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 Johnston, Cumberland, and Steering Committee meetings.

   B. Finance Committee (10 minutes) – page 86
      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 November 7, 2019, meeting, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending October 31, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

      CEO Recommendation
      Receive the reports.

6. June 30, 2019, Audit Presentation (30 minutes) – page 94
   An annual audit is a requirement of the Local Government Budget and Fiscal Control Act GS 159-34. An annual audit is also a requirement of the DHHS-DHB contract with Alliance for the Medicaid Waiver. The auditors will present the results of the June 30, 2019, audited statements and allow time for questions.

   CEO Recommendation
   Receive the report.

7. Consent Agenda (5 minutes)
   A. Draft Minutes from November 7, 2019, Board Meeting – page 95
   B. Executive Committee Report – page 99
   C. Quality Management Committee Report – page 102
   D. Calendar Year (CY) 2020 Schedule of Board Meetings and Locations – page 106

   CEO Recommendation
   Approve the minutes and CY2020 calendar; receive the reports.
8. **Sublease Agreement (10 minutes) – page 109**
   Carol Wolff, General Counsel, will present the sublease to Recovery Innovations, Inc. ("RI") for the Roxy Crisis Facility located at 1724 Roxie Ave, Fayetteville. This item requires supermajority approval pursuant to the Board By-Laws.

   **CEO Recommendation**
   Approve the proposed Sublease to RI International, Inc. dba for Recovery Innovations Inc. for the Roxy Facility located at 1724 Roxie Ave, Fayetteville and authorize the CEO to make non-substantive change and execute the Sublease.

9. **Appointment Recommendation (5 minutes) – page 117**
   In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. The matter before the Board is to recommend to the Cumberland Board of County Commissioners the appointment of John Lesica to Alliance’s Board.

   **CEO Recommendation**
   Recommend to the Cumberland Board of County Commissioners the appointment of Dr. John Lesica to Alliance’s Board.

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

    **CEO Recommendation**
    Receive the update.

11. **Chair’s Report**

12. **Closed Session (20 minutes)**
    The Board will hold a closed session pursuant to NC § 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1.

13. **Adjournment**

    Next Meeting: Thursday, February 6, 2020
    Alliance Health, 521 North Brightleaf Boulevard, Smithfield, NC 27577
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: December 5, 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 Johnston November 19, Cumberland November 21 and November 4 Steering Committee meetings. Durham and Wake committees took the month off due to the Veteran’s Day holiday.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, CFAC Chair; Doug Wright, Director of Community and Member Engagement
**MEMBERS PRESENT:** Jason Phipps, Cassandra Herbert-Williams, Bobby Dixon, Ladeana Dexter, Albert Dixon, and Jerry Dodson  
**BOARD MEMBERS PRESENT:** None  
**GUEST(S):** Jessica Storts, Anthony Navarro, and Roanna Newton  
**STAFF PRESENT:** Doug Wright, Director of Community and Member Engagement, Noah Swabe, Individual and Family Engagement Specialist

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES – The minutes from the October 15, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Jerry Dodson and seconded by Ladeana Dexter to approve the minutes. Motion passed.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>3. Public Comment Individual/Family Challenges and Solutions</td>
<td>Albert Dixon, voiced concerns about the lack of services in the community for our deaf and blind members. Albert also made the CFAC aware of a situation he recently experienced with his doctor and some billing errors. Albert encouraged members to keep a close eye on their billing statements to ensure people weren’t being taken advantage of, Albert was able to resolve the issue but felt it was important that CFAC be aware.</td>
<td>Ongoing</td>
<td>Ongoing</td>
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<td>4. LME/MCO Updates</td>
<td>Doug Wright, discussed the Open Letter to the NC General Assembly and presented a draft of the letter to the Johnston CFAC for approval. Doug read the letter aloud and led a discussion on any changes to the letter. It was noted Leanna Georges name needed be corrected on the letter. Other than the name correction the Johnston CFAC feels the letter is appropriate to be sent out to legislators. Doug discussed the new CST definition and some of the additions and changes to the service. Explaining some of the new components and training being put in place with the new definition.</td>
<td>The open letter will be presented at the Steering Committee meeting in December for final approval. Leanna’s name will be corrected before presenting the letter to the steering committee. Alliance staff will keep the CFAC updated as the new CST definition is implemented.</td>
<td>Ongoing</td>
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<td>5. State Updates</td>
<td>Roanna informed the CFAC of a press release from the Department of Health and Human Services (DHHS) stating that Medicaid Transformation has been suspended and no new go live date has been set. Explaining according to the release the state will begin “winding down” transformation efforts effective November 20, 2019. Doug and Roanna went on to lead a conversation about what the suspension meant and answer CFAC member’s questions and concerns about the delay. Roanna reviewed a power point explaining CFAC’s role with the BH/IDD Tailored Plans and solicited input from the Johnston CFAC on regulations and guidelines. Roanna sent out a survey discussing some of the suggestions for DHHS Empowerment Team and Alliance staff will continue to update the CFAC as developments occur with Medicaid Transformation. CFAC members will make efforts to complete the survey and feel free to reach out to Noah for assistance if needed.</td>
<td></td>
<td>December 2, 2019</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.
### AGENDA ITEMS:

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<td>122C and CFAC by-laws. Roanna reviewed the current results of survey thus far and encouraged CFAC members to complete the survey if they have not done so.</td>
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<tr>
<th>6. Medicaid Transformation Forum</th>
<th>Monitor developments with Medicaid Transformation, continue to market the event throughout the community</th>
<th>December 7, 2019</th>
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<tr>
<td>Noah updated the CFAC on current PHP’s who have RSVP’d to the event and community partners. The event is currently scheduled for December 7, 2019 from 10am to 1pm at the Johnston Medical Mall. The Johnston CFAC and Alliance will monitor developments with Medicaid Transformation and adjust educational content for the event as needed.</td>
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<th>7. Current Events</th>
<th>Ongoing</th>
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<tr>
<td>Noah gave flyer out with upcoming events around the county and state, members are encouraged to contact Noah if they wish to attend any of the upcoming trainings</td>
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<th>8. Announcements</th>
<th>None</th>
<th>None</th>
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<td>None</td>
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9. **ADJOURNMENT:** the next meeting will be December 17, 2019, at 5:30 p.m.

Respectfully Submitted by:

Noah Swabe, Individual and Family Engagement Specialist

Click here to enter text.
An Open Letter to the North Carolina General Assembly

Honorable General Assembly Members,

As members of the Consumer and Family Advisory Committee (CFAC) for Alliance Health LME/MCO, we are dismayed by the continuing cuts to single stream funding for mental illness, substance use disorder, and intellectual/developmental disability.

Alliance CFAC is comprised of individuals and family members who receive mental health, intellectual/developmental disability, and substance use/addiction services. CFAC is a self-governing, state mandated committee that serves as an advisor to the Alliance administration and board of directors, with a statutory requirement to participate in the Alliance budget process. The single-stream cuts in the pending state budget would mark the sixth consecutive year of reductions to the non-Medicaid state appropriation for services for uninsured/underinsured citizens with mental health, IDD, and SUD needs – some of the most vulnerable residents of our state. These cuts to this critical state behavioral health funding have diverted more than half a billion dollars from the state’s public behavioral health system, including what would be nearly $80 million from Alliance.

I urge you and your colleagues in the General Assembly to stop cutting single stream funding. These state funds are critical for providing services for uninsured/underinsured citizens with mental health, intellectual/developmental disabilities, and substance use disorder needs, and these budget cuts are directly at the expense of North Carolina’s most vulnerable populations.

Please hear and take to heart the following comments shared by our members:

“Budget cuts will affect me tremendously with OJ. It is hard enough to take care of an adult child. It will be even harder with the budget cuts.”

Carrie Morrisey, CFAC member

“With the cuts who will be responsible for the so-called future criminal activities and the criminal justice system who is not going to know what to do with the mental health consumers except lock them up.”

Dr. M. Michael Bryant McGuire, voter, retired LTC, disabled veteran, person living with a disability, advocate with a loud voice, and a CFAC member

“If funding cuts continue, the services for below poverty level residents will continue to be an issue.”

Ellen Gibson, CFAC Co-Chair
“I have a daughter who lives with schizophrenia who was diagnosed in her twenties and is now fifty years old. She lives by herself and is doing well at the present time. The reason that she is doing so well is because of the mental health program in place which could be in jeopardy when funding is cut or done away with.”

Dorothy Johnson, CFAC member

“State budget cuts have already been felt by the community. Further cuts will ripple through the community restricting access to care”
“Cuts have direct impact on families and stakeholders”
“Have caused children and families to go without crucial services needed to maintain health”
“Direct impact on homelessness within the catchment area”

Johnston County members

“I am living with bi-polar and I am an advocate for myself, my family and my community. I want more funding for people with no insurance and for the people that need help paying for services that their insurance does not pay for.”

Tammy Harrington, CFAC member

“Without this funding it causes a rippling effect which involves homelessness, unemployment, lack of retention, high emergency cost to the county in which you live.”

Charlitta Burriss, CFAC member

“Concerning health insurance, I feel it is unfair if the person or family can’t afford it, to take from and limit the needs of those that desperately need the help.”

Pinkey Dunston, CFAC member

“It grieves me as a mother to think of the world that my son will have to try to live a successful life as proposed changes take place. “

Regina Mays, CFAC member

“My biggest fear with the cuts is that I will be readmitted to the hospital and not be able to see my family”.

Faye Griffin, CFAC member

We have two clear and emphatic requests for you:
• Stop the single stream funding cuts to the LME/MCOs
• Sufficiently fund and strengthen our public behavioral healthcare system
Sincerely,

David Curro
Chair, Alliance Health CFAC

Members, Alliance Health CFAC:

Vicky Bass  Ellen Gibson  Regina Mays
Dorothy Best  Tracey Glenn-Thomas  Dr. Michael Bryant McGuire
Jackie Blue  Wanda (Faye) Griffin  Karen McKinnon
Jamille Blue  Briana Harris  Felishia McPherson
Charlitta Burruss  Sharon Harris  Trula Jean Miles
Helen Castillo  James Henry  Israel Pattison
Andrea Clementi  Steve Hill  Jason Phipps
Christopher Dale  Carole Johnson  Carrie Morrisey
LaDeana Dexter  Connie King Jerome  Anthony Sarasona
Bobby Dixon  Dorothy M. Johnson  Gregory Edward Schweizer
Albert Dixon, Jr.  Latasha Jordan  James (Dan) Shaw
Jerry Dodson  Joe Kilsheimer  Tammy Harrington Shaw
Marie Dodson  Jessica Larrison  Annette Smith
Pinkey Dunston  Renee Lloyd  Ben Smith
Shirley Francis  Tekeyyon Lloyd  Brenda Solomon
Bradley Gavriluk  Carson Lloyd, Jr.  Cassandra Williams-Herbert
Anna George  Megan Mason
To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service
Community Support Team (CST) provides direct support to adults with a Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis of mental illness, substance use, or co-morbid disorder and who have complex and extensive treatment needs. This service consists of community-based mental health and substance use services, and structured rehabilitative interventions intended to increase and restore a beneficiary’s ability to live successfully in the community. The team approach involves structured, face-to-face therapeutic interventions that assist in reestablishing the beneficiary’s community roles related to the following life domains: emotional, behavioral, social, safety, housing, medical and health, educational, vocational, and legal.

This is an intensive community-based rehabilitation team service that provides direct treatment and restorative interventions as well as case management. CST is designed to provide:
a. symptom stability by reducing presenting psychiatric or substance use disorder symptoms;
b. restorative interventions for development of interpersonal, community, coping and independent living skills;
c. psychoeducation;
d. first responder intervention to deescalate a crisis; and
e. service coordination and ensure linkage to community services and resources.

This team service consists of a variety of interventions available 24-hours-a-day, 7-days-a-week, 365-days-a-year, and delivered by the CST staff, who maintain contact and intervene as one organizational unit. CST services are provided through a team approach, however discrete interventions may be delivered by any one or more team members if clinically indicated. Not all team members are required to provide direct intervention to each beneficiary on the caseload. The Team Lead shall provide direct clinical interventions with each beneficiary.

1.1 Definitions
None

2.0 Eligibility Requirements
2.1 Provisions
2.1.1 General
(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)
a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in Section 3.0 of this policy.

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19J31
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific
(The term “Specific” found throughout this policy only applies to this policy)
a. Medicaid
   An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover Community Support Team services for an eligible beneficiary who is 18 years of age and older and meets the criteria in Section 3.0 of this policy.

b. NCHC
   NCHC shall cover Community Support Team services for an eligible beneficiary who is 18 years of age till he or she reaches their 19th birthday and meets the criteria in Section 3.0 of this policy.

   Retroactive eligibility does not apply to the NCHC program.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age
a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
   Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

   This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: [https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html](https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html)

   EPSDT provider page: [https://medicaid.ncdhhs.gov/](https://medicaid.ncdhhs.gov/)

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within Section 3.0 of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.
3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Community Support Team (CST) when ALL following criteria are met:

a. The beneficiary has a mental health or substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;

b. There is documented, significant impairment in at least two of the life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal). This impairment is related to the beneficiary’s diagnosis and impedes the beneficiary’s use of the skills necessary for independent functioning in the community;

c. For a beneficiary with a primary substance use disorder diagnosis, the American Society for Addiction Medicine Criteria Level I or higher level is met;

d. The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions; and there is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards; and

e. Two or more of the following conditions related to the diagnosis are present:

1. The beneficiary requires active rehabilitation and support services to achieve the restoration of functioning and community integration and valued life roles in social, employment, daily living, personal wellness, educational or housing domains;

2. Deterioration in functioning in the absence of community-based services and supports would lead to hospitalization, other long-term treatment setting or congregate care, such as adult care or assisted living;

3. The beneficiary’s own resources and support systems are not adequate to provide the level of support needed to live safely in the community;
4. One or more admissions in an acute psychiatric hospital or use of crisis or emergency services per calendar year, or a hospital stay more than 30-calendar days within the past calendar year;
5. Pending discharge (less than 30-calendar days) from an adult care home, acute psychiatric hospital, emergency department or other crisis setting;
6. Traditional behavioral health services alone, are not clinically appropriate to prevent the beneficiary’s condition from deteriorating (such as missing office appointments, difficulty maintaining medication schedules);
7. Legal issues related to the beneficiary’s mental or substance use disorder diagnosis;
8. Homeless or at high risk of homelessness due to residential instability resulting from the beneficiary’s mental health or substance use disorder diagnosis or has difficulty sustaining a safe stable living environment; or
9. Clinical evidence of suicidal gestures, persistent ideation, or both in past three months.

**Admission Criteria**

A comprehensive clinical assessment (CCA) is completed by a licensed clinician that meet the criteria included in 10A NCAC 27G. 0104 (12). The CCA demonstrates medical necessity must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may qualify as a current CCA. Relevant diagnostic information must be obtained and documented in the beneficiary’s Person-Centered Plan (PCP).

**Continued Stay Criteria**

a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary’s PCP; or the beneficiary continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; and
b. ONE of the following applies:
   1. The beneficiary has achieved current PCP goals and additional goals are indicated, as evidenced by documented symptoms;
   2. The beneficiary is making satisfactory progress toward meeting goals and there is documentation supporting continuation of this service is effective in addressing the goals outlined in the PCP;
   3. The beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary’s pre-morbid or potential level of functioning are possible; OR
   4. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. The beneficiary must be reassessed to identify any unrecognized co-occurring
disorders, and treatment recommendations need to be revised based on the findings.

**Transition and Discharge Criteria**
The beneficiary meets the criteria for discharge if any **ONE** of the following applies:

a. The beneficiary’s level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

b. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery, and is no longer in need of CST services;

c. The beneficiary has made limited or no progress, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or

d. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

### 3.2.2 Medicaid Additional Criteria Covered

None apply.

### 3.2.3 NCHC Additional Criteria Covered

None apply.

#### 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

##### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;

b. the beneficiary does not meet the criteria listed in **Section 3.0**;

c. the procedure, product, or service duplicates another provider’s procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

##### 4.2 Specific Criteria Not Covered

**4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

Medicaid and NCHC shall not cover these activities:

a. Transportation for the beneficiary or family members;

b. Any habilitation activities;

c. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;

d. Clinical and administrative supervision of CST staff, which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified on the beneficiary’s Person-Centered Plan;
i. Services provided without prior authorization;
j. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary’s life to address problems not directly related to the beneficiary’s needs and not listed on the Person-Centered Plan; and
k. Payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in Subsection 4.2.1 of this policy, NCHC shall not cover…
b. NC GS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under [the] North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Upon admission to Community Support Team, a beneficiary is allowed up to 36 units of service for an initial 30-day pass-through (calendar days). An authorization from the approved Department of Health and Human Services (DHHS) utilization review contractor is required after this initial 30-day pass-through. This pass-through is available only once per treatment episode per state fiscal year.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the DHHS Utilization Review Contractor the following:
   a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the beneficiary’s diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary’s Person-Centered Plan (PCP). Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review Contractor who evaluates the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary’s physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization, the CCA, service order for medical necessity, PCP, and the required NC Medicaid authorization request form must be submitted to the DHHS approved Utilization Management Review Contractor within the first 30-calendar days of service. Medicaid may cover up to 128 units for 60-calendar days for the initial authorization period.

