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 from the Cumberland, Durham, Wake and Johnston CFAC meetings, and the CFAC
      steering meeting.

   B. Finance Committee (10 minutes) – page 47
      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 draft minutes from the April 4, 2019,
      meeting, Statement of Net Position, the Summary of Savings/(Loss) by Funding Source, the Statement
      of Revenue and Expenses (budget to actual) report and ratios for the period ending March 31, 2019
      and recommendations to the Board to approve all presented contracts over $250,000.

       **CEO Recommendation**
       Receive the reports.

6. Consent Agenda (5 minutes)
   A. Draft Minutes from April 4, 2019, Board Meeting – page 56
   B. Executive Committee Report – page 61
   C. Human Rights Committee Report – page 66
   D. Network Development and Services Committee Report – page 112
   E. Quality Management Committee Report – page 114

       **CEO Recommendation**
       Approve the minutes; receive the reports.

7. Fiscal Year (FY) 2019-2020 Recommended Budget (30 minutes) – page 119
   Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, will present the FY 2019-2020
   recommended budget for consideration. The board will vote on the FY 2019-2020 budget at its June
   meeting.

       **CEO Recommendation**
       Receive the presentation.
8. Review of FY20 Board Officer Selection Process (10 minutes) – page 154
Alliance Board Chair, Cynthia Binanay, will review the annual process for selecting board officers; board members will vote on FY2019-2020 officers at the June 6, 2019, Board meeting.

CEO Recommendation
Receive the update.

9. Legislative Update (20 minutes)
Brian Perkins, Senior Vice-President/Government Relations, and Sara Wilson, Government Relations Director, will provide an update.

CEO Recommendation
Receive the update.

10. Chair’s Report

11. Closed Session (45 minutes)
The Board will hold a closed session pursuant to NC § 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.

12. Adjournment

Next Meeting: Thursday, June 6, 2019
Alliance Health, 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: May 2, 2019

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

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

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

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

REQUEST FOR BOARD ACTION: Receive draft minutes and supporting documents from the Cumberland March 28th meeting, the Durham April 8th meeting, the Wake April 9th meeting, the Johnston April 16th, and the steering committee minutes from April 1st.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, CFAC Chair; and Doug Wright, Director of Community and Member Engagement
MEMBERS PRESENT: ☒ Steve Hill, ☒ Tammy Shaw, ☐ Joe Kilsheimer, ☐ James Henry, ☐ Latasha Jordan, ☒ Dave Curro, ☒ Trulia Miles, ☒ Brenda Solomon, ☒ Chris Dale, ☒ Dan Shaw
BOARD MEMBERS PRESENT: None
GUEST(S): ☐ Susan Hertz, ☐ Tina Barnes
STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Engagement, ☒ Terrasine Gardner, Member Engagement Manager, ☒ Ramona Branch, Individual & Family Engagement Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the March 11, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Chris Dale and seconded by Dave Curro to approve the minutes. Motion passed.

<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>None</td>
<td></td>
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<tr>
<td>4. Interest in Membership/Outreach</td>
<td>Steve Hill asked if there was any updates or communication with Susan Hertz. Ramona advised she would reach out to her and give update at next meeting.</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Complete Care</td>
<td>Doug went over the Complete Care Implementation update. In summary: Over the next 6-9 months Alliance will be making some changes in how Care Coordination is offered to our members. These changes are part of an agency-wide effort to prepare for the transition to a Tailored Plan. The team will be led by a Care Navigator who will be the point of contact for members and families. Among the additional expertise that may be added are nurses, pharmacist, community health workers, and senior clinicians. Implementation of the team approach to Care Coordination for IDD will begin July 1, 2019. Transition of the team approach for Care Coordination for MH/SUD will occur between July-December 2019. Additional information regarding that transition and listening sessions will be provided at a later date.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6. LME/MCO Updates</td>
<td>Doug engaged the group and got a list of needs and gaps for Durham County. The following is a list the group decided upon: Youth Peer Support, Youth Advisory Council, More access to OPT, Transportation, Drop in</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.
AGENDA ITEMS: DISCUSSION: NEXT STEPS: TIME FRAME:

Centers (After Hours), Peer Run Respite, SUD Long Term Care, Extended hours for services (providers), innovations slots, Housing options for IDD

Ramona went over the Member Engagement Questionnaire and asked the group to answer the following question, “What is Member Engagement”? The question entailed responses to the following prompts: Best member experience, Worst member experience, and What does it mean to participate in your healthcare? The responses will be typed up and given to Doug and Terrasine.

