and those in the community with a personal stake in NC Innovations services. Committee meetings focus on topics related to the NC Innovations Waiver, allowing for input about updates, changes and opportunities. Partners receives feedback on topics including:

- NC Innovations Waiver services implementation
- Employer of Record
- Supports Intensity Scale (SIS) policy and use
- Resource allocation policy and use

Case-specific information is not discussed during meetings.

Partners welcomes new members and family members to this committee. Please InnovationsStakeholders@partnersbhm.org .

Long Term Services and Supports Stakeholder Committee

Partners Long Term Services & Supports (LTSS) Member Advisory Committee's purpose is to ensure

meaningful participation by consumers and families to assist and have a voice in managing the delivery of LTSS services. Membership reflects the LTSS populations covered by the Tailored Plan and their representatives: (1) Members accessing LTSS; (2) Representatives of LTSS members (e.g., authorized representatives); (3) LTSS providers; (4) Care managers from AMH+ practices and CMAs serving members with LTSS needs; and (5) BH I/DD Tailored Plan staff involved in the authorization of LTSS and/or care management of LTSS members.". For LTSS membership inquiries or concerns, please contact Member Engagement at 704-888-2729 or LTSS@partnersbhm.org.

State-Funded Waiting Lists and Service Requests

Partners supports our network of providers to ensure we are all working together with the common goal to serve members/recipients who need it most, to improve recipient health outcomes and make sure we are good stewards of state funds. Partners' recipient-facing staff and providers receive annual training on the Medicaid program. Training includes qualification criteria, overview of benefits, where recipients can find an application, how to assist a recipient in the application process and referral to the Department of Social Services (DSS). We train Partners' staff and providers to encourage recipients to apply for benefits, even if their reported income is close to or slightly over federal poverty level guidelines, as DSS makes final eligibility determinations. Partners has developed a comprehensive approach to expand reach of state funds and services.

State-funded Provider Waiting List Reported to Partners Weekly

In line with NC Medicaid Tailored Plan requirements, provider reporting of waiting lists is part of the state-funded (SFS) waiting list process. This means that when members request services and providers cannot serve members at that time, they will notify Partners at least weekly of those members that will now be on the provider waiting list. When members present to providers requesting state-funded services and the provider is unable to serve them, providers are required to fill out the electronic form on Provider Knowledge base or call Partners SFS List Coordinator.

https://providers.partnersbhm.org/state-funded-services-waitlist-submissions/

statefundswaitlist@partnersbhm.org

Phone: (828) 325-4682.

Substance Use Disorder Residential Procedure Update Recipients/Consumers Eligible:

Any PRIMARY DX SUD member/recipient who is enrolled and eligible for state funding AND referred for SUD residential treatment services.

Codes/Services affected:

YP760 - Group Living Low

YP770 - Group Living Moderate

YP780 Group Living High

IF the SUD provider has existing funds in their State contract to cover the services requested, they will NOT be required to go through the waitlist process of pre-approval.

- **If the SUD provider has existing funds in their state-funded contract to cover the services requested, they will not be required to go through the waitlist process of pre-approval.**
- **Providers must submit a Notification SAR to Partners Utilization Management for MH and SU Group, Supervised, and Family Living services. The SAR will likely be administratively approved.**
- **If the provider agency does not have existing funds in their State-Funded Contract to cover the services, they must follow the waiting list submission and pre-approval process.**

For questions regarding state-funded services or the process please email Partners Waiting (list) Coordinator @ statefundswaitlist@partnersbhm.org

If the Provider Agency does NOT have existing funds in their State Funded Contract to cover the services, they will need to follow the existing WAIT LIST submission and pre-approval process.

Please see additional SUD service changes in the grid below:

State Funded Services Where the Provider is Expected to Manage and Prioritize State-Funded Recipient

Access to Services:

For the following categories of services, the State Funded Providers will be able to manage serving those referred to them, provided funds are in their State Funded contract:

Category	**Services**
Crisis Services	• Mobile Crisis Services • Facility Based Crisis Services
Basic Outpatient Services	• Outpatient Services such as group/individual services available on the State Funded benefit grid • Medication Management for those coming out of an inpatient/facility-based crisis service
Substance Use Services	• Outpatient Substance Use Services • Medication Assisted Treatment

	• Group Living Low • Group Living Moderate • Group Living High

	• Services to the Opioid Use Disorder Members SAIOP SACOT • •
MH/SU Services	• Psychosocial Rehabilitation (PSR) ACTT (this should be limited) Community • Support Team – PSH (this should be • limited) Tenancy Management Services •
I/DD Day Services for 18–21-year-old	• Day Activity, Day Supports, Supported Employment Services for 18 to 21-year-old recipients with I/DD or TBI that have graduated from school o Exceptional children can go to school until 22. Only if the member has finished school Documentation that school system services are not available any longer
I/DD Respite	• For the recipients with I/DD not otherwise eligible for or receiving any services who meet one of these three criteria

	1) At imminent risk of institutionalization 2) Has behavioral complexity resulting in recurrent crisis service usage 3) At imminent risk of out of home placement from parents/guardians • For any new service requests, provider must document how one of these criteria exists

State Funded Services/Referrals for State Funded Services <u>requiring Partners approval</u>:

Due to continued restraints on the availability of state funds, Partners will require providers to seek approval for services using a screening process. Recipients who cannot be managed by available funding will be added to Partners' State-funded Waiting List. Providers should maintain their own waiting lists to share with Partners to add to the network's waiting list. More information is available below. The state will maintain a statewide waiting list to monitor the need for funding for services.

The following services require Partners' approval before a recipient can be accepted into services:

MH/SUD Residential	• Group Living Low • Group Living Moderate Group Living • High Supervised Living Low Supervised Living Moderate Supervised Living • High Family Living Low • Family Living Moderate
I/DD and TBI Residential	• Residential Supports • Supported Living

State Funded Referrals for those recipients with an intellectual/developmental disability, mental health or substance use (I/DD/MH/SU) or Traumatic Brain Injury (TBI) diagnosis and requesting one of the aforementioned residential services, will be required to meet at least one of the following criteria to be assessed for State Funded Services:

	At imminent risk of entry into institutional settings (e.g., state developmental facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities [ICF-IIDs]), state psychiatric facilities or adult care homes) Describe:
	Has behavioral complexity resulting in recurrent crisis service usage (e.g., emergency department, behavioral health urgent care and facility crisis) Describe:
	At imminent risk for out of home placement from parents or legal guardians
Additional Information:	

For providers who deliver a residential service that requires approval and have a vacancy, they should:

- Providers should fill out Partners "State-Funded Service Request & Waiting List Form" for Partners' review via form found on the Provider Knowledge Base at https://providers.partnersbhm.org/partners-state-funded-service-request-waiting-list-form/

- Clinical teams meet weekly to review requests for residential services in cross functional staffing. Providers are notified via email that the member has been added to the waiting list or when the provider may submit a service authorization request.

- When services end, funding will not remain for a new recipient to fill the opening. If providers have a member requesting service, they need to submit the referral to Partners above contact information and Partners will offer the provider three members who have been waiting the longest if applicable.
    - However, the services and funding will follow that person if they move to another service provider. For example, if a provider is serving a state funded recipient who ends a service requiring Utilization Management approval, and is seeking services with another State Funded provider, the money designated in the initial provider's contract for that recipient will be reduced and added to the new providers' State Funded contract in order to continue to support the recipient in a State Funded service. In these situations, providers should work with the Care Management and assigned Provider Network Specialist to ensure the dollars are following the recipient for service continuity.
- As part of this transparent process, many stakeholders have asked Partners how to advocate for additional funding so that these cuts can be stopped. It is always helpful to let your member of the House and Senate know you advocate for increased funding for mental health, developmental disabilities, and substance abuse services. You can find out who serves you in the General Assembly here:

o https://www.ncleg.gov/FindYourLegislatorsor by calling 919-733-4111 and request to speak to a member of the General Assembly.

- If you have questions about how the Department of Health and Human Services distributes the money among LME/MCOs, you can direct your comments or questions

here: contactdmh@dhhs.nc.gov

Member Transitions of Care

Individuals you serve will continue to move between delivery systems and health plans. As an extension of Partners' Provider Agreement, all Partners' contracted providers are obligated to coordinate services the Medicaid member is receiving from another health plan during transitions to ensure continuity of care. Providers will receive training on identifying members' plan enrollment status, prior authorization submission requirements, managing substance use disorder release of information (ROI), and on applicable continuity of care provisions. Providers are obligated to:

- Share the results of identification and assessment for any member with special health or behavioral health needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated.
- Share all relevant information (including the member's current Care Plan and/or Care Needs Screening, initial and final discharge plans, pertinent socio-clinical data, and medical information) among the Transition of Care Point(s) of Contact with the sending or receiving health plans, the Partners cross-functional TOC team, and the member's care team.

- Notify Partners of any changes in address, phone number, or other key contact information that could impact member access to care. Follow established procedures for coordination of in-network and out-of-network services for members.

Provider Rights

Provider Rights Partners' providers have the right to:

- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for member/recipient's care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in member/recipient's treatment plans.
- Expect members/recipients to follow their directions, such as taking the right amount of medication at the right times.
- Make a grievance/complaint or file an appeal against Partners and/or a member/recipient.
- File a grievance/complaint with Partners on behalf of a member, with the member/recipient's consent.
- Have access to information about Partners quality improvement programs, including program goals, processes, and outcomes that relate to member/recipient care and services.
- Contact Partners Provider Services with any questions, comments, or problems at **877-398-4145**.
- Collaborate with other healthcare professionals who are involved in the care of member/recipient
- Not be discriminated against by Partners based solely on any characteristic protected under state or federal non-discriminate laws.

Provider Responsibilities

As an extension of the Partners Participating Provider Agreement, all Partners' contracted providers are obligated to comply with the requirements stipulated in this Provider Operations Manual.

Partners providers have the responsibility to:

- Help members/recipients or advocate for members/recipients to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat members/recipients with fairness, dignity, and respect
- Not discriminate against members/recipients on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of member/recipient's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality

- Give members/recipients a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members/recipients with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members/recipients to request restriction on the use and disclosure of their personal health information
- Provide members/recipients, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members/recipients, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Tell a member, prior to the medical care or treatment, that the service(s) being rendered are not a covered benefit. Inform the member of the non-covered service and have the member acknowledge the information. If the member still requests the service, obtain the acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, that agreement becomes null and void if a claim is submitted to the health plan.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members/recipients' advance directives and include these documents in the member's medical record
- Allow members/recipients to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions
- Allow members/recipients to obtain a second and third opinion, and answer member questions about how to access healthcare services appropriately
- Follow all state and federal laws, regulations and policies related to patient care and patient rights
- Participate in Partners data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of performance data for QI activities
- Review clinical practice guidelines distributed by Partners
- Comply with Partners Medical Management program as outlined in this Manual
- Disclose overpayments or improper payments to Partners and promptly return overpayments within 60 days of identifying the overpayment
- Provide members/recipients, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Partners information regarding other insurance coverage
- Notify Partners in writing if the provider is leaving or closing a practice
- Notify Partners of any changes in address, phone number, or other key contact information that could impact member access to care
- Contact Partners to verify member eligibility or coverage for services, if appropriate

- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members/recipients, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with American Sign Language
- Not be excluded, penalized, or terminated from participating with Partners for having developed or accumulated a substantial number of patients in the Partners with high-cost medical conditions
- Coordinate and cooperate with other service providers who serve members/recipients such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school-based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Partners, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Partners and the physician or physician group
- Report all suspected physical and/or sexual abuse and neglect
- Partners requires providers to follow the Child Medicaid Evaluation and Medical Team Conference for Child Maltreatment Policy and bill according to 1A-5 Attachment A (https://files.nc.gov/ncdma/documents/files/1A-5.pdf)
- Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse
- Monitor and report on provider preventable conditions including:
    - Reporting of Never Events and Hospital-Acquired Conditions
    - Procedures to Follow for Reporting Avoidable Errors (Never Events)
    - Procedures to Follow for Report POA and HAC Indicators
    - Retain patient records for the mandated period
    - Ensure that all documentation regarding services provided is timely, accurate, and complete
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care
- Ensure Medicaid except when that member is also accessing State-Funded Services where State-Funded Services is the payer of last resort

GRIEVANCES/COMPLAINTS AND APPEAL PROCESS

A member, a member's authorized representative or a member's provider (with consent from the member), may file an appeal or grievance/complaint either verbally or in writing.

Partners TP/PIHP/State Funded plan gives beneficiaries reasonable assistance in completing all forms and taking other procedural steps in the appeal and grievance/complaint process, including, but not limited to,

providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.

Grievance/Complaint Process

Grievances/complaints are defined as “an expression of dissatisfaction” about any matters other than an “adverse determination” (summarized as UM decisions to deny, reduce, suspend or terminate any requested services).

The Office of Legal Affairs (OLA) is responsible for assignment of grievances/complaints to appropriate staff/departments for resolution, tracking, monitoring and ensuring completeness of all grievances/complaints received.

Any Partners staff may receive grievances/complaints via phone calls (including TTY/TTD), e-mail, in-person, in writing or on Partners’ provider web portal. A form is also accessible on every page of the Partners website, https://www.partnersbhm.org/feedback/.
Partners will issue a written acknowledgement of receipt, within five business days of each grievance/complaint. Grievances/Complaints related to the denial of an expedited appeal request, will be acknowledged in writing via trackable mail, within 24 hours of receipt of the grievance/complaint.

Partners works to resolve grievances/concerns as expeditiously as the member’s condition warrants. Grievances/Complaints are resolved, along with written notification of the resolution, no later than thirty (30) days from when Partners received it. In most cases, Partners can resolve concerns within a much shorter time frame; however, the highest priority is to assure a thorough process with the best possible outcome and is following the various binding rules, regulations and laws.

Partners may extend the timeframe for resolution of the grievance/complaint up to 14 calendar days if the grievant/complainant requests the extension or Partners demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the grievant/complainant’s best interest. For any extension not requested by the grievant/complainant, Partners will provide written notice to the grievant/complainant within two calendar days of the reason for the delay and the right to file a grievance/complaint if they disagree with the decision.

Grievances/Complaints related to the denial of an expedited appeal request will be resolved and resolution notice issued, within five calendar days of receipt of the grievance/complaint.

In any case, where the reason for the grievance/complaint involves clinical issues or relates to denial of expedited resolution of an appeal, Partners shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member’s condition or disease. [42 CFR § 438.406]

Should a grievant/complainant require assistance, please contact the Office of Legal Affairs at 1-877-864-1454 (option 3), or in writing at the following address:

Partners Health Management
c/o Grievances/Complaints
901 S. New Hope Road

Gastonia, NC 28054
*Include the grievance/complaint reference number located at the top of the Grievance/Complaint Acknowledgement letters in the request.

Member/Beneficiary Appeal Process

An appeal is the request for Partners to review an adverse benefit determination. The appeal process allows the member, the member's authorized representative acting on behalf of the member or provider acting on the member's behalf with the member's written consent, to file an appeal either orally or in writing, within 60 calendar days from the date on the Notice of Adverse Benefit Determination.

Partners will acknowledge, in writing within one business day of receipt of each standard appeal request, whether it was received either orally or in writing.

If the member or legally responsible person needs assistance, the letter asks them to call the Appeals department at 704-884-2650. Any oral request can start the appeal process. Requests may be submitted by telephone, fax, mail, in person. Members who need assistance related to an Appeal, may call the Appeals department at 704-884-2650. The member, legally responsible person, or a provider or other designated personal representative, acting on behalf of the member, with the member's signed consent, has the right to review any information used as part of the appeal process. This information may be requested, free of charge, through the Appeals department at 704-884-2650. The standard appeal must be completed, and the written notice issued to the member or legally responsible person within 30 calendar days of Partners' receipt of the request for an appeal.

Partners will provide written notice of resolution of the appeal to the member and/or authorized representative as expeditiously as the member's health condition requires and within 30 calendar days of the receipt of the standard appeal request. Partners may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Partners demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Partners will provide written notice to the member within two calendar days of the reason for the delay and the right to file a grievance/complaint if they disagree with the decision.

To request an appeal, the member, legally responsible person, or a provider or other designated personal representative, acting on behalf of the member; with the member's signed consent, may file either an oral or written reconsideration review. These may be submitted by one of the following:

In person: Partners Health Management, 901 S. New Hope Rd., Gastonia NC 28054

By Mail: Partners Health Management, 901 S. New Hope Rd., Gastonia NC 28054

Appeals department:

- Fax: 704-842-2720
- Telephone: 704-884-2650

Upon completion of the appeal decision, if the member or legally responsible person disagrees with the Partners' Appeal decision, the member, member's LRP, or other designated legal representative can then appeal the decision to the Office of Administrative Hearing (OAH) by filing a Request for Hearing, also known as the State Fair Hearing process.

Non-Medicaid Appeals Process

Non-Medicaid services are not an entitlement. Non-Medicaid service decisions regarding termination, reduction, suspension or denial of non-Medicaid services are handled within the Utilization Management Appeals Unit. If the member or legally responsible person disagrees with the non-Medicaid service decision, he or she may complete a Non-Medicaid Appeal request. Instructions on how to submit this appeal accompanies the decision; and may be submitted to the Partners' Utilization Management Appeals Unit within 15 working days of the date of the Notice of Decision Letter.

These may be submitted by one of the following:

By USPS Mail or In person: Partners Health Management, 901 S. New Hope Rd., Gastonia NC 28054

Appeals department:

- Fax: 704-842-2720
- Telephone: 704-884-2650

The UM Appeals Unit acknowledges receipt of the appeal in writing to the member or legally responsible person and to the provider. The acknowledgement letter is mailed the next business day.

The Non-Medicaid Service Appeals process maintained by Partners provides an opportunity for the member or legally responsible person, or provider, or other designated personal representative, upon consent by the member/LRP to submit information related to the case, including any documents, records, written comments, or other information that may be helpful in processing the appeal.

Clinical Peer Reviewers who process the appeal consider all the information received from the member or legally responsible person ordering/treating provider and/or facility rendering service, regardless of whether the information was presented during the initial clinical review.

The member or legally responsible person receives a Clinical Review Decision conducted by a Licensed Psychiatrist or Psychologist that has appropriate clinical expertise in treating the member's condition or disorder within appropriate timeframes.

Timeframes for the appeal process, which are in accordance with the requirements of the NC Division of Mental Health/Developmental Disabilities/Substance Use Services (DMHDDSAS) and NCQA (the external accrediting body) are documented in Partners' Policies and Procedures and are available upon request, to any member or legally responsible person, provider or facility rendering service.

If the appeal decision is to uphold the original non-certification, the written notification explains that there is an opportunity to appeal the decision to the Division's Non-Medicaid Appeals Panel, as well as the process for doing so.

Expedited Appeal Process

An Expedited Appeal Review may be requested by the member / member's legally responsible person, (or the provider or other designated personal representative), if it is indicated that taking the time for a standard review could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. This request can be made verbally or in writing to the Appeals department. Oral expedited appeal requests do not require a written appeal to follow. Specific contact information is listed on the Notice of Adverse Benefit Determination letter. For expedited appeal requests made by providers on behalf of beneficiaries, Partners presumes an expedited appeal resolution is necessary and will grant the request for expedited resolution. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal.

Expedited appeals may be submitted by:

By USPS Mail or In person: Partners Health Management, 901 S. New Hope Rd., Gastonia NC 28054

Appeals department:

- Fax: 704-842-2720
- Telephone: 704-884-2650

In instances where the member's request for an expedited appeal is denied, the appeal will be immediately transferred to a standard appeal timeframe and provide written notice to the member, and when applicable, an authorized representative, if the denial of the expedited resolution request. Partners will acknowledge, in writing, receipt of each expedited appeal request within 24 hours of receipt. Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, and will provide written notice, and make reasonable efforts to provide oral notice, of the resolution no later than 72 hours from the initial receipt of the appeal. Partners may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Partners demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Partners will provide written notice to the member within two calendar days of the reason for the delay and the right to file a grievance/complaint if they disagree with the decision.

Extension timeframes Partners may extend the timeframes for expedited resolution of an appeal request by up to 14 calendar days if the member requests the extension, or Partners determines there is a need for additional information and the delay is in the member's interest. If the timeframe is extended other than at the member's request, Partners will:

- Make reasonable efforts to give the member oral notice of the delay.
- Within two calendar days, provide written notice and inform the member of the right to file a grievance/complaint if he or she disagrees with that decision.

- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Appeals on Behalf of a Member

An Appeal Review may be requested by the member/member's legally responsible person, or the provider or other designated personal representative. This request can be made verbally or in writing to the Appeals department. Oral expedited appeal requests do not require a written appeal to follow. Specific contact information to file an appeal is listed on the Notice of Adverse Benefit Determination letter. An appeal is the request for Partners to review an adverse benefit determination. The appeal process allows the member, the member's authorized representative acting on behalf of the member or Provider acting on the member's behalf with the member's written consent, to file an appeal either orally or in writing.

Partners will acknowledge, in writing within one day of receipt of each standard appeal request, whether it was received either orally or in writing.

If the member or legally responsible person needs assistance, the letter asks them to call the Appeals department at 704-884-2650. Any oral request can start the appeal process. Requests may be submitted by telephone, fax, mail, in person. *Members who need assistance related to an Appeal, may call the Appeals department at 704-884-2650.* The member, legally responsible person, or a provider or other designated personal representative, acting on behalf of the member, with the member's signed consent, has the right to review any information used as part of the appeal process. Partners will confirm that consent has been obtained by verifying that there is consent from the member or their LRP.

The member's record information may be requested, free of charge, through the Appeals department at 704-884-2650. The standard appeal must be completed, and the written notice issued to the member or legally responsible person. Partners will provide written notice of resolution of the appeal to the member and/or authorized representative.

To request an appeal, the member, legally responsible person, or a provider or other designated personal representative, active on behalf of the member; with the member's signed consent, may file either an oral or written reconsideration review. These may be submitted by one of the following:

By USPS Mail or In person: Partners Health Management, 901 S. New Hope Rd., Gastonia NC 28054

Appeals department:

- Fax: 704-842-2720
- Telephone: 704-884-2650

Upon completion of the appeal decision, if the member or legally responsible person disagrees with the Partners' local reconsideration decision, the member, member's LRP, or other designated legal representative can then appeal the decision via the State Fair Hearing process.

Continuation of Benefits

The member, or the member's authorized representative, may request for the continuation of benefits during an appeal and or State Fair Hearing within 10 calendar days of Partners sending the adverse benefit determination or on the intended effective date of the proposed adverse benefit determination, whichever comes later. Providers may not request continuation of benefits on behalf of a member. Within 24 hours, Partners will inform the NCDHHS of our decision to approve or deny member requests to continue benefits and will not seek to recover the cost of services provided without NCDHHS prior approval. A member is eligible to receive continuation of benefits when the following is met:

- The Reconsideration is requested within 10 days from the date the Notice of Action is mailed or the intended effective date of Partners' proposed action.
- The Reconsideration involves the termination, suspension or reduction of a previously authorized service; the service was ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests a continuation of benefits.

If, at the member's or legally responsible person's request, Partners continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The member or legally responsible person withdraws the appeal; 10 days after the Notice of Action indicating an Upheld or
- Partially Upheld decision is mailed, unless the recipient requests a State Fair Hearing within those 10 day or
- A State Fair Hearing decision is made against the member

If the final resolution of the appeal is adverse to the member (upholds Partners' action) Partners may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the Partners or State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Partners will authorize the disputed services promptly and as expeditiously as the member's health condition requires and no later than 72 hours from the date it received notice of reversing the determination. Additionally, in the event that services were continued while the appeal was pending, Partners will provide payment for those services in accordance with the terms of the contract.

State Fair Hearing Process

If a member is not satisfied with the outcome of a Partners appeal decision, they have the right to request a State Fair Hearing. The State Fair Hearing process allows the member, the member's authorized representative acting on behalf of the member or provider acting on the member's behalf with member's written consent to file for a State Fair Hearing within 120 calendar days from the date on the Notice of Resolution issued by Partners. Beneficiaries must exhaust the internal appeals process with Partners before they may file a request for a State Fair Hearing. Beneficiaries have the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of the request for a State Fair Hearing with the North Carolina Office of Administrative Hearings (OAH).

Partners will comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.

During mediation, Partners staff are trained to attempt to reach satisfactory resolution to all parties before a State Fair Hearing is necessary, including educating members on alternative services and gathering additional information from members that may impact the service decision. The goal is transparency, communication, mutual education and issue narrowing to avoid escalation.

We fully support OAH in preparation for and participation in State Fair Hearings, including providing all medical records documentation. If a decision is changed, within 48 hours of notification of reversal by OAH of a decision to deny, limit, or delay services, or sooner depending on the health condition of the member, Partners will authorize the provision of services not furnished during the appeals process. If OAH reverses a decision to deny, limit, or delay services, Partners will pay for services rendered during the appeals process.

Appeal Hearings

How to File a Medicaid State Fair Hearing

Instructions to request the appeal is included in the Notice of Resolution Letter to the member or legally responsible person. Upon receipt of the request, OAH will offer the member or legally responsible person the option of mediation or an appeal before an Administrative Law Judge. If mediation is chosen, one of the mediators who are a part of The Mediation Network of North Carolina will contact the member or legally responsible person to offer an opportunity to mediate the disputed issue(s) to resolve the pending appeal informally. If the member or legally responsible person accepts mediation, it is usually scheduled to be completed within 10 days of the date of the OAH Appeal request.

If the issue(s) is resolved at mediation, the appeal is withdrawn, and services will be provided pursuant the Mediation Agreement. The decision because of mediation is final and binding. The outcome of mediation can be settlement, withdrawal or an impasse. If the member or legally responsible person does not accept the offer of mediation or the mediation results in an impasse, the case proceeds to a formal hearing and will be heard by an Administrative Law Judge with the OAH. This is referred to as the State Fair Hearing Process.

The State Fair Hearing is conducted by an Administrative Law Judge (ALJ) at the OAH. The hearing is scheduled to occur by telephone unless the member or legally responsible person requests to attend in person. The member or legally responsible person receives notice of the date, time and location of the hearing. The hearing is scheduled at the member's or legally responsible person's convenience in a location close to the member or legally responsible person.

If the final resolution of the appeal is not decided in the member's favor, (meaning Partners or NCDHHS action is upheld), Partners may recover the cost of the services furnished to the member while the appeal is pending.

Partners will comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge. If a member is unsatisfied with the results of an appeal or grievance/complaint to Partners, they may initiate a State Fair Hearing via the contact information below:

Office of Administrative Hearings:
Address: 6714 Mail Service Center Raleigh NC 27699-6700
Phone: 984-236-1860
Fax: 984-236-1947
If there are questions, the member or legally responsible person may call the NC Department of Health and Human Services (DHHS) Division of Health Benefits Appeals Unit toll-free at 1-800-662-7030 or at 919-855-4260. Ask for the call to be transferred to the DHB Appeals Unit, Clinical Policy and Programs. To learn more about the appeals process, contact the North Carolina Office of Administrative Hearings at 984-236-1850.

How to File a Non-Medicaid DMHDDSAS Hearing

If a member or legally responsible (LRP) person disagrees with the non-Medicaid service Reconsideration decision, he or she may appeal by submitting a Non-Medicaid Appeal Request to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS). Instructions are included with the Notice of Non- Medicaid Service Appeal Determination Decision Upheld letter.

The internal Partners' Non-Medicaid Service Appeal process must be completed prior to filing an Appeal with the Division. The DMHDDSAS Hearing Office must receive the member's appeal within 11 calendar days from the date on the Partners' Notice of Action Request for Non- Medicaid Services Letter [10A NCAC 271 .0600-.0609]. If the 11th day falls on a weekend or holiday, the deadline is the next business day. Members who need assistance related to an Appeal may call the Appeals department at 704-884-2650.

The Non-Medicaid Appeal Request is reviewed by a Hearing Officer designated by DMHDDSAS. Hearing Officers issue their findings and decisions within 60 days of Hearing to both the member or legally responsible person and Partners' CEO. When the findings and decisions are received,

Partners issues a final decision based on those recommendations in writing within 10 days. This decision is final and there are no further appeal rights as set forth in NC GS 143B-147(a) (9). (See first paragraph under Final LME/MCO Decision - Level IV heading above.)

Receiving Services During the Non-Medicaid Appeal Process

Partners has the option of authorizing other appropriate non-Medicaid services. Services may be authorized for the duration of the Reconsideration process at Partners' discretion. Other community resources may also be referred to the member for support.

When a member/legally responsible person, or provider, or other designated personal representative; upon consent given by member/LRP; files an appeal for the denial of a service, Partners is under no obligation to provide the requested service during the appeal process.

Provider Grievance/Complaint and Appeals

TP/State Funded Provider Appeals

Partners shall not discriminate or retaliate against any provider based on any action taken by the provider under the Provider Grievances/Complaints and Appeals Section of the Contract (Section V.B.4.v.) or under the

Member Grievances/Complaints and Appeals Section of the Contract (Section V.B.1.vi.) taken on behalf of a member.

Partners shall handle provider appeals and grievances/complaints promptly, consistently, fairly, and in compliance with state and federal law and NCDHHS requirements.

Partners shall be transparent with providers regarding its appeals and grievance/complaint processes and procedures.

Partners shall accept and resolve provider grievances/complaints regarding Partners Plan referred from NCDHHS.

A participating provider must submit a request in writing using the Dispute Resolution form, which can be found on Partners' website or via the provider web portal, no later than 30 calendar days from which provider receives written notice from Partners of the decision giving rise to the right to appeal, or Partners should have taken a required action and failed to take such actions.

This provider dispute process is intended to be an informal reconsideration by Partners of its decision or action; however, Partners will allow providers to be represented by an attorney during the appeals process.

Partners shall limit the issue on appeal in cases of suspension or withhold of provider payment to whether Partners had good cause to commence the withhold or suspension of provider payment. Partners will not address whether the provider has or has not committed fraud or abuse.

Partners will offer providers appeal rights as described in Section VII. Attachment I, for Medicaid, and State-funded providers.

Partners must allow a participating provider to appeal an adverse decision. Appeals to Partners will be available to a network provider for the following reasons:

1. Program Integrity related findings or activities
2. Finding of waste, or abuse by Partners
3. Finding of or recovery of an overpayment by Partners Withhold or suspension of a payment related to waste, or abuse concerns
4. Termination of, or determination not to renew, an existing contract for Local Health Department care/case management service
5. Determination to de-certify an Advanced Medical Home+ or CMA (applicable to Medicaid providers only)
6. Violation of terms between Partners and provider

Partners must allow a provider to appeal an adverse decision. Appeals to Partners will be available to an out-of-network provider for the following reasons:

1. An out-of-network payment arrangement

2. Finding of waste or abuse by Partners
3. Finding of or recovery of an overpayment by Partners

Partners will ensure the Grievance/Complaints and Appeals system complies with TP RFA, Section V.A.1.iv.

Member Safety Mechanism

Partners' first priority is the well-being of its members. If the Partners' Chief Medical Officer or Chief Clinical Officer is of the opinion that the provider who is the subject of any dispute poses a significant risk to the health, welfare or safety of members, the provider may be immediately suspended pending the results of an investigation.

A. A suspended participating provider will not receive funding or new referrals from Partners. Any suspension decisions must be made by the Partners Network Management Committee pursuant to LME/MCO/Tailored Plan Issued Sanctions Policy.
B. Written notification of the intent to suspend the provider pending investigation is sent to the provider as soon as possible based on the urgency of the situation, but no later than five (5) calendar days of becoming aware of the issues. The notification includes the availability of the Appeal Process including the Appeal Resolution Form and the mechanism for initiation.
C. In addition, Partners provides written notification to the appropriate entities, such as:
    1. Division of Health Service Regulation (DHSR)
    2. The Department of Social Services (DSS)
    3. The Division of Mental Health/Developmental Disability/Substance Abuse Services (DMH/DD/SAS) Program Integrity Unit
A. As with any appeal, the provider may contact Partners' Provider Network Management department to share any information that they believe may bring about a favorable outcome.
B. Partners makes every effort to achieve a final resolution to these kinds of cases ahead of the designated deadlines, given the provider has been suspended. However, Partners does not compromise the outcome to complete the case quickly.
C. A first-level panel convenes once the information gathering and investigation is complete.
D. All other steps to the panel review process are the same as outlined above, including the written notification and the right to a second-level panel review.

<u>Initiation of the Dispute Resolution Process</u>

I. Initiation of the Provider Appeals Resolution Process
    A. A participating provider can submit a request in writing using the Provider Appeals/Dispute Resolution Form, which can be found on the Partners' website or the provider web portal, within 30 calendar days on which:

1. Provider receives written notice from Partners of the decision giving rise to the right to appeal.
2. Partners should have taken a required action and failed to take such actions.

If the provider fails to meet the timeframes to request initiation of the Provider Appeals Process, Partners' decision becomes final, and the provider may not further exercise the Provider Appeals Process.

B. The provider will receive a copy of the Provider Appeals/Dispute Resolution Form, along with the notification of action or decision taken by the LME/MCO/Tailored Plan. A provider may also contact Partners by telephone or in-person, and the appropriate staff person will assist the provider with obtaining a copy of the Provider Appeals/Dispute Resolution Form.
C. The Provider Appeals Resolution Form collects the following information, at a minimum:
   1. The nature of the problem
   2. Previous attempts, if any, to resolve it
   3. Any other pertinent information that the provider feels is important
D. In addition, the provider may submit additional information in writing either by electronic mail, surface mail, special delivery, hand delivery, provider web portal or other source of written communication. The provider will not submit originals unless requested to do so. Partners is under no obligation to return documents submitted by a provider in support of its dispute unless expressly agreed upon in advance in writing.

If you have questions or need assistance with filing a dispute, please contact us at provider_disputes@partnersbhm.org

Nature or Type of Provider Appeal

A. Once Partners receives the completed Provider Appeal/Dispute Resolution Form from the provider, the Partners' provider network appeals specialist will perform an analysis of the nature or type of the dispute and assign it to the appropriate track described below. The provider network appeals specialist may confer with other departments as appropriate to assist with making this determination if needed.
   1. Type I: Provider Appeals of an *administrative* or *non-clinical* nature are those pertaining to matters such as, but not limited to, the following:
      a. Claims and billing, including timely filing of claims and demands for payback of an overpayment
      b. Adequacy of facility and staffing
      c. Compliance with state and Partners' policy
      d. Compliance with contractual requirements not excluded below
      e. Compliance with state regulatory requirements (e.g., Core Rules, Client Rights Rules, etc.)
      f. Network accessibility issues

g. Not submitting requested medical records

2. Type II: Provider Appeals of a *clinical* nature are those that involve the provider's professional competency or conduct and/or the participating provider's status within the network. They include, but are not limited to, the following:
   a. The appropriateness or quality of professional services including assessment, treatment, consultation and referral
   b. The appropriateness of interactions between a provider's treatment staff and a member
      (i) Conduct by a professional that may adversely affect treatment outcomes, e.g., failure to exercise professional judgment in disclosing client information: termination, suspension and/or other sanction or action directed by Partners at a specific participating provider that directly results in a substantial change in that provider's status in Partners' network.
3. Exclusions: Not all parties and issues are subject to this participating provider appeals process.
   a. Parties: This process is limited to participating providers under an existing contract with Partners. Excluded include Applicants, credentialed but not contracted providers, employees of providers (including Relatives of Direct Support Employees (RDSE) and others not defined as participating providers below.
      (i) If a participating provider has been issued a notice of dismissal or termination from the network, then the provider is considered participating for purposes of this dispute process up to and through the last day of participation as indicated on the notice, unless the notice is received on or after the last participation day, in which case, the provider will be given reasonable time to initiate the dispute mechanism. The time frame is generally stated in the dismissal/termination notice.
   b. Medical Necessity and Other Enrollee Appeals: Medical necessity appeals, including disputes regarding resource allocation and Supports Intensity Scale (SIS) scores, are not included within the scope of this provider dispute process but are addressed as adverse benefit determinations by the Utilization Management department under separate policies and procedures for enrollees and beneficiaries.
      (i) This provider dispute process does not include disputes primarily or exclusively belonging to the member, beneficiary, enrollee or their legally responsible person (LRP).
   c. Clear For-Cause Contract Violations: If the provider contract is explicit and breached, this provider dispute process is not required. For example, if a providers' clinical license is revoked, if the provider is convicted of claims fraud or if the provider receives a failing fidelity score (TMACT), the provider loses its facility license, etc.

(i) For those violations described in the Integrated Payment and Reporting System (IPRS) (aka non-Medicaid) contract (the contract with providers who deliver State-Funded Services), Article IV, Term and Termination, the dispute resolution process is not available. Those violations include but are not limited to:
   (a) Repeated non-performance of obligations without corrective action
   (b) Violations of professional standards
   (c) The commission of unlawful acts

d. Grievances/Complaints: Disputes by individuals and entities not covered by this process may be eligible for the grievance/complaint process covered in Partners' Policy and Procedure 6.00.
e. Untimely or Previously Adjudicated Disputes: Each dispute must be brought timely and cannot be brought again by the same participating provider regarding the same action or decision by Partners.

Appeals to State

A. Final Decision: The participating provider must exhaust the full provider dispute process afforded by Partners to appeal Partner's final decision to the state. The potential for appealing and how to do so will be included in any final decision issued by Partners under this provider dispute process.
B. TP/PIHP Medicaid: Partners provider dispute decisions involving Medicaid funds or contracts, if appealable, are to the North Carolina Office of Administrative Hearings to the extent required by law.
C. Non-Medicaid: Partners' provider dispute decisions involving non-Medicaid funds or contracts, if appealable, are to a North Carolina DMHDDSAS hearing officer, to the extent required by law.

Disputes Related to Provider Payment Withhold or Suspension:

A. Partners shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.
B. For appeals related to payment withhold or suspension, Partners will resolve each appeal within fifteen (15) business days. If the review of an appeal related to payment results in the determination that Partners did not have good cause for withholding or suspending payment, withheld or suspended payments will be made to the provider within five business days.
C. Partners shall offer the provider an in person, telephone, or virtual hearing when provider is Appealing whether Partners has good cause to withhold or suspend payment to the provider.

PIHP/Medicaid Grievances and Appeals

It is the policy of Partners Health Management (Partners) to respect participating providers' rights while also holding them accountable in fulfilling Partners' obligations to ensure an adequate and quality provider network while protecting members, other stakeholders and public funds (Medicaid and non-

Medicaid). To this end, and consistent with controlling authorities including applicable contracts, laws, regulations and accreditation requirements, Partners maintains a robust, formal process consistent with its written agreements to address and reconsider certain actions or decisions by Partners against participating providers before becoming final.

Partners handles provider appeals and grievances promptly, consistently, fairly, and in compliance with State and federal law and North Carolina Department of Health and Human Services (NCDHHS) requirements, via the robust provider appeal and grievance system described here. While streamlined with other due processes at Partners, the provider appeal and grievance system is distinct from that offered to members, recipients and other stakeholders. It includes a grievance/complaint process for providers to bring issues to Partners, an appeals/disputes process for providers to challenge certain Partners decisions, and information regarding access to a state level review through the North Carolina Office of Administrative Hearings (NCOAH) or other forums as appropriate. By this policy and other materials and communications, Partners intends to and will be transparent with providers regarding appeal and grievance/complaint processes and procedures.

The purpose is not to create another perceived "layer of litigation," but to provide a user-friendly, streamlined due process by which Partners can reconsider its own actions and decisions and be certain of its position before issuing a final formal decision in response to disputes by participating providers over which the provider has appeal rights. This Policy and Procedure should be interpreted as a mandatory alternative dispute process (ADR) to further, formal litigation and disputation as allowed by law.

As defined in official procedures, not all disputes are subject to this process. Provider disputes not covered by this policy and procedure are treated as grievances/complaints. Grievances/complaints are an expression of dissatisfaction about any matter other than an adverse benefit determination.

Partners shall not discriminate or retaliate against any provider based on any action taken by the provider under the Provider Grievances and Appeals Section of the Contract (Section V.B.4.v.) or under the Member Grievances and Appeals Section of the Contract (Section V.B.1.vi.) taken on behalf of a member.

Partners shall handle provider appeals and grievance/complaint promptly, consistently, fairly, and in compliance with state and federal law and NCDHHS' requirements.

Partners shall be transparent with providers regarding its appeals and grievance/complaint processes and procedures.

Partners shall accept and resolve provider grievances/complaints regarding Partners Plan referred from NCDHHS.

A participating provider must submit a request in writing using the Dispute Resolution form, which can be found on Partners' website or via the provider web portal, no later than 30 calendar days from which provider receives written notice from Partners of the decision giving rise to the right to appeal, or Partners should have taken a required action and failed to take such actions.

This provider dispute process is intended to be an informal reconsideration by Partners of its decision or action; however, Partners shall allow providers to be represented by an attorney during the Appeals process.

Partners shall limit the issue on appeal in cases of suspension or withhold of provider payment to whether Partners had good cause to commence the withhold or suspension of provider payment. Partners will not address whether the provider has or has not committed fraud or abuse.

Partners will offer providers appeal rights as described in Section VII. Attachment I, for Medicaid, and State-funded providers.

Partners must allow a participating provider to appeal an adverse decision. Appeals to Partners will be available to a network provider for the following reasons:

- Program Integrity related findings or activities
- Finding of waste, or abuse by Partners
- Finding of or recovery of an overpayment by Partners
- Withhold or suspension of a payment related to waste, or abuse concerns
- Termination of, or determination not to renew, an existing contract for Local Health Department care/case management service
- Determination to de-certify an Advanced Medical Home+ or CMA (applicable to Medicaid providers only)
- Violation of terms between Partners and provider

Partners must allow a provider to appeal an adverse decision. Appeals to Partners will be available to an out-of-network provider for the following reasons:

- An out-of-network payment arrangement
- Finding of waste or abuse by Partners
- Finding of or recovery of an overpayment by Partners

i. The PIHP shall notify Department if a provider has sued PIHP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.

   a. Payment for Crisis Providers
      The PIHP shall reimburse in-network providers for mobile crisis services and facility-based crisis services no less than the Department's Enhanced Behavioral Health Fee Schedule unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.
   b. Provider Hardship Payments
      1. The PIHP shall have the capability to process Hardship Payment requests from a provider within seven (7) Calendar Days of receipt of a hardship request or three (3)

Calendar Days of receipt of an urgent hardship request.

2. The PIHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval within thirty (30) Calendar Days of Contract execution. The Provider Hardship Payment Policy shall include:

i. Method for providers to submit hardship payment requests;
ii. Description of timeline for payment for standard and urgent requests, including integration into check write schedule;
iii. Criteria for requests to be reviewed and approved by the PIHP; and
iv. Description of how providers and Department will be notified of status of the request and payment, if applicable.

Partners will provide notice to NCDHHS of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by Partners, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five business days of the appeal.

How to File a Provider Grievance/Complaint

Partners has a process and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience. It is the policy of Partners Health Management (Partners) to provide and encourage providers, the right and ability to bring any expression(s) of dissatisfaction via a grievance/complaint (substantially synonymous) to the attention of Partners in compliance with accreditation requirements, federal and state laws and regulations, state contracts, and any other controlling authorities. Grievances/complaints are accepted by all staff, in all forms and formats, including oral, written and anonymous. Grievances/complaints will be processed formally or informally as appropriate. Partners will comply with all regulatory expectations regarding timeframes for investigation, resolution and notification. However, Partners may not exceed 90 calendar days for full investigation, resolution, and notification of grievances/complaints, unless permitted/required by regulatory authority. Providers can submit grievances/complaints through Partners provider web portal. Please refer to Grievance/Complaint Management Policy P&P 6.00 for reference.

A. Partners Office of Legal Affairs (OLA) is responsible for the grievance/complaint process, which includes the following tasks:
    1. Intake and reviewing submitted grievances/complaints.
    2. Assigning grievances/complaints to appropriate person(s) and department(s) for resolution.
    3. Ensuring complete and timely resolution of those grievances/complaints by those who have been assigned.
    4. Compiling/submitting all required aggregate reporting requirements unless otherwise noted.

B. Any Partners staff may receive grievances/complaints via phone calls (including TTY/TTD), e-mail, in-person, in writing or on Partners' provider web portal. A form is also accessible on every page of the Partners website, https://www.partnersbhm.org/feedback/.

Grievances/Complaints can be filed several ways:

- Call the Office of Legal Affairs. The phone number is toll-free at 877-864-1454 option 3.
- Send by email to grievances@partnersbhm.org
- Electronic Form found on www.partnersbhm.org.
- In person or by mail at:
  Partners Health Management
  c/o Grievances/Complaints
  901 S. New Hope Road
  Gastonia, NC 28054

To request an appeal, the member, legally responsible person, or a provider or other designated personal representative, acting on behalf of the member; with the member's signed consent, may file either an oral or written reconsideration review. These may be submitted by one of the following:

In person: Partners Health Management – 901 S. New Hope Rd., Gastonia NC 28054
By Mail: Partners Health Management – 901 S. New Hope Rd., Gastonia NC 28054
Fax – Appeals department – 704-842-2720
Telephone – Appeals department – 704-884-2650

Providers can initiate the dispute process several ways:

A participating provider initiates the provider dispute resolution process by submitting an Appeals/Dispute Resolution Form generally included with the action or decision being disputed and also available on Partners' website. A provider may also contact Partners by telephone or in person, and the appropriate staff person will assist the provider with obtaining a copy of the Appeal/Dispute Resolution Form and answer relevant questions on how to complete it. While the form is the preferred method for initiating this dispute process, other writings covering substantially the same information will be accepted.

Send by E-mail to provider_disputes@partnersbhm.org

Electronic Form found at https://providers.partnersbhm.org/provider-disputes

In person or by mail at:
Partners Health Management
c/o Disputes
1985 Tate Blvd. SE
Hickory, NC 28602

Partners Provider Grievances/Complaints/Appeals Policy: https://www.partnersbhm.org/wp-content/uploads/partners-tailored-plan-provider-grievance-and-appeals-policy.pdf

Provider Ombudsman

The NC Medicaid Provider Ombudsman represents the interests of the provider community by offering supportive resources and assistance in resolution of provider inquiries, concerns, and complaints regarding health plans.

Separate from the health plan's Provider Grievance/Complaint and Appeals process in which health plans are expected to resolve complaints and provide a summary of final resolution to NC Medicaid, the Provider Ombudsman will investigate and address complaints of alleged maladministration or violations of rights against the health plans when problems persist after following the health plan's process.

Additionally, the Ombudsman will assist providers with Health Information Exchange (HIE) inquiries related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Inquiries may be submitted by:

- Emailing Medicaid.ProviderOmbudsman@dhhs.nc.gov.
- Calling the Medicaid Managed Care Provider Ombudsman at 866-304-7062**.**

The Provider Ombudsman contact information, as well as the health plan's Provider Grievance/Complaint and Appeal Process, can also be found in each health plan's provider manual linked located at https://medicaid.NCDHHS.gov/transformation/health-plans/health-plan-contacts-and-resources.

FRAUD, WASTE AND ABUSE for PARTNERS TP/PIHP/State Funds

Fraud, Waste and Abuse (FWA)

Partners takes the detection, investigation, and prosecution of fraud, waste and financial abuse (FWA) very seriously, and has a Program Integrity department that assists with ensuring program integrity in the detection and prevention of FWA and that all providers comply with state and federal laws, rules, regulations and policies. Partners' program integrity strategies help improve lives and strengthen communities, serving as an intricate component of our integrated, companywide compliance program. We work collaboratively across multiple departments and cross-functional business units to ensure members/recipients can select providers that deliver high quality care at the right frequency and level. We monitor provider documentation to ensure it supports medical necessity and complies with health care quality standards. Our PID safeguards taxpayer dollars and makes sure we spend limited funds appropriately and compliantly through rigorous detection and prevention of FWA. Partners balanced and adaptable approach keeps our strategies ahead of the curve in response to North Carolina's rapidly changing health care landscape.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider or subcontractor and office staff is educated on proper billing requirements and/or claim submission.

Abuse means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Partners instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- Deficit Reduction Act
- US Criminal Codes
- Third-Party Liability (coordination of benefits)

Overpayments are not always intentional or fraudulent but must still be identified and recovered. Partners is transparent with our providers regarding our subcontractors claims processing requirements and the controls we have in place to prevent and detect FWA, as described below. We educate providers so they understand appropriate billing practices and the methods we employ to minimize FWA in the system. This transparency fosters collaboration with providers and helps to balance any tensions regarding timely and accurate claims payment and Partners' due diligence to protect limited federal and state resources. Program Integrity functions include using data analysis, performing audits and conducting investigations. The Program Integrity department identifies providers for possible prepayment and post payment claims review through various methods (e.g., data mining, complaints). Our program integrity director reviews each case, analyzes data and consults with our provider network and finance departments to understand all aspects of the provider and their billing practices.

Authority and Responsibility

One of the responsibilities of Partners is to protect the provider network – and the members, patients and others we all serve with taxpayer dollars – from health care FWA. The Program Integrity department helps Partners meet its responsibilities to ensure that funds are utilized for the appropriate level and intensity of services through preventative and detective activities designed to reduce fraud, waste and financial abuse as well as ensure compliance with federal, state, and local laws, rules and regulations. The Program Integrity

department is charged with these responsibilities in accordance with 42 Code of Federal Regulations (CFR) part 455, and all applicable policies and procedures.

The Program Integrity department carries out its responsibilities through the conduct of proactive and reactive audits and investigations that may result in referrals of potential fraud to NC DHB, issuance of a tentative notice of overpayment (TNO) and/or issuance of a warning letter. TNOs may be issued because of:

- Failure to comply with state, federal, Medicaid or other revenue source requirements.
- Payment for a service or a portion of a service that should have been disallowed.
- Payment for a claim that was fraudulently billed.

Overpayments are not always intentional or fraudulent but must still be identified and recovered.

The Program Integrity department's functions include using data analysis, performing audits and conducting investigations. Data analysis proactively identifies trends in claims data that may be indicative of fraud or financial abuse. Information developed by Program Integrity's data analyst is provided to auditors or investigators who use it to start work or in furtherance of existing work.

PID's audits are proactive reviews of paid claims to ensure compliance with all federal and state laws, rules, regulations and contract requirements. Specifically, auditors will validate the presence of information to support billing of services.

Program Integrity investigations are typically reactive in nature and are based on allegations of fraud or financial abuse regarding services rendered by Partners' providers. Reporting to State and Federal Authorities

Partners is obligated to report each case of potential health care fraud. Information reported to NC DHB Office of Compliance and Program Integrity must include, but is not limited to, the following:

- The provider's name and number
- The source of the complaint
- The type of provider
- The nature of the complaint
- The approximate range of dollars involved and the legal and administrative disposition of the case.

Potentially fraudulent billing may include, but is not limited to:

- Unbundling service
- Billing for services by non-credentialed or non-licensed staff
- Billing for a service the provider never rendered or for which documentation is absent or inadequate

Prepayment Claims Review

The purpose of prepayment claims reviews, conducted primarily by the Program Integrity Department (PID) in collaboration with Partners' Finance and Claims departments and Carolina Complete Health/Centene (CCH), is to ensure that claims presented by a provider for payment to Partners meet the requirements of federal and state laws and regulations. Partners' priority is to minimize potential future loss of public funds through targeted prepayment claims reviews. PID will conduct prepayment claims review(s) to analyze claims along with supporting documentation submitted by the provider prior to claims payment to assure appropriate claims payment.

Prepayment claims review is a process in which the payment of a provider's submitted claims is temporarily pended in the payment system until reviewed by PID for supporting documentation. Unless otherwise provided by law, the claims that are identified for prepayment claims review will be selected using the record sampling process provided under Policy and Procedure on Provider Claims/Records Sampling, P&P 4.17.

I. Prepayment Claims Review Determination

A. PID receives case leads using analytics tools, referrals and complaints. The PID Director evaluates recommendations from the PID team members to place a provider on Prepayment Claims Review. Prior to placing a provider on Prepayment Claims Review, the PID Director will consult with the Provider Network, Finance and Claims departments as needed. The grounds for placing a provider on prepayment claims review must comply with NCGS 108C-7, which includes but is not limited to the following:

1. Receipt of a credible allegation of fraud, identification of aberrant billing practices as a result of investigations, data analysis by Partners, failure of provider to timely respond to a document request by Partners or other grounds defined by law or the NC Department of Health and Human Services (NCDHHS).

