AGENDA

1. Call to Order

2. Announcements (5 minutes)

3. Agenda Adjustments

4. Public Comments (5 minutes)

5. Committee Reports
   A. Consumer and Family Advisory Committee (5 minutes) – page 3
      The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report includes draft minutes and supporting documents from the Cumberland, Durham, Wake, Johnston, and the steering committee meetings.

   B. Finance Committee (10 minutes) – page 90
      The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report includes the draft minutes from the June 6, 2019, meeting, the Summary of Savings/(Loss) by Funding Source, The Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending May 31, 2019. And recommendations to the Board to approve all presented contracts.

   C. By-Laws/Policy Committee Report – page 99
      Per Alliance Board Policy "Development of Policies and Procedures," the Board is to review all policies annually. The Board Policy Committee reviews a number of Policies each quarter in order to meet this requirement. In coordination and consultation with members of the Board Executive Committee, the Board Policy Committee presents the attached amendments to the By-Laws for consideration and approval. The proposed amendments were provided to Board members on July 1, 2019, for review. Pursuant to the By-Laws of the Board of Directors, this action requires a super-majority vote.

      CEO Recommendation
      Receive the reports. Approve presented contracts. Consider and approve the proposed revisions to the By-Laws.

6. Consent Agenda (5 minutes)
   A. Draft Minutes from June 6, 2019, and June 27, 2019, Board Meetings – page 110
   B. Executive Committee Report – page 116
   C. Human Rights Committee Report – page 119
   D. Network Development and Services Committee Report – page 163
   E. Quality Management Committee Report – page 165

      CEO Recommendation
      Approve the minutes; receive the reports.
7. **Presentation/Training: Crisis Services for Alliance’s Catchment Area (30 minutes)** – page 170
   Alliance has developed and continues to improve upon crisis services available to citizens in the catchment area. Sean Schreiber, Executive Vice-President/Network and Community Health, will provide an overview of the crisis continuum, utilization of crisis services and improvement activities.

   **CEO Recommendation**
   Receive the training/presentation.

8. **Legislative Update (20 minutes)**
   Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Director of Government Relations, will provide the update.

   **CEO Recommendation**
   Receive the update.

9. **Chair's Report (5 minutes)**

10. **Closed Session (30 minutes)**
    The Board will hold a closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence and performance of an employee.

11. **Adjournment**

    Next Meeting: Thursday, September 5, 2019
    Alliance Health, 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The Alliance Consumer and Family Advisory Committee, or CFAC, is made up of consumers and/or family members that live in Durham, Wake, or Cumberland Counties who receive mental health, intellectual/developmental disabilities and substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to Alliance administration and Board of Directors.

State statutes charge CFAC with the following responsibilities:
- Review, comment on and monitor the implementation of the local business plan
- Identify service gaps and underserved populations
- Make recommendations regarding the service array and monitor the development of additional services
- Review and comment on the Alliance budget
- Participate in all quality improvement measures and performance indicators
- Submit findings and recommendations to the State Consumer and Family Advisory Committee regarding ways to improve the delivery of mental health, intellectual/other developmental disabilities and substance use/addiction services.

The Alliance CFAC meets at 5:30pm on the first Monday in the months of February, April, June, August, October and December at the Alliance Corporate Office, 5200 West Paramount Parkway, in Morrisville. Sub-committee meetings are held in individual counties; the schedules for those meetings are available on our website.

The Alliance CFAC tries to meet its statutory requirements by providing you with the minutes to our meetings, letters to the board, participation on committees, outreach to our communities, providing input to policies effecting consumers, and by providing the Board of Directors and the State CFAC with an Annual Report as agreed upon in our Relational Agreement describing our activities, concerns, and accomplishments.

REQUEST FOR BOARD ACTION: Receive draft minutes and supporting documents from the Cumberland June 27th meeting, the Durham June 10th and July 8th meeting, the Wake June 11 and July 9th meeting, the Johnston June 18th, and the steering committee minutes from July 1st.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, CFAC Chair; Doug Wright, Director of Community and Member Engagement
CFAC MEETING - REGULAR MEETING
711 Executive Place, Fayetteville, NC 28305
5:30-7:00 p.m.

MEMBERS PRESENT:  Michael McGuire  Ellen Gibson  Dorothy Johnson  Carrie Morrisy  Jackie Blue  Jamille Blue  Sharon Harris  Briana Harris  Shirley Francis  Tekeyon Lloyd  Tracey Glenn  Thomas  Renee Lloyd  Carson Lloyd Jr.

BOARD MEMBERS PRESENT: None

GUEST(S): Andrea Clementi  Alex McArthur  Valencia Handy  Preston Harris  Saadia Smith  Marisa Ramos, Mason  Stepheeria Nicholson

STAFF PRESENT: Doug Wright, Director of Community & Member Engagement  Terrasine Gardner, Member Engagement Manager  Starlett Davis, Individual & Family Engagement Specialist  Nathania Headly

Dial-In Number: (605) 472-5464
Access Code: 289674

1. WELCOME AND INTRODUCTIONS: Michael McGuire

2. REVIEW OF THE MINUTES – The minutes from the May 23, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Shirley Francis and seconded by Jackie Blue to approve the minutes. Choose an item.

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<thead>
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<th>DISCUSSION:</th>
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<tr>
<td>3. Public Comments</td>
<td>Community events and resources were provided by Starlett Davis. Starlett Davis proposed putting the community events for each month on a calendar for the committee instead of printing out flyers for everything. The calendar will include the name and time of event in date block and the information on the event such as registration and address will be in the information block below. I would still print out some flyers that needed to be printed. The committee agreed on this. I provided them with calendar events for June, July, and August. I asked them to send me any additional events via email for next meeting.</td>
<td>Committee members will update Star on community events to be added to calendar.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4. CFAC/SOC Forums</td>
<td>Terrasine Gardner spoke to the committee about the SOC doing forums in the community to address needs and gaps as well as provide resources and information. Terrasine asked the committee to think about what they feel the community needed more information on. Of course Medicaid transformation and the direction of Alliance and the Tailored Plans is a topic that is being discussed as information is updated. She ask for additional topics to be brought back to the next meeting.</td>
<td>The committee is to think about topics that the SOC can discuss with the public.</td>
<td>7/25/19 and ongoing</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
# CFAC MEETING - REGULAR MEETING

**711 Executive Place, Fayetteville, NC 28305**

**5:30-7:00 p.m.**

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<tr>
<td>5. MCO/ State Updates</td>
<td>Doug went over the Community Engagement and Empowerment Team Update. Each member received a copy of the updates. Doug presented the Medicaid Managed Care Policy Paper. Please see attached Policy Paper. He explained that the paper was about Care Management and Care Teams. Community forums have been held in Cumberland. The Care Teams will start July 1st in all of the communities. It will be with I/DD population first and will be implemented in mental health and substance use population by December. He explained what is different with Care Teams as they relate to how you manage care which is explained in the policy paper. We will be serving a smaller population. This will allow Alliance to care for the individuals with the highest needs. This population takes up about 95% of the money used already for services. Doug went over how the Care Teams would be set up and expectations. He explained the whole person approach with managing physical health and pharmacy as well with services. He also explained how the individual would utilize the care team and how many different professionals could be utilized to suit the individual’s needs via Care Navigator. He talked about creation and expectations for Care Management Agencies in the discussion that needs to be had to make sure they are up to par. Advance Medical homes exist and are working with standard plans that start November 1st. Doug and Terrasine addressed questions and concerns from members and guest. Committee members and guest also gave input on resources and experiences that could be helpful and to consider during this transformation.</td>
<td>Please see flyer for updates on state meetings. Care Teams for I/DD population start July 1st. Care Teams for Mental Health and Substance Use population start December 2019.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6. Upcoming Community Events/ Community Outreach event</td>
<td>Anonymous People Viewing room reservation update: September and October CFAC days are booked. However, October 17th, the Thursday prior may be an option. I have to wait until July 1st to reserve due to 90 days out policy. The committee decided that having the meeting a week prior on October 17th would be fine to do the viewing. Starlett will contact DSS and submit the room reservation form.</td>
<td>Starlett will contact DSS to submit room reservation form.</td>
<td>July 1, 2019</td>
</tr>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
### AGENDA ITEMS:

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<td>7. Membership Discussion</td>
<td>Michael McGuire - Benefits of CFAC and becoming a member. Michael spoke about becoming a member and what CFAC does. We had a few guest explain that they would like to be member. Starlett explained that the membership was for individuals and families that have challenges with mental health, substance use, and I/DD. Providers and organizations are free to come to the meetings because they are open meetings but are not able to become members.</td>
<td>Doug and Starlett will look at the Bylaws in regards to membership for a specific situation and report back to the committee on the next meeting.</td>
<td>7/25/19</td>
</tr>
<tr>
<td>8. Prep for next meeting</td>
<td>The committee members are to bring a guest with them. The members are also to bring activities and events they would like added to the calendar.</td>
<td>The committee members are to bring a guest with them. The members are also to bring activities and events they would like added to the calendar.</td>
<td>7/25/19</td>
</tr>
<tr>
<td>9. Appreciation</td>
<td>Everyone went around and gave their appreciation.</td>
<td>N/A</td>
<td>N/A</td>
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</table>

**ADJOURNMENT:** the next meeting will be 7/25/19 at 5:30pm at Alliance Health in Cumberland. Rm 109.

Respectfully Submitted by:

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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.


1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the May 13, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dan Shaw and seconded by Chris Dale to approve the minutes. Motion passed.

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<tr>
<td>3. Public Comments</td>
<td>Chris Dale mentioned that the community forum that took place on May 14, 2019 at the Lyon Park Recreational Center went well.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interest in Membership/Outreach</td>
<td>Pinkey Dunston was voted back into the Durham, CFAC Subcommittee. Welcome Pinkey.</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
| 5. LME/MCO Updates | Tailored Plan Regions:
Doug went over the latest information on the tailored plan regions. As of now, there will be 5-7 tailored plans beginning in July 2021. The final announcement on the regions should come by the end of June.

November Standard Plan Implementation – what will be different:
Doug went over the standard plan implementation updates and talked about what that would like. Notable points:

- Maximus is the broker assisting members with standard plan choices and enrollment. Their call center should be up and running by July 1, 2019. | Ongoing | Ongoing |

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<td></td>
<td>Raise Your Hand: An individual who qualifies for Medicaid who believes they meet the eligibility and wishes to be in the BH/IDD Tailored Plan can make that request with the help of their provider. Individuals that stay with Alliance, everything will remain the same. Those that move into a standard plan will have the most changes. Doug went over the Care Team portion of the North Carolina’s Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans. This paper was sent electronically to all members and they were encouraged to read and send any questions to Ramona or Doug for responses/clarification.</td>
<td></td>
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<td></td>
<td>6. 2019 Annual Plan Summary</td>
<td>Steve Hill asked all CFAC members to respond to him in an email with any suggestions/comments for the annual summary. He has asked members to please send the emails by Thursday, 06.13.2019.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>7. Event Planning</td>
<td>Outreach Opportunities: Ramona mentioned (3) events in the next few weeks for CFAC members to come out and educate the community about CFAC. These events are part of the Safe Summer Community Events and will be held at different locations within the Durham Community. Ramona will send out emails with information and directions to members. They are asked to respond if they are planning to attend.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

ADJOURNMENT: 6:50pm The next meeting will be held July 8, 2019, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch, Individual & Family Engagement Specialist

06.11.2019

Click here to enter text.

Date Approved

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
MEMBERS PRESENT: ☒ Steve Hill, ☐ Tammy Shaw, ☐ Joe Kilsheimer, ☐ James Henry, ☐ Latasha Jordan, ☐ Dave Curro, ☐ Trulia Miles, ☒ Brenda Solomon, ☐ Chris Dale, ☒ Dan Shaw, ☒ Pinkey Dunston

BOARD MEMBERS PRESENT: None

GUEST(S): ☐ Susan Hertz, ☐ Tina Barnes, ☒ Margaret Watson, ☐ Tommy Henry

STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Engagement, ☐ Terrasine Gardner, Member Engagement Manager, ☒ Ramona Branch, Individual & Family Engagement Specialist

Dial-In Number: (605) 472-5464
Access Code: 289674

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the June 10, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Chris Dale and seconded by Dan Shaw to approve the minutes. Motion passed.

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<td>3. Public Comments</td>
<td>Steve Hill commented on TROSA’s 25th Anniversary and their recent Durham Community Honors recognition. The group welcomed guests: Margaret Watson and Tommy Henry. Ramona gave a basic overview of CFAC and other members chimed in. The group also took some time answering questions from attending guests.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interest in Membership/Outreach</td>
<td>N/A</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>5. LME/MCO Updates</td>
<td>Doug Wright went over all of the LME/MCO updates which included the following take away points: July Update from the Community Engagement &amp; Empowerment Team (DHHS): CJ Lewis will no longer be working with DHHS and Ken Schusselin will be leaving on July 12. FY20 Budget Update: The budget was approved in the amount of a $535,759,800. The packet was emailed to everyone and they are encouraged to read over the 34 page document and submit any questions to Ramona or Doug.</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
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</table>

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<tr>
<td>Maximus Presentation: Doug reviewed the presentation given to the SCFAC about Maximus (enrollment broker) for Medicaid. He explained that their primary role is to do choice counseling with members so they can decide which health plan is best for them. They will also assist when members want to change plans but that will remain a DHHS decision. Good information for members to be aware of and share with their contacts about what to expect.</td>
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<td>Raise Your Hand Form: Feedback was presented to the state from CFAC and other stakeholders. The state has reviewed that information and has redone the form to simplify the process for members.</td>
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<tr>
<td>Medicaid letters to members transitioning into standard plans are in the process of being mailed from July 8th-11th. These letters will include information on the enrollment broker Maximus and how to choose their standard plan.</td>
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<td>The State CFAC meeting will be Wednesday 07.10.2019. Topics of discussion will include: Tailored Plan regions, and perception of care.</td>
<td></td>
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<tr>
<td>6. Community Forum Brainstorming</td>
<td>The group brainstormed on the next topics for community forums. The main focus so far seems to be affordable housing and they would like to have the Mayor of Durham involved as well as housing providers and developers. The group would like to target all 3 of our populations.</td>
<td>Revisit this topic next CFAC Meeting on August 12, 2019.</td>
<td>30 days</td>
</tr>
<tr>
<td>7. Event Planning</td>
<td>Ramona went over the next upcoming event on September 14 from 2-6: Recovery Community of Durham; Durham Celebrates Recovery. We will host a resource table. CFAC members are encouraged to come out and support this event. Dave Curro has stated that he will be in attendance so far.</td>
<td></td>
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**ADJOURNMENT:** the next meeting will be August 12, 2019, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch, Individual & Family Engagement Specialist

Click here to enter text.

Date Approved: 07.09.2019

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
NC Medicaid Managed Care Enrollment Broker

June 12, 2019
NC Consumer and Family Advisory Committee
SCFAC Raleigh, NC
Enrollment Broker
Enrollment Broker Defined

• An enrollment broker is an individual or entity that performs choice counseling or enrollment activities, or both.

• Enrollment activities include:
  – Distributing, collecting, and processing enrollment materials
  – Taking enrollments by phone or through electronic methods of communication

• Eligibility services are completed by the state, not by an enrollment broker.

Source:
The Centers for Medicare & Medicaid Services (CMS)
Code of Federal Regulations 42 CFR § 438.810 - Expenditures for enrollment broker services
Largest Medicaid Administrative Services Provider

70% market share of Medicaid managed care
Enrollment Broker Services in North Carolina

- Unbiased 3rd party
- Enroll beneficiaries in right health plans for their needs
- Provide communication hub for beneficiaries, providers and plans
- Outreach and education
- Partner with and support local DSS offices
- Maintain web and mobile sites/tools, including Provider Directory
Choice Counseling

• Delivering information and assistance effectively to consumers
  – Provide unbiased, culturally competent choice counseling services to beneficiaries
  – Simplify the enrollment process so it’s easy for consumers to understand, and satisfy program requirements
  – Achieve improved voluntary choice rates for better health outcomes

Trained customer service team  
Responsive and empathetic  
6th grade level of health literacy
Enrollment Assistance through Health Literacy

• Making a real connection with those we serve
  – Understand underserved populations better than anyone
  – Speak their language (multi-language support and translation services)
  – Provide user-friendly, culturally appropriate support
  – Perform usability and community testing
  – Nationally recognized for work in health literacy

– Communicate with consumers on their preferred channels – whether by web, phone, email, text and mobile app

– Proactively engage beneficiaries at critical points to ensure they enroll as necessary
Digital Solutions and Analytics

• Gaining a window into consumer/member engagement
  – Simplify the enrollment process for consumers, while satisfying program requirements

• Enrollments by channel
• Mobile enrollments
• Mobile sessions
• Weekly app updates
• Member views/updates of case information
Outreach and Education

• Ensuring a seamless and streamlined beneficiary experience
  – Partner with North Carolina’s county DSS offices and community organizations to provide education on the Enrollment Brokers role and process flow
  – Provide member materials that are understandable and accessible
    o Posters, Flyers, Palm cards and Fact Sheets
  – Conduct outreach services that meet consumer’s cultural and behavioral expectations

In-person services, group presentations and health fairs
Distribution of information and educational materials
Training
• Managed Care Transition and Mandatory Notice
  • Mandatory and Exempt Members
• Welcome Packet – comparison chart, enrollment form, fact sheet
• Grievance
  – Acknowledgement
  – Resolution
• Member Plan Change Request
# Health Plan Comparison Chart

All plans are required to have the same type of Medicaid services you get now. These include:

- Doctor visits
- Hospital visits
- Behavioral health care
- Prescriptions
- Eye care
- Medical supplies
- Lab tests and X-rays
- Therapies
- Hospice

To see the full list of NC Medicaid covered services provided by the plans, go to [ncmedicaidplans.gov](http://ncmedicaidplans.gov). Use this chart to learn more about your plan choices.

<table>
<thead>
<tr>
<th>Plan Provider</th>
<th>Phone Number</th>
<th>Website</th>
<th>Address</th>
<th>Coverage Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellCare</td>
<td>1-866-799-5318</td>
<td>wellcare.com/nc</td>
<td>421 Fayetteville Street, Suite 1100, Raleigh NC 27601</td>
<td>Statewide (all 100 counties)</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>1-800-349-1855</td>
<td>uhccommunityplan.com/nc.html</td>
<td>3803 N Elm Street, Greensboro NC 27455</td>
<td>Statewide (all 100 counties)</td>
</tr>
<tr>
<td>HealthyBlue</td>
<td>1-844-594-5070</td>
<td>HealthyBlueNC.com</td>
<td>4613 University Drive, Durham NC 27707</td>
<td>Statewide (all 100 counties)</td>
</tr>
<tr>
<td>AmeriHealth Cantas</td>
<td>1-855-375-8811</td>
<td>amerihealthcaritasnc.com</td>
<td>PO Box 7338, London KY 40742</td>
<td>Statewide (all 100 counties)</td>
</tr>
</tbody>
</table>

**Questions?** Go to [ncmedicaidplans.gov](http://ncmedicaidplans.gov) or call us at **1-833-870-5500 (TTY: 1-833-870-5588)**. We can speak with you in other languages. You can get this information in other languages or formats, such as large print or audio.
Enrollment Broker FAQs

• Enrollment Broker Call Center
  – Phone, Chat, Website and Mobile App are scheduled to go live on 06/28/2019
  – Located in Morrisville, NC
  – Hours of Operations: Monday to Saturday 7:00am to 5:00pm, extended hours during open enrollment Monday to Sunday 7:00am to 8:00pm
MAXIMUS Contacts

Maritza Nowakowski  
Project Director  
224.456.5416  
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Deputy Director  
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pamelachampagne@maximus.com

Carter Wade  
Outreach & Education Manager  
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cartermwade@maximus.com

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Tribal Liaison  
919-480-4030  
christinatheodorou2@maximus.com

Gina Padilla  
Vice President, Health Services  
720.987.8733  
ginampadilla@maximus.com

Renee Moore  
DSS Liaison  
910-581-3843  
reeneelmoore@maximus.com
**Alliance Health**  
**Annual Budget**  
**FY 2019-2020**

**Board of Directors**

Cynthia Binanay, Chair  
George Corvin, Vice Chair

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<td>George Corwin, MD</td>
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<td>Commissioner Heidi Carter</td>
<td>Commissioner Greg Ford</td>
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<tr>
<td>David Curro</td>
<td>David Hancock</td>
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<tr>
<td>Gino Pazzaglini</td>
<td>Donald McDonald</td>
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<tr>
<td>Pam Silberman</td>
<td>Lynne Nelson</td>
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<td>Lascel Webley, Jr.</td>
<td>McKinley Wooten, Jr.</td>
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<td>Commissioner Tony Braswell</td>
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<td>Lee Jackson</td>
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**Robert Robinson, CEO**
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June 6, 2019

Alliance Board Members,

We are pleased to share with you our FY20 budget for your approval.

The approved budget reflects a few changes from the recommended budget that was presented to you on May 2nd. To summarize, increases were made in the following areas:

- Overall increase in Administration due to adjustments in County funding and increase in the Medicaid PMPM rate offer
- Medicaid by over $1.7M due to the current PMPM rate offer and an adjustment to the TBI budget
- Local funding decrease by $263,000 due to adjustments to the final budgets

As I mentioned in my introduction to the recommended budget document, this budget that we are presenting for your approval reflects our focus for the upcoming year on our preparations to operate as a Tailored Plan as part of our state’s Medicaid transformation. We believe that it will allow Alliance to serve as many people as possible with quality services and a focus on best practice services, to reduce reliance on our fund balance for ongoing commitments to uninsured individuals, and very importantly, to ensure our future sustainability in a changing healthcare landscape.

We thank you for your continued participation and wise counsel during this budget process.

Best Regards,

Rob Robinson
Chief Executive Officer
Reader’s Guide

FY 2019-2020 is the eighth annual budget presented for Alliance Health (Alliance). This section is provided to help the reader understand the budget by explaining how the document is organized. This document details the budget for fiscal year 2019-2020 for Alliance’s administrative and service operations covering Cumberland, Durham, Johnston and Wake counties. The budget year begins July 1, 2019 and ends June 30, 2020. The document will show how the funds are allocated and how they will be spent.

Alliance Health LME/MCO will have one fund called the General Fund. The General Fund will account for all administrative and service operations and will be divided into functional areas for Administration, Medicaid Services, State Services, Local Services, and Grant Funds, when applicable.

Revenues and Expenditures of the General Fund
The categories of the revenue and expenditures are the same. They include the following:

Administration
Alliance Health is administratively funded through a combination of the Medicaid waiver, state LME allocation, and county administrative contribution.

Alliance began the management of Medicaid services under a waiver according to Session Law 2011-264 House Bill 916 on February 1, 2013. These funds refer to the administration dollars allocated under a contract with the NC Division of Medical Assistance. The funds are allocated based on a per member per month basis. The members per month budgeted is based on historical experience and projections.

The NC Division of Mental Health, Developmental disabilities, and Substance Abuse services (NC DMH) continue to allocate funds to administer state and federal block grant dollars for the purposes of serving the non-Medicaid population.

Cumberland, Durham, and Wake counties allocate a percentage of the county dollars in administrative support for the management of their dollars in serving consumers in their respective county.

Miscellaneous
This category is to account for any funds received during the fiscal year that do not fall into one of the above mentioned categories and are not significant enough to require their own category. The funds roll up into the Administrative budget.
**Medicaid Services**
Alliance Health began the management of Medicaid services under a waiver according to Session Law 2011-264 House Bill 916 on February 1, 2013. These funds refer to the dollars allocated under the contract with the NC Division of Medical Assistance to provide services to Medicaid enrollees of Cumberland, Durham, Johnston, and Wake counties.

**State Services**
These funds represent state allocated dollars for Cumberland, Durham, Johnston, and Wake communities to provide services for non-Medicaid citizens with mental health, intellectual/developmental disabilities and substance abuse needs. The funds include Federal Block Grant dollars as allocated from the NC DMH.

**Local Services**
These funds represent the Cumberland, Durham, and Wake county allocations to Alliance to provide services for citizens with mental health, intellectual/developmental disabilities, and substance abuse needs in their respective counties.

**Grants**
When applicable, grant funds are those that are specified for a particular project or program.

**Draft Budget Ordinance**
A draft budget ordinance is being included for informational purposes.

**Additional Information**
The basis of accounting and budgeting for Alliance Health is modified accrual per G.S. 159-26. This means that revenues are recorded in the time period in which they are measurable and available. Revenues are recognized when they are received in cash. Expenditures are recognized in the period when the services are received or liabilities are incurred.

This document was prepared by Alliance Health Business Operations and is available online at www.AllianceHealthPlan.org. If further information is needed, please contact Kelly Goodfellow, Executive Vice President/CFO, at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or by email at kgoodfellow@AllianceHealthPlan.org.
### Alliance Demographic Information

#### Alliance Regional Population Data

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Medicaid Eligible</th>
<th>Medicaid %</th>
<th>Medicaid Served</th>
<th>Non-Medicaid Served</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>332,546</td>
<td>80,728</td>
<td>24.28%</td>
<td>12,763</td>
<td>3,367</td>
<td>16,130</td>
</tr>
<tr>
<td>Durham</td>
<td>311,640</td>
<td>53,115</td>
<td>17.04%</td>
<td>8,146</td>
<td>3,649</td>
<td>11,795</td>
</tr>
<tr>
<td>Johnston</td>
<td>196,708</td>
<td>39,000</td>
<td>19.83%</td>
<td>5,405</td>
<td>1,719</td>
<td>7,124</td>
</tr>
<tr>
<td>Wake</td>
<td>1,072,203</td>
<td>122,154</td>
<td>11.39%</td>
<td>16,503</td>
<td>7,699</td>
<td>24,202</td>
</tr>
<tr>
<td>Total</td>
<td>1,913,097</td>
<td>294,997</td>
<td>15.42%</td>
<td>42,817</td>
<td>16,434</td>
<td>59,251</td>
</tr>
</tbody>
</table>

Based on 2017 Statistics, US Census Bureau

#### Persons Served by Age and Disability Based on Claims Paid by Medicaid and IPRS

<table>
<thead>
<tr>
<th>Age Group</th>
<th>County</th>
<th>MH</th>
<th>SA</th>
<th>IDD</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
<td>Cumberland</td>
<td>5,488</td>
<td>92</td>
<td>623</td>
<td>6,203</td>
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<tr>
<td></td>
<td>Durham</td>
<td>3,706</td>
<td>75</td>
<td>368</td>
<td>4,149</td>
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<tr>
<td></td>
<td>Johnston</td>
<td>2,331</td>
<td>27</td>
<td>328</td>
<td>2,686</td>
</tr>
<tr>
<td></td>
<td>Wake</td>
<td>7,697</td>
<td>127</td>
<td>941</td>
<td>8,765</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>19,222</td>
<td>321</td>
<td>2,260</td>
<td>21,803</td>
</tr>
<tr>
<td>Adult</td>
<td>Cumberland</td>
<td>8,056</td>
<td>2,435</td>
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<td>11,265</td>
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<tr>
<td></td>
<td>Durham</td>
<td>6,149</td>
<td>2,343</td>
<td>838</td>
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<tr>
<td></td>
<td>Johnston</td>
<td>3,690</td>
<td>1,055</td>
<td>380</td>
<td>5,125</td>
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<tr>
<td></td>
<td>Wake</td>
<td>12,325</td>
<td>3,362</td>
<td>2,014</td>
<td>17,701</td>
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<tr>
<td></td>
<td>Total</td>
<td>30,220</td>
<td>9,195</td>
<td>4,006</td>
<td>43,421</td>
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</table>

#### Provider Breakdown

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Provider Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agencies</td>
<td>285</td>
</tr>
<tr>
<td>Hospital/Residential Treatment Facilities</td>
<td>36</td>
</tr>
<tr>
<td>Licensed Professionals</td>
<td>1,613</td>
</tr>
<tr>
<td>Outpatient Practices</td>
<td>249</td>
</tr>
<tr>
<td>Total</td>
<td>2,183</td>
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</tbody>
</table>
Departmental Information

Clinical Operations Division
Clinical Operations at Alliance Health is a data-informed, collaborative effort that identifies and addresses the full range of medical, functional, social, emotional, and environmental needs across all populations in order to improve health outcomes by focusing on prevention, early intervention, and person-directed care. The Clinical Operations Division is responsible for the smooth and efficient operation of Alliance’s clinical and service delivery system. Division goals include maintaining high quality, cost effective and integrated behavioral healthcare.