For a beneficiary searching for stable housing in the community and require permanent supportive housing interventions, up to 420 units may be approved for the initial authorization period.

Reauthorization

NC Medicaid may cover up to 192 units for a 90-day reauthorization. For a beneficiary searching for stable housing in the community and require permanent supportive housing interventions, NC Medicaid may cover up to 630 units for a 90-day reauthorization. It is expected that service intensity titrates down as the beneficiary demonstrates improvement in targeted life domains. Reauthorization shall be submitted prior to initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the PCP, the authorization request form, and supporting documentation.

When it is medically necessary for services to be authorized for more than six months, a new comprehensive clinical assessment (CCA) or an addendum to the original CCA must be completed and submitted with a new service authorization request.
5.3 Additional Limitations or Requirements

a. A beneficiary will be offered a choice of CST providers that include Certified Peer Support Specialist (CPSS) on the team if it is medically necessary that beneficiary have a CPSS.

b. A beneficiary can receive CST services from only one provider organization during any active authorization period. The beneficiary may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.

c. Family members or legally responsible individuals of the beneficiary are not eligible to provide this service.

d. CST must not be provided in conjunction with Assertive Community Treatment Team Services.

e. CST may not be provided during the same authorization period as any other State Plan service that contains duplicative service components.

f. CST may not be provided to beneficiaries residing in Institutions for Mental Disease (IMD) regardless of the facility type.

g. For the purpose of helping a beneficiary transition to and from a service (facilitating an admission to a service, discharge planning, or both) and ensuring that the service provider works directly with the CST staff. CST services may be provided and billed for a maximum of eight units for the first and last 30-day period for beneficiaries who are authorized to receive one of the following services:
   1. Assertive Community Treatment Team
   2. Substance Abuse Intensive Outpatient Program
   3. Substance Abuse Comprehensive Outpatient Treatment

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary’s needs. A signed service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for twelve (12) months. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;

b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and

c. A service order must be in place prior to or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary’s progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must contain the credentials for professional or job title for associate
professional. A qualified professional (QP) is not required to countersign service notes written by staff who do not have QP status. The PCP and a documented discharge plan must be discussed with the beneficiary and documented in the service record.

5.5.1 Contents of a Service Note
For CST, a full-service note is required for each contact or intervention for each date of service, written and signed by the staff who provided the service. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must contain ALL the following elements:

a. Beneficiary’s name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (face-to-face, phone)
f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary’s progress towards the beneficiary’s goals;
k. Date and signature and credentials or job title of the staff member who provided the service; and
l. Each service note page must be identified with the beneficiary’s name Medicaid identification number and record number.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations
CST services must be delivered by providers employed by mental health or substance abuse provider organizations that:

a. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA);
b. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
c. meet the requirements of 10A NCAC 27G;
d. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
e. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies;
6.2 Provider Certifications

The CST shall be able to provide multiple contacts a week, daily, if needed, based on the severity of the beneficiary’s mental health and substance use disorder clinical and diagnostic needs, as indicated in the PCP.

It is understood that CST is appropriate to serve people who are homeless, transient, and challenging to engage. Therefore, the expectation is that collateral contacts made to locate and engage the beneficiary to continue the beneficiary’s treatment are documented in the service record.

CST varies in intensity to meet the changing needs of beneficiaries with mental illness and substance use disorders who have complex and extensive treatment needs, to support them in community settings, and to provide a sufficient level of service as an alternative to hospitalization. CST service delivery is monitored continuously and “titrated,” meaning that when a beneficiary needs more or fewer services, the team provides services based on that level of need.

Team Composition

CST staff work together as an organized, coordinated unit under the direct supervision of the Team Lead. All CST staff shall know all beneficiaries served by the team, but not all team members necessarily work closely with all beneficiaries. The case load is comprised of beneficiaries who require services ranging from minimal to an intensive nature. CST maintains a beneficiary-to-staff ratio of 12:1 with a team maximum of 48 individuals. The team caseload must be determined by the level of acuity and the needs of the beneficiaries served.

CST must be comprised of four full-time staff positions as follows:

a. One full-time equivalent (FTE) dedicated Team Lead who is a licensed clinician (Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Clinical Social Worker Associate, Licensed Professional Counselor, Licensed Professional Counselor Associate, or Licensed Marriage and Family Therapist) who has at least one-year experience with the knowledge, skills, and abilities required by the population and age to be served. The Team Lead shall meet the requirements specified for licensed clinician, according to 10A NCAC 27G. 0104 (12). An associate level licensed clinician actively seeking licensure may serve as the Team Lead conditional upon being fully licensed within 30-calendar months from the effective date of hire.

b. One FTE dedicated team member who is a licensed substance abuse professional. Team member can be a Certified Clinical Supervisor (CCS), Licensed Clinical Addiction Specialist (LCAS or LCAS-A), or a Certified Substance Abuse Counselor (CSAC).

c. Two FTE team members that are Qualified Professionals, Associate Professionals, Paraprofessionals or NC Certified Peer Support Specialist (NCCPSS). These team members shall have at least one-year of experience working with beneficiaries with mental health or substance use disorders and have the knowledge, skills, and abilities
required by the population and age to be served. These positions shall be filled by no more than four individuals.

The following charts reflect the activities and appropriate scopes of practice for the CST members:

<table>
<thead>
<tr>
<th>Community Support Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team Lead</strong></td>
</tr>
<tr>
<td>• Drives the delivery of this service</td>
</tr>
<tr>
<td>• Provides individual therapy for beneficiaries served by the team</td>
</tr>
<tr>
<td>• Behavioral interventions such as modeling, behavior modification, behavior rehearsal</td>
</tr>
<tr>
<td>• Designates the appropriate team staff so that specialized clinical expertise is applied as clinically indicated for each beneficiary</td>
</tr>
<tr>
<td>• Provides and coordinates the assessment and reassessment of the beneficiary's clinical needs</td>
</tr>
<tr>
<td>• Provides clinical expertise and guidance to the CST members in the team’s interventions with the beneficiary</td>
</tr>
<tr>
<td>• Provides the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all CST members except the Team Lead</td>
</tr>
<tr>
<td>• Determines team caseload by the level of acuity and the needs of the beneficiary served</td>
</tr>
<tr>
<td>• Facilitates weekly team meetings of the CST</td>
</tr>
<tr>
<td>• Monitors and evaluates the services, interventions, and activities provided by the team</td>
</tr>
<tr>
<td>• Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QP, Team Lead or Licensed Substance Abuse Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provides psychoeducation as indicated in the PCP</td>
</tr>
<tr>
<td>• Assists with crisis interventions</td>
</tr>
<tr>
<td>• Assists the Team Lead with behavioral and substance use disorder treatment interventions</td>
</tr>
<tr>
<td>• Assists with the development of relapse prevention and disease management strategies</td>
</tr>
<tr>
<td>• Coordinates the initial and ongoing assessment activities</td>
</tr>
<tr>
<td>• Develops the initial PCP and its ongoing revisions and ensures its implementation</td>
</tr>
<tr>
<td>• Consults with identified medical (i.e., primary care and psychiatric) and non-medical providers, engages community and natural supports, and includes their input in the person-centered planning process</td>
</tr>
<tr>
<td>• Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations</td>
</tr>
<tr>
<td>• Monitors and documents the status of the beneficiary’s progress and the effectiveness of the strategies and interventions outlined in the PCP</td>
</tr>
<tr>
<td>• Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services</td>
</tr>
</tbody>
</table>
### AP, QP, Team Lead or Licensed Substance Abuse Professional

- Provides psychoeducation as indicated in the PCP
- Assists with crisis interventions
- Assists the Team Lead with behavioral and substance use disorder treatment interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the PCP
- Communicates the beneficiary’s progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP
- Provides intensive case management
- Linkage and referral to formal and informal supports
- Monitoring and follow up
- Completes functional needs assessment(s) to determine the scope and anticipated outcomes to the services
- Assist with beneficiary housing search including engaging landlords to rent to beneficiaries and writing reasonable accommodation letters
- Assist with connecting beneficiaries to financial and in-kind resources to set up and maintain their household
- Prevent and mitigate housing crises including being a point of contact for landlord concerns
- Assist with rehousing beneficiaries if they are no longer able to stay in their unit due to eviction or risk of eviction
- Assist in developing daily living skills to stabilize and maintain housing

### Paraprofessional

- Provides psychoeducation as indicated in the PCP
- Assists with crisis interventions
- Assists the Team Lead with behavioral and substance use disorder interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the PCP
- Communicates the beneficiary’s progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP

### Certified Peer Support Specialist

- Serves as an active member of the CST, participates in team meetings, and provides input into the person-centered planning process
- Guides and encourages beneficiaries to take responsibility for and actively participate
in their own recovery
• Assists the beneficiary with self-determination and decision-making
• Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience
• Teaches and promotes self-advocacy to the beneficiary
• Supports and empowers the beneficiary to exercise his/her legal rights within the community
• Provides psychoeducation as indicated in the PCP
• Assists with crisis interventions
• Assists the Team Lead with behavioral and substance use disorder interventions
• Assists with the development of relapse prevention and disease management strategies
• Participates in the initial development, implementation, and ongoing revision of the PCP
• Communicates the beneficiary’s progress and the effectiveness of the strategies and interventions to the Team Lead as outlined in the PCP

Supervision Requirements
Clinical supervision for the CST Staff is provided by the licensed Team Lead who has the knowledge, skills, and abilities required by the population served. The licensed clinician facilitates a weekly face-to-face team meeting to ensure that the planned support interventions are provided; to allow the CST Staff to briefly discuss the status of all beneficiaries receiving services; problem-solve emerging issues; and plan approaches to intervene and prevent crises. The Team Lead monitors the delivery of CST to ensure the interventions are provided effectively to help the beneficiary restore community, daily living, personal, social and specific tenancy skills including obtaining and maintaining his or her own housing and develop natural supports, manage their illness, and reduce crises. Additional supervision or support may be provided as a group or with individual CST Staff as needed to address specific concerns or challenges.

*Clinical and administrative supervision of CST is covered as an indirect cost and therefore, must not be billed separately

6.3 Program Requirements
A face-to-face functional assessment is required to gather information to assist with determining the scope and anticipated outcome of the service. CST providers must use a functional assessment tool, recommended by the LME-MCO or DHHS, that contains the following domains:

a. Housing;
b. Personal Care;
c. Money Management;
d. Safety;
e. Transportation;
f. Communication;
g. Health Awareness;
h. Leisure;
i. Vocational or Educational; and
j. Self-Advocacy/Rights
The functional assessment is administered during the initial 60-calendar days of treatment and up to every 90-calendar days thereafter.

a. Development of a PCP through initial engagement with the beneficiary and promotion of the individual’s active participation in their plan. This consists of assisting the beneficiary to identify their preferences, desired community social roles, activities, and relationships, potential community supports, their strengths and barriers to their recovery adoptions in behavior and restoration of skills to overcome barriers.

b. Skills Development targeted at ONE or more of the following areas:
   1. the restoration of daily living skills (health, mental health and SUD; Focus on chronic illness education, money and benefits management, securing and maintaining housing or other living environment, personal responsibility, nutrition, menu planning and grocery shopping, personal hygiene and grooming).
   2. the restoration of appropriate social and role functioning in various community settings, communication and interpersonal relationships, the use of community services; role, rights, responsibilities of tenancy, and the development of appropriate personal and natural support networks;
   3. accessing and using appropriate mainstream medical, dental, mental health and SUD services;
   4. accessing, renewing, and using appropriate public entitlements and resources such as Social Security, Section 8, meeting requirements for securing and retaining affordable housing, transportation and food stamps;
   5. the restoration of wellness and use of recreational and leisure time and resources;
   6. skill training in maintaining relationships, self-advocacy and assertiveness in dealing with citizenship, legal, tenancy or other social and personal needs;
   7. skills of negotiating for accommodations related to their disabling condition and landlord, neighbor, employer relationships;
   8. the restoration of cognitive and behavior skills such as, the handling of emergencies, requesting reasonable accommodations, emergency preparedness and problem solving;
   9. wellness recovery focused on practicing stress management activities, managing chronic conditions, developing wellness and recovery plans, establishing and maintaining regular exercise, participating in spiritual or religious community; and
   10. the restoration of work and education readiness such as: improving communication skills, personal hygiene and dress, time management, other related skills preparing the beneficiary to take advantage of employment services or employment and educational opportunities.

Symptom Management and Recovery training and support. This consists of:

a. Symptom monitoring and self-management of mental health and SUD symptoms, that consists of identifying and minimizing of the negative effects of psychiatric or SUD symptoms which interfere with the individual’s daily living including securing and sustaining their living arrangements and assisting the beneficiary to identify and minimize their symptoms and potentially harmful behaviors;

b. Medication management;

c. Education and training on mental illness, SUDs, relapse identification, prevention and the promotion of recovery; and
d. Interventions that are evidence-based practices demonstrating effectiveness as a treatment or intervention for specific problems. These consist of: (1) motivational enhancement for eliciting behavior changes by helping individuals explore and resolve their ambivalence and achieve lasting change for a range of problematic behaviors; (2) cognitive-behavioral and behavioral shaping interventions that replace undesirable, unhealthy or unproductive behaviors with more desirable and effective ones through positive or negative reinforcement and cognitive restructuring approaches; (3) evidence based practices for working with individuals with co-occurring mental health and substance use disorders; and (4) harm reduction and implementing practices or programs that address the adverse effects of drug use such as overdose, HIV, hepatitis C, addiction, and incarceration.

Crisis Intervention: Face-to-face, short term interventions with a beneficiary who is experiencing increased distress or an active state of crisis. Interventions and strategies consist of:

a. Development and implementation of the beneficiary’s PCP comprehensive crisis plan, WRAP plan or Psychiatric Advance Directive;

b. Brief, situational assessment;

c. Verbal interventions to de-escalate the crisis;

d. Interventions to mobilize support systems

e. Relapse prevention planning

f. Requesting assistance from and making referrals to alternative services at the appropriate level; and

g. Assistance with addressing any other services or resources related issues, including medical, benefits, housing, or personal issues that may have occurred during the crisis.

Coordinating and managing services by:

a. Providing oversight for the integrated implementation of goals, objectives and strategies identified in the beneficiary’s service agreement;

b. Assuring stated measurable goals, objectives and strategies are met within established timeframes;

c. Assuring all service activities such as collaborative consultation and guidance to other staff and agencies serving the beneficiary and family, as appropriate;

d. Coordination to gain access and maintain housing, education, necessary rehabilitative and medical services, transportation, wellness and recovery services and benefits access; and

e. Monitoring and follow up to determine if the services accessed have adequately met the beneficiary’s needs.

Training Requirements

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Training Required</th>
<th>Who</th>
<th>Total Minimum Hours Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 calendar</td>
<td>▪ 3 hours CST Service Definition Required Components ▪ 3 hours of Crisis Response</td>
<td>▪ All Staff</td>
<td>6 hours</td>
</tr>
<tr>
<td>Time Frame</td>
<td>Training Required</td>
<td>Who</td>
<td>Total Minimum Hours Required</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td><strong>days</strong> of hire to provide service</td>
<td>▪ 3 hours of PCP Instructional Elements</td>
<td>CST Team Lead QPs responsible for PCP</td>
<td>3 hours</td>
</tr>
</tbody>
</table>
| Within **90 calendar days** of hire to provide this service | ▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training)  
▪ 15 hours of Permanent Supportive Housing Training  
▪ 3 hours of Basics of Psychiatric Rehabilitation and Functional Assessments  
▪ 3 hours of Trauma Informed Care  
▪ 12 hours of Designated therapies, practices or models below specific to the population(s) to be served by each CST Team. Practices or models must be treatment focused models, not prevention:  
  Cognitive Behavior Therapy:  
  Trauma-Focused Therapy (For Example: Seeking Safety, TARGET, TREM, Prolonged Exposure Therapy for PTSD:) or  
▪ 6 hours of Basic ASAM Criteria                                                                                                                                                                                                                                                                 | All Staff CST Team Lead QP AP Licensed Substance Abuse Professional | 46 hours                     |
| Annually  | ▪ Follow up training and ongoing continuing education required for fidelity to chosen modality*** (If no requirements are designated by developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.).                                                                                                                                                  | All CST Staff                                                        | 10 hours***                  |

*Provider must demonstrate documentation and hours reflect completion of chosen evidence-based treatment model.

** Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer.
***Modalities must be ONE of the following: Cognitive Behavioral Therapy, Trauma Focused Therapy, and Illness Management and Recovery (SAMHSA Toolkit).

Annual training for CST Staff shall be training that is appropriate for the population being served.

Trauma-focused therapy and Illness Management and Recovery training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific trainer qualifications are specified by the model, then the training must be delivered by a licensed professional.

The initial training requirements may be waived by the hiring agency if the team member can produce documentation certifying that training was completed no more than 24-months prior to hire date.

Licensed (or associate level licensed, under supervision) staff shall be trained in and provide the aspects of these practice(s) or model(s) that require licensure, such as individual therapy or other therapeutic interventions falling within the scope of practice. It is expected that licensed (or associate level licensed, under supervision) staff shall practice within their scope of practice.

Non-licensed staff (QPs, APs, PP, NCPSS) shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff must practice under supervision per the policy. It is the responsibility of the licensed (or Associate Level licensed, under supervision) supervisor and the CABHA Clinical Director to ensure that the non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

All the follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.