2. Multiple substantiated PID cases in a 12-month period, including:

    a. Providers who have four plus service-related allegations submitted for payment during the last 12 months.
    b. Providers who have less than 70% clean claims compliance and four plus service-related allegations.

3. Claims denial rates greater than 15% are subject to prepayment review.

II. Interagency Notification Memo of Provider Placement on Prepayment Claims Review

A. An Interagency Notification Memo or email of Provider Placement on Prepayment Claims Review is completed by a designated PID team member when the PID Director, or other decision-making body, determines that a provider will be placed on prepayment claims review.

B. Once the decision is made, PID notifies Claims, Finance and Provider Network departmental designees and others as deemed appropriate of the decision to place a provider on prepayment claims review. This notice provides the following information:

1. Date decision issued by the PID Director and/or other decision-making body to place provider on prepayment claims review.
2. Provider Name, address, contact person, National Provider Identifier (NPI) number and PID case number.
3. Type of service(s) to be placed on prepayment claims review.
4. Copy of the Provider Notification Letter.

III. Planning Phase:

A. Recommendation by the PID team member or CCH is made to the PID Director. The PID Director renders any decision to approve the recommendation that the provider be placed on prepayment claims review.

B. The PID team member reviews the provider claims volume for the past three months to determine the average weekly claims volume to discern PID resource needs to conduct the prepayment claims review.

C. The PID team member gathers preliminary information related to the number of claims, number of detail line items (claim header ID), and service and/or procedure codes billed by provider during this timeframe.

1. Providers are assigned to prepayment claims review of claims where they are the identified *Billing Provider*.
2. PID does not place a pend on claims for providers shown as *Attending/Rendering Provider* on the claims form.
3. Claims may be pended for any services billed or PID may limit prepayment claims review to specific service and/or procedure codes.

D. The PID team member will identify and coordinate the appropriate review team, review tools and written guidelines for evaluating provider compliance.

IV. Implementation Phase:

A. Interdepartmental Notification:

1. PID notifies the Claims, Finance, Provider Network and IT departments' designees of provider prepayment claims review placement using the appropriate PID approved notification form.

   a. Claims that are selected for prepayment review will go through the adjudication process using the pre-defined edits/audits to determine if the claim should be paid, denied or pended. Once the claims have been identified to be paid, steps are taken to ensure that these claims will be pended in the system before the provider is issued payment.
   b. Each claim that is pended will be examined to ensure that claims presented by a provider for payment meet all applicable requirements, including but not limited to the following:

      i. Federal and state laws, regulations
      ii. Services were provided according to Division of Health Benefits (DHB) policy requirements
      iii. Billed services, if not pre-authorized by Partners, were medically necessary, appropriate and not in excess of the members' needs pursuant to physician order, etc., as documented in policy or service standards; PID will ensure the appropriate Partners' clinical professional(s) makes any such determinations
      iv. Prior authorization was obtained, if required by policy
      v. Providers possessed the proper license, certification or other accreditation requirements specific to the provider's scope of practice, Medicaid policy, and conditions of participation with the NC Medicaid Program at the time the service was provided to the member

2. Once the claim has been checked and verified that it complies with related uniform guidelines for that service(s) the valid claim will be processed for payment. If the claim does not comply it will not be accepted and therefore denied. The invalid claim will not be paid.

3. The claims will be selected using the record sampling process found in P&P 4.17.

B. Provider Notification

1. PID has established the following process to assure providers are notified in accordance with NCGS 108C-7(b).

2. PID will mail, via certified mail, the Provider Prepayment Claims Review Initial Notice to the provider no less than 20 calendar days before start of claims pending, which gives notice of claims pending date and the details/requirements of the provider while on prepayment claims review.

3. The Provider Prepayment Claims Review Initial Notice Letter provides the following information to the provider:

    a. An explanation of the decision to place the provider on prepayment claims review
    b. A description of the review process and claims processing times
    c. A specific list of all supporting documentation that the provider must submit simultaneously with the claims that will be subject to the review
    d. The process for submitting claims and supporting documentation
    e. The standard of evaluation PID uses to determine when a provider's claims will no longer be subject to prepayment claims review

4. Provider Failure to Accept Certified Mail: In the event a provider refuses or otherwise fails to accept the Prepayment Claims Review Initial Notice Letter by the fifth business day after the first attempted delivery, PID may:

    a. Attempt to confirm address location
    b. Create a numbered memo to change the first date of claims pending to assure the provider has a full 20-calendar day notice (NCGS 108C-7(b))
    c. Send a second and final notice to the provider via certified mail
    d. If the provider does not respond or pick up the mail from the final notice, the PID Director will determine the next steps to be taken
    e. An email will be sent to the provider with the (title of letter) attached and read receipts will be requested (RRR)

C. Receipt of Claims and Deadlines:

1. The PID team member assigned to manage the prepayment claims review prints the appropriate *submitted claims report* for the pending prepayment claims review on a weekly basis. The PID team member will notate the time and date of the report, which is posted as the received date. The processing deadlines are 20 calendar days from the date the claim was posted as received by Partners, provided all are clean claims.
2. If any claim and its subsequent detail line item is missing documentation, the processing deadline gets an additional **20 calendar days** from the date the documentation is due based on the Final Records Request.
3. CCH's pre-pay review team uses PISCES, a code editor to pend, deny, approve and review claims. PISCES is linked to the claims system, AMISYS and when a provider is put on PPR, claims for the services under review are pended in AMISYS and transferred to PISCES for the review team to review. When a claim comes from a provider with a service that is subject to PPR, just the service under review is pended and not the entire claim. The provider will receive an explanation of payment (EOP) with the denial code and a request for service documentation.
4. Upon receipt, the service documentation is given to the PID/SIU clinical team to review. If during the review the provider's claims are adequately supported and meet criteria it can be taken off PPR. The goal is for the provider's claims to be at a 70 percent approval rate.

V. Prepayment Claims Review Process for Records Request and Tracking

A. An *Initial Records Request Letter* is generated and sent via certified mail to the provider within 48 hours of claims receipt. The *Initial Records Request Letter* will be sent for each member listed in the claims batch.

B. Delivery of records request letters to the provider is tracked via the US Postal Service (USPS) (www.usps.gov) and the date the letters are received by the provider is documented by designated PID staff. The provider is given five business days from the date received to submit all requested documentation to support the claims billed.

   1. The USPS website is checked by the assigned PID team member until receipt of the letter is documented as received by the provider.
   2. If a provider refuses to pick up the request letter by the end of business on the fifth business day from the date of the letter, a Final Records Request letter is sent.

C. The assigned PID team member performs a preliminary review to determine if all documentation requested has been received within 15 business days from the claim's submission date.

   1. If all requested documentation is present, claims are moved to review.
   2. If documentation is missing, a *Final Records Request letter* is sent to the provider via certified mail giving the provider five business days to submit any missing documentation requested in the initial request letter.
   3. If a provider fails to submit the documentation requested in the Final Records Request letter by the fifth business day from the date of the letter, the claim moves forward to review with the information on hand.

D. If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be 0% for each month in which no claims were submitted. If the provider does not meet the 70% clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review, Partners may implement sanctions, including termination of the applicable Medicaid contract(s), or continuation of prepayment. Partners will give adequate advance notice of any modification, suspension, or termination of the Medicaid contract.

E. A provider shall not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of 70% clean claims rate for three consecutive months, the expiration of the 24-month time limit, or the provider's termination.

VI. Provider Not Meeting the 70% Accuracy Rate

A. Providers on prepayment claims review who fail to meet 70% clean claims for three consecutive months within a six-month timeframe may be considered for additional action. The PID Director will initiate a recommendation assessed on the provider to include, but not limited to:

   1. Continuation of prepayment claims review, not to exceed 24 months.
   2. Partners may report the provider to appropriate oversight agencies and/or law enforcement as appropriate and within legal requirements.
   3. Referrals may be frozen for a period of time determined by the appropriate Partners decision/review body.
   4. New provider services may not be added for a period of time as determined by the appropriate Partners decision/review body.
   5. Partners may suspend the provider from the Partners' Provider Network for a period of time as determined by the Partners decision/review body.
   6. Partners may terminate the contract with cause.

a. The termination action taken shall reflect the failure of the provider to meet the 70% clean claims rate minimum requirement.
b. Partners will also refer the provider to the Department for proposed exclusion from future participation in the Medicaid program.

B. If a provider fails to meet the 70% clean claims rate minimum requirement and subsequently requests a voluntary termination, the termination shall reflect the provider's failure to successfully complete prepayment claims review and will result Partners' referral of the provider to the Department for proposed exclusion from future participation in the Medicaid program.
C. Prepayment claims review shall not continue longer than 24 consecutive months unless Partners has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction. If Partners has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction, then the provider shall remain on prepayment review until the final disposition of the proposed action or other sanction.

VII. Removal from Prepayment Claims Review Status

A. Providers are removed from prepayment claims review when any of the following occur:

1. Provider has met the prepayment claims review accuracy rate of 70% for three consecutive months within a six-month period, provided that the number of claims submitted per month is no less than 50% of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review.
2. PID has received a Tentative Restraining Order (TRO) to halt the prepayment claims review.
3. The provider contract is terminated (voluntarily or involuntarily) and claims submission has ceased.

B. The assigned PID team member will complete the Provider Prepayment Claims Review Termination Notice Letter and submit to the PID Director for approval. The Provider Prepayment Claims Review Termination Notice Letter is mailed via certified mail informing the provider of the removal from prepayment claims review.

VIII. Temporary Restraining Order (TRO)

A. If Partners' PID receives a Temporary Restraining Order (TRO) from the Office of Administrative Hearings (OAH) to remove a provider from prepayment claims review, a copy of the TRO is sent to the PID Director, Chief Legal Officer and the Chief Operating Officer.

B. The assigned PID team member prepares a memorandum for the PID Director's signature addressed to Claims, Finance, Provider Network and IT department designees, instructing them to remove the provider from prepayment claims review during the time period that the TRO is effective.

C. The PID prepayment review is halted until such a time the Chief Legal Officer provides final guidance of the outcome of the TRO.

IX. Appeal Rights

A. The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of the Department to place or maintain a provider on prepayment review.

B. If a provider elects to appeal Partners' decision to impose sanctions on the provider as a result of the prepayment review process to the Office of Administrative Hearings, then the provider shall have 45 days from the date that the appeal is filed to submit any documentation or records that address or challenge the findings of the prepayment review.

C. The Department shall not review, and the administrative law judge shall not admit into evidence, any documentation or records submitted by the provider after the 45-day deadline. In order for a provider to meet its burden of proof under G.S. 108C-12(d) that a prior claim denial should be overturned, the provider must prove that (i) all required documentation was provided at the time the claim was submitted and was available for review by the prepayment review vendor and (ii) the claim should not have been denied at the time of the vendor's initial review.

Post-Processing Claims Audit

A post-processing claims audit or investigation consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start, PIDs Investigators request medical records for a defined review period. Providers have five business days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not properly documented in the medical record, Partners will recover all amounts paid for the services in question, which starts with a TNO. Partners Investigators review cases for common FWA practices including:

- Unbundling of codes Up-coding services.
- Add-on codes billed without primary CPT.
- Billing for service by non-credentialed or non-licensed staff.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.
- Claims for services not rendered.

Overpayment Repayment Process/Paybacks

If an identified overpayment is deemed final, which occurs when a provider either completes Partners dispute resolution process described in this manual or the time to dispute the TNO expires unexercised, it must be paid back to Partners.

It is the policy of Partners to recoup the amount owed from current and/or future claims. For paybacks that exceed outstanding claims, Partners invoices the provider the amount owed. The provider then has 30 calendar days from the date of the final determination of overpayment to pay the total amount owed. Balances that exceed 30 days from the date of final determination are subject to a 10% penalty, monthly accrued at an interest rate as set by the Secretary of the NC Department of Revenue and possible collection fees and other activities as permitted by law. Failure to timely repay an overpayment is a breach of contract and grounds for termination from Partners' network and/or other sanctions. As a result, Partners takes this program integrity responsibility seriously and works diligently and collaboratively with providers to ensure fair and accurate processes and outcomes.

Role of Finance Department

The Finance department assists Program Integrity with the review of financial reports, financial statements, and accounting procedures. The Finance and Program Integrity departments work collaboratively with the provider in the collection of any overpayments deemed final.

Provider Program Integrity Requirements

Providers are responsible for reporting any suspicions or knowledge of fraud, waste or financial abuse (FWA) to Partners Alert Line (866-806-8777). Healthcare fraud and abuse are planned deception or misrepresentation that results in a benefit such as payment or coverage. Examples of Medicaid fraud and abuse includes, but is not limited to:

- A member does not report all income when applying for Medicaid.
- A member does not report other insurance when applying for Medicaid.
- A non-Medicaid recipient uses a Medicaid recipient's card with or without the recipient's permission.
- A provider's credentials are not accurate.
- A bill for services that were not rendered.
- A provider performs and bills for services not medically necessary.

You can anonymously report fraud or financial abuse. However, to conduct an effective investigation we may need to confidentially contact you. If you ask for confidentiality, your name will not be shared with anyone who is being investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.) Reports can be made by calling the Alert Line at **866-806-8777** or reporting online through https://www.mycompliancereport.com/report?cid=PHM**.**

Provider Self-Audit and Repayment

Improper payments made to providers within the Partners network inflates the costs of providing care to Medicaid and other publicly funded beneficiaries. Partners encourages providers to conduct self-audits and report identified overpayments. Partners retains its right and responsibility to identify and recover overpayments or take any other action available under law when it identifies overpayments. Providers must submit written notification to the Partners' Finance department of any improper payments identified and must clearly indicate the claim-specific information and findings, preferably a copy of the specific claim detail with a minimum of the following data:

1. Member Name (Last, First, MI).
2. Medicaid ID number.
3. Date of Service.
2. Procedure Code.
3. Individual Claim number (ICN).
4. Provider number.
5. Amount Billed.
6. Amount Paid.
7. Paid Date.
8. Refund Amount.

9. Reason for Error.

Partners' reserves the right to apply penalties and interest to any overpayments made to providers in which full repayment is not received within 30 calendar days.

Deficit Reduction Act

The Deficit Reduction Act (DRA) of 2005, effective January 1, 2007, requires providers to educate employees about false claims recovery. Section 6032 of the DRA amended and codified at 42 USC § 1396(a)(68) requires any entities that receive or make annual payments under the Medicaid State plan of at least $5 million to have detailed, specific written policies established regarding the Federal and State False Claims Acts for their employees, agents and contractors. The Federal False Claims Act–is found at 31 USC §§ 3729-3733 while the North Carolina False Claims Act can be found at General States (NCGS) §§ 1-695 through 1-609--provides for treble damages, costs and civil penalties for certain fraudulent acts.

For any provider that receives annual Medicaid payments of $5 million or more shall:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards. [42CFR§438.608].
2. The designation of a compliance officer and a compliance committee that are accountable to senior management. [42CFR§438.608].
3. Effective training and education for the compliance officer and the organization's employees. [42CFR§438.608].
4. Effective lines of communication between the compliance officer and the organization's employees. [42CFR§438.608].
5. Enforcement of standards through well-publicized disciplinary guidelines. [42CFR§438.608].
6. Provision for internal monitoring and auditing. [42CFR§438.608].
7. Provision for prompt response to detected offenses, and for development of corrective action initiatives. [42CFR§438.608].
8. Establish written policies for all employees (including management) that provide detailed information about the False Claims Act established under 31 USC Sections 3729 through 3733, administrative remedies for false claims and statements established under 31 USC Section 3801 through 3812, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC Section 1320a–7b(f));[42 USC Sec 1396(a)(68)].
    a. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;); [42 USC Sec 1396(a)(68)].
    b. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse); [42 USC Sec 1396(a)(68)].

On an annual basis, providers that receive annual Medicaid payments of $5 million or more shall certify in writing that it meets the requirements outlined above. [Sec 1396(a)(68)] Please visit Partners' Provider

Knowledge Base for information about how to certify compliance and where to send that certification.

Partners will be including as part of its periodic provider monitoring checks to ensure that providers are meeting the requirements outlined above.

Providers Required Compliance Policies

Irrespective of income derived from Medicaid programs, NCDHHS requires all providers to have a compliance program that meets the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005. Those provisions are listed above in the Section on Deficit Reduction Act.

All providers and out-of-network providers are required to have policies and procedures that recognize and agree that Medicaid as "the payer of last resort," except when that member is also accessing State-Funded Services where State-Funded Services are "the payer of last resort."

QUALITY MANAGEMENT

The Quality Management (QM) department promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon findings. The QM program is designed to continually and consistently assess and analyze system performance data which will subsequently guide performance improvement to better support the member population served. It balances three components: quality assurance, quality improvement and quality data. Quality Management activities yield data from multiple sources which, after analysis, is integrated and utilized for planning and guiding administrative and operational processes. The ultimate measure of the QM program's success is the achievement of safe, best practice services and desired individual outcomes for our members. Partners QM program aligns with the NC Medicaid Quality Strategy, as well as the Quality Assessment and Performance Improvement Plan. It complies with the quality management and quality improvement assurances and other requirements contained in the North Carolina federal Medicaid waivers and other active waivers relevant for Tailored Plans.

Program Structure

The ultimate authority for the Partners QM program is its Board of Directors. The Board of Directors delegates this authority to the Quality Improvement Committee (QIC) through the Chief Executive Officer (CEO), and the CEO assigns clinical oversight to the Chief Medical Officer (CMO)/designee. The QIC is responsible for guiding the QM program, including the annual review and approval of the Quality Assessment and Performance Improvement Program Description. The Board is kept up to date on quality improvement initiatives, at least annually, through reported updates and Board review of the annual Quality Management Program Evaluation. This Evaluation is annually shared with providers and other medical delivery systems. The clinical operation of the QM program is overseen by the Chief Medical Officer (CMO), who is a board-certified M.D. Partners is in process of acquiring full National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) and those standards provide guidance for the QM Program.

Quality Improvement Committee (QIC)

The QIC is responsible for, but not limited to, performing the following activities:

- Provide guidance to staff on QM program priorities and projects
- Makes policy recommendations and decisions related to QM program objectives
- Clinical Practice Guidelines (CPG's) annual review and approval
- Routine review and approval of Performance Improvement Projects (PIPs)
- Review and approve the Quality Assessment and Performance Improvement (QAPI) Program Description. Approval and evaluation of the annual QM Work Plan and QM Program Evaluation
- Monitor and document key quantifiable performance measures and use those measures to establish levels of performance, including a baseline and at least an annual re-measurement
- Ensure practitioner and provider participation in the QM program through planning, design implementation or review
- Ensure Health Plan partner participation in the QM program through planning, design, implementation or review
- Identifying objectives for serving a culturally and linguistically diverse membership

The QIC Membership is composed of a cross-functional team of representatives from various units within Partners, the provider community to include physical, behavioral health and pharmacy providers, the Consumer and Family Advisory Committee and representatives from our Standard Plan Partner. All members are voting members unless designated as non-voting members.

Provider Involvement

Partners has active participation on the Quality Improvement Committee (QIC) by both providers and members of the Consumer Family Advisory Committee (CFAC). The Provider Council, Global CQI Committee and CFAC appoint liaisons from its membership to serve on the QIC.

Global Continuous Quality Improvement Committee (GCQI)

Partners' providers lead the GCQI formed through the Provider Council. This committee is composed of provider representatives and a Partners' staff liaison and meets quarterly. The purpose of this committee is to promote improvements and processes within provider agencies which increase member satisfaction with services and choice among providers who use best practice models of treatment throughout the catchment area. The main objectives of this committee are to:

- Review quality concerns developing in the network
- Assess training needs of the network related to quality
- Participate in the selection of Partners Performance Improvement Projects (PIPs) and the formulation of project goals.
- Aggregate trends of network performance and review/ address in this committee.
- May appoint members to QIC.
- Allow for avenues in which providers can learn from each other.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QM program is comprehensive and addresses both the quality of clinical care and the quality of services provided to Partner's members. Partners QM program incorporates all demographic groups, benefit packages, care settings, providers and services in quality improvement activities.

Partners primary QM program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Partner's Quality Assessment and Performance Improvement Plan includes:

- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care for members special health care needs.
- Mechanisms to assess the quality and appropriateness of care provided to members needing Long Term Support and Services (LTSS), including assessment of care between settings and comparison of services and supports received with those set forth in the member's treatment/service plan.
- Mechanisms to assess for a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography, and key population groups.
- Mechanisms to incorporate population health programs targeted to improve outcome measures.
- Mechanisms to prevent, detect, and remediate critical incidents including LTSS and programs.
- Mechanisms to assess and address health disparities.
- Provider Support Plan.
- Quality Improvement Activities that support Healthy NC 2030 goals.

Member Safety and Quality of Care

Incident Monitoring

An incident is defined as any happening which is not consistent with the routine operation of a facility or service, or the routine care of a member that is likely to lead to adverse effects to the member. Incidents are classified into three categories (Level I, Level II and Level III) according to the severity of the incident. Providers are required as outlined in their contract with Partners to develop and maintain a system to collect documentation on any incident that occurs in relation to a member. This includes all state reporting regulations in relation to the documentation and reporting of critical incidents. Providers must enter all Level II and Level III Incident Reports into the Incident Response and Reporting System (IRIS) and provide the verbal notification for all deaths and Level III Incidents to Consumer Rights Officers at iris@partnersbhm.org or via fax to 704-884-2620 within the appropriate timeframes. Partners no longer requires the submission of Level I incident reports on a quarterly basis. However, the provider should continue to collect and report that data to their Human Rights Committee.

Additional information and instruction for the process of Incident Reporting may be found in the *Incident Response and Reporting Manual,* the *IRIS Technical Manual,* this Provider Operations Manual, the *North Carolina Innovations Technical Guide and on the Partners Knowledge Base.* As part of its quality management process, it is important for providers to implement procedures that ensure the review, investigation and follow up for each incident that occurs through its own internal Quality Management process. This includes:

- Conducting reviews of all incidents on an ongoing basis to monitor trends and patterns

- Implementing strategies aimed at the reduction/elimination of trends/patterns
- Documentation of the efforts at improvement as well as an evaluation of ongoing progress
- Ensuring that mandatory reporting requirements are followed
- Minutes of Peer Reviews for all deaths and Level III incidents to be uploaded on IRIS along with death certificates and any media stories related to the incident
- Entering Level II and Level III Incidents into IRIS

Partner's Consumer Rights Officer reviews all incidents when received for completeness, appropriateness of interventions, achievement of short- and long-term follow-up both for the individual member, as well as the provider's service system. If questions/concerns are noted when reviewing the Incident Report, the Consumer Rights Officer works with the provider to resolve them. If concerns are raised related to a member's care or services or the provider's response to an incident, the Consumer Rights Officer or the Partners Incident Review Committee may request that the QM Monitoring staff conduct a review. A Plan of Correction may be required for failure to report incidents as required by Administrative Rule and the provider contract.

Quality of Care

Partners is responsible for the quality of services provided by the Provider Network. The NC Division of MH/DD/SAS and the Division of Health Benefits (DHB) charges Partners with the management of both State and Medicaid services and funds.

Tailored Plan quality requirements are extensive and include:

1. Health and safety of members
2. Rights protection
3. Provider qualifications
4. Member satisfaction
5. Management of complaints
6. Incident investigation and monitoring
7. Assessment of outcomes to determine efficacy of care
8. Management of care for Special Healthcare Needs populations
9. Preventive health initiatives
10. Clinical best practice

Incident Review Committee (IRC) (includes incident/sentinel event review):

The IRC reviews all incidents, adverse events, systemic concerns related to health, safety, and quality of care within the Partners network which involve members, providers, and/or services. Event response and patterns are tracked and analyzed for appropriateness of action. This cross-departmental committee which includes participation from the Standard Plan Partner, reviews findings, provides recommendations, and develops strategies to assist providers in improving their delivery of services to Partners' members. This Committee makes recommendations to the Network Management Committee for potential action. The IRC also performs the following functions:

- Reviews reports of death, Level III incidents, Quality of Care Concerns, Grievances,

- Review of Division of Health Services Regulation (DHSR) reports and Innovations Level I incidents (failure to provide back-up staffing) for discussion, recommendation, and/or follow-up
- Develops and makes recommendations (related to complaints or present findings of safety or systemic concerns, trends, patterns, lack of provider response, and/or isolated events such as: attitude, customer service issues, billing/financial, quality of service sites) to departments within the organization or to the Standard Plan Partner for any sanctions and/or other applicable responses
- Makes recommendations to enhance or improve the care for Partner's members
- Develops, facilitates, and/or coordinates safety or quality of care training and education for providers and BH I/DD Tailored and Standard Plan staff as deemed appropriate
- Reviews quality of care trends and identifies sentinel event trends or other adverse or potentially adverse occurrences
- Recommends Performance Improvement Projects (PIPs) to the QIC

At any time, events may trigger a more in-depth review of provider processes and action may be requested of a provider (e.g., Root Cause Analysis, Plan of Correction, Plan of Action etc.)

Unlicensed Alternative Family Living (UAFL) Review

An UAFL Review is conducted initially once a Home and Community Based Services (HCBS) submission has been received from the provider and approved by Partners. Annual reviews are conducted thereafter to ensure the ongoing health and safety of members in the community.

Employer of Record (EOR) Reviews

Employer of record reviews are conducted annually by the monitoring unit. Technical assistance is provided to the EOR as needed and/or a Plan of Correction (POC) may be required to ensure compliance with requirements.

Cultural Competency Review

Partners Quality Management Monitoring unit will review provider Cultural Competency plans during all monitoring reviews not to exceed an annual Cultural Competency Review. All providers contracted with Partners must develop and maintain an ongoing Cultural Competency Plan and must be available for review upon request by the MCO. Plans will be reviewed to ensure plans are in effect and are reviewed/updated annually. Technical assistance is provided, as needed.

State Funded Post Payment Reviews

All providers with a State Funded contract are monitored on a biennial basis via post-payment review to ensure the provision of MH/DD/SA services in the provider network meet program compliance with the procurement contracts between providers and Partners Health Management. In addition, these reviews ensure compliance with Federal and State law, rules, and regulations. Technical assistance will be provided as appropriate and/or a Plan of Correction (POC) may be issued to address compliance-related deficiencies.

Individual and Family Directed Services

Providers of Individual and Family Directed Services (IFDS) will be monitored at least once every three years at a

frequency determined by the PHIP, per Clinical Coverage Policy 8P. These services include Community Navigator agencies, Financial Support Agencies, and Agency With Choice. Technical assistance will be provided as appropriate and/or a Plan of Correction (POC) may be issued to address compliance-related deficiencies.

Targeted Monitoring Review

Targeted monitoring may be site and/or service specific or there are occasions when a health and safety concern or grievance/complaint rises to the need for a targeted review of a provider and specific services related to the concern or grievance/complaint. Targeted monitoring review requests are generated internally within Partners or by the Standard Plan Partner and sent to QM Monitoring to complete. This type of review may be announced or unannounced depending on the circumstances. Copies of review results are sent electronically or mailed to the provider within 15 business days of the completion of the review. The results letter will outline areas reviewed, any discrepancies noted and required follow up.

Tailored Care Management (TCM) Reviews

Tailored Care Management (TCM) reviews occur annually to ensure adherence to the required guidelines of the Tailored Care Management model and to monitor the quality of services being provided to TCM eligible members.

Plan of Correction

Partners will provide general training and technical assistance based on needs identified by a provider or from deficiencies identified through monitoring activities, as applicable or upon request. If compliance issues are found during a monitoring review, one or more of the following actions will be implemented by Partners: recommendations to the provider, request for a Plan of Correction (POC), request for a Plan of Action (POA), referral to oversight agencies, and/or referral to Network Management Committee for potential sanctions or actions as deemed appropriate by Partners. All monitoring and oversight of a POC or POA will follow the Partners Plan of Correction Policy and Procedure for Review, Approval and Follow-up of POC, which outlines an informal appeal process.

<u>Performance Improvement Process</u>

Partners integrates a quality improvement philosophy and model which is based on PDSA (Plan, Do, Study, Act) and the use of “SMART” goals (specific, measurable, attainable, relevant, and time-specific) for quality related improvement projects. The PDSA principles include *Planning* improvements and development of tools and resources for identified change; *doing* which is actual implementation of the improvement strategies; *Studying* to determine if those strategies made any significant transformation; and finally, *acting* on outcomes and measurements of those elements implemented with planning of next value-based action steps. A process for implementing appropriate remedial action for continuous quality improvement includes the following elements:

- A structured and systematic approach to identify quality improvement opportunities
- A common language for problem solving techniques
- Facilitation of communication among committees and groups

- Managing and reporting of key data elements and outcomes which provides supports for value-based contracting (VBC) which leads to an increase in the credibility of data

Performance Improvement Projects (PIPs), focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Partners to monitor improvement over time.

Annually, Partners develops a QM Work Plan for the upcoming year. The QM Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and non-clinical) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Results, conclusions, recommendations, and implemented system changes are reported to the QIC monthly. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QM Work Plan.

Partners expects network providers to perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes. Providers are required to follow all Quality Assessment and Improvement standards outlined in North Carolina Administrative Code as well as the Provider Contract and Provider Operations Manual. The assessment of need as well as the determination of areas for improvement should be based on valid and reliable data. The providers' Quality Improvement system, as well as systems used to assess services, plans and initiatives for improvement, along with their effectiveness, are evaluated by Partners.

A Performance Improvement Project (PIPs) is an endeavor to measure improvement and quality of service delivery and/or outcomes of care provided by providers. The data collected from the PIPs aid in improving overall service delivery to members. Data collection and analysis may require the provider to make changes, modifications, and/or improve processes and service delivery.

Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying improvement projects per fiscal year (July-June). Partners requires providers (contracted agencies/not LIPs) to submit three PIPs annually including the topic, methodology, frequency or monitoring, target date and target goal for each project. Partners may request a sample of the provider's CQI outline, intervention strategies and findings and/or results annually. PIPs are designed to meet the regulatory standards for the provider organization's national accrediting body, DHB and DMHDDSAS rules.

It is the expectation that providers utilize all the following factors for selected Performance Improvement Project(s):

- Quality assessments are based on process and outcome indicators and not solely relying on inputs
- PIPs include measurable goals, projected timeframes for meeting goals, identifying barriers, implementing interventions as necessary
- Quality outcomes are built into the regular functioning of service delivery for members and families served

Partners may make use of the data analysis for various quality assurance functions (i.e., to review patterns and trends, creating interventions which develop opportunities for provider education, evaluation and

monitoring). Interventions developed and implemented within the provider network improve clinical care and service delivery to members.

Provider Responsibilities

1. Develop and implement a system of continuous quality improvement which includes, at a minimum, the development of systems to self-evaluate services, systems to evaluate data collected and to identify needed areas of improvement.

At any time, Partner's providers may request additional information on the Tailored Plan programs including a description of the QM Program and a report on Partner's progress in meeting the QM program goals by contacting the Quality Management department.

Tailored Plan/PIHP/State Funded Quality Measures

The Quality Management program has oversight for Tailored Plan Quality Measures established by the North Carolina Department of Health and Human Services (NCDHHS) and its Division of Health Benefits (DHB), North Carolina Division of Mental Health/Developmental Disability/Substance Abuse Services (DMHDDSAS). Partners is expected to calculate and report on those measures that require claims, encounter data or clinical data with detailed specifications around interim and annual measure reporting, stratification and data submission. These measures are for Medicaid and State-Funded Services. Tailored Plan Quality Measures include Pediatric, Adult, Maternal, Member and Provider Satisfaction, Innovations Waiver, TBI Waiver and State-Funded Services. The measures do not reflect the entire scope of the organization or the entire service array but were chosen by NCDHHS because they have a direct impact on member care and reflect accepted standards of care, fair and reliable measures, and readily available data sources.

Measure of Outcomes: NC TOPPS

NC Treatment Outcomes and Program Performance System (NC-TOPPS) is a web-based program that gathers outcome and performance data on behalf of mental health and substance abuse consumers 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 to improve service and manage quality throughout the service system.

The NC-TOPPS interviews provide information to improve each member's service needs and outcomes, support monitoring of services, and provide data for meeting federal performance and outcome measurement requirements. NC-TOPPS interviews are required for all Medicaid and State Benefit Plan, (formerly IPRS) adults and children ages six years and above who are receiving any qualifying service for any mental health and/or substance use issues or Supported Employment. Providers must complete an initial NC-TOPPS interview with the member in an in-person (preferred) or call interview at the beginning of an episode of care. The initial interview should be completed during the first or second treatment visit as part of the development of the member's treatment plan.

When a member leaves a provider, the responsibility of the provider depends on whether the member is continuing services at a new provider, or no longer continuing in services that require NC-TOPPS submissions.

Partners' Quality Management department monitors NC-TOPPS completion monthly. For providers who fail to complete NC-TOPPS, training and technical assistance is provided. If non-compliance persists, the provider is

referred to the Network Management Committee for review and appropriate corrective action. “Intro to NC-TOPPS Super User Training” is periodically offered by Partners in addition to a webinar posted in ProviderCONNECT, that can be accessed at any time. All notices of changes from NC-TOPPS are forwarded via email to Provider Agency Super Users.

Provider Satisfaction Surveys

An annual Provider Satisfaction Survey is conducted by the Division of Health Benefits (DHB). DHB contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess provider satisfaction. The results are reviewed by Partner’s Quality Improvement Committee (QIC). The QIC can recommend actions to address results in any areas that score below 80% satisfaction.

Member Satisfaction Surveys

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with the Tailored Plan and practitioner services and gives a general indication of how well we are meeting the member’s expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. The results are reviewed by Partners Quality Improvement Committee (QIC). The QIC can recommend actions to address results in any areas that score below 80% satisfaction.

Perception of Care Survey

The NC Division of MH/DD/SAS conducts a Perception of Care survey on an annual basis to assess members perception of care of services received from network providers. A designated number of Tailored Plan members are selected to participate in the survey. Once the designated number of surveys are completed, the surveys are returned to NC DMHDDSAS for analysis. The results are reviewed by Partners Quality Improvement Committee (QIC). The QIC can recommend actions to address results in any area that score below 80% satisfaction.

National Core Indicators Survey

National Core Indicators is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) and the Tailored Plan. The purpose of the survey is to gather a standard set of performance and outcome measures for I/DD members that can be used to track performance over time, to compare results across states, and to establish national benchmarks.

Caller Surveys

Partners, with the assistance of Lumen technology, has designed a Consumer Satisfaction survey which is administered 24 hours after the completion of the crisis call. The Caller survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a five-question survey which provides information on the experiences of beneficiaries with call center clinicians, health plan and practitioner services

and gives a general indication of how well we are meeting the member's expectations. Member responses to the survey are used in various aspects of the quality program including monitoring of practitioner access and availability as well as staff responsiveness.

Provider Profiling and Incentive Programs

Our overarching Value-Based Payment (VBP) strategy is to leverage clinical insight and best practices into population health and alternative payment models (APMs) that improve quality and medical cost performance and advance the NCDHHS priorities. In partnership with providers, we create VBP arrangements that reflect their experience with key metrics, evidence-based interventions and care paths. We support providers by providing them the tools and resources they need to succeed and tailor our support to meet their individual needs and preferences. For example, we ask providers how they prefer to communicate with us (e.g., telephone, email, in person) and build that into our action plans with them.

Partners brings value to the communities we serve by implementing VBPs that promote service integration and whole-person care. With that in mind, we focus on three objectives as we design and implement VBP models:

- Identifying categories of needs-based populations to determine where to focus efforts and align them to physical health (PH) and behavioral health (BH) providers
- Collaborating with providers to move them into VBP arrangements and advance along the multi-payer HCP-LAN APM continuum to population health management
- Ensuring care is integrated and coordinated across PH, BH and I/DD providers, and other providers and stakeholders

Partners stratifies members based on intensity of medical utilization, cost and performance on key quality outcomes measures based on NCQA, Pharmacy Quality Alliance and NCDHHS stewardship, as outlined in Section VII, Attachment E, Tailored Plan Quality Metrics. This analysis informs our strategy in three ways. First, the needs-based population tools identify potential opportunities to make medical utilization more efficient, reduce costs and improve outcomes. Strategies to manage members in these populations could revolve around episodic, bundled, or condition-specific care plans that require more coordination and integration of an array of providers and resources to execute. Second, we link the scale and scope of interventions to appropriate categories of VBP, from Category 2 pay-for-performance models to Category 3 and 4 bundled payments, episodes of care and condition-specific models. Third, by knowing the metrics to improve, the scale and scope of interventions to implement and the type of payment models to pursue, we can start to identify, allocate, coordinate and integrate resources appropriately across the population. To do that, the second part of our analysis focuses on understanding the PH, BH, community and other services required to improve the member and provider experience, quality and efficiency of utilization. We can use this knowledge to reduce costs and streamline the integration required to deliver services. The analysis includes the following:

- Type of provider practice and structure (e.g., integrated health system, independent physician association, clinically integrated network and independent clinics)
- Geographic reach
- Population needs profile

The analysis will tell us how to integrate and coordinate the services and information for various needs-based populations. This information can be shared among providers and community resources to execute VBP contracts across different member populations. While this analysis provides a picture of what conditions and care pathways Partners can target with different categories of VBP contracts, not all providers are in the same state of readiness to implement them. Therefore, we conduct readiness assessments to understand the provider's ability to successfully execute the requirements of a VBP contract.

During the assessment, we evaluate a provider's ability to implement VBP models across four categories:

1. Technology and analytical capabilities and resources
2. Organization and culture
3. Degree of focus on quality metrics
4. Care management approach

Combined, Partners' needs-based population assessment and provider analysis allows us to link membership with provider capabilities to provide a roadmap for building VBP models.

Partners' network providers, including those participating in our VBP program, will have access to integrated member data via direct data feeds and through ProviderCONNECT, our provider portal. This will include member utilization data such as claims history, authorization, immunization records, lab results and care and disease management data to support providers in managing members' whole-health needs and facilitating communication among providers and participants in the member's care team.

PHARMACY

Preferred Drug List (PDL)

Partners adheres to The North Carolina Medicaid Pharmacy Program preferred drug list, utilization management criteria, and clinical policies which offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need. Partners provides pharmacy benefits in collaboration with its Pharmacy Benefit Manager, CVS Health.

Partners adheres to the NC Medicaid Preferred Drug List (PDL). Partners also covers additional therapeutic classes to determine medications that are covered under the pharmacy benefit, as well as which medications may require prior authorization. Please visit the Partners Pharmacy website and the ProviderCONNECT portal, for a link to the state's current PDL as well as prior authorization/UM criteria and other resources. Most beneficiaries will have a copayment or cost share when utilizing their prescription benefits unless they are exempt.

Preferred Drug List (PDL)

The Partners PDL is compliant with NC Medicaid criteria and includes therapeutic categories of generic and brand name medications. Some preferred drugs require Prior Authorization (PA). Non-preferred medications are available via the prior authorization mechanism if the request meets criteria. Providers may contact Partners' Pharmacy Line with questions regarding the PDL at 833-353-2095.

The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the provider or pharmacist
- Relieve the provider or pharmacist of any obligation to the member or others

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by Partners. following requirements in Social Security Act 1927. Experimental drugs and investigational drugs are not eligible for coverage.

Coverage of Compounded Drugs

Partners shall cover compounded products when:

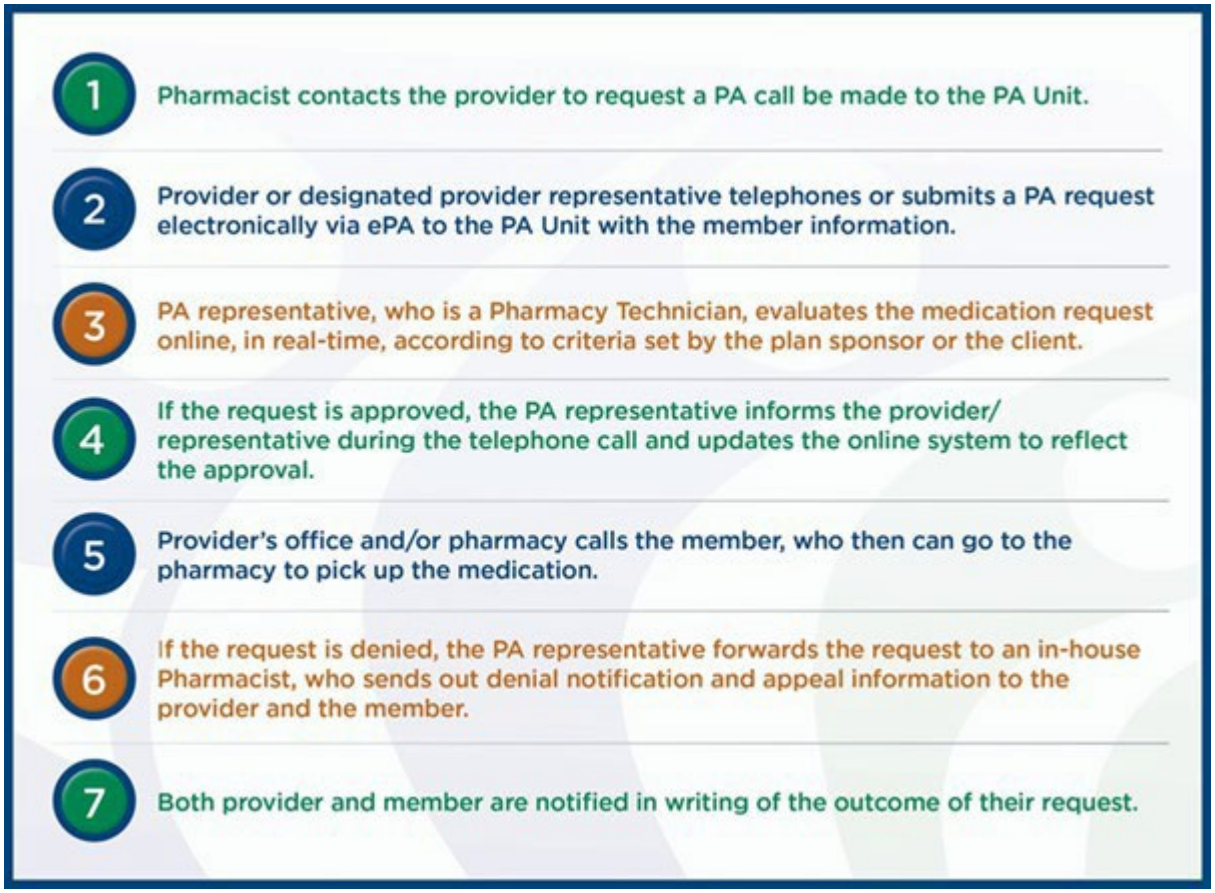
- A mixture of two or more ingredients is physically inseparable
- At least one of the components of the compounded drug is a legend drug
- It is expected that the quantity of legend drug is sufficient to have a therapeutic effect
- The legend drug is manufactured by a company that has signed a national Medicaid Drug Rebate Agreement with Centers for Medicaid and Medicare Services (CMS)

Prior Authorization Process

The Partners PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the approved list for their members. Some drugs on the PDL will require clinical criteria to be met via a PA and that requirement will be indicated on the PDL. If a request for prior authorization is needed the information should be submitted by the physician, clinician, or pharmacy. This document is located on the Partners ProviderCONNECT Portal.

In the traditional prior authorization system, the member presents the prescription to the pharmacy or the provider e-scribes the information to the pharmacy and in processing the prescription, the CVS online claims processing system alerts the community pharmacy at the point of services when a drug requires prior authorization. Pharmacy personnel will see the message ‘Prior Authorization Required’ and will notify the provider to begin the prior authorization process. Figure DD-1 describes the prior authorization process for designated medications which require a prior authorization. To avoid a disruption in care, we educate pharmacy partners, care managers, and members on the steps to dispense a 72-hour supply of medications for prescriptions under prior authorization review.

Figure DD-1. PA process including overall prescriber experience.



Prior to launch of the PA process, all clinicians and associated personnel will be fully trained in the process and information materials will be available online for easy access.

Partners will cover the medication if it is determined that:

- The request meets all approved criteria.
- Depending on the medication, other medications on the PDL have not been effective.

All prior authorization reviews are performed by a licensed clinical pharmacist using the clinical criteria provided by the NC Medicaid. Once approved, CVS Health notifies the physician/clinician of the approval. If the clinical information provided does not meet the coverage criteria for the requested medication the member and physician/clinician will be notified of alternatives and provide information regarding the appeal process.

PA is established for certain drug classes, or particular drugs or for medically accepted indication for uses and doses. If a member requires a medication that requires a PA, the physician/clinician may request a prior authorization for the medication. A phone, fax, and electronic portal process is available for prior authorization requests. There are some therapeutic classes or drugs on the PDL that require PAs as well as there is Clinical Coverage Policies that may also require PA for drugs/therapeutic classes not listed on the PDL. Please note that the entire formulary of coverage by Partners is a combination of the PDL and an open supplemental formulary with certain requirements for PAs per NC Medicaid requirements. Please see CVS Health Contact Information Section below.

CVS Health Contacts - Prior Authorization

Phone: 1-866-453-7196

72-Hour Emergency Supply Policy

State and federal law require that a pharmacy may dispense a seventy-two (72) hour (three-day) supply of medication to any member awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee for the 72- hour supply of medication, whether or not the prior authorization request is ultimately approved or denied.

Prospective Drug Utilization Review (DUR) Response Requirements

Partners is committed to providing a safe and quality pharmacy benefit. Our pharmacy program will utilize prospective and concurrent drug utilization review (DUR) edits to detect potential problems at the point-of-service. All DUR messages appear in the claim response utilizing NCPDP standards. This allows the provider to receive and act on the appropriate DUR clinical conflict codes. Pharmacy providers can find detailed instructions on the DUR system by accessing the provider manual or Partners outpatient pharmacy policies. Question regarding the DUR process may be directed to Partners' Pharmacy Line by calling 1-866-453-7196 24/7.

Benefit Exclusions

The following drug categories are not part of the Partners PDL and are not covered:

- OTC products, unless they are specifically listed on the PDL.
- • Any drug manufactured by a company that has not signed a CMS rebate labeler agreement (Exception shall be made for CroFab).
    - Fertility drugs
    - Drugs used for cosmetic indications
    - Medical supplies and devices (may be covered under Durable Medical Equipment).
    - Diaphragms, which are a family planning service.
- Intravenous (IV) fluids (Dextrose 500 ml or greater) and irrigation fluids; except for living arrangement codes 10 (Private Living Arrangement (not 1/3 reduction), 11 (Private Living Arrangement (with 1/3 reduction) (Medicaid Only), 13 (Living with Supplemental Security Income (SSI) Member), 52 (Domiciliary care, Six or More Beds (Special Assistance for the Aged (SAA), Special Assistance for the Disabled (SAD), 53 (Foster Care (Medicaid for Families (MAF), Medicaid for Infants and Children (MIC), State Foster Home Fund (HSF), Medicaid with IV-E Adoption Subsidy and Foster Care (IAS)) or 80 (Adoptive Home (MAF, MIC, MRF (Refugee Medical Assistance), HSF, IAS))Erectile dysfunction drugs
- Drug samples
- Drugs obtained from any member assistance program
- Drugs used for the symptomatic relief of cough and colds that contain expectorants or cough suppressants
- Legend vitamins and mineral products
- All DESI drugs and combinations equivalent to a DESI drug in compounded prescriptions. Drugs described by the FDA as DESI are products that the FDA has found to be less than effective or not proven to be as effective as indicated. Drug products that are identical, related, or similar to DESI drugs are considered DESI. Updates and corrections are published in the Pharmacy Newsletters on Medicaid's website.

<u>Physician Administered Drug Program</u>

The Physician Administered Drug Program covers drugs purchased for use in an outpatient/ambulatory care office setting. Medicaid covers the cost of the drug when it is purchased by the same provider administering the drug.

All drugs are not automatically covered in the Physician Administered Drug Program

- • Drugs and biological medications must be approved by the Food and Drug Administration as reasonable and necessary for the diagnosis and treatment of the illness or injury.
- • Experimental drugs or drugs for investigational use are not covered by the Medicaid Program.

Covered medications include:

- Injectable drugs.
- Intravenous administration.
- Chemotherapy.

- Vaccines/toxoids.
- Immune globulins.
- Radiopharmaceuticals.

Providers are encouraged to refer to the Physician Drug Program Drug Catalogue and the NC State Medicaid Bulletins, published monthly, that contains individual articles regarding drugs and specific billing guidelines or contact Partners with specific questions.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 34-day supply for each new or refill noncontrolled [JM1] substance. Medicaid beneficiaries may obtain a 90-day supply of medications if the claim is for a non-controlled, maintenance medication. A total of 75% of the prior fill days supplied must have elapsed before the prescription can be refilled. Opioid prescriptions cannot be filled until 85% of the prior fill days supplied have elapsed. Partners may limit how much medication a member may obtain at one time. Some medications may have age limits. Age limits are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns and quality standards of care. The age limit aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Dispensing outside the quantity limit (QL) or age limit (AL) requires prior authorization. If the physician/clinician feels a member has a medical reason for getting a larger amount, please submit a prior authorization request.

Mandatory Generic Substitution When generic drugs are available, the brand name drug will not be covered without prior authorization unless specifically allowed on the Partners PDL as a brand name preferred production most cases, generic drugs have the same active ingredient and work the same as brand name drugs.

If the physician/clinician believes a brand name drug to be medically necessary, the physician/clinician may ask for prior authorization or must indicate on a Prescription order in their own handwriting “Brand Medically Necessary.” The brand name drug will be covered according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug.

Working with the Pharmacy Benefit Manager (PBM)

Partners contracts with CVS Health to administer pharmacy benefits, including the prior authorization process. Certain drugs require prior authorization to be approved for payment.

These include:

- Some Partners preferred and formulary drugs (designated clinical criteria apply on the PDL) Formulary drugs/classes that have clinical coverage criteria according to NC Medicaid and can be found with the specific drug criteria on NC Medicaid’s website.

Drug Prior Authorization request forms and prior authorization /utilization management criteria are available at Partners pharmacy website or by contacting the Partners/CVS Health provider support service resources through phone, fax or online.

Complete the Partners CVS Health prior authorization form: Medication Prior Authorization Request Form, located on ProviderCONNECT.

Online Prior Authorization (PA)

All prescription and over-the-counter medications covered are in compliance with North Carolina Medicaid's requirement for rebate eligibility.

Non-Preferred Drug List (PDL) therapeutic classes who have medications with rebate eligible, non-obsolete, National Drug Codes (NDCs) are covered without a PA.

Therapeutic Medication Classes on the PDL are covered in one of the following scenarios:

- Prescription drug(s) are covered if they are the preferred therapy on the PDL without clinical criteria, or
- If the preferred agent on the PDL meets clinical criteria requirements, or
- Non-preferred agents are covered as well if the member has tried and failed 2 preferred agents (1 preferred where indicated) and met any clinical criteria that may exist or if there is a medical reason the member cannot use the preferred agent.

In many cases, real-time PDL information may be integrated into the prescriber's electronic health record and workflow to allow easy identification of therapies covered for a particular diagnosis, avoiding many PA requests.

For information regarding this EMR application, please telephone the Partners' Pharmacy PA Team at 1-866-453-7196.

Prior to launch of the PA process, all prescribing and dispensing providers and associated personnel will be fully trained in the process and information materials will be available online for easy access.

CVS Health Contacts - Prior Authorization

Phone1-866-453-7196
When calling Partners' Pharmacy Line (1-866-453-7196) please have member information, including TP/PIHP Medicaid ID number, member date of birth, complete diagnosis, medication history, and current medications readily available in order to expedite the call. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive the specific drug.

If the request is denied, the member and physician/clinician will be notified and provided information regarding the appeal process.

Providers are requested to utilize the PDL when prescribing medications for their beneficiaries. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included on PDL.

In the event that a provider or member disagrees with the decision regarding coverage of a medication, the member, or the provider, on the member's behalf, may submit an appeal.

Partners Pharmacy Portal and Provider Links

Partners TP/PIHP website includes the PDL, UM criteria for all agents, links to the Partners portal, clinical policies, opioid stewardship resources, evidence-based medicine guidelines/publications/clinical guidelines for provider information.

MEDICAL RECORDS REVIEW

Medical Records

Partners TP/PIHP/State Funded providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Partners to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Partners requires providers to maintain all records for members in accordance with the appropriate retention schedule.