Care Management/Care Coordination

Brief Description of Department and Units
Clinical Operations is comprised of four units and receives clinical oversight from the Alliance Chief Medical Officer.

- MH/SUD and IDD Utilization Management (UM) are responsible for authorizing services and monitoring and managing individuals during an episode of care. Activities include monitoring utilization of services authorized, reviewing effectiveness of treatment interventions and making recommendations to improve the effectiveness of individual treatment plans.
- MH/SUD Care Coordination is responsible for working with specific high-risk populations identified within the waiver contract and priority populations that have been identified by Alliance, including individuals discharging from inpatient and those identified by advanced data analytics to be at risk for higher levels of services. Care Coordination links individuals with both services and supports and helps eliminate barriers that allow individuals to live as successfully as possible within the community. MH/SUD Care Coordination is extending their ability to better address the needs of individuals with serious and persistent mental illness with co-occurring physical health conditions.
- IDD Care Coordination is responsible for working with individuals on the Innovations waiver, as well as those needing periodic coordination of state-funded IDD supports. IDD care coordination helps individuals identify the services and supports they need to live the lives they want in the community. Additional IDD care coordination staff are focused on addressing the behavioral health needs of these individuals, as well as in helping them to transition out of facilities and into the community.
- The Medical Team is responsible for maintaining the clinical integrity of the program, including concurrent reviews of inpatient and rehabilitation services; provision of oversight to utilization management and quality staff; oversight of the Credentialing Program; providing medical/clinical support for care coordination units and the Access to Care unit; and consultation to providers and other community based clinicians, including general practitioners. The Medical Team conducts medical necessity review and recommendations, service denial reviews, grievance issues, medication reviews, and develops clinical best practices guidelines in collaboration with regional experts. The team is comprised of physicians, senior clinicians, and a pharmacist.

Accomplishments for FY19
- A Care Management Software (Jiva) Platform was implemented for Care Coordination in October 2018. Configuration of the UM module is currently in process. The tool standardizes efforts, promotes increased quality and efficiency, and offers enhanced tracking of cases, activities, and outcomes.
• Implementation of Alliance Complete Care, a transition to a multi-disciplinary team approach to care management building on the success of the Complex Integrated Care Team. IDD Care Coordination will transition to this new model by the end of the fiscal year.
• Implementation of Social Determinants of Health assessment within Jiva to assist in creation of care plans to address those barriers and support collaboration with Community Health and Well-Being department.
• Implementation of an advance analytics model to identify risk factors for members and assist with assignment to care teams to address most effectively address the member’s needs.
• The TCLI team took leadership for developing a statewide in-reach learning collaborative to improve quality of service.
• TCLI is implementing a nationally recognized Community Inclusion initiative with ACTT and TMS providers and utilizing incentive payments to support implementation.
• Developed systems and strategies that address physical health care and promote whole person care by funding two pilot projects. The first uses risk stratification to identify individuals with significant behavioral and physical health needs and works with providers supports providers with useful clinical data and standard clinical interventions. The second pilot works with a primary care practice using an enhanced primary care home model and are working toward development of a value based funding model to support these enhanced services.
• Continued to support staff to complete and pass their national exam for NACCM certification. The certification enhances the quality of IDD care coordination professionals.
• Integrated physical health Registered Nurses (RNs) into several IDD and MHSUD care coordination teams.
• Implemented medication assisted treatment (MAT) in office based setting in Durham and coordinated with pharmacies to support the model.

Summary of Goals and Objectives for FY20
Complete implementation of Jiva care management platform for UM and for a provider portal. Begin implementation of a member portal.
• Full implementation of care teams in for MH/SUD. Complete implementation of Alliance Complete Care across the agency.
• Meet state requirements for individuals discharged from MH/SUD facilities to attend a follow-up appointment within seven days and remain engaged in treatment.
• Decrease services that require prior authorization and manage based on data review, including outcome measures.
• Use predictive analytics across all populations.
• Implement standard assessments and care plans
• Decrease average length of stay (ALOS) for inpatient and Psychiatric Residential Treatment Facilities (PRTF).
• Increase the number of physical health RNs and pharmacy technicians to support transition toward integrated care coordination.
• Expand MAT in office settings across all counties and remove barriers to implementation.

Network and Community Health
The Network and Community Health Division is comprised of the Provider Network and Evaluation Department and the Department of Community Health and Well-Being. The primary purposes of the division is to ensure that there is an high quality, accessible network of community treatment providers that offer culturally and linguistically competent services that are part of an overall system of care.
Additionally, the Division is responsible to provide education to members and stakeholders, develop systems to address health disparities and address social determinants of health. The Division is also responsible to evaluate the effectiveness of clinical services offered through the Alliance provider network as well as community level interventions and supports provided or led by Community Health and Well-Being.

**Provider Network and Evaluation**

**Brief Description of Department and Units**

The Provider Network and Evaluation Department is responsible for the continuous review and evaluation of the provider network for quality of services, adherence to contract requirements, standards of care and performance, while ensuring a full array of providers is available to meet the needs of our service recipients. It also is responsible to ensure the quality of all Alliance services by reviewing program outcomes and evaluating program effectiveness.

The Department is comprised of three sections:

- **Provider Network Operations** has three components:
  - *Provider Networks* is a liaison to providers including managing the communication and dissemination of information to the community of providers, developing and reviewing provider contract scopes of work, and providing or arranging for technical assistance for currently enrolled providers.
  - *Credentialing* assures that all providers in the Alliance network meet agency, State, Federal and accreditation requirements and that credentialing information is reviewed and tracked for continuous and timely review.
  - *Contracts* is responsible for the timely development and distribution of all contracts, amendments, and extensions and ensures coordination of administrative activities including official correspondence with providers, provider education and liaison, and administration of provider contracts.

- **Strategic Initiatives and Special Projects** manages the following functions and initiatives:
  - Community Needs Assessment and Network Development Plan
  - New Service Definitions
  - Special Provider Initiatives
  - Provider Collaboratives
  - Requests for Proposals
  - Hospital Relations

- **Provider Evaluation**
  - Monitoring of providers
  - Collect and analyze provider outcome data
  - Evaluate service and program effectiveness
  - Produce reports and analysis to better manage the provider network and provide information to providers to support quality improvement

**Accomplishments for FY19**

- Expansion of provider collaboratives to provide technical assistance and improve quality
- Implementation of additional value based service contracts in treatment foster care, assertive community treatment and family centered treatment.
- Inclusion of outcome measures in all provider contracts
- Improved process for monitoring provider performance and evaluating provider outcome measures.
• Expansion of Behavioral Health Urgent Care service model to address gaps in the crisis continuum
• Expand capacity of opioid treatment services
• Implemented new Peer Bridging program
• Implemented provider profiling tools
• Streamline process for new service development
• Developed new provider expectations for psychiatric residential treatment facilities

Summary of Goals and Objectives for FY20

• Expand network crisis services capacity
• Implement psychiatric rehabilitation service model within Psychosocial Rehabilitation programs
• Implement provider scorecards
• Establish practice transformation unit within the Strategic Initiatives and Special Projects section of the department
• Develop and pilot behavioral health home model
• Evaluate effectiveness of incentive based contracts
• Pilot a shared risk service contract
• Improve processes for data sharing with providers
• Implementation of HEDIS data analysis at the MCO level and provider level
• Improve relationships with and contract management of hospitals/health systems, including identifying opportunities to improve billing
• Address provider network needs and gaps as specified in network development plan
• Focus provider collaborative efforts on implementation of evidence based practices

Community Health and Well-Being

Brief Description of Department and Units

Community Health and Well-Being is one of the most varied and diverse departments within Alliance. Recognizing that a local and visible presence is essential to building and sustaining partnerships critical to meeting organizational outcomes, the Community Health and Well-Being teams take an innovative approach to improving the systems that support the effectiveness of services.

Teams are continually assessing system and service gaps from multiple vantage points including co-location within other systems, outreach activities to stakeholders and advocates, and hosting community collaborative and workgroups. Utilizing a System of Care (SOC) framework, Community Health and Well-Being focuses on the strengths and vulnerabilities of complex public systems, treatment of the “whole person,” and system transformation to improve policy, shared funding, collaboration and best practices.

Recognizing that social determinants of health (i.e. homelessness, poverty/inequality and lack of education/employment) are key drivers of health care costs, Community Health and Well-Being often plays a tangential role to the MCO functions - improving the environments in which people live increases engagement and retention in services, overall health and wellness, and more meaningful and productive lives that promote recovery.

Accomplishments for FY19

• Realignment of department functions to that included a name change from Community Relations to Community Health and Well-Being
- Implemented short-term rental assistance program (ILI) in each community. Also created a longer term rental assistance program for a higher risk population. On track to expend full allotment of ILI funds
- Implemented a comprehensive landlord recruitment strategy that has almost tripled our housing placements in private units for TCLI participants
- Enterprise Consulting completed an assessment of all affordable housing properties in our counties to increase access to safe and affordable housing
- Implemented a Staying Well initiative with Care Coordination and the Office of Individual and Family Affairs to conduct follow up for persons discharged from Care Coordination
- Successfully implemented a FEMA crisis outreach program in Cumberland County.
- Implemented a standardized SDOH screening tool with Jiva
- Participated on a statewide social determinant advisory group
- Beginning to implement a variety of health literacy strategies
- Implemented a supportive housing pilot with Duke Healthcare
- Implemented the first Bridge Housing Program in Wake County
- In partnership with Durham Housing Authority and the City of Durham secured funding for 2 supportive housing positions and 20 vouchers to implement a Justice Involved Supportive Housing Program
- Partnered with the Durham Housing Authority to apply for HUD Mainstream vouchers specifically designated for permanent housing for persons with disabilities. Received almost 15 vouchers
- Implemented transportation pilot program
- Durham, Johnston and Wake have highly successful Crisis Intervention Training (CIT) training programs with designated CIT Coordinators. The CIT Veterans training started in Wake has now expanded to Johnston Co with plans to expand into Cumberland.
- Expanded Mental Health First Aid (MHFA) trainers and now have a CR staff trained on almost every module. Trained the Raleigh and Durham PD’s on MHFA with over 1000 participants.
- Completed significant enhancements to Wake and Durham Network of Care
- Implemented Care Review in each community and expanded to include a Homeless Care Review Team in each county
- Funding renewed for two HUD-funded supportive housing programs in Durham
- All Community Collaborative completed strategic plans outlining SOC priorities

**Summary of Goals and Objectives for FY20**
- Expand a SOC approach to reflect an integrated model of care that will expand partnerships and improve outcomes
- Research and implement health related social needs models that close the gap between clinical care and community resources
- Promote cross-departmental collaboration to improve person and service outcomes
- Assist in the development of models of care for special and high-risk populations
- Assist in the development of comprehensive community supports to increase community tenure and quality of life for high-risk adolescents and adults
- Identify activities of Community Health and Well-Being (i.e. housing, Care Review) and develop key performance indicators to show the impact and return on investment
- Fully implement a variety of health literacy strategies
- Develop a more comprehensive residential continuum that enhances permanent supportive housing capacity
**Business Operations Division**
The Business Operations Division is responsible for the oversight and management of Alliance’s financial accountability relating to budgeting, claims, auditing and financial analysis.

**Claims Processing**

**Brief Description of Department and Units**
Claims Processing is responsible for the monitoring and review of all claims processing for all funding sources, analysis of paid and denied claims, special ED claim review, etc. The team consists of Specialists, that assist providers daily on basic billing, and Claims Analysts that work on denials and analysis, encounter claim submission, and large projects. In addition, we have an EDI Specialist who specifically is focused on provider EDI files and EDI files that we send to the State.

**Accomplishments for FY19**
- Alliance claims staff continues to provide weekly claims training for providers to ensure updated knowledge of systems and claim information is shared will all providers.
- Continued to make improvements in the Accounts Receivable (AR) system including regular reporting of outstanding claims and write-offs. This has greatly improved the ability to research and identify claims to rebill and write off.
- Maintained a nearly consistent 100% in encounter claims approved by the State.
- Claims Staff continued to collaborate with IT/Report Development to create reports that provide analysts with paid claims in different categories. This year’s report success included percentage of paid/denied by specific provider and reason codes to better educate why claims deny which has helped in working with the provider.
- Claims continue to receive positive and outstanding remarks in Customer Service.
- The HMS audit for March 2018 through August 2018 resulted in high scores of 98.03% in timeliness of provider payment, 99.91% in claims processing accuracy, and 99.91% in financial accuracy.

**Summary of Goals and Objectives for FY20**
- Maintain high focus on meeting and exceeding the encounter requirement to have 95% approved claims. Evaluate processes to determine modifications and efficiencies needed for Tailored Plan efforts.
- Focus on claim system development as it relates to physical health claims in preparation for the Tailored Plan.
- Work with IT to continue to make improvements in the AR system so that we can maintain accurate accounting of all outstanding NC TRACKs submitted claims.
- Continue to enhance training and development so that staff are fully trained and have the tools they need to do their job. We will focus on claims processing and management of physical health claims and diversifying staff knowledge and expertise.

**Financial Operations**

**Brief Description of Department and Units**
- Accounting - responsible for the agency's financial transactions, financial reporting, adherence to Generally Accepted Accounting Principles (GAAP), ensuring adequate and effective internal controls, etc.
• Budget and Financial Analysis - responsible for the development and monitoring of the Alliance budget and analyzing budget to actual at both the administrative and service level. The staff in this unit are also responsible for the review and analysis of Medicaid dollars to include Per Member Per Month (PMPM) spending by category of service and aid, budget vs. actual, individual provider or service trends, etc. Responsibility also includes rate setting for programs, services, and providers.
• Accounts Payable – responsible for ensuring all providers and vendors are paid accurately and timely.
• Purchasing – responsible for ensuring all administrative purchases are made in accordance with applicable laws and procedures as well as meet the purchasing needs of the Organization

Accomplishments for FY19
• Redesigned the Budget and Finance Committee to incorporate review of our Medicaid Per Member Per Month (PMPM) service expense. This allowed for a more cohesive review of our financial position and allowed for conversation on service initiatives.
• Collaborated with the claims and IT teams to improve reporting to providers to enhance their internal reconciliations related to Alliance payments.
• Continued our focused efforts on monitoring the Medical Loss Ratio (MLR) so that all allowable expenses are included in the calculation. The MLR increased by 5.9 % in FY19.
• Evaluated and implemented a new payroll system which allowed for greater integration with HR and more effective payroll reporting
• Completed another successful independent financial statement audit and compliance audit receiving no material weaknesses, significant deficiencies and no required adjustments.
• Implemented a chart of accounts conversion to incorporate the Organization’s recent reorganization into our reporting and budgeting.
• Continued the departmental focused administrative budgets, as well as budget to actual reports, to allow for budget ownership and flexibility of spending.

Summary of Goals and Objectives for FY20
• Evaluate internal processes for potential efficiencies in preparation for the Tailored Plan
• Evaluate our General Ledger system for potential growth and enhancement opportunities. The Tailored Plan financial requirements will be assessed and considered in this evaluation.
• Continue to enhance our reporting and analysis of our services especially in the area of Medicaid drilling down to the population level, Medicaid eligible lives, and category of service.
• Continue engagement with consultants to assist with higher level reporting and forecasting. Specific efforts will be put forward as it relates to our PMPM rate for Standard Plan “Go Live” dates as well as Tailored Plan implementation date.
• Continue to enhance training and development so that staff are fully trained and have the tools they need to do their job. We will focus on claims processing and management of physical health claims and diversifying staff knowledge and expertise
Organizational Performance Division

The Organizational Performance division’s primary focus is on driving and supporting the infrastructure requirements of the other divisions within the organization. The goal is to maximize the organization’s performance and achieve operational excellence. This is accomplished through the alignment of divisional departments including Organizational Effectiveness, Human Resources, Customer Service/Access Center, Quality Management, Information Technology and Analytics.

Organizational Effectiveness Department

Brief Description of Department and Units

The Organizational Effectiveness Department (OED) powers our organizational performance by integrating Alliance’s enterprise level projects, our people, our systems, and our leadership, and aligning all with our organizational mission, vision, and strategy. This dynamic department brings together the Communications unit, Facilities unit, Organizational Project Portfolio Management Office (OPPMO), and the Organizational Development and Learning (ODL) team to 1) facilitate positive change within the organization that is in alignment with our strategic plan; and 2) enhance and support a healthy organizational culture in alignment with our values. There are 16 staff in OED and together they support and drive Alliance’s change, growth and development.

- The Organizational Project Portfolio Management Office (OPPMO) is chartered to manage the Alliance portfolio of Strategic Initiatives. This supports leadership's need to closely manage investment funds, staff resources, and business priorities in an effort to tightly manage projects that affect the strategy, health, and profitability of the company.
- The Alliance Communications Unit has oversight of all internal and external organizational communications to multiple stakeholders within our catchment area. This broad scope of work includes all organizational marketing development and production, organizational branding efforts, content maintenance of a complex website and highly-regarded social media program.
- Organizational Development & Learning (ODL) strives to engage employees, promote learning, transform leaders, enhance culture, build teams and measure effectiveness by providing quality learning interactions, leadership development programs, and building a culture of continuous learning. ODL also supports the Recovery University learning platform for our community, which is a free resource for our members and others in our communities.
- The Facilities team is responsible for the management of multiple construction projects, property management of Alliance’s Crisis Facilities, and day-to-day facility management of Alliance’s four office sites. Health and Safety also falls within this unit, as does the Emergency Action Plan.

Accomplishments for FY19

- Successfully implemented the multi-year Strategic Facilities Plan that consolidated the Durham Office, Home Office and Call Center into one office building.
- Expanded the Facilities team to include a Facilities Director in a cost neutral way, to be accountable for the growing responsibilities created through our expansion
- Facilitated two-day planning session with the Joint Leadership Team to design a 3-year, multi departmental project plan for transition to Tailored Plan.
- Led the Phase 1 development of the Tailored Plan Project Plan including Complete Care project for integrated care, Jiva, our platform to transform Care model, and a new HR system, UltiPro.
- Launched comprehensive, evidence based Change Management program for all staff, to support the people side of change to a Tailored Plan, certifying two staff in the Prosci Change Management model.
• In collaboration with HR, developed and launched Employee Engagement survey to provide insights and direction to assist with company culture and staff retention
• As a result of the Engagement survey, led the Telecommuting Initiative to implement alternative Work Options at Alliance, in an effort to build organizational culture and engagement.
• Created and implemented a wide variety of learning opportunities for all staff, to prepare them for the future:
  o Technical Skills Academy (TSA) to provide employees with training on Microsoft Office tools such as Word, Excel, PowerPoint, Skype, and others
  o Change Champion program to assist employees in adapting to and navigating organizational changes and imbedding change competencies within the organization.
  o Team Building interventions to assist supervisors with improved communication, increased collaboration and building trust among team members.
  o Peer Success Coach program to help employees expand and refine their skills through mentoring by other Alliance SMEs.
  o Peer Advisory Leader (PAL) mentoring program geared to assist new employees with their transition to the organization.
  o Learning Labs consisting of one-hour trainings for employees on topics such as the Medicaid Transformation, Skills for Success, and Whole Person Care to prepare staff for the future.
• Launched a new Thought Leadership component of the Alliance website designed to highlight the innovation and forward-thinking of staff across the organization, including Complete Care, housing initiatives, community empowerment, and leadership development.
• Partnered with the Government Relations Team and a local pharmaceutical company to coordinate the strategic distribution of over 18,000 pouches used to safely dispose of unused opioids and other prescription drugs as part of our “Alliance for Action on Opioids” campaign.
• Created a high-quality organizational interactive newsletter distributed by email to highlight Alliance innovation, community involvement and service, and our efforts to become an employer of choice in our field.
• Coordinated a comprehensive organizational rebranding to Alliance Health, consisting of a dynamic new logo and graphic package design, reprinting of all core information materials, rebranding of the Alliance website, migration of the web domain to AllianceHealthPlan.org, creation of new interior and exterior building signage, and revision of a myriad of video and print materials directed to a variety of audiences.

Summary of Goals and Objectives for FY20
• Implement year 3 of Organizational and Development and Learning plan which includes launching an internal Diversity specialist and expanding cultural competence education into year round learning modules and events.
• Collaborate with Alliance leadership to define needs for training related to transition to management of physical health and develop plan to provide needed learning.
• Continue implementation of organization wide Change Management plan for Tailored plan and increase change literacy and competencies across Alliance.
• Create and implement a staff succession planning program that includes career lattices, cross-departmental trainings, job shadows, etc., collaborating with HR.
• Complete the final stage of the Strategic Facilities Plan, which involves moving the Wake office to the new Home office, in July 2019.
• Continue to implement and refine the Thought Leadership Marketing Plan developed in FY19.
• Continue leadership and management of the Tailored Plan Project Plan.
• Train staff and expand utilization of the Project Portfolio Management system to better monitor and manage project level-of-effort estimation and forecasting to prepare for the future.
• Continue efforts to build public engagement with our social media platforms, including Twitter, utilizing more video and original material augmented by an advertising maintenance plan.
• Continue Evolutionary Website Redesign by identifying, analyzing, and fine-tuning a variety of performance and Search Engine Optimization issues.
• Create a dynamic new website component showcasing the diversity of Alliance’s outreach to and influence in our communities, including initiatives promoting quality partnerships and collaborative change, redesign of system of care to improve health outcomes, our work to help people more actively engage in their own healthcare, and efforts to connect people to social and community supports that enhance recovery and well-being.

Access Center

Brief Description of Department and Units
The Access and Information Center (the Alliance 24/7 call center) links consumers to a range of services in the community and ensures that callers in need of crisis services are provided with timely access and follow-up. In addition to screening and referral activities, the call center provides information to general healthcare providers, CCNCs and to crisis providers to help coordinate the care of consumers needing routine services or during an after-hours crisis. It handles general information requests for Alliance as well.

Accomplishments for FY19
• Answered 57,009 calls. 98.1% of these calls were answered within 30 seconds. Average hold time was 1 minutes and 8 seconds.
• Met DHHS contractual requirements for time of answer and abandonment rate. Maintained low speed of answer of 6 seconds and 0.9% abandon rate.
• Call Center turnover rate is < 1%. Two staff returned to the Department.
• Maintained URAC Health Call Center accreditation.
• Redesigned our Clinical Decision Guide with the help of our CMO to better align with Emergency Medicine standards.
• Implemented the TBI waiver. 8 members successfully placed on the TBI waiver this year.
• Successfully closed out our Access to Care- Emergent QIP based on our higher rate of member engagement.
• IDD Access team participated in 10 IDD community events to inform more members and stakeholders about services and resources for people with IDD and TBI.
• New Training modules presented in multiple ways to support learning and increased retention.
• Pending- Positive EQR review that is reflected in Enrollee Services and Delegation Section.
• Collaborated with Primary Care offices to coordinate care for members. Over 500 assessment appointments set for members in 2018.
• Use technology to streamline the Innovations slot allocation process.
• Filled all the IDD Innovations available slots in a timely manner.
• Registry of Unmet Needs. Collaborated with Alliance report writers to address data discrepancies and move further away from the use of spreadsheets for tracking.
• Collaboration with IDD Care Coordination to expand their capacity to serve Alliance members by leveraging the untapped talented workforce in Customer Service.
• 4 trainings hosted at Alliance by IDD Access team on behalf of NC Start.
• Promoted Open Access model of care to decrease the time between appointments.
• Collaborated with Provider Networks and providers to increase choice for members.
• Increased the number of Saturday assessment appointments for all funding and ages.
• Implemented the use of MicroStrategy to create a Provider Capacity Dashboard. Assists staff to locate appointments that most clearly meet the necessary timeframe and location for callers. Collaborated with other departments to gain access. Informs Alliance staff of gaps in the network.
• Attempted to address language barriers for our members within our provider community. Piloting the use of our interpreter vendor for a single enhanced service provider serving a non-English speaking member. Alliance is funding the use of this telephonic interpreting service.
• Successful physical move of department without service disruption.
• Collaborated with other Alliance Departments on “Complete Care” project.
• LogistiCare transportation pilot implementation to remove barriers to care.
• Worked collaboratively with Network development on rolling out new service definitions, and assessing the needs and gaps in our service continuum. Increased the number of ABA providers for our membership.
• Collaborated with Duke and Durham Public Schools to create a Suicide Prevention Training.
• Improved departmental communication and integrated agency-wide communication strategy during inclement weather events to ensure timely access to emergency services.