**Expected Outcomes**

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary’s PCP.

Expected outcomes are the following:

a. increased ability to function in the major life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal) as identified in the PCP;

b. reduced symptomatology;

c. decreased frequency or intensity of crisis episodes;

d. increased ability to function as demonstrated by community participation (time spent working, going to school, or engaging in social activities);

e. increased ability to live as independently as possible, with natural and social supports;

f. engagement in the recovery process;

g. increased identification and self-management of triggers, cues, and symptoms;
h. increased ability to function in the community and access financial entitlements, housing, work, and social opportunities;

i. increased coping skills and social skills that mitigate life stresses resulting from the beneficiary’s diagnostic and clinical needs;

j. increased ability to use strategies and supportive interventions to maintain a stable living arrangement; and

k. decreased criminal justice involvement related to the beneficiary’s mental health or substance use disorder diagnosis.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).
# 8.0 Policy Implementation and History

**Original Effective Date:** July 1, 2010

**History:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Section or Subsection Amended</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/2019</td>
<td>All Sections and Attachment(s)</td>
<td>The existing Service definition, Community Support Team removed from policy 8A, to become a stand-alone clinical coverage policy, 8A-6, <em>Community Support Team</em>.</td>
</tr>
<tr>
<td>11/01/2019</td>
<td>Attachment A</td>
<td>Updated policy template language “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines.
All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

<table>
<thead>
<tr>
<th>HCPCS Code(s)</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2015</td>
<td>1 unit = 15 minutes</td>
</tr>
</tbody>
</table>

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.
D. Modifiers

<table>
<thead>
<tr>
<th>Team Staffing Description</th>
<th>HCPCS Modifier 1</th>
<th>HCPCS Modifier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Team Lead</td>
<td>HT</td>
<td>HO</td>
</tr>
<tr>
<td>Licensed Clinical Addictions Specialist, Licensed Clinical Addictions Specialist-Associate, Certified Clinical Supervisor, or Certified Substance Abuse Counselor</td>
<td>HT</td>
<td>HF</td>
</tr>
<tr>
<td>Qualified Professional or Associate Professional</td>
<td>HT</td>
<td>HN</td>
</tr>
<tr>
<td>NC Peer Support Specialist</td>
<td>HT</td>
<td>U1</td>
</tr>
<tr>
<td>Paraprofessional</td>
<td>HT</td>
<td>HM</td>
</tr>
</tbody>
</table>

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Units are billed in 15-minute increments.

LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their network providers’ adherence to service guidelines to assure quality services for beneficiaries.

F. Place of Service

CST is a direct and indirect periodic rehabilitative service in which CST members provide medically necessary services and interventions that address the diagnostic and clinical needs of the beneficiary and help the beneficiary successfully transition to community living. CST members also arrange, coordinate, and monitor services on behalf of the beneficiary. CST provider shall deliver services in various environments, such as, primary private residences, schools, courts, homeless shelters, street locations, and other community settings.

Program services are primarily delivered face to face with the beneficiary and in locations outside the agency’s facility. The aggregate services delivered by the credentialed provider site must be assessed and document annually by each credentialed provider site using the following quality assurance benchmarks:

- At least 75% of CST services must be delivered face-to-face by the team with the beneficiary. The remaining time may either be by phone or collateral contact; and
- At least 75% of staff time must be spent working outside of the agency’s facility with or on behalf of the beneficiary.

CST also contains telephone time with the beneficiary and collateral contact with persons who assist the beneficiary in meeting the beneficiary’s rehabilitation goals specified in the PCP. CST provides participation and ongoing clinical involvement in activities and meetings for the planning, development, implementation and revision of the beneficiary’s PCP.

Providers that deliver CST shall provide “first responder” crisis response 24-hours a day, 7 days a week, 365 days a year, to a beneficiary of this service.
G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/
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. ☐Felishia McPherson ☐Alejandro Vasquez ☐Andrea Clementi

BOARD MEMBERS PRESENT:

GUEST(S): ☐Vic Dawson, ☒Jason Francis, ☒Alexander McArthur, ☐Tim Thomas

STAFF PRESENT: ☐Doug Wright, Director of Community & Member Engagement, ☒Terrasine Gardner, Member Engagement Manager, ☒Starlett Davis, Individual & Family Engagement Specialist, Nathania Headley, ☒Briana Parkins

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

1. WELCOME AND INTRODUCTIONS: Michael McGuire

2. REVIEW OF THE MINUTES – The minutes from the September 26, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Click here to enter text. and seconded by Click here to enter text. to approve the minutes. Choose an item.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>Michael and Starlett Starlett went over the community events and resources have been provided. Jackie mentioned that she will be working on a Mayor’s Council for People with Disabilities. Terrasine shared that on January 13th at 1pm to 5pm there will be a Crisis Continuum Mapping Meeting hosted by Alliance. Alliance is wanting to have it at DSS. It is the planning phases. They want the Community Collaborative, CFAC and providers to come. Alejandro explained a situation he had with his Social Security. He offered to send everyone an electronic copy of the 2019 SSA handbook. He explained that this was a valuable resource to him and wanted to share. He will send it to Starlett and she will get it out to the committee.</td>
<td>See Starlett, Terrasine or Doug for any questions on upcoming events.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4. State Updates</td>
<td>Roanna explained the CFAC and BHIDD Tailored Plans feedback needed. She posed the question about portion of the Future Local CFAC composition. In the Composition it says “Adult consumers of mental health, developmental disabilities, and substance abuse services, and at least two individuals with health co-morbidities….“ She asked if the committee felt that this information should be a part of the standards for an individual to be a member. She went on to explain that this would mean that as a member discloses their challenge with mental health, substance use or I/DD, they would also disclose if they had any physical health challenges as a part of</td>
<td>See Starlett, Terrasine or Doug for any questions on the CFAC BHIDD Tailored Plans Feedback. Roanna will keep us updated. Complete the survey by December 6th.</td>
<td>December 6, 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.
the identified population of the committee. The committee members did not agree with this. They felt that they already had the challenge of disclosing their mental health, substance use and I/DD status and the stigma that came with it. They did not feel it necessary to add more to that. They felt that their physical health records were very personal and not something they should have to share. Her second question for feedback was if it should be required for a person with a TBI to be a population group for the local CFAC committees. The members did not agree with this. They felt that CFAC is already inclusive and open to anyone of that population. However, it shouldn’t be a requirement that an individual with a TBI to be a part of the committee. This could pose problems if the population slots were not filled. Ms. Roanna gave her feedback on how this process would work. She explained that in December, she would pull all the information from the surveys and present it to the CFACs. She explained the importance of completing the surveys. Starlett stated she would send the survey link out again the next day and asked that everyone go ahead and complete it on Friday if they could. However, the deadline to get it in would be December 6th.

Terrasine went over the CST Final Definition and the Peer Support Definition. The committee was provided a copy of them via email and some were available at the meeting. Some questions came up about the changes with Peer Support and having to start the process over. Terri explained that she didn’t think that anything would start over but possibly more training would be involved. Starlett will send out a synopsis of them to give the committee a better idea of the definitions.

Roanna spoke about the November 2019 CE&E Update. She explained that the updates would be a bit different in the new year. They intended to cut down on the paper and make it a bit more environmental.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
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</thead>
<tbody>
<tr>
<td>5. MCO</td>
<td>Terrasine Gardner discussed the Open Letter to General Assembly. We went over the copy given to everyone. She thanked everyone for their efforts in getting it done.</td>
<td>N/a</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>
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</tr>
</thead>
<tbody>
<tr>
<td>6. Upcoming Community Events/ Community Outreach event</td>
<td>Starlett Davis and Michael McGuire CFAC hosted a viewing of the Anonymous People at Health Department. It went well. The staff at the viewing enjoyed it and some wanted CFAC to sponsor viewings at other venues in the community. Starlett explained that this was the goal for the committee and how important it is for us to keep going with spreading awareness. Michael spoke about the Community Medicaid Transformation at DSS the previous night. He spoke about the wealth of information given. The standard plans were there and representatives from Raise the Age and First Families. He also mentioned the delay in Medicaid Transformation. He explained the importance of advocacy. Starlett added more details about the forum and that Alliance will keep moving forward and keep the committee updated. The committee, Terrasine, and Roanna spoke a bit more about the delay in Medicaid Transformation. A Q&amp;A sheet from DHHS was distributed to the committee and guest to assist with understanding the delay.</td>
<td>Starlett, Michael and Ellen will keep the committee updated on the next viewing in the community.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>7. Membership Discussion</td>
<td>Michael McGuire gave the benefits of CFAC and becoming a member. The question about Capped membership was brought up. Michael explained that the discussion was had about putting a cap on membership. The bylaws were reviewed and there wasn’t anything about a cap in them. However, he explained that he wanted to make sure that those who joined would be consistent and wanting to participate.</td>
<td>See Starlett, Terrasine or Doug for any questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>8. Prep for next meeting</td>
<td>Michael McGuire- Discuss the next meeting agenda items. He proposed a vote for the December meeting. It was decided by the committee that we would not meet in December and would resume in January. He also asked everyone to bring 2 people with them at the next meeting.</td>
<td>Bring 2 people with you to the next meeting. No meeting in December. Next meeting January 23rd.</td>
<td>January 23, 2020</td>
</tr>
<tr>
<td>9. Appreciation</td>
<td>Everyone gave their appreciation</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**ADJOURNMENT:** 7:10pm

Respectfully Submitted by:

---

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
CFAC Composition & Structure
BH I/DD Tailored Plans

October 9, 2019
DHHS CFAC Composition Recommendations
Future State CFAC Composition

State CFAC Purpose

The State CFAC shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

State CFAC Composition

- 21 members total, appointed as follows (aligns with today’s process):
  - 9 appointed by the Secretary
    - Each of the disability groups (mental health, developmental disabilities, and substance abuse services, including at least two individual with a physical health co-morbidities) must be represented
    - The terms shall be staggered so that 3 of the appointees’ terms expire each year
  - 4 appointed by the President Pro Tempore of the Senate*
    - 1 from the Eastern Region; 1 from the Central Region; 2 from the Western Region
  - 4 appointed by the Speaker of the House of Representatives*
    - 1 from the Eastern Region; 1 from the Western Region; 2 from the Central Region
  - 4 by the North Carolina Association of County Commissioners*
    - 1 from the Central Region; 1 from the Western Region; 2 from the Eastern Region

* The terms shall be staggered so that 1 appointee’s term expires every year

Note: The term “substance abuse” is consistent with current 122C statutory language
Future Local CFAC Composition

Local CFAC Purpose

- A local CFAC shall be a self-governing and a self-directed organization that advises the area’s BH/IDD Tailored Plans in its catchment area on the planning and management of the local public mental health, developmental disabilities, and substance abuse services system

Local CFAC Composition

- Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters
- Each of the disability groups (mental health, developmental disabilities, and substance abuse services) shall be equally represented on the CFAC
- The CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area
- The terms of members shall be three years, and no member may serve more than three consecutive terms
- CFAC composition:
  - Adult consumers of mental health, developmental disabilities, and substance abuse services, and at least two individuals with physical health co-morbidities
  - Family members of consumers of mental health, developmental disabilities, and substance abuse services

*Note*: The term “substance abuse” is consistent with current 122C statutory language
CFAC and BH/IDD Tailored Plan Governing Boards
DHHS is not recommending legislative changes related to the role of CFAC members on BH/IDD TP Governing Boards compared to the current LME Governing Boards.

Current legislation, under 122C-118.1 requires the following CFAC representation on LME boards:

- The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.
- At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
  - Individuals with mental illness.
  - Individuals in recovery from addiction.
  - Individuals with intellectual or other developmental disabilities.
- At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
  - Individuals with mental illness.
  - Individuals with intellectual or other developmental disabilities.
  - Individuals in recovery from addiction.
CFAC Feedback and Priorities
Thank You!
Medicaid Managed Care FAQ

What is the impact of Managed Care Suspension?

For now, North Carolina will not move Medicaid to Managed Care. Current Medicaid beneficiaries will keep getting uninterrupted Medicaid services from the State the way they do now and will continue to receive care from their current primary care provider (PCP). Beneficiaries do not need to choose a health plan at this time. The State will inform beneficiaries when Managed Care restarts and when they will need to choose a health plan.

WHEN WILL MANAGED CARE RESTART? WHEN WILL MY HEALTH PLAN START?

For now, the move to Managed Care is on hold. The State will tell you when it restarts and when you will need to choose a health plan.

DOES THIS CHANGE MY MEDICAID COVERAGE?

No. Your coverage will stay the same. You will keep getting your Medicaid coverage and health services from the State the way you do now. You will keep the primary care provider (PCP) you have now.

DO I NEED TO DO ANYTHING RIGHT NOW? DO I NEED TO STILL CHOOSE A HEALTH PLAN?

No. You do not need to do anything now. You do not need to choose a health plan. You will keep getting your Medicaid coverage and health services from the State the way you do now. You will get a letter in the mail. It will confirm that you will keep the Medicaid coverage you have now. The State will tell you when Managed Care restarts and when you will need to choose a health plan.

CAN I STILL SEE MY DOCTOR?

Yes. You can go to the primary care provider (PCP) listed on your Medicaid card. If you want to confirm the name of the PCP listed or change to a new PCP, call the North Carolina Medicaid Contact Center at 1-888-245-0179. Or call your DSS county caseworker.

WILL I STILL GO TO MY LME-MCO FOR BH/IDD BENEFITS?

Yes. If you are currently receiving services from an LME-MCO, you will continue to get those services.
### WHAT IF MY MEDICAID COVERAGE IS SET TO END BEFORE MANAGED CARE RESTARTS?

If your coverage is set to end before Managed Care restarts, your Medicaid coverage will go through the same yearly eligibility review and recertification process used today.

### WHAT IF I ALREADY CHOSE A HEALTH PLAN? DO I STILL GET THE ADDED SERVICES FROM THAT PLAN?

No. You will not move to a health plan now, so you will not get any added services the health plan offers. You will keep the same Medicaid coverage and health services from the State that you have today.

### DO I STILL NEED TO ENROLL WHILE MANAGED CARE IS ON HOLD? CAN I STILL CHOOSE A PLAN OR PRIMARY CARE PROVIDER (PCP) FOR MY HEALTH PLAN?

No. You cannot choose a health plan or PCP for a health plan now. The State will tell you when Managed Care restarts. You will be asked to choose a health plan then.

### WHY WAS MANAGED CARE DELAYED? WHY DID THIS HAPPEN?

Legislators did not take actions needed to move forward with managed care, so Managed Care can't go-live at this time. You will continue to get health services as you do today through Medicaid Direct.

### WILL MANAGED CARE EVER RESTART/HAPPEN?

Managed Care is on hold at this time until further notice. The State will tell you when Managed Care restarts and when you will need to choose a health plan.

### WHO DO I CALL IF I HAVE MORE QUESTIONS?

You can call the North Carolina Contact Center at **1-888-245-0179**. The Center is open Monday through Friday from 8 a.m. to 5 p.m.
Community Engagement & Empowerment Team – Update

November 2019

Medicaid Managed Care Open Enrollment Now through December 13, 2019 – Medicaid beneficiaries in all 100 counties can now chose a health plan to provide their Medicaid services, and their primary care provider. To find out how to enroll visit www.ncmedicaidplans.gov or call 1-833-870-5500.
https://www.ncmedicaidplans.gov/

1. The Department of Health and Human Services is committed to providing our county partners with resources to help Medicaid beneficiaries smoothly transition to managed care. This webpage is your "County Playbook," a place where general and detailed information will be stored to help you support North Carolina’s transformation to Medicaid Managed Care. Visit your County Playbook often for new additions.
https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care

2. Just a FYI/Reminder – SAMHSA has a 24/7, 365 day- a-year, Disaster Distress Hotline to provide immediate crisis counseling for anyone experiencing emotional distress related to disasters, including hurricanes. The Department’s Comms team is already pushing the phone number through social media. The phone number is 1-800-985-5990 or text TalkWithUS to 66746. Spanish speakers can call the hotline and press 2 for bilingual support.

3. DMH DD SAS Customer Service and Community Rights Team may be contacted concerning any complaints and or concerns regarding access to or quality of MH DD SAS Services. Here are the phone numbers for the CSCR Team:
919-715-3197 – Office
1-855-262-1946 – Toll-free
Link to the webpage https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/customer-service-and-consumer-empowerment

4. NC DHHS does fund a Refugee Assistance program, which could possibly be of assistance to refugees from Latin American countries. Individuals eligible for NC Refugee Assistance Program include:
   - Refugees, individuals fleeing from persecution in their homelands
   - Certain Cuban/Haitian entrants and parolees...
   - Victims of human trafficking
   - Asylees
Link to the webpage https://www.ncdhhs.gov/assistance/refugee-services

5. Link to bilingual counseling services offered by the Diocese of Raleigh Catholic Charities.
https://www.catholiccharitiesraleigh.org/causes/counseling/
6. **#CareForNC** – All LME/MCO’s have joined to work together to make sure everyone can reach their potential. Each LME/MCO’s websites have access to this project. You can also visit **#CareforNC**.

7. Some legislative committee meetings are on the calendar. To keep track of the scheduled meetings, go to: [https://www.ncleg.gov/LegislativeCalendar](https://www.ncleg.gov/LegislativeCalendar).