Due to time, Doug asked the group to read the other documents that were given in tonight’s meeting. Those included Health Opportunities Pilot, Legislative Perception of Care Report.

7. State CFAC Advocacy Day

Dave Curro went over the importance of being in attendance for the State CFAC Legislative Day that will be on May 16, 2019 in Raleigh. He also stated that he has asked Sarah and Brian of Alliance Health’s government relations department to put together a sheet with statistics as a guide to talking with the legislatures that day.

8. Event Planning

Community Forum: A reminder that the Community Forum on Medicaid transformation will take place on May 14, 2019 from 6-8pm. The flyer was printed and given out to members. They are all encouraged to circulate the flyer as well as personally invite someone to attend the forum.

ADJOURNMENT: 7:15pm The next meeting will be May 13, 2019, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch, Individual and Family Engagement Specialist

Click here to enter text. Date Approved

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Healthy Opportunities Pilots to Further Whole Person Care

As a part of the Medicaid 1115 waiver application, NC DHHS submitted a “Healthy Opportunities” pilot. The pilot was approved along with the Medicaid 1115 waiver. This pilot brings an exciting prospect for achieving an important aspect of whole person care because it allows for Medicaid/Health Choice reimbursement in four areas of Social Determinants of Health (SDOH): housing, transportation, food insecurity and interpersonal violence/toxic stress. Very limited Medicaid reimbursement is currently available for these types of services, yet studies have proven that addressing health disparities including social determinants of health can save money and improve outcomes. A 2011 study by The Joint Center for Political and Economic Studies found that $230 billion in direct medical care expenditures between 2003 and 2006 were excess costs due to socially determined health inequalities for minorities. NC DHHS will identify two to four geographic areas of the state “to test evidence-based interventions designed to improve health and reduce costs by directly addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid enrollees.”

Framework for Pilot
NC DHHS unveiled the framework for the Healthy Opportunities pilot in a recent webinar. NC DHHS will contract with a limited number (up to 4) of Lead Pilot Entities. These organizations are expected to have (a) experience directly providing relevant non-medical services or working closely with organizations that provide such services; (b) strong, longstanding relationships in the proposed Pilot geographic area with a variety of human service organizations; (c) expertise in providing services in a culturally competent manner; and (d) the commitment and expertise to strengthen the capacity of human service organizations to work effectively with healthcare systems and providers.

The Lead Pilot Entities will then develop networks of Human Service Organizations (HSOs). The HSOs are community-based and social service agencies. Care Managers will play a key role in identifying Medicaid/Health Choice beneficiaries who can benefit from participating in the pilot. They will look for the following physical/behavioral health risk factors (varies by population):

- Adults (such as two or more chronic conditions).
- Pregnant women (such as multifetal gestation).
- Children, age 0-3 (such as a baby that was in a neonatal intensive care unit).
- Children, age 0-21 (such as experiencing three or adverse childhood experiences).

The State is collaborating with the Foundation for Health Leadership and Innovation to implement a statewide tool, NCCARE360, to serve as a platform to (i) directly connect patients to community resources, and (ii) track and monitor referrals. They have also contracted with the UNC Cecil B. Sheps Center to conduct an evaluation of the pilot.