**Summary of Goals and Objectives for FY20**

• Successful URAC re-accreditation.
• Successful EQR review.
• Create a new Member Service Department aligned with anticipated requirements of the Tailored Plan RFP.
• Set up and manage one or more Health Plans Behavioral Health Crisis Line delegations.
• Increase our knowledge of Population Health Management and explore ways to serve the “whole person” in all service areas.
• Increase understanding of NCQA and our role in achieving accreditation.
• Improve interflow call performance by moving our interflow vendor delegation contract to another entity.
• Work with provider network to improve access for routine and urgent appointments.
• Reduce call times and reduce customer experience of redundancy by focusing on essential screening information.
• Create phone line (hardware) redundancy for all Call Center services under our new Business Continuity Plan.
• Expand the use of LogistiCare for members needing transportation to providers and pharmacy
• Implement call center performance metrics to match anticipated Tailored Plan requirements.
• Increase the number of calls monitored with innovative technologies to ensure members rights are protected and needs are met
• Challenge the way in which we have approached member care. Use creative ways to increase the number of members seeking services to obtain the services in a timely manner.
• Collaborate with community stakeholders to prepare for possible natural or manmade disasters in order to protect and respond to the needs of our membership.
• Develop brief explanations in simple language around Medicaid Transformation for our members.
• Develop a strong working relationship with the new Ombudsman and Standard Plans to assist callers to exercise their rights and increase their understanding of Medicaid benefits.
Quality Management

Brief Description of Department and Units
Quality Management is responsible for creating a culture of continuous quality improvement across Alliance and assuring quality within the agency. Quality Management has three teams:

- Quality Improvement: oversees our Quality Improvement Projects (QIPs); performs quality reviews to identify opportunities for improvement; and develops quality management standards and training.
- Data and Reporting: assists Alliances departments with developing operational metrics to focus on effective and efficient work; develops and validates reports for Alliance management, committees and the state; facilitate the completion and analysis of network-wide surveys to identify strengths and opportunities.
- Grievances and Incidents: investigates and resolves incidents and complaints; and analyzes data related to individual-level concerns to ensure that Alliance responds effectively to issues and trends.

Accomplishments for FY19

- Improved satisfaction with grievance resolutions resulting in dramatically lower appeal rates
- Streamlined medical team consultation for grievances and incidents resulting in faster feedback to providers and resolution of quality concerns.
- Created a database of DHSR actions that Alliance staff can use to research issues related to licensed facilities.
- Reduced late submission of critical incident reports.
- Added provide performance related to critical incident submission to the credentialing process.
- Demonstrated an annual savings of $15,000 with streamlining process for managing provider site moves.
- Created process maps to prepare for implementation of Jiva system for utilization management and appeals and for implementation of TBI services.
- Streamlined Level of Care process resulting in improved communication, automated notifications indicating when steps are completed, more efficient use of Medical team time through technology, and development of automated reporting. ROI is currently being calculated.
- Review of ADHD clinical guidelines indicated ongoing provider adherence to key best practices of filling approved medication prescriptions and participation in psychotherapy.
- Created multiple dashboards to facilitate data sharing and data-informed decision making.
- Developed systematic data validation strategy to ensure that reporting follows required specifications.
- Developed the TBI Waiver Reporting Guide for the State.
- Provided significant input to the State during the creation of the Watch Measures / HEDIS measures included in all LME/MCO contracts.

Summary of Goals and Objectives for FY20

- Prepare for MBHO accreditation through NCQA
- Align the Quality Management department with Tailored Plan requirements and the quality strategy published by DHHS.
Human Resources

Brief Description of Department and Units

The primary focus of Alliance’s Human Resources Department is its people; recruiting, developing, and retaining a talented diverse workforce. This is accomplished by each Senior Business Partner who serves as subject matter experts within their respective areas under the leadership of the Senior Vice President. The main areas include Benefits Administration, Employee Relations and Policy Administration, Compensation and Classification, and Talent Management. Together, the staff within the HR department address the various needs of both internal and external customers, often serving as an initial face of Alliance. Two key organizational committees, Employee Engagement Committee and Rewards and Recognition Committee, were recently transformed into one committee. This newly formed committee will identify and execute future activities to promote and enhance overall employee engagement. In addition, the Wellness Committee will continue to focus on employee health and wellbeing. These committees work in tandem with the HR department to promote a culture of self-improvement, employee engagement, and staff appreciation, and to move the organization closer to becoming an employer of choice.

Accomplishments for FY19

- Posted 72 vacancies; Hired 70 (24 Internal 35%, 46 external 65%) candidates
- Created 26 new positions
- On boarded 13 Johnston staff after merger
- Selected Ultimate Software (UltiPro) as new Human Capital Management system and began implementation of Payroll and Human Resources modules
- Outsourced candidate background review process to include all current background checks and incorporate verification of work history, education, licensure, driver’s license as well as completion of a national criminal history search and reference checks
- Launched monthly HR News blitz to internal workforce in June 2018
- Revised/created a significant number of HR procedures
- Launched telecommuting throughout organization
- Scheduled launch of 2nd Employee Engagement survey

Summary of Goals and Objectives for FY20

- Research, develop and implement organizational retention plan
- Utilize functionality within Succession Planning module to identify and address skill gaps throughout organization
- Offer benefits premium differential in FY20 Open Enrollment by implementing Health Assessments and other wellness related initiatives
- Complete implementation of Human Resource modules (Benefits, Perception/Reporting); evaluate and modify processes to maximize efficiency and system functionality
- Create and install workforce demographics on manager’s dashboard within UltiPro
Information Technology

Brief Description of Department and Units
The IT department is comprised of five distinct teams:

- **Application Development and Quality Engineering** - Responsible for all internal application development and support, including SharePoint and the corporate Intranet. Manages all quality assurance and user acceptance testing and documentation to support corporate audits. This Team also provides database administration and security, support for file downloads, IT Project management as well as managing User Acceptance Testing (UAT) for all Alpha releases for the organization.

- **Enterprise Analytics** – This Team is responsible for the engineering and management of the Alliance Enterprise Data Warehouse and the utilization of the key software platforms of Microsoft SQL Server, Microsoft R and MicroStrategy. They are additionally responsible for developing and deploying data actionable reports, dashboards and other data products to meet the advanced analytics and other informational needs of the organization.

- **Data Science** - The Data Science team is responsible for mining out pattern, insights, and advanced data elements using an interdisciplinary mix of statistics, machine-learning, and discrete mathematics. The deliverables range from the creation of datasets from which may be consumed in the Enterprise Data Warehouse, to a more narrative output that reviews and summarizes the analytical insights to be explored with the various business units. The Team also engages in independent, exploratory R&D with the goal of anticipating the needs of the business and prototyping proofs-of-concepts to enhance our business initiatives.

- **IT Infrastructure and Support** - Installs and supports all business data and voice networks within the Alliance sites. They are responsible for maintaining all corporate PC and software resources, network and data security, HIPAA compliancy, email security, network/server administration and performance, and the IT Helpdesk.

- **Product Management and Support** – This Team provides the main conduit between IT and the various business units to support the WellSky AlphaMCS System and the ZeOmega Jiva system. They provide the configuration, testing and implementation of many facets of these Enterprise software solutions.

Accomplishments for FY19

- Implemented a near-real time replication process of the AlphaMCS production databases to the Alliance SQL database infrastructure providing improved access to data in our Enterprise Data Warehouse and reporting systems.

- Reengineered Alliance Enterprise Data Warehouse to source data from AlphaMCS OLTP, eliminating the need for AlphaMCS DW, while allowing our reports and dashboards to have up-to-date data.

- Continued development of reports, user defined datasets and dashboards for the organization. We currently have more than 150 in MicroStrategy reports, datasets and dashboards resulting on average 2,000 executions per month.

- Added multiple data domains to our Enterprise Data Warehouse and MicroStrategy, e.g. GEF, HEARTS Census and Discharges, EDI 820, 837, 835 and 834 datasets.

- Integration of ZeOmega Jiva episode, assessment and other business data in our Enterprise Data Warehouse and MicroStrategy to support enhanced reporting.

- Provided training for all users at Alliance through monthly Power Users workshops and direct involvement in the TSA (MicroStrategy, Data Analytics, Excel, Access).

- Deployed an Advanced Power Users pilot, which allows Power Users to integrate their own datasets into their MicroStrategy reporting.
• Created the Jiva Application Configuration Team consisting of an Application System Analyst and an Application Configuration Specialist to support the successful implementation of the UM module and the continued evolution of the Care Management module within the Jiva Enterprise application.
• Constructed a Jiva SharePoint site for the reporting and tracking of Jiva issues, new configuration requests, product documentation library, product maintenance calendar, and FAQs.
• Constructed a Product Management TFS site to track all approved configuration requests (requirements, tasks, bugs...).
• Developed a Provider Portal to allow internal Alliance staff and external providers to access the Alliance suite of applications.
  o Developed and added modules for Accreditation and Referrals to the Provider Portal to meet state requirements
  o Created the Clinician Maintenance module that allowed providers to submit clinician changes and specialties to Alliance. Alliance was the only MCO to meet state guidelines on time
  o Modified the Provider Search website to include mobile access as well as languages, clinician search and provider referral status.
• Modified the Claims Department AR application to include business functionality and report enhancements. This application was used to showcase how we are working claims during the EQR review.
• Enhanced the ILI application to allow management of vendors by the Finance team
• Upgraded the SharePoint farm from SharePoint 2013 to SharePoint 2016, providing optimized communication and performance as well as high availability.
• Assisted the Communications Department with the implementation of the New Intranet Branding program by participating in the design discussions, setup, implementation and migration of the content from the old Intranet to the new environment.
• Developed numerous business forms and workflows within SharePoint to support the business initiatives for different departments within Alliance. Examples are the New Service Process Flow, a Performance Tracking tool for MHSUD and IDD departments, tracking and workflows for Care Review, the Innovations Dashboard, and for TCL RSVP Tracking.
• Worked with the business on multiple advanced analytic/data science initiatives including:
  o Support business departments’ alignment with Tailored Plan objectives through data science techniques using GLM (generalized linear model)
• Support Care Coordination Risk Stratification efforts by utilizing data science and statistical techniques. Areas of focus included the following:
  o Probabilistic analysis of future cost
  o Outlier detection based on John Hopkins attributes of active ingredient count, and risk of inpatient admissions
  o Propensity of subsequent Behavioral Health crisis episodes
  o Identification of high-risk diagnostic categories by mining association rules across the diagnostic spectrum
  o Developed a proof of concept using Text Analytics (Natural Language Processing) to predict risks associated with the presence of specific clinical documents
• Coordinated the successful relocation of the corporate office, and integrated the Johnston County site including design and implementation of the data and communications network, all required equipment and servers, and setup of user workstations and offices.
• The IT Helpdesk this Fiscal Year through February 2019 has received and closed 6,873 tickets, 67% within 8 hours of receipt.
• Successfully migrated 53 servers to our new hyper-convergence hardware for improved efficiency extended our data storage and processing capabilities including the migration of all database servers to SQL Server 2017.
• Upgraded our disaster recovery capabilities by implementing new replication software between the primary datacenter at Peak10 Morrisville and the secondary data center, located in Greensboro.
• Implemented internal network security scans with Nessus software.
• Continued to support our internal security controls by conducting monthly phishing campaigns using the Wombat tool. Individuals failing the campaigns receive additional mandatory training using the integrated training modules.
• Planned and implemented domain name and email changes to support Alliance Health.

Summary of Goals and Objectives for FY20
• Participate in All Project Plans and Initiatives to Support the Transition to the Tailored Plan Model.
• Perform Claims System Analysis and implementation of a solution to support physical health claims processing.
• Participate in RFP process to select PBM for Tailored Plan Implementation.
• Transition to MicroStrategy 2019, providing enhanced Business Intelligence and Analytics capabilities to all users in the Alliance Data Ecosystem.
• Deprecate SharePoint BI Site, allowing all our reports and dashboards to be part of our MicroStrategy reporting framework.
• Continue providing Data Analytics and MicroStrategy training opportunities for Advanced Data Users in order to promote data use and to engage them with our business initiatives.
• Develop Enhanced Analytics capabilities to support Alliance’s Social Determinants of Health initiatives.
• Augment Power Users capabilities by providing them access to MicroStrategy DataMart.
• Implement and support for MicroStrategy 2019 Notebooks to resolve one-time data requests.
• Support for full implementation of the ZeOmega Jiva modules – UM, Provider Portal, Member Portal and HIE (Health Information Exchange).
• Continue to enhance the look and feel of the Provider Search website to meet all business requirements.
• Develop a Provider Monitoring application to allow this team to automate several tools that are currently manual processes. The first tool to be automated will be the HCBS tool.
• Development and integration of Team Collaboration Sites within our SharePoint and Intranet environment.
  o Continue our advanced analytic/data science initiatives to include:
  o Completion of Care Coordination Risk Stratification
  o Expansion of Event Frequency Modeling (eligibility churn, total days of service received, diagnostic stability, etc.)
  o Identifying “Windows of Opportunity” in which intervention can have optimal effect.
  o Provide information and guidance regarding Johns Hopkins ACG system to assist with understanding and appropriate implementation.
- Provide consultation regarding statistical methods to guide visualization and analysis processes.
- Develop and implement an enhanced Disaster Recovery Plan to improve our recovery capabilities of all critical corporate systems into our Greensboro DR site.
- Implement our Call Center phone system redundancy plan and provide support for Standard Plan Crisis Line.
- Evaluate HiTrust Certification as a potential initiative for Alliance Health.
- Evaluate for implementation Rights Management, Data Loss Prevention (DLP), and Security Information and Event Management (SIEM) systems.
- Review and develop an Alliance Health Corporate Cloud Strategy to consider:
  - Server/critical system relocation to the Cloud (if applicable)
    - Microsoft 365 Implementation
    - Other appropriate Cloud Initiatives
Office of Compliance

Brief Description of Department and Units
The Alliance Office of Compliance focuses on the prevention, detection and correction of identified violations of federal and state laws and regulations, and fraud control and unethical conduct, and encourages an environment where employees can report compliance concerns without fear of retaliation. It includes sixteen employees in the Special Investigations Unit and Claims Audit Unit, which together make up the Program Integrity Department, and the Corporate Compliance Unit, which also includes Health Information.

Accomplishments for FY19
- Opened 84 fraud and abuse investigations in the first 6 months of FY19 (146 total in FY18) and referred 5 full investigations to DMA Program Integrity for determination of credible allegation of fraud (16 total in FY18).
- Conducted internal audits and monitoring activities.
- Monitored all sites for HIPAA Privacy compliance. Contracted with external vendor to conduct the annual Security Risk Assessment.
- Issued and tracked 72 actions and sanctions to providers in response to Network compliance issues in the first 6 months of FY19 (149 total in FY18).
- Issued over $154,000 in overpayments through the Corporate Compliance Committee process in the first 6 months of FY19 ($908,000 total in FY18).
- Managed 10 requests for reconsideration of actions against providers in the first 6 months of FY19 (13 total in FY18).
- Audited 3% of adjudicated claims as well as inpatient and ED claims weekly.
- Conducted internal investigations and developed remediation plans where applicable, monitored remediation plans to ensure successful implementation.
- Conducted new hire orientation, annual compliance and HIPAA training to all employees, compliance training to Board of Directors, and published informational materials related to compliance, fraud and abuse to a variety of stakeholder groups.
- Conducted Compliance and Program Integrity training to Network Providers.
- Coordinated activities to celebrate Corporate Compliance and Ethics Week organization-wide at each site with the purpose to increase compliance awareness.

Summary of Goals and Objectives for FY20
- Our goal is to embed compliance, fraud control, and business ethics into Alliance day-to-day operations through the use of procedures, infrastructures and tools designed to help achieve compliance with federal, state, and local laws and regulations, contracts and accreditation standards. We will achieve these goals through ongoing efforts of:
  - Employee and stakeholder training and information sharing
  - Policy and procedure oversight and management
  - Internal audits and compliance monitoring
  - Privacy and security audits, annual security risk assessment
  - Random and targeted claims audits
  - Fraud and abuse investigations to detect and deter fraud and abuse in the Alliance Network, prioritizing areas of highest risk
  - Investigation and correction of non-compliance
  - Development and implementation of risk mitigation plans
  - Identification and resolution of provider compliance issues
• An annual work plan developed as a result of the annual risk assessment drives major compliance operations. Items selected for the work plan pose risk to Alliance. The updated plan is reflective of the current risk environment in which Alliance operates.
• Provide specialized training to department staff to promote professional development.
# General Fund Revenues

FY2019-2020 Recommended Budget

**Total General Fund Revenues: $535,759,800**

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General Fund Revenues
FY2019-2020 Recommended Budget
Total General Fund Revenues: $535,759,800

- Administration: $38,787,140 (7%)
- Medicaid: $57,348,078 (11%)
- State: $53,383,119 (10%)
- Local: $500,000 (0%)
- Miscellaneous: $385,741,463 (72%)
General Fund Expenditures
FY2019-2020 Recommended Budget
Total General Fund Expenditures: $535,759,800

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## Budget Comparison

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WHEREAS, the proposed budget and budget message for FY 2019 - 2020 was submitted to the Alliance Health Area Board on May 2, 2019 by the Budget Officer; was filed with the Executive Secretary to the Board;

WHEREAS, on June 6, 2019, the Alliance Health Area Board held a public hearing pursuant to NC G.S. 159-12 prior to adopting the proposed budget;

BE IT ORDAINED by the Alliance Health Area Board that for the purpose of financing the operations of Alliance Health, for the fiscal year beginning July 1, 2019 and ending June 30, 2020, there is hereby appropriated funds the following by function:

### Section 1: General Fund Appropriations

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</tr>
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<td>Medicaid Services</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$535,759,800</strong></td>
</tr>
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</table>

### Section 2: General Fund Revenue

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<th>Function</th>
<th>Amount</th>
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</table>

### Section 3: Authorities

A. The LME/MCO Board authorizes the Budget Officer to transfer within an appropriation up to $100,000 cumulatively without report to the Board.

B. The LME/MCO Board authorizes the Budget Officer to transfer up to $100,000 between appropriations with a report to the Board at the subsequent meeting.

C. The CEO may enter into the following within budgeted funds:
   1. Form and execute grant agreements within budgeted appropriations;
   2. Execute leases for normal and routine business;
   3. Enter into consultant, professional, maintenance, provider, or other service agreements;
   4. Approve renewals for of contracts and leases;
   5. Purchase of apparatus, supplies, materials or equipment and construction or repair work;
   6. Reject any and all bids and re-advertise to receive bids.
Budget and Amendment Process

Overview
The purpose of the budget and amendment process is to ensure that public dollars are spent in the manner as intended and in an effort to meet the needs of the citizens in relation to mental health, intellectual/developmental disabilities, and substance abuse needs. Through the budget, Alliance Health aims to fulfill its mission as granted by NC G.S. 122-C.

Governing Statutes
Alliance Health abides by the North Carolina Local Government Budget and Fiscal Control Act. It is the legal framework in which all government agencies must conduct their budgetary processes. NC G.S. 159 provides the legislation which includes several key dates such as:
- 159-10 – by April 30, Departments must submit requests to the Budget Officer
- 159-11(b) – by June 1, the Recommended Budget must be submitted the Board
- 159-12(b) – a public hearing must be held
- 159-13(a) – from 10 days after submitting to the Board, but by July 1, a balanced budget must be adopted

Budget Process
FY 2019-2020 is the eighth recommended budget representing Alliance Health as a multi-county Area Authority. The budget represents services for Cumberland, Durham, Johnston and Wake counties.

The administrative budget for this fiscal year was driven by our Per Member Per Month (PMPM) rate, FY20 projected costs, FTE positions, Department of Health and Human Services contract requirements, and costs related to the operating the Medicaid waiver.

The Medicaid service budget was created based on historical experience and projections into the next fiscal year. Alliance will review the need for a budget amendment in the first quarter of FY20 if the projection of lives has changed based on payments received.

The State and Local services budget was developed by gathering service information for each area based on the claims trends and information from staff. The FY19 allocations and benefit packages were reviewed and staff worked together to ensure all services were appropriately planned to be consistent with current services.

Amendment Process
The budget ordinance is approved at a function/appropriation level. The Budget Officer is authorized to transfer budget amounts within an appropriation up to $100,000 cumulatively without reporting to the Board. The Budget Officer is authorized to transfer budget amounts between functions up to $100,000 with an official report of such transfer being noted at the next regular Board meeting.
Per G.S. 159-15, the governing board may amend the budget ordinance at any time after the ordinance's adoption in any manner, so long as the ordinance, as amended, continues to satisfy the requirements of G.S. 159-8 and 159-13.

**Budget Calendar**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>By Thursday, May 2, 2019</td>
<td>FY 2019-2020 recommended budget presented at LME/MCO Board meeting</td>
</tr>
<tr>
<td>By Friday, May 10, 2019</td>
<td>Notice of June 6, 2019 Public Hearing published</td>
</tr>
<tr>
<td>By Thursday, June 6, 2019</td>
<td>Public Hearing</td>
</tr>
<tr>
<td>By Friday, June 28, 2019</td>
<td>LME/MCO Board adoption of FY 2019-2020 Budget Ordinance</td>
</tr>
<tr>
<td>By Monday, July 1, 2019</td>
<td>Budget is available in the General Ledger system</td>
</tr>
</tbody>
</table>

**Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME</td>
<td>Per G.S. 122C-3(20b), Local Management Entity or LME means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization; LMEs that have adopted the financial risk and service review functions of the 1915(b) and 1915(c) waivers. LME-MCOs carry out the function of an LME and also act as health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals.</td>
</tr>
<tr>
<td>Medicaid Waiver</td>
<td>States can submit applications to the federal Centers for Medicare and Medicaid Services, asking to be exempt from certain requirements. If granted a “1915(b)” waiver, a state can limit the number of providers allowed to serve consumers, easing the state’s administrative burden and saving money. If granted a “1915(c)” waiver, a state can offer more services focused on helping an intellectually or developmentally disabled consumer continue living in his or her home, rather than a group home.</td>
</tr>
</tbody>
</table>
MEMBERS PRESENT: ☑ Carole Johnson, ☑ Megan Mason, ☑ Karen McKinnon, ☑ Connie King-Jerome, ☑ Israel Pattison, ☑ Annette Smith, ☑ Ben Smith, ☑ Wanda (Faye) Griffin, ☑ Gregory Schweitzer, ☑ Vicki Bass, ☑ Anthony Baracena, ☑ Jessica Larrison.

GUEST(S):
STAFF PRESENT: ☑ Doug Wright, Director of Individual and Family Affairs, ☑ Terrasine Garner, Community Member and Engagement Manager, ☑ Stacy Guse, Individual and Family Affairs Specialist.

1. WELCOME AND INTRODUCTIONS:

2. REVIEW OF THE MINUTES: The minutes from the May 14, 2019, Wake Consumer and Family Advisory Committee (CFAC) Subcommittee meeting reviewed; a motion made by Annette Smith and seconded by Karen McKinnon to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
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</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>Short discussion about the State CFAC legislative day and member’s participation. Everyone that went enjoyed the opportunity to visit with legislators and found value in the effort. Very complimentary of Benita Purcell, SCFAC chairperson. Questions about Social security were referred.</td>
<td>Prepare for next year and encourage more members to participate. Continue communicating with legislators.</td>
<td>On-Going</td>
</tr>
<tr>
<td>4. Medicaid Managed Care Policy</td>
<td>Doug reviewed the Care Management White paper for BH/IDD/SUD Tailored plans. We talked about care teams, the need for Advanced Medical Homes and Care Management Agencies. The tailored plan would eventually do the care management for 20% of our population with 80% being done by providers in the community. Members were encouraged to make comments on the DHHS website. An interesting discussion about what care management will look like for members and their families, how it will differ from care coordination and case management. Seem to be a consensus that a wait and see how it works giving appropriate feedback to the LME/MCO would be the right course to take.</td>
<td>Make any comments on DHHS website. Participate in the care team role out at Alliance and give feedback about its effectiveness.</td>
<td>6-29-19</td>
</tr>
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### AGENDA ITEMS:  

<table>
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<tr>
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<th>DISCUSSION:</th>
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<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>5. June 2019 Updates</td>
<td>Reviewed the state updates from the Community Engagement and Empowerment Team.</td>
<td>Information/participate where appropriate.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| 6. RCNC Rally        | Who will attend with Stacy  
Several members were interested in participating again this year but needed to know the date. Annette and Ben, Karen, and Carole. | Confirm date and sign up with Stacy.            | 7-15-19     |
| 7. Move to Morrisville | Possible Raleigh locations  
Concerns regarding the distance from Raleigh to Morrisville. Discussed several possible locations where members could meet in the Raleigh proper area. Several members were okay with Morrisville. Doug was waiting on confirmation for Healing Transitions. Members like Healing Transitions as a central place. Doug or Stacy will send out notice once space is found and locked in. Worst case scenario was we would meet at the Morrisville office and continue the discussion. | Firm up options and communicate to members.     | 7-8-19      |
Annual report is due to the Board of Directors; Carole will write the report with the assistance of Stacy but would like feedback from members about the past year's activities, successes and concerns. | Please send your comments to Carole within the next week. | 7-22-19     |
| 9. CFAC log          | Need members to add information about events and conferences that they would like to attend. | Please send information to Stacy                 | 7-8-19      |
| 10. Next Meeting     | 7-9-19  
Plan to attend                                                        |                                                   |             |

5. ADJOURNMENT
1. WELCOME AND INTRODUCTIONS:

2. REVIEW OF THE MINUTES: The minutes from the June 11, 2019, Wake Consumer and Family Advisory Committee (CFAC) Subcommittee meeting reviewed; a motion made by Annette Smith and seconded by Jessica Larrison to approve the minutes at 5:48. Motion passed unanimously.