8. [https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf](https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf)

   [https://files.nc.gov/ncdhhs/BH-IDD-TP-FinalPolicyGuidance-Final-20190318.pdf](https://files.nc.gov/ncdhhs/BH-IDD-TP-FinalPolicyGuidance-Final-20190318.pdf)

10. [https://www.ncdhhs.gov/assistance/medicaid-transformation](https://www.ncdhhs.gov/assistance/medicaid-transformation) and click on “Read the Final Policy Guidance” found in the “Latest News” banner.


12. NCDHHS Newsletter – please sign up so that you will receive the most recent news and information from the Department: [https://www.ncdhhs.gov](https://www.ncdhhs.gov)

13. [www.NoKidHungryNC.org](http://www.NoKidHungryNC.org) – Please go on this site if you know of or need food for your child.

14. [NCGWG.org](http://NCGWG.org) – use this website for all the updated information form the Governor’s Working Group on veterans, service members, and their families.

*Please check these web sites for the newest updates and information.*

1. DHHS Joint Communication Bulletins:  
   [https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins](https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins)

2. Medicaid Transformation:  
   [https://www.ncdhhs.gov/assistance/medicaid-transformation](https://www.ncdhhs.gov/assistance/medicaid-transformation)  
   More information NC Medicaid Managed Care Public notices, press releases, session laws and submit a comment feedback is welcome and encouraged.
Upcoming Events
Check attached flyers

Webinar’s
➢ Webinar’s on TBI – www.bianc.net
➢ Additional Webinars on Medicaid Transformation: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses
➢ Nov. 6, 2019: How Beneficiaries Move Between the Standard Plan and BH I/DD Tailored Plan. 2:00PM -3:00PM https://www.ncdhhs.gov/how-beneficiaries-move-between-standard-plan-and-bh-idd-tailored-plan
➢ Nov. 14, 2019: PAIMI Advisory Council Quarterly Call: Peer Support Model: 3:00-4:00 PM—Go to the National Disabilities Rights web site to register. www.ndrn.org

EVENTS
➢ Nov. 7, 2019: Rockingham County: Newsmakers Forum on Hunger • 1:00pm–5:30pm Location: Rockingham Community College, 560 County Home Road – open to the public
➢ Nov. 20, 2019: 1:00pm-3:00pm CET Training: The link between Gut Health and Behavioral Health, Eastern AHEC. Location: 2600 W. Arlington Blvd PO Box 7224, Greenville, NC 27835-7224
➢ Nov. 21, 2019: Brunswick County: Newsmakers Forum on Hunger • 12:30pm–4:00pm Location: Virginia Williamson Event Center, Brunswick Community College
➢ January 24, 2020 – Behavior plans for Adults with Autism Spectrum Disorders and/or Intellectual Developmental Disabilities Location: The Education Center at Eastern AHEC 2600 W. Arlington Blvd., Greenville, NC 27835-7224
➢ February 6, 2020 – CIT Conference Location: Them McKimmon Center, Raleigh NC Keynote Speaker: NC Attorney General Josh Stein
- **March 19 - 20, 2020** – 2020 Intellectual & Developmental Disabilities Services Conference
  **Location:** The Education Center at Eastern AHEC 2600 W. Arlington Blvd., Greenville, NC 27835-7224

- **March 31, 2020** – NCSBHA 2020 Annual Conference “Sowing the Seeds of Hope” - Stay tuned for registration announcements. For more information, contact Carty Beaston at 336-713-7754 or cbeaston@wakehealth.edu


**Youth/Young Adult Voice Award Nominations are being sought.**

Any youth/young adult can be nominated for the Recovery Voice Award! Award winners will be recognized at the 11th Annual NC “ONE Community in Recovery” Conference, March 11 – 13, 2020 and will be provided FREE LODGING AND REGISTRATION to the conference! This year’s conference will be held at: Wyndham Garden – 415 S. Swing Street – Greensboro, NC 27409

Youth/Young Adult Voice Award Description: This award will recognize and celebrate a youth/young adult under the age of 22 in North Carolina who has dedicated their individual talents, whether through sharing their story, advocacy or volunteering, to successfully promote resilience mental health and/or substance abuse recovery.

Nominations should describe how a youth/young adult has used their voice to do any of the following:

- Educate agencies and the provider network workforce (including schools, child welfare, law enforcement and community-based organizations) who support youth/young adults receiving mental health, substance abuse and/or trauma-related services;

- Promote recovery-oriented systems of care by advocating for meaningful youth/young adult participation as full partners in service planning and systems level decision-making; and/or

- Advocate for system-wide oriented change through youth-led/guided approaches that is trauma-informed, promotes positive youth development and individualized pathways to mental health and/or substance use recovery.

Additional information including how to complete and submit a nomination can be found at this link:

[https://northwestahec.wakehealth.edu/brochures/NCONE2020YouthAward.pdf](https://northwestahec.wakehealth.edu/brochures/NCONE2020YouthAward.pdf)

Nomination Deadline: December 20, 2019

Award Recipient Notification: January 10, 2020

Questions may be directed to: Nicole Ness

email: nicole.ness@dhhs.nc.gov

Phone: 919-715-2454
Recovery Champion Award Nominations are being sought.

Anyone can be nominated for the Recovery Champion Award! Award winners will be recognized at the 11th Annual NC “ONE Community in Recovery” Conference, March 11 – 13, 2020 and will be provided FREE LODGING AND REGISTRATION to the conference!

This year’s conference will be held at: Wyndham Garden – 415 S. Swing Street – Greensboro, NC 27409

Recovery Champion Award Description: This award will recognize three individuals: one each from the Western, Central and Eastern regions of North Carolina.

Recovery Champion Awards will be given to people who have dedicated their individual talents, whether through professional work or volunteering, to successfully promote mental health and/or substance use recovery.

Nominations should describe how a NC Recovery Champion has promoted recovery-oriented programming, created system-wide recovery-oriented change, or supported the recovery process of specific individuals.

Instructions on how to submit a nomination can be found here: https://northwestahec.wakehealth.edu/brochures/NCONE2020ChampionAward.pdf

Nomination Deadline: December 20, 2019

Award Recipient Notification: January 10, 2020

Questions may be directed to: Nicole Ness email: nicole.ness@dhhs.nc.gov Phone: 919-715-2454
PhotoVoice Project

Join us for 5 hands-on PhotoVoice workshop sessions that provide you an opportunity to express yourself creatively through photography. In this workshop, participants will take photos, share their photos with the group, and develop insights through facilitated discussions and personal reflection. You will be taking photos between sessions using a digital camera. No photography experience or training needed.

Participation in all 5 sessions is important.

<table>
<thead>
<tr>
<th>Session #1</th>
<th>Saturday</th>
<th>11/9/2019</th>
<th>11:00a-1:30p</th>
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</thead>
<tbody>
<tr>
<td>Session #2</td>
<td>Wednesday</td>
<td>11/13/2019</td>
<td>6:00p-8:30p</td>
</tr>
<tr>
<td>Session #3</td>
<td>Saturday</td>
<td>11/16/2019</td>
<td>11:00a-1:30p</td>
</tr>
<tr>
<td>Session #4</td>
<td>Wednesday</td>
<td>11/20/2019</td>
<td>6:00p-8:30p</td>
</tr>
<tr>
<td>Session #5</td>
<td>Saturday</td>
<td>11/23/2019</td>
<td>11:00a-1:30p</td>
</tr>
</tbody>
</table>

PhotoVoice:
Digital storytelling for youth and young adults promoting self-expression, self-empowerment, and healing by breathing life into recovery.

Free workshop series ages 12 to 18

Loaner Cameras will be provided

MHA of Central Carolinas
3703 Latrobe Drive
Suite 220
Charlotte, NC 28211

If you are interested in participating please return the PhotoVoice Interest form (page 2) to:

Kevin Markle
704.365.3454 ext. 225
kmarkle@mhacentralcarolinas.org
Understanding the Juvenile Justice System
Lunch & Learn Workshop

Sponsored by Randolph/Montgomery: A Family Support Program of Sandhills Center in collaboration with NC Families United

Presenter: Sheryl Conrad, Field Service Specialist

November 19, 2019
12:00-1:30 pm

Objectives:
1. Explain Juvenile Code 7B-1501 Definition of a Juvenile
2. Explain the Juvenile Justice Process
3. Identify Resources used to Strengthen Juveniles & Families

“People Helping People”

Lunch will be provided at no cost!

Location of Event: Montgomery Co. Partnership for Children
404 N. Main St. Troy, NC 27371

Registration Ends November 15, 2019 by 5:00 pm
To Register Contact: Brenda Goss, Family Advocate
Toll Free: 1-877-211-7252 or email: randmontadvfsp@gmail.com
Conversations with Families, Family Partners, and Community Partners: Medicaid Transformation Webinar- Part 2

November 19, 2019, 1:00 p.m.

The i2i Center for Integrative Health is partnering with the NC Collaborative for Children Youth and Families (NCCCYF) and NC Families United (NCFU) to host 2 webinars - Conversations on Medicaid Transformation. These webinars are specifically designed to educate families, Family Partners, and Community Partners on Medicaid Transformation to increase their collective understanding of the changes occurring with the start of Medicaid managed care in North Carolina. In addition, representatives from two Medicaid managed care organizations – Carolina Complete Health and NC Healthy Blue – will bring information to answer any plan or service specific questions/concerns you may have.

Webinar Locations

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<thead>
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<th>Contact</th>
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<tr>
<td>Trillium Health Resources</td>
<td><a href="mailto:sjustiss@ncfamiliesunited.org">sjustiss@ncfamiliesunited.org</a></td>
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<td>Ahoskie Boardroom</td>
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<td>144 Community College Road</td>
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<td>Robeson County Cooperative Extension</td>
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If you would like to register for the webinar send participant name, agency and location of webinar attending to Stacy Justiss at NC Families United: sjustiss@ncfamiliesunited.org. This is an ON-SITE webinar. Registration is limited at most locations and will close at noon Friday November 15, 2019.

Thank you to our Webinar Sponsors:
Understanding Medicaid Transformation for Community Leaders: How to Prepare Today for Tomorrow

On February 1, 2020, North Carolina is adopting a nationally recognized managed care model for Medicaid and its effect is far-reaching for anyone who works with Medicaid consumers. This change requires the integration of all sectors of healthcare, as well as integration with human services. And with each change, comes a change in Medicaid infrastructure that has impact at the community level.

SYMPOSIUM OBJECTIVES:

- Review the overall vision for Medicaid Transformation and how it will integrate care for North Carolina’s citizens and address Social Determinants of Health
- Define the differences between the benefit packages of the Standard Plan and Tailored Plans, including services, care integration, networks, regions, and role of the PHPs and LME/MCOs
- Review the Consumer Engagement and Outreach aspects of Medicaid Transformation
- Define the new quality of care aspects of Transformation that will involve outcomes and Value-Based Care, Advanced Medical Homes, Care Management Agencies and Clinically Integrated Networks
- Discuss the role of Social Determinants of Health and the expectation for community involvement in addressing these needs
- Identify how local communities will be impacted by Medicaid Transformation, how to prepare for the coming changes and your role in operationalizing and creating community partnerships and opportunities that will improve care for Medicaid recipients

THIS SYMPOSIUM IS DESIGNED TO:

- Offer you details on the key aspects of Medicaid Transformation
- Help you understand how all the pieces fit together
- Discover how you and your community can respond in order to operationalize these changes locally.

TARGET AUDIENCE:

Rural Health, Federally Qualified Health Centers, Departments of Social Services, Special Education/School Mental Health, Primary Care Providers, County Commissioners, Independent Mental Health Practitioners, Providers, Direct Support Staff, Juvenile Justice, System of Care Professionals, and Court Officers. This event will also be of interest to people with lived experience and family members.
SOUTHERN REGIONAL AHEC WILL OFFER - UP TO 4.25 HOURS OF CONTINUING EDUCATION CREDITS

Substance Abuse - 4.25 hours of NAADAC Credit will be awarded to participants who attend 100% of the program. Southern Regional AHEC adheres to NAADAC Education Provider Guidelines Provider #943

Social Workers and others - 4.25 contact hours. 4.25 Contact hours for social workers are included in this program. This program does not provide specific NBCC Credits. However, per LPC licensure guidelines, you may submit up to 4.25 contact hours of continuing education by attending programs by affiliates of the National Area Health Education Center Education (NAO). SR-AHEC is a member of the NAO.

$99 INCLUDES LUNCH
REGISTER AT I2ICENTER.ORG/EVENTS/CONFERENCE/

MODERATOR:
TARA LARSON, Vice President, Candor Collaborative Resources, Inc.
January 24, 2020
The Education Center at Eastern AHEC
2600 W. Arlington Blvd.
Greenville, NC

About the Workshop
This workshop will teach participants how to implement behavior management strategies that utilize Structured TEACChing methods for adults with Autism Spectrum Disorder (ASD) and Intellectual Developmental Disabilities (I/DD). Participants will learn how ASD and I/DD affects the learning style and behavior of individuals and how to avoid, analyze, and address behavior problems. The format of this workshop will include presentations, interactive discussions, video presentations, and small group activities.

Objectives
- Identify learning styles of individuals with ASD/IDD and how these learning styles affect behavior
- Review similar and distinct symptoms of ASD/IDD and other co-morbid diagnoses
- Discuss how to distinguish between antecedent and consequence-based approaches to behavior management
- Implement Structured TEACChing strategies and other current practices to address behavioral issues
- Apply a behavioral assessment and implement problem solving approaches to reduce behavioral difficulties
- Demonstrate how to develop and implement behavior plans that utilize meaningful visual structure to reduce problem behaviors and promote independence

Target Audience
- Licensed Professional Counselors
- Psychologists
- Marriage and Family Therapists
- School-based Personnel
- Care Coordinators
- Therapists and Clinicians working with individuals with Autism Spectrum Disorder and/or Intellectual Developmental Disabilities
- Psychiatric Nurses
- Case Managers
- Social Workers
Faculty

Nicole Ginn Dreiling, PhD is a Clinical Assistant Professor at the UNC School of Medicine at the Raleigh TEACCH Center, which is part of the statewide TEACCH program that serves children and adults with autism and their families. She completed her clinical internship at the Mailman Center for Child Development in Miami, FL and received her Ph.D. in Clinical Psychology from the University of Florida. Her clinical and research interests include assessment and intervention for children, adolescents, and adults with autism, as well as treatment outcomes for young children with ASD with disruptive or aggressive behaviors.

Lindsey Williams, PhD is a Clinical Assistant Professor at the UNC School of Medicine at the Raleigh TEACCH Center, which is part of the statewide TEACCH program that serves children and adults with autism and their families. She completed her clinical internship at the Indiana University School of Medicine in Indianapolis and received her Ph.D. in Clinical Psychology from Louisiana State University. Her clinical and research interests include assessment and intervention across the lifespan, with particular focus on mental illness, transitioning to adulthood, and healthy aging in our adolescent and adult population.

Americans with Disabilities Act

Individuals requesting accommodations under the Americans with Disabilities Act (ADA), should contact the ECU Department of Disability Support Services at (252) 737-1016 (V/TTY) at least five business days prior to the program.

Credit

Category A-NC Psychology Credit
This program will provide 6.0 contact hours of (Category A) continuing education for North Carolina psychologists. No partial credit will be given.

Contact Hours
Certificates reflecting 6.0 contact hours of education will be awarded at the completion of the program.

National Board for Certified Counselors Credit (NBCC)
Eastern AHEC has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 5645. Programs that do not qualify for NBCC credit are clearly identified. Eastern AHEC is solely responsible for all aspects of the programs.

Registration Information

Registration is online only at www.easternahec.net and requires a current MyAHEC account. Registration will close the day before the program at 6:00 a.m.

Fee: $90.00
The registration fee includes program materials, refreshments, and credit.

Attendance at this activity grants permission for Eastern AHEC to use any photographs, audio, video, or other images from this activity for promotional or educational purposes. Please notify an AHEC staff member if you have concerns.

Eastern AHEC Cancellation Policy

• Cancellations must be in writing (easternahec@ecu.edu).
• Registrants canceling between two weeks and two full business days prior to the first day of the event are refunded at 70% of the registration fee subject to a minimum $25 cancellation fee.
• No refunds or credits will be given for cancellations received less than two full business days prior to the event.
• Cancellations greater than two weeks prior to the event will receive 100% refund.
• No vouchers will be issued in lieu of a refund.
• Transfers/substitute(s) welcome (notify in advance of the program).

If you would like more information on the program, please contact Mental Health Education at (252) 744-5228 or legere14@ecu.edu.