If a provider contract is terminated, closes network operations or closes its business in North Carolina, a maintenance and storage plan must be submitted for approval by Partners or copies of medical records must be turned over to Partners. Partners' Health Information Management department must be notified immediately of any decisions made by a provider to terminate contract, close network operations or close a NC business to coordinate the proper handling and transferring of medical records.

Providers may contact the Health Information Management department at 828-323-8064.

Required Information

MH/SU/IDD Providers

Each provider must adhere to the regulations set forth in the following:

- APSM 45-2: Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services, and Local Management Entities
- The NCTracks Provider Claims and Billing Assistance Guide
- APSM 45-1: Confidentiality Rules
- APSM 10-5: Records Retention and Disposition Schedule DMHDDSAS Provider Agency
- Clinical Coverage Policies
- NC MH/DD/SAS Health Plan and NC Innovations Waivers
- HIPAA Privacy and Security Regulations, including the HITECH Act and Omnibus Rule
- Provider Procurement and State-Funded Contract with Partners

It is the expectation of Partners that all information developed or received by the provider about the member during treatment would be included in the service record. Information needed for reimbursement purposes may at times be filed in the clinical service record, but this is not required. Providers should record and retain billing records and related information according to the specific requirements of the payors involved.

Many service definitions included in the Clinical Coverage Policies contain documentation requirements that are specific to those services. For this reason, refer to each service definition to ensure compliance with the documentation requirements specific to that definition. The array of MH/DD/SAS service definitions can be accessed on the Service Definitions page of the Division web site, found at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies The links listed here should be used to obtain detailed implementation information regarding the MH/IDD/SUD service definitions.

Some longstanding state-defined service definitions also contain certain documentation requirements.

The official posting of many of the MH/IDD/SUD service definitions is found within the various clinical coverage policies published by DHB.

These definitions are located on the Clinical Coverage Policy page of the NCDHHS website, which includes, but is not limited to, the following clinical coverage policies:

- A4 Services for Individuals with Mental Retardation/Developmental Disabilities, and Mental
- Health/Substance Abuse Co-Occurring Disorders
- 8A Enhanced Mental Health and Substance Abuse Services
- 8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- 8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21
- 8D-2 Residential Treatment Services

Medical records mean the complete, comprehensive member records and at a minimum the record must contain:

1. Demographics (member name, gender, race, date of birth, Medicaid ID number, service record number)
2. Member's treatment plan including goals
3. Service progress/treatment notes that are individualized and specific to the date the service was delivered, the duration of the service billed and the signature of the person who delivered the service
4. Confidentiality of recipient information
5. Service orders
6. Consent for treatment
7. Reason for admission
8. Evidence that the recipient meets entrance criteria per the service definition
9. Presenting problem at admission
10. Mental status at admission
11. Psychiatric history
12. Special status situations and suicide risk

13. Medical history
14. Developmental/education history for minor
15. Medications
16. Allergies and adverse reactions
17. Preventive services/risk screening
18. Documentation of clinical findings and evaluation of each visit
19. Admission/discharge date
20. All entries must be legible and maintained in detail
21. Prominent notation of any spoken language translation or communication assistance
22. Signed and dated required consent forms
23. Laboratory and other studies ordered as appropriate
24. Evidence that an advance directive has been offered to adults 18 years of age and older
25. Any corrections, additions, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change

It is the provider's responsibility to stay abreast of the requirements for delivering the services they are credentialed and contracted to provide in the Partners' Provider Network.

Primary Care Providers

Medical records means the complete, comprehensive beneficiary records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the beneficiaries participating primary care physician or provider, that document all medical services received by the beneficiary, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

<u>Providers must maintain complete medical records for beneficiaries in accordance with the following standards:</u>

- Beneficiary's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented

- An up-to-date immunization record is established for pediatric beneficiaries, or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with Carolina Complete Health practice guidelines
- Appropriate subjective and objective information pertinent to the beneficiary's presenting complaints is documented in the history and physical
- Past medical history (for beneficiaries seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and 105 of 108 2019-09-03
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the beneficiary
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- For beneficiaries 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for beneficiaries seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the beneficiary is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of beneficiary information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older
- Any corrections, additions, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, . or change shall be included, as well as the reason for the correction, addition, or change

Medical Records Release

All member's medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian unless allowed by law. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

NOTE: When members enroll, they sign a waiver to release medical records and other requested participant protected health information to the state of North Carolina and to agents of the state, such as Partners.

Medical Records Transfer for New Beneficiaries

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within 10 business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Partners' members. If the member or member's guardian is unable to disclose the names and/or addresses of providers who delivered prior care, then this should also be noted in the medical record.

Medical Records Audits

Partners will conduct random medical record audits to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Partners will provide written notice prior to conducting a medical record review.

TELEHEALTH, VIRTUAL PATIENT COMMUNICATIONS AND REMOTE PATIENT MONITORING

Telemedicine Covered Services: Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Partners shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid, State-funded beneficiaries as an alternative service delivery model where clinically appropriate in compliance with all state and federal laws, including HIPAA and record retention requirements.

Services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration, and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program.

Telehealth, Virtual Patient Communications and Remote Patient Monitoring may be used as tools for facilitating access to needed services in a clinically appropriate manner that are not available within Partners' network.

Members shall not be required to seek services through Telehealth and must be allowed to access an in-person service through an out-of-network provider if the member requests.

Partners will cover procedures, products, and services related to telemedicine when they are medically necessary, and:

- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs
- The procedure, product, or service can be safely furnished, and not equally effective and more conservative or less costly treatment is available statewide
- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider

Partners will cover Telemedicine and Telepsychiatry services where clinically appropriate under the following conditions:

- The member will be present at the time of consultation
- The medical examination of the member must be under the control of the consulting provider.
- The consultation must take place by encrypted two-way real-time interactive audio and video telecommunications system.

Partners will pilot new approaches to Telehealth, Virtual Patient Communications and Remote Patient Monitoring and Value Based Payment and shall support providers in optimizing the use of these services in their practices.

Telehealth Reimbursement

Partners will pay at least the in-person rate for the same service delivered via Telehealth (i.e., payment parity).

For all services provided through Telehealth, Partners shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

Telemedicine Appeals

Providers wishing to submit a grievance/complaint or appeal related to telemedicine decisions should follow the instructions outline in the Provider Grievance/Complaint and Appeal section of this manual.

BILLING GUIDELINES

Thank you for being part of Partners network of participating physicians, hospitals, and other healthcare professionals. The information below is to support your claims billing needs. Behavioral health claims are billed to Partners Health Management for both Tailored Plan Medicaid, PIHP, and State Funded services. Carolina Complete Health (CCH) is our designated Third-Party Administrator for Physical Health claims management and claims processing. CCH and Partners will leverage and implement policies and procedures related to claims receipt and payment in accordance with all federal and state requirements.

Providers should bill claims to the appropriate payer based on the member/recipient's approved Medicaid/state eligibility program/status.

Policies and procedures cover all areas of processing including claims entry, third party liability (TPL) and coordination of benefits (COB), claims adjudication, payment and overpayment recovery.

Tailored Plan Medicaid/PIHP (Medicaid Direct) Claims Filing Requirement

Payment Schedule Medicaid Providers – https://www.nctracks.nc.gov/content/public/providers.html Partners follows the DHB Cutoff and Check Write Schedule for Payments.

Claims Adjudication Medicaid Providers – https://www.nctracks.nc.gov/content/public/providers.html Providers billing under Partners' Provider Number shall follow the state process regarding billing enrollment protocols.

Direct enrolled Medicaid Providers refer to: https://www.nctracks.nc.gov/content/public/providers.html For claims and billing assistance please refer to the NCMMIS Provider Claims and Billing Assistance Guide.

For more billing guidance, please use the following link:
https://medicaid.ncdhhs.gov/health-plan-billing-guidance-version-25-20230103/download?attachment

Claim Editing

All claims submitted to Partners Health Management undergo standard editing common to all healthcare claims to ensure compliance with national and local claims requirements. The edits apply to both Tailored Plan and PIHP claims. There are additional claim edits in place to ensure compliance with requirements that are unique to each claim type. All claims, regardless of claim type, must comply with the policies and requirements as documented in provider billing manuals and training packets.

SNIP (Strategic National Implementation Process) Level Validation and Edits

SNIP validation and edits work as a compliance checklist for EDI to ensure compliance with the auto-adjudication process. Partners Health Management utilizes SNIP validation and edits during EDI processes for both TP and PIHP/MD.

Testing features include:

(1) Integrity Testing
(2) Requirement Testing
(3) Balancing
(4) Situational testing
(5) Code set testing
(6) Line of Business testing
(7) Trading Partner testing

Required Electronic formats

Providers are contractually required to submit billing electronically through the Partners Health Management claims system upon completion of a Trading Partner Agreement (TPA).

Billing through the Partners Health Management Claims system is either by:

1. Paper Claims.
2. Direct entry of data where an electronic CMS1500 or UB04 form is accessed, and billing information is entered and submitted to Partners for reimbursement.
3. 837 Claims Submissions: The HIPAA compliant ANSI transactions are standardized. Partners only accepts HIPAA compliant transactions as required by law.

Partners provides the following transaction files back to providers.

- 999 acknowledgment files.
- 824 line by line acceptance/rejection file.

835 files, which is an electronic version of the electronic remittance advice (ERA).GG.5. Mandated Timelines

State Funding

Timeframes for Claims Submissions:
All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in the Provider's contract. Claims filed outside of requirement will be denied for payment.

Replacement Claims:
Providers may submit replacement claims for originally processed claims within 180 days from date of service. Replacement claims submitted outside these guidelines will be denied due to timely filing requirements. Replacement claims originally denied for timely filing will continue to deny. Third Party Billing Agents/Clearinghouses

Providers can use external billing agents. Billing agents must have a Trading Partner Agreement with Partners. A Trading Partner Agreement (TPA) is a document that is required to be completed for any entity that is transmitting or receiving HIPAA compliant X12 Electronic Transactions with Partners Behavioral Health Management. An entity could be a Provider, Clearinghouse, or Billing Agency. The TPA allows for the exchange of information for the purpose of conducting electronic transactions through the EDI Partner for health care services provided to beneficiaries of the Partners Behavioral Health Management.

This agreement provides for the exchange of information between these parties necessary for the processing of such transactions. These transactions must be in accordance with the American National Standards Institute (ANSI) accredited standards and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, CFR 45 Parts 160 and 162, Standards for Electronic Transactions, published in the Federal Register August 17, 2000.

Tailored Plan/PIHP Medicaid Claims Time frames for Claims Submissions:
All claims must be submitted within 365 days of the date of service to ensure payment, unless otherwise specified in Provider's contract. Claims filed outside of requirement will be denied for payment.

Interest and penalty provisions (including liquidated damages provisions) for late or under-payment by the Tailored Plan/PIHP

We agree to pay interest on late payments to the provider, including, but not limited to, AMH+ practices and CMAs, at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the contract. In addition to the interest on late payments, we will pay the provider, including, but not limited to, AMH+ practices and CMAs, a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid as specified in the contract.

North Carolina Medicaid payer of last resort requirement

Providers Billing for members with Tailored Plan Medicaid/Medicaid Direct

Based on 10A NCAC 22J .0106:

(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services or supplies but will charge the patient for all services or supplies provided. If a provider refuses to accept a patient as a Medicaid patient, the provider shall inform the patient before providing any services or supplies, except when it would delay provision of an appropriate medical screening, medical examination, or treatment as required by 42 U.S.C. 1395dd.

(b) A provider will be deemed to have accepted a patient as a Medicaid patient if the provider files a Medicaid claim for services or supplies provided to the patient. Verification of eligibility alone shall not be deemed acceptance of a patient as a Medicaid patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:

(1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;

(2) stating either orally or in writing that the patient has Medicaid coverage; or

(3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

(1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;

(2) before the service or supply is provided, the provider has informed the patient that the patient may be billed for a service or supply that is not one covered by Medicaid regardless of the type of provider or is beyond the limits of Medicaid coverage as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b);

(3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is not eligible for Medicaid as defined in the Medicaid State Plan.

(d) When a provider files a Medicaid claim for services or supplies provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services or supplies for which it receives no reimbursement from Medicaid when:

(1) the provider failed to follow program regulations;

(2) the Division denied the claim on the basis of a lack of medical necessity; or

(3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment, and third party payment as payment in full for all Medicaid covered services or supplies provided, except that a provider shall not deny services or supplies to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance, or co-payment amount as specified in the Medicaid State Plan. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this paragraph, a provider may pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services or supplies covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services or supplies covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in the Medicaid State Plan.

Coordination of Benefits

- Federal and state regulations require Medicaid to be the payer of last resort," except when that member is also accessing State-Funded Services where State-Funded Services are "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 member. This can include worker's compensation, disability insurance or other health insurance.
- 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 Partners. Medicaid claims submitted without third-party information will be denied.
  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 member or provider complied with the plan's requirements. Examples of common private plan non-compliance denials include, but are not limited to:
  i. Failure to get an authorization referral from a primary care physician.
  ii. The provider is a “non-participating provider” in the first and/or third-party plan.
  iii. Failure to obtain prior approval.

- Partners will not reimburse providers 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 or have paneled staff with the primary payer, the provider should refer the member to an eligible provider of third-party covered services.
- First-party payers are the clients/member or their guarantors.

* Partners 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.

All claims are required to identify amounts collected from both first and third parties and only request payment for any remaining amounts.

Eligibility Determination Process by Provider:

Providers should conduct a comprehensive eligibility determination process whenever an individual enters the service delivery system. Periodically (and no less than annually), providers should update the eligibility information to determine if there are any first or third-party liabilities for this individual. It is the responsibility of the provider to monitor this information and to adjust the billing accordingly.

Obligation to Collect

Providers should make good faith efforts to collect all first and third-party funds prior to billing Partners. First party charges should be shown on the claim whether they were collected or not.

Reporting of Third-Party Payments

Providers are required to record on the claim form either the payment or denial information from a third-party payer. Copies of the Explanation of Benefits (EOB) from the insurance company should be retained by the provider if they submit electronic billing. If a paper claim is submitted, it is required that a copy of the

EOB be submitted with the claim form. Providers are required to bill any third-party insurance carriers. This includes worker's compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time to obtain a response from the insurance company. Providers may submit claims to Partners up to 365 days from the date of service in the event of Coordination of Benefits has occurred.

Uniform Copayment For Non-Medicaid Services

a) The Provider shall indicate on the claim form submitted to Partners all required first party fees and copays owed by the member regardless of whether those fees have been collected. Payments to the Provider from Partners shall be reduced dollar for dollar by first party liability.

b) If a member does not qualify for State funding based upon the current poverty guidelines, the member must pay one hundred percent (100%) of the cost of the services being provided by Provider and should not be enrolled into the Partners System. Claims for these services should not be billed to Partners.

c) Documentation shall be maintained by Provider showing how all first party liability was calculated.

d) Enforcement of this procedure is a contract requirement. The Finance Department will conduct periodic audits to determine if Providers are following the policy. Copayments or other forms of cost sharing from Medicaid members is prohibited.

Member cost sharing requirements

The same cost-sharing amounts as specified in North Carolina's Medicaid plans are applied through the CCH claims system. Plan members are not required to pay for any covered services other than the co-payment amounts required under the state plans. CCH tracks cost sharing obligations of each member.

Cost-sharing does not apply to:

- Well-child visits and age-appropriate immunizations. Pursuant to 42 C.F.R. §456.505(d), all Plan members receive these services at no cost to their families.
- The subset of the population including children under age 21, pregnant women, individuals receiving hospice care, federally recognized American Indians/Alaska natives Breast Cancer and Cervical Cancer Control Program (BCCCP) beneficiaries, foster children, disabled children under Family Opportunity Act, Qualified Medicare beneficiary, 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.
- Behavioral health services as defined by NCDHHS.

Court-ordered Evaluations Coordination

Partners coordinates with courts in all 15 counties to ensure completion of court-ordered evaluations. Two types of evaluations are ordered by courts, forensic evaluations and multidisciplinary evaluations (MDEs).

- Forensic evaluations are performed by a Local Certified Forensic Evaluator (LFCE) to determine if a defendant is competent to proceed to trial.

- To become an LCFE for Partners:
    - Must be a licensed clinician as defined in Rule 10A NCAC 27G.0104
    - Must have completed the LCFE training provided by Central Regional Hospital, or willing to attend training
    - Be contracted with Partners
- MDEs are an important tool that assists in both incompetency and guardianship proceedings. An MDE is an evaluation that contains three parts: medical. psychological, and social work evaluations. The MDE may include current evaluations by professionals in other disciplines, including education, vocational rehabilitation, occupational therapy, vocational therapy, speech language therapy, and others. The statutory definition of an MDE contemplates a dynamic and multifaceted evaluation that covers various areas of a respondent's cognitive and functional capacity. The goal of the MDE is to determine/ show the nature and extent of disability and recommend a guardianship plan.
- To become and MDE provide for Partners:
    - Must have the capacity to complete all 3 parts of the MDE in a timely manner. There is a 30-day deadline for MDEs.
    - Provider must be contracted with Partners.
- For additional information please email Court Ordered Evaluations at CourtOrderedEvaluations@partnersbhm.org.

SECTION: BH/IDD Tailored Plan Information

TAILORED PLAN and STATE FUNDED POPULATIONS

Eligible Populations

State-funded Care

Partners has a specified amount of state funds to pay for Mental Health/Substance Use, Intellectual and or Developmental Disability Services (I/DD) and Traumatic Brain Injury (TBI). I/DD and TBI services are for those who have limited funding resources.

Partners manages State-Funded Services for populations with low and modest incomes and for those who may need specialized services that are otherwise not available to them. All uninsured recipients of State-Funded Services are encouraged to apply for Medicaid to obtain comprehensive insurance coverage. The impact of limited state funds is maximized for behavioral health, I/DD and TBI services by ensuring that other available coverage and payments sources are pursued.

Tailored Plan Eligible Populations

In accordance with N.C. Gen. Stat. § 108D-40(a)(12), the following populations who are not otherwise excluded from Medicaid Managed Care shall be eligible for enrollment in Tailored Plans upon their launch:

1. Individuals with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or TBI.
2. Individuals with a developmental disability as defined in N.C. Gen. Stat. § 122C-3(12a).
3. Individuals with a mental illness diagnosis who also meet any of the following criteria:
    a. Individuals with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between NCDHHS and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living Initiative (TCLI) settlement agreement.
    b. Individuals with two or more psychiatric hospitalizations or re-admissions within the prior 18 months.
    c. Individuals who have had two or more visits to the emergency department for a psychiatric problem within the prior 18 months and are assessed by NCDHHS as eligible for the Tailored Plan.

d. Individuals known to NCDHHS or an LME/MCO to have had one or more involuntary treatment episodes within the prior 18 months.

4. Individuals who, regardless of diagnosis, meet any of the following criteria:
    a. Individuals who have had two or more episodes using behavioral health crisis services within the prior 18 months and are assessed by NCDHHS as eligible for the Tailored Plan.
    b. Individuals receiving any of the BH, I/DD, or TBI services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered by a Standard Plan in accordance with N.C. Gen. Stat. § 108D-35(1)
    c. Individuals who are receiving or need to be receiving BH, I/DD, or TBI services funded with state, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
    d. Children with complex needs, as that term is defined in the 2016 settlement agreement between NCDHHS and Disability Rights of North Carolina.
    e. Children aged zero to three years old with, or at risk for, developmental delay or disability.
    f. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by NCDHHS.

Voluntary Populations

Medicaid Managed Care eligible members in the above specified eligibility groups may voluntarily disenroll from the Medicaid Managed Care program or choose not to enroll in the Medicaid Managed Care program if they are:

1. Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. Described in section 501(a)(1)(D) of the Act. Described in Section 1902 (e)(3) of the Act.
2. Receiving foster care or adoption assistance under part E of Title IV of the Social Security Act.
3. In foster care or otherwise in out-of-home placement.
4. Meet the SSI disability definition as determined by the NCDHHS Division of Social Services.
5. Not receiving Tailored Plan enhanced services.

The Tailored Plan shall only process enrollment for members who are eligible for Tailored Plan coverage.

Member Disenrollment

1. The Tailored Plan shall adhere to the NCDHHS Medicaid Managed Care disenrollment approach as defined in Section VII, Attachment M.1. North Carolina Medicaid Managed Care and Tailored Plan Enrollment Policy and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
    a. Member disenrollment requests.
    b. NCDHHS disenrollment requests.

2. The Tailored Plan shall accept and process all Tailored Plan enrollments and disenrollment within 24 hours of receipt of the standard eligibility file defined by NCDHHS and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
3. The Tailored Plan shall comply with NCDHHS membership reconciliation process as defined in Section V.B.8. Technical Specifications.
4. The Tailored Plan shall develop and maintain a member enrollment policy. No later than 90 days after the contract award the policy shall be submitted to NCDHHS for review and approval. The Tailored Plan shall submit to NCDHHS for review any updates to the policy at least 90 days prior to implementation.

Member disenrollment from the Tailored Plan may occur pursuant to specific criteria described below, which may include complete disenrollment from Medicaid Managed Care or disenrolling from a Tailored Plan to a Standard Plan.

Member Requested Disenrollment

1. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the Tailored Plan to the Enrollment Broker by phone, mail, in-person, or electronically.
2. A member who is not excluded from Standard Plan enrollment may request disenrollment from a Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if applicable) any time during the coverage year.
3. A member who is excluded from Standard Plan enrollment may request disenrollment from a Tailored Plan and transfer to NC Medicaid Direct any time during the coverage year.
4. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
5. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
6. The Enrollment Broker will process disenrollment requests in accordance with the following:
    a. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
    b. The Enrollment Broker will notify NCDHHS of its decision by the next business day following receipt of the request.
7. Notice of disenrollment determination.
    a. NDHHS will notify the member or authorized representative, and the Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
    b. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or NCDHHS fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.

8. Expedited review of member-initiated requests for disenrollment.
    a. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the Tailored Plan could jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function.
    b. The Enrollment Broker will process requests for expedited review in accordance with the following:
        i. The Enrollment Broker will transmit expedited review requests to NCDHHS for evaluation within 12 hours of receipt of the request.
        ii. NCDHHS will evaluate and decide whether to approve or deny the request
    c. NCDHHS will notify the member, or authorized representative and the Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date will be within three calendar days of receipt of the request by the Enrollment Broker.

Disenrollment Required by NCDHHS

1. NCDHHS may disenroll a member from Medicaid Managed Care for any of the following reasons:

a. Loss of eligibility.
b. If NCDHHS determines that a member is no longer eligible for Medicaid, the member will be notified by NCDHHS and the member will be disenrolled from the Tailored Plan. The disenrollment effective date will be the last date of the member's Medicaid eligibility.
c. If a member is disenrolled from a Tailored Plan solely because the member loses his or her eligibility for Medicaid for a period of two months or less, the member will automatically be reenrolled in the Tailored Plan upon reenrollment in Medicaid.
d. Change in Medicaid eligibility category.
e. If NCDHHS determines that a member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in Section V.B.1.i.(iii)(c) the member will be notified by NCDHHS and NCDHHS will disenroll the member from the Tailored Plan. The disenrollment effective date will be the date when the member's change in eligibility category was effective.
f. Nursing facility long-term stays.
    ii. A member with a nursing facility stay that exceeds 90 continuous calendar days will be disenrolled from the Tailored Plan on the first day of the next month following the 90th day of stay and receive services through NC Medicaid Direct.
    iii. The Tailored Plan shall utilize the NCDHHS-developed standardized process for monitoring length of stay for members in nursing facilities to ensure members receive appropriate levels of care and to report to the NCDHHS members who need to be disenrolled due to stays that exceed 90 calendar days.
    iv. To monitor and report a member's length of stay in a nursing facility, the Tailored Plan must use the following process:
        a. Within 30 days of admission to a nursing facility, the Tailored Plan will assess a member's health care needs and estimate the potential length of stay. If the member requires a stay for longer than 90 calendar days, the Tailored Plan must notify NCDHHS in writing within five calendar days of the assessment, the results of the assessment, the facility admission date and the estimated discharge date.
        b. The Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.
        c. NCDHHS will send the Tailored Plan and the member, or authorized representative, a written notice of disenrollment at least 14 calendar days before the effective date of the member's disenrollment from the Tailored Plan.
        d. The Tailored Plan must notify NCDHHS with an attestation of any member still enrolled in Medicaid Managed Care prior to the first day of

the next month following the ninetieth day of stay if there is a delay in NCDHHS disenrollment notification.

e. Coverage of the member by the Tailored Plan will end on the effective date provided by NCDHHS.

2. Neuro-Medical Centers and Veterans Homes

a. A member, otherwise eligible for enrollment in the Tailored Plan, residing in a state-owned Neuro-Medical Center or a Department of Military and Veteran Affairs (DMVA)-operated Veterans Home when NCDHHS implements the Tailored Plan is excluded and will receive care in these facilities through NC Medicaid Direct.
b. A member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of Tailored Plans will be disenrolled from the Tailored Plan by NCDHHS.
    i. The Neuro-Medical Center or Veterans Home will submit the member's information, including date of admission, to NCDHHS within 14 calendar days of admission.
    ii. NCDHHS will notify the member and the Tailored Plan of the disenrollment and the disenrollment effective date.
    iii. Coverage of the member by the Tailored Plan will end on the effective date provided by NCDHHS.
    iv. In accordance with 42 C.F.R. § 438.56(f), members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or NCDHHS through an appeals process defined by NCDHHS.

MEMBER ENROLLMENT

Provider Restrictions

The Department of Health and Human Services, Division of Social Services is responsible for Tailored Plan Medicaid eligibility determinations. The state agency will conduct enrollment activities for Medicaid Managed Care eligible members.

Provider Restrictions

Providers shall not conduct or participate in Medicaid Managed Care health plan enrollment, disenrollment, or transfer or opt-out activities, or attempt to influence a member's enrollment into a health plan. Prohibited activities include:

- Requiring or encouraging the member to apply for a Medicaid assistance category.
- Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits.
- Mailing or faxing enrollment forms.
- Aiding the member in filling out health plan enrollment forms or enrolling

- Aiding the member in completing online health plan enrollment.
- Photocopying blank health plan enrollment forms for potential beneficiaries.
- Distributing blank health plan enrollment forms.
- Participating in three-way calls to the enrollment helpline.
- Suggesting a member transfer to another health plan.

Provider Marketing Guidelines

Providers may:

- Make available and/or distribute state-approved marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates.
- If a provider agrees to make available and/or distribute managed care plan marketing materials (such as displaying posters or other materials in common areas such as the provider's waiting room) it should do so knowing it must accept future requests from other managed care plans with which it participates.

Providers must comply with the following:

- To the extent that a provider can assist a member or recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. The provider may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Participating providers may conduct marketing activities to beneficiaries however, providers shall comply with all marketing requirements/restrictions, and Partners will monitor and oversee the marketing activities to ensure that members receive accurate verbal and written information.

VERIFYING ELIGIBILITY

Medicaid Member Eligibility Verification

Providers are responsible for monitoring and verifying BH/IDD Tailored Plan Medicaid eligibility for their members. This can be completed through NCDHHS' CCRP and NCTracks. Providers' employees who are responsible for this function need an NCTracks unique login and password.

For more information about getting started with NCTracks, go to: https://www.nctracks.nc.gov/content/public/providers/getting-started.html.

Medicaid Member Identification Card

Providers are required to implement a policy of requesting and inspecting an adult member's health plan member identification card, prior to providing non-emergency services. If you suspect fraud, please contact Partners Regulatory Compliance Alert Line at 1-866-806-8777, or you can report your concern online at https://partnersbhm.alertline.com.

STATE-FUNDING ELIGIBILITY CRITERIA

Partners has a specified amount of state funds to pay for Mental Health/Substance Use, Intellectual/Developmental Disability (I/DD) and Traumatic Brain Injury (TBI) services. I/DD and TBI services are for those who have limited funding resources.

Partners manages State-Funded Services for populations with low and modest incomes and for those who may need specialized services that are otherwise not available to them under their insurance. All uninsured recipients of State-Funded Services are encouraged to apply for Medicaid or other resources to obtain comprehensive insurance coverage. The impact of limited state funds is maximized for behavioral health, I/DD and TBI services by ensuring that other available coverage and payment sources are pursued.

The following eligibility guidelines will be used for State-Funded Services:

Citizenship: The individual must be a resident of North Carolina for most State-funded service; however, there are limited Federal Block Grant funds available for individuals with Severe and Persistent Mental Illness (SPMI) and Children with Severe Emotional Disturbance (SED). Exceptions for BH/IDD/SUD emergency services as defined in 42 CFR § 438.114.

Exceptions to the above are as follows:

- Crisis/emergent services and emergency services as defined in 42 CFR § 438.114.
- Members who have third-party insurance but are receiving services on the Third-Party Liability (TPL)/Medicare bypass list. The most current list of services can be located at
- TPL Medicare Bypass List
-

Behavioral health services:

a. Income: ≤300% of the federal poverty level.
b. Insurance coverage/other financial resources.
c. Uninsured, or insured with third-party insurance (including Medicaid) that:
    - Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage.
    - Covers the State-funded SUD services, but associated cost-sharing is unaffordable.
d. Tailored Plans shall encourage non-Medicaid covered potential recipients to apply for Medicaid coverage.

I/DD and TBI services:

1. Income: no specified limits.

2. Insurance status/other financial resources:
    a. Uninsured.
    b. Third-party coverage, including TP or other recognized NC Medicaid program, does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage.
    c. Applied for Medicaid coverage.

Please note: The eligibility guidelines are not applicable to the BH/IDD/SUD crisis service continuum. Anyone who presents for behavioral health crisis services receives crisis services, despite their financial situation.

Individuals who are uninsured residents of the Partners catchment area, who present for services that are not eligible for Tailored Plan Medicaid may be eligible for State-funded (non-Medicaid-funded) services.

Individuals with third-party coverage are not eligible for State-Funded Services, with the exception of an emergent or crisis event and within the Partners catchment area. Third-party coverage includes:

1. Private Insurance.
2. TRICARE.
3. Medicare.

However, if after being assessed and receiving services from one of the above payor sources, the provider must determine if the individual meets medical necessity for a service that is not part of the benefit package (State-funded Service only) and/or on the bypass list. If applicable, the provider should submit an enrollment request via Alpha+ and enter a comment explaining why they are requesting enrollment for State-Funded Services and rendering service they are requesting. Please note, enrollment into state funding does not guarantee payment.

Court ordered assessments, including Driving While Impaired (DWI) assessments, are not paid with state funding.

State funding eligibility income requirements/financial eligibility

To qualify for state funding for behavioral health services, household income for the recipient must be 300% or less of the most recent federal poverty guidelines, based on family size. If a member's household income exceeds this amount, (three times the poverty guideline amount per household size), the individual is not eligible for state funding. Below are the 2024 poverty guidelines for the 48 contiguous states. The most current version of the Federal Poverty Guidelines can be found at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Note: Income guidelines do not apply to crisis/emergent events, or I/DD or TBI and income limit is waived.

The 2024 poverty guidelines are in effect as of January 17, 2024.

U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Programs

HHS Poverty Guidelines for 2024

2024 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
For families/households with more than 8 persons, add $5,380 for each additional person.	
Persons in family / household	Poverty guideline
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720

State-funding: Enrolling qualifying individuals into State-Funded Services

Partners will educate providers on eligibility requirements and required documentation to submit for State-funded Services eligibility. Training will include:

- How to verify income and calculate federal poverty level for prospective recipients.
- Checklists of acceptable documentation to prove current legal residence and proof of insurance denial or non-coverage.
- The process for annual eligibility recertification.
- Protocols to re-verify information when recipients relocate to new areas.

Providers will submit completed applications to Partners' Enrollment and Eligibility department via email (eligibilityenrollment@partnersbhm.org), fax (3368352075), mail or through ProviderCONNECT. Eligibility specialists will review and store applications and associated documentation within our system. Applications will be processed within five business days of receipt and confirmed recipients will be set up in Partners' system for 12 months of eligibility. Providers must recertify recipients annually and complete a new intake to obtain current information when submitting an annual Client Update Request, submit a valid DL/ID card, and insurance card if applicable and proof of member income. Providers can run a state-funded benefit plan caseload report in Alpha+. In the Provider's Alpha Portal>Download Q providers should locate a report entitled "Current Client Target Pops." This will generate a list of state-funded benefit recipients for the provider, which will include active benefit plans and the effective and end dates. Providers should sort this report by the end date so they

can prepare to submit an annual client update request in Alpha+ at the time the current target pop expires. Please note that Alpha will not allow approval of a pre-dated/future effective date state benefit plan.
Also note, should a recipient's eligibility expire before reverification is complete, the recipient will only be eligible for crisis services.

Approach for monitoring the implementation of the eligibility criteria:

Partners' eligibility department will review each application to ensure eligibility requirements are met. This review will include:

- Verification that income and family size do not exceed 300% of the federal poverty level, except for I/DD services where there is no income limit.
- Verification that recipient's Social Security number and documentation are on file.
- Verification that the recipient's legal residence is within our catchment area.
- Verification against a national insurance database and/or state Health Information Exchange to ensure recipient does not have third-party insurance that was not reported on their application.
- If the recipient has private insurance, proof of non-covered service or service denial.

We use internal processes and quality checkpoints to ensure recipients are correctly enrolled. The eligibility and enrollment supervisor generates a daily report detailing all recipients enrolled the previous day and audits 100% of these transactions to ensure proper processing and documentation storage. Incorrect enrollments will be corrected (disenrolled) within the next 30 days, as allowed by enrollment rules. The Partners' enrollment processor associated with the error will then be coached and retrained on eligibility processes. On an annual basis, Partners' quality data management team will conduct a statistically valid, 95% confidence-level audit of State-Funded Services enrollments. The audit report will be issued to the enrollment department management and Partners' Chief Operating Officer.

Approach for assisting uninsured State-funded service recipients in submitting Medicaid applications:

Partners' recipient-facing staff and providers receive annual training on the Medicaid program. Training includes qualification criteria, overview of benefits, where recipients can find an application, how to assist a recipient in the application process and referral to the Department of Social Services (DSS). We train Partners' staff and providers to encourage recipients to apply for benefits, even if their reported income is close to or slightly over federal poverty level guidelines, as DSS makes final eligibility determinations. Our care managers, care coordinators, PartnersACCESS staff and Member Engagement staff inform and educate recipients about the Medicaid application process. When a recipient expresses interest in applying for Medicaid and would like to speak with DSS, Partners' staff warm transfers the recipient to DSS. Partners also funds Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) workers in several counties to assist potential Medicaid members with their application process and connect them with other available social services.

Approach to managing access to State-Funded Services:

Removing barriers to care is critical to ensuring optimum health for our recipients. Partners' Provider Network team contracts with a sufficient number of providers to deliver State-Funded Services in each county. Access

to providers is managed through our assignment and wait list processes. For inquiries, contact Statefundswaitlist@partnersbhm.org.

Providers are allocated funding by county, based on availability, provider capacity and historical service utilization. We closely monitor the current utilization of assigned, funded dollars, by provider. If one provider is not utilizing assigned funding, we will move dollars to another provider. This ensures recipients are served and funding dollars are effectively used. If no provider is available, the recipient will be placed on a wait list.

County dollars will sometimes be used to ensure recipients' needs are met on an emergency, case-by-case basis. When a recipient in crisis contacts Partners, we will connect the recipient with their provider's first responders for immediate assistance. We may also help them identify a convenient walk-in clinic for assessment. If the recipient contacts us regarding a dispute or issue with their assigned therapist, we will offer to connect them with our grievance/complaint coordinator. The grievance/complaint coordinator will file the grievance/complaint and help resolve the issue. If the issue cannot be resolved, the recipient will be connected with a different provider.

Enrollments completed by PartnersACCESS:

Enrollments initiated by Partners for emergent/crisis services are approved immediately at the time of the enrollment. Approving the enrollment automatically assigns the individual an Alpha+ record number and the effective date of State-funded benefit coverage. All enrollments completed by PartnersACCESS department are documented as follows: **Primary Disability**	**Benefit Plan** **(Formerly Target Pop)**	**Diagnosis**
Primary MH	AMI – ADULT CMSED – CHILD	F99 – Not otherwise specified
Primary SA	ASTER – ADULT CSSAD – CHILD	F19.99 – Other psychoactive substance use unspecified with psychoactive substance use disorder

Primary I/DD	ADSN – ADULT CDSN – CHILD	F79 – Unspecified intellectual disabilities

Providers are to use the newly assigned medical record number to search Alpha+ and access demographic information on the referred recipient. If, after the provider sees and assesses the recipient enrolled and referred by Partners, corrections need to be made in the demographics and benefit plan (target pop) and/or diagnosis, the provider must submit a client update request via Alpha+, to make the necessary corrections for treatment and/or billing purposes.

Enrollments handed over to provider:

Enrollments initiated by Partners for recipients being referred to a provider for urgent or routine services are started and handed over to the provider via Alpha+. Once the recipient shows for the appointment, providers have seven calendar days to complete the handed over enrollment and submit via Alpha+ to Partners Enrollment and Eligibility department. The Enrollment and Eligibility department review for accuracy and completeness. Once accuracy is verified, the enrollment is approved. Approval automatically assigns a record number and the effective date of State-funded benefit coverage. Any enrollments that are incomplete or inaccurate are returned to the provider for corrective action and resubmission. Any enrollments not received correctly within the seven-calendar day timeframe will be updated to be effective the day of the correct submission.

Enrollment requests submitted by contracted providers:

To facilitate timely access to services, all contracted providers are expected to complete the Alpha+ recipient enrollment correctly, in its' entirety (two pages total) on uninsured members in the following instances, and submit to Partners within seven calendar days of the admitting event:

- When the recipient walks into the provider's office/agency requesting services and the contract provider initiates services, the enrollment should be completed, dated and submitted on the first date of service.

All enrollment requests must be submitted to Partners within seven calendar days of assessing and enrolling the recipient. No exceptions.

Enrollment requests:

- Must be complete (page one and page two).
- May not contain blanks or answers of "unknown."
- Must contain a diagnosis, benefit plan (target pop) and complete SUD details (when a SUD diagnosis is documented).
- Must have a matching screening date, admission date and start date of diagnosis and benefit plan (target pop).

Before submitting a new enrollment request, the provider should always search Alpha+ for the recipient and a current enrollment. If an Alpha+ number is found, providers need to always determine if the recipient has an effective date for state and/or Medicaid insurance.

Providers may search Alpha+ for referred or previously seen recipient by:

- Entering first name, last name and date of birth.
- Entering last name, first name and Social Security number.

Intake assessments are completed by licensed clinicians. The enrollment information may be keyed in Alpha+ by any employee, however the name entered into the enrollment form as the person who completed the enrollment must be the name of the licensed clinician who completed the assessment and gave the diagnosis. His or her professional credentials must be included. Make certain the presenting problem by recipient age/disability, benefit plan (target pop) and diagnosis all match. For example, if the recipient is a child, be sure the presenting problem and member age/disability is checked for a child and that a child benefit plan (target pop) is indicated on the additional clinical information, page two.

If the "in need of detox" question is checked yes, the following must also be documented:

- Withdrawal symptoms.
- At least one SU diagnosis, SA benefit plan and drug of choice information entered on page two, additional clinical information.

Information related to the enrollment comment section:

- When Partners returns an enrollment request pending or denied, there is always an explanation in the comment section.
- Should the enrollment request be returned with a note in the comment section, please do not delete the note entered by Partners when the enrollment request is resubmitted.
- If a reply comment is needed, enter the date and the comments directly under the note entered by Partners staff.
- Once comments are entered by Partners and/or the provider they are never to be deleted.

Provider requests for enrollment may not be back dated to cover dates of service when the recipient was not officially enrolled because the provider did not submit the enrollment in a timely manner and/or within seven calendar days of the first date of service. If the enrollment request is submitted to Partners via Alpha+ after seven calendar days of the screening/admission date, the date that the enrollment was submitted to Partners is considered the effective date of the state benefit plan. No exceptions. Providers may not back date the admission date on a request for enrollment to cover dates of service after an individual becomes ineligible for Medicaid coverage and before the individual was appropriately enrolled in the state benefit plan.

The screening date and the admission date of the provider enrollment request must match and should be the same date that the provider completed the comprehensive clinical assessment (screening) and admitted the member. Admission date must match screening/intake date and may not precede it. The provider should always search Alpha+ for the recipient and an enrollment thoroughly before submitting a new enrollment

request. If an Alpha+ number is found, it is imperative to always determine if the member has an effective date for state and/or Medicaid insurance.

Client update requests submitted by contract providers:

All requests for changes to a currently enrolled recipient's record must be made by submitting a client update request via Alpha+. Providers should note that client update requests cannot go back further than 90 days from the date of submission. If a client update request is submitted outside of the 90-day period, the effective dates(s) will be changed to retro back 90 days. This applies only to diagnosis, benefit plans and substance use. State layer funding effective dates cannot be changed outside of the seven-day enrollment period rule.

Prior to submitting a client update request to change a Benefit Plan (Target Pop), check Alpha+ to ensure that the recipient has a state benefit effective date with no end date.

If a search has been done correctly and the member does not display in Alpha+ as actively enrolled to state benefits, an enrollment request must be submitted. When submitting a client update request for a change of name and/or Social Security number, providers are responsible for making certain that the name and/or Social Security number on the client update request matches the member's Social Security card prior to requesting an update of a member's name in Alpha+. The provider should notify Partners via a note in the client update request when this verification process has been completed. Otherwise, Partners returns the client update request for appropriate verification.

When submitting a client update request for a change in the recipients' date of birth (DOB), providers are responsible for verifying the DOB requested on the client update request matches the DOB on a valid N.C. ID, driver's license or birth certificate. The provider should notify Partners via a note in the client update request when this verification process has been completed. Otherwise, Partners will return the client update request for appropriate verification.

NCTracks Benefit Plan (formerly Target Populations)

1. An NCTracks Benefit Plan (Benefit Plan) must always be documented on page two of the additional clinical information electronic form inside of Alpha+.
2. Always enter an end date for the benefit plan.
3. Adult Substance Use Treatment Engagement and Recovery (ASTER), Any Mental Illness (AMI), Adult Substance Use-Women (ASWOM), Adult Mental Health for Veterans and their families, (AMVET), Adult Substance Use Communicable Disease (ASCDR), Adult with Developmental Disability (ADSN), Adult with Mental Illness Transitions to Community Living (AMTCL), Child with Mental and Serious Emotional Disturbance (CMSED), Child with Substance Use Disorder (CSSAD) and Child with Developmental Disability (CDSN) benefit plans are valid for one year. These qualifiers must be reviewed annually to ensure that the member still qualifies. A client update request must be submitted to renew the benefit plan for an additional year.
4. Prior to submitting a client update request for a benefit plan, always check Alpha+ to determine what benefit plan(s) and end dates are documented. The benefit plan dates requested should not, in any way, overlap dates that are already in Alpha+. For example: if there is already an Any Mental Illness

(AMI) benefit plan documented in Alpha+ with an effective date of December 15, 2022, and an end date of December 14, 2023, the newly requested end date cannot be extended by entering a new "overlapping" AMI benefit plan with a start date of December 1, 2023, and an end date of November 30, 2024.

5. Prior to adding or updating a benefit plan for a recipient, the provider should always search Alpha+ under Menu, Patient Maintenance, Docs, Assignments tab and select the Target Pop tile, to see what benefit plans are already entered in Alpha+.
6. If the benefit plan that the recipient needs is not found under the Alpha+ benefit plan tile, the provider needs to enter the appropriate benefit plan with an appropriate effective date and end date.
7. If the benefit plan that the recipient needs, is found under the Alpha+ benefit plan tile:
    a. The provider needs to make certain the benefit plan has an appropriate end date.
    b. If the end date of the benefit plan needs to be adjusted, the provider needs to create a new entry with the same effective date that is documented in Alpha+ for that benefit plan and then enter a new end date.
8. If a benefit plan with an incorrect effective date has been submitted and the benefit plan is approved but needs to be corrected, the provider must request correction of the benefit plan via an additional client update request. The provider can note this in the comment section of the update request.

Eligibility Documentation – Alpha+ Enrollment/Update Module

In order to ensure accuracy of information and eligibility, when submitting an enrollment or client update request through the Alpha+ enrollment and client update request modules, providers are to attach/upload eligibility documentation through Alpha+. When this information has been provided by the recipient to the provider, walk-in clinics must submit the financial information to Partners through Alpha+ within seven calendar days of initial visit.

Documents to be uploaded to enrollments and client update requests are:

- State issued driver's license/identification card (in the event of a minor, the parent's or legal guardian's).
- Social Security card.
- Income verification in the form of a member's paystub, tax return, or in the event of no income, a signed and dated statement of no income verification form.

Documents should be attached/uploaded upon initial enrollment and upon each annual client update request to add a new annual benefit plan.

Providers may also upload these documents to recipients' record through the patient maintenance module under clinical documents. Clinical document type to be selected is "eligibility documentation."

Federal Funding Restrictions and Responsibilities for State Funding

The state and federal fiscal requirements of contract providers will be communicated to the providers via the standardized contract in addition to this Provider Operations Manual.

The contract also will require that the contract providers accept the responsibility for being knowledgeable and compliant with all federal and state requirements. When items of noncompliance are identified related to a provider, the Regulatory Compliance Department will review and take the appropriate steps to investigate the matter.

Provider contracts shall specify the federal aid category when federal funds are utilized to reimburse the provider.

Providers shall not use Child Mental Health Block Grant Funds (CMHBG) and Substance Abuse Prevention and Treatment Block Grant Funds (SAPTBG) funds to provide inpatient hospital services, except for SAPTBG funds that may be used as described in 45 CFR 96.135(c).

Providers shall not use CMHBG and SAPTBG funds to make cash payments or allow the purchase of any cash equivalents (e.g., gift cards) for payments to or use by any recipients or intended recipients of BH and I/DD services.

Providers shall not use CMHBG and SAPTBG funds for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.

Providers shall not use CMHBG and SAPTBG funds to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e., Federal funds may not be used to satisfy any condition for any State, local or other funding match requirement).

Providers shall not use CMHBG and SAPTBG funds to provide financial assistance to any entity other than a public or nonprofit private entity.

Providers shall not use CMHBG and SAPTBG funds towards the annual salary of an employee or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.

SAPTBG Restrictions

Providers who receive SAPTBG funds shall not use those funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Providers shall not use SAPTBG funds to provide individuals with treatment services in penal or correctional institutions of the state

The contract with each specific block grant provider has Attachment A which lists the service category (Work First, Substance Abuse Prevention, etc.), Non-UCR Funding Source, dollar amount and provider-specific instructions for each category. The contract also details the mission of the initiative, eligible populations to be

served along with billing/invoicing procedures. The reporting requirements and due dates for the Work First quarterly reports are stated.

Also, the SAPTBG Semi-Annual Compliance Report and due dates are detailed for all substance use disorder providers.

The federal program requirements are covered in these contracts which are signed annually. The Memorandum of Agreements (MOA) for the Work First/Child Protective Services Substance Use Initiative is signed annually for providers of this initiative. The MOA also details the mission, eligible populations to be served, assessments to be completed, reports to be completed and any tracking requirements. The MOA is signed with the provider, LME-MCO and the county Department of Social Services. These are completed annually by the grants monitoring specialist and sent to the finance department to be emailed for signatures by DocuSign.

Provider shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).

GUIDELINES FOR TP PROVIDERS

Primary Care Providers (PCP)

The primary care provider (PCP) is the cornerstone of Partners' TP service delivery model. A PCP is the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member/provider relationship, supports continuity of care and patient safety, leads to elimination of redundant services, more cost-effective care and better health outcomes. Partners offers a robust network of PCPs to ensure every member has access to a medical home within the required travel distance. Partners requests that PCPs inform the member service line 1-888-235-4673 when a Partners member misses an appointment so we may monitor it in our systems and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of emergency department services.

Provider types that may serve as PCPs

Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, internal medicine physicians, nurse practitioners and physician assistants. The PCP may practice in a solo or group setting or at a federally qualified health center (FQHC), rural health clinic or outpatient clinic. Partners may allow some specialists to serve as a member's PCP for beneficiaries with multiple disabilities or with chronic conditions as long as the specialist agrees, in writing and is willing to perform the responsibilities of a PCP as stipulated in this manual and their participating provider agreement/contract.

Primary Care Provider (PCP) Responsibilities

As an extension of the Partners participating provider agreement, all Partner's contracted providers are obligated to comply with the requirements stipulated in this provider manual. Primary care providers (PCP) shall serve as the member's initial and most important contact. PCP responsibilities include, but are not limited to, the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members or entering into an arrangement for management of inpatient hospital admissions of member.
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times, including members with special needs and chronic conditions.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide screening, well care and referrals to community health departments and other agencies in accordance with Partners provider requirements and public health initiatives.
- Conduct a behavioral health screen to determine whether the member needs behavioral health services.
- Maintain continuity of each member's healthcare by serving as the member's medical home.
- Offer hours of operation that are no less than the hours of operating hours offered to commercial beneficiaries or comparable to commercial health plans if the PCP does not provide health services to commercial beneficiaries.
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
- Ensure follow-up and documentation of all referrals including services available under the state's fee for service program.
- Collaborate with Partners care management program as appropriate including, but not limited to, performing member screening and assessment, development of care plans to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed.
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule for members under age 21.
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization, as well as coordinating services the member is receiving from another health plan during transition of care.
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated.

- Actively participate in and cooperate with all Partners quality initiatives and programs.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.

PCPs may have a formalized relationship with other primary care providers to see their members when needed. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them.

Assignment of a Primary Care Provider (PCP)

Partners offers a robust network of primary care providers to ensure every member has access to a "medical home" within the required travel distance standards. For those members who have not selected a PCP during enrollment, Partners will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look to see if the member is a returning member and attempt to match them to their previous PCP. If the member is new to Partners, claim history provided by the state will be used to match a member to a PCP with whom the member had a previous relationship where possible.
2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.
3. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members' travel time and mileage do not exceed required access standards.
4. Appropriate PCP type. The algorithm will use age, gender, language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs. Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. If the pregnant member does not select a pediatrician, or other appropriate PCP, Partners will assign one for her newborn.

Choice of a Primary Care Provider (PCP) or Change of PCP

Members can choose their PCP. Members are offered assistance in finding a PCP through the Partners' Provider Directory, which includes providers in the network with whom Partners' contracts. Partners' Member Services Team is available to assist members with this process. Members may want to choose someone that they have seen before and understands their health history. Each member enrolled in Partners' Tailored Plan may have a different PCP, or a PCP can be chosen to care for the entire family.

The PCP's name and contact information will be listed on the Medicaid card. If a member would like to change their PCP, they have 30 days from the date of receipt of the card to do so. To change a member's PCP use the PCP change form on Partnersbhm.org or via MemberCONNECT portal. Partners' Member and Recipient Services line at 1-888-235-4673 will also be available to assist in this process. Members can choose to change their PCP two times per year without cause or anytime with cause.

For Members to change their PCP more than once per year, the member will need to cite good cause for the change. Members may have good cause if:

- PCP does not provide accessible and proper care, services or supplies (for example, does not set up hospital care or consults with specialists when required for treatment)
- Member disagrees with their treatment plan
- PCP moves to a different location that is not convenient for the member
- PCP changes the hours or days available
- Member has trouble communicating with PCP due to a language barrier or another issue
- PCP is not able to accommodate your special needs
- PCP and Member agree that a new PCP is best for member care

Medical Home Model

Partners is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by beneficiaries of their own care and reduce avoidable costs over time. Partners will actively partner with our providers, with community organizations and groups representing our beneficiaries to achieve this goal through the meaningful use of health information technology (HIT). Partners will evaluate all potential medical home providers according to the criteria established by NCDHHS and will regularly assess each contracted medical home's compliance with these requirements.

Advanced Medical Homes (AMH)

The Advanced Medical Home (AMH) program refers to an initiative under which Partners as a Tailored Plan must pay medical home fees to all participating primary care practices that act as PCPs. *Please use the following link for more information:* *https://medicaid.ncdhhs.gov/advanced-medical-home* For Tailored Plans, only AMH practices certified as AMH+ practices will play the lead role in providing Tailored Care Management. In order to be contracted as an advanced medical home (AMH) with Partners, all AMH providers must demonstrate and maintain their compliance with the following required standard terms and conditions:

- Accept members and be listed as a PCP in the Tailored Plan's member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- Provide primary care and patient care coordination services to each member, in accordance with Tailored Plan policies.
- Provide or arrange for primary care coverage for services, consultation or referral and treatment for emergency medical conditions, 24 hours per day, seven days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services, in accordance with the primary care provider section of this manual and VII. Attachment M.2. Table 1: Required Preventive Services.
- Maintain a unified patient medical record for each member following the Tailored Plan's medical record documentation guidelines.
- Review and use the monthly enrollment report provided by the Tailored Plan for the purpose of participating in Tailored Plan or practice-based population health or care manager activities.
- Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.