<table>
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<tr>
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<tbody>
<tr>
<td>3. Public Comments</td>
<td>Dianne Morris has two children with autism who are on the waiver and is experiencing frustrating securing services. Welcome to CFAC and please come again.</td>
<td>Doug discussed the staff changes: CJ and Ken has resigned with the state. Doug discussed the Medicaid transformation. Letters will be sent out this week for those on Medicaid and will need to decide to be on a standard plan or tailored plans. State CFAC is moving from Dorothea Dix Campus to the DHHS building on Six Forks Rd. The Raise Your Hand Form established parameters. The concerns are those in the middle and the state and fear these individuals will slip in the middle. DHHS has</td>
<td>None</td>
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| 4. LME/MCO updates   | July Update
FY 20 Budget Update
Maximus training | | None |
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<thead>
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<tr>
<td></td>
<td>created a 2 page form for members to fill out with their individual's preferences. Letters have been delayed due to lack of a budget possibly until March 2020. This will only impact those on the standard plan and not tailored plans. Doug explained the Alliance Health Fiscal Year. Doug explained the Medicaid enrollment broker and process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. RCNC Rally</td>
<td>Who will attend with Stacy: RCNC Rally is September 21 at Mordecai Historic Park 1 Mimosa St Raleigh Several members were interested in participating</td>
<td>Karen McKinnon will be there. Carole will host with Stacy</td>
<td>On Going</td>
</tr>
<tr>
<td>6. Annual Plan Summary</td>
<td>Please review</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>7. Possibly new Member</td>
<td>Bradley Garlik</td>
<td>Bradley introduced himself. Bradley has been admitted has a member to Wake CFAC.</td>
<td>On Going</td>
</tr>
<tr>
<td>8. CFAC log</td>
<td>Need members to add information about events and Conferences that they would like to attend.</td>
<td></td>
<td>On Going</td>
</tr>
<tr>
<td>9. Bullying training</td>
<td>Stacy</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>10. Next meeting</td>
<td>8-13-2019</td>
<td></td>
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</table>

5. ADJOURNMENT
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the May 21, 2019, Consumer and Family Advisory Committee (CFAC) meeting reviewed; a motion made by Jerry Dodson and seconded by Leanna George

<table>
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<tr>
<td>3. Public Comment</td>
<td>While addressing the minutes Dorothy asked about the fear that providers would choose not to contract with Alliance Health due to the population we would be serving as a tailored plan. Doug led a discussion on the possibilities and explained that the majority of providers will contract with Alliance Health to make sure they are meeting the needs of the individuals they serve.</td>
<td>Alliance will update members if a problem arises and continues to encourage members to ask questions and raise concerns.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4. LME/MCO Updates</td>
<td>Tailored Plan Regions- Doug led a discussion regarding the pending tailored plan regions. Doug did give a brief recap and overview of the process for choosing the regions. Updated the CFAC that Orange County had voted to “move to the region with Wake County”. No official decisions have been made and Secretary Cohen does ultimately have final say. Managed Care Policy Paper- Doug gave a brief overview of the Managed Care Policy Paper and how these changes would affect members and Alliance. #NCCARES- Doug discussed the #NCCARES campaign and the purpose of the joint effort campaign. Several CFAC members showed support of the campaign by giving brief speeches about their experience within the mental health system of NC.</td>
<td>Alliance Health will continue to update the CFAC as information becomes available during Medicaid Transformation. Members are encouraged to ask questions and offer feedback.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5. State Updates</td>
<td>Community Empowerment Team Update- The Community Empowerment Team newsletter was passed out. Information about SCFAC and events around the state were included.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Annual Report</td>
<td>Members have received a copy of the annual report and had no feedback at this time.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>7. July Meeting</td>
<td>Due to the season and most local committees and collaborative taking July off Johnston CFAC will not meet in July. A special meeting will be called if a situation arises. Otherwise the next CFAC meeting will be August 20, 2019.</td>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
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<tr>
<td>8. Events</td>
<td>Guardianship Event in the Fall- The CFAC wants to host a Guardianship Event in the fall preferably at Johnston County Public Schools. The event would raise awareness around guardianship and the process.</td>
<td>Noah will speak with Amanda Allen from Johnston County Public Schools and Becky Fescina Community Education Specialist with Alliance Health. To begin looking at a suitable date and time for the event. CFAC members were encouraged to attend community events.</td>
<td>August 20, 2019</td>
</tr>
<tr>
<td></td>
<td>Albert Dixon Peer Support Event- Albert is hosting an event at the Smithfield Library this Saturday June 22, 2019 from 12-2pm discussing the importance of peer supports and what peer supports do in the community.</td>
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<td></td>
<td>“I’m In” Regional Kickoff- NAMI Johnston County and Alliance Health have partnered on a pilot through the i2i Center for Integrated Health and the “I’m In” innovative to form a Regional Community Inclusion Collaborative. The event will be Wednesday June 26th from 9:30am to 11:30am at the Johnston Medical Mall.</td>
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9. **ADJOURNMENT:** the next meeting will be August 20, 2019, at 5:30 p.m.

Respectfully Submitted by:

Noah Swabe, Individual and Family Engagement Specialist

Click here to enter text.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Medicaid Managed Care
Policy Paper

North Carolina’s Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans

North Carolina Department of Health and Human Services

May 29, 2019
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This document is part of a series of Department of Health and Human Services policy papers that provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid Managed Care; however, anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver and previously released policy papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.
I. Introduction

The first priority of the North Carolina Department of Health and Human Services (the Department) is the health and well-being of the individuals we serve. As North Carolina transitions its Medicaid and NC Health Choice programs from a predominantly fee-for-service (FFS) delivery system to managed care, the Department is focused on building robust and effective models for managing beneficiaries’ comprehensive needs through care management.

Over a five-year period, the majority of Medicaid and NC Health Choice beneficiaries will transition to one of two types of prepaid health plans (PHPs), customized to the populations they serve.1,2

- Standard Plans will launch starting in November 2019 (in two regions in November 2019 and in the remaining four regions in February 2020) and will serve the vast majority of Medicaid beneficiaries (approximately 1.6 million).

- Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans will launch in July 2021 and will serve approximately 115,000 individuals with more serious behavioral health disorders (serious mental illness (SMI), serious emotional disturbance (SED), and/or substance use disorders (SUD)), intellectual/developmental disabilities (I/DDs), and traumatic brain injuries (TBIs).3

The Department’s goal for the transition to managed care is to improve the health of North Carolinians through an integrated and well-coordinated system of care that addresses both medical and nonmedical drivers of health. In a significant change from today’s structure, both Standard Plans and BH I/DD Tailored Plans will be fully integrated managed care plans with a benefit package that spans both physical and behavioral health services, as well as long-term services and supports (LTSS) and pharmacy benefits.4 For individuals enrolling in BH I/DD Tailored Plans, this integration is an opportunity to begin breaking down silos among physical health, behavioral health, I/DD and TBI services, LTSS, pharmacy benefits, and unmet health-related resource needs.

Care management is at the heart of BH I/DD Tailored Plan design. Care management will provide the “glue” for integrated care, fostering coordination and collaboration among care team members across disciplines and settings. The care management design, as described next, is built on the principle that provider- and community-based care management is crucial to the success of fully integrated managed care. As under Standard Plans, the Department strongly believes that placing care management as close as possible to the beneficiary and the site of care will drive better health outcomes.

The care management model for the BH I/DD Tailored Plan population, called “Tailored Care Management,” will be built on the foundation of the federal Health Home State Plan option as described below. Tailored Care Management will build on the Standard Plan care management model, but will be more intensive and customized, reflecting the specific needs of the population. Those targeted for enrollment in BH I/DD Tailored Plans may cycle through multiple health care, social service, criminal justice and other systems, without

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1 For purposes of this paper, the term “Medicaid” refers to North Carolina Medicaid and NC Health Choice programs, unless specifically described otherwise.

2 The Department is also considering creating a Specialized Foster Care Plan.

3 The full BH I/DD Tailored Plan eligibility criteria are available in the BH I/DD Tailored Plan Eligibility and Enrollment Final Policy Guidance. Individuals eligible for BH I/DD Tailored Plans will by default remain in FFS and Local Management Entities-Managed Care Organizations (LME-MCOs) prior to BH I/DD Tailored Plan launch, but will be able to choose to enroll in a Standard Plan.

4 Certain high-intensity behavioral health, I/DD and TBI services will be available only in BH I/DD Tailored Plans, in recognition of the more intensive needs of the population.
coordination across systems and services. Care management models that place individuals with complex needs at the center of a multidisciplinary care team facilitated by a dedicated care manager have been shown to improve individuals’ health by enhancing coordination of care, and helping beneficiaries and caregivers more effectively manage health conditions.\textsuperscript{5,6,7}

In alignment with the Department’s broader goals for the transition to Medicaid managed care, the design of Tailored Care Management is being guided by the following core principles:\textsuperscript{8}

1. **Broad access to care management.** Tailored Care Management will be available to all BH I/DD Tailored Plan beneficiaries continuously throughout their enrollment, unless beneficiaries are already receiving intensive care coordination or case management services through other programs or services, such as intermediate care facilities for individuals with intellectual disabilities.\textsuperscript{9}

2. **Single care manager taking an integrated, whole-person approach.** To the maximum extent possible, each BH I/DD Tailored Plan beneficiary will receive integrated, whole-person care management from a single care manager with expertise and training in addressing behavioral health, I/DD and/or TBI needs in addition to physical health needs and unmet health-related resource needs. Care managers will have access to timely beneficiary-level information to guide their work. By default, individuals enrolled in the Innovations and TBI waivers will be enrolled in Tailored Care Management to receive whole-person services, rather than care coordination solely for home- and community-based services (HCBS) as currently provided. Care managers serving individuals enrolled in one of these HCBS waivers will be responsible for addressing beneficiaries’ whole-person needs alongside coordinating their HCBS waiver services.

3. **Person- and family-centered planning.** Care planning for BH I/DD Tailored Plan beneficiaries will be person-centered\textsuperscript{10} and will consider the unique needs of the beneficiary. Family members and other informal caregivers can also serve as members of beneficiaries’ care teams, with beneficiaries’ consent.

4. **Provider-based care management.** To the maximum extent possible, care managers for BH I/DD Tailored Plan beneficiaries will be embedded within provider organizations—primary care practices, or behavioral health or I/DD providers—to support collaboration among providers and beneficiaries, and to place care management as close to the site of care as feasible (see section II for more information on the Department’s targets for provider-based care management).\textsuperscript{11}


\textsuperscript{7} Hasselman, D. *Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs*, October 2013.

\textsuperscript{8} For the Standard Plan approach, see the Department’s *Care Management Strategy under Managed Care*.

\textsuperscript{9} See *Approach for Avoiding Duplication of Care Management* section for additional detail.

\textsuperscript{10} Person-centered planning is a process of determining real-life outcomes with individuals and their families, as well as developing strategies to achieve those outcomes. Person-centered planning provides for the individual or the family of a beneficiary assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability and his/her family or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

\textsuperscript{11} As discussed below, providers performing the care management role will be required to undergo a rigorous state certification process. BH I/DD Tailored Plans will be required to contract with all *certified* AMH+ practices and CMAs in their region, not “any willing provider.”
5. **Community-based care management.** Care managers should live near and be actively engaged in the communities of beneficiaries; have frequent face-to-face interaction with beneficiaries; and have deep familiarity with local resources, including social services and supports.

6. **Community inclusion.** BH I/DD Tailored Plan care managers will support beneficiaries in living meaningful, productive lives in the community of their choice to the greatest extent possible.

7. **Choice of care managers.** BH I/DD Tailored Plan beneficiaries may choose a care manager and may change care managers without cause.

8. **Consistency across the state.** Regardless of geography or the type of organization providing care management, all BH I/DD Tailored Plan beneficiaries will have access to consistent, high-quality care management.

9. **Harness existing resources.** Tailored Care Management will build on existing care management infrastructure in the state, particularly Local Management Entities-Managed Care Organizations (LME-MCOs) and the Advanced Medical Homes rolling out for the Standard Plan population. Care management activities will align with overall statewide priorities for achieving quality and value.

This paper outlines the key components of the Tailored Care Management model and provide a road map for the work ahead. The Department welcomes feedback from Medicaid beneficiaries, families and other stakeholders as it continues to refine the Tailored Care Management model.

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**Key Terminology**

North Carolina recognizes that standardized, industrywide definitions related to care management and care coordination do not exist. For the purposes of its care management strategy, North Carolina has developed the following definitions.

**Care Management:** A team-based, person-centered approach to effectively managing patients’ medical, social and behavioral conditions, which includes:

- Management of rare diseases and high-cost procedures (e.g., transplant, specialty drugs)
- Management of beneficiary needs during transitions of care (e.g., from hospital to home)
- High-risk care management (e.g., high utilizers, high-cost beneficiaries)
- Chronic care management (e.g., management of multiple chronic conditions)
- Management of high-risk social environments (e.g., adverse childhood events, domestic violence)
- Identification of beneficiaries in need of care management (e.g., screening, risk stratification, priority populations)
- Development of care management assessments/care plans (across targeted populations)
- Development and deployment of prevention and population health programs
- Coordination of services (e.g., appointment/wellness reminders, social services coordination/referrals)

**Care Coordination:** The process of organizing patient care activities and sharing information among all the participants concerned with a beneficiary’s care to achieve safer and more effective care. Through organized care coordination, beneficiaries’ needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate and effective care. Local Management Entities-Managed Care Organizations (LME-MCOs) currently provide care coordination to select groups of beneficiaries. As described below, Tailored Care Management is broader than and inclusive of care coordination.

**Case Management:** Federal regulations define case management as “services furnished to assist individuals eligible under the [Medicaid] State Plan who reside in a community setting or who are transitioning to a community setting, in gaining access to needed medical, social, and other services” (42 CFR 44.169). See section II for information on avoiding duplication between care management and case management embedded in enhanced behavioral health services. Case management provided within the Innovations and TBI waivers, which currently addresses only waiver services, will be incorporated into Tailored Care Management.
II. Transition to Whole-Person Care Management in BH I/DD Tailored Plans

The design of the Tailored Care Management model reflects the Department’s broader goal for integrated care in the Medicaid managed care environment. In the current North Carolina Medicaid environment, physical health services are provided in the FFS system and are coordinated (for the majority of beneficiaries) by Community Care of North Carolina (CCNC), North Carolina’s statewide primary care case management program. Meanwhile, the Department currently contracts with LME-MCOs to provide care coordination for behavioral health, I/DD and TBI services only.\(^\text{12}\) Whereas Medicaid beneficiaries currently may have a CCNC care manager for their physical health services and an LME-MCO care coordinator for their behavioral health, I/DD and TBI services, the Department envisions that BH I/DD Tailored Plan beneficiaries will have a single designated care manager trained to provide fully integrated care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs (Figure 1).\(^\text{13}\)

Today’s LME-MCOs will have exclusive rights to operate BH I/DD Tailored Plans in the first four years of the program (July 2021–June 2025).\(^\text{14}\) In order to win a BH I/DD Tailored Plan contract, each LME-MCO will need to demonstrate the ability to oversee and implement the Tailored Care Management. Tailored Care Management will have key differences from today’s model of care coordination under LME-MCOs. Tailored Care Management will be available throughout the entire duration of a beneficiary’s enrollment in a BH I/DD Tailored Plan;\(^\text{15}\) will be based in provider settings to the maximum extent possible, to support integrated care and collaboration; will prioritize frequent in-person interactions between care managers and beneficiaries; and will place additional emphasis on outcomes and population health management. The Department recognizes that under today’s system, LME-MCOs often work to address beneficiaries’ needs beyond the scope of their contract for care coordination. The BH I/DD Tailored Plan Health Home model will allow BH I/DD Tailored Plans to build on efforts undertaken under the current framework while more comprehensively integrating physical health and designating a distinct role for providers.

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\(^\text{12}\) Certain populations, such as children under age 3 and children enrolled in NC Health Choice, are excluded from LME-MCOs.

\(^\text{13}\) Beneficiaries dually enrolled in Medicare and Medicaid (duals) will receive Medicaid-covered physical health services, LTSS and pharmacy through Medicaid FFS; care managers serving these beneficiaries will be required to coordinate across Medicaid FFS and the BH I/DD Tailored Plan. High-risk pregnant women receiving care management from local health departments during the first year of BH I/DD Tailored Plan operation will be eligible for a second care manager (see Approach for Avoiding Duplication of Care Management for more details).

\(^\text{14}\) DHHS will award no less than five and no more than seven BH I/DD Tailored Plan contracts.

\(^\text{15}\) As described below under the Approach for Avoiding Duplication of Care Management, there may be limited periods when a beneficiary is not eligible for Health Home care management because of receipt of a duplicative service.
III. The Tailored Care Management Model

Federal Health Home Structure

The Department plans to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to authorize BH I/DD Tailored Plans to offer and oversee care management as federally designated Health Homes. Health Homes are an optional Medicaid State Plan benefit, established by Section 2703 of the Affordable Care Act, for states to build a robust care management infrastructure for Medicaid beneficiaries who have chronic conditions. States operating Health Homes can receive an enhanced, 90 percent federal match rate for care management services for the first eight quarters (two years) that the program is effective. The federal model is flexible according to the needs of states, as long as the model encompasses six “core” Health Home services and uses health information technology to coordinate across these services. CMS expects Health Homes to operate within a culture of continuous quality improvement to enhance health outcomes and quality of life by taking a fully integrated care management approach, to coordinate with all of the individual’s care providers, to establish prevention strategies, and to educate beneficiaries so they have

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16 North Carolina’s 1115 Demonstration Waiver to implement managed care was approved in October 2018. A separate State Plan Amendment (SPA) will be submitted to add Health Homes as a State Plan benefit.


18 The six required Health Home services are: 1) Comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) individual and family supports; and 6) referral to community and social support services.

19 Centers for Medicare & Medicaid Services. Health Homes Frequently Asked Questions Series II.
the knowledge and skills to support wellness.\textsuperscript{20,21} The Department is designing the model to incorporate each of these core services and thereby meet all federal Health Home requirements.

**Roles and Responsibilities for Tailored Care Management**

The Department, BH I/DD Tailored Plans, Tier 3 Advanced Medical Homes (AMHs), and Care Management Agencies (CMAs) will all play a vital role in the success of the managed care transition and the Tailored Care Management strategy. The Department’s vision is that Tailored Care Management will be provided primarily by care managers embedded within Tier 3 AMHs that have demonstrated capacity to provide integrated care management for the BH I/DD Tailored Plan population, and by CMAs—other behavioral health and I/DD providers that serve the BH I/DD Tailored Plan population today (approaches 1 and 2 in Figure 2). The AMH program will go live in November 2019 to serve the Standard Plan population.\textsuperscript{22} A subset of AMHs that are able to meet certification standards for the Tailored Care Management model (known as “AMH+” practices) will provide care management to the BH I/DD Tailored Plan beneficiaries. The “CMA” designation is new and will be unique to providers serving the BH I/DD Tailored Plan population. Organizations that may be certified as CMAs by the Department will include behavioral health and/or I/DD providers with the experience and capacity to provide care management to the BH I/DD Tailored Plan population.

**FIGURE 2. OVERVIEW OF TAILORED CARE MANAGEMENT APPROACH**

<table>
<thead>
<tr>
<th>Department of Health and Human Services</th>
<th>Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH I/DD Tailored Plan Health Home</td>
<td>The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements</td>
</tr>
<tr>
<td>BH I/DD Tailored Plan beneficiaries</td>
<td>BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet DHHS standards and be provided in the community to the maximum extent possible.</td>
</tr>
</tbody>
</table>

**Approach 1: AMH+**

BH I/DD Tailored Plans will be required to contract with AMH+ practices to provide Tailored Care Management. These AMH+ practices must serve a substantial number of BH I/DD Tailored Plan beneficiaries and have experience serving these populations.

**Approach 2: Care Management Agency (CMA)**

BH I/DD Tailored Plans will be required to contract with organizations that obtain CMA certification from the Department to provide Tailored Care Management. Organizations that may serve as CMAs include those that provide BH or I/DD services, such as mental health or substance use agencies and I/DD agencies, among others.

**Approach 3: BH I/DD Tailored Plan-Employed Care Manager**

BH I/DD Tailored Plans may provide care management in alignment with the Department’s targets for provider-based care management.

BH I/DD Tailored Plans will be required to contract for care management with all providers in their region that have demonstrated capacity for the model through the state certification process (i.e., the design for care


\textsuperscript{21} North Carolina previously operated a Health Home program targeted toward individuals with chronic physical conditions (enhanced federal match from 2011 to 2013). The Department will not be able to claim enhanced Health Home match for individuals who were enrolled in the previous Health Home program.

\textsuperscript{22} Information about the Advanced Medical Home program is available on the Department’s [AMH website](https://www.medicaid.gov/medicaid/medicaid-CHIP-operations/health-homes/index.html).
management is not “any willing provider”). The Department understands that in practice, beneficiaries will be assigned across a mix of the three approaches to ensure beneficiary choice, capacity, expertise and quality, subject to an overall four year “glide path” toward predominantly provider-based care management, as described below. The Department, BH I/DD Tailored Plans, and the AMH+ practices and CMAs providing care management will each have distinct roles and responsibilities.

**Department Roles and Responsibilities**

The Department is ultimately responsible for all aspects of the Medicaid program, including North Carolina’s transition to managed care and implementation of BH I/DD Tailored Plans. The Department will perform the following functions:

- **Oversight of BH I/DD Tailored Plans.** The Department will contract with each BH I/DD Tailored Plan, enroll beneficiaries into each plan, and perform general oversight in a fashion similar to its oversight of Standard Plans. As under Standard Plans, the Department will conduct oversight of contractual performance measures and issue sanctions or corrective action plans as necessary. The Department’s external quality review organization (EQRO) will play a role in oversight of each BH I/DD Tailored Plan.

- **Payment to BH I/DD Tailored Plans.** The Department will pay BH I/DD Tailored Plans a capitated managed care rate; a separate per-member per-month (PMPM) care management payment for each beneficiary under active Tailored Care Management; and an “engagement” PMPM payment, as described in the Payment for Care Management section.

- **Certification of Care Management Agencies and Advanced Medical Homes.** To promote implementation of care management that is based in community-based provider settings, the Department will launch a process to certify CMAs and AMHs (to become AMH+ practices) that can specialize in providing Tailored Care Management to BH I/DD Tailored Plan populations in accordance with robust standards, and will place contracting requirements on BH I/DD Tailored Plans to enter agreements with these organizations.

**BH I/DD Tailored Plan Roles and Responsibilities**

BH I/DD Tailored Plans, serving as the federally defined Health Homes for beneficiaries, will oversee all aspects of Tailored Care Management and will be ultimately responsible for ensuring that beneficiaries receive care management in compliance with the Department’s requirements. They will perform the following functions:

- **Assignment to an organization providing care management.** BH I/DD Tailored Plans will develop networks of AMH+ practices and CMAs and assign each beneficiary to one of these specially qualified organizations or to its own staff, according to one of the three approaches in Figure 2 above and taking the beneficiary’s preferences into account.

- **Administration of care management payment claims and distribution to CMAs and AMH+ practices.** BH I/DD Tailored Plans will issue monthly claims to the Department for the PMPM care management and engagement payments and will be responsible for making payments to CMAs and AMH+ practices for care management.

- **Coordination among AMH+ practices, CMAs, other providers and organizations addressing unmet health-related resource needs.** By creating and maintaining strong relationships with local providers and social service agencies across the delivery system, BH I/DD Tailored Plans will create pathways for
frontline providers and social service agencies to work together, both within the traditional healthcare system and outside its boundaries.  

- **Training.** BH I/DD Tailored Plans will be responsible for training all care managers serving their beneficiaries and developing training curricula encompassing training topics specified by the Department.

- **Population health management.** BH I/DD Tailored Plans will be expected to take a population-wide view of their assigned beneficiaries. Mirroring expectations for Standard Plans, BH I/DD Tailored Plans will be required to establish prevention and population health programs aligned with priorities in the Department’s Quality Strategy.  

CMA, AMH+ practices and BH I/DD Tailored Plans

CMAs, AMH+ practices and BH I/DD Tailored Plans will be responsible for organizing and providing care management to each BH I/DD Tailored Plan beneficiary once the beneficiary is assigned to them by the BH I/DD Tailored Plan, in accordance with the Department’s requirements detailed below.

**Provider-based Care Management**

The Department is committed to giving BH I/DD Tailored Plan beneficiaries access to provider-based care management that is performed at the site of care, in the home or in the community, where face-to-face interaction is possible. The Department’s strategy will include the following components:

- **Provider-based targets that will increase over a four-year “glide path.”** Recognizing that the expansion of the population eligible for care management services will require a multiyear effort to enhance the workforce at the AMH+ and CMA level, the Department will establish a glide path for the provision of provider-based care management (see Figure 3). The glide path aims to create a planned approach for most Tailored Care Management to move to being primarily provider-based over the first four-year BH I/DD Tailored Plan contract, while creating a smooth transition for beneficiaries and current care coordinators. Through this glide path, the Department will establish targets for the proportion of Tailored Care Management occurring at the level of certified CMAs and AMH+ practices, which will ramp up over the first four years of BH I/DD Tailored Plan implementation, aligning with the initial period in which LME-MCOs will have exclusive rights to operate the BH I/DD Tailored Plans. The starting target percentage at BH I/DD Tailored Plan launch will assume that BH I/DD Tailored Plans will retain their current workforce of LME-MCO care coordinators at their launch and that these care coordinators will obtain the requisite training to serve as Health Home care managers. Calculation of actual percentages compared with the targets will be performed at the start of each contract year. During

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23 BH I/DD Tailored Plans will also play a critical role in North Carolina’s Healthy Opportunities Pilots (the Pilots) when they launch. The Pilots, authorized by the state’s 1115 waiver, will launch in late 2020 in two to four geographic areas of the state to test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries. For more information on the Healthy Opportunities Pilots, see “North Carolina’s Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders.”  

24 Priorities contained in the Quality Strategy include diabetes, asthma, obesity, hypertension, tobacco cessation, infant mortality, low birth weight, and early childhood health and development.  

25 As described below, the Department plans to develop a standardized methodology for assigning acuity tiers to beneficiaries for the purposes of payment and monitoring of the intensity of care management.
these four years, BH I/DD Tailored Plans will be required to work with CMAs and AMH+ practices to grow their capacity to provide care management to the BH I/DD Tailored Plan population.

Ultimately, the Department’s goal is for at least 80 percent of care management across the state to be provider-based by July 2024, the beginning of the fourth year of BH I/DD Tailored Plan implementation. However, the glide path takes into account the Department’s anticipation that BH I/DD Tailored Plans will continue to employ care managers to provide care management to beneficiaries in regions where capacity among AMH+ practices and CMAs may be insufficient, as well as employ staff with the requisite experience to oversee AMH+ practices and CMAs in the delivery of provider-based care management. In alignment with federal regulations, BH I/DD Tailored Plans will also be responsible for providing care coordination to beneficiaries who opt out of Tailored Care Management (see Care Management Process Flow).

**FIGURE 3. ANNUAL TARGETS FOR PROVIDER-BASED CARE MANAGEMENT**

<table>
<thead>
<tr>
<th>Year (May)</th>
<th>Year 1 (Mid)</th>
<th>Year 2 (Mid)</th>
<th>Year 3 (Mid)</th>
<th>Year 4 (Mid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 0</td>
<td>Target 1</td>
<td>Target 2</td>
<td>Target 3</td>
<td>Target 4 = 80%</td>
</tr>
<tr>
<td>Target percentage of beneficiaries served by care managers/Supervisors based in CMA/AMH+</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Direct certification process for CMAs and AMH+ practices and required contracting with certified CMAs and AMH+ practices.** As described above, the Department plans to implement a direct process to certify providers and agencies to deliver provider-based care management under this model as AMH+ practices or CMAs. Because of the specialized needs of BH I/DD Tailored Plan populations, as well as the requirements to meet Health Home standards, this certification process will be more extensive than the previously established attestation process for entry into Tier 3 of the AMH program. To be successful in gaining certification, providers will be required to show that care managers and supervisors have experience serving populations with behavioral health, I/DD and/or TBI needs; that the organization has the ability to operationalize delivery of all aspects of the Tailored Care Management model described in this paper; and that the organization has the capacity and financial sustainability to establish care management as a service line. Certified CMAs and AMH+ practices will be required to convene and coordinate multidisciplinary care teams for their beneficiaries, but do not necessarily need to have all the care team members on staff or embedded in the practice—providers of various specialties may virtually participate in care teams from other settings. The Department envisions that most CMAs and AMH+ practices will be existing provider organizations in North Carolina that already carry out functions...