Agenda

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<th>Time</th>
<th>Session Description</th>
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<tr>
<td>8:30 a.m.</td>
<td>CHECK-IN</td>
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<tr>
<td>9:00 a.m.</td>
<td>Learning Styles of Autism and Intellectual Developmental Disabilities along with Differentiating other Diagnoses</td>
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<tr>
<td>10:15 a.m.</td>
<td>BREAK</td>
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<tr>
<td>10:30 a.m.</td>
<td>Understanding Behavior - Group Problem Solving and Generating Hypotheses</td>
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<tr>
<td>12:00 p.m.</td>
<td>LUNCH (on your own)</td>
</tr>
<tr>
<td>1:00 p.m.</td>
<td>Understanding Behavior - Designing a Behavior Plan</td>
</tr>
<tr>
<td>2:15 p.m.</td>
<td>BREAK</td>
</tr>
<tr>
<td>2:30 p.m.</td>
<td>Teaching New Skills and Your Back-up Plan</td>
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<tr>
<td>4:15 p.m.</td>
<td>Wrap Up/Discussion</td>
</tr>
<tr>
<td>4:30 p.m.</td>
<td>ADJOURNEMENT</td>
</tr>
</tbody>
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Program Location

This program is being held at the Eastern Area Health Education Center located at 2600 W. Arlington Blvd, Greenville, NC.
http://eahec.ecu.edu/hs/map_directions.cfm

Handouts & Evaluations

Handouts will be available online only. One week prior to the program, registrants will receive a confirmation email with instructions to access handouts along with other program information.

Evaluations will be emailed after the program. Once the evaluation has been completed, your certificate will be available.

Please bring a jacket or sweater to ensure your comfort.
New From SAMHSA: FindTreatment.gov

Yesterday, the Department of Health and Human Services’s Substance Abuse and Mental Health Services Administration (SAMHSA) announced the launch of FindTreatment.gov, a new and improved website for helping to connect Americans throughout the United States who are looking for substance abuse treatment.

More than 19.3 million American adults had substance use disorders in 2018, and connecting them with appropriate treatment is a critical step to combating the opioid crisis in America. FindTreatment.gov is designed to provide the most relevant information for each individual’s recovery needs by creating a modern, user-friendly experience that is visually clear, simple, and welcoming to those in crisis.

Visitors can access information on treatment providers’ locations, treatment options, payment and insurance information, and on more than 13,000 state-licensed facilities, based on data compiled by SAMHSA.
Young people with mental illnesses are at high risk for developing a substance use disorder. Primary care providers can be a first-line defense, but they need to have the right tools to help. Screening, Brief Intervention and Referral to Treatment (SBIRT) is one of the most effective tools available.

The Improving Adolescent Health: Facilitating Change for Excellence in SBIRT Change Package, supported by the Conrad N. Hilton Foundation, provides practical examples and standardized guidance to facilitate a conversation with adolescent patients in primary care settings using SBIRT. The guide, developed by a national team of multidisciplinary experts, includes scripts, concrete strategies and recommendations that will help navigate difficult conversations about substance use with adolescents.

This low-risk and high-reward investment in early intervention will help youth across the nation thrive now and grow into healthy adults.
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the October 7, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Michael McGuire and seconded by Ellen Gibson to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS:

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<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>3. Public Comment Individual/Family Challenges and Solutions</td>
<td>No public comments.</td>
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<td>4. Letter to General Assembly</td>
<td>Members reviewed the draft letter to the General Assembly about state cuts, Innovation slots, and Medicaid expansion. Many members sent in feedback and that was incorporated into the letter. This group approved the letter asking that it be taken back to the local CFACs for final okay. Doug will clean up the letter, ask Brian and Sara about how best to disseminate the letter to have maximum effect and will add it to the CFAC webpage.</td>
<td>Clean up letter Feedback from Brian and Sara Add to the webpage Okay from local CFACs</td>
<td>December 2, 2019</td>
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<td>5. Community Support Team</td>
<td>Aimee Izawa presented to the group the final definition for the new Community Support Team. She emphasized this was a new definition and not just a reworking of the old definition. She went through and pointed out the emphasis on tenancy supports, the addition of team members and the recommendation for Peer Support. Many of our current providers will continue to provide this service with the expectation that more individuals will qualify for this service and additional teams will have to be established.</td>
<td>Be aware of the changes.</td>
<td>Went into effect on November 1, 2019</td>
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<td>6. CFACs and Tailored Plans</td>
<td>Feedback and Priorities – Doug presented a presentation delivered at the State CFAC about 122 (c) and the need for feedback from CFACs about what changes they thought were needed. Make up of CFACs, both local and state with added slots for people with physical health challenges. Also discussed was the makeup of the tailored plan boards of directors, the state did not have any changes recommended for that, discussed that Alliance currently operates under an exception allowed with only one CFAC member on its board, not sure if that should or will continue. The question was raised about whether only consumers receiving services from the tailored plan should be allowed to serve on the CFAC or should it be anyone that self-disclosed as having a diagnosis as it is currently. TBI representation was discussed for</td>
<td>Compile feedback and present to the State by December 15th.</td>
<td>December 15, 2019</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.
**AGENDA ITEMS:** | **DISCUSSION:** | **NEXT STEPS:** | **TIME FRAME:** |
---|---|---|---|
local and state, the state already has recommended the change at that level, since the waiver is currently only in the Alliance region there was some discussion about how to word it so that representation could be included on the local CFACs. The group ask that it be taken back to the local CFACs for additional discussion and recommendations. Roanna ask that they try to have their feedback available in December. |  |  |  |
7. State Updates | Roanna let everyone know the updates had come out today and verified that Doug had forwarded the information to them. She also reminded folks that the NC One Community in Recovery submissions for presenters was due this week. | N/A | N/A |
8. Subcommittees  
• Wake  
• Durham  
• Cumberland  
• Johnston  
• Area Board  
• Human Rights  
• Quality Management | Each local CFAC has scheduled a community forum in collaboration with the community collaborative in their area to talk about Families First, Raise the Age, and Medicaid Transformation. DSS, Juvenile Justice, and Standard Plans have been invited to present at each event.  
Johnston – December 7th  
Cumberland – November 20th  
Wake – December 10th  
Durham – December 12th  
Flyers will be distributed announcing times and places.  
Human Rights Committee received annual training at their most recent meeting.  
Quality Management is talking about Hedis measures and how that will be a part of the tailored plan going forward. Dave will ask for additional information to be shared with CFAC.  
Dave ask for feedback to report to the Board from each local group. He will talk about all of their activities in the communities. | Prepare for events and spread the word. | November and December |
9. Announcements | None | N/A | N/A |

10. **ADJOURNMENT:** The next meeting will be December 2, 2019, at 5:30 p.m. in person at the Alliance home office.
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

Respectfully Submitted by:

Doug Wright

Click here to enter text. Date Approved
To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Peer Support Services (PSS) are an evidenced-based mental health model of care that provides community-based recovery services directly to a Medicaid-eligible adult beneficiary diagnosed with a mental health or substance use disorder. PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS can be provided in combination with other approved mental health or substance use services or as an independent service. Due to the high prevalence of beneficiaries with co-occurring disorders (mental health, substance use or physical health disorders) it is a priority that integrated treatment be available to these beneficiaries.

PSS are based on the belief that beneficiaries diagnosed with serious mental health or substance use disorders can and do recover. The focus of the services is on the person, rather than the identified mental health or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. The services promote skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

Peer Support Services (PSS) are provided one-on-one to the beneficiary or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the beneficiary and CPSS; supports the beneficiary in accomplishing self-identified goals; and may further support the beneficiary’s engagement in treatment. Peer Support Services provided in a group setting allow the beneficiary the opportunity to engage in structured services with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the beneficiary in his or her recovery. PSS are based on the beneficiary’s needs and coordinated within the context of the beneficiary’s Person-Centered Plan. Structured services provided by PSS include:

a. **Peer mentoring or coaching (one-on-one)** –
   to encourage, motivate, and support beneficiary moving forward in recovery. Assist beneficiary with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.

b. **Recovery resource connecting** – connecting a beneficiary to professional and nonprofessional services and resources available in the community that can assist a beneficiary in meeting recovery goals.
c. **Skill Building Recovery groups** – structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.

d. **Building community** – assist a beneficiary in enhancing his or her social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

1. **Definitions**

   1.1. **Recovery:**
   
   Recovery is a process of change through which a beneficiary improves their health and wellness, lives a self-directed life and strives to reach their full potential; to live, work, learn, and participate fully in their communities.

   1.1.2 **Self-Determination:**
   
   Self-Determination is the right of a beneficiary to direct his or her own services, to make decisions concerning their health and well-being, and to have help to make decisions from whomever they choose.

   1.1.3 **Self-Advocacy:**
   
   Self-Advocacy is the ability to identify and purposefully ask for what one needs.

   1.1.4 **Health:**
   
   Health is learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one’s physical and emotional wellbeing.

   1.1.5 **Community:**
   
   Community is defined as relationships and social networks that provide support, friendship, love and hope.

2. **Eligibility Requirements**

2.1 **Provisions**

   2.1.1 **General**
   
   *(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

   a. An eligible beneficiary shall be enrolled in either:
      1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*; or
      2. the NC Health Choice *(NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in Section 3.0 of this policy.

   b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific
(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid
An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

A retroactively eligible beneficiary is entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover Peer Support Services for an eligible beneficiary who is 18 years of age and older and meets the criteria in Section 3.0 of this policy.

b. NCHC
NCHC shall cover Peer Support Services for an eligible beneficiary who is 18 years of age until he or she reaches his or her 19th birthday and meets the criteria in Section 3.0 of this policy.

Retroactive eligibility does not apply to the NCHC program.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed
practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

\[ \text{NCTracks Provider Claims and Billing Assistance Guide:} \]
\[ \text{https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html} \]

EPSDT provider page: \[ \text{https://medicaid.ncdhhs.gov/} \]

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within Section 3.0 of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.
3.1 General Criteria Covered
Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC
Medicaid and NCHC shall cover Peer Support Services when ALL following criteria are met:

a. The beneficiary has a mental health or substance use diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
b. The beneficiary meets the Level of Care criteria for Locus Level 1 or the American Society of Addiction Medicine (ASAM) Level 1 criteria;
c. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards; and
d. The beneficiary has documented identified needs, in at least ONE or more of the following areas (related to diagnosis):
   1. Acquisition of skills needed to manage symptoms and utilize community resources;
   2. Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health system;
   3. Assistance and support needed to prepare for a successful work experience;
   4. Peer modeling needed to take increased responsibilities for his or her own recovery; or
   5. Peer supports needed to develop or maintain daily living skills.

3.2.2 Admission Criteria
A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed clinician prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA. Relevant clinical information must be obtained and documented in the beneficiary’s Person-Centered Plan (PCP).

3.2.3 Continued Stay Criteria
The beneficiary meets criteria for continued stay if any ONE of the following applies:

a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame documented in the beneficiary’s PCP;
b. The beneficiary continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; or

c. Continuation of service is supported by documentation of beneficiary’s progress toward goals within the beneficiary’s PCP.

### 3.2.4 Transition and Discharge Criteria

The beneficiary meets the criteria for discharge if any ONE of the following applies:

a. The beneficiary’s level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

b. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services; The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or

c. The beneficiary chooses to withdraw from Peer Support Services or the legally responsible person(s) chooses to withdraw the beneficiary from services.

### 3.2.5 Medicaid Additional Criteria Covered

None Apply.

### 3.2.6 NCHC Additional Criteria Covered

None Apply.

### 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

#### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in Section 2.0;

b. the beneficiary does not meet the criteria listed in Section 3.0;

c. the procedure, product, or service duplicates another provider’s procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

#### 4.2 Specific Criteria Not Covered

##### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following activities of Peer Support Services:

a. Transportation for the beneficiary or family members;

b. Habilitation activities;

c. Time spent performing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of the Peer Support Specialist which is covered as an indirect cost and part of the rate;

e. Covered services that have not been rendered;

f. Childcare services or services provided as a substitute for the parent or other beneficiaries responsible for providing care and supervision;

g. Services provided to teach academic subjects or as a substitute for education personnel;

h. Interventions not identified in the beneficiary’s Person-Centered Plan;

i. Services provided without prior authorization;

j. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary’s life to address problems not directly related to the beneficiary’s needs and not listed on the Person-Centered Plan; and

k. Payment for room and board.

**4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

**4.2.3 NCHC Additional Criteria Not Covered**

a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under [the] North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

*Note: Subsection 4.2.3(b) applies to NCHC only.*

**5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**5.1 Prior Approval**

Medicaid and NCHC shall require prior approval for Peer Support Services beyond the unmanaged unit limitation. Coverage of Peer Support Services is limited to twenty-four (24) unmanaged units once per episode of care per state fiscal year. Refer to **Subsection 5.3** for additional limitations.

A service order must be signed prior to or on the first day PSS are rendered. Refer to **Subsection 5.4** of this policy.

Prepaid Inpatient Health Plans (PIHP) or Prepaid Health Plans (PHP) can offer less restrictive limitations for unmanaged units but cannot impose more restrictive limitations than the NC Medicaid Policy. All units beyond Medicaid limitations or limitations imposed by the PIHPs or PHPs require prior approval.
PIHPs or PHPs that offer less restrictive limitations on unmanaged units than that of the NC Medicaid policy shall provide assurance that there are mechanisms in place to prevent over-billing for services.

Providers shall seek prior approval if they are uncertain that the beneficiary has reached the unmanaged unit limit for the fiscal year.

Providers shall seek prior approval if beneficiary is engaged in other behavioral health or substance use services. Providers shall collaborate with beneficiary’s existing provider to develop an integrated plan of care.

Prior authorization is not a guarantee of claim payment.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the beneficiary’s diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary’s Person-Centered Plan (PCP) Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review Contractor or the Cherokee Indian Hospital Authority who evaluate the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary’s physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization, the CCA, service order for medical necessity, PCP, and the required NC Medicaid authorization request form must be submitted to the DHHS approved Utilization Management Review Contractor or the Cherokee Indian Hospital Authority. Medicaid may cover up to 270 units of service (individual and group) for 90 days for the initial authorization period, if medically necessary. Refer to Subsection 5.4 for Service Order requirements.
Reauthorization

Reauthorization requests must be submitted to the Utilization Management Review Contractor or the Cherokee Indian Hospital Authority 10-days prior to the end date of the beneficiary’s active authorization. Medicaid may cover up to 270 units of service (individual and group) for 90 days for subsequent reauthorization periods, if medical necessary. Reauthorization is based on medical necessity documented in the PCP, the authorization request form, and supporting documentation. The duration and frequency at which PSS is provided must be based on medical necessity and progress made by the beneficiary toward goals outlined in the PCP.

Additional units may be authorized as clinically appropriate. If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to interventions with a more intense clinical component.

Note: Any denial, reduction, suspension, or termination of PSS requires beneficiary or legally responsible person(s) of the beneficiary be notified of their appeal rights.

5.3 Additional Limitations or Requirements

a. A beneficiary can receive PSS from only one provider organization during an active authorization period. The beneficiary may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.
b. Family members or legally responsible person(s) of the beneficiary are not eligible to provide this service to the beneficiary.
c. A beneficiary with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for PSS funded by Medicaid.
d. Peer Support must not be provided during the same authorization period as Assertive Community Treatment Team (ACTT), as a peer support specialist is a requirement of that team.
e. Peer Support must not be provided during the same authorization period as Community Support Team (CST), as a peer support specialist may be a component of the service and a beneficiary who is in need of CST and peer support will be offered CST providers who have peers on the team.
f. PSS must not be provided during the same time of day when a beneficiary is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation, Respite, or Individual Support services.
g. PSS must not be duplicative of other Medicaid services the beneficiary is receiving.
h. Transportation of a beneficiary is not covered as a component for this policy. Any provision of services provided to a beneficiary during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided. This limitation does not impact a beneficiary’s ability to access non-emergency medical transportation (NEMT).
Note: PSS is not a “first responder” service. As documented in the beneficiary’s PCP Comprehensive Prevention and Intervention Crisis Plan, the PSS provider shall coordinate with other service providers to ensure “first responder” coverage and crisis response.

5.4 Service Orders
Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary’s needs. A service order must be signed by a physician or other licensed clinician per his or her scope of practice, prior to or on the first day service is rendered.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. A service order must be in place prior to or on the first day that the service is initially provided to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid the provider shall not bill Medicaid without a valid service order; and

d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP service order.

5.5 Documentation Requirements
The service record documents the nature and course of a beneficiary’s progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service. The PCP and a documented discharge plan must be discussed with the beneficiary and documented in the service record.

5.5.1 Contents of a Service Note
For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must document ALL following elements:

a. Beneficiary’s name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (face-to-face, phone);
f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary’s progress towards the beneficiary’s goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Peer Support Services must be delivered by practitioners employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;

b. meet the requirements of 10A NCAC 27G;

c. demonstrate that they meet these standards by being credentialed and contracted by a Prepaid Health Plan or Prepaid Inpatient Health Plan, or the Cherokee Indian Hospital Authority;

d. within one calendar year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and

e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

6.2 Provider Certifications

PSS must be provided by a Peer Support Specialist certified by North Carolina’s Peer Support Specialist Program.

6.2.1 Staff Requirements

The Peer Support Services (PSS) program is provided by qualified providers with the capacity and adequate workforce to offer this service to eligible Medicaid beneficiaries. PSS must be available during times that meet the needs of the beneficiary which may include evening, weekends, or both. The PSS program must be under the direction of a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104 (19).

The PSS program must have designated competent mental health or substance use professionals to provide supervision to CPSS during the times of service provision.

The maximum program staff ratios are as follows: QP-to-CPSS is 1:8; CPSS-to-beneficiary is 1:15; and group ratio for CPSS Group Facilitator-to-beneficiaries is 1:12.
The PSS program must follow the NC Peer Support Specialist Code of Ethics and Values and principles when rendering PSS services. All ethical issues must be governed by the administrators of the Peer Support Specialist Registry and policies and procedures established by the hiring provider agency.