New service definitions will be developed. Below is a list of the federally-approved pilot services by category of SDOH:


**Housing:**
- Housing and Tenancy Supports
- Housing Quality and Safety Improvement Services
- Legal Assistance
- Securing Housing Payments
- Short-Term Post-Hospitalization

**Food Insecurity:**
- Food Support Services
- Meal Delivery Services

**Transportation:**
- Non-emergency health-related transportation

**Interpersonal Violence (IPV)/Toxic Stress:**
- Interpersonal violence-related transportation
- IPV and parenting support resources
- Legal Assistance
- Child Parenting Support

**Request for Information (RFI) Published**
The webinar also kicked off a Request for Information (RFI) in which NC DHHS is seeking design feedback and quantitative data for the pilot. Comments are due to NC DHHS by 2 p.m. EST on March 15, 2019.

Most of the services listed above are already being provided in North Carolina in some way. Much of it is through non-profit organizations that receive private funding and that create structures for the service. This formal process of the RFI is partially focused on obtaining accurate qualitative and quantitative data on who likely Human Service Organizations are, what is currently being offered and the cost related to that service. NC DHHS also uses the RFI process to seek feedback from Medicaid beneficiaries and other interested stakeholders. They noted in the recent webinar that organizations do not have to answer every question in the RFI. NC DHHS will use the feedback they receive to design the full pilot that they anticipate beginning by the end of 2020. NC DHHS anticipates publishing the Request for Proposals to identify the Lead Pilot Entities by mid-2019 and awarding those contracts by the end of 2019.

**Life Expectancy by Zip Code**
Robert Wood Johnson Foundation provides an interactive tool that will tell you the average life expectancy in your zip code. The RWJF site states, “…where we live can have an even greater impact. Improving health and longevity in communities starts with ensuring access to healthy food, good schools, affordable housing, and jobs that provide us the resources necessary to care for ourselves and our families—in essence, the types of conditions that can help keep us from getting sick in the first place.
SAVE THE DATE

State CFAC Legislative Day

May 16, 2019
10:00am to Noon
Community Forum

Please join us for a community forum and Q/A to learn more about Medicaid Transformation and how it will impact healthcare delivery.

Tuesday May 14, 2019
6-8pm

Where:
Community Family Life & Recreation Center
At Lyon Park
1309 Halley Street
Durham NC 27707

Sponsored by the Durham County Consumer and Family Advisory Committee
MEMBERS PRESENT: ☒ Carole Johnson, ☒ Megan Mason, ☒ Karen McKinnon, ☐ Connie King-Jerome, ☒ Israel Pattison, ☒ Annette Smith, ☒ Ben Smith, ☒ Wanda (Faye) Griffin, ☒ Gregory Schweitzer.

STAFF PRESENT: ☒ Doug Wright, Director of Individual and Family Affairs, ☐ Terrasine Garner, Community Member and Engagement Manager, ☒ Stacy Guse, Individual and Family Affairs Specialist.

Call your Dial-In Number: (646) 558 8656
Meeting Code: 244 907 890

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the March 12, 2019, Wake Consumer and Family Advisory Committee (CFAC) Subcommittee meeting reviewed; a motion made by Israel Pattison and seconded by Gregory Schweitzer to approve the minutes. Motion passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>Public Comments</td>
<td>Faye asked for prayers for a smooth move to her new apartment 4-15-2019.</td>
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<tr>
<td>LME/MCO Updates 2019</td>
<td>Healthy Opportunities Pilot Legislative Priority. Perception of Care Report: By the numbers.</td>
<td>Dave Curro is asking for CFAC members to go to the Legislative offices by the end of April before the deadline if CFAC Legislative Day May 16, 2019 regarding a loss of funding for needed services.</td>
<td>May 16, 2019</td>
</tr>
<tr>
<td>Annual Event Planning</td>
<td>Discuss the outcomes</td>
<td>Start thinking about next year event.</td>
<td>Ongoing</td>
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<td>Showing of Resilience</td>
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<tr>
<td>Complete Care</td>
<td>Complete Care Implementation Update.</td>
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<td>Questionnaire/feedback</td>
<td>Best member experience</td>
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<td>Worst Member experience</td>
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<td></td>
<td>What does it mean to participate in your healthcare?</td>
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<td>New Members vote</td>
<td>Vicky Bass, Jessica Larrison, Anthony Saracena has been voted in and</td>
<td>Stacy will deliver new members CFAC packets.</td>
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<tr>
<td></td>
<td>welcomed into the Wake CFAC. Welcome!</td>
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<tr>
<td>State CFAC Advocacy Day</td>
<td>Continuing the discussion. Legislative Conversations. Annette agreed to talk</td>
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<td>with County Commissioner Carole agreed would contact Wake Human Services.</td>
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<tr>
<td>MHFA Training</td>
<td>Continue this discussion</td>
<td></td>
<td>May 14, 2019</td>
</tr>
<tr>
<td>Needs and Gaps for Wake County I/DD, MH, SUD.</td>
<td>CFAC members recommendations for Social Determinants:</td>
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<tr>
<td></td>
<td>- Education outreach</td>
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<td></td>
<td>- Countywide resource-staff pre-trained and embedded for emergency backup</td>
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<td></td>
<td>(shortage of direct care-workers)</td>
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<td></td>
<td>- Difficulties with transportation.</td>
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<td></td>
<td>- Certified Peer-support specialist.</td>
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### AGENDA ITEMS