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26 42 CFR 438.208 – Coordination and continuity of care.
similar to the new Tailored Care Management model. The Department plans to launch the CMA/AMH+ requirements and certification process well in advance of the BH I/DD Tailored Plan launch, to allow ramp-up time for the providers and agencies to align with all required aspects of the model prior to launch. At the conclusion of the certification process, BH I/DD Tailored Plans will be required to contract with all Tier 3 AMH+ practices and certified CMAs to provide Tailored Care Management to their beneficiaries.

- **Role for Clinically Integrated Networks/Other Partners.** Tier 3 AMH practices contracting with Standard Plans must meet a set of standards that describe a range of care management capabilities. Tier 3 AMH practices may—but are not required to—work with “Clinically Integrated Networks (CINs) or other partners” to perform data management and/or advanced care management on their behalf. A “CIN or other partner” may be a hospital, health system, integrated delivery network, or Independent Practice Association (IPA); another provider-based network or association; or a technology vendor. Most practices attesting for entry into AMH Tier 3 under Standard Plans indicated that they would be working with a CIN or another partner to meet the requirements of the model. Similar to AMH certification under Standard Plans, the Department is anticipating allowing—but not requiring—CMAs and AMH+ practices to work with a CIN or another partner to assist with the requirements of the Tailored Care Management model, as long as any care management organized at the CIN level is fully integrated with the care team (i.e., with care managers embedded at the practice level and with the care team) and in full communication with external providers as specified in the Department’s requirements.

- **Capacity-building funding.** The Department recognizes that there is a gap between today’s delivery system and the integrated care management model it envisions for the BH I/DD Tailored Plan population, and that it will take several years to implement the glide path. In its 1115 waiver application submitted to CMS in November 2017, the Department requested capacity-building funding in order to develop the Tailored Care Management delivery system. At the time of publication, the Department remains in discussions with CMS. To the extent that capacity-building funding is approved, the Department will design a distribution methodology that allows funding to be used for training and onboarding of new care management staff and for strengthening health information technology used for care management, particularly at the CMA/AMH+ level.

**Care Management Process Flow**

The Department, BH I/DD Tailored Plans, and AMH+ practices and CMAs will work together to ensure that every BH I/DD Tailored Plan beneficiary has access to care management. The care management process is outlined below and displayed in Figure 4.

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27 More detail on the role of CINs/other partners is contained in a [February 2019 policy paper](#) on this topic. The Department anticipates releasing additional guidance on the role of CINs and other partners for BH I/DD Tailored Plans as part of provider-facing information closer to the launch of the provider certification process.
1. **"Opt-Out" Enrollment and Care Management Assignment.** At BH I/DD Tailored Plan launch, the Department will auto-enroll eligible individuals into the BH I/DD Tailored Plan in their region. With enrollment into the BH I/DD Tailored Plan, a beneficiary will be auto-enrolled into care management if he/she is not enrolled in a service or program that is duplicative of the Tailored Care Management model.

**FIGURE 4. TAILORED CARE MANAGEMENT PROCESS FLOW**

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Care Management Assignment</th>
<th>Engagement into Care Management</th>
<th>Care Management Comprehensive Assessment</th>
<th>Care Team Formation and Person-Centered Care Planning</th>
<th>Ongoing Care Management</th>
</tr>
</thead>
</table>

If a beneficiary opts out of Tailored Care Management, BH I/DD Tailored Plans will still be required to provide the minimum level of care coordination set by federal requirements, funded through the capitation rate. If a beneficiary enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, he/she will still be entitled to waiver services, and the BH I/DD Tailored Plan must provide care coordination for HCBS in compliance with the waivers.

If a beneficiary does not opt out, the BH I/DD Tailored Plan will be responsible for assigning the beneficiary to an AMH+, to a CMA, or to the plan itself for care management. The assignment process will seek to uphold beneficiary choice and preserve the beneficiary’s established relationships wherever possible, including with any provider or primary care practice that has become certified as a CMA or AMH+. The assigned AMH+, CMA or BH I/DD Tailored Plan will, in turn, be responsible for assigning a specific care manager to the beneficiary. All beneficiaries will have the option of switching care managers at any time, either within the same organization or across CMAs/AMH+ practices within the BH I/DD Tailored Plan network. Recognizing that Innovations and TBI waiver beneficiaries may have close relationships with their current care coordinators, Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinator if the care coordinator meets all the Health Home care manager requirements to serve BH I/DD Tailored Plan beneficiaries.

2. **Engagement into Care Management.** BH I/DD Tailored Plans will be required to share with each AMH+ or CMA a roster of assigned beneficiaries and their current demographic information to facilitate outreach and engagement in care management. The assigned AMH+, CMA or BH I/DD Tailored Plan will be responsible for engaging the individual in care management services and for documenting his/her consent. The Department recognizes that some beneficiaries may never engage in care management or may formally opt out, but AMH+ practices, CMAs and BH I/DD Tailored Plans will be required to attempt to engage all assigned beneficiaries.

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28 42 CFR § 438.208, “Coordination and Continuity of Care.” Note that the requirements for “care coordination” in the BH I/DD Tailored Plan contract will meet federal requirements but will not align exactly with today’s LME-MCO care coordination model.

29 While it is possible that a beneficiary would be assigned to a CMA or AMH+ at which the beneficiary is not currently receiving services, guidance for the assignment process will prioritize aligning with current provider relationships, wherever possible and subject to conflict considerations (discussed below).

30 Care managers for beneficiaries enrolled in the Innovations or TBI waiver must meet federal requirements for conflict-free case management.
3. **Care Management Comprehensive Assessment.** The care management comprehensive assessment will be a required, comprehensive, in-person evaluation of BH I/DD Tailored Plan beneficiaries’ physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. The care manager will conduct the care management comprehensive assessment and will use information obtained as the basis for each beneficiary’s care plan or Individual Support Plan (ISP). Since many BH I/DD Tailored Plan beneficiaries will have complex needs, this process will pull together current and historical information provided by the beneficiary, as well as information received from available healthcare records and historical LME-MCO records, input received through consultation with other healthcare providers and social supports, and other clinical assessments or level of care determination tools, as appropriate. The care management comprehensive assessment will incorporate the Department’s standardized screening questions to identify health-related resource needs across the Department’s four Healthy Opportunity domains—food insecurity, housing instability, transportation needs and interpersonal violence/toxic stress.\(^{31}\) Reassessment will be required at least annually, upon beneficiary request, after changes in scores on level of care determination tools, after care transitions, after joining the Innovations/TBI waiver waiting list, and/or after a significant change in health or functional status.

4. **Care Team Formation and Person-Centered Care Planning.** Consistent with federal requirements, BH I/DD Tailored Plan beneficiaries (and their authorized representative, to the extent applicable) will play a role in the development of their own care plans or ISPs through a person-centered planning process within a care team.\(^{32}\) The care manager will be responsible for bringing together the appropriate group, which, in addition to the beneficiary, should generally include key primary care, behavioral health, I/DD, and/or specialist providers as well as peer supports and support members.\(^{33,34}\) The care manager will lead the development of the care plan or ISP (for individuals with an I/DD or TBI, including those enrolled in the Innovations or TBI waiver) in collaboration with the beneficiary, the multidisciplinary care team, and individuals identified by the beneficiary to contribute to the planning process.\(^{35}\) The care plan/ISP will be required to reflect the beneficiary’s strengths, needs, and goals, and the types and frequency of all needed services, including those addressing unmet health-related resource needs, as well as the person responsible for providing each service and any areas that may require further follow-up or revisions to the plan. For beneficiaries enrolled in the Innovations or TBI waiver, the ISP will document the beneficiary’s approved waiver services.

5. **Ongoing Care Management.** As noted above, all BH I/DD Tailored Plan beneficiaries actively engaged in care management will have a designated care manager who, along with the other care team members, will be responsible for integrating behavioral and physical healthcare and, where applicable, I/DD or TBI-related supports, by providing linkages to and coordinating their services. The Department strongly believes that for Tailored Care Management to be successful, care managers must formalize and activate relationships across the traditional physical/behavioral health divide and between the traditional healthcare system and community and social services. Therefore, the Department will place requirements on care management activities that are more specific than those under Standard Plans, including (but not necessarily limited to) those outlined below. As market experience with the

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\(^{31}\) See the Department’s [Updated Standardized Screening Questions for Health-Related Resource Needs](https).

\(^{32}\) 42 CFR § 441.275(b)—Person-Centered Service Plan.

\(^{33}\) “Support members” means family, informal and formal caregivers.

\(^{34}\) BH I/DD Tailored Plans will be required to ensure that the multidisciplinary care team includes peer supports for beneficiaries with behavioral health disorders, if desired by the beneficiary; this requirement will not apply for beneficiaries with I/DDs or TBIs.

\(^{35}\) Centers for Medicare & Medicaid Services, [Consolidated Implementation Guide: Medicaid State Plan – Health Homes](https).
model grows, the Department may transition away from process requirements to increase the focus on outcomes to the extent allowed by federal Health Home requirements.

- **Case conference requirements.** Care managers (whether based at the AMH+, CMA or BH I/DD Tailored Plan level) will be required to conduct regular case conferences with the full care team, spanning physical and behavioral health, I/DD and TBI supports, and pharmacy, where applicable. Since regular, on-the-ground communication across settings is essential to the success of the model, the Department will require all organizations performing care management to have information technology and policies and procedures in place to support such regular communication and information sharing.

- **Contact requirements.** Given the importance of trusted, high-quality relationships in care management, the Department will establish minimum levels of contact between care managers and beneficiaries engaged in the model, including contact that is provided face-to-face within the practice setting, the home or another community setting. The Department plans to establish a standardized methodology based on claims history for determining the acuity of each beneficiary, which will be used to guide both these minimum contact requirements and minimum dollar amounts for care management fees as set out below (“Care Management Payments”).

<table>
<thead>
<tr>
<th>Beneficiaries with Behavioral Health Disorders</th>
<th>High Acuity</th>
<th>Moderate Acuity</th>
<th>Low Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 4 contacts per month; at least 1 of these in-person with beneficiary</td>
<td>At least 3 contacts per month; 1 in-person beneficiary contact quarterly (includes care management comprehensive assessment)</td>
<td>At least 2 contacts per month and 2 in-person beneficiary contacts per year (includes care management comprehensive assessment)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiaries with I/DDs or TBIs</th>
<th>High Acuity</th>
<th>Moderate Acuity</th>
<th>Low Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 2 in-person beneficiary contacts per month; 1 telephonic contact per month or as needed</td>
<td>At least 3 contacts per month; 1 in-person beneficiary contact quarterly (includes care management comprehensive assessment)</td>
<td>At least 2 in-person beneficiary contacts per year (including care management comprehensive assessment) and 1 telephonic contact per month</td>
<td></td>
</tr>
</tbody>
</table>

- **Care transition requirements.** When a beneficiary transitions from one setting to another, such as from the hospital back to the community, care managers will be required to provide transitional care management to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. Specifically, care managers will be required to create and implement a 90-day transition plan (as an amendment to the care plan/ISP), in consultation with the beneficiary, relevant facility staff, and the beneficiary’s providers and social supports, that outlines how the beneficiary will access needed services and supports, transition to the new setting, and integrate into his/her community. Transitional care management will also be

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36 Innovations/TBI waiver beneficiaries will be placed in the highest tier of care management upon waiver enrollment. They will be reassessed after six months to determine whether they should remain in the high-acuity tier. Prior to BH I/DD Tailored Plan launch, BH I/DD Tailored Plans should determine the frequency of service monitoring visits that each Innovations/TBI waiver beneficiary is required to receive from his or her care coordinator under the waiver and place the beneficiary in the appropriate acuity tier to ensure that he or she does not have fewer care manager contacts at the launch of BH I/DD Tailored Plans. In addition, this process will ensure that organizations providing care management can receive appropriate reimbursement for the number of contacts required by the waiver.
required for “life transitions,” such as when a beneficiary is transitioning from school to adult services or when a beneficiary experiences the loss of, or a change in, his/her primary caregiver.

- **Requirements to address unmet health-related resource needs.** Throughout the Tailored Care Management model, service providers and care managers will be required to address both the medical and nonmedical drivers of beneficiaries’ health. In light of the needs of the BH I/DD Tailored Plan population, the Department will place additional (as compared to the care management requirements under Standard Plans) requirements concerning unmet health-related resource needs for Tailored Care Management. Specific activities that will be required include in-person assistance with securing health-related services (e.g., assistance with filling out and submitting applications to programs such as Food and Nutrition Services, Temporary Assistance for Needy Families and ABLEnow Accounts). Care managers will also be required to assist with referral to, information about, and obtaining and maintaining community-based resources and social support services (e.g., housing, transportation and employment services).

In addition to the care management features described above, the Department is developing specialized care management features for other populations, including beneficiaries with LTSS needs and individuals involved in the criminal justice system, among others. The Department is also considering implementing the High-Fidelity Wraparound model as the Tailored Care Management model for children with serious emotional disturbance who meet Department-established eligibility criteria for the High-Fidelity Wraparound program.

**Care Manager Qualifications and Training**

In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will require that care managers serving this population possess the minimum qualifications outlined in Table 2. Current LME-MCO care coordinators may become BH I/DD Tailored Plan care managers if the care coordinator meets the education and experience requirements to serve as a BH I/DD Tailored Plan care manager and obtains all required training. The Department will require that all care managers be overseen by supervisors with additional experience to ensure that care managers receive the support they need to address beneficiaries’ complex health and social needs. In addition to the members of the multidisciplinary care team, the organization providing care management under the model (whether an AMH+, a CMA or the BH I/DD Tailored Plan itself) will be required to ensure that care managers and supervisors have access to clinical consultants—behavioral neurologists, adult or child psychiatrists, and primary care providers—to advise on complex clinical issues as they arise.

The Department will set the required training domains for care managers and care manager supervisors, while BH I/DD Tailored Plans will be responsible for developing and implementing training curricula that meet the Department’s requirements. Potential BH I/DD Tailored Plans will be required to include training plans as part of the care management approach described in their request for application (RFA) responses during the Department’s procurement phase. Training domains will include (but will not be limited to) integrated care management, trauma-informed care, addressing unmet health-related resource needs, and person-centered

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37 When the Healthy Opportunities Pilots launch, some BH I/DD Tailored Plan beneficiaries also will be eligible for additional Pilot services, which will be integrated into the portfolio of services coordinated by care managers. See the Department’s [Healthy Opportunities Pilots Fact Sheet](#), November 14, 2018.

38 The Tailored Care Management model requirements for beneficiaries with LTSS needs will align with those for Standard Plans to the maximum extent possible. For additional detail, see [North Carolina’s Vision for Long-term Services and Supports under Managed Care](#).

39 The minimum qualifications for Health Home care managers and supervisors are distinct from and intentionally higher than the requirements for “Qualified Providers” outlined in 10 A NCAC 27G.0104.

40 Consultants may be contracted or employed by the organization.
planning. Additionally, training will encompass domains specific to the BH I/DD Tailored Plan beneficiaries, such as 1915(c) waiver eligibility criteria, HCBS, physical comorbidities relevant to people with behavioral health disorders and/or I/DD, and local supportive housing and supported employment programs. The trainings will also place strong emphasis on strategies to support community integration and diversion from institutional settings.\(^{41}\)

**TABLE 2. MINIMUM CARE MANAGER AND SUPERVISING CARE MANAGER QUALIFICATIONS**

<table>
<thead>
<tr>
<th>Position</th>
<th>Minimum Qualifications</th>
</tr>
</thead>
</table>
| Care managers serving all beneficiaries | Bachelor’s degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area  
Two years of experience working directly with individuals with behavioral health conditions (if serving beneficiaries with behavioral health needs) or with I/DD or TBI (if serving beneficiaries with I/DD or TBI needs)  
(Best practice, but not required) For care managers serving beneficiaries using LTSS: two years of prior LTSS and/or HCBS coordination; care delivery monitoring and care management experience; and background in social work, geriatrics, gerontology, pediatrics or human services |
| Supervising care managers serving beneficiaries with behavioral health disorders | A licensed master’s-level clinical qualification, such as a Licensed Clinical Social Worker (LCSW), a Licensed Professional Counselor (LPC) or a licensed nurse with a Bachelor of Science in Nursing (BSN)  
Three years of supervisory experience working directly with complex individuals with a behavioral health condition |
| Supervising care managers serving beneficiaries with I/DD or TBI | Bachelor’s degree in a human services field  
Five years of applicable I/DD experience as a care coordinator or care/case manager, or an equivalent combination of education and experience |

**Conflict-free Care Management**

The Department plans to give individuals enrolled in the 1915(c) Innovations and TBI waivers, in the same way as other BH I/DD Tailored Plan beneficiaries, a choice of provider- or plan-based care management. In cases where a waiver enrollee is receiving provider-based care management, the AMH+ or CMA must comply with all federal requirements for conflict-free case management for 1915(c) waiver enrollees, which call for the separation of case management and care plan development from waiver service delivery functions.\(^{42}\) Thus, a waiver enrollee cannot obtain both waiver services and care management from employees of the same CMA. However, for example, a CMA could embed care managers of an independent CIN within its practice to provide care management to enrollees receiving waiver services from the CMA.

Additionally, the Department is devising oversight measures that BH I/DD Tailored Plans will need to exercise to protect against provider conflicts of interest in relation to all beneficiaries, whether or not they are waiver enrollees. As part of their utilization management process, BH I/DD Tailored Plans will be required to review the utilization patterns of all enrollees receiving care management (whether from BH I/DD Tailored Plans, AMH+ practices or CMAs). The utilization review will look for utilization patterns that may suggest that care managers have steered beneficiaries in a way that favors particular providers, favors more costly interventions over more cost-effective ones, or results in under- or overutilization of services. As part of their standard utilization management responsibilities, BH I/DD Tailored Plans will assess whether beneficiaries are receiving the appropriate level of care corresponding to their clinical information. Additionally, BH I/DD Tailored Plans

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\(^{41}\) For Standard Plan care manager training requirements, see the care management section of the North Carolina Request for Proposal for Medicaid Managed Care Prepaid Health Plan (Section V – Scope of Services, August 9, 2018).

\(^{42}\) 42 CFR §431.301(c)(1)(vi) – Conflict-Free Case Management.
will be held ultimately responsible for ensuring that no care managers serving BH I/DD Tailored Plan beneficiaries (whether employed by BH I/DD Tailored Plans, AMH+ practices or CMAs) are related by blood or marriage to any of their enrollees, are financially responsible for any of their enrollees, or have any legal power to make financial or health-related decisions for any of their enrollees. In instances where BH I/DD Tailored Plans provide care management directly to beneficiaries, the BH I/DD Tailored Plan will be required to create separate departments for and firewalls between utilization management and care management, overseen by separate clinical leadership. The Department will conduct oversight of these firewalls to monitor for potential conflicts.

**Approach for Avoiding Duplication of Care Management**

CMS guidance stipulates that states must ensure that one beneficiary does not receive duplicative care management from multiple sources, such as a managed care plan or case management provided through a waiver or service. Many of North Carolina’s enhanced behavioral health services that will be available to BH I/DD Tailored Plan beneficiaries currently include case management in their service definitions. The Department will release further guidance on the interface of Tailored Care Management with these services and how BH I/DD Tailored Plans should avoid duplication of services and payments. BH I/DD Tailored Plans will bear ultimate responsibility for ensuring that there is no duplication of care management services and payments.

The Department is considering the following policies:

- Recognizing that among the enhanced behavioral health services, assertive community treatment (ACT) and multi-systemic therapy (MST) provide more robust case management and are held to fidelity standards, the Department’s approach to these services may differ from the approach to other enhanced behavioral health services with case management. The Department would welcome feedback on whether ACT and MST should be incorporated into the Tailored Care Management model.

- Beneficiaries residing in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) will continue to obtain case management as they do today and will not obtain Tailored Care Management; however, Health Home care managers will provide transitional care management to BH I/DD Tailored Plan beneficiaries in ICF/IIDs if they are being discharged and transitioning to community-based settings.

**Approach to Local Health Department Programs**

Currently, North Carolina provides care management for women experiencing high-risk pregnancies and at-risk children ages 0–5 through programs run by local health departments (LHDs)—the Pregnancy Medical Home (PMH)/Obstetric Care Management (OBCM) programs and the Care Coordination for Children (CC4C) program. In the managed care environment, the PMH/OBCM and CC4C programs will be known as Care Management for High-Risk Pregnant Women (CMHRP) and Care Management for At-Risk Children (CMARC), respectively. For a three-year transitional period (November 2019–July 2022), Standard Plans will be required to extend to LHDs the “right of first refusal” as contracted providers of CMHRP and CMARC.

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44 The PMH/OBCM program consists of education, support, linkages to community and health-related resources, and services for and management of high-risk conditions that may have an impact on birth outcomes. CC4C provides coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports to children ages 0–5 who have experienced adverse life events (including, but not limited to, parental substance abuse or neonatal exposure to substances).
There is one year of overlap between this transition period and the BH I/DD Tailored Plan launch (July 2021–June 2022). Accordingly, the Department has developed BH I/DD Tailored Plan requirements specific to both programs to ensure that BH I/DD Tailored Plan beneficiaries participating in these programs receive whole-person care management and do not experience disruption to the continuity of their care. The Department will require BH I/DD Tailored Plans to extend LHDs “right of first refusal” as contracted providers of care management for high-risk pregnant women for the first BH I/DD Tailored Plan contract year (July 2021–June 2022). LHDs that accept the contract will continue to provide care management to address BH I/DD Tailored Plan beneficiaries’ pregnancy-related needs. Additionally, BH I/DD Tailored Plan beneficiaries participating in care management for high-risk pregnant women will be eligible for a second care manager (employed by an AMH+, a CMA or the BH I/DD Tailored Plan, in limited circumstances) who will address needs not addressed by the LHD. BH I/DD Tailored Plans must ensure that AMH+ and CMA care managers coordinate with LHD care managers to address all of their beneficiaries’ needs, share pertinent information and make sure services are not duplicated.

BH I/DD Tailored Plan-eligible children ages 0–5 who are already enrolled in CMARC at the time of the BH I/DD Tailored Plan launch will continue to receive CMARC through the CMARC transition period. However, children who meet eligibility criteria for CMARC after the BH I/DD Tailored Plan launch will receive similar care management through the new Tailored Care Management model described in this paper.

Payment for Care Management

Care Management Payments

The Department is developing requirements governing care management payments to BH I/DD Tailored Plans, as well as downstream payments from BH I/DD Tailored Plans to AMH+ practices, and CMAs. Unlike care management payments under Standard Plans, Tailored Care Management payments will be:

- Paid to BH I/DD Tailored Plans on a PMPM basis separate from the managed care capitation rate
- Subject to set minimum rates, tiered by beneficiary acuity (i.e., the state will set the minimum dollar amount of each per-member per-month payment that an AMH+ or CMA will receive)\(^{45}\)
- In general, paid at significantly higher rates than for Standard Plan care management
- Paid only for beneficiaries who are “actively engaged” in care management

The Department will set care management rates that will vary according to the acuity tier of each beneficiary and his/her needs. The BH I/DD Tailored Plan will be responsible for billing the Department for care management payments each month. In turn, AMH+ practices and CMAs will bill BH I/DD Tailored Plans monthly, demonstrating that they have delivered at least one of the Health Home core services in that month and attesting that they have adhered to the minimum contact requirements associated with a beneficiary’s acuity tier. The Department will reserve the right to audit care plans and other records at any time.

Engagement Payments

Tailored Care Management will be available to all BH I/DD Tailored Plan beneficiaries, unless they are already receiving intensive care coordination or case management services through other programs or services. However, not all beneficiaries who enroll in Tailored Care Management will necessarily respond to their

\(^{45}\) Under Standard Plans, care management fee rates paid to Tier 3 practices are negotiated, with no fixed minimum rate.
assigned care manager and engage in care management. Recognizing the potential difficulty in engaging individuals in services, the Department intends to permit BH I/DD Tailored Plans to submit claims for “engagement payments” to fund outreach to beneficiaries, and is developing the parameters for what activities will be covered by such payments. The Department will establish limits on the number of times that engagement payments may be billed for an individual beneficiary. As with care management payments, AMH+ practices and CMAs will be responsible for submitting claims to BH I/DD Tailored Plans for months in which they have attempted to engage a beneficiary.

**Link to Value Based Payment**

In all aspects of the Medicaid Transformation, the Department is committed to paying for outcomes, focusing on increasingly tying provider payments to measures related to value, while giving plans flexibility to contract creatively with different providers based on their capacity to take on risk. Further details of the Department’s Value Based Payment strategy are forthcoming and will include the role of BH I/DD Tailored Plans.

**Accountability and Quality**

The Department will establish a common set of quality measures as a key mechanism to ensure BH I/DD Tailored Plan accountability to the Department. All quality measures for BH I/DD Tailored Plans will align with and build on the Department’s Quality Strategy, which will be updated to include BH I/DD Tailored Plans and which primarily emphasizes outcomes for beneficiaries over process measures. BH I/DD Tailored Plans will be required to report robust and dedicated measures that prioritize person-centeredness and personalization of goals, as well as management of a wide range of comorbidities. Outcomes such as beneficiary choice, independent living, employment and community participation will be considered alongside clinical quality measures. These outcomes may be measured through the use of beneficiary surveys, or by linking Medicaid data to data from other state agencies. Although the Department aims to align with Standard Plan quality measures when possible, the Department also recognizes the need to differentiate and prioritize alternative measures for the BH I/DD Tailored Plans to reflect the needs and experiences of beneficiaries. As for Standard Plans, the Department will introduce financial incentives at the BH I/DD Tailored Plan level over time, tied to performance on these population-based quality measures.

In addition to the quality measures developed by the Department, BH I/DD Tailored Plans will be required to report to the Department all federal Health Home quality measures (Table 3). The Department will submit these measures annually to CMS for all beneficiaries in the Health Home program (i.e., all beneficiaries actively engaged in Tailored Care Management in the state).

The Department will conduct oversight of BH I/DD Tailored Plans in a fashion similar to Standard Plan monitoring and oversight. While it is the BH I/DD Tailored Plans that will have primary accountability to the Department for the requirements of the Tailored Care Management model, the Department will initially play a direct role in provider accountability through the certification process for CMAs and AMH+ practices described above. After the Department’s initial certification of AMH+ practices and CMAs, BH I/DD Tailored Plans will be primarily responsible for conducting monitoring and oversight on an ongoing basis to ensure AMH+ practices and CMAs meet specific requirements, such as care manager qualifications and contact requirements. BH I/DD

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Tailored Plans will be required to include their policies and procedures for oversight of AMH+ practices and CMAs within their care management plans submitted for the Department’s approval as part of BH I/DD Tailored Plan procurement. When necessary, BH I/DD Tailored Plans will be expected to report and/or terminate underperforming AMH+ practices and CMAs.