CPSS shall not work outside the scope of their certification or core competencies. CPSS shall only provide services to a beneficiary with similar lived experiences.

The following charts provide required services of the PSS Program Supervisor and core competencies of relationship building and peer support interaction for the CPSS (according to NC’s Certified Peer Support Specialist Program).

<table>
<thead>
<tr>
<th>Peer Support Services Program Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trained in quality supervisory skills.</td>
</tr>
<tr>
<td>• Possesses knowledge of the CPSS role and work, as well as, understand the principles and philosophy of recovery and the code of ethics of the NC Peer Support Specialist Certification Program.</td>
</tr>
<tr>
<td>• Understand and support the role of the CPSS.</td>
</tr>
<tr>
<td>• Understand and promote the beneficiary’s recovery.</td>
</tr>
<tr>
<td>• Advocate for the CPSS and PSS across the organization and in the community.</td>
</tr>
<tr>
<td>• Promote both the professional and personal growth of the CPSS within established human resource standards.</td>
</tr>
<tr>
<td>• Coordinate assessments needed for the beneficiary. If appropriately licensed, the QP may conduct the assessments.</td>
</tr>
<tr>
<td>• Collaborate with beneficiary(s) and CPSS to develop recovery-oriented person-centered plan for the beneficiary that demonstrates consideration for integrated care.</td>
</tr>
<tr>
<td>• Conduct at least one face-to-face contact with the beneficiary within 90 days of PSS being initiated and no less that every 90 days thereafter to monitor the beneficiary’s progress and effectiveness of the program; and to review with the beneficiary the goals of their PCP and document progress.</td>
</tr>
<tr>
<td>• Plan work assignments, monitors, reviews and evaluates work performance of program staff and facilitates staff meetings and conduct routine reviews of service notes for quality assurance.</td>
</tr>
<tr>
<td>• Provide administrative and supportive supervision to program staff individually at least once per month or more if needed. Provision of supervision must be based on the experience of the individual staff.</td>
</tr>
<tr>
<td>• Collaborate with program staff to assess strengths and areas of growth and develop an individual supervision plan.</td>
</tr>
<tr>
<td>• Collaborate and foster collegial roles with program staff.</td>
</tr>
<tr>
<td>• Determine team caseload size based on the level of acuity and needs of the beneficiary(s).</td>
</tr>
<tr>
<td>• Facilitate or co-facilitate skill building recovery groups based on the needs or request of beneficiaries.</td>
</tr>
<tr>
<td>• Ensure referrals for community resources requested by beneficiary(s) are completed.</td>
</tr>
</tbody>
</table>
Certified Peer Support Specialist

- Knowledge of peer support principles, values and ethics.
- Ability to share lived experience to support, encourage and enhance a beneficiary’s treatment and recovery.
- Possess recovery-oriented skills and knowledge to provide peer support services.
- Ability to collaborate with the program QP to assess their own strengths and areas of growth and develop a supervision plan.
- Ability to collaborate with a beneficiary to explore and identify barriers to accessing community resources or treatment providers.
- Ability to model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for beneficiaries served and to promote a recovery environment in the community, residence, and workplace.
- Ability to explore with a beneficiary served, the importance and creation of a wellness identity through open sharing and challenging viewpoints.
- Ability to promote a beneficiary’s opportunity for personal growth by identifying teachable moments for building relationship skills to empower the beneficiary and enhance personal responsibility.
- Ability to model and share decisions-making tools to enhance a beneficiary’s healthy decision-making process.
- Ability to provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community.
- Ability to recognize and appropriately respond to conditions that constitute an emergency to include both physical and behavioral health crisis utilizing the emergency response procedure of employer.
- Ability to provide support to the beneficiary in navigating systems (medical, social services, or legal).
- Ability to promote self-advocacy by facilitating each beneficiary’s learning about his or her human and legal rights and supporting the beneficiary while exercising those rights to support the empowerment of the beneficiary.

6.2.2 Training Requirements

To provide effective peer support services, all PSS program staff shall possess the knowledge and competencies of peer support principles, values and ethics and participate in additional trainings required to provide the service. Required trainings for PSS program staff are as follows:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Training Required</th>
<th>Who</th>
<th>Total Minimum Hours Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 calendar days of</td>
<td>• 3 hours of Peer Support Services Policy components review</td>
<td>All staff</td>
<td>4 hours</td>
</tr>
<tr>
<td>hire to provide service</td>
<td>• 1 hour of Documentation Training</td>
<td></td>
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</tr>
</tbody>
</table>
Within **90 calendar days** of hire to provide service:

- 3 hours of Peer Support Supervisor Training
- 12 hours of Person-Centered Thinking
- 3 hours of PCP Instructional Elements with Comprehensive Prevention and Intervention Crisis Plan Training

<table>
<thead>
<tr>
<th>Peer Support Services Program Supervisor</th>
<th>18 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annually</strong></td>
<td></td>
</tr>
<tr>
<td>10 hours</td>
<td></td>
</tr>
</tbody>
</table>

Peer support program staff shall complete initial requirements of training identified above within identified timeframes. The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training was completed no more than 24-months prior to hire date.

Peer support program staff shall participate in additional hours of peer support related training that is appropriate for the population being served. Additional training options for all PSS program staff include:

a. Trauma Informed Care
b. Wellness and Recovery Action Plan (WRAP)
c. Whole Health Action Management (WHAM)
d. Basic Mental Health and Substance Use 101
e. Mental Health First Aid
f. Housing First, Permanent Supportive Housing, Tenancy Support Training

### 6.3 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary’s PCP.

Expected outcomes:

a. increased engagement in self-directed recovery process;
b. increased natural and social support networks;
c. increased ability to engage in community activities;
d. increased ability to live independently as possible and use recovery skills to maintain a stable living arrangement;
e. higher levels of empowerment and hopefulness in recovery;
f. improved emotional, behavioral and physical health;
g. improved quality of life;
h. improved vocational skills;
i. decreased substance use;
j. decreased frequency or intensity of crisis episodes; or
k. decreased use of crisis services or hospitalizations.
7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).
8.0 Policy Implementation and History

Original Effective Date:

History:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section or Subsection Amended</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/2019</td>
<td>All Sections and Attachment(s)</td>
<td>New policy implementing Peer Support Services.</td>
</tr>
<tr>
<td>11/01/2019</td>
<td>Attachment A</td>
<td>Updated policy template language “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

<table>
<thead>
<tr>
<th>HCPCS Code(s)</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td>1 unit = 15 minutes</td>
</tr>
<tr>
<td>H0038 HQ</td>
<td>1 unit = 15 minutes</td>
</tr>
</tbody>
</table>

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.
E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Units are billed in 15-increments.

PHPs, PIHPs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. PHPs and PIHPs shall assess their PSS network providers’ adherence to service guidelines to assure quality services for beneficiaries.

F. Place of Service

PSS is a direct periodic service provided in a range of community settings. It may be provided in the beneficiary’s place of residence, community, in an emergency department, or in an office setting. It may not be provided in the residence of PSS staff.

The intent of the service is to be community-based rather than office-based. Telephone time is supplemental rather than a replacement of face to face contact and is limited to (20) percent or less of total service time provided per beneficiary per fiscal year. Documentation of service rendered via telephone with the beneficiary or collateral contacts (assisting beneficiary with rehabilitation goals) must be documented according to Subsection 5.5 of this policy.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov//
ITEM: Finance Committee Report

DATE OF BOARD MEETING: December 5, 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 2:30 p.m. prior to the regular Board Meeting. This month’s report includes the draft minutes from the November 7, 2019 meeting, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending October 31, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

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

(Back to agenda)
Finance Committee Meeting
Thursday, December 5, 2019
2:30-4:00 pm

AGENDA

1. Review of the Minutes – November 7, 2019

2. Monthly Financial Reports as of October 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. Approval of Contract(s)

4. Review of Budget Transfer Policy

5. Audit Report as of June 30, 2019

6. Closed Session
   a. A motion to close the meeting pursuant to NC General Statute 143-318.11 (a) 6 to consider the qualifications, competence, and performance of an employee.

   b. After discussion, a motion to open the meeting.

7. Adjournment
1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 3:04 PM

2. REVIEW OF THE MINUTES – The minutes from the October 3, 2019, meeting were reviewed; a motion was made by Mr. Pazzaglini and seconded by Mr. Corvin to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS: DISCUSSION: NEXT STEPS: TIME FRAME:

   The monthly financial reports were discussed which includes the Statement of Net Position, Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of September 30, 2019.  
   Ms. Pacholke discussed the monthly reports.  
   - As of 9/30/19, we have total assets of $144.4M, total liabilities of $55.7M and net position of $88.7M with $33.3M unrestricted  
   - As of 9/30/19 we have savings of $745,000  
   - We are meeting all SB208 and DMA contract ratios.  
   Moving forward Alliance will bring forward cash flows analysis for the Finance Committee to review

4. Quarterly Updates  
   Ms. Goodfellow provided updates on  
   - Solvency standards – Provided feedback to the state on proposed new Solvency Standards. We will report back when we have more information.  
   - PMPM  
   Ms. Pacholke provided updates on  
   - Non-Medicaid budget – Discussed the non-Medicaid budget to actual report as of 9/30/19. We currently show a loss under Alliance benefit plan, however we were recently issued additional allocation letters related to Opioid funding which will balance the loss.  
   Ms. Goodfellow discussed the budget transfer policy, which requires Board approvals for transfers within service categories. A recommendation was made to revise the policy and bring it to the Committee for review and approval.  
   Review and revise Budget Transfer Policy (BO-19) and bring to the Finance Committee for review

5. Reinvestment Plan  
   Ms. Goodfellow went over the recommended three-year reinvestment plan. DHB requires each LME/MCO submit a three-year reinvestment plan. A motion was
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Next Meeting</td>
<td>made by Mr. Corvin and seconded by Mr. Pazzaglini to recommend to the Board approval of submitting the $21,377,494 three-year reinvestment plan to DHB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms. Pacholke reminded the Committee that the auditors will present the 6/30/19 audit at the December 5th Finance Committee and Board Meeting. The Committee will go into close session during this meeting, asking staff and guests to leave to have an opportunity to speak privately with the auditors.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **ADJOURNMENT**: the meeting adjourned at 3:33 pm; the next meeting will be December 5, 2019, from 2:30 p.m. to 4:00 p.m.
Summary of Savings/(Loss) by Funding Source as of October 31, 2019

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$128,738,900</td>
<td>$124,422,273</td>
<td>$4,316,628</td>
</tr>
<tr>
<td>Medicaid Waiver Risk Reserve</td>
<td>$2,977,315</td>
<td>-</td>
<td>$2,977,315</td>
</tr>
<tr>
<td>Federal Grants &amp; State Funds</td>
<td>$20,278,748</td>
<td>$23,467,774</td>
<td>-</td>
</tr>
<tr>
<td>Local Funds</td>
<td>$9,349,864</td>
<td>$9,256,742</td>
<td>$93,122</td>
</tr>
<tr>
<td>Administrative</td>
<td>$19,849,824</td>
<td>$21,550,335</td>
<td>$(1,700,511)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$181,194,651</strong></td>
<td><strong>$178,697,124</strong></td>
<td><strong>$2,497,527</strong></td>
</tr>
</tbody>
</table>

Committed
- Legislative Reductions $(3,189,027)
- Intergovernmental Transfers $(1,002,606)
- Reinvestments-Service $(59,247)
- Reinvestments-Administrative $(234,770)
- **Total Committed** $(4,485,649)

Unrestricted $6,983,176

**Total Fund Balance Change** $2,497,527

Fund Balance as of October 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2019</th>
<th>Change</th>
<th>October 31, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,946,365</td>
<td>(188,423)</td>
<td>4,757,942</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>51,602,006</td>
<td>2,977,316</td>
<td>54,579,321</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statutes</td>
<td>7,005,672</td>
<td>-</td>
<td>7,005,672</td>
</tr>
<tr>
<td>Prepaids</td>
<td>858,436</td>
<td>1,331,876</td>
<td>2,190,312</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>7,864,108</td>
<td>1,331,876</td>
<td>9,195,984</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>7,342,029</td>
<td>(3,189,027)</td>
<td>4,153,002</td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>3,007,817</td>
<td>(1,002,606)</td>
<td>2,005,211</td>
</tr>
<tr>
<td>Reinvestments-Service</td>
<td>1,832,000</td>
<td>(59,247)</td>
<td>1,772,753</td>
</tr>
<tr>
<td>Reinvestments-Administrative</td>
<td>4,953,013</td>
<td>(234,770)</td>
<td>4,718,243</td>
</tr>
<tr>
<td><strong>Total Committed</strong></td>
<td>17,134,859</td>
<td>(4,485,649)</td>
<td>12,649,210</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>6,426,721</td>
<td>2,862,407</td>
<td>9,289,128.38</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td>87,974,059</td>
<td>2,497,527</td>
<td>90,471,586</td>
</tr>
</tbody>
</table>
## Statement of Revenue and Expenses (Budget and Actual) - As of October 31, 2019

<table>
<thead>
<tr>
<th>REVENUES</th>
<th>Budget</th>
<th>Current Period</th>
<th>Q1</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Grants</td>
<td>$38,787,140</td>
<td>$1,901,294</td>
<td>$7,448,570</td>
<td>$9,349,864</td>
<td>$29,437,276</td>
<td>24.11%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>$53,383,119</td>
<td>$8,134,032</td>
<td>$12,144,715</td>
<td>$20,278,748</td>
<td>$33,104,371</td>
<td>37.99%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$385,741,463</td>
<td>$33,250,274</td>
<td>$98,465,941</td>
<td>$131,716,215</td>
<td>$254,025,248</td>
<td>34.15%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$477,911,722</strong></td>
<td><strong>$43,285,601</strong></td>
<td><strong>$118,059,227</strong></td>
<td><strong>$161,344,827</strong></td>
<td><strong>$316,566,895</strong></td>
<td><strong>33.76%</strong></td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td></td>
<td>$32,222</td>
<td>$96,975</td>
<td>$129,197</td>
<td>$258,387</td>
<td>33.33%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td></td>
<td>$363,283</td>
<td>$1,089,849</td>
<td>$1,453,132</td>
<td>$2,906,253</td>
<td>33.33%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td></td>
<td>$4,536,636</td>
<td>$13,421,208</td>
<td>$17,957,844</td>
<td>$34,643,264</td>
<td>34.14%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td></td>
<td>$66,822</td>
<td>$242,828</td>
<td>$309,650</td>
<td>$190,350</td>
<td>61.93%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td><strong>$57,848,078</strong></td>
<td><strong>$4,998,964</strong></td>
<td><strong>$14,850,860</strong></td>
<td><strong>$19,849,824</strong></td>
<td><strong>$37,998,254</strong></td>
<td><strong>34.31%</strong></td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>$535,759,800</strong></td>
<td><strong>$48,284,564</strong></td>
<td><strong>$132,910,087</strong></td>
<td><strong>$181,194,651</strong></td>
<td><strong>$354,565,149</strong></td>
<td><strong>33.82%</strong></td>
</tr>
</tbody>
</table>

## EXPENSES

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>Budget</th>
<th>Current Period</th>
<th>Q1</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Services</td>
<td>$38,787,140</td>
<td>$1,878,017</td>
<td>$7,378,726</td>
<td>$9,256,742</td>
<td>$29,530,398</td>
<td>23.87%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>$53,383,119</td>
<td>$8,604,406</td>
<td>$14,863,369</td>
<td>$23,467,774</td>
<td>$29,915,345</td>
<td>43.96%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$385,741,463</td>
<td>$30,714,321</td>
<td>$93,707,952</td>
<td>$124,422,273</td>
<td>$261,319,190</td>
<td>32.26%</td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td><strong>$477,911,722</strong></td>
<td><strong>$41,196,743</strong></td>
<td><strong>$115,950,046</strong></td>
<td><strong>$157,146,789</strong></td>
<td><strong>$320,764,933</strong></td>
<td><strong>32.88%</strong></td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>$9,335,253</td>
<td>$963,455</td>
<td>$2,480,396</td>
<td>$3,443,851</td>
<td>$5,891,402</td>
<td>36.89%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>$43,819,039</td>
<td>$3,883,542</td>
<td>$12,386,230</td>
<td>$16,269,772</td>
<td>$27,549,266</td>
<td>37.13%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>$4,193,786</td>
<td>$488,856</td>
<td>$1,347,855</td>
<td>$1,836,711</td>
<td>$2,357,075</td>
<td>43.80%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>$500,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$500,000</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td><strong>$57,848,078</strong></td>
<td><strong>$5,335,853</strong></td>
<td><strong>$16,214,481</strong></td>
<td><strong>$21,550,335</strong></td>
<td><strong>$36,297,743</strong></td>
<td><strong>37.25%</strong></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$535,759,800</strong></td>
<td><strong>$46,532,597</strong></td>
<td><strong>$132,164,527</strong></td>
<td><strong>$178,697,124</strong></td>
<td><strong>$357,062,676</strong></td>
<td><strong>33.35%</strong></td>
</tr>
</tbody>
</table>

**CHANGE IN NET POSITION**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$1,751,968</strong></td>
<td><strong>$745,559</strong></td>
<td><strong>$2,497,527</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Senate Bill 208 Ratios - As of October 31, 2019

**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 (7/1/19-6/30/20).
ITEM: June 30, 2019, Audited Financial Statements and Related Documents

DATE OF BOARD MEETING: December 5, 2019

BACKGROUND: An annual audit is a requirement of the Local Government Budget and Fiscal Control Act GS 159-34. An annual audit is also a requirement of the DHHS-DHB contract with Alliance for the Medicaid Waiver.