<table>
<thead>
<tr>
<th>Steering Committee Updates</th>
<th>DISCUSSION:</th>
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</table>
| CFAC Spreadsheet          | -Lack of housing and services for women with children just getting out of prison.  
                            -Higher wages for those receiving supportive employment.  
                            -People looking for day support services for individuals with I/DD.  
                            -Drop in center for those aged 18 and older.  
                            -More SOAR workers.  
                            -Forums and community events where Susan Gerger would have an expo for families and individuals to learn more from Alliance and Providers.  
                            -Provide and connect with public libraries with Alliance brochures/support.  
                            -Inform individuals about the free phones.  
                            -Benefits counseling.  

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<th>NEXT STEPS:</th>
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<tr>
<td>Stacy will send out the excel document to Wake CFAC members.</td>
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3. **ADJOURNMENT:** the next meeting will be May 14, 2019, at 5:30 p.m.

Respectfully Submitted by:

Stacy Guse, Individual and Family Engagement Specialist

April 9, 2019
SAVE THE DATE
State CFAC Legislative Day
May 16, 2019
10:00am to Noon
Celebrate Children’s Mental Health Awareness Day at our
4th Annual Mental WELLness Matters Dinner

Please join Wake System of Care, the Wake County Community Collaborative for Children and Families, and Alliance Health on May 9, 2019, in supporting Children’s Mental Health Awareness Day by joining us for our 4th annual Mental WELLness Matters Dinner. Dinner will be buffet style and will include vegetarian options.

Come have dinner, hear from speakers about their own experiences and the importance of mental wellness, and spend some time with friends and colleagues. Children ages 13 and up may accompany parents/legal guardians.

**When:** Thursday, May 9, 2019, from 6:00 PM to 8:00 PM

**Cost:** Free

**Where:** William F. Andrews Center on the main campus of WakeMed, 3024 New Bern Ave., Raleigh, NC 27610 (919-350-7305)

**Parking:** No cost for parking in the parking deck beneath the Andrews Center (P4 Yellow Parking Deck)

**Pre-registration by 4/22/19** is encouraged due to limited space. Pre-register by emailing Clarette Glenn at cglenn@alliancebhc.org. When you pre-register, please include the first and last name for each person for whom you are pre-registering.
### MEMBERS PRESENT:
- Michael McGuire
- Ellen Gibson
- Dorothy Johnson
- Carrie Morisy
- Jackie Blue
- Jamille Blue
- Sharon Harris
- Briana Harris
- Shirley Francis
- Tekeyon Lloyd
- Tracey Glenn-Thomas
- Renee Lloyd
- Carson Lloyd Jr.