- Transfer the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or Tailored Plan (if applicable) and as authorized by the member within 30 days of the date of the request, free of charge. (Members can change their PCP without cause twice per year.)
- Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the Tailored Plan's network adequacy standards.
- Refer for a second opinion as requested by the member, based on NCDHHS guidelines and Tailored Plan standards.
- Review and use member utilization and cost reports provided by the Tailored Plan for the purpose of AMH-level utilization management and advise the Tailored Plan of errors, omissions or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the Tailored Plan for the purpose of participating in Tailored Plan or practice-based population health or care management activities.

For more information and frequently updated information, please use the following link to stay up to date:

https://medicaid.ncdhhs.gov/tailored-care-management

From an information technology perspective, Partners will be offering several HIT applications for our network providers. Our secure provider portal, ProviderCONNECT, offers tools that will help support providers in the medical home model of care.

These tools may include, but not be limited to:

- Online care gap notification.
- Member panel roster including member detail information.
- Member care plan.

SPECIAL PIHP NOTE: Advanced Medical Homes may be serving Members that fall into PIHP/Medicaid Direct based on their Medicaid eligibility. These providers would bill their physical health services to NC TRACKS directly.

AMH+ Practice and CMA Certification (applies to both PIHP/Medicaid Direct and Tailored Plan)

Provider organizations interested in delivering provider-based care management will be required to be certified in order to deliver this function.

- AMH+ practices will be primary care practices actively serving as AMH tier three practices, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, severe SUD diagnosis, an I/DD or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or

I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for Tailored Plans. While NCDHHS expects only a minority of AMH tier three practices to be ready to obtain certification as AMH+ practices at Tailored Plan launch, NCDHHS vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.

- CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid, or State-Funded Services, other than care management, to the Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the Tailored Plan population.

The AMH+ and CMA provider manual can be found in the Partners ProviderCONNECT portal as well as directly at the NCDHHS website: https://medicaid.ncdhhs.gov/advanced-medical-home and https://medicaid.ncdhhs.gov/tailored-care-management

Care Management for High-Risk Pregnancies

Care management for high-risk pregnancies (CMHRP) is a program available to all pregnant women enrolled with Partners. With a focus on healthy moms and babies, pregnant members receive comprehensive, coordinated maternity care services with a focus on preventing pre-term birth. These services are provided by local health departments.

Care Management for At-Risk Children

Care management for at-risk children (CMARC) is a program offered to children enrolled with Partners that are between ages zero to five and who meet specified criteria. Under this program, local health departments work with the member's primary care provider as well as social service organizations to assure these children have access to coordinated care management services between health care providers, linkages and referrals to community programs and family supports.

Vaccines for Children

The vaccines for children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Partners encourages primary care providers who serve members aged 19 and under to participate in the VFC program, which allows providers to receive vaccines at no cost for children eligible for Medicaid who are age 19 or under. Partners will only pay for the vaccine administration fee for VFC eligible children. Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.

Care Coordination and Discharge Planning Requirements

Partners trusts our network providers to provide excellent discharge planning and coordination of care for the members and recipients they serve, and to comply with all legal obligations of their profession, certifications

and licenses. We incorporate these expectations during the contracting process through general and specific legal compliance language, like the following:

- Provider shall comply with North Carolina continuity of care requirements as set forth in N.C.G.S. §122C-63 which requires 60 days' notice by the provider to Partners of intent to close a facility or discharge a member with intellectual or developmental disabilities who may be in need of continuing care as determined by Partners.
- Provider shall provide 30 days of intent to close a facility or discharge a member with a mental illness or substance use disorder who may be in need of continuing care as determined by Partners.

Partners' Care Management team will support our providers in this work through assisting with referrals, assessment scheduling, obtaining required utilization management documentation, treatment planning, assembling the care team, etc.

Referrals

As promoted by the medical home concept, primary care physicians (PCPs) should coordinate the healthcare services for Partners members/beneficiaries. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a member's healthcare, Partners encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans. In accordance with North Carolina Law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the provider's family has a financial relationship. Referrals can be submitted via Partners ProviderCONNECT, fax or phone. Any member seeking care from an out-of-network primary or specialty care provider will continue to require prior authorization, which is subject to medical necessity review.

As a participating PCP in Partners' network, it is important to understand the requirements for both the referral and prior authorization processes to ensure your patients do not experience any disruption in care and claims are paid in a timely and accurate manner. Please see the referral process outlined below for more detail.

Partners' referral process utilizes both referrals and prior authorizations to help manage member care delivery. Prior authorization, or pre-certification, may be required prior to a member receiving a service or procedure. Some covered services and procedures require a prior authorization even if the service is provided by an in-network provider. All services and procedures provided by an out-of-network provider require prior authorization.

Referral-approval required prior to a member seeing a specific in-network specialty provider for an office visit.

Referral submission:

- Referrals can be submitted by PCPs via phone, fax or Partners ProviderCONNECT.
- Referrals will cover the member's office visits to the specialist indicated on the referral for a span of six months from the date of submission.

- If additional services or procedures are required following the specialist office visit, providers should utilize the prior authorization tool located on Carolina Complete Health's provider website (via ProviderCONNECT) to determine whether the needed procedure is covered or requires prior authorization before proceeding.
- Payment will be denied for any claims submitted by one of the above-listed specialty types if there is not an active referral in place on the date of service.
- A referral cannot be submitted for an out-of-network specialist.

If you are a participating PCP, you are responsible for managing the care for your patients, including the care provided by other clinicians. The referral process helps to facilitate adequate contact between you and the specialist to whom you are referring a member. It will help provide you with opportunities to complete health screenings, manage ongoing conditions and understand how beneficiaries are navigating available healthcare resources. The referral process outlined herein is aligned with current goals in healthcare around the Quadruple Aim – the right care, at the right time, in the right place.

Specialist Responsibilities

Specialists are required to report to Partners limitations on the number of referrals accepted. The specialist must notify Partners when the specialist reaches 85% capacity. Partners encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensure the referred specialty physician is a participating provider within the Partners' network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following Partners' referral guidelines.

Emergency admissions will require notification to Partners' Medical Management department within one business day, following the date of admission to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Partners.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain authorization from Partners' Utilization Management department if needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Actively participate in and cooperate with all Partners quality initiatives and programs. As a participating specialist in the Partners network, it is important to understand the requirements for both the referral and prior authorization processes to ensure your patients do not experience any disruption in care and claims are paid in a timely and accurate manner. Please see the referral process for more detail.

Protected Health Information (PHI)

Providers are charged with ensuring all people providing services maintain the confidentiality of all members and other information received during providing services. Providers may not discuss, transmit or narrate in any form, member information of a personal nature, medical or otherwise, except as authorized in writing by the member or his/her legally responsible person, or except as otherwise permitted by applicable federal and state confidentiality laws and regulations. This includes NC GS §122C, Article 3, which addresses confidentiality of all information acquired in attending or treating a member and 42 CFR, Subchapter A, Part 2, which addresses confidentiality of records of drug and alcohol use service recipients.

Protected health information (PHI) PHI may be shared for treatment, payment or operations (TPO).

- **Treatment**: The provision, coordination or management of healthcare and related services by a healthcare provider(s), to include third party healthcare providers and health plans for treatment alternatives and health-related benefits.
  Example: A PCP discloses identifying information to Partners when obtaining authorization for services.
- **Payment**: Activities to determine eligibility benefits and to ensure payment for the provision of healthcare services.
  Example: Provider submitting a claim with PHI to Partners for the purpose of payment for services.
- **Health care operations**: Activities that manage, monitor and evaluate the performance of a healthcare provider or health plan.
  Example: CMS conducting an internal audit. Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA privacy rule.

A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor (under 18 years of age) has the right to agree to some treatments without the consent of his/her parent or guardian for:

- Use of controlled substances or alcohol.
- Emotional disturbance.
- Has behavior that presents threat to life or physical well-being.

If the member disagrees with what a physician, treating provider, clinician or case manager has written in his/her record, the member can write a statement from his/her point of view to go in the record, but the original notes will also stay in the record in accordance with state requirements.

Mainstreaming

Partners considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national

origin ancestry, marital status, sexual orientation, health status, income status, program member or physical or behavioral disabilities except where medically indicated.

Examples of prohibited practices include:

- Denying a member/beneficiary a covered services or availability of a facility.
- Providing a Partners' member/beneficiary a covered service that is different or in a different manner, at a different time, or at a different location than to other "public" or private pay member/beneficiary's (examples: different waiting rooms or appointment times or days).
- Subjecting a member/beneficiary to segregation or separate treatment in any manner related to covered services.

Appointment Accessibility Standards

Partners follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Partners monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency department utilization. Providers who fail to comply with published appointment standards may be subject to corrective action.

Partners will also ensure compliance with network adequacy and appointment wait time standards for adult and pediatric providers separately, Medicaid, which vary by the type of service:

Appointment Wait Time Standards for Medicaid Tailored Plan			
Reference number	**Visit type**	**Description**	**Standard**
Primary Care			
1.	Preventive care services – 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.
1.a.	Preventive care services – child, birth through 20 years of age.		Within 14 calendar days for members less than six months of age Within 30 calendar days for members six months of age and older.
2.	Afterhours 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 nonemergent illness or injury with acute symptoms that require immediate care.	Within 24 hours.

		Examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	
4.	Routine/check-up without symptoms.	Non-symptomatic visits for routine health check-up.	Within 30 calendar days.
Prenatal Care			
5.	Initial appointment – first or second 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.
5.a.	Initial appointment – high risk pregnancy or third trimester.		Within five calendar days.
Specialty Care			
6.	Afterhours 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 nonemergent 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.	Refer to RFA Section VII, Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within two hours.

10.	Facility-based crisis (FBC) management services (FBC for child and adolescent, FBC for adults, non-hospital medical detox).	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Emergency services available immediately (24 hours a day, 365 days a year).
11.	Emergency services for serious mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Immediately (available 24 hours a day, 365 days a year).
12.	Emergency services for severe substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Immediately (available 24 hours a day, 365 days a year).
13.	Urgent care services for serious mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 24 hours.
14.	Urgent care services for severe substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 24 hours.
15.	Routine services for serious mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 48 hours
16.	Routine services for severe substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards	Within 14 days

		for Medicaid and State-funded recipients.	

No Reject Requirements

Providers are required to attest that upon application to Partners' network that a "no-reject policy" for referrals within the capacity and the parameters of their competencies is in place. Providers also agree to accept all referrals meeting criteria for services they provide when there is available capacity.

Covering Providers

Providers must arrange for coverage with another Partners network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify the Provider Network department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement.

Telephone Arrangements

PCPs and specialists must:

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  a. After hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  b. Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member medical record.

Note: If after hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Partners will monitor appointment and after-hours availability on an on-going basis through its quality improvement program (QIP).

24-Hour Access: After Hours Coverage

Partners PCPs, behavioral health providers and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, seven days a week.

- A provider's office phone must be answered during normal business hours and normal business hours must be maintained for at least 30 hours per week.
- During afterhours, a provider must have arrangements for:
    - Access to a covering physician.
    - An answering service.
    - Triage service.
    - A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish if the provider's practice includes a high population of Spanish speaking beneficiaries.

Examples of unacceptable afterhours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered afterhours by a recording that tells patients to leave a message.
- The provider's office telephone is answered after hours by a recording that directs patients to go to an emergency department for any services needed.
- Returning after-hours calls outside thirty minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP, behavioral health provider or specialist for a clinical decision. Whenever possible, PCP, behavioral health provider, specialty physician or covering medical/behavioral professional must return the call within 30 minutes of the initial contact. Afterhours coverage must be accessible using the medical office's daytime telephone number. Partners will monitor provider offices through afterhours calls conducted by Partners Provider Network department.

Provider Directory Demographic Changes

Partners strives to maintain the most accurate and up-to-date information in its provider directory. When Partners receives new information from a practitioner or facility or the provider terminates, the provider directory is updated within 10 business days of the date the new information is received. Demographic changes can be submitted via the provider change form and submitted to Enrollment@partnersbhm.org. Provider will need to complete a Managed Change Request (MCR) through NCTracks for demographic changes.

Hospital Responsibilities

Partners utilizes a network of hospitals to provide services to Partners members/recipients. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this provider manual.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency department (ED) visit.
- Obtain prior authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Partners Medical Management department by sending an electronic file of the ED admission by the next business day. The electronic file should include the member's name, presenting symptoms/diagnosis, date of service (DOS) and beneficiaries phone number.
- Notify Partners Medical Management department of all admission within one business day.
- Notify Partners Medical Management department of all newborn deliveries within one business day of the delivery.

Partners' hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

A prospective hospital that will be delivering behavioral health inpatient services to members with Medicaid eligibility from the Partners catchment area, may apply and be enrolled as a provider with Partners and qualify for reimbursement for hospital services under the Partners Medicaid waiver. Hospitals must have a signed contract to qualify for reimbursement for hospital services with State (North Carolina) funds.

Partners accepts the hospital and/or health systems' enrollment in NCTracks and information from NCDHHS CCRP in lieu of credentialing and recredentialing. This includes all facilities and sites enrolled in NCTracks and affiliated with the hospital/health system and all practitioners billing through the hospital/health system's NPI(s). Hospital and/or health systems may request to contract with Partners by submitting the appropriate request form posted on the Partners website at https://providers.partnersbhm.org/hospitals-working-partners or call the Provider Service Line at 877-398-4145.

Hospital Patient Enrollment & Discharge Instructions for Behavioral Health Facilities

Indigent: Three-way contract, state benefits.

State-funded members (indigent) will be enrolled by one of the following methods.

- Keying the enrollment information directly into the Partners' Alpha+ system. Free training is available for those hospitals interested in this method of submission by contacting the Partners' service desk at 704-842-6431.
- Submitting a completed special project enrollment form (SPEF) by encrypted email or fax to the PartnersACCESS department. This form can be found on the quick links section of this page: https://providers.partnersbhm.org/hospitals-working-partners/.
    - Email – AccessStaff@partnersbhm.org.
    - Daytime fax (8 a.m. to 4:30 p.m.) 336-835-2075.
    - After hours fax (4:30 p.m. to 8 a.m.) 336-527-8010.

The PartnersACCESS department will review the SPEF/enrollment request for completion and will enter into Alpha+ within 24 hours of receipt and will approve if all required information is submitted. If all required information is not documented correctly, the SPEF will be returned to the hospital for correction.

Medicaid

Medicaid members.

- Hospitals do not need to submit the SPEF for a Medicaid member.
- Hospitals should confirm the member has Medicaid originating from one of the counties within Partners' regional catchment area. Hospitals can confirm the Medicaid county of origin by using their own internal process of verification or by using one the following methods.
    - Requesting recipient's Medicaid eligibility card
    - Medicaid global eligibility file
    - Alpha+
    - Calling the PartnersACCESS department at-888-235-4673

Discharge

Discharge follow up appointments.

The PartnersACCESS department will schedule discharge follow up appointments 24 hours a day, seven days a week, 365 days a year for:

1. Tailored Plan members whose Medicaid originates from the Partners catchment area

Indigent members who reside in a county from the Partners catchment area

Discharge follow up appointments for members with private insurance, Standard Plan PHPs, Medicare or Medicaid originating from a county covered by another Tailored Plan or LME/MCO must be handled through the entity managing that member's payer source.

Hospital Patient Authorization Instructions

Partners Health Management Enrollment

For authorization and reimbursement, patients must be enrolled with Partners. Enrollment status can be determined by checking the Alpha+ system or calling the PartnersACCESS department at 1-888-235-4673.

For more information regarding member enrollment, please contact: PartnersACCESS department at 1-888-235-4673 or email EnrollmentEligibility@partnersbhm.org.

Utilization Management (UM)

Partners UM reviews all inpatient service authorization requests (SARs). Acute services team (AST) Utilization Management (UM) staff (the team that reviews requests for inpatient services) are available from 8am to 6pm, , seven days per week, including weekends and holidays. AST UM staff can be contacted at 704-842-6434.

A SAR begins with the admission day and does not include the day of discharge. Hospital staff are responsible for determining the number of days needing authorization and when the next SAR is due.

Submitting Inpatient Requests

Information requested on the inpatient review form is required with each SAR. This form and other information pertaining to requesting authorization for inpatient services can be found at https://providers.partnersbhm.org/hospitals-working-partners/.

The inpatient review form can be completed and attached to the SAR. If the form is completed and attached, then that information does not need to be duplicated in the SAR justification. However, if the inpatient review form is not completed and attached, then the information requested on that form needs to be documented in the SAR justification.

The initial or continued stay SAR information will be reviewed and the requested service will be approved if medical necessity criteria (Clinical Coverage Policy 8B Program Specific Clinical Coverage Policies | NC Medicaid))) for inpatient hospitalization has been established. If further clinical information is needed, UM staff will attempt to contact the identified hospital utilization review staff via phone outreach to obtain additional information. If UM is unable to approve based on the information received, the request will be referred for a peer review. UM will attempt to set up a peer- to-peer conversation prior to issuing an adverse decision. If there is no hospital utilization review (UR) coverage and/or UM cannot obtain an attending physician's contact information, a peer review may be done without consultation. In the event of an adverse decision, a provider can request a peer-to-peer conversation within five business days by calling the UM Appeals department, 704-884-2650.for inpatient hospitalization has been established. If further clinical information is needed, UM staff will attempt to contact the identified hospital utilization review staff via phone outreach to obtain additional information. If UM is unable to approve based on the information received, the request will be referred for a peer review. UM will attempt to set up a peer- to-peer conversation prior to issuing an adverse decision. If there is no hospital utilization review (UR) coverage and/or UM cannot obtain an attending physician's contact information, a peer review may be done without consultation. In the result of an adverse decision, a provider can request a peer-to-peer conversation within five business days by calling the UM Appeals department, 704-884-2650.

Hospital utilization staff will need to check the ProAuth system to determine the number of days authorized and when the next review is due.

Initial Inpatient Requests

Medicaid (101) and State-Funded Services (YP820).

Authorization is required for initial Medicaid and State-Funded Service authorization requests (SARs) within 72 hours of admission. Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Clinical Coverage Policy 8B, allows a hospital up to 72 hours from time/date of admission to notify an LME/MCO of the admission. If initial SARs are submitted within 72 hours of admission, Partners UM will

review back to the first day of treatment. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

Institute for Mental Disease (IMD) Medicaid (160)

Medicaid beneficiaries ages 21-64, who meet medical necessity for inpatient care may be treated at an institute for mental disease (IMD) up to 15 days per calendar month*.

Hospitals can submit a service authorization request (SAR) within one business day of discharge, for the entire length of stay (LOS), up to maximum 15 days per calendar month) for MH IMD requests. For SU IMD requests, there is no maximum length of stay.

Hospitals have the option of seeking authorization upon admission.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

*For 0160- MH IMD admissions spanning two consecutive months, the total length of stay may exceed 15 days, but no more than a 15-day LOS each month is eligible for authorization. Substance Use IMD length of service may exceed 15 days per month.

Three-Way (YP821, YP821SA, YP822, YP822SA)

Authorization is required for Initial three-way funded service authorization requests (SARs) within three calendar days of admission.

Three-way hospital providers have up to three calendar days, after midnight of the day of admission to submit a SAR. Partners Utilization Management staff will review the documentation and SAR for medical necessity back to the date of admission. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

A SAR begins with the day of admission and does not include the day of discharge.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Continued Stay (Concurrent) Inpatient Requests

Prior authorization is required for any continued stay service authorization requests (Medicaid, 101; State, YP820; or Three Way YP821/SA, YP822/SA). Continued stay SARs will not be reviewed retroactively. A SAR must be submitted in ProAuth on the last day of the current authorized timeframe or on the first day service is continued. UM reviewers perform ongoing concurrent review for inpatient admissions through contact with the hospital's Utilization Review and Discharge Planning department and when necessary, with the member's attending physician. The UM reviewer will review the member's status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care.

Concurrent review decisions will be made within 24 hours of receipt of necessary information and notification within one business day after the decision is made. Written or electronic notification includes the number of days a service is approved and the date of the next review.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Exceptions for Inpatient Benefit Plan Limits

Involuntary Commitment (IVC) Admissions:

Partners recognizes when an IVC leads to a member/recipient being admitted to a psychiatric inpatient unit, the facility needs time to fully assess the need for the commitment to stand or be dismissed. Since the law related to IVCs legally allows the facility to take up to 72 hours to complete their evaluation, UM will authorize the initial three days for these admissions.

If the third day of the authorization falls on a Saturday or Sunday, Partners will allow the request to extend to Monday as outlined below:

- **Weekends –** Partners allows an exception for SARs with a LOS covering including a weekend day. Specifically, hospitals submitting SARs with an end date of Saturday can request one additional day to extend the maximum allowed days requested to four (allowing a request for Thursday, Friday, Saturday and Sunday). A continued stay SAR must be submitted on or by end of inpatient business day hours on Monday. SARs will be reviewed for medical necessity.

  UM inpatient staff will still be available seven days a week including holidays. If a hospital needs or chooses to submit a SAR during that time, UM staff will be available 10 hours a day.

- **Monday holidays –** Partners allows a similar exception for holidays that are on a Monday. Hospitals can submit a SAR for additional days)to make a request through a holiday weekend. For example, if a three-day SAR is submitted with a start day of Friday, hospitals can request Friday, Saturday, Sunday and the Monday-holiday. A continued stay SAR must be submitted on or by end of the day on Tuesday. SARs will be reviewed for medical necessity.

Alternative Methods for Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the ProAuth system used by Partners UM. Providers may contact the Partners service desk, 704-842-6431, to request login information and assistance.

For circumstances when ProAuth cannot be utilized, SARs can be processed:

- **Live review by phone**: Hospital staff will need to call 704-842-6434, to reach a UM reviewer 10-hours a day, seven days a week. The UM reviewer will collect information detailed on the inpatient review form.
- **Manual review by fax or e-mail:** A manual SAR form must be completed to include information on the inpatient review form. Documents can be faxed to 704-884-2703 or emailed to BHIDDManualAuthorizations@partnersbhm.org.

Prior authorization guidelines still apply.

Retroactive Medicaid Service Authorization Requests

Partners' Utilization Management (UM) department reviews requests for retroactive Medicaid requests submitted within 90 days from the modified date in NCTracks. All retroactive service authorization requests (SAR) must be submitted to UM for medical necessity review. For further questions on retroactive Medicaid requests, please contact the AST UM workgroup at 704-842-6436.

Hospital Claims Instructions – Behavioral and Acute

Claims may be submitted from hospitals for emergency department, inpatient, and hospital outpatient. Partners contracts with Emdeon for hospital clearinghouse services**.** Claims may be submitted through the hospital's clearinghouse, direct 837I submissions and direct entry individual claims into the Partners claims management system.

Rates paid to the hospital under the terms of this agreement will be equal to the current published per diem rate by the NC Division of Health Benefits (DHB) for services provided after January 31, 2013. For emergency room services, the reimbursement rates will be calculated using the hospital's unique RCC outpatient percentage in effect on January 31, 2013, times 80% of the hospital's billed service costs. These rates may be adjusted as the DHB updates their rates based on changes in hospital.

Only members with Medicaid coverage for one of Partners' covered counties will be paid. Members with Medicaid coverage outside of the Partners' catchment area should be billed to the appropriate LME/MCO based upon recipient's county eligibility.

Claims are required to be submitted within 365 days of a member's discharge date. Providers may submit claims to Partners up to 365 days from the date of service in the event of coordination of benefits has occurred.

Timely filing requests should be sent directly to claimsdepartment@partnersbhm.org prior to submitting the claims.

- Retroactive Medicaid: Claims based on retroactive Medicaid eligibility must have authorization requested within 90 days. Timely filing requests and submission of claims must be within 90 days of the date modified in NCTracks for eligibility date range.

Only appropriate services/codes will be paid. They are listed below:

- **Emergency Room**
  - RC450-RC459.
  - Bill Type 13X.
  - Ancillary charges are paid as appropriate.
  - Subject to coordination of benefits.
  - No Partners BHM Authorization is required.
  - ICD-10 codes between F01-F99.
  - Paid at 80% times the RCC of the Approved Medicaid rate.
- **Inpatient Hospital Charges**
  - Revenue Codes 101, 113, 114, 116, 120, 123, 124, 126, 128.

- Paid upon the state negotiated per diem rate, which includes ancillary charges, ED charges, labs, testing, etc.
- ICD-10 codes between F01-F99.
- Bill Type of 0111-0114 or 0117-0118.
- Admit Type of 11X.

Subject to coordination of benefits.

Reimbursement is limited to the number of days authorized.

Hospital Outpatient Charges

- Revenue Codes: 901-903, 905-907, 912-916, 918-919.
- Bill Type 0130-0135, 0137-0138.
- Admit Type of 3.
- ICD-10 codes between F01-F99.

- **Subject to coordination of benefits.**
- **Partners authorization required.**

Payments are required to be processed through EFT (Electronic Funds Transaction) transactions (Electronically deposited into the Hospitals bank)**.**

- For more information regarding claims or to ask questions, please contact Partners' Claims department: Phone: 704-842-6486
- Fax: 704-854-4203
- Email: claimsdepartment@partnersbhm.org

Advanced Directives

Advanced Directives are legal documents in which individuals give written instructions about their health and mental health care if, in the future, they cannot speak for themselves.

CMS 42 CFR Statute "§ 489.102 Requirements for providers.

"Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

Provide written information to such individuals concerning an individual's rights under State law to make decisions concerning such medical care.

- Providers must document such information in the permanent medical record.
- Partners recommends that providers:
    - Ask the member if they have executed an advance directive. This should be conducted at the first point of contact with the member. Providers will ask if the member has executed an advance directive with the response documented in their medical record.
    - If the member has executed an advance directive, the member should share a copy with the provider for the member's medical record.
    - An advance directive should be included as a part of the member's medical record and include any mental health directives.
    - If an advance directive exists, the provider/physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any discussion should be documented in the medical record.

Per 42 CFR 489.104, providers must also have written policies and procedures respecting the implementation of such rights to advance directives and include a provider's statement of limitation. Providers must train staff regarding these policies and procedures and offer community education as well. Details of requirements are in the statute. Providers of home health services are strongly advised to read the statute in full and assure they are following these requirements.

42 CFR 489.104: https://www.govinfo.gov/content/pkg/CFR-2006-title42-vol4/pdf/CFR-2006-title42-vol4-sec489-102.pdf

Types of Advance Directives

Advance Directives are instructions that individual makes so their wishes can be followed if they become unable to make their own decisions. Advance Directives include a living will, durable power for health care, medical power of attorney, physician orders for life-sustaining treatment, do not resuscitate orders and psychiatric advanced directives.

- Living Will: Also known as "A declaration of a desire for a natural death," a living will is a legal document which states the desires to not to have an individual's life prolonged by extraordinary measures if they have a terminal or incurable illness or if they are in a vegetative state.
- Durable Power of Attorney for Health Care/Medical Power of Attorney: Also known as a "medical power or attorney" or "health care proxy" or "health care power of attorney." A health care power of attorney allows an individual to name a person they trust to make health care decisions if they cannot make themselves.
- POLST (Physician Orders for Life-Sustaining Treatment) or MOST (Medical Order for Scope of Treatment: A physician order that helps give seriously ill patients more control over their end-of-life care.
- Do not resuscitate (DNR) orders: A physician order that instructs health care providers not to do cardiopulmonary resuscitation (CPR).

- Psychiatric Advanced Directive (PAD): Also known as an "Advance Instruction for Mental Health Treatment," a psychiatric advanced directive is a legal declaration of instructions, information and preferences regarding a person's mental health treatment. It also states that the person is aware that the advance instruction authorizes a mental health treatment provider to act according to their wishes. It may also outline consent or refusal of mental health treatment.

Resources

Copy of the N.C. form: https://www.nrc-pad.org/images/stories/PDFs/north%20carolinastatute.pdf

Ten commonly asked questions about PADs for North Carolina and NC form: National Resource Center on Psychiatric Advance Directives: https://www.nrc-pad.org/states/north-carolina/

Advance Health Care Directive FAQs Secretary of State website and North Carolina Regulations:

- https://www.sosnc.gov/frequently_asked_questions/by_title/_advance_healthcare_directives
- https://www.sosnc.gov/divisions/advance_healthcare_directives

National Resource Center on Psychiatric Advance Directives brief videos for PADs: https://www.nrc-pad.org/videos/

- Psychiatric Advance Directives – a quick introduction
- How to write a Psychiatric Advance Directive?
- Federal Law on Advance Directives: The Patient Self-Determination Act

SAMHSA My Mental Health Plan free app: https://www.samhsa.gov/newsroom/press-announcements/202010010505

Medical advance directives free app for mobile devices: https://mydirectives.com/en/about/company/

Voluntarily Leaving the Network

Ensuring Continuity of Care when a Provider Leaves the Network

Partners will provide care transition assistance to ensure that members/recipients experience no disruption in care when a provider leaves the network. In addition to assistance by our member services team, our care managers support members through the transition process.

Member services will assist impacted members/recipients currently receiving services from a provider leaving the network to transition to a new network provider and offer additional assistance with the provider selection process.

Partners will also conduct outreach to members/recipients receiving services from a terminating specialist to explain their options for selecting a new provider. Partners will educate members/recipients about the online Provider Directory and share information about available resources in their area. It is important to note that a member has the right to stay with the provider even if they choose to leave the network. In instances in which a provider is terminated or leaves the Tailored Plan's network for expiration or nonrenewal of the contract and the member is in an ongoing course of treatment or has an ongoing special condition, Partners

shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

Maintaining Continuity of Care for Members with Scheduled Appointments

To ensure continuity of care and prompt service delivery for members/recipients affected by a provider's decision to leave the network, care managers will assist, as indicated, with scheduling an appointment (or setting up regular appointments) so they can be seen by the new provider as soon as possible.

For members/recipients in active treatment, our utilization management team will notify the new provider that the member/recipient has open authorizations. The new provider can view this information, as well as appointment frequency and scheduled appointments, in ProviderCONNECT, our secure provider portal.

Notifying Members/Recipients and Ensuring Access to Services in the Event of a Provider Leaving the Network

Partners' process for notifying members/recipients who are receiving State-Funded Services is the same as for notifying members who are receiving Medicaid services. Recognizing the funding limitations for State-Funded Services, we promptly transition members/recipients to the care and services they need and ensure funds are available to support their care. To ensure continuation of care and service delivery, the funds follow the recipient to the new provider.

Transition of Care Obligations

Partners is committed to an integrated, well-coordinated system of care for members, including those transitioning into and out of Partners Tailored Plan. We will ensure seamless transitions through close collaboration with other entities involved in the member's care. We will identify and exchange physical health, behavioral health, pharmacy and social determinants of health (SDOH) information on a timely basis for members transitioning between entities and providers. We will honor requests to maintain relationships with existing providers, including specialists, assuming the provider is willing to meet Department standards. Partners believes this flexibility is important given the complex needs of members receiving services through Partners' Tailored Plan.

Member Education

Partners will educate current and new members about the transition process through the Member and Recipient Handbook, new member Welcome Call, Partners' website, MemberCONNECT and through interaction with care managers.

Provider Education

We will inform providers about the transition process and stress the importance of notifying Partners when a member requires transition assistance. Information about the transition process will be available through ProviderCONNECT, Partners' website and care managers working with members in active care.

The following response details the roles and processes:

- The role of the transition coordinator
- Our approach for transition and warm hand offs
- How Partners will support member transitions in the rare event a provider is terminated

Through these processes, Partners will support the health and well-being of members with complex healthcare needs.

Partners Transitions of Care Coordinator

Partners' transitions of care (TOC) approach, programs and policies reflect contract requirements and the unique needs of members who transition among Standard, Tailored and Medicaid Direct plans based on eligibility and clinical needs. Our Transition of Care (TOC) Coordinator leads this effort and serves as a liaison with providers involved in the member's transition. The TOC Coordinator will oversee our strategy for coordinating continuity of care for members enrolling with Partners, regardless of situation or circumstance. Contact information: toc_partners@partnersbhm.org or by calling (704) 884-2578. The TOC Coordinator will be responsible for:

- Identification of transferring members.
- Close coordination between transferring and receiving entities.
- Receiving or sending all relevant member information to ensure continuity of care.
- Data Exchange Processes

Partners has established secure file transfer protocol (FTP) sites for external Tailored Plans, LME/MCOs, Standard Plans, Community Care of North Carolina (CCNC), Medicare or other transition entities and payers. The transition coordinator and team use the sites to transmit and receive available data including physical health, BH, I/DD, TBI, long term support services (TSS) and pharmacy open service authorizations. Partners uses the sites to submit claims data, care management information such as care plans/individual support plans (ISPs), care needs screenings, consents, and adverse benefits determinations to receiving entities. We use real-time application programming interfaces.

Transition into Partners and Ongoing Transition Support

The TOC team checks enrollment reports daily, receives disenrollment spreadsheets from health plans providing lists of members who are transitioning to Partners through State-generated processes, and receives beneficiary or provider submitted "Request to Move" notifications from the Enrollment Broker to determine member who are entering or leaving Partners plan. Within five days of notification of a transition, TOC staff confirm successful transfer and receipt of relevant member information including:

- A summary page narrative of member-specific circumstances that are time-sensitive or could potentially impact continuity of care
- A summary of providers serving the member
- PH, BH, I/DD, TBI, LTSS and pharmacy treatment and care management records

- Open service authorizations
- Prescheduled appointments
- Non-emergency medical transportation data
- Historic claims and encounter data

Partners will, within five business days from NCDHHS notification of the member's anticipated enrollment date, conduct a warm transfer meeting on behalf of high need members. TOC staff will contact the member (if necessary) to confirm the name of the former entity from whom we should request relevant member information. . All transfer of clinical data and communication adhere to 42 CFR Part 2 regulations to maintain confidentiality of substance use disorder patient records.

Partners provides education and guidance on Transition of Care to Tailored and Medicaid Direct plans as described below:

- For members under 21 years of age, the member or guardian should contact the Standard plan to request review for coverage under EPSDT guidelines.
- For assistance with Partners Transition of Care related questions, please contact the Transition of Care Team toc_partners@partnersbhm.org
- Provider can electronically complete the expedited Request to Move form with Service Associated Request (SAR) on the DHHS website at https://ncmedicaidplans.gov/submit-forms-online.

Resources:

Provider Ombudsman 866-304-7062 email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Enrollment Broker (members) 833-870-5500

Member Ombudsman 877-201-3750

Honoring Outstanding Authorizations

Our priority for new members transitioning into Partners is to ensure that members have continued access to needed services without disruption. We will implement strategies to minimize disruption of benefits for members of Partners' Tailored Plan by adhering to prior authorization requirements. We will reset the number of visits that do not require prior authorization, honor current authorizations for ongoing benefits and comply with NCDHHS-defined protocols for streamlining prior authorization requests. The TOC Coordinator, with support from our data analytics team, will retrieve all available claims, authorization and care plan/ISP records. The transition coordinator will ensure this information is available in our care management documentation system.

Partners will honor outstanding prior authorizations from a new member's previous source of coverage, such as another transition entity, for the first 90 days of enrollment or until expiration of the current authorization, whichever occurs first. We will also maintain incoming care management stratification until a new care management comprehensive assessment is complete. We will allow pregnant members to continue to receive services from their BH provider or obstetrician, without any form of prior authorizations, until birth, end of pregnancy or loss of Medicaid eligibility during pregnancy.

Partners will honor existing and active prior medical authorizations on file with NC Medicaid Direct, Standard Plans, and BH I/DD Tailored Plans minimally for the first ninety (90) Calendar Days after PIHP implementation or until the end of the authorization period, whichever occurs first to ensure continuity of care for Members. For service authorizations managed by Partners and impacted by 42 C.F.R. Part 2, Partners shall deem authorizations submitted directly by impacted providers as covered under this requirement. For the first ninety (90) Calendar Days after PIHP launch, Partners shall pay claims and authorize services for Medicaid-eligible non-participating/out-of-network providers equal to that in network providers to ensure that providers fully understand Partners' prior authorization requirements during the transition. Partners shall process and pay for services rendered during this Crossover transitional period if:

1. A provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
2. A provider submits for retroactive prior authorizations.

Transitioning of Care - Providers

Partners will support members in transitioning to an in-network provider at the end of the service authorization period established by their previous plan. Partners will allow the member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, if the member:

- Is in an ongoing course of treatment.
- Has an ongoing special condition. I/DD, a mental health diagnosis, substance use disorder or traumatic brain injury (TBI) are considered special conditions under N.C. General Statute § 58-57-88(a)(1).

In lieu of the transitional period established in N.C. General Statute § 58-67-88(d), we will honor the transitional period for 180 days. We will notify contracted providers to extend current or future authorization requests.

Our Provider Network staff will contact out-of-network servicing providers before current authorizations expire to engage them in the contracting process.

To prepare for transition, we will obtain:

- The most recent psychiatric evaluation and/or care management comprehensive assessment
- Current treatment plan
- Level of Care Utilization System (LOCUS) or acuity level tool
- All other information on Partners' Transition Checklist

Using the transition checklist, the transition coordinator will confirm we have received or sent all necessary member information. We conduct all contact and information sharing in compliance with privacy and security of protected patient information laws and regulations.

<u>Coordination of Benefits and Services requirements</u>

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. The exclusion is procedure codes listed on the Medicare/TPL Bypass list.

See Billing Guidelines Section of this Manual for more information.

BENEFIT INTEGRATION

Overview

Partners will provide a fully integrated model of care with comprehensive physical health (PH), behavioral health (BH), I/DD, traumatic brain injury (TBI), long term services and supports (LTSS), pharmacy and Unmet Health-Related Resource Needs services.

Members and recipients in Partners' Tailored Plan will have access to a comprehensive network of providers to meet their integrated, whole-person health care needs. We have partnered with Carolina Complete Health, Inc. (CCH) to expand members' access and choice when seeking a physical health (PH) care provider and CVS to develop our pharmacy network. As the only Standard Plan led by doctors from the North Carolina Medical Society and the North Carolina Community Health Center Association, CCH's network strategies are supported by providers and value-based approaches. This provider-focused approach closely aligns with Partners' commitment to locally based strategies and solutions.

Through our partnership with CVS Caremark (CVS), the pharmacy benefit manager (PBM), Partners will facilitate access to the safe and effective medicines that members need, reducing costs and improving member health outcomes. CVS supports Medicaid programs in 35 states with over 26 million members, including three other Medicaid PHPs (as of July 1, 2021) in North Carolina. CVS is URAC-accredited and has supported managed Medicaid clients since 1988.

Building on our strong regional partnerships, we will promote an integrated continuum of care that improves individual health outcomes, as well as the population health of the communities we serve. We will facilitate the full integration of the benefit package. Partners will offer innovative telehealth and virtual care delivery approaches and coordinate care with carved-out services.

Partners' pharmacy leadership, including our Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee, with the support of our Pharmacy Benefit Management's account team, will review Preferred Drug List (PDL) adherence data monthly to improve adherence to the PDL, the prior authorization process, and member safety and health outcomes. Pharmacies or prescribers who are flagged as outliers (e.g., having unusual prescribing or dispensing patterns) will receive peer-delivered academic detailing as follow-up including sharing of their own data compared to de-identified peers. This education will improve their understanding of therapeutic alternatives covered under the PDL.

The Partners Benefit Plan can be found on the ProviderCONNECT Portal.

In Lieu of Services and Value-Added Services

Partners has created and modified new services to meet members/recipient's needs. In collaboration with our providers and input from CFAC, we design innovative, tailored and targeted solutions to better serve members and conduct rigorous oversight to ensure services are effective. Our In Lieu of Services and value-added services demonstrate our commitment to whole person care and align with the NCDHHS vision for health and targeted public health initiatives. Our proposed In Lieu of Services and value-added services address health disparities, meet member needs and fill gaps in services. Through In Lieu of Services and value-added services, we advance the Quadruple Aim by creating services that are cost-effective, increasing access to care, applying evidence-based practices and improving member and provider satisfaction.

Our In Lieu of Services are categorized under the primary clinical outcome that the service will address. Some programs may accomplish more than one clinical objective as demonstrated within the rationale and the Medicaid State Plan service the program is in lieu of. In Lieu of Services categories include:

- Strengthening Care: Unique service offerings for members with complex needs who benefit from tailored services and approaches.
- Community Integration: Services to support members to live as independently as possible in their community.
- Emergency Department (ED) Diversion: Interventions to reduce overutilization of the ED and assist members to seek care in a more appropriate setting.
- Continuity of Care: Interventions to avoid potential gaps in care due to transitions, disaster, pandemic, or a member's individualized needs.

Partners monitors the clinical efficacy and cost efficiency of each In Lieu of Service and value-added services. Prior to implementing a new service, we identify the success factors, metrics and health outcome goals for the program. We review the data points, data sources and dashboard reporting format required for program evaluation. The Dashboard includes service utilization, clinical outcome metrics and average daily service rate data. Each quarter, we create a dashboard that contains the defined metrics, data points and trends. We provide the dashboard to the Network Management Cross Functional Team (NM-CFT) for performance evaluation.

During the first year of implementation, we monitor the In Lieu of Services or VAS quarterly to ensure rapid cycle improvement. Upon completion of the first year of a new In Lieu of Service, we complete reviews semi-annually. A listing of Partners In Lieu of Services can be found on the ProviderCONNECT Portal.

Whole-Person Integrated Care for Members and Beneficiaries

Partners and Carolina Complete Health will work together to seamlessly deliver integrated care to our members/recipients through a system of care aligned with North Carolina's Medicaid Transformation model. With shared expertise, efforts and resources, we will provide members/recipients with access to the highest quality integrated health care services, focused on each individual's unique behavioral health (BH), physical health (PH), I/DD, long term services and supports (LTSS), traumatic brain injury (TBI), pharmacy and Unmet Health-Related Resources Needs.

Refer to Partners ProviderCONNECT portal for a listing of medical and behavioral covered benefits and services, The Benefit Grids are a guide to benefit limits and documentation required for authorization. However, they are not intended to be an all-inclusive list of covered services.

Non-Emergent Medical Transportation

Partners will provide non-emergent transportation for covered services requested by the member or someone on behalf of the member. At the time of transport, the member must be eligible with Partners through a medical eligibility code that includes this benefit. Partners requests its participating providers, including its transportation vendor, to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

Language Assistance

Language Services

PartnersACCESS provides Spanish-speaking licensed clinicians to assist when needed. We also offer additional professional interpreting services within seconds, in 180 languages, through Pacific Interpreters/Fluent Interpreting Services. These services are available 24 hours a day, seven days a week, 365 days a year, free of charge, to assist any non-English speaking caller/member contact the PartnersACCESS department at 1-888-235-4673.

Deaf and Hard of Hearing

The hearing-impaired caller/ member may contact the PartnersACCESS department by using a Relay NC 711 or TTY (English) 1-800-735-2962; (Spanish) 1-888-825-6570 and then request assistance to call the PartnersACCESS number 1-888-235-4673. The Telephone Relay Service at 711 provides a communication assistant who facilitates the call and the conversation between the hearing-impaired person via their TTY and the PartnersACCESS employee.

In-Person Services

Partners requires in-network providers to have the ability to communicate appropriately with individuals in need of communication and language assistance. Providers shall offer oral interpreter and American Sign Language services both in-person and through video remote interpreting, Relay Video Conferencing Captioning, video relay services, 711 relay services, TTY machines or assisted communication devices free of charge to members/recipients seeking health care-related services in a provider's service location, 24 hour a day, seven days a week, and as necessary to ensure effective communication on treatment, medical history, health education, and any contract-related matter. Members/recipients are educated about these support services and how to obtain them through the New Member Welcome Packet and our member newsletter.

PARTNERS TP/ STATE FUNDED MEDICAL MANAGEMENT

Overview

Partners Medical Management department hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. EST. After normal business hours, Utilization Management (UM) staff are available to answer questions regarding prior authorization. Medical Management services include the areas of utilization management, care management, population health, pharmacy, and quality management. The areas are overseen by the Partners Chief Medical Officer ("Medical Director"). The Chief Medical Officer has responsibility for direct and/or clinical supervision and operation of the Clinical Services department (i.e., Utilization Management, Care Management, and PartnersACCESS) and Clinical Practice Standards (and evidence-based practices).

Partners maintains UM policies and procedures that are fully compliant with North Carolina standards. Our UM program, fully detailed in our policy, is based on Division of Health Benefits Medicaid criteria. We will use nationally recognized, evidence-based physical health (PH) and behavioral health (BH) practice guidelines and decision support methods. Partners' UM program establishes a framework for oversight and guidance of Medicaid and State-funded programs. Through established policies and processes, we will assure consistent application of service eligibility criteria when processing requests for initial and continued service authorization. Our approach supports UM and prior authorization processes for services that extend beyond mandated clinical coverage policies. Through UM, we determine medical necessity according to best practice and community standards. Partners will comply with required clinical coverage policies. To ensure consistent knowledge and application of these policies, our clinical leadership team train staff and providers on medical necessity criteria and conduct inter-rater reliability tests with UM staff.

Partners' policies and procedures will support an integrated, holistic look at physical health, long-term services and supports (LTSS), BH, I/DD and medications, noting alternative treatments or supports that may be appropriate in light of a member's complete clinical and other support needs. Our cross-functional UM team will consider a member's whole health needs. Our UM staff and medical directors make medical necessity determinations by applying clinical policy, evidence-based clinical standards of care, where available, and considering the individual member's specific circumstances and health care needs. Our UM staff enlist a variety of resources and processes to successfully implement and maintain a quality program that oversees utilization and provider quality.

These include use of:

- Established procedures to request, review and approve service authorizations
- Clinical tools and criteria to evaluate medical necessity in accordance with the North Carolina Clinical Coverage Policies
- Application of standardized UM and clinical decision-making processes through interrater reliability reviews
- Identify best practice treatment outcomes, appropriate utilization, level and intensity of services
- Review mechanisms to identify and minimize over- and under-utilization
- Implement cost-effective strategies to manage health care resources for members and recipients with high-risk and inappropriate high-utilization rate and high-costs
- Identify utilization trends and work with providers to make any needed improvements

<u>Clinical Practice Standards (and evidence-based practices)</u>

Partners develops clinical practice guidelines for behavioral and physical health management of its members that are consistent with national or professional standards and covered benefits. The following guidelines are reviewed and updated annually by Partners' Clinical Advisory Committee (CAC). It is expected that all network providers will follow the below guidelines and requirements as delineated in contracts.

For the most current version of the Clinical Practice Guidelines adopted by Partners, visit Partners' ProviderCONNECT portal. Our website contains information for providers for all UM programs, policy, and requirements at https://providers.partnersbhm.org/. https://providers.partnersbhm.org/

Partners uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The monitoring results of each guideline is reported to the Clinical Operations Committee (COC) and the Clinical Advisory Committee (CAC) quarterly.

The following are examples of clinical practice guidelines:

Clinical Practice Guideline (CPG) 1: AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder

Aspects to Track:

A. Frequency of Periodic assessment, Initial within 30 days (recommendation #12 under treatment section, presence of a follow-up visit during the 30-day initiation phase for 6-12-year-old prescribed ADHD medication).
B. Frequency of Periodic assessment, at least two follow-up visits within 9 months after initial (recommendation #12 under treatment section, presence of at least two follow-up visits 9 months after IPSD for 6-12-year-old prescribed ADHD medication).

Clinical Practice Guideline (CPG) 2: CDC: Guidelines for Prescribing Opioids for Chronic Pain (2016)
Aspects to Track:

A. History of Substance Use Disorder.
B. Use of State Prescription Drug Monitoring Program.
C. Use of State Prescription Drug Monitoring Program.

Clinical Practice Guideline (CPG) 3: APA: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition (2010)

Aspects to Track:

A. Presence or absence of treatment (Depression Care Quality: Patient with a diagnosis of depression who is not receiving treatment).
B. Quantity of treatment if receiving psychotherapy (recommendation under depression treatment, acute phase choice of an initial treatment modality plus detailed review and evaluation in treatment planning phase).

Compliance expectations and requirements for these guidelines are reflected in Partners Practice Guidelines Policy (13.09) and the Provider Operations Manual, including notification to the provider stating adherence to these guidelines will be monitored. Provider compliance may be monitored in the following ways:

- Focused audits completed via Utilization Reviewer and others as appropriate and applicable.
- Routine review of Service Authorization Requests/Prior Authorization requests (identifying any areas of concern).
- Peer Review activities.
- QOC Committee activities.
- CAC activities.
- Medical record audits by the QM department Monitoring Team.
- Program Integrity monitoring, if indicated.

Partners clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Partners adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Partners providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by Partners.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric HealthCare
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Partners, visit our website at providers.partnersbhm.org

Evidence-Based Practices (EBP)

Use of evidence-based practices provides a structured method of higher quality service provision. EBPs have outcome data that demonstrate the effectiveness of the program if there is adherence to the fidelity of the program. Most EBPs include training programs, ongoing consultation and fidelity measures to ensure effectiveness. Partners encourages the use of EBPs that meet four criteria.

Partners' Criteria for Selected Evidence-Based Practices:

- Must be registered with the National Registry of Evidenced Based Programs and Practices (NREPP), California Evidenced-Based Clearinghouse (CEBC) or Washington State Institute for Public Policy (WISPP) (can be emerging or promising practices).
- Must include the training of non-licensed direct care staff.
- Must include continuous quality control practices.

- Must include outcomes measures.

In addition to models meeting the above listed criteria; Partners accepts the EBPs listed on the website at https://providers.partnersbhm.org/evidence-based-practices/.

Evidence-Based Practices are interventions, treatments, and programs that are proven effective in producing specific positive outcomes. These methods are based in solid research and study to produce positive changes in individuals. Partners encourages our network providers to adopt and use evidence-based practices as part of the treatment array. The use of evidence-based practices ensures that we are offering the best available treatment and services to our members.

The following are some evidence-based practices that Partners encourages providers to adopt and use.

Assertive Community Treatment Team (ACTT)

Assertive Community Treatment Team (ACTT) consists of professionals who use a team approach to meet the needs of those with severe and persistent mental illness. Teams are composed of, at a minimum, a licensed behavioral health clinician, psychiatrist, nurse, substance use specialist, vocational specialist and peer specialist. ACTT serves as the single point of responsibility in addressing all the needs for those whose functioning is impaired by a serious mental illness. It is intended to help those with a significant history of hospitalization, homelessness and/or incarceration. A fundamental feature of ACTT is that many services are provided outside of an office and in the member's home or in another community location. ACTT teams have staff available 24 hours a day, 7 days a week, and 365 days a year.
This service/evidence-based practice is designed for adults, 18 years and older, who are diagnosed with severe and persistent mental illnesses (such as schizophrenia, schizoaffective disorder, and bipolar disorder). These illnesses are more likely to cause long-term psychiatric disability. ACTT has been found to help those who have not benefitted from traditional office-based services and has a history of frequent mental health crises and functional impairment.
ACTT is not intended for the treatment of a primary diagnosis of substance use disorders, intellectual and developmental disabilities, borderline personality disorder, traumatic brain injury or autism spectrum disorder.

Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy (DBT) is a structured outpatient treatment, as defined by Marsha Linehan, PhD, which combines strategies from behavioral, cognitive, and other supportive psychotherapies. DBT services encompass individual therapy, DBT skills group, therapeutic consultation with the beneficiary on the telephone and the therapists' internal consultation meeting(s). Through an integrated treatment team approach to services, DBT seeks to enhance the quality of the member's life through group skills training and individual therapy with a dialectical approach of support and confrontation.
DBT is a comprehensive cognitive-behavioral treatment for difficult to treat mental health disorders. Although originally developed for chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with borderline personality disorder (BPD). DBT is a recognized and highly respected Evidence-Based Practice for adults. It is considered by the American Psychological Association and the American Psychiatric Association to be a "best practice" and a "first line" treatment option for individuals who suffer from borderline personality disorder.
DBT is an appropriate treatment modality for adults who are experiencing chronic instability with episodes of serious affective dysregulation and dangerous impulsivity, which results in self-injury and high utilization of both health and mental health resources. Persons suffering from BPD react abnormally to emotions; they often refuse to cooperate in the therapeutic setting, experience intense rage and impulsively self-injure.
DBT treatment is comprised of both individual and group therapy per the DBT model. In addition, DBT trained staff are available for phone coaching if needed for crisis between sessions to gradually lessen parasuicidal behavior and crisis

episodes. Staff receive specialized training on the Linehan Institute's DBT model but are also expected to continually participate in a DBT Consultation Group. This ongoing support helps mitigate burnout with high intensity consumers and offers oversight for providers to assure adherence to the DBT model. Individual therapy usually occurs weekly and DBT Skills Group occurs one to two times weekly. The focus of the group therapy is to teach skills that are needed to enhance the member's life; Individual therapy is aimed at identifying issues that the member confronted during the past week and developing a treatment strategy to address those issues by applying DBT skills learned. For DBT to be effective, individuals participating in DBT must agree to do related homework, which includes daily "diary cards" that track more than 40 emotions, urges and behaviors, such as lying, self-injury or self-respect. The diary cards are used to identify the individual's skill needs and current use of skills.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is an evidenced based form of individual psychotherapy designed to reduce trauma-related stress, anxiety and depression symptoms. EMDR is primarily used in the treatment of posttraumatic stress disorder (PTSD); however, literature shows successful treatment of other mental health problems. Treatment is provided by an EMDR-trained therapist. Therapists work with members to identify a positive memory associated with feelings of safety or calm that can be used to reduce the psychological distress associated with traumatic memories. To achieve that response, EMDR uses repetitive motor exercises during which members attend to the exercise while focusing on changing their thoughts and reactions to traumatic memories. The most common motor task used in EMDR is side-to-side eye movements that follow the therapist's finger. Exercises are repeated until the client reports no emotional distress. EMDR is well researched in treating adults. Although, interventions have been developed for use with children and adolescents. The number of sessions varies with the complexity of the trauma being treated.

Family Centered Treatment (FCT)

Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children, adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions. Children and adolescents eligible for FCT may be facing involvement in the juvenile justice system, out-of-home placements and/or reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse) and/or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of recidivism. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate trauma-focused treatment.
FCT is delivered by an assigned Quality Professional. FCT is supervised by a trained FCT supervisor, or an FCT supervisor in the process of completing FCT Supervisor Certification. A distinctive aspect of FCT is that it has been developed as a result of front-line Quality Professionals' effective practice. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis, as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

High Fidelity Wraparound (HFW)

High Fidelity Wraparound (HFW) is built on system of care values. HFW is an ecological model described through ten principles: *Family "voice and choice," Team Based, Natural Supports, Collaboration, Community-based, Culturally Competent, Individualized, Strengths Based, Persistence or Unconditional Support and Outcome Based*. It is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who:

- are involved with multiple systems;
- are experiencing serious emotional or behavioral difficulties;
- have dual diagnosis (MH and/or SUD, and IDD) with complex need;
- are at risk of placement in PRTFs or other insti-tutional settings; and/or
- are aging out of Department of Social Services (DSS) care.

It is designed to facilitate a collaborative relationship among youth with SED (serious emotional disorder), his/her family and other involved child-serving systems.

High Fidelity Wraparound (HFW) team facilitates care planning and coordination of services; provides access to family and youth peer support services; establishes a strengths-based individualized child and family team plan; and addresses youth and family needs across domains of physical and behavioral health, social determinants of health and natural supports. The HFW Team consists of a Facilitator, Family Partner and/or a Youth Partner. Each team must have access to a Supervisor/Coach. Each Facilitator may serve 10-12 families. The HFW Facilitator is a Qualified Professional who coordinates the development of a Child and Family Team (CFT). This includes development of a Crisis/Safety plan to address needs and goals developed by the family, convening CFT meetings, coordination and communication with the Team members and working with family to integrate information from multiple sources into the strengths, needs and culture discovery. The Coach/Supervisor is a Licensed or Associate Licensed Professional who provides supervision, ongoing consultation and crisis support. The Family Partner must have lived experience as a primary caregiver for a child who has/had mental health or substance abuse challenges. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) to provide information and support throughout the care planning process. The Youth/Young Adult Peer Partner must have lived experience with mental health or substance abuse challenges and have experience in navigating any of the child and family-serving systems to provide support, encourage leadership and camaraderie.

HFW activities are grouped into four phases:

1. Engagement and Team Preparation: 2-4 weeks, initiates a strengths-based, non-judgmental engagement process.
2. Plan Development: 1-2 weeks, includes a discussion of treatments and strategies that have been successful in the past and identification of individuals who play key roles in the life of the youth and family.
3. Plan Implementation: 2-12 months, work with the family to build the transition assets that will prepare the family to move forward successfully after HFW ends. This includes transferring responsibility to the family and natural supports.
4. Transition Phase: 1 meeting to ensure successful transition.

The expected outcomes for HFW include the following:

- Decrease frequency or intensity of crisis episodes;
- reduction in symptomatology;
- engagement in the recovery process;
- increased ability for self-advocacy and resource gathering; and
- increased use of available natural and social supports.

Multisystemic Therapy (MST)

The purpose of Multisystemic Therapy (MST) is to keep youth in the home by delivering intensive therapy to the family within the home. The service is delivered through a team approach to youth and their families. MST is a service, supported by evidence-based practice and designed to address the needs of children and adolescents with significant behavioral problems. The children receiving this service are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the home and community.

MST includes a variety of therapeutic and crisis interventions for those with mental health or substance abuse issues. MST has solid evidence of effectiveness as a treatment for problematic substance use in adolescents and is promoted

by the National Institute on Drug Abuse. Services are available at home, at school and in other community settings. The duration of MST intervention is three to five months. MST involves families and other systems such as the school, probation officers, extended families and community connections.
Ideally, this service is delivered by a masters-level therapist supporting a caseload of four to six families. The therapist provides most mental health services and coordinates access to other important services (e.g., medical, educational and recreational). While the therapist is available to the family 24 hours a day, seven days a week, the direct contact hours per family varies according to clinical need.
Generally, the therapist spends more time with the family in the initial weeks of the program (daily, if needed) and gradually tapers off (as infrequently as once a week) during a three-to-five-month course of treatment. Treatment fidelity is maintained by weekly group supervision meetings involving three to four therapists along with a doctorate- or advanced masters-level clinical supervisor.
The goals and progress of each case are reviewed during group supervision to ensure the multisystemic focus of the therapists' intervention strategies, identify barriers to success and facilitate the attainment of treatment goals. In addition, an MST expert consultant reviews each case with the team weekly to promote treatment fidelity and favorable clinical outcomes.

MST-PSB (Multisystemic Problem Sexual Behavior) is designed for sexual offenders and delivered similarly to standard MST. It focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior. Treatment includes:

- Reducing parent and youth denial about sexual offenses and their consequences;
- Promoting development of friendships and age-appropriate sexual experiences; and
- Modifying the individual's social perspective-taking skills, belief systems or attitudes that contributed to sexual offenses.

Intervention is individualized for each family; families are provided family therapy and the youth receives individual therapy. Services are delivered over a period of five to seven months. Therapists have three to five families on their caseloads and members of the team rotate to cover. Team members are available to respond to crises 24 hours a day, seven days a week.
This service is designed for youth generally between the ages 12 through 17 who:

- Have antisocial, aggressive or violent behaviors;
- Are at risk of out-of-home placement due to delinquency;
- Adjudicated youth returning from out-of-home placement;
- Chronic or violent juvenile offenders; or
- Youth with serious emotional disturbances or a substance use disorder and their families.

Psychosocial Rehabilitation (PSR)—Clubhouse Model

The Psychosocial Rehabilitation (PSR) service is designed to help adults with psychiatric disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice, with the least amount of ongoing professional intervention. The goal is to contribute to the individual's recovery through a therapeutic environment that includes responsibilities within the clubhouse, as well as through outside employment, education and meaningful relationships. PSR focuses on developing skills related to one's life in the community and to increase the person's ability to manage their illness and live as independently as possible.
The Psychosocial Rehabilitation- Clubhouse Model is an evidence-based practice that has proven to help people achieve and maintain recovery. People who participate in the Clubhouse are called "members." Fundamental elements of participation include openness and choice in the type of work activities, choice in staff and a lifetime right of reentry and access to Clubhouse services. Each person is welcomed, wanted, needed and expected each day. They are considered a critical part of the PSR community.

The day-to-day operation of the Clubhouse is the responsibility of members and staff who work side by side in a rehabilitation environment. Clubhouse staff function as generalists who maintain a caseload, including managing employment placements, housing issues, and access to community supports. The service is based on the principles of recovery, including skill building in daily living (personal care, housekeeping, shopping/cooking, money management, educational/employment, use of transportation, etc.), social and interpersonal relationships, leisure activities and educational/vocational domains. The emphasis is on improving functioning in real world environments and allowing time for interventions to have an effect over the long term.

Services are available at least five days per week and may include weekends or evenings. Attendance is voluntary and participation can be as little or as much as members choose.

Psychosocial Rehabilitation (PSR) is designed for adults with psychiatric disabilities to help improve their daily functioning in the areas of education/employment, money management, accessing community resources, social skills and/or personal care. PSR is not available to those receiving Assertive Community Treatment Team (ACTT) services.

Utilization Management

Partners' Utilization Management (UM) department's function is to make authorization decisions by conducting initial, continuing care and retrospective reviews of services based on whether medical necessity is substantiated in the request for authorization. The UM department utilizes guidelines based on the *North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies* and *Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH) State-funded Service Definitions.*

Partners' UM program will help sustain an integrated, well-coordinated system of care for members and recipients that addresses their BH, PH, LTSS, TBI, I/DD, pharmacy and Unmet Health-Related Resource Needs. Our UM process brings together CCH and Partners' expertise to create an integrated approach. Partners' (UM clinicians, care managers, medical directors and pharmacy staff) and CCH staff will work side-by-side to best meet members' whole health needs.

Our multi-disciplinary care teams will connect in a similar seamless fashion with the CVS clinical pharmacy team members to ensure medication interventions are coordinated with all utilization to ensure a whole person approach to all care decisions. Through their daily work, our teams will collaborate to ensure members and recipients have access to the right services and providers to achieve their health and recovery goals.

Partners' UM staff will consult with co-located CCH staff when evaluating requests for PA, particularly for requests related to members with complex PH and BH needs. In instances where the request is primarily related to PH needs, we will rely on CCH's expertise and appropriate clinical guidelines to determine medical necessity. For all PA requests, we will ensure that staff have the expertise to make an appropriate determination. Further, our policies and procedures will incorporate processes for applying an integrated approach.

Partners' integrated UM process is supported through data-sharing, integrated clinical leadership and integrated oversight. Our UM process will support an integrated, holistic look and note alternative treatments or supports that may be appropriate in light of the individual's clinical and other support needs. UM staff will consider member/recipient whole health needs. For example, if a member is admitted to an inpatient psychiatric facility, we train and alert UM staff to look for co-morbid physical conditions co-occurring with and/or triggering the member's current condition. Key features include:

Single, Centralized UM Platform. Our care management platform, TruCare will house all PH, BH and UM authorizations in a single view. The system will be fully integrated with our claims system and provide a complete view of each individual's health record, medication history, unmet health-related resource needs, claims history, authorizations and care plans/individual service plans. All clinicians and service providers will have access to this single source of member information when considering authorization decisions and utilization trends. We integrate our electronic visit verification system into TruCare, allowing us to monitor timely service delivery, ensure delivery of authorized Long Term Supports and Services (LTSS) and facilitate efficient claims submission and payment.

Integrated Clinical Leadership and Staff. Partners' clinical leadership, with support from CCH, will represent BH, PH, pharmacy, LTSS and social service expertise. We will leverage our significant experience in North Carolina to design and implement cohesive population health strategies and improve health outcomes. Our medical directors will conduct joint clinical rounds and offer consultations about members and recipients with complex and co-morbid needs. We will conduct multidisciplinary rounds on a weekly basis to closely coordinate care for members. This approach determines root cause of service utilization (e.g., inpatient admission), an appropriate path for discharge or intervention and removes level of care barriers. All Partners staff will operate under a single set of fully integrated policies aimed at operational integration.

Integrated Oversight. The Clinical Operations Committee (COC), a subcommittee of the QIC, meets no less than quarterly. The committee monitors use of clinical resources and provides support to ensure services are only delivered for authorized purposes, uniformly available to members/recipients and provided effectively and efficiently. The COC assures availability of high-quality care by evaluating service delivery, clinical practices, program eligibility determination and service authorization decisions. This committee implements the UM program and is comprised of BH, PH, pharmacy, I/DD and LTSS staff who review Partners clinical programs and ensure the overall needs are met for the members/recipients we serve.

Our unique North Carolina experience and dedicated local leadership demonstrate our ability to reduce administrative burden and serve as responsible stewards of NCDHHS resources.

Through our shared experience with CCH, we will promote integration through:

Accessible, User-friendly Information on UM Activities. Our provider portal, ProviderCONNECT, includes information on UM activities, PA processes, clinical proactive guidelines, clinical criteria and benefit grids, as well as a link to our provider knowledge base website. This website offers links to clinical criteria checklists (for PH, BH, LTSS, I/DD, TBI and pharmacy services), coverage policies, practice guidelines and Partners' and State-funded Service definitions. Our website contains information for providers for all UM programs, policy, and requirements at https://providers.partnersbhm.org/

Provider Education. Partners offers orientation sessions monthly for new BH/IDD Tailored Plan/PIHP network providers and providers who need or want a refresher on processes and resources. This orientation will include information on the Tailored Plan integrated care model and how to access the full-service array. Partners' Provider Network account specialists and Care Management monitoring team will provide online, face-to-face and telephonic education and technical assistance on claims submission and PA processes to

newly contracted providers. We notify providers of changes to UM or PA processes at least 30 days prior to implementation or in accordance with Department mandates.

Bi-Directional Communication. Partners' UM and Claims representatives participate in monthly provider council meetings. Partners has provider representation on our Clinical Advisory Committee, QIC and Quality of Care Committee. Our learning collaboratives also offer bi-directional communication between providers and UM staff.

Peer-to-Peer (P2P) Consultation. Based on provider feedback, Partner's UM team revised our P2P consultation process, which now encourages pre-decision authorization conversations with the CMO or designee for specific providers and post-decision P2P conversations conducted by our CMO or designee, when availability permits.

Partners' UM program, fully detailed in our UM program policy, will be based on Division of Health Benefits (DHB) Medicaid criteria; nationally recognized, evidence-based practice guidelines (for PH, BH, LTSS, I/DD, TBI and pharmacy services); and decision support methods. The UM program policy will create a framework for oversight and guidance of Medicaid and State-Funded Services by applying service eligibility criteria and processing requests for initial and continued authorization of services.

Partners maintains UM policies and procedures that are fully compliant with North Carolina standards. Our UM program, fully detailed in our policy, is based on DHB Medicaid criteria. We will use nationally recognized, evidence-based physical health (PH) and behavioral health (BH) practice guidelines and decision support methods.

Partners' UM program establishes a framework for oversight and guidance of Medicaid and State-funded programs. Through established policies and processes, we will assure consistent application of service eligibility criteria when processing requests for initial and continued service authorization.

Under the leadership of our Chief Medical Officer (CMO), we tailor our UM program to align with each unique North Carolina requirement. As an Organization with over eight years of experience in the state, we have direct practical understanding of how to implement the NCDHHS required clinical coverage policies. Our approach supports UM and prior authorization processes for services that extend beyond mandated clinical coverage policies. Through UM, we determine medical necessity according to best practice and community standards.

Partners develops our UM program policy with participation and oversight from our CMO, Chief of Benefits and Services and the Deputy Chief Medical Directors. We rely on consultation with Provider Network staff and current evidence-based practices, such as industry standard clinical practice guidelines.

Partners (UM clinicians, care managers, medical directors and pharmacy staff) and CCH staff will work side-by-side to best meet members' whole health needs. Through this team's daily work, staff will collaborate to ensure members and recipients have access to the right services and providers to achieve their health and life goals.

Partners will comply with required clinical coverage policies. To ensure consistent knowledge and application of these policies, our clinical leadership team apply medical necessity criteria and conduct inter-rater reliability tests with UM staff.

Partners does not offer incentives to Utilization Management employees or providers to deny, reduce, terminate, or suspend, limit or discontinue medically necessary services to any member. There are no financial rewards for UM decision makers that would discourage approval of services. Decisions made by Partners' UM are based only on the appropriateness of care, the service requested, and existence of coverage.

State-Funded Services utilize Benefit Plan Eligibility criteria that crosswalk from the member's diagnosis, age, disability group and other designated criteria. The State Benefit Plan then crosswalks to the Array of Services available to members that meet the requirements of a specific Benefit Plan. The most current version of State Benefit Plan Criteria can be found on the NC Division of MH/DD/SAS website.

Prior Authorization and Notifications

Prior authorization is a request to the Partners' Utilization Management (UM) department for approval before start of services. Authorization determinations will be communicated to the provider via fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. Partners utilizes an information technology system to receive request for authorization. The information is entered into a Service Authorization Request (SAR)/Prior Authorization (PA) request. As a participating provider with Partners, it is important to understand the requirements for both the SAR/PA and Referral processes to ensure members do not experience any disruption in care, and claims are paid in a timely and accurate manner.

Authorization must be obtained prior to the delivery of certain services. The PCP should contact the UM department via telephone, fax or through the provider portal with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization. Please refer to Partners website for a listing of Medical and Behavioral covered Benefits and Services Grids https://providers.partnersbhm.org/benefit- grids/ for most up-to-date benefit limits and documentation requirements. These Benefit Grids are not intended to be an all-inclusive list of covered services.

Emergency department and crisis services never require prior authorization. Providers should request authorizations from Partners for **inpatient admissions within 72 hours** of the admission. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Partners providers are contractually prohibited from holding any Partners member financially liable for any service administratively denied by Partners for the failure of the provider to obtain timely authorization. For a list of services requiring prior authorization please see the Partners Providers Knowledge Base Website Benefit Grids linked above.

Alternative Methods for Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the ProAuth system used by Partners' UM. Providers may contact the Service Desk, 704-842-6431, to request login information and assistance.

For circumstances when ProAuth cannot be utilized, emergent SAR/PAs can be processed:

- **Live Review by Phone**: (For Acute Services only) Provider Staff will need to call 704-842-6434 to reach UM from 8 a.m. to 6 p.m., seven days per week, including weekends and holidays. The UM staff will collect information detailed on the UM Review Form.
- **Manual Review By Fax or Email:** A **Manual Service Authorization Request Form** must be completed to include **all accompanying documentation**. Manual Service Authorization Request Form can be found at https://providers.partnersbhm.org/utilization-management/.
    - Email Address:
        - Behavioral Health, I/DD, TBI Requests: BHIDDManualAuthorizations@partnersbhm.org
    - Fax Numbers:
        - I/DD & TBI Requests: 704-884-2690
        - Inpatient Requests: 704-884-2703
        - MH & SU Requests: 704-884-2701

Authorization Determination Timelines

Partners' Utilization Management decisions are made as expeditiously as the member's health condition requires.

Services are expected to be requested on or before the start date. The following are exceptions:

- Basic Outpatient Services to include but not limited to Individual, Family and Group Therapy visits are unmanaged.
- Emergency/Crisis Services.
- Services that indicate a "*pass-through"* in the service definition.
- Codes agreed upon by Partners as not requiring authorization or having a pass-through and indicated on the Medicaid and State-Funded Benefit Plans, located on the Partners website.

Partners must decide and provide notice within 14 calendar days of receiving a standard request for authorization of service with a possible extension of an additional 14 calendar days if:

- The member or provider requests an extension, or
- Partners can demonstrate to North Carolina Division of Health Benefits (DHB) that there is need for additional information and the delay is in the member's best interest.

Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum

functioning. Partners must decide and provide notice within 72 hours for a prospective or initial and concurrent request. Expedited concurrent requests are reviewed within 24 hours of the received request. There is also the option of an extension of an additional 14 calendar days if:

- The member or provider requests an extension on behalf of the member, or
- Partners can demonstrate to North Carolina DBH that there is a need for additional information and the delay is in the member's best interest.*

Clinical Coverage Policy 8B, allows a hospital **up to 72 hours from time/date of admission** to notify an LME/MCO of the admission. If Initial SARs are submitted within 72 hours of admission, Partners' UM will review back to the first day of treatment. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners' medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

If SARs are submitted after the first 72 hours, UM will review for the 72 hours prior to the submission date of the SAR and will not process days outside of that 72 -hour timeframe.

Transplant Authorizations

PIHP/Medicaid Direct – Providers will continue to bill NC TRACKS for these services for Medicaid Direct members.

The Centralized Transplant Unit (CTU) is responsible for medical necessity review for all transplant services. Prior authorization requests for transplant services should be submitted by the provider rendering the beneficiary's transplant care (i.e., transplant coordinator from the facility where the evaluation and listing services will be performed). In the event a prior authorization request is received by Partners, the request should be redirected to the CTU fax number 1-866-753-5659.

The transplant review process begins when a request is received by the CTU. Requests are reviewed by a CTU clinical nurse coordinator. The transplant review process is complete when written notification of a determination for the request is sent to the member and requesting provider.

The CTU does not review requests for corneal transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy; or CAR-T therapy. HLA Typing/Stem Cell Collection/Donor Search and Transplant Consultation at an in-network facility (1 visit) will be approved by the CTU without medical necessity review.

Transplant Centers

All organ transplant providers should meet the CMS Conditions of Participation (CoP)s for clinical experience, data submission and outcome and process requirements. These criteria focus on the transplant program's ability to perform successful transplants and deliver quality patient care.

Transplant Evaluations

Transplant evaluations are pre-transplant diagnostic testing and services that determine a member's candidacy for transplantation.

A transplant evaluation request by an in-network provider can be approved after nurse review if all necessary documentation has been provided. If all necessary documentation has not been provided the case is referred to the Partners medical director for review and determination. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide at 1-866-447-8773.

To avoid delay in authorization, all required clinical documentation must accompany the request.

If the request is from an out of network provider (OON) provider, the case is referred to the Partners medical director for review and determination.

Transplant evaluations are authorized for a total of 12 visits to be completed within a six-month time frame. At times, additional visits may be necessary and should be requested by the provider prior to the authorization expiration. If additional visits are requested after the authorization expiration; the provider must submit new clinical documentation for review and determination.

Transplant Listings

Once the member has completed the transplant evaluation process, the provider may request the member be listed for the transplant. Transplant listing requests must be accompanied by clinical documentation that supports the need for the type of organ(s) requested. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide.

To avoid delay in authorization, all required clinical documentation must accompany the request. A transplant listing requested by an in-network provider may be approved by the nurse coordinator if all necessary documentation has been provided and if it meets all aspects of the pertinent Clinical Policy or appropriate medical necessity criteria. If all necessary documentation has not been provided, or if the documentation submitted does not support medical necessity, the nurse coordinator will refer the case to the Partners medical director for review and determination.

If the request is from an out of network provider, the nurse coordinator will refer the case to the Partners medical director for review and determination.

Once approved, transplant listings are authorized for a period of 12 months. If the candidate has not received the transplant within the 12-month timeframe; the provider must submit a request for a new authorization with updated clinical documentation.

Out of Network (OON) Transplant Providers

All Transplant Evaluation and Transplant Listing requests from OON providers, or from facilities that do not meet CMS approval requirements must be approved by the Partners medical director regardless of the outcome of the CTU medical necessity review process.

Adverse Determinations

All adverse determinations will be issued by the Partners Medical Director, Partners Chief Medical Officer or Deputy Chief Medical Directors.

If additional and/or clarifying information is needed due to insufficient or conflicting information obtained during the Level I review, the Partners Medical Director may discuss the case with the managing physician. Only the treating physician/provider may participate in this peer- to-peer discussion.

Treating practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer.

At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the CTU nurse notifies the requester of the opportunity for the treating physician to discuss the case directly with the CTU Medical Director or applicable practitioner reviewer making the determination. The peer-to-peer process is also included in the written denial notification.

Out of Network Transplant Financial Determinations

The CTU will work with the Partners to coordinate contract negotiations for payment of transplant services rendered out of network.

If a financial agreement cannot be reached, or if a facility is denied for any other reason, it is the responsibility of the CTU and the Partners medical director to work with the requesting provider to coordinate services at an approved facility.

Transplant Continuity of Care Requests

Requests for authorization for transplant services through continuity of care (COC) must be accompanied by appropriate documentation and requested within the COC timeframe specified by the contract. Continuity of Care Requests will be initially reviewed by the nurse coordinator. In the event that determinations are not able to be made with the information provided, it will be sent to the Partners medical director for review and determination. Requests for continuity of care authorization must include the following:

- Documentation of previous insurer coverage, such as if previously covered by state Medicaid fee for service
- Documentation of authorization for coverage of transplant evaluation or listings by previous insurer
- Copy of member's United Network for Organ Sharing (UNOS) listing

Duration of Authorizations

Providers not considered in-network for transplant services for Partners must reach a payment agreement. If a financial agreement cannot be made, the CTU will help to identify an in-network provider that can ensure the member's health care needs are met.

Second and Third Opinions

Members or a provider with the member's consent may request and receive a second opinion from a qualified professional within the Partners network. If there is not an appropriate provider to render the second opinion within the network, it may be obtained from an out-of-network provider at no cost to the member. In-network and out-of-network providers may require prior authorization by Partners when performing second and third opinions.

Members and recipients, legally responsible person or healthcare professional with member's consent, may seek care from licensed, qualified out-of-network providers when a network provider is not available for the covered service, member does not agree with the diagnosis, treatment, or the medication prescribed or the member is seeking a second opinion.

To qualify as an out-of-network provider, we confirm the following:

- Member/recipient enrollment with Partners
- Provider enrollment as a Medicaid provider in NCTracks
- Out-of-network services are authorized as medically necessary per benefit plan limits or requested by the member for a second opinion

Once confirmed and as soon as the member's or recipient's condition warrants, but no later than one business day, we execute a single case agreement with the provider that defines reimbursement and payment terms in accordance with contract requirements such as term of the contract, services approved to provide, authorization process and expectations for service delivery and documentation.

Once a member's/recipient's immediate needs are met, our network development staff contacts the provider and invites the entity to join our provider network in accordance with our Good Faith Provider Contracting Policy.

For emergent situations, we expedite the single case agreement process and conduct priority authorization reviews in accordance with required timelines, based on the member's needs. In non-emergent situations, our utilization management (UM) reviewer reviews the request, renders a decision and communicates the determination to the requesting provider and member/recipient. Network development staff contacts the out-of-network provider and educates them on our UM and claims submission policies, scope of the authorization and any requirements for submitting clinical information or collaborating with the member's/recipient's care manager to manage transition of care or update the Care Plan/Individual Service Plan.

Partners will honor member/recipient transfers from other LME/MCOs, as required. For example, if a member who participates in the Innovations Waiver transfers to Partners from another Tailored Plan and was receiving services from an out-of-network provider, the member has the right to continue services with their existing provider. Partners will offer the provider a single case agreement that includes continuity of care provisions.

Educating Members and Recipients about Out-of-Network Services

Member and recipient services, service line staff and care management staff educate all members and recipients about accessing out-of-network services, including obtaining second opinions from out-of-network providers, as long as the provider is not excluded from participation in federal health care programs. Our Member and Recipient Handbook, Innovations Member and Family Handbook and TBI Handbook will clearly explain how members/recipients can obtain benefits from out of network providers and the right to a second opinion.

<u>Clinical Information</u>

For all services on the prior authorization list, documentation supporting medical necessity will be required. If additional clinical information is required, UM staff will notify the provider of the specific information needed to complete the authorization process.

Partners UM staff may request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical and behavioral health information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Partners is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Partners Benefit and Services Grids identify necessary information to be included with SARs/PAs. Failure to submit necessary clinical information can result in an adverse decision. Refer to Partners website for a listing of Medical and Behavioral covered Benefits and Services Grids: https://providers.partnersbhm.org/benefit-grids/ for most up-to-date benefit limits and documentation requirements. The Benefit Grids are not intended to be an all-inclusive list of covered services.

Documents Required for Authorizations

Specialty Outpatient Services:

* Service Authorization Request/Prior Authorization (SAR/PA):

- Person Centered Plan or Basic Treatment Plan.
- Service Order.
- Other documents required per Service Description.
- Comprehensive Clinical Assessment (CCA) or other evaluation.
- Discharge plans.

Enhanced Benefits (Including Residential and PRTF):

- Service Authorization Request/Prior Authorization (SAR/PA).
- Person Centered Plan.
- Comprehensive Clinical Assessment (CCA) or other evaluation.
- Other Documents required by DHB Clinical Coverage Policy and state and federal regulations.
- For PRTF, a Certificate of Need (CON) is required prior to admission.
- Service Order.

Innovations/ICF-IID Facilities:

- Service Authorization Request/Prior Authorization (SAR/PA).
- Individual Supports Plan (ISP).
- I/DD Health Risk Assessment (Innovations only).
- NC Support Needs Assessment Profile (NC-SNAP) or Supports Intensity Scale (SIS).
- Innovations Level of Care Form (replaces MR-2).
- ICF-IID requires updated Level of Care (LOC) every six months.

- Any psychological testing specialty or medical assessments that apply.

Additional Requirements for Valid or Complete Requests:

A Valid Request for Medicaid Members must contain:

- Member Name/Address/DOB/MID.
- Identification of Service or Procedure Code.
- Name and NPI of Provider to perform service.
- Provider location if the request is for an ambulatory or office procedure.
- Date the service is requested to begin or proposed surgery date if the request is for a surgical procedure.
- Consistent information throughout the request (i.e., name and MID matching).
- Behavioral health diagnosis must be covered by the benefit plan.
- All required signatures on forms required by statute, and/or any documents or forms required by state or federal statute.
- A valid ICD-10 diagnosis.

Clinical Decisions

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Partners Medical staff, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria.

Partners' Utilization Management (UM) department's function is to make authorization decisions by conducting initial, continuing care and retrospective reviews of services based on whether medical necessity is substantiated in the request for authorization. The UM department utilizes guidelines based on the North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-funded Service Definitions and McKesson InterQual® Criteria. Partners does not offer incentives to Utilization Management employees or providers to deny, reduce, terminate, or suspend, limit or discontinue medically necessary services to any member. There are no financial rewards for UM decision makers that would discourage approval of services. Decisions made by Partners' UM are based only on the appropriateness of care, the service requested, and existence of coverage. A State Benefit Plan does not apply to members who are only receiving Medicaid services. The most current version of State Benefit Plan Criteria can be found on the NC Division of MH/DD/SAS website.

Denial Process

Services provided without pre-authorization will be denied.

If present, the following elements will keep a request from being processed:

- Duplicate Requests (the latter of the two to be UTP).

- Per diem service and dates/units that do not match.
- Service Authorization Request for a service that does not require authorization.
- Incorrect Service Code (e.g., requesting ALL for non-therapy package).
- Retrospective request that does not meet criteria in policy.
- Service Exclusions for Adults.
- Member is not enrolled or registered in Alpha+.
- Request for something not covered.
- SAR submitted more than 30 days prior to start date.
- Contract issues.

The SAR will be marked as an Incomplete Request and an Administrative Denial is issued if any of the information as requested (see list below) is not received.

- Comprehensive Crisis Plan (CCP) when applicable.
- CCA where indicated in Clinical Coverage Policy.
- A complete PCP/Service Order/ISP with all pages, services, and service units present and accurate.
- Attestation Statement for members required to have Child and Family Team (CFT) meetings or assignment of Treatment Accountability for Safer Communities (TASC) manager.
- LOC Forms.
- NC SNAP or SIS.
- Individual Budget (Innovations) is correct and complete.
- Attestation of the previous l Level of Care Form and supporting documentation for ICF-IID member.
- Risk Support Needs Assessment (Innovations).
- Documentation for ICF-I/DD.
- Letters of medical necessity required quotes, MD orders (Innovations).
- Orders, Individual/Family Support Documents (self-direction only, Innovations).
- All required signatures on forms (PCPs, ISP, Redetermination and Freedom of Statement).
- Certificate of Need (CON).

*Service Exclusions for Children under 21 years of age and covered by Medicaid must be reviewed under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

When the request is missing items (from the list above) that result in an incomplete request, Partners' UM staff communicates what is missing to the provider. If this information is not received the designated amount of time, the request is deemed an Administrative Denial with appeal rights.

If all the required information has been submitted and the request is complete, but the information is illegible or there is still insufficient clinical information to determine medical necessity, the initial reviewer attempts to collect the needed information from the provider within the applicable prospective, concurrent, and

retrospective timeframes. If the provider does not respond to the request within the allotted amount of time, the request will be denied as an Administrative Denial with appeal rights.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorizations within the standard time frame (i.e.,14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for an initial request. Concurrent Inpatient requests are reviewed within 24 hours of the receipt of the request.

Discharge Review:

Providers are highly encouraged to submit Discharges for members with only State-Funded Services.

Providers are highly encouraged to submit Discharges for members with only Enhanced Medicaid services.

Providers are highly encouraged to submit Discharges for members with state and Medicaid services.

Providers are highly recommended to submit a Discharge Request via the Discharge Module in Alpha+ for State-funded Benefit members. This includes members who have State-Funded Services only, as well as state and Medicaid funded services.

When initiating discharges for members having substance use issues, the required SU fields (noted by yellow box beside the field) must be completed by the provider initiating the discharge. In the event the discharge is determined to be a full discharge by the LME/MCO, all existing diagnosis, SU fields, target pops and state insurances will be end dated with the discharge date. A discharge reason of "other" or "unknown" must include comments by the provider.

If the member is transferred to another provider, the following must be documented in the comments section:

- Designation that it is a transfer.
- Name of the provider receiving the transfer.

<u>Clinical Tools</u>

- Partners uses evidence-based decision support tools to authorize services. This includes level of care and service decision support tools to make sure members receive the right care, in the right facility, at the right time. Decision support tools include McKesson InterQual Criteria. InterQual® provides a consistent, evidence-based platform for decisions that promotes appropriate use of services and improved health outcomes. Clinical practice guidelines are developed and updated using national resources, including American Psychological Association, American Medical Association, American Academy of Pediatrics, American Pharmaceutical Association, United States Preventative Health Services Task Force, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and NCQA.
- Level of Care Utilization System/Child & Adolescent Level of Care Utilization System; American Society of Addiction Medicine; and Child and Adolescents Needs and Strengths. Support Intensity Scale (SIS)

and North Carolina Support Needs Assessment Profile. Initial intermediate care facilities for members with intellectual disabilities (ICF-IID) Level of Care Form and supporting psychological testing and/or medical evaluations used to establish eligibility for Innovations and ICF-IID services

- Practice guidelines from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry for most commonly occurring categories of diagnoses.
- Comprehensive PH and BH assessments and supporting evaluations.
- The current Diagnostic Statistical Manual.
- Partners evaluates the need for LTSS based on face-to-face functional assessments, completed with members and legally responsible persons through a person-centered planning process.
- Together, we determine resources needed to help members remain in the community. Services authorized by the UM reviewer follow state benefit and policies.

Building expertise in UM for PH, pharmacy and LTSS

Partners will build upon the expertise we have gained as an LME/MCO for the past eight years further enhance our UM processes. Current UM staff will receive required integrated care training as it relates to PH, BH, LTSS, TBI and pharmacy needs. We will require future UM hires to have experience in and complete trainings in integrated care.

Partners will also draw on the ability of CCH to help build PH and LTSS UM capacity. CCH and Partners staff will collaborate daily to discuss specific member needs. Through daily knowledge sharing across disciplines, we will make timely and appropriate decisions, facilitating member access to the right care. By bringing together the vast experience of CCH and Partners' teams, we will strengthen all staff's ability to apply an integrated approach, leading to a more experienced team with increased capacity to deliver whole-person care.

Partners utilizes the ProAuth Information Technology system to receive requests for authorization. The information is entered into a Service Authorization Request/Prior Authorization (SAR/PA), which includes:

- Provider name and site code for where services are to be offered.
- Authorization date range.
- Services requested per Benefit Plan (Medicaid B, Medicaid C, Medicaid (b)(3), and State).
- Guardian/relationship to member.
- Member's disability: MH, IDD, SU
- ASAM level is recommended for all members with a substance use and co-occurring disorders that include a substance use disorder diagnosis.
- LOCUS/CALOCUS /CANS scores for members are recommended for members with a mental health diagnosis only and co-occurring disorders that include a mental health diagnosis.
- NC-SNAP or Supports Intensity Scale for Individuals with Intellectual or Developmental Disorder.
- Primary Care Physician and release of information.
- Medication dosages, frequency and compliance with medications.
- ICD-10 Diagnoses.
- Substance use details.
- Justification for services (provider comments).

- Uploaded documents as indicated on the current benefit plan.

Providers can see reviewer comments in the comments section. If additional information is requested and it is possible, three calendar days are allowed for a response to the request. Failure to do so could lead to the request being administratively or clinically denied.

Medical Necessity

Medical necessity must be met for all services. Medical Necessity is defined as services that are viewed as medically necessary to diagnose or treat a behavioral or medical health condition. This includes healthcare services, supplies or equipment provided by a licensed healthcare professional that are appropriate, safe and efficiently provided to the member, consistent with the diagnosis or treatment of the member's condition, illness, or injury but are not for personal comfort or convenience of the member, family, or provider. These services are not experimental or investigational or for research or education.

The UM department utilizes guidelines based on the North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-Funded Service Definitions and McKesson InterQual® Criteria.

The Clinical Coverage Policies and other coverage criteria can be found on the Service Definitions page on Partners Provider Knowledge Base website: https://providers.partnersbhm.org/service-definitions/

Determining Medical Necessity

UM staff consider clinical coverage policies and the member's or recipient's unique circumstances and needs when making a determination of medical necessity. UM staff adhere to applicable state or federal requirements and apply evidence-based clinical standards of care. Partners makes all criteria available to members/recipients and service providers upon request and include criteria in notices of service denial.

Partners' UM staff will consult with co-located CCH staff when evaluating requests for prior authorization (PA), particularly for requests related to members and recipients with complex PH and BH needs. In instances where the request is primarily related to PH needs, we will rely on CCH's expertise and appropriate clinical guidelines to determine medical necessity. For all PA requests, we will ensure that staff – Partners and CCH – have the expertise to make an appropriate determination. Further, our policies and procedures will incorporate processes for ensuring an integrated approach.

Peer to Peer Discussions

Peer-to-Peer discussions are arranged to minimize unnecessary denials, appeals and avoid escalation and member frustration. Partners communicates regularly with providers regarding SAR/PA requests not fully approved. Prior to issuing a notice of adverse benefit determination, our Medical Director is available for a peer-to-peer consult with the requesting provider to discuss the denial rationale and assist with identifying other services as appropriate. In the event of an adverse determination, including a denial, reduction, or termination of coverage, the provider may request a peer-to-peer discussion with the medical staff. At the time of notification of denial, the provider will be notified of this right, and has five business days to initiate a

peer-to-peer discussion. This can often resolve miscommunications about standards and requirements for medical necessity criteria.

Review Criteria

Partners utilizes review criteria developed by McKesson InterQual® products to determine medical necessity for physical health services. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Partners' medical staff, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

We closely monitor delivery of the full benefits package of Medicaid and State-Funded Services through our comprehensive UM program, which is built upon North Carolina Medicaid Direct Clinical Coverage Policies and definition of medical necessity.

Through our Partners UM program, we evaluate medical necessity, clinical appropriateness, efficiency and effectiveness of requests for authorization of State-Funded Services against established service definitions. Partners also utilizes American Society for Addiction Medicine (ASAM) criteria for substance use service reviews, SIS/NC-SNAP for IDD services, and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-Funded Service Definitions for community-based service reviews.

New Technology

Partners evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Chief Medical Officer and/or Medical Management staff may identify relevant topics for review pertinent to the Partners population. The Clinical Advisory Committee (CAC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Utilization Management department at UMquestions@partnersbhm.org..

Our systems hardware and software architecture, permits scalability of the technology platform to meet current and future capacity needs. We know technology can be a powerful tool that improves operations and delivers measurable impact to members, recipients and providers. We continually search for ways to apply existing and new technology to:

- Better understand and enable access to health care services and benefits for members/recipients.
- Ease the operational burden on providers related to claims and authorizations.
- Maintain a high level of member/recipient and provider satisfaction.
- Improve the quality and efficiency of data collection.

- Maximize the impact of performance improvement studies and results.
- Provide measurable results to the state programs.

Notification of Pregnancy

Members that become pregnant while covered by Partners may remain a Partners member during their pregnancy. The managing or identifying physician should notify the Partners prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit or confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Pregnancy Management Program (PMP)

Partners will adhere to PMP requirements in the Scope of Services. We will incorporate new guidance, policies, manuals and other program-specific requirements into our operations and PMP contracts within Department-specified timelines. We will coordinate pregnancy intendedness services that include member education, screening for risk factors, contraceptives, well woman exams and health coaching. Members that become pregnant may remain as Partners members during their pregnancy. Partners will adopt the PMP standardized screening tool, with modifications determined by the NCDHHS. We will work with PMP providers to establish data sharing processes and arrange enrollment into Care Management for High-Risk Pregnancy (CMHRP) provided by the local health department (LHD). For ease of reference, use the following link for more information. https://medicaid.ncdhhs.gov/transformation/care-management/care-management-high-risk-pregnancies-cmhrp

Serving women with high-risk pregnancies

Partners will work with LHDs for the provision of Care Management for High-Risk Pregnancy (CMHRP) to appropriate members. We will use multiple methods to identify women with high-risk pregnancies including a standardized risk screening tool conducted by providers; risk stratification by Partners; or direct referral by providers, members, or families.

LHD care management will include engagement, assessment, risk stratification, development of person-centered Care Plans/ISPs, identification of community resources and implementation of interventions. LHDs will provide referrals to childbirth education, oral health, BH or other needed Medicaid services. Because members can receive CMHRP and Tailored Care Management simultaneously, Partners' care managers will take the lead to ensure services are not duplicated. Women may choose to opt out of CMHRP services. In this situation, Partners will continue to provide care coordination services. At conclusion of contract year one, Partners will choose to continue contracts with LHDs for CMHRP or include CMHRP services within BH I/DD Tailored Care Management. Partners will provide wrap-around supports to LHDs that may need assistance serving women with high-risk pregnancies. Additional supports include CCH's pregnancy care management program, Start Smart for Your Baby, which engages pregnant women early in their pregnancy to help them access the care they need. The program offers a range of care management techniques designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery and babies born

with low birth weights. The program provides educational materials as well as incentives for going to prenatal, postpartum and well child visits. Postpartum, we will continue to support the mother and her growing child through the Birth to 5: Watch Me Thrive! and the Bright Futures EPSDT programs.

In collaboration with our PHP partner, Partners will offer the Start Smart for Your Baby Program. The Start Smart for Your Baby program engages pregnant women early in their pregnancy to help them access the care they need. The program offers a range of care management techniques designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease, which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to prenatal, postpartum and well child visits. Through the Notification of Pregnancy (NOP) process, we engage with OB providers to ensure they are notifying Partners as soon as possible about a newly identified pregnant member. A member will receive personalized pregnancy assistance with tracking for weekly prevention and pregnancy milestones based on due date, podcasts and educational guides and resources. In addition, Partners will collaborate with local health departments to deliver the program as a wraparound for their high-risk pregnancy program. Routine, uncomplicated vaginal or cesarean-section delivery does not require concurrent review, however; the hospital must notify Partners within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

Prenatal and New Mother Outreach

To make sure new mothers are aware of the EPSDT program and offerings, Partners exhausts all available avenues. We encourage and track referrals to public health and social programs such as Head Start and Women, Infants and Children (WIC). We also engage with OB providers through the Notification of Pregnancy process.

To identify new members for EPSDT outreach, Partners uses the eligibility files that we receive from NCTracks to identify newly enrolled newborn members. At orientation, we educate newly enrolled mothers on the importance of EPSDT services (North Carolina's Health Check program) within 60 days of enrollment. Thereafter, we conduct monthly outreach to families of children who are due or overdue for an EPSDT screening service.

Partners' care managers will educate mothers to ensure they know what services are available. In collaboration with our PHP partner, Carolina Complete Health (CCH), Partners will offer the Start Smart for Your Baby® Program. In addition to supporting pregnant women through their pregnancy, the program provides educational materials and incentives for going to prenatal, postpartum and well child visits.

Partners will collaborate with Local Health Departments to deliver the multidimensional Start Smart for Your Baby perinatal and NICU management program as a wraparound for their OB care management programs. Care managers will assist mothers in selecting a PCP for their newborn. By connecting newborns to a PCP, Partners can improve clinical outcomes.

A provider is required to promptly notify Partners when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Member Incentives

We will promote EPSDT and preventative services through our Virtual Events and Birth & Birthday Postcards. These innovative programs reflect Partners' continuous effort to design new services that lead to healthier outcomes for members by strengthening the relationship between members and their primary care provider and promoting personal health care accountability.

Provider Education and Incentives

Partners contractually requires all network providers to offer EPSDT preventative health services to their eligible members according to the AAP periodicity schedule. EPSDT services include routine physical examinations, screenings for developmental delays, screenings for autism spectrum disorder, appropriately scheduled immunizations, oral health assessments, dental counseling, lab testing and health education for children and caregivers.

Children's Screening Services

Partners will not require members to obtain a referral or prior authorization for children's screening services or for Local Health Department services.

Newborn Screening Program

Consistent with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-Up program, Partners will ensure that all lab testing for samples drawn for newborn screening be sent NC State lab for processing.

Partners will coordinate with the Division of Health Benefits on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula.

During contract Year 1 or a time period otherwise defined by DHB, Partners will work jointly with DHB to ensure reporting, education and care management activities occur regarding children who screen positive for hereditary and congenital disorders, including sickle cell anemia.

Newborn Hearing Screening Program

Partners will comply with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the Early Hearing Detection and Intervention (EHDI) program at https://wcs.ncpublichealth.com.

During Contract Year 1 or a time period otherwise defined by DHB, Partners will work jointly with DHB to implement requirements of hearing screening by one month of age, diagnostic evaluation by three months of age, and intervention by six months of age.

NC Immunization Registry

Partners will offer education to providers on the Vaccines for Children (VFC) program and NC Immunization Registry.

Providers will be referred to the NCDPH Immunization Branch for enrollment requests and additional information.

Abortions

The PHP shall require providers to follow the Abortion clinical coverage policy 1E-2, complete and submit the Abortion Statement outlined in Attachment B of the policy to the PHP, (https://files.nc.gov/ncdma/documents/files/1E-2_2.pdf) and maintain records of completed consent form consistent with the PHP contract and federal statute.

Sterilization

The PHP shall require providers to follow Clinical Coverage Policy 1E-3 which includes the completion and submission to the PHP of the Sterilization Consent Form outlined in– Attachment B ((https://files.nc.gov/ncdma/documents/files/1E-3_6.pdf) and maintain completed consent forms consistent with the PHP contract and federal statute.

Concurrent Review and Discharge Planning

Contracts, processes and procedures have been established for hospitals, residential facilities, state operated health facilities, ICF-IIDs and adult care homes. Partners will build on our relationships with SNFs, NICUs and rehabilitation facilities prior to launch of the Tailored Plan. Partners will be aware of any admissions through our prior authorization process. This allows for timely in-reach of transition staff, including the care manager, in-reach specialist or peer support specialist and/or transition coordinator, to engage in the discharge planning process.

Skilled Nursing Facility (SNF)

Partners currently works with SNFs to assess the needs of members who are in, or seeking admission to, an SNF. Partners will work with DHB and the member's nursing facility to coordinate Specialized services as defined by the federal Pre-admission Screening and Resident Review (PASRR) regulations for members admitted to nursing facilities.

Partners will ensure the provision of Specialized services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits. We will ensure that any approved Specialized services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.

We collaborate regularly with SNF staff on discharge planning for members. We will leverage these relationships to develop contracts, policies and procedures for in-reach, transition and discharge.

Neonatal Intensive Care Unit (NICU)

Partners will work with local health departments (LHDs), the care management for at-risk children (CMARC) program and NICUs to develop contracts, processes and partnerships for seamless transitions.

Hospitals

Our extensive experience working with hospitals has led to established contracts, policies, procedures and workflows. Our dedicated hospital liaisons are assigned to serve as primary points of contact for specific inpatient facilities/hospitals, coordinating communication and discharge planning between hospital staff and care managers. Care managers collaborate with Partners' hospital liaison and the member's care team on all discharge planning activities.

For planned admissions, the assigned care manager collaborates with the member, legally responsible person (LRP) and the care team to coordinate the member's admission and discharge plan, prior to admission. For unplanned admissions, the hospital notifies Partners' hospital liaison on the day of admission. Care managers visit the member during their stay in the hospital to identify needs, understand what led to admission and formulate a discharge plan.

Rehabilitation Facilities

Partners will work with rehabilitation facilities prior to launch of the Tailored Plan contract to develop contracts, policies and procedures for in-reach, transition and discharge.

Residential Settings

Partners has broad experience contracting and collaborating with residential settings in and out of our network, including group homes, supervised living settings and alternative family living homes. With many of these facilities, Partners has developed a single point of contact or liaison that will support care management for all Partners members under the Tailored Plan. All AMH+, CMA and Partners care managers will work in collaboration with the liaison.

When facilities do not have a single point of contact or liaison, the AMH+, CMA and Partners care manager work directly with the residential or inpatient care team to plan discharge and community-based services. The care manager works with the member and their family/caregiver to gather input and preferences about the Care Plan/ISP and transition, always keeping member goals and preferences central to the transition process.

State Operated Health Facilities and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Partners has considerable experience providing in-reach, transition and discharge support for members in ICF-IIDs, including Murdoch Developmental Center, J. Iverson Riddle Developmental Center and Caswell Developmental Center. We have established processes and partnerships designed to relocate members to a community setting, while maintaining the appropriate level of services and supports.

We work collaboratively with facilities to develop 90-day transition plans as an amendment to members' Care Plans/ISPs, share transition plans with members and identified community providers and secure all prior authorizations. Designated staff are present to support members on the day of discharge.

To ensure successful transitions, we assist in scheduling all post-discharge appointments, based upon members' identified needs and no later than seven calendar days following discharge.

These include transportation, in-home services and follow-up outpatient visits.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for an initial request. Concurrent requests that are expedited are reviewed within 24 hours of the receipt of the request.

Retrospective Review of Services

Retrospective review is an initial review of services provided to a member but for which authorization and/or timely notification to Partners was not obtained due to justifiable circumstances. Requests for retrospective review must be submitted to Partners UM department within 90 days from the modified date in NCTracks. A decision will be made within 30 calendar days following receipt of the request. All Retroactive SARs will be reviewed for medical necessity. For further questions on Retroactive Medicaid requests, please contact the MHSU UM Workgroup at 704-842-6436, MHSU UM Acute Team Workgroup at 704-842-6434 or I/DD UM Workgroup at 704-884-2605.

Opioid Misuse Prevention and Treatment Program Policy

Partners has implemented a comprehensive Opioid Misuse Prevention and Treatment Program, a member lock-in program, a cumulative maximum morphine milligram equivalent dosage limit not subject to utilization management prior approval, as established in opioid clinical coverage policy, and diagnoses codes exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM program.

Partners Opioid Misuse Prevention and Treatment Program aligns with the North Carolina Opioid Action Plan.

Pharmacy Elements: Dispensing Limits, Quantity Limits and Age Limits: Effective January 2, 2018, clinical coverage criteria for opioid analgesics were updated to comply with the quantity limits mandated by the ***Strengthen Opioid Misuse Prevention (STOP) Act***, S.L. 2017-74 (https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf). Prior approval is required for short-acting opioids for greater than a five-day supply for acute pain and seven-day supply for post-operative acute pain. Prior approval is required for long-acting opioids for greater than a seven-day supply. Effective June 1, 2018, clinical coverage criteria for opioid analgesics were updated to include prior approval required for a) total daily doses greater than 90 morphine milliequivalents per day (down from 120) and b) for Schedule III and IV opioid analgesics (i.e., tramadol) added to schedule II opioids already subject to the clinical criteria. If there are additional questions regarding these processes, contact Partners' Pharmacy Line at 833-353-2095.