The auditors will present the results of the June 30, 2019, audited statements and allow time for questions.

REQUEST FOR BOARD ACTION: Receive the report.

CEO RECOMMENDATION: Receive the report.

RESOURCE PERSON(S): David Hancock, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
ITEM: Draft Minutes from the November 7, 2019, Board Meeting

DATE OF BOARD MEETING: December 5, 2019

REQUEST FOR BOARD ACTION: Approve the draft minutes from the November 7, 2019, Board meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
MEMBERS PRESENT: ☐ Glenn Adams, Cumberland County Commissioner, JD, ☐ Cynthia Binanay, Chair, MA, BSN, ☐ Tony Braswell, Johnston County Commissioner, ☐ Heidi Carter, Durham County Commissioner, MPH, MS, ☐ George Corvin, Vice-Chair, MD, ☐ David Curro, BS, (via phone), ☐ Greg Ford, Wake County Commissioner, MA, ☐ Lodies Gloston, MA, ☐ David Hancock, MBA, MPAff, ☐ Duane Holder, MPA, (via phone), ☐ D. Lee Jackson, BA, (via phone), ☐ Donald McDonald, MSW, (via phone; exited at 4:46 pm) ☐ Lynne Nelson, BS, (entered at 4:45 pm), ☐ Gino Pazzaglini, MSW LFACHE, ☐ Pam Silberman, JD, DrPH, ☐ Lascel Webley, Jr., MBA, MHA, (via phone; exited at 5:04 pm), and ☐ McKinley Wooten, Jr., JD

GUEST(S) PRESENT: Mary Hutchings, Wake County Finance Department; and Yvonne French, NC DHHS DMH/DD/SAS (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; Veronica Ingram, Executive Assistant II; Mehul Mankad, Chief Medical Officer; Jennifer Meade, Community Health and SOC Manager; 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; Erika Singleton, Administrative Assistant II; Tammy Thomas, Director of Project Portfolio Management; Sara Wilson, Director of Government Relations; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

1. CALL TO ORDER: Chair George Corvin called the meeting to order at 4:00 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td>A. Board Emails: Ms. Portugal reminded Board members that effective immediately, emails will only be sent to Board members’ Alliance email addresses.</td>
</tr>
<tr>
<td></td>
<td>B. Update on Property Sale: Ms. Wolff mentioned a potential change to the timeframe for the sale of the property on 3309 Durham Drive, Raleigh, as requested by the buyer. She reminded Board members that the board previously authorized the CEO to finalize this sale.</td>
</tr>
<tr>
<td></td>
<td>C. Upcoming Board Orientation 2.0: Mr. Robinson reminded Board members of an upcoming orientation session on Thursday, November 14 from 2:00-4:00 pm at Alliance’s Morrisville office. Members may contact Ms. Ingram to confirm attendance.</td>
</tr>
<tr>
<td></td>
<td>D. Introduction of New Staff: Mr. Robinson introduced Alliance’s new Chief Medical Officer, Dr. Mehul Mankad.</td>
</tr>
</tbody>
</table>

3. Agenda Adjustments       | There were no adjustments to the agenda.                                                                                                              |

4. Public Comment           | There were no public comments.                                                                                                                        |

5. Committee Reports        | A. Consumer and Family Advisory Committee – 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 included draft minutes and supporting documents from the Durham, Wake, Johnston, Cumberland and Steering Committee meetings. |

| The committee reports were sent as part of the Board packet; Doug Wright, Director of Community and Member Engagement, presented the CFAC report. He shared about recent CFAC meetings including staff presentations and feedback from CFAC members regarding... |
AGENDA ITEMS: Medicaid Transformation and pending changes due to reduced State Single Stream funding. The CFAC report is attached to and made part of these minutes.

**BOARD ACTION**
The Board received the report.

B. Finance Committee – page 46
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 October 3, 2019, meeting, the Statement of Net Position, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending September 30, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

David Hancock, Committee Chair, presented the report. Mr. Hancock shared that all contractual ratios were met and revenues exceeded expenditures. Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, presented a proposal and requested approval to submit the three-year reinvestment plan to the State; Ms. Goodfellow provided an overview of this plan. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**
A motion was made by Mr. Hancock to recommend approval and submission of the three-year, $21,377,494 reinvestment plan to DHB (Division of Health Benefits); motion seconded by Ms. Gloston. Motion passed unanimously.

6. Consent Agenda
A. Draft Minutes from October 3, 2019, Board Meeting – page 55
B. County Commissioners Advisory Board Report – page 60
C. Executive Committee Report – page 62
D. Human Rights Committee Report – page 65
E. Quality Management Committee Report – page 150

The consent agenda was sent as part of the packet; it is attached to and made part of these minutes. There were no comments or discussion about the consent agenda.

**BOARD ACTION**
A motion was made by Mr. Pazzaglini to approve/adopt the consent agenda; motion seconded by Dr. Silberman. Motion passed.

7. Appointment Recommendation – page 154
In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. The matter before the Board is to recommend to the Durham Board of County Commissioners the appointment of Jennifer Anderson to Alliance’s Board.

**BOARD ACTION**
A motion was made by Dr. Silberman to forward Jennifer Anderson’s application to the Durham Board of County Commissioners and to request her appointment to Alliance’s Board; motion seconded by Ms. Gloston. Motion passed.
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>#</th>
<th>AGENDA ITEMS</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Legislative Update</td>
<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, shared about the lack of progress with finalizing the current State budget and the NC General Assembly’s (NCGA) adjournment on October 31, 2019.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sara Wilson, Government Relations Director, presented an update on Medicaid Transformation, including current progress with open enrollment for Standard Plans and implementation milestones, particularly for auto enrollment for physical health ACOs (accountable care organizations).</td>
</tr>
<tr>
<td></td>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the update.</td>
</tr>
<tr>
<td>9</td>
<td>Group Living Services Update</td>
<td>Ann Oshel, Senior Vice-President/Community Health and Well-Being, provided an update on Alliance’s residential continuum of services; this included a review in 2015 by a consultant who reviewed usage, evaluated the current services, and provided recommendations. Ms. Oshel shared about the agency’s progress to more effectively provide these services with a recovery oriented and self-determination focus. Part of the progress also included input from community stakeholders and internal, cross-departmental work groups. Ms. Oshel concluded by sharing plans and target dates for December 2019 through July 2020.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Board members discussed potential challenges with this transition and planning to support people served throughout the transition; Board members also discussed housing options within Alliance’s catchment area, especially an affordable housing bond that recently passed in Durham County.</td>
</tr>
<tr>
<td></td>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the report.</td>
</tr>
<tr>
<td>10</td>
<td>Chair’s Report</td>
<td>Chair Corvin reminded Board members of next month’s Board meeting, which will be at the Morrisville office and overlaps the i2i conference in Pinehurst. He encouraged Board members to participate remotely as needed.</td>
</tr>
<tr>
<td>11</td>
<td>Closed Session</td>
<td><strong>BOARD ACTION</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A motion was made by Dr. Silberman to enter closed session pursuant to 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; motion seconded by Commissioner Carter. Motion passed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Board returned to open session.</td>
</tr>
<tr>
<td>12</td>
<td>Adjournment</td>
<td>All business was completed; the meeting adjourned at 6:06 p.m.</td>
</tr>
</tbody>
</table>
ITEM: Executive Committee Report

DATE OF BOARD MEETING: December 5, 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 November 18, 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 4:03 pm.

### 2. REVIEW OF THE MINUTES

- The minutes from the October 21, 2019, meeting were reviewed; a motion was made by Vice-Chair Pazzaglini and seconded by Mr. McDonald to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Updates</td>
<td>a) LEGISLATIVE UPDATE: Mr. Perkins stated that a delay for implementing Standard Plans due to the lack of a final budget from the NC General Assembly (NCGA) is pending. It is unclear if the NCGA will finalize a budget when it reconvenes in January 2020.</td>
<td>a) None specified.</td>
<td>a) N/A</td>
</tr>
<tr>
<td></td>
<td>b) MEDICAID TRANSFORMATION: Mr. Robinson provided an update and on the impact of the NCGA’s lack of a final budget on NC Medicaid Transformation.</td>
<td>b) None specified.</td>
<td>b) N/A</td>
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<td>c) PROPOSED REVISIONS FOR BOARD ORIENTATION: Mr. Robinson reviewed the current onboarding process for new Board members and the proposed revision to the process: the recommendation is to move from in-person trainings to electronic trainings. The new process would provide expedited onboarding in a more convenient format for new Board members. He requested input from Committee members, who supported the proposal.</td>
<td>c) Ms. Ingram will develop an electronic orientation for new Board members.</td>
<td>c) 12/31/19</td>
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<td></td>
<td>d) SALE OF PROPERTY: Ms. Wolff provided an update from the November Board meeting regarding the sale of the Wake vacant crisis facility. She reported that the buyer decided to cancel purchasing this property.</td>
<td>d) None specified.</td>
<td>d) N/A</td>
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**AGENDA ITEMS:**

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<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
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<tr>
<td>4. Property Lease</td>
<td>Ms. Wolff presented information about the sublease for property at 1724 Roxie Ave, Fayetteville to RI International for operation of the Roxie Crisis Facility. Per the by-laws, the lease will need to be approved by a super majority of the Board.</td>
<td>Topic will be presented at the December Board meeting.</td>
<td>12/5/19</td>
</tr>
<tr>
<td><strong>COMMITTEE ACTION:</strong></td>
<td>A motion was made by Dr. Silberman to forward to the Board the sublease for the property at 1724 Roxie Ave, Fayetteville to RI International for operation of the Roxie Crisis Facility. Motion seconded by Mr. McDonald. Motion passed unanimously.</td>
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<tr>
<td>5. 2020 Schedule of Executive Committee Meetings</td>
<td>Committee members reviewed the draft 2020 schedule of Committee meetings and considered alternate dates for the January meeting, which would occur on an agency holiday.</td>
<td>Notice for the 2020 calendar of meetings will be provided per NC Open Meetings Law.</td>
<td>December 2019</td>
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<td><strong>COMMITTEE ACTION:</strong></td>
<td>A motion was made by Ms. Nelson to approve the amended 2020 schedule of Executive Committee meetings with the January meeting occurring on Tuesday, January 21 at 4:00 pm. Motion seconded by Vice-Chair Pazzaglini. Motion passed unanimously.</td>
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<td>6. Applicant Interview</td>
<td>The Committee interviewed an applicant for the vacant Cumberland seat. Committee members discussed applications received for this vacancy and applicant interviews.</td>
<td>Topic will be presented at the December Board meeting.</td>
<td>12/5/19</td>
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<tr>
<td><strong>COMMITTEE ACTION:</strong></td>
<td>A motion was made by Ms. Gloston to recommend that the full Board forwards John Lesica’s application to the Cumberland Commissioners for appointment to Alliance’s Board. Motion seconded by Mr. Hancock. Motion passed unanimously.</td>
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<tr>
<td>7. Agenda for December Board Meeting</td>
<td>The Committee reviewed the draft agenda and provided input.</td>
<td>Ms. Ingram will forward the agenda to staff.</td>
<td>11/19/19</td>
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<tr>
<td>8. <strong>ADJOURNMENT:</strong></td>
<td>the meeting adjourned at 5:58 pm; the next meeting will be December 16, 2019, at 4:00 p.m.</td>
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ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: December 5, 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): Pam Silberman, Committee Chair; Wes Knepper, Director of Quality Management
1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 1:01 pm

2. REVIEW OF THE MINUTES – The minutes from the October 3, 2019, meeting were reviewed. After correcting the misspelling of George Corvin’s name, the start time, moving Mary Hutchings name from an appointed member to a guest and changing Cynthia Binanay’s attendance from present to absent, a motion was made by Dave Curro and seconded by George Corvin to approve the minutes. The motion passed unanimously.

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<td>3. OLD BUSINESS</td>
<td>Quality Work Plan Review (Wes) – this is the foundation of what is driving our major quality initiatives at Alliance. Three 7-day follow up state contract measures and three HEDIS measures we’ve selected. The targets for those were set by the 50th percentile for Medicaid plans in the most recent year it was published. The others are QIPs. We have had some turnover to the QI team in Quality Management. New people that have been hired have some expertise that is causing us to reevaluate some things. HEDIS Measure Update (Damali) – we are pushing data back out to providers, so that they know what their performance is. We recently looked at full year 2018 calendar year data and drilled that down for providers. We are looking at attribution. We will be reporting out how agencies perform on these measures. For the PCPs, at very least they should be aware of who the primary physician is, the medication the clients are taking and how that may be playing out in behavioral health issues that they are working on with the members. Not responsible for medication, but they are responsible for being aware of what medication they are on and seeing that they are getting the screenings while they are on the medications.</td>
<td>• Pam requested that a notation be made about when we did the intervention and started sending things out to the provider. Damali will let Wes know what months to notate.</td>
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<td><strong>Performance Measure Review (Damali)</strong> - We have taken a step back in past few months with these measures. We have started going to our major facilities, walked through their discharge process. We are figuring out where they can be more effective and we can be more effective with our interventions, help improve discharge coordination and getting people to the next service. Completed process mapping of discharge process with Holly Hill, Triangle Springs and Recovery Innovation. We have a second process mapping with Holly Springs in a couple of weeks and are working on mapping for two of UNC’s units. Have removed barriers to hospital physician teams so that they can get their referrals, get into facilities, introduce their services and can get to individuals much quicker than with our prior process. Are looking at their data to see if they are able to touch more individuals and get more individuals involved with their program. These teams are the bridge between the person leaving the facility and getting to the next appointment. The hope is that they are able to see more people now and that our rate will go up as well. That service by itself counts towards the measure, but we really want to see if they are connecting members to services because that counts toward the 30 day follow up.</td>
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4. **NEW BUSINESS**

**Performance Standards Dashboard** – Two measures not met are uninsured 7-day follow up for substance use disorders and mental health. For mental health, we hit it in March but not in April. For SUD, we have hovered in mid-30s for a long time. It’s an especially difficult population to engage. We are hoping that our work with the providers can help move the needle. For the TBI waiver, we realized that we had to transition a lot of our care coordination efforts away from waiting for people to be in the waiver and coordinating their care to doing the outreach educations and helping them navigate the enrollment process. Eventually we will not have the bandwidth to do as much. Next month, we have QIP updates and clinical guidelines review. Clinical guidelines are going through a reimagining. Those are reviewed by a provider subcommittee of CQI.

Wes asked if there anything else you want to hear about. Pam requested that Damali give us an update at a future meeting on whether any of the interventions are making a difference.

- Wes will put radio buttons on the supermeasures right under current status of metrics on performance dashboard
- Damali will update the committee in the future about whether any of the interventions are making a difference.

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.
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<td>are making a difference. Damali said that we can only look at what the providers report to us until we get verified claims data. Some of our monthly LME/MCO report monthly measures will be quarterly measures and some will go away entirely. The State is proposing this. Wes should have a little more information for the next meeting.</td>
<td>• Wes and/or Diane will call or email committee members to find out if they will be attending the next meeting.</td>
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5. **ADJOURNMENT**: the meeting adjourned at 1:49 pm; the next meeting will be December 5, 2019, from 1:00 p.m. to 2:30 p.m.
ITEM: Calendar Year (CY) 2020 Schedule of Board Meetings and Locations

DATE OF BOARD MEETING: December 5, 2019

BACKGROUND: As stated in the Board By-laws, regular meetings of the Board shall be held at least six times each year at a location and time designated by the Board. All meetings of the Board shall be conducted in accordance with provisions set forth in the NC Open Meetings Law. The Board currently holds its regularly scheduled meetings on the first Thursday of each month with the exception of January and July.

The matter placed before the Board for a vote is whether the Board would like to continue holding one meeting annually at each of Alliance’s community sites. The proposal includes meeting at the Johnston County location in February, and at the Cumberland County location in August. All other Board meetings would be at Alliance’s home office. The meetings at the local sites may be relocated back to the Home Office at the discretion of the Board, should unforeseen circumstances arise.

The 2020 schedule also includes the Annual Budget Retreat on March 16, 2020. The proper notice of Board meetings and locations will be published according to NC Open Meetings Law.

REQUEST FOR AREA BOARD ACTION: Determine the 2020 Board meeting dates and locations.