**TABLE 3. FEDERAL HEALTH HOME QUALITY MEASURES**

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Measure Description</th>
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</thead>
<tbody>
<tr>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>Percentage of members ages 18–74 who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year</td>
</tr>
<tr>
<td>Prevention Quality Indicator (PQI) 92: Chronic Condition Composite</td>
<td>The total number of hospital admissions for chronic conditions per 100,000 Health Home beneficiaries age 18 and older</td>
</tr>
<tr>
<td>Care Transition – Transition Record Transmitted to Health Care Professional</td>
<td>Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, for whom a transition record was transmitted to the facility, primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness</td>
<td>Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge</td>
</tr>
<tr>
<td>Plan All-Cause Readmission Rate</td>
<td>For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by both an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>Percentage of patients age 18 and older screened for clinical depression using a standardized tool and follow-up documented</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment</td>
<td>Percentage of adolescent and adult members with a new episode of AOD dependence who received the following: Initiation of AOD treatment, Engagement of AOD treatment</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>The percentage of patients ages 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90) during the measurement year</td>
</tr>
</tbody>
</table>

**Data and Health Information Technology (HIT)**

The efficient exchange of timely and actionable beneficiary health information will be critical to Tailored Care Management. BH I/DD Tailored Plans, AMH+ practices and CMAs, as well as physical health, behavioral health and I/DD providers, will be expected to regularly collect, use and share data in support of an integrated and coordinated approach to patient care, using the data to manage population health, respond to individual beneficiary needs, track referrals and follow-ups, monitor medication adherence, and respond to unmet health-related resource needs.

In accordance with federal Health Home requirements, BH I/DD Tailored Plans will be expected to ensure that AMH+ practices and CMAs maintain systems and processes that allow for interdisciplinary care team communication and care coordination. Systems should also be capable of documenting and storing beneficiary care plans/ISPs, and providing role-limited “views” of plans for the beneficiary and members of his/her care team. BH I/DD Tailored Plans, AMH+ practices and CMAs will also be expected to facilitate “warm handoffs” of
beneficiaries between plans, care managers and care settings, as needed, ensuring the beneficiary care team members have access to timely and complete beneficiary clinical information. BH I/DD Tailored Plans will play a supporting role in transitional care management by contracting with institutions in their provider networks (hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers) to establish policies and procedures to facilitate beneficiary transitions (e.g., notifications of beneficiary admission/discharge and other information sharing). Additionally, BH I/DD Tailored Plans, AMH+ practices and CMAs will be expected to interface with NCCARE360 (the new statewide coordinated care network to facilitate connection of individuals with identified needs to community resources) on similar timelines as those being set for Standard Plans and other providers. The details of the HIT expectations at the level of each CMA and AMH+ will be forthcoming as part of the rollout of the certification process.

To support care manager data use, BH I/DD Tailored Plans will be expected to share information with AMH+ practices and CMAs including, but not limited to, care management assignment rosters, beneficiary summary information (e.g., demographics, enrollment history, care manager history, medication summaries), risk stratification results, and historical claims and encounter data. The Department will work with BH I/DD Tailored Plans, AMH+ practices and CMAs after contracts are awarded to develop consensus around specific data formats, content, triggers and transmission methods for these critical data exchanges.

IV. Next Steps

The Department is eager to continue engaging with stakeholders as it refines its Tailored Care Management model and begins operational planning. The Department expects that providers, potential BH I/DD Tailored Plans, potential AMH+ practices and CMAs, beneficiaries, and advocacy groups will play important roles in this planning process to promote a smooth rollout of Tailored Care Management. Later this year, the Department will develop and publish the process by which potential AMH+ practices and CMAs will apply for and obtain certification to provide care management to the BH I/DD Tailored Plan population. This work will include developing an application for an organization to serve as an AMH+ or as a CMA and determining how the Department will evaluate whether a potential AMH+ or CMA is prepared to provide care management to the BH I/DD Tailored Plan population. Future planning will also include work around care management for populations obtaining state-funded services and the distribution of available capacity-building funds.

Comments may be submitted to Medicaid_Transformation@dhhs.nc.gov. Input received by June 28, 2019, will be used by the Department as it develops the Request for Applications.
**CFAC MEETING - REGULAR MEETING**

5200 W. Paramount Parkway, Morrisville, NC 27560
5:30 – 7:00 p.m.

**MEMBERS PRESENT:** Jason Phipps, Tekeyon Lloyd, Renee Lloyd, Dan Shaw, Tammy Shaw, Carson Lloyd, Dave Curro, Brianna Harris, Sharon Harris, Carole Johnson, Shirley Francis, Faye Griffin, Pinkey Dunston

**BOARD MEMBERS PRESENT:** None

**GUEST(S):** None

**STAFF PRESENT:** Doug Wright, Director of Individual and Family Affairs, Star Davis, Stacy Guse, Noah Swabe, Ramona Branch

1. **WELCOME AND INTRODUCTIONS**

2. **REVIEW OF THE MINUTES** – The minutes from the June 3, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dan Shaw and seconded by Tekeyon Lloyd to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>3. Public Comment Individual/Family Challenges and Solutions</td>
<td>Doug made the announcement that letters to individuals transitioning to Standard plans have been delayed due to legislation that was introduced that could delay the start of the move to managed care until March of 2020. The state continues to move forward in all other aspects to a November 1 go live date but did not want to confuse beneficiaries with a letter that may change.</td>
<td>Wait for legislative action or inaction and announcement from the Department of Health and Human Services.</td>
<td>Unknown</td>
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<tr>
<td>4. Tailored Plans</td>
<td>Tailored Plan Regions – expectations/announcement – DHHS has decided to accept the recommendation of the County Commissioner’s Association to leave the LME/MCO regions as they stand. Any counties that decide they would like to change will be dealt with on a one by one basis. Maximus Presentation from SCFAC meeting – Doug reviewed the presentation given to the SCFAC about Maximus (enrollment broker) for Medicaid. Explained that their primary role is to do choice counseling with members so they can decide which health plan is best for them. They will also assist when members want to change plans but that will remain a DHHS decision. Good information for members to be aware of and share with their contacts about what to expect.</td>
<td>N/A</td>
<td>N/A</td>
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<td>5. LME/MCO Updates</td>
<td>UM Adverse Decision Letters Project Charter – This charter was presented to CFAC for their feedback. Members felt it was straightforward and are very interested in hearing about the results from interventions taken. By the numbers – reviewed the monthly LME-MCO Administrative Functions Monitoring Report. Discussed highlighted areas and any actions taken so far. Raise your hand form- presented by Sara and Brian (update) – discussed the feedback that was presented to the state from CFAC and other stakeholders and that the state had taken the action of reviewing and redoing the form to</td>
<td>Receive follow up information when available.</td>
<td>TBD</td>
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</table>

*Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.*
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<thead>
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<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
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<tbody>
<tr>
<td>make the process simpler for members. Waiting for the new form to come out for review.</td>
<td>Budget – approved Reviewed the budget presentation and packet from the board meeting. The budget was approved, it was noted that changes would occur throughout the year, one time in particular would be when standard plans go live and there is a significant population shift.</td>
<td>N/A</td>
<td></td>
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<tr>
<td>6. Elections</td>
<td>Dave Curro – chair, Jason Phipps – Vice-Chair, Michael McGuire – Treasurer/Secretary – results announced</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7. State Updates</td>
<td>CJ and Ken are leaving the division</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>8. Subcommittees</td>
<td>Members gave brief updates on their community meetings.</td>
<td>N/A</td>
<td>N/A</td>
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<td>• Wake</td>
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<td>• Area Board</td>
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<td>• Human Rights</td>
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<td>• Quality Management</td>
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<tr>
<td>9. Announcements</td>
<td>None</td>
<td></td>
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</table>

10. ADJOURNMENT: the next meeting will be August 5, 2019, at 5:30 p.m.

Respectfully Submitted by:

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
**TEAM/PROJECT CHARTER**

**Project Name:** UM Adverse Decision Letters  
**Date (Last Revision):** 5/15/2019  
**Prepared By:** Shruti Mehta, MA, CSSGB (smehta@alliancehealthplan.org)  
**Approved By:** QMC and Project Team

### Rationale for Project:
Timeliness of adverse decision notification to members is a monitoring requirement for the UM dept (Proc# 7515 Training, Supervision and Monitoring of UM Care Managers). As per procedure, QM is required to review a 10% sample of adverse decisions to ensure correct member notification letter was sent within required timeframes (i.e. within 1 business day of decision date). When the review was conducted, other errors were detected. Thus, QM is proposing a QIP to reduce these errors.

### Opportunity Statement:
Baseline findings indicate that 83% of the overall quality elements were met (492 out of 592). The quality element for timeliness standards was met at 86% (i.e. notification letters were mailed out within 1 business day of the service decision). Closer analysis indicated 54% of the letters reviewed had at least one error, resulting in 46% meeting full quality. Full quality is defined as meeting all eight quality elements. Specific elements where we saw lower quality include: Correct service request dates = 74% met  
Correct decision date = 65% met  
Verified mailing address = 84% met  
There are opportunities to increase the percentage of letters meeting full quality.

### Focused Goal Statement:
Improve the quality of UM decision documentation as evidenced by an increase in the % of letters meeting full quality.

### Project Scope:
- **Process Start Point:** Date of service request decisions (decision date).  
- **Process End Point:** USPS mailing date.

### In Scope:
- Only the following SAR status/dispositions: clinical denials, partial denials, and admin denials would be included in project.

### Out of Scope:
- All other SAR status/dispositions.

### Key Performance Indicators | Baseline | Goal
--- | --- | ---
Increase % of adverse letters meeting full quality to 85% | 46% | 85%

### Targeted Intervention(s)
1. Daily MSTRGY subscriptions in excel format for service denial reports.  
2. Re-align business process with staff workflow for daily mailing process.  
3. Develop monitoring system to error-proof process.  
4. Refine mail program utility (Dazzle program feasibility).

### Data Sources (reliability & validity):
MicroStrategy Report #0650 SAR Decision Date Report and record review within AlphaMCS for SAR documentation.

### Potential Barriers to Success:
- Staff turnover, staff reduction, change in focus by leadership.
Data Analysis Plan:
Pull all adverse decisions for specific reporting period from Microstrategy Report 0650 and validate all the quality elements on the letter using PDF uploads within member record in AlphaMCA. Check elements against standard quality review tool.

Stakeholders/Potential Partners:
Administrative staff, Quality Management, Utilization Management, Compliance.

<table>
<thead>
<tr>
<th>Task/Phase</th>
<th>Start Date</th>
<th>End Date</th>
<th>Actual End</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement interventions 1, 2, 3</td>
<td>May-19</td>
<td>Dec-19</td>
<td>Actual</td>
<td>Shruti Mehta</td>
</tr>
<tr>
<td>Research intervention 4</td>
<td>Jun-19</td>
<td>Dec-19</td>
<td></td>
<td>April Parker</td>
</tr>
<tr>
<td>Post intervention measurement</td>
<td>May-19</td>
<td>Jun-20</td>
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<td>Robert Bell</td>
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<td>Cristina Windley</td>
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<td></td>
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<td></td>
<td>Sherry Perkins</td>
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<th>Name:</th>
<th>Signature</th>
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<tbody>
<tr>
<td>Shruti Mehta</td>
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<td>April Parker</td>
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<tr>
<td>Robert Bell</td>
<td></td>
</tr>
<tr>
<td>Cristina Windley</td>
<td></td>
</tr>
<tr>
<td>Sherry Perkins</td>
<td></td>
</tr>
</tbody>
</table>
ITEM: Finance Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Board Meeting. This month’s report includes the draft minutes from the June 6, 2019, meeting, the Summary of Savings/(Loss) by Funding Source, The Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending May 31, 2019. And recommendations to the Board to approve all presented contracts.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): David Hancock, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
AGENDA

1. Review of the Minutes – June 6, 2019

2. Monthly Financial Reports as of May 31, 2019
   a. Summary of Savings/(Loss) by Funding Source
   b. Statement of Revenue and Expenses (Budget & Actual)
   c. Senate Bill 208 Ratios
   d. DMA Contractual Ratios

3. 6/30/19 Close Update

4. Approval of Contract(s)

5. Adjournment
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the May 2, 2019, meeting were reviewed; a motion was made by Chair Cynthia Binanay and seconded by Mr. Gino Pazzaglini to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 3. Monthly Financial Reports | The monthly financial reports were discussed which includes the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of April 30, 2019. Ms. Sara Pacholke discussed the monthly reports.  
- As of 4/30/19, we have a loss of $23M and need $19.3M from fund balance to offset legislative reductions. The loss will continue to grow during FY19 due to legislative cuts.  
- As of 6/30/19, Alliance is projecting a loss of $32.4M with $31.5 previously committed by the Board to cover legislative reductions, the required intergovernmental transfer, and reinvestment into the community.  
a) We are meeting all SB208 and DMA contract ratios. | Take the motions to the Board for approval. | 6/6/19 Meeting |
| 4. Approval of Contract | Mr. Joey Dorsett went over the work Alliance has done for several months to evaluate the AlphaMCS system and the provider portal. This was work was done to prepare for tail plan operations as well as because WellSky has made a business decision to continue to support the Alpha MCS system only until the LME/MCO’s transition to the tailored plan. As a result, the Alliance Team made a recommendation to pursue the purchase of the WellSky AlphaMCS system.  
- A motion was made by Chair Cynthia Binanay and seconded by Mr. Gino Pazzaglini to approve a sole source exception under NC G.S. 143-129-(e)(g) and to authorize the CEO to enter into a contract for the Alpha system/source code in an amount not to exceed $1,000,000.  
Ms. Sara Pacholke provided detail on additional furniture items needed as a result of the Wake site moving to the new home office site (5200 W. Paramount Parkway) and due to the Johnston Merger. | | |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. FY19 Budget</td>
<td>An increase to administrative and Medicaid revenue related to retroactive eligibility.</td>
<td>Take the motion to the Board for approval.</td>
<td>6/6/19 Meeting</td>
</tr>
<tr>
<td>Amendment Approval</td>
<td>An Increase State and Federal block grant funding related to additional allocations related to things like TCLI, ADAPT, Opioid funding, NC Start, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A decrease to local funding due to a program change in Wake County.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>An increase in grant funding related to a HUD grant.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>An increase in miscellaneous funding because of higher than expected dividend and interest income.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fund balance appropriations for legislative reductions, intergovernmental transfer, reinvestment plans an increase in pension expense and the projected Medicaid expense loss.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A motion was made by Mr. Gino Pazzaglini and seconded by Chair Cynthia Binanay to approve the FY19 Amendment 1 to increase the budget by $62,895,697. This brings the total FY19 budget to $563,222,712.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. FY20 Recommended</td>
<td>Ms. Kelly Goodfellow went over highlights of the FY20 recommended for approval budget presentation that she will give to the full Board.</td>
<td>Take the motions to the Board for approval.</td>
<td>6/6/19 Meeting</td>
</tr>
<tr>
<td>Budget for Approval</td>
<td>Increase from initial recommendation of $1,516,680.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Increase in Medicaid due to slight increase in Medicaid PMPM however, negotiations are still in process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Removed administrative funding increase from counties. Counties did not approve increase.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid highlights</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Current PMPM is for July-October; however, service budget is set using for full year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Adjustments for November PMPM to come later.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Innovations and TBI will not change.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reinvestment Plan for FY20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A motion was made by Mr. Gino Pazzaglini and seconded by Chair Cynthia Binanay to approve the FY20 Recommended Budget for Approval for $535,759,800.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A motion was made by Mr. Gino Pazzaglini and seconded by Chair Cynthia Binanay to approve the FY20 reinvestment plan.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. **ADJOURNMENT**: next meeting will be August 1, 2019, from 3:00 p.m. to 4:00 p.m.

Respectfully Submitted by:

<table>
<thead>
<tr>
<th>Click here to enter text.</th>
<th>Date Approved</th>
</tr>
</thead>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
### Summary of Savings/(Loss) by Funding Source as of May 31, 2019

<table>
<thead>
<tr>
<th>Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>336,440,665</td>
<td>347,305,385</td>
<td>(10,864,719)</td>
</tr>
<tr>
<td>Medicaid Waiver Risk Reserve</td>
<td>7,856,320</td>
<td>-</td>
<td>7,856,320</td>
</tr>
<tr>
<td>Federal Grants &amp; State Funds</td>
<td>38,089,325</td>
<td>58,198,272</td>
<td>(20,108,947)</td>
</tr>
<tr>
<td>Administrative</td>
<td>52,488,225</td>
<td>53,944,602</td>
<td>(1,456,378)</td>
</tr>
<tr>
<td>Total</td>
<td>461,306,008</td>
<td>485,879,732</td>
<td>(24,573,724)</td>
</tr>
</tbody>
</table>

### Fund Balance as of May 31, 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>June 30, 2018</th>
<th>Change</th>
<th>May 31, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,409,429</td>
<td>129,621</td>
<td>4,539,050</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>43,027,793</td>
<td>7,856,320</td>
<td>50,884,113</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statutes</td>
<td>5,217,343</td>
<td>-</td>
<td>5,217,343</td>
</tr>
<tr>
<td>Prepaids</td>
<td>639,095</td>
<td>467,130</td>
<td>1,106,225</td>
</tr>
<tr>
<td>Total Restricted - Other</td>
<td>5,856,438</td>
<td>467,130</td>
<td>6,323,568</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>25,141,196</td>
<td>(20,108,947)</td>
<td>5,032,249</td>
</tr>
<tr>
<td>Intergovernmental Transfers</td>
<td>3,007,817</td>
<td>(2,757,166)</td>
<td>250,651</td>
</tr>
<tr>
<td>Reinvestments-Service</td>
<td>10,355,000</td>
<td>(2,225,287)</td>
<td>8,129,713</td>
</tr>
<tr>
<td>Reinvestments-Administrative</td>
<td>8,414,500</td>
<td>(422,526)</td>
<td>7,991,974</td>
</tr>
<tr>
<td>Total Committed</td>
<td>46,918,513</td>
<td>(25,513,926)</td>
<td>21,404,587</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>12,723,765</td>
<td>(7,512,869)</td>
<td>5,210,897</td>
</tr>
<tr>
<td>Total Fund Balance</td>
<td>112,935,938</td>
<td>(24,573,724)</td>
<td>88,362,216</td>
</tr>
</tbody>
</table>
## Statement of Revenue and Expenses (Budget and Actual) - As of May 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$37,931,390.00</td>
<td>$2,927,740.82</td>
<td>$26,431,473.07</td>
<td>$11,499,916.93</td>
<td>69.68%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>77,881,018.00</td>
<td>4,754,988.47</td>
<td>38,089,325.41</td>
<td>39,791,692.59</td>
<td>48.91%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>379,107,645.00</td>
<td>30,250,539.41</td>
<td>344,296,985.35</td>
<td>34,810,659.65</td>
<td>90.82%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$494,920,053.00</td>
<td>37,933,268.70</td>
<td>408,817,783.83</td>
<td>86,102,269.17</td>
<td>82.60%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>369,054.00</td>
<td>9,153.33</td>
<td>390,129.36</td>
<td>(21,075.36)</td>
<td>105.71%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,359,385.00</td>
<td>363,283.00</td>
<td>3,996,113.08</td>
<td>363,271.92</td>
<td>91.67%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>55,780,727.00</td>
<td>4,119,638.45</td>
<td>46,937,422.80</td>
<td>8,483,304.20</td>
<td>84.15%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>885,000.00</td>
<td>109,837.84</td>
<td>1,164,559.28</td>
<td>(279,559.28)</td>
<td>131.59%</td>
</tr>
<tr>
<td>Total Administrative Revenue</td>
<td>61,394,166.00</td>
<td>4,601,912.62</td>
<td>52,488,224.52</td>
<td>8,905,941.48</td>
<td>85.49%</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$556,314,219.00</td>
<td>42,535,181.32</td>
<td>461,306,008.35</td>
<td>95,008,210.65</td>
<td>82.92%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>37,931,390.00</td>
<td>2,956,976.49</td>
<td>26,431,473.07</td>
<td>11,499,916.93</td>
<td>69.68%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>77,881,018.00</td>
<td>5,570,713.12</td>
<td>58,198,272.46</td>
<td>19,682,745.54</td>
<td>74.73%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>379,107,645.00</td>
<td>30,640,492.57</td>
<td>347,305,384.66</td>
<td>31,802,260.34</td>
<td>91.61%</td>
</tr>
<tr>
<td>Total Service Expenses</td>
<td>494,920,053.00</td>
<td>39,168,182.18</td>
<td>431,935,130.19</td>
<td>62,984,922.81</td>
<td>87.27%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>7,832,123.51</td>
<td>864,405.75</td>
<td>8,925,577.64</td>
<td>(1,093,454.13)</td>
<td>113.96%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>44,912,299.33</td>
<td>3,733,466.20</td>
<td>41,018,016.59</td>
<td>3,894,282.74</td>
<td>91.33%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>7,764,743.16</td>
<td>325,041.84</td>
<td>4,001,007.81</td>
<td>3,763,735.35</td>
<td>51.53%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>885,000.00</td>
<td>-</td>
<td>-</td>
<td>885,000.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>61,394,166.00</td>
<td>4,922,913.79</td>
<td>53,944,602.04</td>
<td>7,449,563.96</td>
<td>87.87%</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$556,314,219.00</td>
<td>44,091,095.97</td>
<td>485,879,732.23</td>
<td>70,434,486.77</td>
<td>87.34%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>($1,555,914.65)</td>
<td>($24,573,723.88)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Current Ratio = Compares current assets to current liabilities. Liquidity ratio that measures an organization’s ability to pay short term obligations. The requirement is 1.0 or greater.

Percent Paid = Percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.
**Defensive Interval** = Cash + Current Investments divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The requirement is 30 days or greater.

**Medical Loss Ratio (MLR)** = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue. The requirement is 85% or greater cumulative for the rating period (7/1/17-6/30/19).
ITEM: Policy Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: Per Alliance Behavioral Healthcare Board Policy “Development of Policies and Procedures,” the Board is to review all policies annually. The Board Policy Committee reviews a number of Policies each quarter in order to meet this requirement.

In coordination and consultation with members of the Board Executive Committee, the Board Policy Committee presents the attached amendments to the By-Laws for consideration and approval. The proposed amendments were provided to Board members on July 1, 2019, for review. Pursuant to the By-Laws of the Board of Directors, this action requires a super-majority vote.

REQUEST FOR BOARD ACTION: Accept the report. Consider and approve the proposed amendments to the By-Laws.

CEO RECOMMENDATION: Accept the report. Approve the proposed amendments to the By-Laws.

RESOURCE PERSON(S): Lodies Gloston, Committee Chair; Monica Portugal, Chief Compliance Officer
BOARD OF DIRECTORS
POLICIES & PROCEDURES

TITLE: By-Laws
BOARD POLICY #: BL
LINES OF BUSINESS: Governance
RESPONSIBILITY: Board of Directors
REFERENCE(S): N.C.G.S. 122C, Joint Resolution
URAC STANDARDS:
APPROVAL DATE: 5/3/2012
LATEST REVIEW DATE:

BOARD OF DIRECTORS BY-LAWS

ARTICLE I
PURPOSE

The Alliance Behavioral Health Care Board of Directors, also known as the Board of Directors, by virtue of powers contained in Chapter 122C of the North Carolina General Statutes is responsible for comprehensive planning, budgeting, implementing and monitoring of community based mental health, developmental disabilities and substance abuse services to meet the needs of individuals in Alliance’s Catchment Area as that term is defined in the contract between NC Department of Health and Human Services (NCDHHS) and Alliance for Medicaid waiver management services. Any use of the term Board of Directors or CEO in these bylaws shall be deemed to include the Area Board, Area Authority, LME, Area Director and other such terms used in North Carolina General Statutes.

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.
Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.
Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.
Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.
Innovation: We challenge the way it’s always been done. We learn from experience to shape a better future.

ARTICLE II
STRUCTURE

A. AUTHORITY

1. The Alliance Board of Directors is accountable to the citizens of the Alliance Catchment Area.
2. The powers and duties of the Board of Directors derive from General Statutes 122C-115.5 and 122C-117.
3. In addition to exercising those powers, duties, and functions set forth in 122C-115.5 and 122C-117, the Board of Director’s primary responsibilities include:
   a. Defining services to meet the needs of citizens (within the parameters of the law) through an annual needs assessment.
   b. Governing the organization by adopting necessary and proper policies to carry out the obligations under its contract as a Pre-paid Inpatient Health Plan (PIHP).
   c. Evaluating quality and availability of services in meeting the needs of the population.
   d. Providing Fiscal oversight.
   e. Performing public relations and community advocacy functions.
   f. Appointing a CEO in accordance with General Statute 122C-121 (d). The CEO is an employee of the Board of Directors and shall serve at the pleasure of the Board of Directors.
   g. Evaluating annually the Chief Executive Officer for performance based on criteria established by the Secretary of NCDHHS and the Board of Directors.
   h. Delegating responsibility to the Chief Executive Officer who shall be responsible for the appointment of employees, the implementation of the policies and programs of the Board of Directors, for compliance with the rules of the North Carolina Commission Division for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.
   i. Delegating to the Chief Executive Officer authority to execute contracts and agreements, where appropriate.
   j. Maintaining open communication with the Consumer and Family Advisory Committee (CFAC).
   k. Participate in strategic planning, including consideration of local priorities as determined by the County Commissioner Advisory Board;
   l. Government affairs and advocacy.

B. COMPOSITION

1. The Board of Directors shall consist of twenty (20) members.
2. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland County Commissioners.
3. The Durham and Wake County Commissioners shall appoint seven (7) members respectively, the Cumberland County Board of Commissioners will appoint four (4) members, and the Johnston County Board of Commissioners will appoint two (2) members.
4. The Board of Directors will advertise, accept applications, interview and recommend appointments to the respective Boards of Commissioners.
5. Board of Directors membership may consist of the following:
   a. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse
   b. CFAC member
   c. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
   d. Individual with financial expertise
   e. Individual with provider experience in a managed care environment.
6. The Board of Directors shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board.
7. No individual who contracts with the Board of Directors for the delivery of mental health, intellectual/developmental disabilities, or substance abuse services may serve on the Board of Directors during the period in which the contract for services is in effect.