The prescribing provider may submit prior approval requests to the pharmacy benefits manager as outlined in the pharmacy section of the Provider Operations Manual (Z.3-Prior Authorization) Process. Members with diagnosis of pain secondary to cancer will continue to be exempt from prior approval requirements.

Lock-in Program: Partners, in collaboration with its PBM partner CVS Health, will operate a member lock-in program for those members meeting criteria as defined in NC Gen. Stat. 188A-68.2. This lock-in program is designed to address potential overutilization of opioids, benzodiazepines, and certain anxiolytics and focuses on member safety. Members in this program will be locked into one provider and one pharmacy for a two-

year period to obtain opioids, benzodiazepines, and certain anxiolytics, at which time they will be reassess for continuing eligibility.

Reducing Opioid Misuse: Partners will promote appropriate utilization of healthcare resources by monitoring potential abuse or inappropriate utilization of targeted medications. We will proactively analyze data to identify potential opioid misuse and take actions to ensure all members receive the right medications in the right dosages to meet their needs.

Children/Adolescents: Partners' Pharmacy Review Committee (PRC) will review instances where more than a three-day supply of short-acting opioids is prescribed in opioid-naïve members who are age 19 or younger. Provider outreach and education will focus on use of stepwise pain management treatment practices consistent with CDC guidelines to minimize chronic patient exposure to opioids where clinically appropriate.

System-Wide: As part of our commitment to addressing the opioid abuse epidemic via opioid stewardship, Partners and CVS will collaborate to advance existing efforts to reduce opioid misuse, consistent with the NC DMA Outpatient Pharmacy PA Criteria for Opioid Analgesics, the NCDHHS Opioid Action Plan and the NC STOP Act.

Examples of Partners' harm reduction initiatives include member and provider/pharmacy education and prevention; encouraging members to properly dispose of unneeded medication; promotion of the use of medication drop boxes for safe medication disposal; offering community and provider support for treatment services; and educating providers, pharmacy partners and members accessing and using naloxone (opioid-overdose reversal medication).

Partners will promote tools such as the Prescription Drug Monitoring Program, an electronic database that helps pharmacists and prescribers detect potential instances of prescription opioid misuse/abuse (e.g., MMEs exceeding threshold, use of multiple providers and pharmacies). We are a member of the NCDHHS Opioid and Prescription Drug Abuse Advisory Committee, which keeps us apprised of opioid trends and harm reduction opportunities. Our standard opioid management program aligns with the NCDHHS opioid stewardship parameters, NCDHHS opioid UM criteria and the CDC March 2016 Guideline for Prescribing.

Opioids for Chronic Pain: The program encourages appropriate treatment of acute and chronic pain with non-pharmacologic, non-opioid and opioid modalities as appropriate. It complements measures already in place, including ongoing monitoring for patterns of inappropriate prescribing or use and controls such as those found in the DUR program. To complement our program, we will promote use of non-opioid alternatives to chronic pain management.

For members in the Lock-In Program, we will use a pharmacy and provider lock-in, consistent with the NC Medicaid Clinical Coverage Policy. The member will obtain all prescriptions for opioid analgesics, benzodiazepines and certain anxiolytics from their lock-in prescriber and lock-in pharmacy only and receive educational outreach via care management on harm reduction strategies for their medication use.

Partners' Pharmacy Review Committee will review medication use for members in the Lock-In program. It will inform the member, care manager and provider/community pharmacy of identified concerns and provide education, as indicated.

Partners will receive opioid utilization reporting from CVS' Rx Navigator. Reports will include overall opioid utilization metrics and UM outcomes for program components (MMEs, opioid quantity limits, step therapy edits, acute pain duration edits). The pharmacy staff and P&T/DUR Committee will review reports monthly and take action to address member, provider and community pharmacy trends.

Partners will work with network pharmacies to obtain medication drop boxes for members to return unneeded medications, minimizing the risk for potential misuse.

As part of the statewide naloxone access program, Naloxone Saves, managed by the NC Department of Public Health Injury and Violence Prevention Branch, Partners will continue current educational outreach projects focused on appropriate opioid use for acute/chronic pain and naloxone co-prescribing/dispensing, to promote medication safety.

Partners Opioid Misuse Prevention and Treatment Program contains interventions that support and promote safer prescribing of opioids, management of acute and chronic pain, early detection of opioid misuse and intervention and increased access to naloxone and substance use disorder treatment. We also focus on harm reduction through strategic interventions, including:

- Offer training and encourage primary care providers to use Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Increase access to substance/opioid use disorder treatment and BH treatment through telehealth when clinically appropriate
- Support programs focused on the treatment and transport to alternative sites of care for people with substance/opioid use disorder, for example, paramedicine
- Meet network adequacy for medication-assisted treatment (MAT) for opioid use disorders through initiatives targeted at increasing number of MAT programs
- Increase access to substance/opioid use disorder treatment, including office based opioid treatment (OBOT), SA comprehensive outpatient (adult), SA Intensive Outpatient program (adults and children) and opioid treatment (adult)
- Provide non-emergency medical transportation for members to substance use disorder treatment
- Encourage member screening for opioid use disorder and use of medication assisted treatment (MAT) when indicated and incentivize members who successfully remain in MAT for 90 and 180 days. Educate members and providers when a member may be at elevated risk for opioid overdose and steps to take to minimize the risk

Members, providers and pharmacies will have access to online practical, evidence-based materials on proper opioid use, promoting a community-wide approach to reducing misuse.

TP SPECIALTY THERAPY AND REHABILITATION SERVICES

Partners offers beneficiaries access to all covered, medically necessary outpatient physical, occupational and speech therapy services. Partners works with Carolina Complete Health

to ensure that the physical medicine services (physical, occupational, and speech therapy) provided to Partners beneficiaries are consistent with nationally recognized clinical guidelines.

Therefore, physical, occupational, and speech therapy services claims will be reviewed by Utilization Management to determine whether the services met/meet criteria for medically necessary and medically appropriate care. These determinations are based on a review of the objective, , clearly documented clinical records. These reviews help us determine whether such services (past, present, and future) are medically necessary and otherwise eligible for coverage.

There may be a request for clinical documentation to support the medical necessity and appropriateness of the care. There is no need to send patient records with your initial claim. You will be notified if records are needed and your options for submitting them. . If records are necessary, it is important you know that Carolina Complete Health cannot authorize services until the necessary information is received. If the documentation received fails to establish medicalnecessity Carolina Complete Health may deny authorization for services and future related therapy services thereafter. If requested records are not received, claims will be denied due to lack of information.

Please keep in mind you will need to ensure that the member has not exhausted his/her PT/OT/ST benefit and/or has a habilitative benefit prior to providing services. The purpose of Utilization Management is to review medical necessity of PT/OT/ST services, and not to manage the member's benefits. Non-Network Providers must obtain prior authorization for all services. Carolina Complete Health does not retroactively authorize treatment.

Prior authorization for home health occupational, physical or speech therapy services, as well as comprehensive day rehabilitation, should be submitted to ProviderCONNECT.

PIHP/Medicaid Direct – Providers will continue to bill NC TRACKS for these services for Medicaid Direct members.

IMPORTANT: Hi Tech Radiology Services

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our beneficiaries, Partners utilizes , Evolent to provide prior authorization and utilization management services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA MRI/MRA PET Scan
- Myocardial Perfusion Imaging – Nuclear Cardiology
- MUGA Scan
- Transthoracic Echocardiology Transesophageal Echocardiology Stress Echocardiography

If a convenient, cost-effective, in-network imaging facility is not selected at intake for MR and CTs, Evolent will assign one that is closest to the member's zip code. Exceptions will be made in situations where there is a clinical reason the test must take place at a specific, higher cost facility. The finalized authorization will reflect the imaging facility selected. In addition, the imaging provider selected or assigned pursuant to this process will become the **provider of record for**

claims payment. Any claim billed with an imaging provider's Tax ID that differs from the imaging provider's Tax ID selected or assigned during this process will be denied. Claim denial reasons are:

- EXNo-DENY Procedure code and Provider does not match authorization.
- EXNq-DENY Provider and DOS does not match authorization.
- EXNs-Deny Did not use authorized provider in network.
- EXy1- Deny: Services Rendered by Non-Authorized Non Plan Provider.

Please communicate to your patient which facility is on the authorization and the importance of them having the imaging study conducted there to ensure proper payment of the claim.

Key Provisions

Emergency department, observation and inpatient imaging procedures do not require authorization. It is the responsibility of the ordering physician to obtain authorization. Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Evolent provides an interactive website to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department at 1-833-552-3876. To reach Evolent for urgent requests or other questions, please call 800-424-4889 and follow the prompt for high tech imaging authorizations.

24-HOUR NURSE ADVICE LINE (BH/IDD Tailored Plan)

Our members have many questions about their health, their primary care provider, and/or access to emergency care. PartnersACCESS Call Center offers a Nurse Advice Line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care. Partners 24/7/365 Nurse Advice Line is available by calling 833-353-2094.

Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access to physical health services. Nurse Line staff often answer basic health questions but are also available to triage more complex health issues using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are also referred to care management for education and encouragement to improve their health. Care Management receives daily updates from calls on behalf of members for follow up. Members may use Partners' Nurse Line to request information about providers and services available in the community after hours. Nurse Line staff are available in both English and Spanish and can provide additional translation services if necessary. We provide this service to support your practice and offer our members access to a registered nurse at any time, day or night. If you have any additional questions, please call our Member Service Line at 888-235-4673

WOMEN'S HEALTHCARE

Partners supports the unique needs of Women's Health in the following ways:

Family Planning Services

Partners will ensure there are sufficient family planning providers to ensure timely access to covered services. We will also provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services, which is in addition to the member's designated provider of primary care services if that provider is not a women's' health specialist.

Members shall not be required to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies.

Members have free choice of family planning services and supplies providers.

Members will not be held liable for payment for family planning services or supplies that are not in Partners network.

Members will not be required to obtain referrals for services provided by women's health specialists.

Members will not be required to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.

Providers will not be required to obtain prior approval for any obstetrical ultrasound.

Women's routine and preventive health care services may include but are not limited to initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted infections.

Women's Health and Cancer Rights

In accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA), Partners provides protections to members who choose to have breast reconstruction relating to a mastectomy, including coverage of:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema

Providers serving Medicaid Direct members will continue to bill NC TRACKS Directly for physical health services.

PREVENTION AND POPULATION HEALTH PROGRAMS

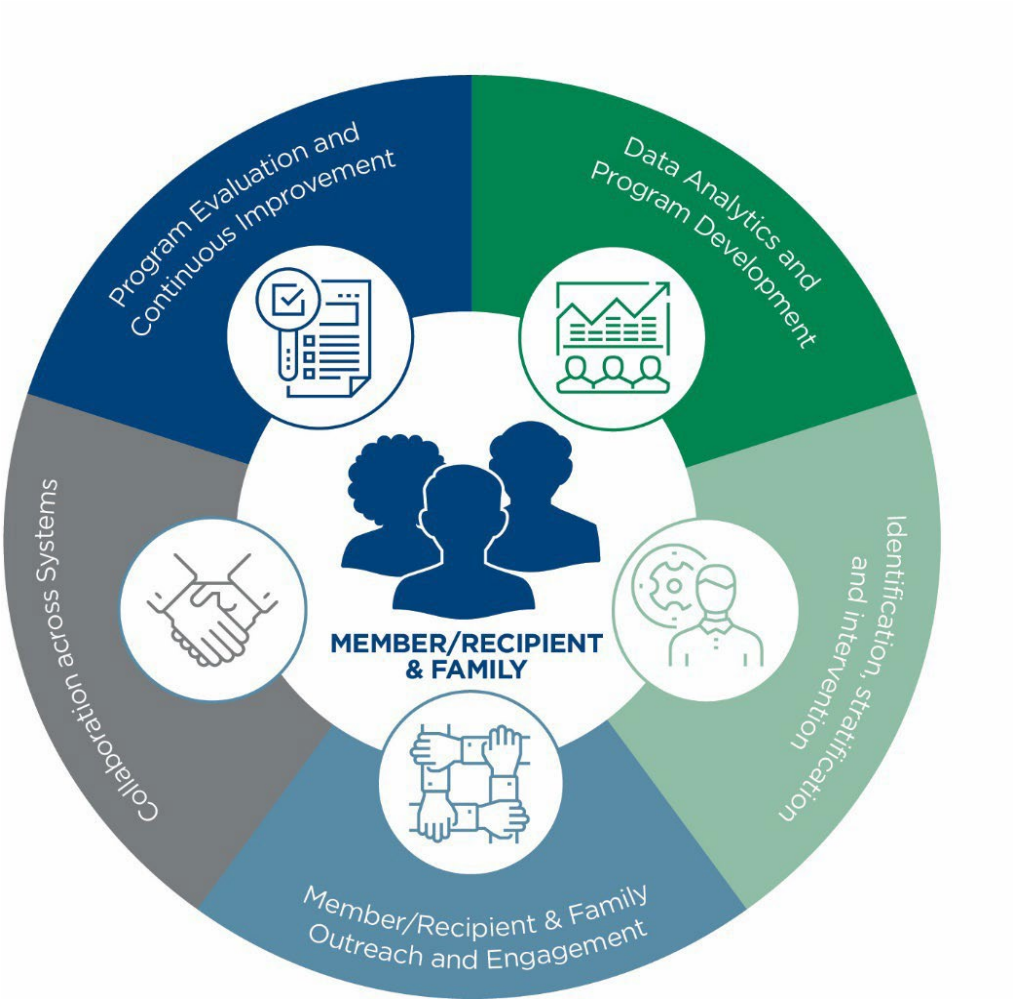
Partners collaborates with local health departments (LHDs), community stakeholders, providers and members to build sustainable support systems. We take a population-based approach to improve the overall health of TP/PIHP Medicaid members and State-funded recipients and collaborate with community partners on

targeted initiatives. Working together with our PHP Partner, Carolina Complete Health, we will establish prevention and population health programs aligned with NCDHHS larger public health goals and quality strategy. We will utilize population-level measures from NCDHHS that inform on regional trends and assist performance improvement efforts.

Partners Prevention and Population Health programs will be available to all members.

The goals of our Prevention and Population Health Management Plan are to understand members' physical health (PH), behavioral health (BH), and social determinants of health (SDOH) needs; identify impact on health; and take action to improve health outcomes. Our comprehensive Prevention and Population Health Management Plan outlines methods to promote improved health outcomes. The objectives of our program include:

Partners' Prevention and Population Health Approach



Partners uses a comprehensive prevention and population health approach centered around the member/recipient and family.

Our planned prevention and population health management program designs are based on in-depth analysis of member information and include engagement and collaboration with members/recipients and stakeholders.

All planned prevention and population health management program designs are multi-faceted to include interventions at provider, member, and system levels, as described below.

Provider Level Interventions

Partners has forged long-standing collaborative relationships with providers who deliver Medicaid and State-Funded Services. Partners offers providers a continuum of topic-specific trainings, hands-on support and technical assistance driven by each provider's specific needs. We will give providers resources for prevention and population health programs and clinical practice guidelines , via ProviderCONNECT, our online portal.

Through ProviderCONNECT, providers can build their knowledge of evidenced-based and best practice guidelines and value-based payment arrangements that promote compliance and results in improved health outcomes. Partners Training Resource and Collaborative (TRAC) team will also offer providers opportunities to exchange best practices through virtual and in-person learning collaboratives. We will create and share provider population health dashboards that enable providers ability to analyze performance in population health trends, costs, quality measures, and predictive risk for chronic conditions such as diabetes, hypertension, and suicide.

The following table provides examples, by clinical area of focus, of our prevention and population health programs, in alignment with the NCDHHS population health priorities.

Partners' Prevention and Population Health Programs

Opioid Misuse	
Program Description	Our opioid misuse prevention and treatment program incorporates a comprehensive approach, including overdose prevention and treatment engagement. Using several approaches, such as member outreach, overdose response team, and pharmacy strategy.
Provider Level Intervention	Outreach and education to prescribers with the highest prescribing patterns includes sending letters to prescribers. Our pharmacy strategy includes use of a member lock-in program, a cumulative maximum morphine milligram equivalent (MME) dosage limit not subject to utilization management (UM) prior authorization, and diagnosis codes exempt from prior authorization requirements in opioid clinical coverage criteria. We promote access to naloxone through formulary structures and benefit design. Partners also has value-based contract for MAT providers to incentivize for their members who are engaged in 180 days of continuous MAT treatment.

Expected Outcomes	3. Decrease quantity of opioids dispensed. 4. Increase MAT patients. 5. Decrease number of Opioid Related Deaths
Tobacco Cessation	
Program Description	The tobacco cessation program will seek to prevent and reduce tobacco use and tobacco-related health concerns through education, resources, support, and promotion of and access to QuitlineNC. Special Note: Tobacco-related policy requirements will be effective January 1, 2027, for NC Medicaid Managed Care Standard Plans, Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans, and Medicaid Direct. The posted bulletin is now available https://medicaid.ncdhhs.gov/blog/2025/06/10/updated-tobacco-related-policy-requirements-delayed-until-jan-1-2027
Provider Level Intervention	We promote tobacco free campuses at contracted facilities, in alignment with the NCDHHS content from the state webinar on tobacco reduction. We will train providers about the importance of screening for tobacco use and resources available to support members that would like to quit.
Expected Outcomes	Reduction in Tobacco use. Increase of Nicotine Replacement Therapy
	•
Birth Outcomes	
Program Description	The pregnancy management program provides whole person support to members who are pregnant. The goal of this program is to provide early identification and appropriate effective management of pregnancy to reduce or prevent serious complications and improve outcomes for the member and infant. .
Provider Level Intervention	Provide education, training, technical assistance and support. Partners will coordinate care and promote programs to support pregnancy intendedness with LHDs and CCH.

Expected Outcomes	3. • Increase pregnant members identified in the first trimester through claims data and member self-report • Increase enrollment in Care Management High Risk Pregnancy (CMHRP) Program • Increase the number of members who are pregnant that deliver an infant weighing 2500 grams or greater • Increase member engagement in prenatal care • Reduce number of pregnant women who have complications during delivery
Chronic Condition Management of Diabetes	
Program Description	The Chronic Condition Management of Diabetes Program is a short-term self-management program for adults with Diabetes. This program will provide education to members on how to effectively manage their chronic condition. .
Provider Level Intervention	Physical and Behavioral Health Care Providers will be provided with education on how to make a referral. A referral of a member can be made via the Care Manager, by contacting a member of the Chronic Condition Management team, or by emailing a referral to PopulationHealthPrograms@partnersbhm.org. Provide
Expected Outcomes	• Increase in the number of members diagnosed with diabetes that receive a semi-annual HbA1c screening and/or blood glucose test annually. Members of the Chronic Condition Management of Diabetes Program will obtain a better understanding of how to manage their diabetes upon completion of the program as evidenced by self-reporting by survey. •
Chronic Condition Management of Asthma	
Program Description	The Chronic Condition Management of Asthma Program is a short-term self-management program for adults and children with Asthma. This program will provide education to members on how to effectively manage their chronic condition.
Provider Level Intervention	Physical and Behavioral Health Care Providers will be provided with education on how to make a referral. A referral of a member can be made via the Care Manager, by contacting a member of the Chronic Condition Management team, or by emailing a referral to PopulationHealthPrograms@partnersbhm.org.
Expected Outcomes	• Partners will have a decrease in the percentage of members that complete the Chronic Condition Management of Asthma Program that have a high or very high risk for ED utilization.

	• Members of the Chronic Condition Management Program for Asthma will obtain a better understanding of how to manage their condition upon completion of the program as evidenced by self-reporting by survey. • • •
Early Childhood Interventions	
Program Description	Partners closely monitors adherence to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) schedules to ensure all children under the age 21 who are enrolled in Medicaid, receive preventative health care services, screenings, and follow-up services. EPSDT is a federal Medicaid requirement and required to cover medically necessary procedures, services, or products to correct or improve a condition identified through screenings. If a follow-up service is identified, the assigned care manager will connect the member to the service and coordinate with UM for authorization. If a child is identified as needing a service for physical, intellectual, developmental, or significant behavioral issues, Partners will re-evaluate their care management level and provide more intensive support and education, as identified. Partners closely monitors adherence to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) schedules to ensure all children receive needed screening and follow-up services. If a follow-up service is identified, the assigned care manager will connect the member to the service and coordinate with UM for authorization. If a child is identified as needing a service for physical, intellectual, developmental, or significant behavioral issues, Partners will re-evaluate their care management level and provide more intensive support and education, as identified.
Provider Level Intervention	Provide education, training, technical assistance, and support.
Expected Outcomes	1. Improve EPSDT compliance rates. 2. Increase member satisfaction.

Partners has additional planned prevention and population health management program designs to support priority domains in the clinical areas of asthma, obesity, interpersonal safety, trauma, physical activity/exercise, nutrition, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, and stress management.

Partners expects all providers to educate members about availability and accessibility of Prevention and Population Health programs and services.

Our Provider Support Plan offers additional information and resources for providers eligibility criteria, objectives, and referral mechanisms for all Prevention and Population Health programs. The Provider Support Plan can be found at the ProviderCONNECT portal.

Advanced Medical Homes Plus (AMH+) and Care Management Agencies (CMA) and Partners care managers are required to promote wellness and prevention by educating members and referring them to programs that

address exercise and nutrition, stress management, substance use reduction, cessation and relapse prevention, harm reduction, suicide prevention, self-help recovery and other wellness services. **Please refer to Partners AMH+/CMA manual for additional information or through the link here https://files.nc.gov/ncdma/documents/Transformation/Advanced-Medical-Home-Provider-Manual.pdf. The manual can be found on the ProviderCONNECT portal as well.*

Partners will notify PCPs and AMH+s/CMAs (if applicable) by letter, email, fax or secure web portal of their member's involvement, unless the member notified us not to inform them.

CARE MANAGEMENT PROGRAM

SPECIA NOTE to PIHP Providers serving Medicaid Direct members will continue to bill NC TRACKS Directly for physical health services.

Care Management Requirements

Partners TP care management model is designed to help our members obtain needed services, whether they are covered within the Partners array of covered services, from community resources, or from other noncovered venues. Our model supports our provider network whether you work in an individual practice or large multi-specialty group setting. The program is based upon a coordinated care model that uses a multi-disciplinary care management team in recognition that a holistic approach yields better outcomes.

The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the behavioral health provider, PCP or specialist office with administrative work. The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP and behavioral health provider.

Our care management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, functional, social and other needs. We will coordinate access to services such as behavioral health, dental and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs. A care management team is available to help all providers manage their Partners members. Listed below are programs and components of services that are available and can be accessed through the care management team. We look forward to hearing from you about any Partner members that you think can benefit from the addition of a Care Manager.

High Risk Pregnancy Program

Care Management for High-Risk Pregnancies (CMHRP) is a program available to all pregnant women enrolled with Partners. With a focus on healthy moms and babies, pregnant beneficiaries receive comprehensive, coordinated maternity care services with a focus on preventing pre-term birth. These services are provided by local health departments.

Partners works with Local Health Departments (LHD) for the provision of Care Management for High-Risk Pregnancy (CMHRP) to appropriate members. LHD care management will include engagement, assessment, risk stratification, development of person-centered Care Plans, identification of community resources, and implementation of interventions. LHDs will also provide referrals to childbirth education, oral health, Behavioral Health, or other needed Medicaid services.

Because members can receive CMHRP and Tailored Care Management simultaneously, Partners' care managers will take the lead to ensure services are not duplicated. Women may choose to opt out of CMHRP services. In this situation, Partners will continue to provide care coordination services.

Partners provides wrap-around supports to LHDs that may need additional assistance serving women with high-risk pregnancies. Additional supports include our Prepaid Health Plan (PHP) partner's pregnancy care management program Start Smart for Your Baby, which engages pregnant women early in their pregnancy to help them access the care they need. The program offers a range of care management techniques designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and babies born with low birth weights. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well child visits. Postpartum, we continue to support the mother and her growing children through the Birth to 5: Watch Me Thrive! and the Bright Futures EPSDT programs.

Complex Teams

These teams are be led by clinical licensed nurses in conjunction with licensed behavioral clinicians with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Partners complex teams will manage care for beneficiaries whose needs are primarily functional as well as those with such complex conditions as severe and persistent mental illness, traumatic brain injury, hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care beneficiaries and children with special health care needs are at special risk and are also eligible for enrollment in care management. Partners will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist beneficiaries in making better health care choices.

Chronic Care/Disease Management Programs

Disease Management Programs (DM) are offered to members. Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrated care. Chronic care management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Care Management

Partners has extensive experience providing comprehensive care coordination since 2013. Our Tailored Care Management program supports the principle that provider-and community-based care management is crucial

to the success of fully integrated managed care. Our model provides continuity and choice, while placing care management at the site of care to improve health outcomes. Partners ensures Tailored Care Management is available to all members throughout enrollment, regardless of geography, unless they are receiving duplicative care management services.

A core principle for our Tailored Care Management model is promoting strong relationships between members and providers. Many members have long-term relationships with providers or service organizations, especially those with prominent behavioral health (BH) or I/DD related needs (exclusive of individuals in the Innovations waiver). Partners is committed to maintaining these relationships. We will honor member choice whenever possible and/or desired by members, to support a smooth transition to Tailored Care Management. All care managers will support continuity of member care by working closely with providers across disciplines work together to support the whole-person and improve member health.

Partners will encourage members to select an AMH+/CMA with the right skills and expertise to serve as their care management provider. When introducing members to our Tailored Care Management program, we will present them with a list of certified AMH+s/CMAs near their home that can meet their preferences for culture, gender, location and language. We will identify providers with specialized expertise to address their unique circumstances such as providers that serve children or members with I/DD. If a member declines care management services through an AMH+ practice/CMA, we will assign an internal Partners care manager. Ultimately, members may choose their care management assignment. Partners will help them understand their assignment and options for changing it.

Our care management and care manager assignment will:

- Be person-centered.
- Honor existing provider relationships.
- Consider complexity of PH, BH, I/DD and TBI needs.
- Support member preferences to enhance engagement. Members may change their care management provider (AMH+ practice, CMA, or Partners) or care manager up to twice a year without cause, or at any time with cause. Individuals who decline care management will receive ongoing engagement and care coordination. Partners will provide these services to ensure the member's needs are routinely assessed and addressed.

Diversion from Institutionalization

Partners is committed to ensuring that members are given the information, experiences and support they need to make an informed choice and given assistance accessing services and supports in the community with the benefit of person-centered planning. Partners is committed to strong diversion practices to ensure that the individual requesting admission or who is at risk of admission to an institutional setting is provided information to support informed choices.

Diversion specialists support efforts to place recipients in appropriate settings and avoid institutionalization. Our diversion specialists are knowledgeable about community services and supports, including supportive

housing and meet all state licensure and experience requirements. Partners will maintain caseload ratios for each diversion specialist, as determined by the NCDHHS.

Diversion specialists:

- Screen and assess recipients' eligibility for State-Funded Services, Medicaid and other entitlement programs beyond Medicaid.
- Educate recipients on the choice to remain in the community and services available to support that decision.
- Coordinate and provide referrals, information and assistance in obtaining and maintaining State-Funded Services.
- Coordinate social services and services geared toward recipients' Unmet Health-Related Resource Needs.
- Assist in obtaining and maintaining low or no cost medical services (e.g., from federally qualified health care centers, and rural health centers, community resources and social support services).
- Determine if recipients are eligible for supportive housing, if needed.
- Develop a Community Integration Plan (CIP) that documents a recipient's decision to remain in the community. The diversion specialist works with the recipient's care manager to integrate the CIP as an addendum in their Care Plan if the recipient enrolls in Medicaid.

In-Reach and Transition

Partners is committed to ensuring that members are given the information, experiences and support they need to make an informed choice and given assistance accessing services and supports in the community with the benefit of person-centered planning. Partners is committed to strong in-reach and transition practices for members admitted to or residing in the following settings: state psychiatric hospitals, Adult Care Homs (members with serious mental illness), state developmental centers. ICF-IIDs not operated by the state, Psychiatric Residential Treatment Facilities (PRTFs), and Residential Treatment Levels II/Program, III and IV.

Partners In-Reach Specialists conduct in-reach with the goal of identifying and engaging members receiving care in who may be able to have their needs safely met in a community setting. Transition Coordinators assist members identified through the in-Reach process who voiced a desire to explore other possible community-based supported-living opportunities. The primary purpose of transition coordination is to support a member transitioning from one of the settings listed above in securing appropriate community-based housing and clinical services.

NC INNOVATIONS

What is the NC Innovations Waiver?

The Medicaid 1915(c) Waiver, most commonly referred to as "NC Innovations," is a Medicaid Waiver program for members with intellectual and other developmental disabilities. It is designed to give members and families an alternative to placement in an Intermediate Care Facility (ICF-IID). NC Innovations offers services

and support options designed to help members of all ages remain in their community and to live as independently as possible. The NC Innovations Waiver helps members have a role in planning and selecting how to receive and maintain community-based services for themselves. It helps empower the member to live a more independent life.

The NC Innovations Waiver is not an entitlement or right. It is a set of Medicaid services that members may be eligible for if they meet specific criteria. The number of members who can participate in the waiver is limited by the state of North Carolina and the Centers for Medicaid and Medicare Services.

Self Determination

Individual and Family Directed Support Options

The NC Innovations Waiver gives people with disabilities clear choice about how they receive services. Participant Direction is a meaningful option for members as well as their families. In the NC Innovations Waiver, Self-Directed Services are called Individual and Family Directed Supports. Members can direct some or all allowable NC Innovations services received. This gives members and families more control over the way their services are provided, including the authority to manage an Individual Budget and employ/manage workers who provide support.

The models of Participant Direction described in this manual are included in the CMS-approved North Carolina Innovations waiver. No other model of Participant Directed Services may be offered to an individual in the North Carolina Innovations waiver. All Agencies with Choice must be approved by the LME/MCO. NC Innovations Services may only cover the services defined in the waiver and only be used to provide services, supports, equipment and supplies in the service definitions approved by CMS. Provider agencies may not offer the member an expectation of "savings" to use for equipment, supplies or any other incentive or an offer of a co-employment arrangement as a condition of provision of services to that member. Supervision of services must always be provided as written in the provider qualifications of the service definition.

Principles of Self Determination

The Individual and Family Directed Supports Option is based on the principles of Self Determination. Self-Determination empowers members to gain control over selecting the services or supports that meet their unique needs. It is a process that varies from person to person according to what each individual feel is necessary and desirable to create a satisfying and personally meaningful life. It is both person-centered and person directed. The Principles of Self-Determination are:

- Freedom – The ability of an individual, together with freely chosen family and friends, to plan a life with necessary supports rather than purchase or conform to a set program.
- Authority – The ability of a person with a disability (with a social support network or circle if needed) to control a certain sum of money to purchase services.
- Autonomy – The arranging of resources and personnel (both formal and informal) to assist an individual with a disability to live a life in the community rich in personal and community affiliations.

- Responsibility – The recognition of a person's valued role in the community through competitive employment, organizational affiliations, spiritual development, and general caring of others in the community as well as accountability for spending public dollars in ways that are life-enhancing for people with disabilities.
- Confirmation – The recognition of the importance of the leadership of self-advocates in the Self-Determination movement.

Models of Individual and Family Directed Supports

The two Models of Individual and Family Directed Supports are available:

- The **Employer of Record** Model allows the member or the legally responsible person for the member to be the individual who legally can exercise authority over workers and assume the other responsibilities associated with member direction of services. The member or the legally responsible person is known as the Employer of Record.
- The **Agency with Choice** Model allows the member or legally responsible person for the member to work with an agency that agrees to hire employees referred by them. The agency approves/disapproves the hiring of the referred individuals and ultimately retains the responsibility of being the employer while allowing the member or legally responsible person to partner in managing the employee's training and supervision. The member or the legally responsible is known as the Managing Employer.

<u>Application Process and the Registry of Unmet Needs</u>

Members may request to be screened for the NC Innovations Waiver by contacting Partners at 1- 888-235-HOPE (4673).

A consistent process is followed for all members requesting or presenting as potentially eligible for NC Innovations Services. The time and date of the initial contact with Partners is recorded. Such documentation is used in the event the member is determined potentially eligible for NC Innovations Services and placed on the Registry of Unmet Needs (i.e., waiting list). If funding is not available for needed NC Innovations services at the time of screening, the person is assessed for and may receive other appropriate services or may wait until funding becomes available. If the member has Medicaid, he or she may receive medically necessary Medicaid services that are currently offered by Partners through alternative Medicaid Service Array or services offered through Partners known as In Lieu of Services. In Lieu Of Services are services Partners has created to address areas of need when regular Medicaid does not offer the support needed by the member and NC Innovations is unavailable.

To determine preliminary eligibility, Partners screens members for the NC Innovations Waiver, based on the waiver eligibility criteria outlined in the NC Clinical Coverage Policy 8P and the member's need for waiver services.

The screening process consists of

- Initial call between member requesting the screening for NC Innovations waiver services and the I/DD Registry Specialist. The Registry Specialists completes a Care Needs Screening to assess the members risks and support needs. The member is given information regarding what documentation should be submitted to I/DD Registry Specialist for review of potential eligibility criteria (i.e., Psychological Evaluation, Developmental Assessments - Children's Developmental Services Agency (CDSA), Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) evaluation, Speech Therapy/Occupational Therapy/Physical Therapy Evaluations, Individualized Education Plan, etc.).
- Once requested information is submitted to I/DD Registry Specialist, a review of the information takes place. A letter is then sent to the member stating one of two scenarios:
    1. Potential eligibility criteria have been determined and the member has been placed on the Registry of Unmet Needs (wait list); or
    2. Potential eligibility criteria have not been met and the member will not be placed on the Registry of Unmet Need list. Then the member will be notified by letter that he/she has the right to appeal the decision.

If health or welfare risks are identified, Partners will review the assessments and decide as to whether the person's needs can be met on the waiver. Partners' Medical Directors review the assessments of members who appear to be not eligible for the waiver, including those individuals who appear to have needs that cannot be met within the waiver cost limits, and makes the final determination. Individuals who appear to meet potential level of care for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and whose needs cannot be met on the waiver are provided Care Management to assist in pursuing ICF-IID placement, if interested.

A person with intellectual disability and/or a related developmental disability may be considered for NC Innovations Waiver funding if all the following criteria are met:

I. Be a U.S. citizen or provide proof of eligible immigration status.
II. Be a resident of North Carolina.
III. Have a Social Security number or have applied for one.
IV. Apply and be approved for Medicaid at the local Department of Social Services (DSS).
V. Be in one of the Medicaid aid categories that qualifies members for the NC MH/IDD/SUD Health Plan.
VI. Meet the requirements for ICF-IID level of care:
    A. Require active treatment necessitating the ICF/IID level of care; and
    B. Have a diagnosis of Intellectual Disability per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, text (DSM-5), or a condition that is closely related to mental retardation.
        - 1. Intellectual Disability is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.
        - 2. People with closely related conditions refers to individuals who have a severe, chronic disability that meets ALL of the following conditions:

1. . Is attributable to:
    a. i. Cerebral palsy, epilepsy; or
    b. ii. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of Intellectually Disabled people, and requires treatment or services similar to those required for these people;
2. The related condition manifested before age 22;
3. Is likely to continue indefinitely; and
4. Have Intellectual Disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:
    - i. Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)
    - ii. Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)
    - iii. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
    - iv. Mobility (ambulatory, semi-ambulatory, non-ambulatory) v. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)
    - vi. Capacity for independent living (age-appropriate ability to live without extraordinary assistance).

Specific Requirements for Providers of North Carolina Innovation Services

1. Complete the Health and Safety Checklist on an annual basis for any staff who provides Community Living and Supports or Respite in the home of the agency staff person. This Checklist does not apply to staff providing services under the Relative as Direct Service Employee Policy. The form is retained in the provider agency's Employer of Record or Agency with Choice files and uploaded into ProAuth. Additionally, the provider agency's Qualified Professional (QP) and/or Employer of Record/Agency with Choice QP is required to monitor services in the staff's home monthly.
2. Participate in the Supports Intensity Scale (SIS) interview.
3. Participate in the development of the member's Individualized Service Plan (ISP) including the updates.
4. Ensure that personnel meet the requirements of the service being delivered.
5. Implement the services authorized in the ISP.
6. Develop short-range goals, training, and interventions/task analysis/strategies for achievement of long-range outcomes in the ISP with the member and or legally responsible person, and other planning team participants that are appropriate.
7. Assist in the coordination of services and communication with the member/family.
8. Monitor services authorized by Partners to ensure consistency with the ISP.

9. Review and maintain adequate documentation of services making documentation available to Care Coordinators, Partners and others as needed.
10. Notify the Care Manager about significant changes in the member needs and service delivery.
11. Submit Incident Reports to Partners per state rule requirements and NC Innovations policy. Per NC Innovations policy Level I Incident Reports are completed and submitted for all failures to provide back-up staffing for services approved in the ISP or an attestation form completed if there were no back-up incidents to report.
12. Monitor notes and billing to ensure integrity of all claims submitted to Partners for payment.
13. Provide the services as specified in the provider contract.
14. Respond to emergencies of members and have a back-up system in place to respond to emergencies/crisis on weekends and evenings as outlined in the NC Innovations service definitions. Providers of Community Living and Supports, Residential Supports and Supported Living are required to have QP staff available as Primary Crisis Services Providers for emergencies that occur with members in their care 24 hours per day seven days per week or have an arrangement (memorandum of understanding) with a Primary Crisis Services Provider.
15. Comply with policies and procedures outlined in this Provider Operations Manual, any applicable supplements to the Provider Operations Manual and the Provider's Contract.
16. Provide services in accordance with applicable state and federal laws.
17. Document all services provided in accordance with the DMHDDSAS Records Management and Documentation Manual and the NCTracks Provider Claims and Billing Assistance Guide.
18. Ensure back-up staffing is available when the lack of immediate care would pose a serious threat to the member's health and welfare and formal Providers are not available. If back-up staff is not available, the Provider must complete a Level I Incident Report and submit it to the Quality Management department.
19. Submit documentation required for verification of employment of relatives or legal guardians and adhere to disposition of the decisions made by Partners regarding this policy.
20. Review all Alternative Family Living (AFL) sites using the AFL Checklist Guide-Appendix Y of NC Innovations Technical Guide, this Provider Operations Manual, any applicable supplements to the Provider Operations Manual and the provider's contract.
21. Ensure that settings where Day Supports, Residential Supports or Supported Employment are provided meet Home and Community Based settings requirements.
22. Ensure that Electronic Visit Verification requirements are met for Community Living and Supports and Supported Living - Periodic

Home and Community Characteristics

Home and Community Based Services settings requirements apply to Day Supports, Residential Supports, and Supported Employment.

The following HCBS Characteristics must in all settings:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community.

2. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.
3. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
4. Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources).
5. Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected.
6. Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices.
7. They also facilitate individual choice regarding services and supports, and who provides these.

The following additional HCBS Characteristics must be met in Provider Owned or Controlled Residential Settings:

1. Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity.
2. Provide privacy in sleeping or living unit.
3. Provide freedom and support to control individual schedules and activities, and to have access to food at any time.
4. Allow visitors of choosing at any time.
5. Are physically accessible.

Any modification of these conditions under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan.

Electronic Visit Verification (EVV):

Partners is required by the federal government to use Electronic Visit Verification (EVV) for some Medicaid services. **Two NC Innovations Waiver services require EVV – Community Living and Supports and Supported Living Periodic.** EVV helps make sure that people who should receive services actually receive them.

See Section W of this manual for more information on EVV. The Partners Provider Knowledgebase has more information on EVV: https://providers.partnersbhm.org/electronic-visit-verification/

Documentation

Provider agencies are responsible for the development of short-range goals and task analysis/strategies prior to implementation of the service. The task analysis is a process for determining in detail the specific behaviors required of staff to assist the member with the implementation of an outcome. Task analysis is the breakdown of how a task is accomplished, including a detailed description of any unique factors involved in or required for one or more people to perform a given task. For example: a task analysis would be used to assist a member with a specific self-help or daily living skill. A strategy is a long-term plan of action designed to achieve an

outcome. Strategies are used to make a problem easier to understand and solve. Short range goals and task analysis/strategies must be reviewed with and signed by the member/legally responsible person.

Free Choice of Providers

Members have free choice of providers within the Partners' Network and may change providers as often as desired. If a member's Medicaid changes to one of the counties within the Partners' regional catchment area and is already established with a provider who is not in the Partners provider network, Partners makes every effort to arrange for the member to continue with the same provider if he or she so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if a member needs a specialized Medicaid service that is not available through the network, Partners arranges for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, members are given the choice between at least two providers. Exceptions would involve institutional services or highly specialized services that are usually available through only one facility or agency in the geographic area.

A listing of network providers is available to members and their families for review at https://www.partnersbhm.org/provider-search/.

The Care Manager can assist the member or legally responsible person to identify providers who have:

- Geographic Availability.
- Cultural Specialty.
- Disability Specific Specialties

Services out of state

If a member travels out of state and needs the services of NC Innovations Waiver staff while out of North Carolina, there are certain requirements which must be met. Provider agencies, Agencies With Choice and Employers of Record assume all liability for their staff when out of state. The following criteria must be met:

- Services for members who have been receiving services from direct care staff while in state and who are unable to travel without their assistance.
- Members who live in alternative family living homes or foster homes may receive services when traveling with their alternative family living or foster family out-of-state under these guidelines.
- Members who are residing in residential settings are allowed to go out of state on vacation with their residential provider and continue to receive services as long as the participant's cost of care does not increase.
- Written prior approval of this request for their staff to accompany families/members out-of-state must be received from the supervisor of the staff person and Partners.
- Waiver services may not be provided outside of the United States of America.
- Provider Agencies must ensure that the staffing needs of all their members can be met.
- Supervision of the direct service employee and monitoring of care must continue.
- The ISP must not be changed to increase services while out of state.

- Services can only be reimbursed to the extent they would be had they been provided in state, and only if they benefit the member.
- Respite services **are not** provided during out-of-state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive other state's licensure laws.
- A NC licensed professional may or may not be licensed to practice in another state.
- Medicaid funds cannot be used to pay for room, board, or transportation costs of the participant, family or staff.
- Provider agencies and Agencies With Choice assume all liability for their staff when out of state.

The provider agency, Agency with Choice or Employer of Record must obtain written prior approval from Partners before services are provided outside of North Carolina.

The completed and signed request is submitted, along with the member's current short-range goals, to IDDSupport@partnersbhm.org. A written response will be provided.

*Written prior approval of this request for their staff to accompany families/ members out of state must be received from an Innovations Care Management Supervisor or their designee within the Partners I/DD Care Management department.

Go to https://providers.partnersbhm.org/nc-innovations/ for more details and the Out-of-state Travel Request Form.

ELECTRONIC VISIT VERIFICATION (EVV)

Electronic Visit Verification is a system that uses technology to record and confirm information about the delivery of services. This system uses time, date and location information from a cell phone, a home phone (land line), or an electronic fob to verify that Medicaid services and programs authorized by Partners are received by our members. EVV uses technology to record the times, dates and specific services that are given. This process makes sure that people who should receive services, in fact, receive them.

Section 12006 of the 21st Century Cures Act requires that the North Carolina Department of Health and Human Services (NCDHHS) begin using an Electronic Visit Verification (EVV) system for Personal Care Services (PCS) by Jan. 1, 2021, and for Home Health Care Services (HHS) by January 2023.

Services Impacted by Electronic Visit Verification include some Medicaid (b)(3) Services as well as Medicaid C only services. A current listing can be found on the Provider Knowledgebase: https://providers.partnersbhm.org/electronic-visit-verification/

PIHP POPULATIONS

Eligible Populations

PIHP/Medicaid Direct Plan Eligible Populations

The Department shall maintain sole authority for performing, managing, and maintaining all Medicaid eligibility, PIHP eligibility, enrollment, including but not limited to the following populations who are excluded or delayed from Medicaid Managed Care shall be eligible for enrollment in PIHP upon their launch:

1. Members who reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer.

2. Members who are in one of the following categories will be enrolled in the PIHP until the launch of the Foster Care Plan:

a. Enrolled in the foster care system;

b. Receiving adoption assistance; or

c. Under the age of twenty-six (26) and formerly were in the foster care system.

3. Members who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, except for beneficiaries enrolled in the Innovations waiver.

4. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations waivers excluding federally recognized tribal members

5. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the TBI waivers excluding federally recognized tribal members.

6. Presumptively eligible beneficiaries, during the period of presumptive eligibility, excluding presumptive eligibility for pregnant women.

7. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations and TBI waivers.

8. Beneficiaries being served through CAP/C; and

9. Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice). 10. Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a). iii. In accordance with N.C. Gen. Stat. § 108D-40(a)(5) and (5a), beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are eligible for the PIHP.

a. These beneficiaries will default to the Tribal Option for care management if they reside in a county where the Tribal Option is offered and will default to the PIHP for BH I/DD and TBI services and NC Medicaid Direct for physical health services, pharmacy, and State Plan LTSS.

b. These beneficiaries will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible).

Voluntary Populations

Medicaid Managed Care eligible members in the above specified eligibility groups may voluntarily disenroll from the Medicaid Managed Care program or choose not to enroll in the Medicaid Managed Care program if they are:

1. Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act. Described in section 501(a)(1)(D) of the Act. Described in Section 1902 (e)(3) of the Act.
2. Receiving foster care or adoption assistance under part E of Title IV of the Social Security Act.
3. In foster care or otherwise in out-of-home placement.
4. Meet the SSI disability definition as determined by the NCDHHS Division of Social Services.
5. Not receiving Tailored Plan enhanced services.

The Tailored Plan shall only process enrollment for members who are eligible for Tailored Plan coverage.

Partners PIHP/Medicaid Direct Enrollment and Disenrollment

Partners PIHP Roles and Responsibilities

1. Partners must adhere to PIHP eligibility decisions made by the Department and enroll or disenroll members in accordance with those decisions and this Contract.
2. Partners shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1).
3. Partners Eligibility and Enrollment staff have sufficient knowledge about the North Carolina Medicaid programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.
4. Partners shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect the member's Medicaid eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).
5. Partners shall ensure automatic reenrollment of a member who is disenrolled solely because they lose North Carolina Medicaid eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).
6. Partners shall only process enrollment for beneficiaries who are eligible for PIHP coverage.
7. Partners shall notify the Department in a format defined by the Department of the receipt of enrollment information for any beneficiary who is ineligible for PIHP within five (5) Business Days.
8. Partners shall direct the member to the NC FAST online portal or perform a Warm Transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.).
9. Partners shall ensure as outlined in Section IV.B. Program Operations that its telephone system will have the functionality to transfer beneficiaries and authorized representatives from the call center to the local DSS office without disconnecting the call.

10. If a member's demographic information is not updated during the next member reconciliation cycle with Partners and the Department, Partners shall follow up with members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.

Member Disenrollment

1. Partners shall adhere to the Department's disenrollment approach as defined in Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to: Member disenrollment requests; and Department disenrollment requests.
2. Partners shall accept and initiate all PIHP enrollments and disenrollments within twenty- four (24) hours of receipt of the complete standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
3. Partners shall comply with the Department's membership reconciliation process as defined in Section IV.L. Technical Specifications.
4. Partners shall develop and maintain a Member Enrollment and Disenrollment policy. Due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution the policy shall be submitted to the Department for review and approval. Partners shall submit to the Department for review any updates to the policy at least ninety (90) days prior to implementation. As long as the Member Enrollment and Disenrollment policy clearly states it applies to the Partners, the Member Enrollment and Disenrollment policy may apply to other Partners operations, including without limitation the BH I/DD Tailored Plan contract.

Member Requested Disenrollment

1. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the Tailored Plan to the Enrollment Broker by phone, mail, in-person, or electronically.
2. A member who is not excluded from Standard Plan enrollment may request disenrollment from a Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if applicable) any time during the coverage year.
3. A member who is excluded from Standard Plan enrollment may request disenrollment from a Tailored Plan and transfer to NC Medicaid Direct any time during the coverage year.
4. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
5. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
6. The Enrollment Broker will process disenrollment requests in accordance with the following:
    a. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
    b. The Enrollment Broker will notify NCDHHS of its decision by the next business day following receipt of the request.
7. Notice of disenrollment determination.

a. NDHHS will notify the member or authorized representative, and the Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
b. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or NCDHHS fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.

8. Expedited review of member-initiated requests for disenrollment.
    a. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the Tailored Plan could jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function.
    b. The Enrollment Broker will process requests for expedited review in accordance with the following:
        i. The Enrollment Broker will transmit expedited review requests to NCDHHS for evaluation within 12 hours of receipt of the request.
        ii. NCDHHS will evaluate and decide whether to approve or deny the request
    c. NCDHHS will notify the member, or authorized representative and the Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date will be within three calendar days of receipt of the request by the Enrollment Broker.

The Department of Health and Human Services, Division of Social Services is responsible for PIHP Medicaid eligibility determinations. The state agency will conduct enrollment activities for Medicaid Managed Care eligible members.

Provider Restrictions

Providers shall not conduct or participate in Medicaid Managed Care health plan enrollment, disenrollment, or transfer or opt-out activities, or attempt to influence a member's enrollment into a health plan. Prohibited activities include:

- Requiring or encouraging the member to apply for a Medicaid assistance category.
- Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits.
- Mailing or faxing enrollment forms.
- Aiding the member in filling out health plan enrollment forms.
- Aiding the member in completing online health plan enrollment.
- Photocopying blank health plan enrollment forms for potential beneficiaries.
- Distributing blank health plan enrollment forms.
- Participating in three-way calls to the enrollment helpline.
- Suggesting a member transfer to another health plan.
- Other activities in which a provider attempts to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan.

Provider Marketing Guidelines

Providers may:

- Make available and/or distribute state-approved marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates.
- If a provider agrees to make available and/or distribute managed care plan marketing materials (such as displaying posters or other materials in common areas such as the provider's waiting room) it should do so knowing it must accept future requests from other managed care plans with which it participates.

Providers must comply with the following:

- To the extent that a provider can assist a member or recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. The provider may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

- Participating providers may conduct marketing activities to beneficiaries however, providers shall comply with all marketing requirements/restrictions, and Partners will monitor and oversee the marketing activities to ensure that members receive accurate verbal and written information.

VERIFYING ELIGIBILITY

Medicaid Member Eligibility Verification

Providers are responsible for monitoring and verifying PIHP Medicaid eligibility for their members. This can be completed through NCDHHS' CCRP and NCTracks. Providers' employees who are responsible for this function need an NCTracks unique login and password.

For more information about getting started with NCTracks, go to: https://www.nctracks.nc.gov/content/public/providers/getting-started.html.

Medicaid Member Identification Card

Providers are required to implement a policy of requesting and inspecting an adult member's health plan member identification card, prior to providing non-emergency services. If you suspect fraud, please contact Partners Regulatory Compliance Alert Line at 1-866-806-8777, or you can report your concern online at https://partnersbhm.alertline.com.

Updating Member Demographics and Changes in Circumstances

Update member contact information including address and phone number in your systems and urge members and recipients to update with NC Medicaid using ePASS electronically or by calling their Medicaid case worker at their administrative county Department of Social Services. This is critical for continuity of care, crisis planning and maintaining communication with our health plan members.

GUIDELINES FOR PIHP PROVIDERS

Primary Care Physicians may be serving Members that fall into PIHP/Medicaid Direct based on their Medicaid eligibility. These providers would bill their physical health services to NC TRACKS directly.

Primary Care Providers (PCP)

The primary care provider (PCP) is the cornerstone of Partners' PIHP service delivery model. A PCP is the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member/provider relationship, supports continuity of care and patient safety, leads to elimination of redundant services, more cost-effective care and better health outcomes. Partners offers a robust network of PCPs to ensure every member has access to a medical home within the required travel distance. Partners

requests that PCPs inform the member service line 1-888-235-4673 when a Partners member misses an appointment so we may monitor it in our systems and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of emergency department services.

Provider types that may serve as PCPs

Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, internal medicine physicians, nurse practitioners and physician assistants. The PCP may practice in a solo or group setting or at a federally qualified health center (FQHC), rural health clinic or outpatient clinic. Partners may allow some specialists to serve as a member's PCP for beneficiaries with multiple disabilities or with chronic conditions as long as the specialist agrees, in writing and is willing to perform the responsibilities of a PCP as stipulated in this manual and their participating provider agreement/contract.