### BOARD MEMBERS PRESENT:

### STAFF PRESENT:
- Doug Wright, Director of Community and Member Engagement
- Starlett Davis, Individual and Family Affairs Specialist
- Terrasine Gardner, Member Engagement Manager

### GUEST(S):
- Norma Negron
- Ayna Flacon
- Andrea Clementi
- Nakia Bernier
- Valencia Handy
- Joyce McKettan
- Margie Whitehead
- Alexander McAuthor
- Preston Harris
- Lisa J. Harris
- Robert Jackson

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<tbody>
<tr>
<td>1. Welcome/Introductions</td>
<td>Michael McGuire called the meeting to order at 5:30pm. We gave introductions.</td>
<td>N/A</td>
<td></td>
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<tr>
<td>2. Review of the Minutes</td>
<td>Motion to accept the minutes was made by Jackie Blue. It was seconded by Jamille Blue</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>3. Public Comments</td>
<td>Starlett Davis has provided community events and resources. Jackie shared that PBS will have a documentary about prison and mental health later that night. Dorothy shared her concerns about the possible state of mental health and decisions being made in the white house. NAMI will be having a book discussion coming up in May as well as a fashion show. Michael gave accolades to the school system on their program on suicide and mental illness the previous day. Michael also spoke about how well the CFAC retreat went. Autism Society is having a fundraiser April 5, 2019. It will be at 5:30pm at Kiwanis Recreation Center. Norma Negron expressed her concerns about not having enough state funding for the services she provides for the Hispanic Community. Dorothy and Michael spoke on the importance about us obtaining needs and gaps of the community and all of us working together to bridge those gaps. Alexander McAuthor also gave his concerns about the lack of resources he feels are here. Doug gave clarity on Alliance’s role in managing state funds. He explained how the funding works and the importance on advocating for Medicaid expansion. He explained that we have</td>
<td>See Doug, Terrasine, or Starlett for questions.</td>
<td>Ongoing</td>
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<tr>
<td>4. MCO/ State Updates</td>
<td>resources to assist with speaking with our State Legislatures. Michael spoke about the upcoming Advocacy Day and the importance of addressing concerns. Starlett went over the upcoming events. Each member and visitor received a copy</td>
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<td></td>
<td>Doug Wright addressed Alliance seeking a new provider for 24 hour crisis and assessment services and facility base crisis. We are looking for someone else other than Cape Fear to manage Roxie Crisis Facility. Doug went through the requirements needed for RFP, request for proposals who are interested in taking over management. He explained that Alliance is looking for volunteers to sit on the proposal committees. Transition of the facility will be done by August 1st. We are committed to working with Cape Fear and the new provider to help with a smooth transition. Jamille stated she would like to volunteer to sit on the RFP committee. Doug explained the expectations.</td>
<td>See Doug, Terrasine, or Starlett for questions. Transition is August 1st.</td>
<td>August 1, 2019</td>
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<td></td>
<td>Doug spoke about Medicaid Benefits Plan Memo. He spoke about the different services that have been identified as not being as impactful as expected. Those services will be discontinued because they do not have budget neutrality. Doug explained the Transportation Pilot that Alliance has. He explained that Alliance has contracted with LogistiCare. The target populations are individuals requesting services through Alliance Call Center and discharging from inpatient or crisis services. Individuals can receive a ride to and from initial appointment. Only Alliance Staff can make referrals for this pilot. This started on November 1, 2018.</td>
<td>Started November 1st. Alliance staff and Liaisons are in the facilities and will do referrals.</td>
<td>Ongoing</td>
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<td>The March 2019 CEE Updates were given out to everyone. Doug explained what it was and asked for the committee to go over it. Doug explained that the Needs and Gaps form will be coming out soon and to be thinking out those barriers to identify.</td>
<td>See Doug, Terrasine, or Starlett for questions. Contact CJ Lewis/ State Website for questions on State activities.</td>
<td>March and April 2019</td>
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<td>AGENDA ITEMS:</td>
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<td>5. Upcoming Community Events/Community Outreach event</td>
<td>Starlett Davis explained the importance of us keeping up with upcoming events for the community and who would be participating. We discussed some upcoming events for the rest of the year and who would like to participate. I asked the committee to think about what they would like to do and be ready to give input at the next meeting. We also discussed the community viewing and forum. The committee decided to view the Anonymous People on June 27, 2019 at DSS. We will have water and candy for participants.</td>
<td>Committee will discuss upcoming events and who will be participating at the next meeting.</td>
<td>April 25, 2019</td>
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<td>AGENDA ITEMS</td>
<td>DISCUSSION</td>
<td>NEXT STEPS</td>
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<tr>
<td>6. Membership Discussion</td>
<td>Michael McGuire explained the benefits of CFAC and becoming a member.</td>
<td>See Doug, Terrasine, or Starlett for questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>7. Prep for next meeting</td>
<td>The committee will have ideas about the barriers and needs in the community for the Needs and Gaps Assessment.</td>
<td>Give input on Needs and Gaps Assessment</td>
<td>April 25, 2019</td>
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<tr>
<td>8. Appreciation</td>
<td>Everyone gave their appreciation.</td>
<td></td>
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10. ADJOURNMENT