C. TERMS AND CONDITIONS OF OFFICE

1. Terms of membership shall be for three years except any member of the Board of Directors who is a county commissioner serves on the Board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a County Commissioner.
2. Members shall not be appointed for more than three consecutive terms.
3. Members may be removed with or without cause by the appointing authority, upon recommendation by the Executive Committee.
4. Board of Directors members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Board of Directors.
5. Vacancies on the Board of Directors shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.
6. Board of Directors members are responsible for disclosing and may not vote on any issue in which they have a direct or indirect financial interest or personal gain. All Board members are expected to exhibit high standards of ethical conduct, avoiding both actual conflict of interest and the appearance of a conflict of interest.
7. Neither Board of Directors members nor members of their families will receive preferential treatment through the Area Authority’s services or operations.
8. Board of Directors members must be current with all property taxes in their respective counties.
9. Membership is based on the rules and regulations of the Board of Directors policies and all applicable North Carolina General Statutes.
10. Board of Directors members are required to comply with the Board of Directors Code of Ethics, policies and all applicable North Carolina General Statutes.
11. While Board members may be appointed because they represent a certain community, once on the Board, their responsibility is to all individuals served by Alliance.

D. OFFICERS

1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
2. No officer shall serve in a particular office for more than two consecutive terms.
3. Each Board of Directors member, other than County Commissioners, shall be eligible to serve as an officer.
4. Duties of officers shall be as follows:
   a. Chairperson, and
   b. Vice-Chairperson.

E. COMMITTEES

1. STANDING COMMITTEES - Annually, the Board of Directors Chairperson shall appoint the membership and the Chairperson of each of the Standing committees set forth below. These committees shall have the responsibility of making policy recommendations to the Board of Directors regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the applicable statute, regulation or contract requirements. The chair of any standing committee must be a member of the Board of Directors. If a non-board member having a conflict of interest is appointed to a committee, they shall be a non-voting member of the committee and as such shall not count towards establishing quorum. The Chairperson and Vice Chairperson may serve as standing alternate voting committee members on any committee those officers do not serve on. Except when so serving, the Chairperson and Vice Chairperson have no voting rights on a committee to which they are not regularly appointed. The standing committees shall be as follows:

a. Finance Committee (NCGS 122C-119 (d))
   i. This committee shall be composed in a manner consistent with NCGS 122C-119, having at least 3 members, two of whom have expertise in budgeting and fiscal control. The Finance Officers of Durham, Cumberland, Johnston and Wake Counties or designee may serve as ex-officio members.
   ii. The Chief Financial Officer will serve as staff liaison to the Committee.
   iii. The Committee’s functions include:
        1) Recommending policies/practices on fiscal matters to the full Board of Directors.
        2) Reviewing and recommending budgets to the entire Board of Directors.
        3) Reviewing and recommending approval of audit reports (following a meeting by a designee of this committee with the auditor and receipt of the management letter) and assure corrective actions are taken as needed.
4) Reviewing and recommending policies and procedures for managing contracts and other purchase of service arrangements.
5) Reviewing financial statements at least quarterly.
6) Reviewing the financial strength of the Area Authority.

b. Client Rights/Human Rights Committee (DMH/DD/SAS contract and NCGS 122C-64, 10A NCAC 27G.0504)
i. The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board members. Members should include consumers and family members representing mental health, developmental disabilities and substance abuse. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area.

ii. The CEO will designate a staff liaison to the Committee.

iii. The Client Rights/Human Rights Committee functions include:
1) Reviewing and evaluating Alliance’s Client Rights policies at least annually and recommending needed revisions to the Board of Directors.
2) Overseeing the protection of client rights and identifying and reporting to the Board of Directors issues which negatively impact the rights of persons served.
3) Reporting to the full Board of Directors at least quarterly.
4) Submitting an annual report to the Board of Directors which includes, among other things, a review of Alliance’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).

iv. The Client Rights/Human Rights Committee shall meet at least quarterly.

c. Quality Management Committee (URAC)
i. The Quality Management (QM) Committee shall consist of at least 5 members to include consumers or their family members plus at least 2 non-voting provider representatives. The QM Committee will meet at least 6 times a year.

ii. The QM Director, or designee, will be the staff liaison to the Committee.

iii. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees.

iv. The QM Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

d. Executive Committee - The Board of Directors shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Board of Directors at the next scheduled meeting.

i. The Executive Committee shall be composed of the current Officers of the Board of Directors, Chairpersons of standing committees (who are Board of Directors members), the immediate past Board chairperson or an at-large member in the event the immediate past Board Chairperson is not available.

ii. The Board of Directors Chairperson shall serve as the Chairperson of the Executive Committee.

iii. The Chief Executive Officer will be the staff liaison to the Committee.
iv. The Chairperson shall call the meetings of the Executive Committee. Any member of the Board of Directors may request that the Chairperson call an Executive Committee meeting.

v. The Executive Committee shall be responsible for the following:
   1) Function as the grievance committee to hear complaints regarding board member conduct and make recommendations to the full Board of Directors.
   2) Establish agendas for full Board of Directors meetings.
   3) Act on matters that are time-sensitive between regularly scheduled board meetings.
   4) Provide feedback to the CEO concerning current issues related to services, providers, staff, etc.
   5) Fulfill other duties as set forth in these By-laws or as otherwise directed by the Board of Directors.
   6) Notice of the time and place of every Executive Committee meeting shall be given to the members of the Executive Committee in the same manner that notice is given of Board of Directors meetings.

e. Policy/By-Law Committee
   i. The Policy/By-law Committee shall consist of at least 3 Board members and shall meet at least 3 times a year.
   ii. The Chief Compliance Officer will be the staff liaison to the Committee.
   iii. The Policy/By-law Committee’s functions include:
        1) Developing, reviewing and revising Board of Directors By-Laws and Policies that Govern Alliance.
        2) Recommending policies to the full Board of Directors to include all functions and lines of business of Alliance.
        3) Reviewing Board Policies at least annually, within 12 months of policies’ approval. The Policy/By-law Committee reviews a number of Policies each quarter in order to meet the annual review requirement.
        4) Revising Policies to ensure compliance with applicable law, federal and state statutes, administrative rules, state policies, contractual agreements and accreditation standards.
        5) Ensure that a master Policy Index is kept current indicating Policy names, original approval dates, all revision dates, all review dates, accreditation standards, and references to applicable law, federal and state rules and regulations and state policies.

f. Audit and Compliance Committee
   i. The Audit and Compliance Committee will consist of at least three members of the Board of Directors. At least one member shall have financial expertise. The Chairperson of the Audit and Compliance Committee may not also be the Chairperson of the Finance Committee.
   ii. The Chief Compliance Officer will serve as staff liaison to the Committee.
   iii. The Committee shall meet at least three times a year, with authority to convene additional meetings, to adequately fulfill all the obligations outlined in this charter.
   iv. The purpose of the Audit and Compliance Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. To assist the Board of Directors in fulfilling its oversight responsibilities for:
        1) The integrity of the organization’s annual financial statements;
        2) The system of risk assessment and internal controls;
        3) The organization’s compliance with legal and regulatory requirements;
        4) The independent auditor’s qualifications and independence;
5) The performance of the organization’s internal audit function; and
6) To provide an avenue of communication between management, the independent auditors, and the Board of Directors.

g. **Network Development & Services Committee**
i. The Network Development and Services Committee shall consist of at least three members, a majority of whom shall be members of the Board of Directors and shall meet at least quarterly.
   ii. The *Senior Executive* Vice President of Network Development & Evaluation Community Health or her designee will serve as staff liaison to the Committee.
   iii. The Committee’s functions include:
        1) To review service network development activities.
        2) Reviews progress on the network development plan and progress on fund balance spending on service development.
        3) Provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements.
        4) Areas of focus may include:
           • Emerging needs and Challenges
           • Data related to the Needs and Gaps Analysis
           • Network Development Plan and Status
           • State and Federal Initiatives

2. **AD HOC COMMITTEES**
a. Ad hoc committees may be appointed by the Chair of the Board of Directors with the approval of a majority of the Board members who are present at the meeting during which approval is given.
b. These committees shall carry out their duties as designated by the Board of Directors and shall report their findings to the Board or its committees.

3. **CONSUMER AND FAMILY ADVISORY COMMITTEE** – Consistent with NCGS 122C-170, the Area Authority Alliance shall have a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC). The Consumer and Family Advisory Committee shall be self-governing and self-directed. The CFAC shall advise the Board of Directors on the planning and management of the local mental health, intellectual/developmental disabilities and substance abuse services system.

4. **COUNTY COMMISSIONER ADVISORY BOARD**
Per 122C-118.2, there is a County Commissioner Advisory Board. The County Commissioner Advisory Board is not a board or committee appointed by the Board of Directors. The CEO or designee will assist in facilitation of the County Commissioner Advisory Board meetings.
ARTICLE III
MEETINGS

A. REGULAR MEETINGS

Regular meetings shall be held at least six times each year at a location and time designated by the Board of Directors. The annual meeting for the election of Officers shall be the final meeting of each fiscal year. All meetings of the Board of Directors shall be conducted in accordance with provisions set forth in N.C.G.S. 143, Article 33C of NCGS 143 (the Open Meetings Act Statute).

B. SPECIAL MEETINGS

Special meetings may be called by the Board Chair or by three or more members of the Board of Directors after notifying the Board Chair in writing. Notice of special meetings shall be provided in a manner consistent with those utilized to notify Board of Directors members (and others) of regularly scheduled meetings.

C. EMERGENCY MEETINGS

Emergency meetings may be called for unexpected circumstances that require immediate consideration by the Board of Directors. Due to the urgent need to assemble a meeting as soon as possible, any requirements regarding advanced notice for regularly scheduled meetings may be waived and emergency meetings shall be held as soon as a quorum of the Board of Directors can be convened.

D. NOTICE OF MEETINGS

Notification of Board of Directors meetings shall be sent out no later than 48 hours before the regular meeting and in accordance with requirements set forth in the Open Meetings Statute, Chapter 143 Article 33C. The Board of Directors is scheduled to meet on the first Thursday of each month at the designated Alliance site. Notice of the date, time and place shall be sent to each board member in the form of a Board of Directors agenda. Information concerning Board meetings shall also be made available to the local news media in accordance with Chapter 143 Article 33C. Notice for all Board meetings including the Board packet will be posted on the Alliance website.

E. CONDUCT OF MEETINGS

Board of Directors meetings shall be conducted under parliamentary procedures. It is the policy of this Board that all deliberations and actions be conducted fairly, openly, and consistent with the applicable Statutes of North Carolina. Participation in Board of Directors meetings via electronic means, e.g. telephone, video conferencing, is permissible to the extent allowed by law. Such participation includes the right to vote on issues that arise during the course of the meeting.

The following guidelines should be followed at all Board and committee meetings:
1. The Board/Committee must act as a body in the best interests of the consumers in the Alliance catchment area.
2. The Board/Committee should proceed in the most efficient manner possible.
3. The Board/Committee must act by at least a majority vote.
4. Every member must have an equal opportunity to participate in decision-making.
5. The Board/Committee must apply the rules of procedure consistently.

F. QUORUM

A majority of the actual membership of the Area Board, excluding vacant seats, shall constitute a quorum and shall be required for the transaction of business at all regular, special and emergency meetings. A majority is more than half.

G. APPROVAL OF CERTAIN ITEMS BY A SUPER MAJORITY

Significant actions by the Board of Directors require fifteen (15) affirmative votes, or a 75% from two-thirds of the actual membership of the Board, excluding vacant seats, majority in the event the number of board members changes or there are vacant seats on the Board. Significant actions shall include:
1. any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159),
2. personnel policies,
3. the selection and dismissal of the Chief Executive Officer,
4. changes to the Board of Directors structure,
5. execution of contracts for sale, purchase or leases of real property, or personal property including accepting any assignment thereof,
6. settlement of liability claims against the Area Authority or its officers or employees,
7. approval or amendment of the Area Authority’s Board of Director’s by-laws, and,
8. any other matter so designated by the Area Authority Board of Directors.

H. ABSENCES

1. Absence from three (3) consecutive meetings without notification to the Executive Secretary shall constitute resignation from the Board.
2. Absence from four (4) or more of the regularly scheduled meetings during a 12 month period may also constitute resignation from the Board within the discretion of the Executive Committee.
3. In computing absences, absence from two Board Committee meetings may constitute one absence from a regularly scheduled Board meeting.

ARTICLE IV
GENERAL PROVISIONS

A. AMENDMENTS

1. These By-Laws may be amended or repealed as necessary.
2. Notice of proposed changes must be given to the Board of Directors members at least thirty (30) days prior to the change.
B. SUSPENSION OF BY-LAWS

The Board of Directors has the authority to suspend the By-Laws by an affirmative vote of a majority of Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board, with the exception of those items requiring a Super Majority set forth in Article III (G).

C. REVIEW OF BY-LAWS AND BOARD OF DIRECTORS GOVERNANCE POLICIES

These By-Laws and all Board of Directors governance policies shall be reviewed at least annually.
ITEM: Draft Minutes from the June 6, 2019, and June 27, 2019, Board Meetings

DATE OF BOARD MEETING: August 1, 2019

REQUEST FOR BOARD ACTION: Approve the draft minutes from the June 6, 2019, and June 27, 2019 meetings.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
**AREA BOARD REGULAR MEETING**
5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

**Thursday, June 06, 2019**

**MEMBERS PRESENT:** Glenn Adams, Cumberland County Commissioner, JD, (via phone) Cynthia Binanay, Chair, MA, BSN, Christopher Bostock, BSIM, Tony Braswell, Johnston County Commissioner (via phone; exited at 5:25 pm), Heidi Carter, Durham County Commissioner, MPH, MS, George Corvin, Vice-Chair, MD, David Curro, BS, Greg Ford, Wake County Commissioner, MA, Lodies Gloston, MA, David Hancock, MBA, MAPh (entered at 4:14 pm), Duane Holder, MPA (via phone, exited at 5:24 pm), D. Lee Jackson, BA, Donald McDonald, MSW, Lynne Nelson, BS, Gino Pazzaglini, MSW LFACHE, Pam Silberman, JD, DrPH, Lascel Webley, Jr., MBA, MHA, and McKinley Wooten, Jr., JD

**GUEST(S) PRESENT:** Janet Conner-Knox, A Caring Heart, LLC; Susan Evans, Wake Board of County Commissioners; Denise Foreman, Wake County Manager’s Office; and Yvonne French, NC DHHS/DMH (Department of Health and Human Services/Division of Mental Health, Developmental Disabilities and Substance Abuse Services)

**ALLIANCE STAFF PRESENT:** Michael Bollini, Executive Vice-President/Chief Operating Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Cheala Garland-Downey, Senior Vice-President/Human Resources; Veronica Ingram, Executive Assistant II; Beth Melcher, Senior Director of Clinical Innovation; Ann Oshel, Senior Vice-President/Community Health and Well-Being; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Sean Schreiber, Executive Vice-President/Network and Community Health; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

1. **CALL TO ORDER:** Chair Cynthia Binanay called the meeting to order at 4:01 p.m.

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<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
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<tr>
<td>2. Announcements</td>
<td>Vice-Chair George Corvin, thanked Chair Binanay for her service as Chair of Alliance’s Board for the past 2 years; he presented her with a commemorative plaque on behalf of the Board and staff. Chair Binanay reminded Board members of the upcoming June 27 Board meeting; staff will confirm if the meeting is still needed. Orientation for New Board Members: Mr. Robinson reminded Board members that the next session is Tuesday, June 11 from 2:00-4:00 pm and requested that they RSVP with Ms. Ingram.</td>
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<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
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<td>4. Public Comment</td>
<td>There were no public comments.</td>
</tr>
<tr>
<td>5. Committee Reports</td>
<td>A. Consumer and Family Advisory Committee (CFAC) - page 5 The Alliance CFAC is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes and supporting documents from recent Cumberland, Durham, Wake, Johnston, and steering committee meetings. Doug Wright, Director of Community and Member Engagement, presented the CFAC report. Mr. Wright mentioned recent CFAC events and recognized Board members and staff who attended local CFAC meetings; Mr. Wright also reviewed eligibility and enrollment and the pending CFAC report, which is expected in August 2019. He mentioned feedback from CFAC members regarding Alliance’s listening sessions on Care Coordination Teams. The CFAC report is attached to and made part of these minutes.</td>
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<td>AGENDA ITEMS:</td>
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<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the report.</td>
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| B. Finance Committee – page 64 | The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included the draft minutes from the May 2, 2019, meeting, the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending April 30, 2019, and recommendations to the Board to approve all presented contracts over $250,000.  
Chris Bostock, Committee Chair, presented the report. Mr. Bostock shared that expenses exceeded revenue due to reduction in State Single Stream funding. He also shared preliminary projections, which Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, reviewed in greater detail. He mentioned that contractual ratios were met; he and provided an overview of two contracts per policy G-10: Delegation of Authority to the CEO; the Finance Committee recommended that the Board approve these contracts. He also mentioned a budget amendment, which was vetted by the Finance Committee.  
Ms. Goodfellow shared a detailed overview of three-year projections including the preliminary Tailored Plan costs. Mr. Schreiber reported on the Medical Budget and the strategies for more effective and/or intensive utilization management/review of services. The Finance Committee report is attached to and made part of these minutes. |
| **BOARD ACTION** | A motion was made by Mr. Bostock to approve a sole source exception under NCGS 143-129 (e) (g) and to authorize the CEO to enter into a contract for Alpha systems source code in an amount not to exceed $1,000,000; motion seconded by Vice-Chair Corvin. Motion passed unanimously.  
A motion was made by Mr. Bostock to authorize the CEO to amend the new Home Office furniture contract for an additional amount of $90,000, for a total amount not to exceed $840,000; motion seconded by Vice-Chair Corvin. Motion passed unanimously.  
A motion was made by Mr. Bostock to amend the FY19 budget amendment by $62,893,697 to increase the budget to $563,222,712; motion seconded by Mr. Wooten. Motion passed unanimously. |
| 6. Consent Agenda | A. Draft Minutes from May 2, 2019, Board Meeting – page 73  
B. HR FY20 Classification and Grade Plan – page 78  
C. Audit and Compliance Committee Report – page 89  
D. By-Laws/Policy Committee Report – page 108  
E. Executive Committee Report – page 134  
F. Network Development and Services Committee Report – page 137  
G. Quality Management Committee Report – page 140 |
### AGENDA ITEMS:

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<td>7. FY 2019-2020 Public Hearing and Approved Budget - page 155</td>
<td>The consent agenda was sent as part of the Board packet; it is attached to and made part of these minutes. There were no comments or discussion about the consent agenda.</td>
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<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Ms. Gloston to approve the consent agenda; motion seconded by Mr. Bostock. Motion passed unanimously.</td>
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<td>8. Reappointment Recommendation - page 190</td>
<td>Per GS 159-12 (b), a public hearing shall be held to allow any persons who wish to be heard on the budget to appear. Chair Binanay opened the public hearing. There were no speakers. Chair Binanay closed the public hearing. Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, presented the FY 2019-2020 Budget to the Board for approval and adoption per GS 159-13. The presentation included service line, administration and reinvestment plan areas.</td>
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<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Mr. Bostock to approve the FY 2019-2020 budget; motion seconded by Ms. Nelson. Motion passed unanimously.</td>
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<td>A motion was made by Mr. Bostock to approve the FY 2019-2020 reinvestment plan, which include behavioral health urgent care and child crisis facility, Tailored Plan implementation, etc.; motion seconded by Ms. Nelson. Motion passed unanimously.</td>
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<td>9. Legislative Update</td>
<td>In accordance with the By-Laws of the Area Board, the terms of some Board members are staggered. Duane Holder's term expired May 31, 2019. The Board is requested to consider this member’s reappointment for an additional term and request official reappointment through the respective Board of County Commissioners.</td>
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<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Ms. Gloston to recommend to the Cumberland Board of County Commissioners the reappointment of Duane Holder to Alliance’s Board; motion seconded by Vice-Chair Corvin. Motion passed unanimously.</td>
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### BOARD ACTION

- The Board received the update.
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<td>10. Election of FY20 Board Officers – page 191</td>
<td>As stated in Article II, Section D of the By-Laws, at each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include: Chairperson and Vice-Chairperson. Nominations were opened for FY20 Board Chair. <strong>BOARD ACTION</strong> A motion was made by Mr. Bostock to nominate George Corvin for FY20 Board Chair; motion seconded by Mr. Wooten. Motion passed unanimously. There were no additional nominations for FY20 Board Chair. Nominations were closed. By unanimous show of hands and/or verbal consent, the Board elected George Corvin as FY20 Board Chair. Nominations were opened for FY20 Board Vice-Chair. <strong>BOARD ACTION</strong> A motion was made by Vice-Chair Corvin to nominate Gino Pazzaglini for FY20 Board Vice-Chair; motion seconded by Mr. Bostock. Motion passed unanimously. There were no additional nominations for FY20 Board Vice-Chair. A motion was made by Ms. Gloston to close nominations for FY20 Board Vice-Chair; motion seconded by Vice-chair Corvin. Motion passed unanimously. By unanimous show of hands and/or verbal consent, the Board elected Gino Pazzaglini as FY20 Board Vice-Chair.</td>
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<td>11. Chair’s Report</td>
<td>Chair Binay reminded Board members: the next meeting is August 1, 2019, in Cumberland County. Chair-elect, George Corvin, thanked the Board for electing him as FY20 Board Chair; he also requested input from the Board regarding FY20 Board Committees.</td>
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<td>12. Closed Session(s)</td>
<td><strong>BOARD ACTION</strong> A motion was made by Ms. Gloston to enter closed session pursuant to NC § 143-318.11 (a) (6) to consider the qualifications, competence and performance of an employee; motion seconded by Vice-Chair Corvin. Motion passed unanimously. The Board returned to open session.</td>
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<tr>
<td>13. Adjournment</td>
<td>All business was completed; the meeting adjourned at 6:33 p.m.</td>
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Next Board Meeting  
Thursday, August 01, 2019  
4:00 – 6:00 pm

Respectfully Submitted by:

[Signature]

Robert A. Robinson, Chief Executive Officer

Date Approved
AREA BOARD REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
8:00-8:30 a.m.

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD (via phone), Cynthia Binanay, Chair, MA, BSN (via phone), Christopher Bostock, BSIM (via phone), Tony Braswell, Johnston County Commissioner (via phone), Heidi Carter, Durham County Commissioner, MPH, MS (via phone), George Corvin, Vice-Chair, MD (via phone), David Curro, BS (via phone), Greg Ford, Wake County Commissioner, MA, Lodies Gloston, MA (via phone), David Hancock, MBA, MPAff (via phone), Duane Holder, MPA (via phone), D. Lee Jackson, BA, Donald McDonald, MSW (via phone), Lynne Nelson, BS (via phone), Gino Pazzaglini, MSW LFACHE (via phone), Pam Silberman, JD, DrPH, Lascel Webley, Jr., MBA, MHA (via phone), and McKinley Wooten, Jr., JD (via phone)

GUEST(S) PRESENT: None

ALLIANCE STAFF PRESENT: Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Sara Pacholke, Senior Vice-President/Financial Operations; Robert Robinson, Chief Executive Officer (via phone); and Carol Wolff, General Counsel

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 8:06 a.m.

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<td>2. Sale of 3309 Durham Drive, Raleigh</td>
<td>The Board is requested to consider and approve an offer to purchase 3309 Durham Drive in Raleigh for the purchase price of $1.85M. Alliance purchased this property in 2016 with the intent to renovate it for an adult crisis facility. Due to the continued State single stream cuts, the Board made the decision in February to market and sell the property. Carol Wolff, General Counsel, reminded Board members of the proposal, which was previously sent to Board members.</td>
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<tr>
<td>3. Update</td>
<td>Mr. Robinson shared an update on the NC General Assembly’s budget, the reduced Single Stream funding, and the impact of these funding cuts on the agency’s plan for start-up funds for a child crisis facility. Mr. Robinson shared that the impact of this reduced funding could be to postpone part of the implementation for the child crisis facility. Board members discussed potential next steps including advocacy.</td>
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<td>4. Adjournment</td>
<td>All business was completed; the meeting adjourned at 8:25 a.m.</td>
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Next Board Meeting
Thursday, August 01, 2019
4:00 – 6:00 pm

Respectfully Submitted by:

Robert Robinson, Chief Executive Officer

Date Approved
ITEM: Executive Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. Attached are the draft minutes from the July 16, 2019, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dr. George Corvin, Board Chair; Robert Robinson, CEO
1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 4:00 pm.

2. REVIEW OF THE MINUTES – The minutes from the May 21, 2019, meeting were reviewed; a motion was made by Mr. Pazzaglini and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS:

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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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| 3. Updates                          | A. Legislative Update: Mr. Robinson mentioned that the NC General Assembly does not currently have a budget as the governor vetoed the budget. Mr. Robinson mentioned potential impact (of not having a current budget) on the people Alliance serves.  
B. Medicaid Transformation: Mr. Robinson and Ms. Wolff provided an update about the lawsuits from companies who were not selected for the Standard Plan; they filed a TRO (temporary restraining order), which was ruled in favor of the defendant (NC DHHS); the plaintiffs still have the ability to bring their issues with the RFP process to court. DHHS still plans to go live with Standard Plans on November 1, 2019. | A. None specified.  
B. None specified. | A. N/A  
B. N/A                      |
| 4. Agenda and Location for August Board Meeting | Committee reviewed the draft agenda for the August 1, 2019, Board meeting at Alliance’s Cumberland office. Committee members provided input. | Ms. Ingram will forward the revised agenda to staff. | 7/16/19     |
| 5. Applicant Interview              | The Committee interviewed an applicant for the vacant Durham seat.                                                                                          | Topic will be revisited at the August Committee meeting.                                      | 8/20/19     |
| 6. Committee Structure              | A. By-Laws/Policy Committee: Committee discussed function of this Committee and continued need for this Committee as the agency implements a Tailored Plan.  
B. Network Development and Services Committee: Committee discussed the function of this Committee and the continued need as the agency implements a Tailored Plan. | A. None specified.  
B. None specified.  
C. Ms. Ingram poll Executive Committee members about alternate meeting days; | A. N/A  
B. N/A  
C. None specified; 8/20/19. |
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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Executive Committee Meeting and Times:</td>
<td>Chair Corvin mentioned a potential need to change the series of dates for this meeting.</td>
<td>topic will be reviewed at the next Committee meeting.</td>
<td></td>
</tr>
<tr>
<td>7. Proposed Revisions to the By-Laws</td>
<td>Committee reviewed proposed revisions.</td>
<td>Ms. Wolff will share the Committee's recommendations with the Policy Committee; topic will be presented to the Board for approval during the August 1, 2019, Board meeting.</td>
<td>8/1/19</td>
</tr>
</tbody>
</table>

**COMMITTEE ACTION:**
A motion was made by Mr. Pazzaglini to approve the amended recommendations to the Board; motion seconded by Ms. Nelson. Motion passed unanimously.

**COMMITTEE ACTION:**
A motion was made by Mr. McDonald to enter closed session pursuant to NC General Statute 143-318.11 (a) (6) to consider the qualifications, competence and performance of an employee. Motion seconded by Ms. Nelson; motion passed unanimously.