Primary Care Provider (PCP) Responsibilities

As an extension of the Partners participating provider agreement, all Partner's contracted providers are obligated to comply with the requirements stipulated in this provider manual. Primary care providers (PCP) shall serve as the member's initial and most important contact. PCP responsibilities include, but are not limited to, the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members or entering into an arrangement for management of inpatient hospital admissions of member.
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times, including members with special needs and chronic conditions.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide screening, well care and referrals to community health departments and other agencies in accordance with Partners provider requirements and public health initiatives.
- Conduct a behavioral health screen to determine whether the member needs behavioral health services.
- Maintain continuity of each member's healthcare by serving as the member's medical home.
- Offer hours of operation that are no less than the hours of operating hours offered to commercial beneficiaries or comparable to commercial health plans if the PCP does not provide health services to commercial beneficiaries.
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
- Ensure follow-up and documentation of all referrals including services available under the state's fee for service program.
- Collaborate with Partners care management program as appropriate including, but not limited to, performing member screening and assessment, development of care plans to address risks and

medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed.

- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule for members under age 21.
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization, as well as coordinating services the member is receiving from another health plan during transition of care.
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated.
- Actively participate in and cooperate with all Partners quality initiatives and programs.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.

PCPs may have a formalized relationship with other primary care providers to see their members when needed. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them.

Assignment of a Primary Care Provider (PCP)

Partners offers a robust network of primary care providers to ensure every member has access to a "medical home" within the required travel distance standards. For those members who have not selected a PCP during enrollment, Partners will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria and in the sequence presented below:

5. Member history with a PCP. The algorithm will first look to see if the member is a returning member and attempt to match them to their previous PCP. If the member is new to Partners, claim history provided by the state will be used to match a member to a PCP with whom the member had a previous relationship where possible.
6. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.
7. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members' travel time and mileage do not exceed required access standards.
8. Appropriate PCP type. The algorithm will use age, gender, language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs. Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. If the pregnant member does not select a pediatrician, or other appropriate PCP, Partners will assign one for her newborn.

Choice of a Primary Care Provider (PCP) or Change of PCP

Members can choose their PCP. Members are offered assistance in finding a PCP through the Partners' Provider Directory, which includes providers in the network with whom Partners' contracts. Partners' Member Services Team is available to assist members with this process. Members may want to choose someone that they have seen before and understands their health history. Each member enrolled in Partners' Tailored Plan may have a different PCP, or a PCP can be chosen to care for the entire family.

The PCP's name and contact information will be listed on the Medicaid card. If a member would like to change their PCP, they have 30 days from the date of receipt of the card to do so. Members may change their PCP via the PCP change form on PartnersBHM.org or email at PCP@Partnersbhm.org. Partners' Member and Recipient Services line at 1-888-235-4673 will also be available to assist in this process. Members can choose to change their PCP one time per year without reason.

For Members to change their PCP more than once per year, the member will need to cite good cause for the change. Members may have good cause if:

- PCP does not provide accessible and proper care, services or supplies (for example, does not set up hospital care or consults with specialists when required for treatment)
- Member disagrees with their treatment plan
- PCP moves to a different location that is not convenient for the member
- PCP changes the hours or days available
- Member has trouble communicating with PCP due to a language barrier or another issue
- PCP is not able to accommodate your special needs
- PCP and Member agree that a new PCP is best for member care

Medical Home Model

Partners is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by beneficiaries of their own care and reduce avoidable costs over time. Partners will actively partner with our providers, with community organizations and groups representing our beneficiaries to achieve this goal through the meaningful use of health information technology (HIT). Partners will evaluate all potential medical home providers according to the criteria established by NCDHHS and will regularly assess each contracted medical home's compliance with these requirements.

Referrals

As promoted by the medical home concept, primary care physicians (PCPs) should coordinate the healthcare services for Partners members/beneficiaries. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a member's healthcare, Partners encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans. In accordance with North Carolina Law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the provider's family has a financial relationship. Referrals can be submitted via Partners ProviderCONNECT, fax or phone. Any member seeking care from an

out-of-network primary or specialty care provider will continue to require prior authorization, which is subject to medical necessity review.

As a participating PCP in Partners' network, it is important to understand the requirements for both the referral and prior authorization processes to ensure your patients do not experience any disruption in care and claims are paid in a timely and accurate manner. Please see the referral process outlined below for more detail.

Partners' referral process utilizes both referrals and prior authorizations to help manage member care delivery. Prior authorization, or pre-certification, may be required prior to a member receiving a service or procedure. Some covered services and procedures require a prior authorization even if the service is provided by an in-network provider. All services and procedures provided by an out-of-network provider require prior authorization.

Referral-approval required prior to a member seeing a specific in-network specialty provider for an office visit.

Referral submission:

- Referrals can be submitted by PCPs via phone, fax or Partners ProviderCONNECT.
- Referrals will cover the member's office visits to the specialist indicated on the referral for a span of six months from the date of submission.
- If additional services or procedures are required following the specialist office visit, providers should utilize the prior authorization tool located on Carolina Complete Health's provider website (via ProviderCONNECT) to determine whether the needed procedure is covered or requires prior authorization before proceeding.
- Payment will be denied for any claims submitted by one of the above-listed specialty types if there is not an active referral in place on the date of service.
- A referral cannot be submitted for an out-of-network specialist.

If you are a participating PCP, you are responsible for managing the care for your patients, including the care provided by other clinicians. The referral process helps to facilitate adequate contact between you and the specialist to whom you are referring a member. It will help provide you with opportunities to complete health screenings, manage ongoing conditions and understand how beneficiaries are navigating available healthcare resources. The referral process outlined herein is aligned with current goals in healthcare around the Quadruple Aim – the right care, at the right time, in the right place.

<u>Specialist Responsibilities</u>

Specialists are required to report to Partners limitations on the number of referrals accepted. The specialist must notify Partners when the specialist reaches 85% capacity. Partners encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensure the referred specialty physician is a participating provider within the Partners' network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following Partners' referral guidelines.

Emergency admissions will require notification to Partners' Medical Management department within one business day, following the date of admission to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Partners.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain authorization from Partners' Utilization Management department if needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Actively participate in and cooperate with all Partners quality initiatives and programs. As a participating specialist in the Partners network, it is important to understand the requirements for both the referral and prior authorization processes to ensure your patients do not experience any disruption in care and claims are paid in a timely and accurate manner. Please see the referral process for more detail.

Protected Health Information (PHI)

Providers are charged with ensuring all people providing services maintain the confidentiality of all members and other information received during providing services. Providers may not discuss, transmit or narrate in any form, member information of a personal nature, medical or otherwise, except as authorized in writing by the member or his/her legally responsible person, or except as otherwise permitted by applicable federal and state confidentiality laws and regulations. This includes NC GS §122C, Article 3, which addresses confidentiality of all information acquired in attending or treating a member and 42 CFR, Subchapter A, Part 2, which addresses confidentiality of records of drug and alcohol use service recipients.

Protected health information (PHI) PHI may be shared for treatment, payment or operations (TPO).

- **Treatment**: The provision, coordination or management of healthcare and related services by a healthcare provider(s), to include third party healthcare providers and health plans for treatment alternatives and health-related benefits.
  Example: A PCP discloses identifying information to Partners when obtaining authorization for services.
- **Payment**: Activities to determine eligibility benefits and to ensure payment for the provision of healthcare services.
  Example: Provider submitting a claim with PHI to Partners for the purpose of payment for services.
- **Health care operations**: Activities that manage, monitor and evaluate the performance of a healthcare provider or health plan.
  Example: CMS conducting an internal audit. Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal

or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA privacy rule.

A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor (under 18 years of age) has the right to agree to some treatments without the consent of his/her parent or guardian for:

- Use of controlled substances or alcohol.
- Emotional disturbance.
- Has behavior that presents threat to life or physical well-being.

If the member disagrees with what a physician, treating provider, clinician or case manager has written in his/her record, the member can write a statement from his/her point of view to go in the record, but the original notes will also stay in the record in accordance with state requirements.

Mainstreaming

Partners considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program member or physical or behavioral disabilities except where medically indicated.

Examples of prohibited practices include:

- Denying a member/beneficiary a covered services or availability of a facility.
- Providing a Partners' member/beneficiary a covered service that is different or in a different manner, at a different time, or at a different location than to other "public" or private pay member/beneficiary's (examples: different waiting rooms or appointment times or days).
- Subjecting a member/beneficiary to segregation or separate treatment in any manner related to covered services.

Appointment Accessibility Standards

Partners follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Partners monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency department utilization. Providers who fail to comply with published appointment standards may be subject to corrective action.

Partners will also ensure compliance with network adequacy and appointment wait time standards for adult and pediatric providers separately, Medicaid, which vary by the type of service:

Appointment Wait Time Standards for Medicaid Tailored Plan

Reference number	Visit type	Description	Standard
Primary Care			
17.	Preventive care services – 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.
1.a.	Preventive care services – child, birth through 20 years of age.		Within 14 calendar days for members less than six months or age and older. Within 30 calendar days for members six months or age and older.
18.	Afterhours access – emergent and urgent.	Care requested after normal business office hours.	Immediately (available 24 hours a day, 365 days a year).
19.	Urgent care services.	Care provided for a nonemergent 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.
20.	Routine/check-up without symptoms.	Non-symptomatic visits for routine health check-up.	Within 30 calendar days.
Prenatal Care			
21.	Initial appointment – first or second 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.
5.a.	Initial appointment – high risk pregnancy or third trimester.		Within five calendar days.
Specialty Care			
22.	Afterhours access – emergent and urgent.	Care requested after normal business office hours.	Immediately (available 24 hours a day, 365 days a year).
23.	Urgent care services.	Care provided for a nonemergent illness or injury with acute symptoms	Within 24 hours.

		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.	
24.	Routine/check-up without symptoms.	Non-symptomatic visits for health check.	Within 30 calendar days.
Behavioral Health, I/DD and TBI Services			
25.	Mobile crisis management services.	Refer to RFA Section VII, Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within two hours.
26.	Facility-based crisis (FBC) management services (FBC for child and adolescent, FBC for adults, non-hospital medical detox).	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Emergency services available immediately (24 hours a day, 365 days a year).
27.	Emergency services for mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Immediately (available 24 hours a day, 365 days a year).
28.	Emergency services for substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Immediately (available 24 hours a day, 365 days a year).
29.	Urgent care services for mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards	Within 24 hours.

		for Medicaid and State-funded recipients.	
30.	Urgent care services for substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 24 hours.
31.	Routine services for mental health.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 14 calendar days.
32.	Routine services for substance use disorders.	Refer to RFA Section VII. Attachment M.9. BH service classifications for appointment wait time and routine, urgent and emergent care standards for Medicaid and State-funded recipients.	Within 48 hours.

Medicaid Direct: Section VI. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Behavioral Health and I/DD Services			
1	Mobile Crisis Management Services	Refer to *Section VI. Attachment M.4 BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Emergency Services for Serious Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

4	Emergency Services for Severe SUD	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
5	Urgent Care Services for Serious Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within twenty-four (24) hours
6	Urgent Care Services for Severe SUD	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within twenty-four (24) hours
7	Routine Services for Serious Mental Health	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within fourteen (14) calendar days
8	Routine Services for Severe SUDs	Refer to *Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within forty-eight (48) hours

No Reject Requirements

Providers are required to attest that upon application to Partners' network that a "no-reject policy" for referrals within the capacity and the parameters of their competencies is in place. Providers also agree to accept all referrals meeting criteria for services they provide when there is available capacity. Covering Providers

Providers must arrange for coverage with another Partners network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify the Provider Network department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement.

Telephone Arrangements

PCPs and specialists must:

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule broken and no-show appointments.

- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  a. After hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  b. Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member medical record.

Note: If after hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Partners will monitor appointment and after-hours availability on an on-going basis through its quality improvement program (QIP).

<u>24-Hour Access: After Hours Coverage</u>

Partners PCPs, behavioral health providers and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, seven days a week.

- A provider's office phone must be answered during normal business hours and normal business hours must be maintained for at least 30 hours per week.
- During afterhours, a provider must have arrangements for:
  - Access to a covering physician.
  - An answering service.
  - Triage service.
  - A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish if the provider's practice includes a high population of Spanish speaking beneficiaries.

Examples of unacceptable afterhours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered afterhours by a recording that tells patients to leave a message.
- The provider's office telephone is answered after hours by a recording that directs patients to go to an emergency department for any services needed.
- Returning after-hours calls outside thirty minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP, behavioral health provider or specialist for a clinical decision.

Whenever possible, PCP, behavioral health provider, specialty physician or covering medical/behavioral professional must return the call within 30 minutes of the initial contact. Afterhours coverage must be accessible using the medical office's daytime telephone number. Partners will monitor provider offices through afterhours calls conducted by Partners Provider Network department.

Provider Directory Demographic Changes

Partners strives to maintain the most accurate and up-to-date information in its provider directory. When Partners receives new information from a practitioner or facility or the provider terminates, the provider directory is updated within 10 business days of the date the new information is received. Demographic changes can be submitted via the provider change form and submitted to Enrollment@partnersbhm.org. Provider will need to complete a Managed Change Request (MCR) through NCTracks for demographic changes.

Hospital Responsibilities

Partners utilizes a network of hospitals to provide services to Partners members/recipients. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this provider manual.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency department (ED) visit.
- Obtain prior authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Partners Medical Management department by sending an electronic file of the ED admission by the next business day. The electronic file should include the member's name, presenting symptoms/diagnosis, date of service (DOS) and beneficiaries phone number.
- Notify Partners Medical Management department of all admission within one business day.
- Notify Partners Medical Management department of all newborn deliveries within one business day of the delivery.

Partners' hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

A prospective hospital that will be delivering behavioral health inpatient services to members with Medicaid eligibility from the Partners catchment area, may apply and be enrolled as a provider with Partners and qualify for reimbursement for hospital services under the Partners Medicaid waiver. Hospitals must have a signed contract to qualify for reimbursement for hospital services with State (North Carolina) funds.

Partners accepts the hospital and/or health systems' enrollment in NCTracks and information from NCDHHS CCRP in lieu of credentialing and recredentialing. This includes all facilities and sites enrolled in NCTracks and affiliated with the hospital/health system and all practitioners billing through the hospital/health system's

NPl(s). Hospital and/or health systems may request to contract with Partners by submitting the appropriate request form posted on the Partners website at https://providers.partnersbhm.org/hospitals-working-partners or call the Provider Service Line at 877-398-4145.

Hospital Patient Enrollment & Discharge Instructions for Behavioral Health Facilities

Indigent: Three-way contract, state benefits.

State-funded members (indigent) will be enrolled by one of the following methods.

- Keying the enrollment information directly into the Partners' Alpha+ system. Free training is available for those hospitals interested in this method of submission by contacting the Partners' service desk at 704-842-6431.
- Submitting a completed special project enrollment form (SPEF) by encrypted email or fax to the PartnersACCESS department. This form can be found on the quick links section of this page: https://providers.partnersbhm.org/hospitals-working-partners/.
    - Email – AccessStaff@partnersbhm.org.
    - Daytime fax (8 a.m. to 4:30 p.m.) 336-835-2075.
    - After hours fax (4:30 p.m. to 8 a.m.) 336-527-8010.

The PartnersACCESS department will review the SPEF/enrollment request for completion and will enter into Alpha+ within 24 hours of receipt and will approve if all required information is submitted. If all required information is not documented correctly, the SPEF will be returned to the hospital for correction.

Medicaid

Medicaid members.

- Hospitals do not need to submit the SPEF for a Medicaid member.
- Hospitals should confirm the member has Medicaid originating from one of the counties within Partners' regional catchment area. Hospitals can confirm the Medicaid county of origin by using their own internal process of verification or by using one the following methods.
    - Requesting recipient's Medicaid eligibility card
    - Medicaid global eligibility file
    - Alpha+
    - Calling the PartnersACCESS department at-888-235-4673

Discharge

Discharge follow up appointments.

The PartnersACCESS department will schedule discharge follow up appointments 24 hours a day, seven days a week, 365 days a year for:

2. Tailored Plan members whose Medicaid originates from the Partners catchment area

Indigent members who reside in a county from the Partners catchment area

Discharge follow up appointments for members with private insurance, Standard Plan PHPs, Medicare or Medicaid originating from a county covered by another Tailored Plan or LME/MCO must be handled through the entity managing that member's payer source.

Hospital Patient Authorization Instructions

Partners Health Management Enrollment

For authorization and reimbursement, patients must be enrolled with Partners. Enrollment status can be determined by checking the Alpha+ system or calling the PartnersACCESS department at 1-888-235-4673.

For more information regarding member enrollment, please contact: PartnersACCESS department at 1-888-235-4673 or email EnrollmentEligibility@partnersbhm.org.

Utilization Management (UM)

Partners UM reviews all inpatient service authorization requests (SARs). Acute services team (AST) Utilization Management (UM) staff (the team that reviews requests for inpatient services) are available 10 hours a day, seven days per week, including weekends and holidays. AST UM staff can be contacted at 704-842-6434.

A SAR begins with the admission day and does not include the day of discharge. Hospital staff are responsible for determining the number of days needing authorization and when the next SAR is due.

Submitting Inpatient Requests

Information requested on the inpatient review form is required with each SAR. This form and other information pertaining to requesting authorization for inpatient services can be found at https://providers.partnersbhm.org/hospitals-working-partners/.

The inpatient review form can be completed and attached to the SAR. If the form is completed and attached, then that information does not need to be duplicated in the SAR justification. However, if the inpatient review form is not completed and attached, then the information requested on that form needs to be documented in the SAR justification.

The initial or continued stay SAR information will be reviewed and the requested service will be approved if medical necessity criteria (Clinical Coverage Policy 8B https://medicaid.NCDHHS.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies) for inpatient hospitalization has been established. If further clinical information is needed, UM staff will attempt to contact the identified hospital utilization review staff via phone outreach to obtain additional information. If UM is unable to approve based on the information received, the request will be referred for a peer review. UM will attempt to set up a peer-to-peer conversation prior to issuing an adverse decision. If there is no hospital utilization review (UR) coverage and/or UM cannot obtain an attending physician's contact information, a peer review may be done without consultation. In the result of an adverse decision, a provider can request a peer-to-peer conversation within five business days by calling the UM Appeals department, 704-884-2650.

Hospital utilization staff will need to check the ProAuth system to determine the number of days authorized and when the next review is due.

Initial Inpatient Requests

Medicaid (101) and State-Funded Services (YP820).

Authorization is required for initial Medicaid and State-Funded Service authorization requests (SARs) within 72 hours of admission. Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Clinical Coverage Policy 8B, allows a hospital up to 72 hours from time/date of admission to notify an LME/MCO of the admission. If initial SARs are submitted within 72 hours of admission, Partners UM will review back to the first day of treatment. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

Institute for Mental Disease (IMD) Medicaid (160)

Medicaid beneficiaries ages 21-64, who meet medical necessity for inpatient care may be treated at an institute for mental disease (IMD) up to 15 days per calendar month*.

Hospitals can submit a service authorization request (SAR) within one business day of discharge, for the entire length of stay (LOS), up to maximum 15 days per calendar month) for MH IMD requests. For SU IMD requests, there is no maximum length of stay.

Hospitals have the option of seeking authorization upon admission.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

*For 0160- MH IMD admissions spanning two consecutive months, the total length of stay may exceed 15 days, but no more than a 15-day LOS each month is eligible for authorization. Substance Use IMD length of service may exceed 15 days per month.

Three-Way (YP821, YP821SA, YP822, YP822SA)

Authorization is required for Initial three-way funded service authorization requests (SARs) within three calendar days of admission.

Three-way hospital providers have up to three calendar days, after midnight of the day of admission to submit a SAR. Partners Utilization Management staff will review the documentation and SAR for medical necessity back to the date of admission. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

A SAR begins with the day of admission and does not include the day of discharge.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Continued Stay (Concurrent) Inpatient Requests

Prior authorization is required for any continued stay service authorization requests (Medicaid, 101; State, YP820; or Three Way YP821/SA, YP822/SA). Continued stay SARs will not be reviewed retroactively. A SAR must be submitted in ProAuth on the last day of the current authorized timeframe or on the first day service is continued. UM reviewers perform ongoing concurrent review for inpatient admissions through contact with the hospital's Utilization Review and Discharge Planning department and when necessary, with the member's attending physician. The UM reviewer will review the member's status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of necessary information and notification within one business day after the decision is made. Written or electronic notification includes the number of days a service is approved and the date of the next review.

Refer to Partners Medicaid and state benefit grids (https://providers.partnersbhm.org/benefit-grids/) for most up-to-date benefit limits and documentation requirements.

Exceptions for Inpatient Benefit Plan Limits

Involuntary Commitment (IVC) Admissions:

Partners recognizes when an IVC leads to a member/recipient being admitted to a psychiatric inpatient unit, the facility needs time to fully assess the need for the commitment to stand or be dismissed. Since the law related to IVCs legally allows the facility to take up to 72 hours to complete their evaluation, UM will authorize the initial three days for these admissions.

If the third day of the authorization falls on a Saturday or Sunday, Partners will allow the request to extend to Monday as outlined below:

- **Weekends –** Partners allows an exception for SARs with a LOS covering including a weekend day. Specifically, hospitals submitting SARs with an end date of Saturday can request one additional day to extend the maximum allowed days requested to four (allowing a request for Thursday, Friday, Saturday and Sunday). A continued stay SAR must be submitted on or by end of inpatient business day hours on Monday. SARs will be reviewed for medical necessity.

  UM inpatient staff will still be available seven days a week including holidays. If a hospital needs or chooses to submit a SAR during that time, UM staff will be available 24 hours a day.

- **Monday holidays –** Partners allows a similar exception for holidays that are on a Monday. Hospitals can submit a SAR for one additional day (maximum four-day length of stay request) to make a request through a holiday weekend. For example, if a three-day SAR is submitted with a start day of Friday, hospitals can request Friday, Saturday, Sunday and the Monday-holiday. A continued stay SAR must be submitted on or by end of the day on Tuesday. SARs will be reviewed for medical necessity.

Alternative Methods for Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the ProAuth system used by Partners UM. Providers may contact the Partners service desk, 704-842-6431, to request login information and assistance.

For circumstances when ProAuth cannot be utilized, SARs can be processed:

- **Live review by phone**: Hospital staff will need to call 704-842-6434, to reach a UM reviewer 24-hours a day, seven days a week. The UM reviewer will collect information detailed on the inpatient review form.
- **Manual review by fax or e-mail:** A manual SAR form must be completed to include information on the inpatient review form. Documents can be faxed to 704-884-2703 or emailed to BHIDDManualAuthorizations@partnersbhm.org.

Prior authorization guidelines still apply.

Retroactive Medicaid Service Authorization Requests

Partners' Utilization Management (UM) department reviews requests for retroactive Medicaid requests submitted within 90 days from the modified date in NCTracks. All retroactive service authorization requests (SAR) must be submitted to UM for medical necessity review. For further questions on retroactive Medicaid requests, please contact the AST UM workgroup at 704-842-6436.

Hospital Claims Instructions – Behavioral and Acute

Claims may be submitted from hospitals for emergency department, inpatient, and hospital outpatient. Partners contracts with Emdeon for hospital clearinghouse services**.** Claims may be submitted through the hospital's clearinghouse, direct 837I submissions and direct entry individual claims into the Partners claims management system.

Rates paid to the hospital under the terms of this agreement will be equal to the current published per diem rate by the NC Division of Health Benefits (DHB) for services provided after January 31, 2013. For emergency room services, the reimbursement rates will be calculated using the hospital's unique RCC outpatient percentage in effect on January 31, 2013, times 80% of the hospital's billed service costs. These rates may be adjusted as the DHB updates their rates based on changes in hospital.

Only members with Medicaid coverage for one of Partners' covered counties will be paid. Members with Medicaid coverage outside of the Partners' catchment area should be billed to the appropriate LME/MCO based upon recipient's county eligibility.

Claims are required to be submitted within 365days of a member's discharge date. Providers may submit claims to Partners up to 365 days from the date of service in the event of coordination of benefits has occurred.

Timely filing requests should be sent directly to claimsdepartment@partnersbhm.org prior to submitting the claims.

- Retroactive Medicaid: Claims based on retroactive Medicaid eligibility must have authorization requested within 90 days. Timely filing requests and submission of claims must be within 90 days of the date modified in NCTracks for eligibility date range.

Only appropriate services/codes will be paid. They are listed below:

- **Emergency Room**
  - RC450-RC459.
  - Bill Type 13X.
  - Ancillary charges are paid as appropriate.
  - Subject to coordination of benefits.
  - No Partners BHM Authorization is required.
  - ICD-10 codes between F01-F99.
  - Paid at 80% times the RCC of the Approved Medicaid rate.
- **Inpatient Hospital Charges**
  - Revenue Codes 101, 113, 114, 116, 120, 123, 124, 126, 128.
  - Paid upon the state negotiated per diem rate, which includes ancillary charges, ED charges, labs, testing, etc.
  - ICD-10 codes between F01-F99.
  - Bill Type of 0111-0114 or 0117-0118.
  - Admit Type of 11X.

Subject to coordination of benefits.

Reimbursement is limited to the number of days authorized.

Hospital Outpatient Charges

  - Revenue Codes: 901-903, 905-907, 912-916, 918-919.
  - Bill Type 0130-0135, 0137-0138.
  - Admit Type of 3.
  - ICD-10 codes between F01-F99.
- **Subject to coordination of benefits.**
- **Partners authorization required.**

Payments are required to be processed through EFT (Electronic Funds Transaction) transactions (Electronically deposited into the Hospitals bank)**.**

- For more information regarding claims or to ask questions, please contact Partners' Claims department: Phone: 704-842-6486
- Fax: 704-854-4203
- Email: claimsdepartment@partnersbhm.org

Information needed for authorization of Electroconvulsive Therapy (ECT) Procedures and a checklist are located on the Provider Knowledge Base under the Clinical Criteria Check Sheets (http://providers.partnersbhm.org/clinical-criteria-checksheets.)

Advanced Directives

Advanced Directives are legal documents in which individuals give written instructions about their health and mental health care if, in the future, they cannot speak for themselves.

CMS 42 CFR Statute "§ 489.102 Requirements for providers.

"Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

Provide written information to such individuals concerning an individual's rights under State law to make decisions concerning such medical care.

- Providers must document such information in the permanent medical record.
- Partners recommends that providers:
    - Ask the member if they have executed an advance directive. This should be conducted at the first point of contact with the member. Providers will ask if the member has executed an advance directive with the response documented in their medical record.
    - If the member has executed an advance directive, the member should share a copy with the provider for the member's medical record.
    - An advance directive should be included as a part of the member's medical record and include any mental health directives.
    - If an advance directive exists, the provider/physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any discussion should be documented in the medical record.

Per 42 CFR 489.104, providers must also have written policies and procedures respecting the implementation of such rights to advance directives and include a provider's statement of limitation. Providers must train staff regarding these policies and procedures and offer community education as well. Details of requirements are in the statute. Providers of home health services are strongly advised to read the statute in full and assure they are following these requirements.

42 CFR 489.104: https://www.govinfo.gov/content/pkg/CFR-2006-title42-vol4/pdf/CFR-2006-title42-vol4-sec489-102.pdf

Types of Advance Directives

Advance Directives are instructions that individual makes so their wishes can be followed if they become unable to make their own decisions. Advance Directives include a living will, durable power for health care, medical power of attorney, physician orders for life-sustaining treatment, do not resuscitate orders and psychiatric advanced directives.

- Living Will: Also known as "A declaration of a desire for a natural death," a living will is a legal document which states the desires to not to have an individual's life prolonged by extraordinary measures if they have a terminal or incurable illness or if they are in a vegetative state.
- Durable Power of Attorney for Health Care/Medical Power of Attorney: Also known as a "medical power or attorney" or "health care proxy" or "health care power of attorney." A healthcare power of attorney allows an individual to name a person they trust to make health care decisions if they cannot make themselves.
- POLST (Physician Orders for Life-Sustaining Treatment) or MOST (Medical Order for Scope of Treatment: A physician order that helps give seriously ill patients more control over their end-of-life care.
- Do not resuscitate (DNR) orders: A physician order that instructs health care providers not to do cardiopulmonary resuscitation (CPR).
- Psychiatric Advanced Directive (PAD): Also known as an "Advance Instruction for Mental Health Treatment," a psychiatric advanced directive is a legal declaration of instructions, information and preferences regarding a person's mental health treatment. It also states that the person is aware that the advance instruction authorizes a mental health treatment provider to act according to their wishes. It may also outline consent or refusal of mental health treatment.

Resources

Copy of the N.C. form: https://www.nrc-pad.org/images/stories/PDFs/north%20carolinastatute.pdf

Ten commonly asked questions about PADs for North Carolina and NC form: National Resource Center on Psychiatric Advance Directives: https://www.nrc-pad.org/states/north-carolina/

Advance Health Care Directive FAQs Secretary of State website and North Carolina Regulations:

- https://www.sosnc.gov/frequently_asked_questions/by_title/_advance_healthcare_directives
- https://www.sosnc.gov/divisions/advance_healthcare_directives

National Resource Center on Psychiatric Advance Directives brief videos for PADs: https://www.nrc-pad.org/videos/

- Psychiatric Advance Directives – a quick introduction
- How to write a Psychiatric Advance Directive?
- Federal Law on Advance Directives: The Patient Self-Determination Act

SAMHSA My Mental Health Plan free app: https://www.samhsa.gov/newsroom/press-announcements/202010010505

Medical advance directives free app for mobile devices: https://mydirectives.com/en/about/company/

Voluntarily Leaving the Network

Ensuring Continuity of Care when a Provider Leaves the Network

Partners will provide care transition assistance to ensure that members/recipients experience no disruption in care when a provider leaves the network. In addition to assistance by our member services team, our care managers support members through the transition process.

Member services will assist impacted members/recipients currently receiving services from a provider leaving the network to transition to a new network provider and offer additional assistance with the provider selection process.

Partners will also conduct outreach to members/recipients receiving services from a terminating specialist to explain their options for selecting a new provider. Partners will educate members/recipients about the online Provider Directory and share information about available resources in their area. It is important to note that a member has the right to stay with the provider even if they choose to leave the network. In instances in which a provider is terminated or leaves the Tailored Plan's network for expiration or nonrenewal of the contract and the member is in an ongoing course of treatment or has an ongoing special condition, Partners shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

Maintaining Continuity of Care for Members with Scheduled Appointments

To ensure continuity of care and prompt service delivery for members/recipients affected by a provider's decision to leave the network, care managers will assist, as indicated, with scheduling an appointment (or setting up regular appointments) so they can be seen by the new provider as soon as possible.

For members/recipients in active treatment, our transition of care team will notify the new provider that the member/recipient has open authorizations. The new provider can view this information, as well as appointment frequency and scheduled appointments, in ProviderCONNECT, our secure provider portal.

Notifying Members/Recipients and Ensuring Access to Services in the Event of a Provider Leaving the Network

Partners' process for notifying members/recipients who are receiving State-Funded Services is the same as for notifying members who are receiving Medicaid services. Recognizing the funding limitations for State-Funded Services, we promptly transition members/recipients to the care and services they need and ensure funds are available to support their care. To ensure continuation of care and service delivery, the funds follow the recipient to the new provider.

Transition of Care Obligations

Partners is committed to an integrated, well-coordinated system of care for members, including those transitioning into and out of Partners Tailored Plan. We will ensure seamless transitions through close collaboration with other entities involved in the member's care. We will identify and exchange physical health, behavioral health, pharmacy and social determinants of health (SDOH) information on a timely basis for members transitioning between entities and providers. We will honor requests to maintain relationships with existing providers, including specialists, assuming the provider is willing to meet Department standards. Partners believes this flexibility is important given the complex needs of members receiving services through Partners' Tailored Plan.

Member Education

Partners will educate current and new members about the transition process through the Member and Recipient Handbook, new member Welcome Call, Partners' website, MemberCONNECT and through interaction with care managers.

Provider Education

We will inform providers about the transition process and stress the importance of notifying Partners when a member requires transition assistance. Information about the transition process will be available through ProviderCONNECT, Partners' website and care managers working with members in active care.

The following response details the roles and processes:

- The role of the transition coordinator
- Our approach for transition and warm hand offs
- How Partners will support member transitions in the rare event a provider is terminated

Through these processes, Partners will support the health and well-being of members with complex healthcare needs.

Partners Transitions of Care Coordinator

Partners' transitions of care (TOC) approach, programs and policies reflect contract requirements and the unique needs of members who transition among Standard, Tailored and Medicaid Direct plans based on eligibility and clinical needs. Our Transition of Care (TOC) Coordinator leads this effort and serves as a liaison with providers involved in the member's transition. The TOC Coordinator will oversee our strategy for coordinating continuity of care for members enrolling with Partners, regardless of situation or circumstance. Contact information: toc_partners@partnersbhm.org or by calling (704) 884-2578. The TOC Coordinator will be responsible for:

- Identification of transferring members.
- Close coordination between transferring and receiving entities.
- Receiving or sending all relevant member information to ensure continuity of care.
- Data Exchange Processes

Partners has established secure file transfer protocol (FTP) sites for external Tailored Plans, LME/MCOs, Standard Plans, Community Care of North Carolina (CCNC), Medicare or other transition entities and payers. The transition coordinator and team use the sites to transmit and receive available data including physical health, BH, I/DD, TBI, long term support services (TSS) and pharmacy open service authorizations. Partners uses the sites to submit claims data, care management information such as care plans/individual support plans (ISPs), care needs screenings, consents, and adverse benefits determinations to receiving entities. We use real-time application programming interfaces.

Transition into Partners and Ongoing Transition Support

The TOC team checks enrollment reports daily, receives disenrollment spreadsheets from health plans providing lists of members who are transitioning to Partners through State-generated processes, and receives beneficiary or provider submitted "Request to Move" notifications from the Enrollment Broker to determine member who are entering or leaving Partners plan. Within five days of notification of a transition, TOC staff confirm successful transfer and receipt of relevant member information including:

- A summary page narrative of member-specific circumstances that are time-sensitive or could potentially impact continuity of care
- A summary of providers serving the member
- PH, BH, I/DD, TBI, LTSS and pharmacy treatment and care management records
- Open service authorizations
- Prescheduled appointments
- Non-emergency medical transportation data
- Historic claims and encounter data

Partners will, within five business days from NCDHHS notification of the member's anticipated enrollment date, conduct a warm transfer meeting on behalf of high need members. TOC staff will contact the member (if necessary) to confirm the name of the former entity from whom we should request relevant member information. . All transfer of clinical data and communication adhere to 42 CFR Part 2 regulations to maintain confidentiality of substance use disorder patient records.

Partners provides education and guidance on Transition of Care to Tailored and Medicaid Direct plans as described below:

- For members under 21 years of age, the member or guardian should contact the Standard plan to request review for coverage under EPSDT guidelines.
- For assistance with Partners Transition of Care related questions, please contact the Transition of Care team at toc_partners@partnersbhm.org.
- Provider can electronically complete the expedited Request to Move form with Service Associated Request (SAR) on the DHHS website at https://ncmedicaidplans.gov/submit-forms-online.

Resources:

Provider Ombudsman 866-304-7062 email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Enrollment Broker (members) 833-870-5500

Member Ombudsman 877-201-3750

Honoring Outstanding Authorizations

Our priority for new members transitioning into Partners is to ensure that members have continued access to needed services without disruption. We will implement strategies to minimize disruption of benefits for members of Partners' Tailored Plan by adhering to prior authorization requirements. We will reset the number of visits that do not require prior authorization, honor current authorizations for ongoing benefits and comply with NCDHHS-defined protocols for streamlining prior authorization requests. The TOC Coordinator, with support from our data analytics team, will retrieve all available claims, authorization and care plan/ISP records. The transition coordinator will ensure this information is available in our care management documentation system.

Partners will honor outstanding prior authorizations from a new member's previous source of coverage, such as another transition entity, for the first 90 days of enrollment or until expiration of the current authorization, whichever occurs first. We will also maintain incoming care management stratification until a new care management comprehensive assessment is complete. We will allow pregnant members to continue to receive services from their BH provider or obstetrician, without any form of prior authorizations, until birth, end of pregnancy or loss of Medicaid eligibility during pregnancy.

Partners will honor existing and active medical prior authorizations on file with NC Medicaid Direct, Standard Plans, and BH I/DD Tailored Plans minimally for the first ninety (90) Calendar Days after PIHP implementation or until the end of the authorization period, whichever occurs first to ensure continuity of care for Members. For service authorizations managed by Partners and impacted by 42 C.F.R. Part 2, Partners shall deem authorizations submitted directly by impacted providers as covered under this requirement. For the first ninety (90) Calendar Days after PIHP launch, Partners shall pay claims and authorize services for Medicaid-eligible non-participating/out-of-network providers equal to that in in-network providers to ensure that providers fully understand Partners' prior authorization requirements during the transition. Partners shall process and pay for services rendered during this Crossover transitional period if:

3. A provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
4. A provider submits for retroactive prior authorizations.

Transitioning of Care - Providers

Partners will support members in transitioning to an in-network provider at the end of the service authorization period established by their previous plan. Partners will allow the member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, if the member:

- Is in an ongoing course of treatment.

- Has an ongoing special condition. I/DD, a mental health diagnosis, substance use disorder or traumatic brain injury (TBI) are considered special conditions under N.C. General Statute § 58-57-88(a)(1).

In lieu of the transitional period established in N.C. General Statute § 58-67-88(d), we will honor the transitional period for 180 days. We will notify contracted providers to extend current or future authorization requests.

Our Provider Network staff will contact out-of-network servicing providers before current authorizations expire to engage them in the contracting process.

To prepare for transition, we will obtain:

- The most recent psychiatric evaluation and/or care management comprehensive assessment
- Current treatment plan
- Level of Care Utilization System (LOCUS) or acuity level tool
- All other information on Partners' Transition Checklist

Using the transition checklist, the transition coordinator will confirm we have received or sent all necessary member information. We conduct all contact and information sharing in compliance with privacy and security of protected patient information laws and regulations Coordination of Benefits and Services requirements

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. The exclusion is procedure codes listed on the Medicare/TPL Bypass list.

See Billing Guidelines Section of this Manual for more information.

PARTNERS PIHP MEDICAL MANAGEMENT

Overview

Partners Medical Management department hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. EST. After normal business hours, Utilization Management (UM) staff are available to answer questions regarding prior authorization. Medical Management services include the areas of utilization management, care management, population health, pharmacy, and quality management. The areas are overseen by the Partners Chief Medical Officer ("Medical Director"). The Chief Medical Officer has responsibility for direct and/or clinical supervision and operation of the Clinical Services department (i.e., Utilization Management, Care Management, and PartnersACCESS) and Clinical Practice Standards (and evidence-based practices).

Partners maintains UM policies and procedures that are fully compliant with North Carolina standards. Our UM program, fully detailed in our policy, is based on Division of Health Benefits Medicaid criteria. We will use nationally recognized, evidence-based physical health (PH) and behavioral health (BH) practice guidelines and decision support methods. Partners' UM program establishes a framework for oversight and guidance of

Medicaid and State-funded programs. Through established policies and processes, we will assure consistent application of service eligibility criteria when processing requests for initial and continued service authorization. Our approach supports UM and prior authorization processes for services that extend beyond mandated clinical coverage policies. Through UM, we determine medical necessity according to best practice and community standards. Partners will comply with required clinical coverage policies. To ensure consistent knowledge and application of these policies, our clinical leadership team train staff and providers on medical necessity criteria and conduct inter-rater reliability tests with UM staff.

Partners' policies and procedures will support an integrated, holistic look at physical health, long-term services and supports (LTSS), BH, I/DD and medications, noting alternative treatments or supports that may be appropriate in light of a member's complete clinical and other support needs. Our cross-functional UM team will consider a member's whole health needs. Our UM staff and medical directors make medical necessity determinations by applying clinical policy, evidence-based clinical standards of care, where available, and considering the individual member's specific circumstances and health care needs. Our UM staff enlist a variety of resources and processes to successfully implement and maintain a quality program that oversees utilization and provider quality.

These include use of:

- Established procedures to request, review and approve service authorizations
- Clinical tools and criteria to evaluate medical necessity in accordance with the North Carolina Clinical Coverage Policies
- Application of standardized UM and clinical decision-making processes through interrater reliability reviews
- Identify best practice treatment outcomes, appropriate utilization, level and intensity of services
- Review mechanisms to identify and minimize over- and under-utilization
- Implement cost-effective strategies to manage health care resources for members and recipients with high-risk and inappropriate high-utilization rate and high-costs
- Identify utilization trends and work with providers to make any needed improvements

Clinical Practice Standards

Partners develops clinical practice guidelines for behavioral and physical health management of its members that are consistent with national or professional standards and covered benefits. The following guidelines are reviewed and updated annually by Partners' Clinical Advisory Committee (CAC). It is expected that all network providers will follow the below guidelines and requirements as delineated in contracts.

For the most current version of the Clinical Practice Guidelines adopted by Partners, visit Partners' ProviderCONNECT portal. Our website contains information for providers for all UM programs, policy, and requirements at https://providers.partnersbhm.org/. https://providers.partnersbhm.org/

Partners uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. . The monitoring results of each guideline is reported to the Clinical Operations Committee (COC) and the Clinical Advisory Committee (CAC) quarterly.

The following are examples of clinical practice guidelines:

Clinical Practice Guideline (CPG) 1: AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder

Aspects to Track:

C. Frequency of Periodic assessment, Initial within 30 days (recommendation #12 under treatment section, presence of a follow-up visit during the 30-day initiation phase for 6-12-year-old prescribed ADHD medication).
D. Frequency of Periodic assessment, at least two follow-up visits within 9 months after initial (recommendation #12 under treatment section, presence of at least two follow-up visits 9 months after IPSD for 6-12-year-old prescribed ADHD medication).

Clinical Practice Guideline (CPG) 2: CDC: Guidelines for Prescribing Opioids for Chronic Pain (2016)
Aspects to Track:

D. History of Substance Use Disorder.
E. Use of State Prescription Drug Monitoring Program.
F. Use of State Prescription Drug Monitoring Program.

Clinical Practice Guideline (CPG) 3: APA: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition (2010)

Aspects to Track:

- Presence or absence of treatment (Depression Care Quality: Patient with a diagnosis of depression who is not receiving treatment).
- Quantity of treatment if receiving psychotherapy (recommendation under depression treatment, acute phase choice of an initial treatment modality plus detailed review and evaluation in treatment planning phase).

Compliance expectations and requirements for these guidelines are reflected in Partners Practice Guidelines Policy (13.09) and the Provider Operations Manual, including notification to the provider stating adherence to these guidelines will be monitored. Provider compliance may be monitored in the following ways:

- Focused audits completed via Utilization Reviewer and others as appropriate and applicable.
- Routine review of Service Authorization Requests/Prior Authorization requests (identifying any areas of concern).
- Peer Review activities.
- QOC Committee activities.
- CAC activities.
- Medical record audits by the QM department Monitoring Team.
- Program Integrity monitoring, if indicated.

Partners clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Partners adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Partners providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by Partners.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric HealthCare
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Partners, visit our website at providers.partnersbhm.org

Utilization Management

Partners' Utilization Management (UM) department's function is to make authorization decisions by conducting initial, continuing care and retrospective reviews of services based on whether medical necessity is substantiated in the request for authorization. The UM department utilizes guidelines based on the *North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies* and *Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH) State-funded Service Definitions.*

Partners' UM program will help sustain an integrated, well-coordinated system of care for members and recipients that addresses their BH, PH, LTSS, TBI, I/DD, pharmacy and Unmet Health-Related Resource Needs. Our UM process brings together CCH and Partners' expertise to create an integrated approach. Partners' (UM clinicians, care managers, medical directors and pharmacy staff) and CCH staff will work side-by-side to best meet members' whole health needs.

Our multi-disciplinary care teams will connect in a similar seamless fashion with the CVS clinical pharmacy team members to ensure medication interventions are coordinated with all utilization to ensure a whole person approach to all care decisions. Through their daily work, our teams will collaborate to ensure members and recipients have access to the right services and providers to achieve their health and recovery goals.

Partners' UM staff will consult with co-located CCH staff when evaluating requests for PA, particularly for requests related to members with complex PH and BH needs. In instances where the request is primarily related to PH needs, we will rely on CCH's expertise and appropriate clinical guidelines to determine medical necessity. For all PA requests, we will ensure that staff have the expertise to make an appropriate determination. Further, our policies and procedures will incorporate processes for applying an integrated approach.

Partners' integrated UM process is supported through data-sharing, integrated clinical leadership and integrated oversight. Our UM process will support an integrated, holistic look and note alternative treatments

or supports that may be appropriate in light of the individual's clinical and other support needs. UM staff will consider member/recipient whole health needs. For example, if a member is admitted to an inpatient psychiatric facility, we train and alert UM staff to look for co-morbid physical conditions co-occurring with and/or triggering the member's current condition. Key features include:

Single, Centralized UM Platform. Our care management platform, TruCare will house all PH, BH and UM authorizations in a single view. The system will be fully integrated with our claims system and provide a complete view of each individual's health record, medication history, unmet health-related resource needs, claims history, authorizations and care plans/individual service plans. All clinicians and service providers will have access to this single source of member information when considering authorization decisions and utilization trends. We integrate our electronic visit verification system into TruCare, allowing us to monitor timely service delivery, ensure delivery of authorized Long Term Supports and Services (LTSS) and facilitate efficient claims submission and payment.

Integrated Clinical Leadership and Staff. Partners' clinical leadership, with support from CCH, will represent BH, PH, pharmacy, LTSS and social service expertise. We will leverage our significant experience in North Carolina to design and implement cohesive population health strategies and improve health outcomes. Our medical directors will conduct joint clinical rounds and offer consultations about members and recipients with complex and co-morbid needs. We will conduct multidisciplinary rounds on a weekly basis to closely coordinate care for members. This approach determines root cause of service utilization (e.g., inpatient admission), an appropriate path for discharge or intervention and removes level of care barriers. All Partners staff will operate under a single set of fully integrated policies aimed at operational integration.

Integrated Oversight. The Clinical Operations Committee (COC), a subcommittee of the Quality Improvement Committee (QIC), meets no less than quarterly. The committee monitors use of clinical resources and provides support to ensure services are only delivered for authorized purposes, uniformly available to members/recipients and provided effectively and efficiently. The COC assures availability of high-quality care by evaluating service delivery, clinical practices, program eligibility determination and service authorization decisions. This committee implements the UM program and is comprised of BH, PH, pharmacy, I/DD and LTSS staff who review Partners clinical programs and to ensure the overall needs are met for the members/recipients we serve.

Our unique North Carolina experience and dedicated local leadership demonstrate our ability to reduce administrative burden and serve as responsible stewards of NCDHHS resources.

Through our shared experience with CCH, we will promote integration through:

Accessible, User-friendly Information on UM Activities. Our provider portal, ProviderCONNECT, includes information on UM activities, PA processes, clinical proactive guidelines, clinical criteria and benefit grids, as well as a link to our provider knowledge base website. This website offers links to clinical criteria checklists (for PH, BH, LTSS, I/DD, TBI and pharmacy services), coverage policies, practice guidelines and Partners' and State-funded Service definitions. Our website contains information for providers for all UM programs, policy, and requirements at https://providers.partnersbhm.org/

Provider Education. Partners offers orientation sessions monthly for new PIHP network providers and providers who need or want a refresher on processes and resources. This orientation will include information on the Tailored Plan integrated care model and how to access the full-service array. Partners' Provider Network account specialists and Care Management monitoring team will provide online, face-to-face and telephonic education and technical assistance on claims submission and PA processes to newly contracted providers. We notify providers of changes to UM or PA processes at least 30 days prior to implementation or in accordance with Department mandates.

Bi-Directional Communication. Partners' UM and Claims representatives participate in monthly provider council meetings. Partners has provider representation on our Clinical Advisory Committee, QIC and Quality of Care Committee. Our learning collaboratives also offer bi-directional communication between providers and UM staff.

Peer-to-Peer (P2P) Consultation. Based on provider feedback, Partner's UM team revised our P2P consultation process, which now encourages pre-decision authorization conversations with the CMO or designee for specific providers and post-decision P2P conversations conducted by our CMO or designee, when availability permits.

Partners' UM program, fully detailed in our UM program policy, will be based on Division of Health Benefits (DHB) Medicaid criteria; nationally recognized, evidence-based practice guidelines (for PH, BH, LTSS, I/DD, TBI and pharmacy services); and decision support methods. The UM program policy will create a framework for oversight and guidance of Medicaid and State-Funded Services by applying service eligibility criteria and processing requests for initial and continued authorization of services.

Partners maintains UM policies and procedures that are fully compliant with North Carolina standards. Our UM program, fully detailed in our policy, is based on DHB Medicaid criteria. We will use nationally recognized, evidence-based physical health (PH) and behavioral health (BH) practice guidelines and decision support methods.

Partners' UM program establishes a framework for oversight and guidance of Medicaid and State-funded programs. Through established policies and processes, we will assure consistent application of service eligibility criteria when processing requests for initial and continued service authorization.

Under the leadership of our Chief Medical Officer (CMO), we tailor our UM program to align with each unique North Carolina requirement. As an Organization with over eight years of experience in the state, we have direct practical understanding of how to implement the NCDHHS required clinical coverage policies. Our approach supports UM and prior authorization processes for services that extend beyond mandated clinical coverage policies. Through UM, we determine medical necessity according to best practice and community standards.

Partners develops our UM program policy with participation and oversight from our CMO, Chief of Clinical Services and the Deputy Chief Medical Directors. We rely on consultation with Provider Network staff and current evidence-based practices, such as industry standard clinical practice guidelines.

Partners (UM clinicians, care managers, medical directors and pharmacy staff) and CCH staff will work side-by-side to best meet members' whole health needs. Through this team's daily work, staff will collaborate to ensure members and recipients have access to the right services and providers to achieve their health and life goals.

Partners will comply with required clinical coverage policies. To ensure consistent knowledge and application of these policies, our clinical leadership team apply medical necessity criteria and conduct inter-rater reliability tests with UM staff.

Partners does not offer incentives to Utilization Management employees or providers to deny, reduce, terminate, or suspend, limit or discontinue medically necessary services to any member. There are no financial rewards for UM decision makers that would discourage approval of services. Decisions made by Partners' UM are based only on the appropriateness of care, the service requested, and existence of coverage.

State-Funded Services utilize Benefit Plan Eligibility criteria that crosswalk from the member's diagnosis, age, disability group and other designated criteria. The State Benefit Plan then crosswalks to the Array of Services available to members that meet the requirements of a specific Benefit Plan. The most current version of State Benefit Plan Criteria can be found on the NC Division of MH/DD/SAS website.

Prior Authorization and Notifications

Prior authorization is a request to the Partners' Utilization Management (UM) department for approval before start of services. Authorization determinations will be communicated to the provider via fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. Partners utilizes an information technology system to receive request for authorization. The information is entered into a Service Authorization Request (SAR)/Prior Authorization (PA) request. As a participating provider with Partners, it is important to understand the requirements for both the SAR/PA and Referral processes to ensure members do not experience any disruption in care, and claims are paid in a timely and accurate manner.

Authorization must be obtained prior to the delivery of certain services. The PCP should contact the UM department via telephone, fax or through the provider portal with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization. Please refer to Partners website for a listing of Medical and Behavioral covered Benefits and Services Grids https://providers.partnersbhm.org/benefit- grids/ for most up-to-date benefit limits and documentation requirements. These Benefit Grids are not intended to be an all-inclusive list of covered services.

Emergency department and crisis services never require prior authorization. Providers should request authorizations from Partners for **inpatient admissions within 72 hours** of the admission. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Partners providers are contractually prohibited from holding any Partners member financially liable for any service administratively denied by Partners for the failure of the provider to obtain timely authorization. For a list of services requiring prior authorization please see the Partners Providers Knowledge Base Website Benefit Grids linked above.

Alternative Methods for Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the ProAuth system used by Partners' UM. Providers may contact the Service Desk, 704-842-6431, to request login information and assistance.