CEO RECOMMENDATION: Determine the 2020 Board meeting dates and locations.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
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<tr>
<th>Board Meeting</th>
<th>Date</th>
<th>Time</th>
<th>Location</th>
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<tbody>
<tr>
<td>Monthly Mtg</td>
<td>2/6/20</td>
<td>4:00-6:00 pm</td>
<td>Johnston Office</td>
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<tr>
<td>Monthly Mtg</td>
<td>3/5/20</td>
<td>4:00-6:00 pm</td>
<td>Home Office</td>
</tr>
<tr>
<td>Annual Budget Retreat</td>
<td>3/16/20</td>
<td>12:30-4:00 pm</td>
<td>Home Office</td>
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<tr>
<td>Monthly Mtg</td>
<td>4/2/20</td>
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<td>Monthly Mtg</td>
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<td>Network Services &amp; Development Committee</td>
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<td>Human Rights Committee</td>
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*Meeting may be cancelled or rescheduled due to holiday. Current information can be found at [https://www.alliancehealthplan.org/about-alliance-board](https://www.alliancehealthplan.org/about-alliance-board)*

**Color Key**
- Audit and Compliance Committee
- County Commissioner's Advisory Committee
- Executive Committee
- Human Rights Committee
- Monthly Board Meeting
- Network Development & Services Committee
- Policy Committee
- Quality Management Committee
ITEM: Sublease to RI International, Inc. dba Recovery Innovations Inc. for the Roxy Crisis Facility located at 1724 Roxie Ave, Fayetteville, North Carolina

DATE OF BOARD MEETING: December 5, 2019

REQUEST FOR BOARD ACTION: The Board is requested to approve the Sublease to Recovery Innovations, Inc. ("RI") for the Roxy Crisis Facility located at 1724 Roxie Ave, Fayetteville. Alliance leases this property from County of Cumberland. The Facility is currently undergoing significant renovations and is not open. Alliance awarded a Provider Contract to RI to become the operator of the Facility once it opens.

The Board is requested to approve the proposed Sublease Agreement to RI effective when we open all or a portion of the Facility. The term will run concurrently with our Lease from Cumberland County, which is through June 30, 2025. In the event RI loses the Provider Contract with Alliance for the operation of the Facility, then the Sublease would also terminate. The annual rent will be $0 (same as our rent amount from the County). RI is responsible for routine maintenance and security. This item requires a supermajority pursuant to the Board By-Laws.

CEO RECOMMENDATION: Approve the proposed Sublease to RI International, Inc. dba Recovery Innovations Inc. for the Roxy Facility located at 1724 Roxie Ave, Fayetteville and authorize the CEO to make non-substantive change and execute the Sublease.

RESOURCE PERSON(S): Carol Wolff, General Counsel; Robert Robinson, CEO
This Sublease Agreement, is made and entered into by and between Alliance Health, a political subdivision of the State of North Carolina, existing under N.C.G.S. Chapter 122C, hereinafter referred to as "Lessee", and RI, International, dba for Recovery Innovations Inc. an Arizona not for profit corporation, hereinafter referred to as “Subtenant”.

WHEREAS, Alliance is the Lessee of a certain parcel of real property located at 1724 Roxie Ave, Fayetteville, North Carolina owned by the County of Cumberland; and

WHEREAS, Alliance and Subtenant have entered into a Service Agreement for the provision of mental health, intellectual/developmental disability or substance abuse services including a walk-in crisis center available 24 hours a day at the Leased Premises, dated _____________ (the “Service Agreement”); and

WHEREAS, Alliance and Subtenant desire to enter into this Sublease Agreement in order to effectuate that purpose and to set forth their respective rights and liabilities in connection with said Property;

NOW THEREFORE, IN CONSIDERATION of the mutual promises and subject to the terms and conditions contained or referred to herein, Lessee does hereby lease and demise to Subtenant, that building located at 1724 Roxie Ave, Fayetteville, North Carolina (hereinafter referred to as the "Leased Premises"):

TO HAVE AND TO HOLD said property, together with all privileges and appurtenances thereto belonging including easements of ingress and egress, to the said Subtenant, under the terms and conditions hereinafter set forth:

1. TERM: The Sublease shall commence ______________, 2019, and unless sooner terminated, continue until midnight on June 30, 2025. The parties may agree to extend the Term thereafter upon mutual agreement, so long as Alliance’s Lease with the County of Cumberland is extended. This Sublease shall be subject to those terms and conditions contained in the Lease agreement between Alliance and the County of Cumberland, dated July 1, 2019.

2. RENT: The rent shall be at an annual rate of $0.00.

3. DEPOSIT: Lessee shall not require a security deposit from the Subtenant.

4. CONDITION OF PREMISES: Subtenant accepts the Leased Premises as is. Lessee makes no representation or warranty as to the condition of the Premises. Subtenant shall return the Leased Premises to Lessee at the termination or expiration hereof in as good condition and state of repair as the same was at the commencement of the term hereof, except for loss, damage, or depreciation occasioned by reasonable wear and tear or damage by fire or other casualty.

5. PARKING LOT: The parking lot adjacent to the building shall be included in the Leased Premises for the use of Subtenant and its visitors and invitees.

6. ASSIGNMENT and SUBLEASE: The Subtenant shall not assign this sublease or sublet
the Leased Premises or any part thereof, without the written consent of the Lessee; provided however; that if Subtenant enters into any sublease for which rent is paid, all rent shall be assigned to Lessee.

7. USE AND POSSESSION: The Leased Premises shall be used by Subtenant to provide behavioral health, substance abuse, intellectual and developmental disability and physical health services.

8. DESTRUCTION OF PREMISES: In the event that said building including the Leased Premises is damaged by fire, explosion, accident or any act of God, so as to materially affect the use of the building and Leased Premises, this Sublease shall automatically terminate as of the date of such damage or destruction, provided, however, that if such building and Leased Premises are repaired so as to be available for occupancy and use within sixty (60) days after said damage, then this Sublease shall not terminate; provided further, that the Subtenant shall pay no rent during the period of time that the Leased Premises are unfit for occupancy and use.

9. CONDEMNATION: If during the Term of this Sublease, the whole of the Leased Premises, or such portion thereof as will make the Leased Premises unusable for the purpose leased, be condemned by public authority for public use, then the term hereby granted shall cease and come to an end as of the date of the vesting of title in such public authority, or when possession is given to such public authority, whichever event occurs last. Upon such occurrence the rent shall be apportioned as of such date and any rent paid in advance at the due date for any space condemned shall be returned to Subtenant. Lessee shall be entitled to reasonable compensation for such taking except for any statutory claim of Subtenant for injury, damage or destruction of Subtenant’s business accomplished by such taking. If a portion of the Leased Premises is taken or condemned by public authority for public use so as not to make the remaining portion of the leased premises unusable for the purpose leased, this Sublease will not be terminated but shall continue. In such case, the rent shall be equitably and fairly reduced or abated for the remainder of the term in proportion to the amount of Leased Premises taken. In no event shall Lessee be liable to Subtenant for any interruption of business, diminution in use or for the value of any unexpired term of this Sublease.

10. INTERRUPTION OF SERVICE: Lessee shall not be or become liable for damages to Subtenant alleged to be caused or occasioned by, or in any way connected with, or the result of any interruption in service, or defect or breakdown from any cause whatsoever in any of the electric, water, plumbing, fire suppression, heating, air conditioning, ventilation or elevator systems, or any other structural component of the building, unless such damage arises from an intentional or negligent act or omission of Lessee, its employees or officers.

11. LESSEE’S RIGHT TO INSPECT: Lessee shall have the right, at reasonable times during the term of this Sublease, to enter the Leased Premises, for the purposes of examining and inspecting same and of making such repairs or alterations therein as Lessee shall deem necessary. Lessee shall provide at least 48 hours’ notice to Subtenant and shall be subject to confidentiality procedures deemed necessary for the safety and privacy of the occupants of the property.

12. INSURANCE: Lessee will be responsible for insuring its interest in the building and
Subtenant will be responsible for insuring its personal property within the leased premises. Subtenant shall at all times during the term hereof, at its own expense, maintain and keep in force a policy or policies of general and premises liability insurance against claims for bodily injury, death or property damage occurring in, on, or about the demised premises in a coverage amount of no less than $1,000,000 per occurrence and naming Lessee as an additional named insured. Subtenant shall provide current copies of all such policies of insurance to Lessee.

13. LESSEE'S RESPONSIBILITY FOR MAINTENANCE & REPAIRS: Lessee shall make all repairs and replacements to the Leased Premises (including building fixtures and equipment) except for repairs and replacements that Subtenant must make under Section 14. Lessee’s maintenance and repair obligations shall include generator repairs and maintenance including periodic cutover tests, roof, foundation, windows and exterior walls of the building; interior structural walls and all building systems, such as mechanical, electrical, HVAC, and plumbing; the parking lot, curb and sidewalk repair; pest control, existing chain link and brick fencing; fire suppression system; elevator systems; and repair or replacement of overhead lighting system. Lessee shall provide all services related to the landscaping and grassed areas, including trimming, mowing, planting, mulching and fertilizing as needed.

Repairs or replacements shall be made within a reasonable time (depending on the nature of the repair or replacement needed) after receiving notice from Subtenant or Lessee having actual knowledge of the need for a repair or replacement.

14. SUBTENANT'S RESPONSIBILITY FOR IMPROVEMENTS, MAINTENANCE & REPAIRS: Subtenant shall be responsible for all other maintenance of the Leased Premises not specified as the responsibility of Lessee in this Sublease. Subtenant shall be responsible for the regular maintenance in good condition of all interior surfaces including floors, doors, ceilings, walls and windows, unless damage arises from a Lessee obligation set forth in this Sublease.

Subtenant shall be responsible for the cost of providing commercially reasonable janitorial service and trash removal from the Leased Premises. Security alarms and other security measures will be the sole responsibility of the Subtenant. Subtenant shall not be responsible for ordinary wear and tear or for major damage or destruction caused by casualty or disaster for which there is insurance coverage.

Subtenant shall: (i) keep the Premises and fixtures in good order; (ii) make repairs and replacements to the Leased Premises needed because of Subtenant's misuse or negligence; (iii) maintain Subtenant improvements, including any special equipment or decorative treatments, installed by or at Subtenant's request that serve the Leased Premises; and (iv) not commit waste.

15. TRADE FIXTURES and IMPROVEMENTS: Any additions, fixtures, or improvements placed or made by the Subtenant in or upon the Leased Premises, which are permanently affixed to the Leased Premises and which cannot be removed without unreasonable damage to said premises, shall become the property of the Lessee and remain upon the premises as a part thereof upon the termination of this Sublease. All improvements, trade fixtures, office furniture and equipment, purchased with funds provided by Lessee shall be and remain as the property of the Lessee and may not be removed from the Leased Premises by Subtenant unless provided written
approval by Lessee.

All other additions, fixtures, or improvements, to include trade fixtures, office furniture and equipment, and similar items, which can be removed without irreparable damage to the Leased Premises, and paid for by the Subtenant, shall be and remain as the property of the Subtenant and may be removed from the Leased Premises by the Subtenant upon the termination of this Sublease. Subtenant is permitted to make alterations and improvements to the Leased Premises and shall bear the expense of such improvements not otherwise the responsibility of Lessee. Subtenant shall obtain Lessee’s written consent before making any alterations or changes to the building or Leased Premises, such consent shall not be unreasonably withheld.

16. **TAXES:** In the event any property of Subtenant is or becomes taxable, Subtenant will list and pay all business personal property taxes on its taxable personal property located within the Leased Premises.

**NOTICE:** Any notices to be given by either party to the other under the terms of this Agreement shall be in writing and shall be deemed to have been sufficiently given if delivered by hand, with written acknowledgement of receipt, or mailed by certified mail, return receipt requested, or delivered by receipt controlled express service, to the other party at their respective business addresses listed below:

**Lessee:**
Alliance Health
5200 W. Paramount Pkwy., Suite 200
Morrisville, NC 27560
Attn: General Counsel

**Subtenant:**
R I International dba of Recovery Innovations Inc.
2701 N 16 St., Suite 316
Phoenix, AZ 85006
Attn: CFO office

19. **SUCCESSORS AND ASSIGNS:** This Sublease shall bind and inure to the benefit of the successors and assigns of the parties hereto.

20. **UTILITIES:** Subtenant shall operate all utilities subject to Operation guidelines set forth below. Lessee shall pay the cost of water, gas, electricity, light, heat, and electric power utilities rendered or supplied upon or in connection with the Leased Premises. Lessee shall not be liable for any failure of any public utility to provide utility services over such connections and such failure shall not constitute a default by Lessee in performance of this Sublease. The installation, maintenance and service charges for any other utilities or services such as telephone, cable television, internet, or wireless connectivity shall be the sole responsibility of Subtenant.
21. **RISK OF LOSS:** As between the Lessee and the Subtenant, any risk of loss of personal property placed by the Subtenant in or upon the Leased Premises shall be upon and the responsibility of the Subtenant, regardless of the cause of such loss.

22. **DESTRUCTION OF PREMISES:** If the Leased Premises should be completely destroyed or damaged so that more than fifty percent (50%) of the Leased Premises are rendered unusable, this Sublease shall immediately terminate as of the date of such destruction or damage.

23. **EVENTS OF DEFAULT/TERMINATION:**

a.) The occurrence of any of the following shall constitute an Event of Default and breach of this Sublease:

(i) Subtenant abandons or vacates the Premises without written notification to the Lessee.

(ii) Subtenant utilizes the Premises in a manner not consistent with this Sublease.

(iii) Failure by either Party to observe and perform any other obligation of this Sublease, where such failure continues for thirty (30) days after Written Notice Of Default by the non-breaching party to the breaching party; provided, however, that if the nature of such default is such that the same cannot reasonably be cured within such thirty (30) day period a party shall not be deemed to be in default if that party shall within such period commence such cure and thereafter diligently prosecute the same to completion.

b.) **TERMINATION.** In the event either party Defaults, and such default shall continue for a period of thirty (30) days after written notice of default, the non-defaulting party, at its discretion. If Lessee shall fail to perform any of the terms and conditions heretofore set forth and shall continue such default thirty (30) days after written notice of such default, Subtenant, at its discretion, may terminate this Sublease and vacate the Leased Premises without further obligation to pay rent as heretofore provided from date of said termination, without prejudice to any other remedies provided by law. In the event Subtenant is unable or chooses not to use the Leased Premises for the intended uses, then Subtenant may terminate this Sublease upon ninety (90) days prior written notice to Lessee.

On or before the termination date or date of expiration, Subtenant shall vacate and surrender the Premises to Lessee. All keys to the Premises shall be delivered to the Lessee at that time.

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<th>For all area, offices, conference rooms, common areas, and guest patient bedrooms</th>
<th>Operating Mode</th>
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Notwithstanding the foregoing, this Sublease shall immediately terminate in the event the Service Agreement between the parties is terminated for any reason.

c.) CONDITION OF PREMISES UPON TERMINATION/HOLDING OVER. Upon the termination or expiration of this Sublease, Subtenant shall return the Premises to Lessee substantially in the same condition as received ordinary wear and tear and approved improvements excepted. If Subtenant does not surrender possession of the Premises at the expiration or earlier termination of the Term, Lessee shall be entitled to recover compensation for such use and occupancy at the monthly rate equal to Fair Market Value (as hereinafter defined) for the property at the expiration or earlier termination of the Term, and Subtenant shall be liable to Lessee for any loss or damage it may sustain by reason of Subtenant’s failure to surrender possession of the Premises immediately upon the expiration or earlier termination of the Term. For the purposes of this Sublease, “Fair Market Value” shall be the monthly rent that a willing user would pay and a willing owner would accept in an arm’s length, bona fide negotiation for a monthly lease of the Premises.

24. OCCUPANCY AND QUIET ENJOYMENT: Lessee promises that Subtenant shall have quiet and peaceable possession and occupancy of the Leased Premises in accordance with the terms of this Sublease, and that Lessee will defend and hold harmless the Subtenant against any and all claims or demands of others arising from Subtenant's occupancy of the premises or in any manner interfering with the Subtenant's use and enjoyment of said premises.

25. MODIFICATION: This Sublease may be modified only by an instrument duly executed by the parties or their respective successors.

26. WAIVER: Failure or delay of either party to insist upon the strict performance of the covenants, agreements, or conditions of this Sublease, or any of them, shall not be construed as a waiver or relinquishment of that party’s right to enforce such, but the same shall continue in full force and effect.

27. APPLICABLE LAW: This Sublease is entered into in North Carolina and shall be construed under the laws, statutes and ordinances of this State. All actions relating in any way to this Sublease shall be brought in the General Court of Justice in the County of Cumberland and State of North Carolina.

28. COMPLIANCE WITH LAWS: Subtenant represents that it is in compliance with all Federal, State, and local laws, regulations or orders, as amended or supplemented.

IN WITNESS WHEREOF, Lessee and Subtenant have caused this Sublease Agreement to be executed in duplicate originals by their duly authorized officers, to be effective for the term as stated above.

Subtenant: R I International a dba of Recovery Innovations Inc.

By: ________________________________
Lessee: Alliance Health

By: ____________________________________
Rob Robinson, CEO
ITEM: Appointment Recommendation

DATE OF BOARD MEETING: December 5, 2019

BACKGROUND: In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. John Lesica, MD, met with the Executive Committee on November 18, 2019, to discuss his interest in a Board vacancy representing Cumberland County. The matter before the Board is to recommend to the Cumberland Board of County Commissioners the appointment of John Lesica to Alliance’s Board. If appointed, Dr. Lesica’s initial term would expire September 30, 2022.

REQUEST FOR AREA BOARD ACTION: The Board is requested to recommend to the Cumberland Board of County Commissioners the appointment of John Lesica to Alliance’s Board.

CEO RECOMMENDATION: The Board is requested to recommend to the Cumberland Board of County Commissioners the appointment of John Lesica to Alliance’s Board.

RESOURCE PERSON(S): George Corvin, MD, Board Chair; Robert Robinson, Chief Executive Officer