8. Closed Session

The Committee returned to open session.

| TIME FRAME: | 8/1/19 |

9. **ADJOURNMENT:** the meeting adjourned; the next meeting will be August 20, 2019, at 4:00 p.m.
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The Human Rights Committee shall include consumers and family members representing mental health, developmental disabilities and substance abuse.

The Human Rights Committee functions include:

1) Reviewing and evaluating the Area Authority’s Client Rights policies at least annually and recommending needed revisions to the Area Board.
2) Overseeing the protection of client rights and identifying and reporting to the Area Board issues which negatively impact the rights of persons serviced.
3) Reporting to the full Area Board at least quarterly.

The Human Rights Committee shall meet at least quarterly.

The Human Rights Committee is required by statute and by your by-laws. The Committee meets at least quarterly and reports to you by presenting the minutes of the meetings as well as through Quality Management Reports reviewing grievances and incidents.

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. Draft minutes for the July 11, 2019, meeting are attached.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Lynne Nelson, Committee Chair; Doug Wright, Director of Community and Member Engagement; Todd Parker, QM Incidence and Grievance Manager
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - The minutes from the April 11, 2019, meeting were reviewed; a motion was made by Patricia Wells and seconded by Lodies Gloston to approve the minutes. Motion passed unanimously.

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<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. TCL – Transition to Community Living Initiative</td>
<td>Presentation on TCL to provide an understanding of the TCL process and how members’ rights might be violated and/or how the process might be perceived as challenging by members. Aimee Izawa and Anna Mulhollem presented on the transition to living initiative (presentation attached). They discussed referral, diversion, transition, barriers, post-transitions, and services members receive. Talked about the partnership with providers to deliver the services to members, our efforts to transition members to their relationship with providers and how we reach back out to ensure everything is going well. Lots of discussion and questions about the process, acknowledging the biggest barrier being having enough housing options for members. There is a shortage of affordable housing options and members wanted to ensure the board was aware of this fact.</td>
<td>Communicate through these minutes the concern around affordable housing options in all of our communities.</td>
<td>8/1/2019</td>
</tr>
<tr>
<td>4. Grievance Review</td>
<td>Follow-up – Why do we report grievances differently than other LME-MCOs? Todd reported that QM has decided to report differently internal concerns to the state. This should bring our numbers more in line with other LME/MCOs.</td>
<td>Review next quarter’s report/ follow up to see that grievances reported are reduced by not including internal concerns.</td>
<td>10/10/2019</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Incident Review</td>
<td>Todd reviewed the incident report (attached) with the committee. He answered questions for committee members about trends.</td>
<td>Review next quarter’s report.</td>
<td>10/10/2019</td>
</tr>
<tr>
<td>6. Raise Your Hand Process</td>
<td>Update – Doug gave an update on the “Raise your hand” form developed by the state for members to use if they feel like they need to change Medicaid Health Plans. The initial form was too long and the state took feedback and changed the form to make it easier for members to use. The new form allows members to say why they feel like they need to change and puts the onus on the state to research documentation. There is an additional form that the provider can use to fill out for the member.</td>
<td>Review final document when available.</td>
<td>10/10/2019</td>
</tr>
<tr>
<td>7. Confidentiality Agreements</td>
<td>Members turned in their confidentiality agreements, still need one more.</td>
<td>Follow up with member’s confidentiality agreement.</td>
<td>10/10/2019</td>
</tr>
<tr>
<td>8. Future agenda items</td>
<td>Annual Human Rights Training</td>
<td>Set the next meeting’s agenda.</td>
<td>10/01/2019</td>
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</tbody>
</table>

9. **ADJOURNMENT:** next meeting will be October 10, 2019 from 4:00 p.m. to 5:30 p.m.

Respectfully Submitted by:

Doug Wright

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Transitions to Community Living (TCL)
The DOJ Settlement Agreement

In August 2012, the US Department of Justice entered into an agreement with the state of NC to resolve allegations that NC failed to serve individuals with disabilities in the most integrated setting, appropriate to meet their needs as required by the ADA of 1990* and Section 504 of the Rehabilitation Act of 1973. The settlement was specifically in regard to individuals with SMI or SPMI who reside in or are at risk of residing in an Adult Care Home.

This is about civil rights!

*1999 Supreme Court ruling relating to Title II of the ADA, also known as the Olmstead decision
TCL Eligibility Criteria

- Medicaid eligible (or income of less than $2,000) **AND**
- SMI residing in IMD
- SPMI in >50 Bed ACHs (25% MH)
- SPMI in <50 Bed ACHs (40% MH)
- SPMI in State Hospital and Homeless or Unstable Housing
- Diversion from entering into an ACH (Formerly PASRR)
  - RSVP
Eligibility through RSVP

RSVP is an online portal and took the place of PASRR November 2018.

- Individual does NOT meet TCLI Settlement Agreement criteria for other priority populations.
- Individual has a verified diagnosis of SMI or SPMI.
- Individual has Medicaid, OR is individual Medicaid eligible, OR does individual have a monthly income of $2000 or less
- Individual is being considered for admission to an ACH/domiciliary level of care.

Eligibility is confirmed through documentation and face to face meetings with members/families/GOP’s. Education on housing options and services are presented as well as completion of a Community Integration Plan.
### Diagnoses Acceptable for SMI (Serious Mental Illness) or SPMI (Serious and Persistent Mental Illness) Designation

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<thead>
<tr>
<th>Code</th>
<th>ICD10</th>
<th>Description</th>
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<tbody>
<tr>
<td>6.52</td>
<td>F31.32</td>
<td>Bipolar I disorder, Current or most recent episode depressed Moderate</td>
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<tr>
<td>6.53</td>
<td>F31.4</td>
<td>Bipolar I disorder, Current or most recent episode depressed Severe</td>
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<tr>
<td>6.54</td>
<td>F31.5</td>
<td>Bipolar I disorder, Current or most recent episode depressed With psychotic features</td>
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<tr>
<td>6.50</td>
<td>F31.9</td>
<td>Bipolar I disorder, Current or most recent episode unspecified</td>
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<tr>
<td>6.40</td>
<td>F31.0</td>
<td>Bipolar I disorder, Current or most recent episode hypomanic</td>
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<tr>
<td>6.42</td>
<td>F31.12</td>
<td>Bipolar I disorder, Current or most recent episode manic Moderate</td>
</tr>
<tr>
<td>6.43</td>
<td>F31.13</td>
<td>Bipolar I disorder, Current or most recent episode manic Severe</td>
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<tr>
<td>6.44</td>
<td>F31.2</td>
<td>Bipolar I disorder, Current or most recent episode manic With psychotic features</td>
</tr>
<tr>
<td>6.89</td>
<td>F31.81</td>
<td>Bipolar II disorder, Current or most recent episode unspecified</td>
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<tr>
<td>1.83</td>
<td>F60.3</td>
<td>Borderline personality disorder</td>
</tr>
<tr>
<td>7.1</td>
<td>F22</td>
<td>Delusional disorder, Recurrent episode</td>
</tr>
<tr>
<td>6.32</td>
<td>F33.1</td>
<td>Major depressive disorder, Recurrent episode     Moderate</td>
</tr>
<tr>
<td>6.33</td>
<td>F33.2</td>
<td>Major depressive disorder, Recurrent episode     Severe</td>
</tr>
<tr>
<td>6.34</td>
<td>F33.3</td>
<td>Major depressive disorder, Recurrent episode     With psychotic features</td>
</tr>
<tr>
<td>6.30</td>
<td>F33.9</td>
<td>Major depressive disorder, Recurrent episode     Unspecified</td>
</tr>
<tr>
<td>5.70</td>
<td>F25.0</td>
<td>Bipolar type</td>
</tr>
<tr>
<td>5.70</td>
<td>F25.1</td>
<td>Bipolar type                                    Depressive type</td>
</tr>
<tr>
<td>5.90</td>
<td>F20.9</td>
<td>Schizophrenia</td>
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</table>
TCL Process for Diversion

In-Reach

Individuals have the right to live in their own homes and in the community of their choice.

- Individuals have the Freedom of Choice and are Fully Informed - Individual is provided information about housing options and the option of transitioning to supported housing, its benefits, and the array of services and supports available.
- In-Reach Staff meet the members “where they are”.
- Emphasis on education and advocacy.
- TCL Tool is started- preferences, strengths, and support needs identified.
- Linkage with providers and supports.
- Can provide community visits with members for exploration of options.
- Vital documents collected.
- In-Reach Staffing completed for “next phase”
TCL Process for Diversion

Transition

TCL is not emergency housing and is not an overnight process.
• Transition Coordinator (TC) is assigned along with a housing slot for the member.
• TC is the lead contact for transition.
• Individual must be connected to services in the community.
• TC will coordinate bridge housing if needed and appropriate.
• Ensure PCP is completed
• Begins the housing search and coordinates potential placement options with members.
• Address barriers to housing.
• Assist with identifying housing, coordinate lease-signing and finances (as pertains to TCL), and coordinates move (food, furniture, provider involvement)
• Final Transition Meeting
• Post-Transition

Expectation: Individual will transition to housing 90 days from Housing Slot Approval.
Barriers to Obtaining Housing

• MCO Transfer
• Background (legal and credit history)
• ITP– discharge planning must be clarified
• Obtaining legal documentation
• Provider involvement prior to discharge
• Out of catchment
• Current Living Situation/Guardians
• Limited housing options
*There is not a Medicaid service definition for TMS. Eligibility for the service does not depend on Medicaid status.

Exclusions...
Provider Role During Transition

During the transition process, providers may be responsible for assisting with the following:

• Participating in initial and final transition meetings
• Linking members to primary care doctors and/or other medical services
• Collecting financial and vital documents if this has not already been done or must be completed after discharge due to agency processes
• Completing/updating PCP to contribute to PCRP
• Completing CCAs or addendums
• Collecting FL2s
• Other responsibilities as delegated by the MCO and/or as outlined in the service definition
Provider Role Post Transition

Length of provider engagement is based on medical necessity, service definition, and member choice. Provider responsibilities may include:

• Acting as First Responder
• Providing support as outlined in the service definition
• Collecting FL2s when needed
• Assisting with setting up payee services (if service needs to be established)
• Assisting with addressing tenancy concerns
• Providing behavioral health support as needed
• Assisting members with learning ADLs
• Linking member to community resources, activities, etc.
• Helping members access transportation
• Assisting with the rehousing process
• Aiding members with budgeting
• Other responsibilities as delegated by the MCO and/or as outlined in the service definition
Questions?

Anna Mulhollem - TCL In-Reach Program Supervisor

Amulhollem@alliancehealthplan.org

Aimee Izawa - TCL Manager

Aizawa@alliancehealthplan.org
Q3 Complaint Analysis
QM Quality Assurance
Overview

3Q FY19 yielded 231 entries

- 100 (43%) Grievances – Members/legal guardians
- 97 (42%) Internal Employee Concerns – Alliance staff
- 33 (14%) External Stakeholder Concerns – Outside entities
- 1 (1%) Compliments
<table>
<thead>
<tr>
<th>Reporting Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse, Neglect and Exploitation</td>
<td>Any allegation regarding the abuse, neglect and/or exploitation of a child or adult as defined in APSM 95-2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td>Access to Services</td>
<td>Access to Services as any complaint where an individual is reporting that he/she has not been able to obtain services</td>
</tr>
<tr>
<td>Administrative Issues</td>
<td>Any complaint regarding a Provider’s managerial or organizational issues, deadlines, payroll, staffing, facilities, etc.</td>
</tr>
<tr>
<td>Authorization/Payment Issues/Billing PROVIDER ONLY</td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices regarding providers</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>Any complaint regarding the ability to obtain food, shelter, support, SSI, medication, transportation, etc.</td>
</tr>
<tr>
<td>Clients Rights</td>
<td>Any allegation regarding the violation of the rights of any consumer of mental health/developmental disabilities/substance abuse services. Clients Rights include the rights and privileges as defined in General Statutes 122C and APSM 95-2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td>Confidentiality/HIPAA</td>
<td>Any breach of a consumer’s confidentiality and/or HIPAA regulations.</td>
</tr>
<tr>
<td>LME/MCO Functions</td>
<td>Any complaint regarding LME functions such as Governance/ Administration, Care Coordination, Utilization Management, Customer Services, etc.</td>
</tr>
<tr>
<td>LME/MCO Authorization/ Payment/Billing</td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices of the LME/MCO</td>
</tr>
<tr>
<td>Provider Choice</td>
<td>Complaint that a consumer or legally responsible person was not given information regarding available service providers.</td>
</tr>
<tr>
<td>Quality of Care – PROVIDER ONLY</td>
<td>Any complaint regarding inappropriate and/or inadequate provision of services, customer services and services including medication issues regarding the administration or prescribing of medication, including the wrong time, side effects, overmedication, refills, etc.</td>
</tr>
<tr>
<td>Service Coordination between Providers</td>
<td>Any complaint regarding the ability of providers to coordinate services in the best interest of the consumer.</td>
</tr>
<tr>
<td>Other</td>
<td>Any complaint that does not fit the above areas.</td>
</tr>
</tbody>
</table>
Nature of Issue
(Top 4)

- Quality of Services: 67
- Access to Services: 39
- Administrative Issues: 38
- Abuse, Neglect, Exploitation: 33
Source: Who submitted concerns?

Top 3

- MCO Staff: 98
- Guardian: 49
- Member: 46
## Complaints Against Alliance

<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCO Functions</td>
<td>Complaints related to Care Coordination, housing, gaps in services, contracts, training</td>
</tr>
<tr>
<td>Authorization/Payment/Billing</td>
<td>Provider complaints related to denials for services, guardian’s concerns for budget letter reductions</td>
</tr>
</tbody>
</table>
Service Breakdown

Top 3 Services

- 23% from Residential Services
- 12% Outpatient Service
- 6% from ACTT Services
  - All others represented 6% or less or were non-service related
Service Breakdown

IDD Services
(Top 3)

- 6% from NC Innovations Waiver Services
- 2% IDD Care Coordination
- <1% from ICF
Service Breakdown

MH/SUD Services

- 47% from Enhanced Services
- 30% from Substance Use Disorder Services
- 27% from Basic Services
- 7% from Crisis Services
- 1% from MH/SUD Care Coordination
Human Rights Complaints

- Basic Needs: 2 complaints
- Confidentiality/HIPAA: 2 complaints
- Client Rights: 3 complaints
- Abuse, Neglect, Exploitation: 33 complaints
HR Grievances - Service Breakdown

Abuse/Neglect/Exploitation

- Not Service Related: 1
- Substance Abuse Non-medical Community Treatment: 1
- Substance Abuse Intensive Outpatient Services (SAIOP): 1
- Peer Support Services: 1
- Outpatient Services: 1
- Facility Based Crisis Program: 1
- Adult Day Vocational Program: 2
- Crisis - Inpatient: 2
- Assertive Community Treatment Team (ACTT): 2
- Innovations Services (Non Residential): 3
- Psychiatric Services: 6
- Residential Services (Including Innovations): 12
## HR Grievances - Service Breakdown

<table>
<thead>
<tr>
<th>Assertive Community Treatment Team (ACTT)</th>
<th>Confidentiality/HIPAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Intake</td>
<td>1</td>
</tr>
</tbody>
</table>
# HR Grievances - Service Breakdown

<table>
<thead>
<tr>
<th>Assertive Community Treatment Team (ACTT)</th>
<th>Basic Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Nature of Issue</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Abuse/Neglect/Exploitation | 19 – Staff abuse in licensed facilities  
5 – Sexual Assault/Inappropriate Sexual Behavior  
3 – Auto Accident (Staff)  
2 – Improper supervision  
2 – Perceived medication errors  
1 – Exploitation of members ($)  
1 - Related to Involuntary Commitment (IVC) | 18 – Referred to Division of Health Services Regulations (DHSR)  
19 – Worked with provider for solution/Corrective action  
6 – Information/Technical Assistance to provider. |
| Confidentiality/HIPAA | Members felt their information had been available to unauthorized persons | Verified with providers that no breach had occurred |
| Basic Needs            | Issues related to members receiving ACTT services having access to resources (money and bus passes) | Researched issues. Educated members on access to benefits |
About Alliance

- 912 Reports were entered into NC-IRIS for 463 members
- 662 reports involved children, 250 involved adults

**LEVELS**

- 809 Level 2 reports
- 103 Level 3
Wake County submitted the largest number of Level 2 (494) and Level 3 (66) reports in the 3rd quarter of FY19.
A total of 523 Incidents were reported for children: (488 L2 and 35 L3)
A total of 389 Incidents were reported for Adults: (321 L2 and 68 L3)
• This chart represents services reporting 15 or more incidents during Q3.
• PRTF service category remains the highest reporting service due to reporting requirements for Physical Restraints.
• The higher number of L3 reports in Individual Therapy due to reports of Caregiver Abuse.
REPORTS BY INCIDENT CATEGORY
- 96% of Restrictive interventions in Q3 were Physical Restraints
Restrictive Intervention Breakdown

Service Categories

- Psychiatric Residential Treatment (PRTF) 215
- Child and Adolescent Day Treatment 67
- HRI Residential LIII 5
- Day Supports 5
- Drop-In Center 3
- Child and Adolescent Res. Treatment - LIII 2
- Adult Developmental Vocational Program (ADVP) 1
- Therapeutic Foster Care 1
- Residential Supports Level 2 1
- Community Living Supports 1
- ICF-MR 1
- Residential Supports Level 4 1
- Developmental Therapy 1

- 71% from PRTF Programs
- 22% from Day Treatment Programs
- Higher numbers/percentages in Child and Adolescent programs
• 56 Total - All Member Injury reports were Level II Incidents
• Other Injuries primarily associated with on-the-job injuries or common accidents
• Unknown injuries reported/discovered after the fact
A total of 137 incidents were reported in this category
All Level III reports are reviewed by the Clinical Quality Review Committee
Staff and Caregiver Abuse were the most commonly reported in the category
- A total of 20 deaths were reported during the 3rd quarter
- 45% of reports due to Terminal Illness
- OMT (Opioid Maintenance Therapy) are included in Unknown Death reports
Incident Report Compliance
New Incident Report Compliance Process
(Implemented during the 2nd Quarter FY2019)

• The Incident and Grievance Manager issues an email notification to any provider submitting a late incident report during the quarter

• If a 2nd late incident report is submitted during the current quarter, a Plan of Correction (POC) is issued to the provider

• If a provider receives an email notification for 2 consecutive quarters, a Plan of Correction (POC) is issued to the provider
  • An approved POC must identify the root cause of the late submissions and include a documented plan to prevent future late reports
RESULTS

• Prior to the initiation of the new process, 30% of reports submitted into NC-IRIS were submitted late (more than 72 hours after provider was aware of the incident)

• For the 3rd Quarter, an average of 17% of reports entered into NC IRIS were entered late

• 27 initial emails were sent to providers regarding late reports
• Late submissions in the 3\textsuperscript{rd} quarter were 1 percentage point higher than 2\textsuperscript{nd} quarter (16%).
• Two Plans of Correction (POC) were issued during the 3\textsuperscript{rd} quarter.
ITEM: Network Development and Services Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The committee reviews progress on the agency’s network development plan and progress on service development. The committee reports to the Board and provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements. This month’s report includes draft minutes and materials from the July 10, 2019, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Donald McDonald, Committee Chair; Sean Schreiber, Executive Vice-President/Network and Community Health
**Wednesday, July 10, 2019**

**BOARD NETWORK DEVELOPMENT & SERVICES COMMITTEE - REGULAR MEETING**

5200 W. Paramount Parkway, Morrisville, NC 27560
3:00-4:00 p.m.

**APPOINTED MEMBERS PRESENT:** □ Marilyn Avila, ⦿ Heidi Carter, MPH, MS, Board member, □ Sally Hunter, ⦿ Donald McDonald, MSW, Board member (Committee chair), ⦿ Lynne Nelson, BS, Board member

**BOARD MEMBERS PRESENT:** George Corvin, MD (Board Chair)

**GUEST(S) PRESENT:** Yvonne French, DMH Liaison

**STAFF PRESENT:** Carlyle Johnson, PhD. Director of PN Strategic Initiatives

1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 4:00 pm

2. **REVIEW OF THE MINUTES** – The minutes from the May 8, 2019 meeting were reviewed with a motion to accept. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Network Adequacy and Accessibility Analysis for 2019</td>
<td>Dr. Johnson provided an overview of findings and presented network access plan priorities for the coming year. Ongoing discussion to improve member and family engagement in the needs assessment process. Report had been submitted to the state on July 1, 2019</td>
<td>N/A</td>
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3. **ADJOURNMENT:** the meeting adjourned at 5:15 pm; the next meeting will be September 11, 2019, from 4:00 p.m. to 5:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date].
ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The Global QMC reports to the MCO Board of Directors which derives from General Statute 122C-117. The Quality Management Committee serves as the Board’s monitoring and evaluation committee charged with the review of statistical data and provider monitoring reports. The goal of the committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve LME/MCO operations and local service system with input from consumers, providers, family members, and other stakeholders.

The Alliance Board of Directors’ Chairperson appoints the committee consisting of five voting members whereof three are Board members and two are members of the Consumer and Family Advisory Committee (CFAC). Other non-voting members include at least one MCO employee and one provider representative. The MCO employees typically assigned are the Director of the Quality Management (QM) Department who has the responsibility for overall operation of the Quality Management Program; the MCO Medical Director, who has ultimate responsibility of oversight of quality management; the Quality Review Manager, who staffs the committee; the Quality Management Data Manager; and other staff as designated.

The Global QMC meets at least quarterly each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO’s annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and updates the QM Plan annually.

The draft minutes and materials from the previous meeting are attached

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dr. Pam Silberman, Committee Chair; Wes Knepper, Director of Quality Management
APPOINTED MEMBERS PRESENT: □Dave Curro, BS, (Board member, Committee Chair), □Duane Holder, MPA, (Board member) by phone, □Joe Kilseheimer, (CFAC), MBA, □ Israel Pattison (CFAC) □Pam Silberman, JD, DrPH, (Board member)

APPOINTED, NON-VOTING MEMBERS PRESENT: □ Diane Murphy (Provider Representative, I/DD) by phone; □ Dava Muserallo (Provider Representative, MH/SUD) Yvonne French, LCSW (LME Liaison)

BOARD MEMBERS PRESENT: George Corvin, M.D.(Board Vice-Chair)

GUEST(S) PRESENT: None

STAFF PRESENT: □ Wes Knepper, LPC (Quality Management Director); □ Doug Wright (Director Individual & Family Affairs); □ Diane Fening, (Executive Assistant); □ Beth Melcher, PhD (Executive VP, Care Management); □ Michael Bollini, PhD (Executive VP, Chief Operating Officer)

1. WELCOME AND INTRODUCTIONS Pam Silverman chaired the meeting in Dave Curro’s absence.

2. REVIEW OF THE MINUTES – The minutes from the May 2, 2019, meeting were reviewed; a motion was made by George Corvin to approve the minutes.

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<td>3. New Business: (Wes)</td>
<td>Wes went over the QIP Proposal about UM adverse decision letters. We did not meet all standards like we should, so this is effort to give UM more support, resources. We will be working with MicroStrategy, identifying who needs letters, and will use a mail merge to create the letters. This also checks the box for a URAQ requirement for having two QIPs per accredited module. Israel moved to approve the implementation of this QIP, Duane seconded the motion and the motion passed.</td>
<td>QIP Review-We are going in a good direction with a good number of them. Care Coordination clinical contacts-lot of shifts happening in Care Coordination, and part of this relates to that and some of this has to do with volume. The goal is to have care coordinators meet with members face to face when they are in inpatient or crisis facilities. This is an ambitious project. Are hopeful that there will be daily management tracking which will help us to uncover all barriers. Cynthia asked if QIPs are related to performance benchmarks for the state. In theory, they do relate but it is not necessary. Duane</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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| 4. Old Business     | **Alliance Complete Care-Beth Melcher (PowerPoint attached)**

We started developing Complete Care over two years ago when we were still talking about Special Needs Plans. We had to make assumptions about what we needed to develop and what we were getting ready for. Last week the Department released comprehensive paper around their vision for care management and the Tailored Plan. People that will be in the Tailored Plan are the most complex individuals. They might have food insecurity, housing insecurity. They are the top 10% of Medicaid population in terms of cost and complexity. They need enhanced services, integrated health care and behavioral health treatments and supports. They need community supports (DSS, Public Health), and to make all of that comes together they need care management to ensure they don’t fall through the cracks.

We have a good idea of what the requirements will be for the Tailored Plan. They are mirroring what the Standard Plans are required to do plus a few things for us. We are going to have to tell them what we know about how to do integrated healthcare.

They will want to know how we will do integrated healthcare, transportation, social determinants of health, risk scoring, care management, platform (JIVA for us), care plan to address all member needs, and interdisciplinary care team. We have made many of the right assumptions in the past two years about what will be required of the Tailored Plans. Everyone in the Tailored Plan is eligible for care management and that should be 20,000 people. Now we manage 4,000.

Beth talked about the DHHS goals for Care Management, roles and responsibilities, Care Management requirements, |

* The Alliance Complete Care PowerPoint will be sent out to the committee. |

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<td>multiple approaches to Care Management, risk stratification methodology, supporting provider-led care management. the Alliance care team model and the roles of care team members. NCCares 360 will be integrated into this. We hope to be able to build it into JIVA.</td>
<td>Wet went over the Performance Measures. Complaints resolved in 30 days not met-related to staffing changes in QM dept. New employee just started two weeks ago, so current performance is not an issue. 7 day follow up supermeasures-three not met, two met. Access to Care report – we’ve not in recent history ever hit benchmark for urgent or routine. Making progress on those through the QIP. Innovations quarterly measure-how quickly new waiver beneficiaries receive care. Once they are approved, want them to get care in less than 45 days.</td>
<td>Emergent access to care non-Medicaid marked met on one chart and not on another. Wes will look into that and others that don’t agree with printed version.</td>
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<td>5. Data Review: (QM Team)</td>
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<td>NCI Surveys Data Response-Wes was was able to find benchmarks but can’t find comparison to how we did compared to our peers. We use state and national benchmarks for that. No meeting in July. In August we’ll talk about the QM evaluation and QM plan.</td>
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6. **ADJOURNMENT:** the next meeting will be August 1, 2019 from 2:00 p.m. to 3:30 p.m.
Wes Knepper, QM Director.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
ITEM: Crisis Services for Alliance Catchment Area

DATE OF BOARD MEETING: August 1, 2019

BACKGROUND: Alliance has developed and continues to improve upon crisis services available to citizens in the catchment area. The presentation provides an overview of the crisis continuum, utilization of crisis services and improvement activities.

REQUEST FOR AREA BOARD ACTION: Accept the presentation.

CEO RECOMMENDATION: Accept the presentation.

RESOURCE PERSON(S): Sean Schreiber, Executive Vice-President/Network and Community Health