For circumstances when ProAuth cannot be utilized, emergent SAR/PAs can be processed:

- **Live Review by Phone**: (For Acute Services only) Provider Staff will need to call 704-842-6434 to reach UM from 8am to 6pm, seven days per week, including weekends and holidays. The UM staff will collect information detailed on the UM Review Form.
- **Manual Review By Fax or Email:** A **Manual Service Authorization Request Form** must be completed to include **all accompanying documentation**. Manual Service Authorization Request Form can be found at https://providers.partnersbhm.org/utilization-management/.
    - Email Address:
        - Behavioral Health, I/DD, TBI Requests: BHIDDManualAuthorizations@partnersbhm.org
    - Fax Numbers:
        - I/DD & TBI Requests: 704-884-2690
        - Inpatient Requests: 704-884-2703
        - MH & SU Requests: 704-884-2701

Authorization Determination Timelines

Partners' Utilization Management decisions are made as expeditiously as the member's health condition requires.

Services are expected to be requested on or before the start date. The following are exceptions:

- Basic Outpatient Services to include but not limited to Individual, Family and Group Therapy visits are unmanaged.
- Emergency/Crisis Services.
- Services that indicate a "*pass-through"* in the service definition.
- Codes agreed upon by Partners as not requiring authorization or having a pass-through and indicated on the Medicaid and State-Funded Benefit Plans, located on the Partners website.

Partners must decide and provide notice within 14 calendar days of receiving a standard request for authorization of service with a possible extension of an additional 14 calendar days if:

- The member or provider requests an extension, or
- Partners can demonstrate to North Carolina Division of Health Benefits (DHB) that there is need for additional information and the delay is in the member's best interest.

Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Partners must decide and provide notice within 72 hours for a prospective or initial and concurrent request. Expedited concurrent requests are reviewed within 24 hours of the received request. There is also the option of an extension of an additional 14 calendar days if:

- The member or provider requests an extension on behalf of the member, or
- Partners can demonstrate to North Carolina DBH that there is a need for additional information and the delay is in the member's best interest.*

Clinical Coverage Policy 8B, allows a hospital **up to 72 hours from time/date of admission** to notify Partners of the admission. If Initial SARs are submitted within 72 hours of admission, Partners' UM will review back to the first day of treatment. If medical necessity is met, the request will be approved beginning with the first day of admission. When medical necessity is questionable, the request will be reviewed by Partners' medical staff. If the medical staff determine medical necessity is not met, the request may be fully or partially denied.

If SARs are submitted after the first 72 hours, UM will review for the 72 hours prior to the submission date of the SAR and will not process days outside of that 72 -hour timeframe.

Transplant Authorizations

PIHP/Medicaid Direct – Providers will continue to bill NC TRACKS for these services for Medicaid Direct members.

The Centralized Transplant Unit (CTU) is responsible for medical necessity review for all transplant services. Prior authorization requests for transplant services should be submitted by the provider rendering the beneficiary's transplant care (i.e., transplant coordinator from the facility where the evaluation and listing services will be performed). In the event a prior authorization request is received by Partners, the request should be redirected to the CTU fax number 1-866-753-5659.

The transplant review process begins when a request is received by the CTU. Requests are reviewed by a CTU clinical nurse coordinator. The transplant review process is complete when written notification of a determination for the request is sent to the member and requesting provider.

The CTU does not review requests for corneal transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy; or CAR-T therapy. HLA Typing/Stem Cell Collection/Donor Search and Transplant Consultation at an in-network facility (1 visit) will be approved by the CTU without medical necessity review.

Transplant Centers

All organ transplant providers should meet the CMS Conditions of Participation (CoP)s for clinical experience, data submission and outcome and process requirements. These criteria focus on the transplant program's ability to perform successful transplants and deliver quality patient care.

Transplant Evaluations

Transplant evaluations are pre-transplant diagnostic testing and services that determine a member's candidacy for transplantation.

A transplant evaluation request by an in-network provider can be approved after nurse review if all necessary documentation has been provided. If all necessary documentation has not been provided the case is referred to the Partners medical director for review and determination. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide at 1-866-447-8773.

To avoid delay in authorization, all required clinical documentation must accompany the request.

If the request is from an out of network provider (OON) provider, the case is referred to the Partners medical director for review and determination.

Transplant evaluations are authorized for a total of 12 visits to be completed within a six-month time frame. At times, additional visits may be necessary and should be requested by the provider prior to the authorization expiration. If additional visits are requested after the authorization expiration; the provider must submit new clinical documentation for review and determination.

Transplant Listings

Once the member has completed the transplant evaluation process, the provider may request the member be listed for the transplant. Transplant listing requests must be accompanied by clinical documentation that supports the need for the type of organ(s) requested. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide.

To avoid delay in authorization, all required clinical documentation must accompany the request. A transplant listing requested by an in-network provider may be approved by the nurse coordinator if all necessary documentation has been provided and if it meets all aspects of the pertinent Clinical Policy or appropriate medical necessity criteria. If all necessary documentation has not been provided, or if the documentation submitted does not support medical necessity, the nurse coordinator will refer the case to the Partners medical director for review and determination.

If the request is from an out of network provider, the nurse coordinator will refer the case to the Partners medical director for review and determination.

Once approved, transplant listings are authorized for a period of 12 months. If the candidate has not received the transplant within the 12-month timeframe; the provider must submit a request for a new authorization with updated clinical documentation.

Out of Network (OON) Transplant Providers

All Transplant Evaluation and Transplant Listing requests from OON providers, or from facilities that do not meet CMS approval requirements must be approved by the Partners medical director regardless of the outcome of the CTU medical necessity review process.

Adverse Determinations

All adverse determinations will be issued by the Partners Medical Director, Partners Chief Medical Officer or Deputy Chief Medical Directors.

If additional and/or clarifying information is needed due to insufficient or conflicting information obtained during the Level I review, the Partners Medical Director may discuss the case with the managing physician. Only the treating physician/provider may participate in this peer- to-peer discussion.

Treating practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer.

At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the CTU nurse notifies the requester of the opportunity for the treating physician to discuss the case directly with the CTU Medical Director or applicable practitioner reviewer making the determination. The peer-to-peer process is also included in the written denial notification.

Out of Network Transplant Financial Determinations

The CTU will work with the Partners to coordinate contract negotiations for payment of transplant services rendered out of network.

If a financial agreement cannot be reached, or if a facility is denied for any other reason, it is the responsibility of the CTU and the Partners medical director to work with the requesting provider to coordinate services at an approved facility.

Transplant Continuity of Care Requests

Requests for authorization for transplant services through continuity of care (COC) must be accompanied by appropriate documentation and requested within the COC timeframe specified by the contract. Continuity of Care Requests will be initially reviewed by the nurse coordinator. In the event that determinations are not able to be made with the information provided, it will be sent to the Partners medical director for review and determination. Requests for continuity of care authorization must include the following:

- Documentation of previous insurer coverage, such as if previously covered by state Medicaid fee for service
- Documentation of authorization for coverage of transplant evaluation or listings by previous insurer
- Copy of member's United Network for Organ Sharing (UNOS) listing

Duration of Authorizations

Providers not considered in-network for transplant services for Partners must reach a payment agreement. If a financial agreement cannot be made, the CTU will help to identify an in-network provider that can ensure the member's health care needs are met.

Second and Third Opinions

Members or a provider with the member's consent may request and receive a second opinion from a qualified professional within the Partners network. If there is not an appropriate provider to render the second opinion

within the network, it may be obtained from an out-of-network provider at no cost to the member. In-network and out-of-network providers may require prior authorization by Partners when performing second and third opinions.

Members and recipients, legally responsible person or healthcare professional with member's consent, may seek care from licensed, qualified out-of-network providers when a network provider is not available for the covered service, member does not agree with the diagnosis, treatment, or the medication prescribed or the member is seeking a second opinion.

To qualify as an out-of-network provider, we confirm the following:

- Member/recipient enrollment with Partners
- Provider enrollment as a Medicaid provider in NCTracks
- Out-of-network services are authorized as medically necessary per benefit plan limits or requested by the member for a second opinion

Once confirmed and as soon as the member's or recipient's condition warrants, but no later than one business day, we execute a single case agreement with the provider that defines reimbursement and payment terms in accordance with contract requirements such as term of the contract, services approved to provide, authorization process and expectations for service delivery and documentation.

Once a member's/recipient's immediate needs are met, our network development staff contacts the provider and invites the entity to join our provider network in accordance with our Good Faith Provider Contracting Policy.

For emergent situations, we expedite the single case agreement process and conduct priority authorization reviews in accordance with required timelines, based on the member's needs. In non-emergent situations, our utilization management (UM) reviewer reviews the request, renders a decision and communicates the determination to the requesting provider and member/recipient. Network development staff contacts the out-of-network provider and educates them on our UM and claims submission policies, scope of the authorization and any requirements for submitting clinical information or collaborating with the member's/recipient's care manager to manage transition of care or update the Care Plan/Individual Service Plan.

Partners will honor member/recipient transfers from other LME/MCOs, as required. For example, if a member who participates in the Innovations Waiver transfers to Partners from another Tailored Plan and was receiving services from an out-of-network provider, the member has the right to continue services with their existing provider. Partners will offer the provider a single case agreement that includes continuity of care provisions.

Educating Members and Recipients about Out-of-Network Services

Member and recipient services, service line staff and care management staff educate all members and recipients about accessing out-of-network services, including obtaining second opinions from out-of-network providers, as long as the provider is not excluded from participation in federal health care programs. Our Member and Recipient Handbook, Innovations Member and Family Handbook and TBI Handbook will clearly

explain how members/recipients can obtain benefits from out of network providers and the right to a second opinion.

Clinical Information

For all services on the prior authorization list, documentation supporting medical necessity will be required. If additional clinical information is required, UM staff will notify the provider of the specific information needed to complete the authorization process.

Partners UM staff may request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical and behavioral health information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Partners is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Partners Benefit and Services Grids identify necessary information to be included with SARs/PAs. Failure to submit necessary clinical information can result in an adverse decision. Refer to Partners website for a listing of Medical and Behavioral covered Benefits and Services Grids: https://providers.partnersbhm.org/benefit-grids/ for most up-to-date benefit limits and documentation requirements. The Benefit Grids are not intended to be an all-inclusive list of covered services.

Documents Required for Authorizations

Specialty Outpatient Services:

* Service Authorization Request/Prior Authorization (SAR/PA):

- Person Centered Plan or Basic Treatment Plan.
- Service Order.
- Other documents required per Service Description.
- Comprehensive Clinical Assessment (CCA) or other evaluation.
- Discharge plans.

Enhanced Benefits (Including Residential and PRTF):

- Service Authorization Request/Prior Authorization (SAR/PA).
- Person Centered Plan.
- Comprehensive Clinical Assessment (CCA) or other evaluation.
- Other Documents required by DHB Clinical Coverage Policy and state and federal regulations.
- For PRTF, a Certificate of Need (CON) is required prior to admission.
- Service Order.

Innovations/ICF-IID Facilities:

- Service Authorization Request/Prior Authorization (SAR/PA).
- Individual Supports Plan (ISP).

- I/DD Health Risk Assessment (Innovations only).
- NC Support Needs Assessment Profile (NC-SNAP) or Supports Intensity Scale (SIS).
- Innovations Level of Care Form (replaces MR-2).
- ICF-IID requires updated Level of Care (LOC) every six months.
- Any psychological testing specialty or medical assessments that apply.

Additional Requirements for Valid or Complete Requests:

A Valid Request for Medicaid Members must contain:

- Member Name/Address/DOB/MID.
- Identification of Service or Procedure Code.
- Name and NPI of Provider to perform service.
- Provider location if the request is for an ambulatory or office procedure.
- Date the service is requested to begin or proposed surgery date if the request is for a surgical procedure.
- Consistent information throughout the request (i.e., name and MID matching).
- Behavioral health diagnosis must be covered by the benefit plan.
- All required signatures on forms required by statute, and/or any documents or forms required by state or federal statute.
- A valid ICD-10 diagnosis.

Clinical Decisions

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Partners Medical staff, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria.

Partners' Utilization Management (UM) department's function is to make authorization decisions by conducting initial, continuing care and retrospective reviews of services based on whether medical necessity is substantiated in the request for authorization. The UM department utilizes guidelines based on the North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-funded Service Definitions and McKesson InterQual® Criteria. Partners does not offer incentives to Utilization Management employees or providers to deny, reduce, terminate, or suspend, limit or discontinue medically necessary services to any member. There are no financial rewards for UM decision makers that would discourage approval of services. Decisions made by Partners' UM are based only on the appropriateness of care, the service requested, and existence of coverage. A State Benefit Plan does not apply to members who are only receiving Medicaid services. The most current version of State Benefit Plan Criteria can be found on the NC Division of MH/DD/SAS website.

Denial Process

Services provided without pre-authorization will be denied.

If present, the following elements will keep a request from being processed:

- Duplicate Requests (the latter of the two to be UTP).
- Per diem service and dates/units that do not match.
- Service Authorization Request for a service that does not require authorization.
- Incorrect Service Code (e.g., requesting ALL for non-therapy package).
- Retrospective request that does not meet criteria in policy.
- Service Exclusions for Adults.
- Member is not enrolled or registered in Alpha+.
- Request for something not covered.
- SAR submitted more than 30 days prior to start date.
- Contract issues.

The SAR will be marked as an Incomplete Request and an Administrative Denial is issued if any of the information requested (see list below) is not received.

- Comprehensive Crisis Plan (CCP) when applicable.
- CCA where indicated in Clinical Coverage Policy.
- A complete PCP/Service Order/ISP with all pages, services, and service units present and accurate.
- Attestation Statement for members required to have Child and Family Team (CFT) meetings or assignment of Treatment Accountability for Safer Communities (TASC) manager.
- LOC Forms.
- NC SNAP or SIS.
- Individual Budget (Innovations) is correct and complete.
- Attestation of the previous l Level of Care Form and supporting documentation for ICF-IID member.
- Risk Support Needs Assessment (Innovations).
- Documentation for ICF-I/DD.
- Letters of medical necessity required quotes, MD orders (Innovations).
- Orders, Individual/Family Support Documents (self-direction only, Innovations).
- All required signatures on forms (PCPs, ISP, Redetermination and Freedom of Statement).
- Certificate of Need (CON).

*Service Exclusions for Children under 21 years of age and covered by Medicaid must be reviewed under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

When the request is missing items (from the list above) that result in an incomplete request, Partners' UM staff communicates what is missing to the provider. If this information is not received the designated amount of time, the request is deemed an Administrative Denial with appeal rights.

If all the required information has been submitted and the request is complete, but the information is illegible or there is still insufficient clinical information to determine medical necessity, the initial reviewer attempts to collect the needed information from the provider within the applicable prospective, concurrent, and retrospective timeframes. If the provider does not respond to the request within the allotted amount of time, the request will be denied as an Administrative Denial with appeal rights.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorizations within the standard time frame (i.e.,14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for an initial request. Concurrent Inpatient requests are reviewed within 24 hours of the receipt of the request.

Discharge Review:

Providers are highly encouraged to submit Discharges for members with only State-Funded Services.

Providers are highly encouraged to submit Discharges for members with only Enhanced Medicaid services.

Providers are highly encouraged to submit Discharges for members with state and Medicaid services.

Providers are highly recommended to submit a Discharge Request via the Discharge Module in Alpha+ for State-funded Benefit members. This includes members who have State-Funded Services only, as well as state and Medicaid funded services.

When initiating discharges for members having substance use issues, the required SU fields (noted by yellow box beside the field) must be completed by the provider initiating the discharge. In the event the discharge is determined to be a full discharge by the LME/MCO, all existing diagnosis, SU fields, target pops and state insurances will be end dated with the discharge date. A discharge reason of "other" or "unknown" must include comments by the provider.

If the member is transferred to another provider, the following must be documented in the comments section:

- Designation that it is a transfer.
- Name of the provider receiving the transfer.

<u>Clinical Tools</u>

- Partners uses evidence-based decision support tools to authorize services. This includes level of care and service decision support tools to make sure members receive the right care, in the right facility, at the right time. Decision support tools include McKesson InterQual Criteria. InterQual® provides a consistent, evidence-based platform for decisions that promotes appropriate use of services and improved health outcomes. Clinical practice guidelines are developed and updated using national resources, including American Psychological Association, American Medical Association, American Academy of Pediatrics, American Pharmaceutical Association, United States Preventative Health

Services Task Force, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and NCQA.

- Level of Care Utilization System/Child & Adolescent Level of Care Utilization System; American Society of Addiction Medicine; and Child and Adolescents Needs and Strengths. Support Intensity Scale (SIS) and North Carolina Support Needs Assessment Profile. Initial intermediate care facilities for members with intellectual disabilities (ICF-IID) Level of Care Form and supporting psychological testing and/or medical evaluations used to establish eligibility for Innovations and ICF-IID services
- Practice guidelines from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry for most commonly occurring categories of diagnoses.
- Comprehensive PH and BH assessments and supporting evaluations.
- The current Diagnostic Statistical Manual.
- Partners evaluates the need for LTSS based on face-to-face functional assessments, completed with members and legally responsible persons through a person-centered planning process.
- Together, we determine resources needed to help members remain in the community. Services authorized by the UM reviewer follow state benefit and policies.

Building expertise in UM for PH, pharmacy and LTSS

Partners will build upon the expertise we have gained as an LME/MCO to further enhance our UM processes. Current UM staff will receive required integrated care training as it relates to PH, BH, LTSS, TBI and pharmacy needs. We will require future UM hires to have experience in and complete trainings on integrated care.

CCH and Partners collaborate daily to discuss specific member needs. Through daily knowledge sharing across disciplines, we will make timely and appropriate decisions, facilitating member access to the right care. By bringing together the vast experience of CCH and Partners' teams, we will strengthen all staff's ability to apply an integrated approach, leading to a more experienced team with increased capacity to deliver whole-person care.

Partners utilizes the ProAuth Information Technology system to receive requests for authorization. The information is entered into a Service Authorization Request/Prior Authorization (SAR/PA), which includes:

- Provider name and site code for where services are to be offered.
- Authorization date range.
- Services requested per Benefit Plan (Medicaid B, Medicaid C, Medicaid (b)(3), and State).
- Guardian/relationship to member.
- Member's disability: MH, IDD, SU
- ASAM level is recommended for all members with a substance use and co-occurring disorders that include a substance use disorder diagnosis.
- LOCUS/CALOCUS /CANS scores for members are recommended for members with a mental health diagnosis only and co-occurring disorders that include a mental health diagnosis.
- NC-SNAP or Supports Intensity Scale for Individuals with Intellectual or Developmental Disorder.
- Primary Care Physician and release of information.

- Medication dosages, frequency and compliance with medications.
- ICD-10 Diagnoses.
- Substance use details.
- Justification for services (provider comments).
- Uploaded documents as indicated on the current benefit plan.

Providers can see reviewer comments in the comments section. If additional information is requested and it is possible, three calendar days are allowed for a response to the request. Failure to do so could lead to the request being administratively or clinically denied.

Medical Necessity

Medical necessity must be met for all services. Medical Necessity is defined as services that are viewed as medically necessary to diagnose or treat a behavioral or medical health condition. This includes healthcare services, supplies or equipment provided by a licensed healthcare professional that are appropriate, safe and efficiently provided to the member, consistent with the diagnosis or treatment of the member's condition, illness, or injury but are not for personal comfort or convenience of the member, family, or provider. These services are not experimental or investigational or for research or education.

The UM department utilizes guidelines based on the North Carolina Division of Health Benefits (DHB) Clinical Coverage Policies and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-Funded Service Definitions and McKesson InterQual® Criteria.

The Clinical Coverage Policies and other coverage criteria can be found on the Service Definitions page on Partners Provider Knowledge Base website: https://providers.partnersbhm.org/service-definitions/

Determining Medical Necessity

UM staff consider clinical coverage policies and the member's or recipient's unique circumstances and needs when making a determination of medical necessity. UM staff adhere to applicable state or federal requirements and apply evidence-based clinical standards of care. Partners makes all criteria available to members/recipients and service providers upon request and include criteria in notices of service denial.

Partners' UM staff will consult with co-located CCH staff when evaluating requests for prior authorization (PA), particularly for requests related to members and recipients with complex PH and BH needs. In instances where the request is primarily related to PH needs, we will rely on CCH's expertise and appropriate clinical guidelines to determine medical necessity. For all PA requests, we will ensure that staff – Partners and CCH – have the expertise to make an appropriate determination. Further, our policies and procedures will incorporate processes for ensuring an integrated approach.

Peer to Peer Discussions

Peer-to-Peer discussions are arranged to minimize unnecessary denials, appeals and avoid escalation and member frustration. Partners communicates regularly with providers regarding SAR/PA requests not fully approved. Prior to issuing a notice of adverse benefit determination, our Medical Director is available for a peer-to-peer consult with the requesting provider to discuss the denial rationale and assist with identifying

other services as appropriate. In the event of an adverse determination, including a denial, reduction, or termination of coverage, the provider may request a peer-to-peer discussion with the medical staff. At the time of notification of denial, the provider will be notified of this right and has five business days to initiate a peer-to-peer discussion. This can often resolve miscommunications about standards and requirements for medical necessity criteria.

Review Criteria

Partners utilizes review criteria developed by McKesson InterQual® products to determine medical necessity for physical health services. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Partners' medical staff, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

We closely monitor delivery of the full benefits package of Medicaid and State-Funded Services through our comprehensive UM program, which is built upon North Carolina Medicaid Direct Clinical Coverage Policies and definition of medical necessity.

Through our Partners UM program, we evaluate medical necessity, clinical appropriateness, efficiency and effectiveness of requests for authorization of State-Funded Services against established service definitions. Partners also utilizes American Society for Addiction Medicine (ASAM) criteria for substance use service reviews, SIS/NC-SNAP for IDD services, and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) State-Funded Service Definitions for community-based service reviews.

New Technology

Partners evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Chief Medical Officer and/or Medical Management staff may identify relevant topics for review pertinent to the Partners population. The Clinical Advisory Committee (CAC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Utilization Management department at UMquestions@partnersbhm.org.

Our systems hardware and software architecture, permits scalability of the technology platform to meet current and future capacity needs. We know technology can be a powerful tool that improves operations and delivers measurable impact to members, recipients and providers. We continually search for ways to apply existing and new technology to:

- Better understand and enable access to health care services and benefits for members/recipients.

- Ease the operational burden on providers related to claims and authorizations.
- Maintain a high level of member/recipient and provider satisfaction.
- Improve the quality and efficiency of data collection.
- Maximize the impact of performance improvement studies and results.
- Provide measurable results to the state programs.

Provider Education and Incentives

Partners contractually requires all network providers to offer EPSDT preventative health services to their eligible members according to the AAP periodicity schedule. EPSDT services include routine physical examinations, screenings for developmental delays, screenings for autism spectrum disorder, appropriately scheduled immunizations, oral health assessments, dental counseling, lab testing and health education for children and caregivers.

Concurrent Review and Discharge Planning

Contracts, processes and procedures have been established for hospitals, residential facilities, state operated health facilities, ICF-IIDs and adult care homes. Partners will build on our relationships with SNFs, NICUs and rehabilitation facilities prior to launch of the Tailored Plan. Partners will be aware of any admissions through our prior authorization process. This allows for timely in-reach of transition staff, including the care manager, in-reach specialist or peer support specialist and/or transition coordinator, to engage in the discharge planning process.

Skilled Nursing Facility (SNF)

Partners currently works with SNFs to assess the needs of members who are in, or seeking admission to, an SNF. Partners will work with DHB and the member's nursing facility to coordinate Specialized services as defined by the federal Pre-admission Screening and Resident Review (PASRR) regulations for members admitted to nursing facilities.

Partners will ensure the provision of Specialized services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits. We will ensure that any approved Specialized services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.

We collaborate regularly with SNF staff on discharge planning for members. We will leverage these relationships to develop contracts, policies and procedures for in-reach, transition and discharge.

Hospitals

Our extensive experience working with hospitals has led to established contracts, policies, procedures and workflows. Our dedicated hospital liaisons are assigned to serve as primary points of contact for specific inpatient facilities/hospitals, coordinating communication and discharge planning between hospital staff and care managers. Care managers collaborate with Partners' hospital liaison and the member's care team on all discharge planning activities.

For planned admissions, the assigned care manager collaborates with the member, legally responsible person (LRP) and the care team to coordinate the member's admission and discharge plan, prior to admission. For unplanned admissions, the hospital notifies Partners' hospital liaison on the day of admission. Care managers visit the member during their stay in the hospital to identify needs, understand what led to admission and formulate a discharge plan.

Rehabilitation Facilities

Partners will work with rehabilitation facilities prior to launch of the Tailored Plan contract to develop contracts, policies and procedures for in-reach, transition and discharge.

Residential Settings

Partners has broad experience contracting and collaborating with residential settings in and out of our network, including group homes, supervised living settings and alternative family living homes. With many of these facilities, Partners has developed a single point of contact or liaison that will support care management for all Partners members under the Tailored Plan. All AMH+, CMA and Partners care managers will work in collaboration with the liaison.

When facilities do not have a single point of contact or liaison, the AMH+, CMA and Partners care manager work directly with the residential or inpatient care team to plan discharge and community-based services. The care manager works with the member and their family/caregiver to gather input and preferences about the Care Plan/ISP and transition, always keeping member goals and preferences central to the transition process.

State Operated Health Facilities and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Partners has considerable experience providing in-reach, transition and discharge support for members in ICF-IIDs, including Murdoch Developmental Center, J. Iverson Riddle Developmental Center and Caswell Developmental Center. We have established processes and partnerships designed to relocate members to a community setting, while maintaining the appropriate level of services and supports.

We work collaboratively with facilities to develop 90-day transition plans as an amendment to members' Care Plans/ISPs, share transition plans with members and identified community providers and secure all prior authorizations. Designated staff are present to support members on the day of discharge.

To ensure successful transitions, we assist in scheduling all post-discharge appointments, based upon members' identified needs and no later than seven calendar days following discharge.

These include transportation, in-home services and follow-up outpatient visits.

Requests for authorization must be reviewed and a decision rendered within 14 calendar days of submission of the request. Expedited requests are available when reviewing authorization within the standard time frame (14 calendar days) could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Expedited requests are addressed within 72 hours for an initial request. Concurrent requests that are expedited are reviewed within 24 hours of the receipt of the request.

Retrospective Review of Services

Retrospective review is an initial review of services provided to a member but for which authorization and/or timely notification to Partners was not obtained due to justifiable circumstances. Requests for retrospective review must be submitted to Partners UM department within 90 days from the modified date in NCTracks. A decision will be made within 30 calendar days following receipt of the request. All Retroactive SARs will be reviewed for medical necessity. For further questions on Retroactive Medicaid requests, please contact the MHSU UM Workgroup at 704-842-6436, MHSU UM Acute Team Workgroup at 704-842-6434 or I/DD UM Workgroup at 704-884-2605.

Opioid Misuse Prevention and Treatment Program Policy

Partners has implemented a comprehensive Opioid Misuse Prevention and Treatment Program, a member lock-in program, a cumulative maximum morphine milligram equivalent dosage limit not subject to utilization management prior approval, as established in opioid clinical coverage policy, and diagnoses codes exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM program.

Partners Opioid Misuse Prevention and Treatment Program aligns with the North Carolina Opioid Action Plan.

Pharmacy Elements: Dispensing Limits, Quantity Limits and Age Limits: Effective January 2, 2018, clinical coverage criteria for opioid analgesics were updated to comply with the quantity limits mandated by the ***Strengthen Opioid Misuse Prevention (STOP) Act***, S.L. 2017-74 (https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf). Prior approval is required for short-acting opioids for greater than a five-day supply for acute pain and seven-day supply for post-operative acute pain. Prior approval is required for long-acting opioids for greater than a seven-day supply. Effective June 1, 2018, clinical coverage criteria for opioid analgesics were updated to include prior approval required for a) total daily doses greater than 90 morphine milliequivalents per day (down from 120) and b) for Schedule III and IV opioid analgesics (i.e., tramadol) added to schedule II opioids already subject to the clinical criteria. If there are additional questions regarding these processes, contact Partners' Pharmacy Line at 833-353-2095.

The prescribing provider may submit prior approval requests to the pharmacy benefits manager as outlined in the pharmacy section of the Provider Operations Manual (Z.3-Prior Authorization) Process. Members with diagnosis of pain secondary to cancer will continue to be exempt from prior approval requirements.

Lock-in Program: Partners, in collaboration with its PBM partner CVS Health, will operate a member lock-in program for those members meeting criteria as defined in NC Gen. Stat. 188A-68.2. This lock-in program is designed to address potential overutilization of opioids, benzodiazepines, and certain anxiolytics and focuses on member safety. Members in this program will be locked in to one provider and one pharmacy for a two-year period to obtain opioids, benzodiazepines, and certain anxiolytics, at which time they will be reassess for continuing eligibility.

Reducing Opioid Misuse: Partners will promote appropriate utilization of healthcare resources by monitoring potential abuse or inappropriate utilization of targeted medications. We will proactively analyze data to

identify potential opioid misuse and take actions to ensure all members receive the right medications in the right dosages to meet their needs.

Children/Adolescents: Partners' P&T/DUR Review Committee will review instances where more than a three-day supply of short-acting opioids is prescribed in opioid-naïve members who are age 19 or younger. Provider outreach and education will focus on use of stepwise pain management treatment practices consistent with CDC guidelines to minimize chronic patient exposure to opioids where clinically appropriate.

System-Wide: As part of our commitment to addressing the opioid abuse epidemic via opioid stewardship, Partners and CVS will collaborate to advance existing efforts to reduce opioid misuse, consistent with the NC DMA Outpatient Pharmacy PA Criteria for Opioid Analgesics, the NCDHHS Opioid Action Plan and the NC STOP Act.

Examples of Partners' harm reduction initiatives include member and provider/pharmacy education and prevention; encouraging members to properly dispose of unneeded medication; promotion of the use of medication drop boxes for safe medication disposal; offering community and provider support for treatment services; and educating providers, pharmacy partners and members accessing and using naloxone (opioid-overdose reversal medication).

Partners will promote tools such as the Prescription Drug Monitoring Program, an electronic database that helps pharmacists and prescribers detect potential instances of prescription opioid misuse/abuse (e.g., MMEs exceeding threshold, use of multiple providers and pharmacies). We are a member of the NCDHHS Opioid and Prescription Drug Abuse Advisory Committee, which keeps us apprised of opioid trends and harm reduction opportunities. Our standard opioid management program aligns with the NCDHHS opioid stewardship parameters, NCDHHS opioid UM criteria and the CDC March 2016 Guideline for Prescribing.

Opioids for Chronic Pain: The program encourages appropriate treatment of acute and chronic pain with non-pharmacologic, non-opioid and opioid modalities as appropriate. It complements measures already in place, including ongoing monitoring for patterns of inappropriate prescribing or use and controls such as those found in the DUR program. To complement our program, we will promote use of non-opioid alternatives to chronic pain management.

For members in the Lock-In Program, we will use a pharmacy and provider lock-in, consistent with the NC Medicaid Clinical Coverage Policy. The member will obtain all prescriptions for opioid analgesics, benzodiazepines and certain anxiolytics from their lock-in prescriber and lock-in pharmacy only and receive educational outreach via care management on harm reduction strategies for their medication use.

Partners' Pharmacy Review Committee will review medication use for members in the Lock-In program. It will inform the member, care manager and provider/community pharmacy of identified concerns and provide education, as indicated.

Partners will receive opioid utilization reporting from CVS' Rx Navigator. Reports will include overall opioid utilization metrics and UM outcomes for program components (MMEs, opioid quantity limits, step therapy edits, acute pain duration edits). The P&T/DUR Committee will review reports monthly and take action to address member, provider and community pharmacy trends.

Partners will work with network pharmacies to obtain medication drop boxes for members to return unneeded medications, minimizing the risk for potential misuse.

As part of the statewide naloxone access program, Naloxone Saves, managed by the NC Department of Public Health Injury and Violence Prevention Branch, Partners will continue current educational outreach projects focused on appropriate opioid use for acute/chronic pain and naloxone co-prescribing/dispensing, to promote medication safety.

Partners Opioid Misuse Prevention and Treatment Program contains interventions that support and promote safer prescribing of opioids, management of acute and chronic pain, early detection of opioid misuse and intervention and increased access to naloxone and substance use disorder treatment. We also focus on harm reduction through strategic interventions, including:

- Offer training and encourage primary care providers to use Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Increase access to substance/opioid use disorder treatment and BH treatment through telehealth when clinically appropriate
- Support programs focused on the treatment and transport to alternative sites of care for people with substance/opioid use disorder, for example, paramedicine
- Meet network adequacy for medication-assisted treatment (MAT) for opioid use disorders through initiatives targeted at increasing number of MAT programs
- Increase access to substance/opioid use disorder treatment, including office based opioid treatment (OBOT), SA comprehensive outpatient (adult), SA Intensive Outpatient program (adults and children) and opioid treatment (adult)
- Provide non-emergency medical transportation for members to substance use disorder treatment
- Encourage member screening for opioid use disorder and use of medication assisted treatment (MAT) when indicated and incentivize members who successfully remain in MAT for 90 and 180 days. Educate members and providers when a member may be at elevated risk for opioid overdose and steps to take to minimize the risk

Members, providers and pharmacies will have access to online practical, evidence-based materials on proper opioid use, promoting a community-wide approach to reducing misuse.

PIHP SPECIALTY THERAPY AND REHABILITATION SERVICES

Partners offers beneficiaries access to all covered, medically necessary outpatient physical, occupational and speech therapy services. Partners works with Carolina Complete Health to ensure that the physical medicine services (physical, occupational, and speech therapy) provided to Partners beneficiaries are consistent with nationally recognized clinical guidelines.

Therefore, physical, occupational, and speech therapy services claims will be reviewed by Utilization Management to determine whether the services met/meet Carolina Complete Health's policy criteria for medically necessary and medically appropriate care. These determinations are based on a review of the objective,

, clearly documented clinical records. These reviews help us determine whether such services (past, present, and future) are medically necessary and otherwise eligible for coverage. Clinical documentation may be requested to support the medical necessity and appropriateness of the care. There is no need to send patient records with your initial claim. You will be notified if records are needed and your options for submitting them. . If records are necessary, it is important you know that Carolina Complete Health cannot authorize services until the necessary information is received. If the documentation received fails to establish medical necessity, Carolina Complete Health may deny authorization for services and future related therapy services thereafter. If requested records are not received, claims will be denied due to lack of information.

Please keep in mind you will need to ensure that the member has not exhausted his/her PT/OT/ST benefit and/or has a habilitative benefit prior to providing services. The purpose of Utilization Management is to review medical necessity of PT/OT/ST services, and not to manage the member's benefits. Non-Network Providers must obtain prior authorization for all services. Carolina Complete Health does not retroactively authorize treatment.

Prior authorization for home health occupational, physical or speech therapy services, as well as comprehensive day rehabilitation, should be submitted to ProviderCONNECT.

PIHP/Medicaid Direct – Providers will continue to bill NC TRACKS for these services for Medicaid Direct members.

IMPORTANT: Hi Tech Radiology Services

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our beneficiaries, Partners utilizes Evolent to provide prior authorization and utilization management services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA MRI/MRA PET Scan
- Myocardial Perfusion Imaging – Nuclear Cardiology
- MUGA Scan
- Transthoracic Echocardiology Transesophageal Echocardiology Stress Echocardiography

If a convenient, cost-effective, in-network imaging facility is not selected at intake for MR and CTs, Evolent will assign one that is closest to the member's zip code. Exceptions will be made in situations where there is a clinical reason the test must take place at a specific, higher cost facility. The finalized authorization will reflect the imaging facility selected. In addition, the imaging provider selected or assigned pursuant to this process will become the **provider of record for claims payment**. Any claim billed with an imaging provider's Tax ID that differs from the imaging provider's Tax ID selected or assigned during this process will be denied. Claim denial reasons are:

- EXNo-DENY Procedure code and Provider does not match authorization.
- EXNq-DENY Provider and DOS does not match authorization.
- EXNs-Deny Did not use authorized provider in network.
- EXy1- Deny: Services Rendered by Non-Authorized Non Plan Provider.

Please communicate to your patient which facility is on the authorization and the importance of them having the imaging study conducted there to ensure proper payment of the claim.

Key Provisions

Emergency department, observation and inpatient imaging procedures do not require authorization. It is the responsibility of the ordering physician to obtain authorization. Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Evolent provides an interactive website to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department at 1-833-552-3876. To reach NIA for urgent requests or other questions, please call 800-424-4889 and follow the prompt for high tech imaging authorizations.

WOMEN'S HEALTHCARE

Partners supports the unique needs of Women's Health in the following ways:

Family Planning Services

Partners will ensure there are sufficient family planning providers to ensure timely access to covered services. We will also provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services, which is in addition to the member's designated provider of primary care services if that provider is not a women's' health specialist.

Members shall not be required to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies.

Members have free choice of family planning services and supplies providers.

Members will not be held liable for payment for family planning services or supplies that are not in Partners network.

Members will not be required to obtain referrals for services provided by women's health specialists.

Members will not be required to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.

Providers will not be required to obtain prior approval for any obstetrical ultrasound.

Women's routine and preventive health care services may include but are not limited to initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted infections.

Women's Health and Cancer Rights

In accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA), Partners provides protections to members who choose to have breast reconstruction relating to a mastectomy, including coverage of:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema

Providers serving Medicaid Direct members will continue to bill NC TRACKS Directly for physical health services.

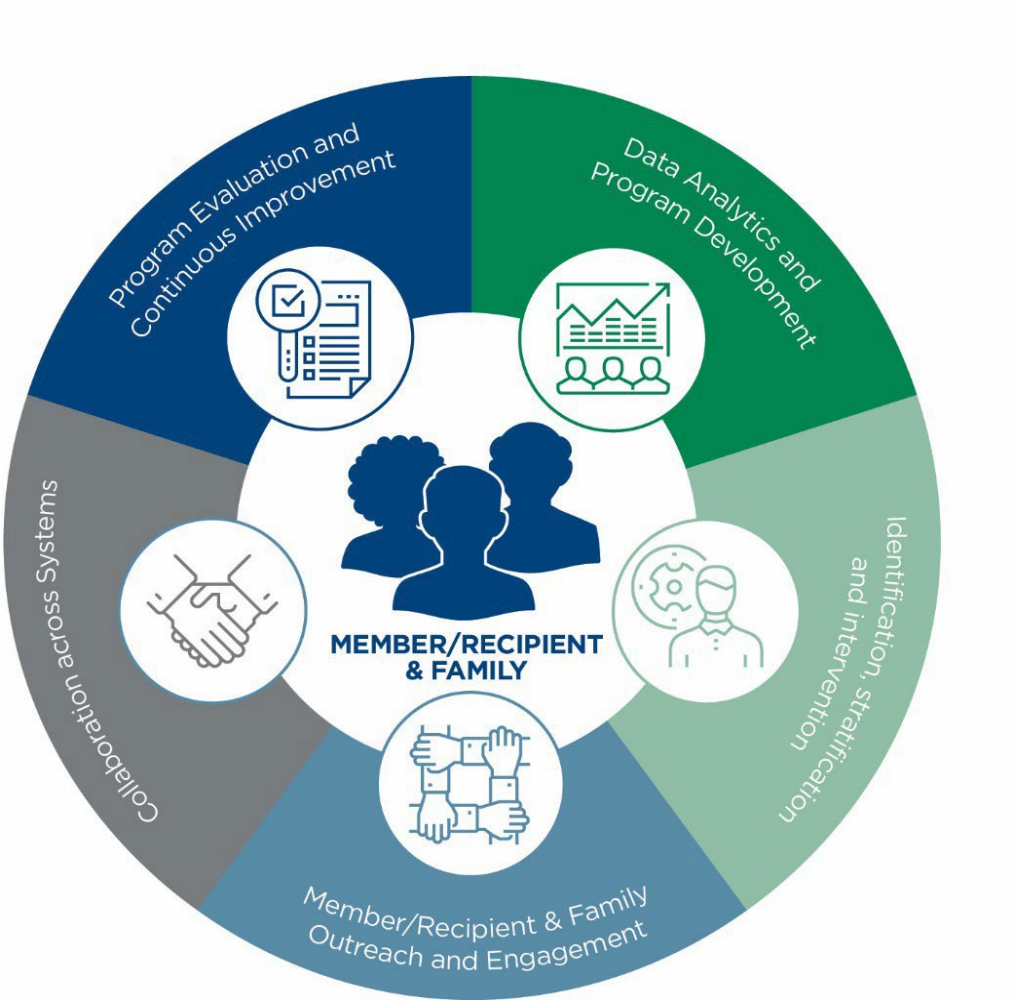
PREVENTION AND POPULATION HEALTH PROGRAMS

Partners collaborates with local health departments (LHDs), community stakeholders, providers and members to build sustainable support systems. We take a population-based approach to improve the overall health of TP/PIHP Medicaid members and State-funded recipients and collaborate with community partners on targeted initiatives. Working together with our PHP Partner, Carolina Complete Health, we will establish prevention and population health programs aligned with NCDHHS larger public health goals and quality strategy. We will utilize population-level measures from NCDHHS that inform on regional trends and assist performance improvement efforts.

Partners Prevention and Population Health programs will be available to all members.

The goals of our Prevention and Population Health Management Plan are to understand members' physical health (PH), behavioral health (BH), and social determinants of health (SDOH) needs; identify impact on health; and take action to improve health outcomes. Our comprehensive Prevention and Population Health Management Plan outlines methods to promote improved health outcomes. The objectives of our program include:

Partners' Prevention and Population Health Approach



Partners uses a comprehensive prevention and population health approach centered around the member/recipient and family.

Our planned prevention and population health management program designs are based on in-depth analysis of member information and include engagement and collaboration with members/recipients and stakeholders.

All planned prevention and population health management program designs are multi-faceted to include interventions at provider, member, and system levels, as described below.

Provider Level Interventions

Partners has forged long-standing collaborative relationships with providers who deliver Medicaid and State-Funded Services. Partners offers providers a continuum of topic-specific trainings, hands-on support and technical assistance driven by each provider's specific needs. We will give providers access to a wealth of

resources for prevention and population health programs and clinical practice guidelines , via ProviderCONNECT, our online portal.

Through ProviderCONNECT, providers can build their knowledge of evidence based and best practice guidelines and value-based payment arrangements that promote compliance and results in improved health outcomes. Partners Training Resource and Collaborative (TRAC) team will also offer providers opportunities to exchange best practices through virtual and in-person learning collaboratives.

The following table provides examples, by clinical area of focus, of our prevention and population health programs, in alignment with the NCDHHS population health priorities.

Partners' Prevention and Population Health Programs

Opioid Misuse	
Program Description	Our opioid misuse prevention and treatment program incorporates a comprehensive approach, including overdose prevention and treatment engagement. Using several approaches, such as member outreach, overdose response team, and pharmacy strategy.
Provider Level Intervention	Outreach and education to prescribers with the highest prescribing patterns includes sending letters to prescribers. Our pharmacy strategy includes use of a member lock-in program, a cumulative maximum morphine milligram equivalent (MME) dosage limit not subject to utilization management (UM) prior authorization, and diagnosis codes exempt from prior authorization requirements in opioid clinical coverage criteria. We promote access to naloxone through formulary structures and benefit design. Partners also has value-based contract for MAT providers to incentivize for their members who are engaged in 180 days of continuous MAT treatment.
Expected Outcomes	6. Decrease quantity of opioids dispensed. 7. Increase MAT patients. 8. Decrease number of Opioid Related Deaths
Tobacco Cessation	
Program Description	The tobacco cessation program will seek to prevent and reduce tobacco use and tobacco-related health concerns through education, resources, support, and promotion of and access to QuitlineNC. Special Note: Tobacco-related policy requirements will be effective January 1, 2027, for NC Medicaid Managed Care Standard Plans, Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans, and Medicaid Direct. The posted bulletin is now available https://medicaid.ncdhhs.gov/blog/2025/06/10/updated-tobacco-related-policy-requirements-delayed-until-jan-1-2027

Provider Level Intervention	We promote tobacco free campuses at contracted facilities, in alignment with the NCDHHS content from the state webinar on tobacco reduction. We will train providers about the importance of screening for tobacco use and resources available to support members that would like to quit.
Expected Outcomes	Reduction in Tobacco use. Increase of Nicotine Replacement Therapy
	•
Birth Outcomes	
Program Description	The pregnancy management program provides whole person support to members who are pregnant. The goal of this program is to provide early identification and appropriate effective management of pregnancy to reduce or prevent serious complications and improve outcomes for the member and infant. .
Provider Level Intervention	Provide education, training, technical assistance and support. Partners will coordinate care and promote programs to support pregnancy intendedness with LHDs and CCH.
Expected Outcomes	4. • Increase pregnant members identified in the first trimester through claims data and member self-report • Increase enrollment in Care Management High Risk Pregnancy (CMHRP) Program • Increase the number of members who are pregnant that deliver an infant weighing 2500 grams or greater • Increase member engagement in prenatal care • Reduce number of pregnant women who have complications during delivery
Chronic Condition Management of Diabetes	
Program Description	. The Chronic Condition Management of Diabetes Program is a short-term self-management program for adults with Diabetes. This program will provide education to members on how to effectively manage their chronic condition.
Provider Level Intervention	Physical and Behavioral Health Care Providers will be provided with education on how to make a referral. A referral of a member can be made via the Care Manager, by contacting a

	member of the Chronic Condition Management team, or by emailing a referral to PopulationHealthPrograms@partnersbhm.org.
Expected Outcomes	• • Increase in the number of members diagnosed with diabetes that receive a semi-annual HbA1c screening and/or blood glucose test annually. • Members of the Chronic Condition Management of Diabetes Program will obtain a better understanding of how to manage their diabetes upon completion of the program as evidenced by self-reporting by survey.
Chronic Condition Management of Asthma	
Program Description	. The Chronic Condition Management of Asthma Program is a short-term self-management program for adults and children with Asthma. This program will provide education to members on how to effectively manage their chronic condition.
Provider Level Intervention	Physical and Behavioral Health Care Providers will be provided with education on how to make a referral. A referral of a member can be made via the Care Manager, by contacting a member of the Chronic Condition Management team, or by emailing a referral to PopulationHealthPrograms@partnersbhm.org.
Expected Outcomes	• • Partners will have a decrease in the percentage of members that complete the Chronic Condition Management of Asthma Program that have a high or very high risk for ED utilization. • Members of the Chronic Condition Management Program for Asthma will obtain a better understanding of how to manage their condition upon completion of the program as evidenced by self-reporting by survey.
Early Childhood Interventions	
Program Description	Partners closely monitors adherence to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) schedules to ensure all children under the age 21 who are enrolled in Medicaid, receive preventative health care services, screenings, and follow-up services. EPSDT is a federal Medicaid requirement and required to cover medically necessary procedures, services, or products to correct or improve a condition identified through screenings. If a follow-up service is identified, the assigned care manager will connect the member to the service and coordinate with UM for authorization. If a child is identified as needing a service for physical, intellectual, developmental, or significant behavioral issues, Partners will re-evaluate their care management level and provide more intensive support and education, as identified.
Provider Level Intervention	Provide education, training, technical assistance, and support.

Expected Outcomes	3. Improve EPSDT compliance rates. 4. Increase member satisfaction.

Partners has additional planned prevention and population health management program designs to support priority domains in the clinical areas of asthma, obesity, interpersonal safety, trauma, physical activity/exercise, nutrition, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, and stress management.

Partners expects all providers to educate members about availability and accessibility of Prevention and Population Health programs and services.

Our Provider Support Plan offers additional information and resources for providers eligibility criteria, objectives, and referral mechanisms for all Prevention and Population Health programs. The Provider Support Plan can be found at the ProviderCONNECT portal.

Advanced Medical Homes Plus (AMH+) and Care Management Agencies (CMA) and Partners care managers are required to promote wellness and prevention by educating members and referring them to programs that address exercise and nutrition, stress management, substance use reduction, cessation and relapse prevention, harm reduction, suicide prevention, self-help recovery and other wellness services. **Please refer to Partners AMH+/CMA manual for additional information or through the link here https://files.nc.gov/ncdma/documents/Transformation/Advanced-Medical-Home-Provider-Manual.pdf. The manual can be found on the ProviderCONNECT portal as well.*

Partners will notify PCPs and AMH+s/CMAs (if applicable) by letter, email, fax or secure web portal of their member's involvement, unless the member notified us not to inform them.



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List of Revisions

Date of Revision	Content Revised/Section	Date Internally Approved	Date Submitted to the NCDHHS	Effective Date Posted for Providers
20230131	Section ALL **Combined TP/PIHP Manual** Section ALL Edited wording Grievance/Complaint Section ALL Added wording Tailored Plan TP and Prepaid Inpatient Health Plan PIHP and State Funded throughout Section General Page 6 Corrected Partners website link Section General Page 6 Insert manual revision and impact Section General Page 10 Renamed section Provider Network Relationship and Engagement Section ALL Renamed Training Resource and Collaborative Section TP Medical Management Page 219 Removed LOCUS/CALOCUS Section General Page 12 Corrected Provider Credentialing Transition Period Section PIHP Populations Page 334 Added Partners PIHP Roles and Responsibilities Section Provider Compliance Page 16 Added MD Section VI Appointment Wait Times Standards Section Network Development and Maintenance Page 38 Added MD Section VI PIHP Time/Distance Standards Section PIHP/Medicaid Grievances and Appeals Page 83 Updated PIHP/Medicaid Grievances and Appeals section Section Benefit Integration Page 182 Removed Pharmacy Carve Out Period Section Claim Editing Page 115 Updated Billing Guidelines and Claim Editing section TOC Update-pagination	20230301		20230301

20230301	TOC Update	20230301		20230301
20230327	**Combined TP/PIHP Manual** TP Amendment 1 Updates Section General Page 13 Added use of NCDHHS Objective Quality Standards Section State Funded Eligibility Criteria Page 133 Corrected Citizenship Eligibility guidelines Section State Funded Eligibility Criteria Page 137 Added State Funded Waitlist email address Section Partners Websites and Information Technology Page 20 Added Member/Recipient Portal content Section ALL Corrected to ProAuth for auths Section Alternative Methods for Requesting Authorizations Page 210 Added manual auth email address Section Partners Transitions of Care Page 176 Updates to Transition of Care section Section Member/Recipients Rights and Responsibilities Page 55 Updates to Member/Recipients Rights and Responsibilities Section General Page 8 Updates to Human Rights Committee Section State Funded Contract Communication and Changes in Process Page 62 Updates to State Funded Contract Communication and Change Process TOC Update--Pagination		20230327	20230327
20230724	**New Manual Structure (3-distinct sections): General Section, TP Section, PIHP Section with TOC reflecting this separation for combined manual** Section General Page 6 Access and Updates to Manual Section General Disaster or Emergency Related Planning Page 9 Added Disaster/Emergency Procedures Section General Page 16 Updated Provider Availability	20230724	20230724	20230731

	Section General Page 17 Updated Insurance Section General Page 13 Updated Additional Information Requested Descriptions and contracting process Section Network Development and Maintenance Page 29 Updated Specialist Table Section PIHP/Medicaid Grievances and Appeals Page 87 Link corrected Section ALL Updated Provider Service Line phone number to 877-398-4145 Section Provider Engagement Page 12 Corrected Provider Contracts link Section Credentialing and Recredentialing Page 16 Added availability Section Poverty Guidelines Page 134 Updated Table and link Section Advanced Medical Homes Page 154 link updated Section Submitting Inpatient Requests Page 168 inserted ProAuth Section Clinical Practice Standards Page 202 Updated Clinical Operations Committee Section Abortion/Sterilization Page 225 Updated Links Section Appointment Accessibility Standards Page 345 Updated Table Section Member/Recipients Rights and Responsibilities Page 55 Updated Notification to member procedure Section Fraud, Waste and Abuse for Partners TP/PIHP/State Funds Page 92 Updated Provider Program Integrity Requirements Section General Disaster or Emergency Related Planning Page 9 Added Disaster/Emergency Procedures			

20230810	Adjust language for Online Prior Authorization (PA) to include "Non-Preferred" and "without a PA." page 109	20230810		20230831
20240125	Updated Medicaid Billing Guidance link page 113	20240125		20240125
20240325	Add Tobacco Related Policy Requirements pages 200 & 272	20240325		20240325
20240617	Annual Revisions Updated URLs, Naming Conventions, grammar, formatting, Contact info, email addresses, Social Media info, Alpha+, After Hours Coverage pgs. 44-49, Human Rights pg 62, EOR pg 99, Pharmacy med qty limits pg 109, Poverty Guidelines pg 132, eligibility & enrollment pg 133, Member Demographics pg 222	20240617	20240617	
20241106	PDL and Network Adequacy	20241031	20241106	20241106