A motion was made by Shirley Francis to adjourn the meeting. Renee Lloyd seconded it. The meeting was adjourned at 7:30pm. The next Subcommittee meeting is 4/25/19. The next Steering Committee Meeting is April 1, 2019.
Date:  March 4, 2019  
Re:  Adjustments to Alliance Medicaid Benefit Plan

Through ongoing review and analysis of our services and medical budget we have identified services that are not producing the expected impact. Several of the new services that we have implemented over the past few years have not produced desired outcomes and have driven up costs. This review, combined with the impact of ongoing cuts to funding, variability in our Medicaid covered lives and the expectation to maintain budget neutrality when implementing new services are requiring us to make targeted rate changes and changes to our Medicaid benefit plan.

The following provides an overview of changes that Alliance will be making to our Medicaid benefit plan and certain Medicaid service rates.

- **Intensive Alternative Family Treatment (IAFT)** is an intensive model of therapeutic foster care that is currently funded at a rate 2.4 times higher than regular therapeutic foster care. This service will receive a 15% downward adjustment which will still provide a rate that is double our typical therapeutic foster care rate. The rate change will go into effect on April 15, 2019.

- **Enhanced Therapeutic Foster Care**, a model of therapeutic foster care that provides a greater level of behavioral support to youth and the treatment foster parents, will also receive a 15% downward rate adjustment. This rate is still 1.75% higher than the standard therapeutic foster care rate which will still enable agencies to provide additional supports to children in this level of care. The rate change will go into effect on April 15, 2019.

- **Outpatient (OPT) Plus** is a bundled service that allows providers to provide a combination of outpatient therapy and care coordination functions. We will be phasing out OPT Plus over a two-year period. Effective May 1, 2019 this service will no longer be available to adults and the reimbursement rate for child OPT Plus will be adjusted downward by 10% and removed from the child service array in 2020.

- **Community Support Team (CST) Plus** is an enhancement to the standard State CST service definition that allows providers greater flexibility in how services are delivered and allows for a greater number of units than CST. The state is significantly updating the current standard CST definition to address the limitations of the service. Alliance is removing CST Plus from the benefit plan effective May 1, 2019.
All Alliance departments will be closely monitoring the impact of these changes and ensuring that members receive needed services. If you have any questions please email providernetwork@alliancehealthplan.org
MEMBERS PRESENT: Jason Phipps, Cassandra Herbert, Bobby Dixon, Jerry Dodson, Albert Dixon, Leanna George  
BOARD MEMBERS PRESENT: None  
GUEST(S): None  
STAFF PRESENT: Doug Wright, Director of Community & Member Engagement, Terrasine Gardner, Member Engagement Manager, Noah Swabe, Individual and Family Engagement Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the March 19, 2019, Consumer and Family Advisory Committee (CFAC) meeting reviewed; a motion made by Jerry Dodson and seconded by Albert Dixon to approve the minutes. Motion passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
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<tbody>
<tr>
<td>3. Public Comment</td>
<td>Jerry Dodson recommended a movie called “hope” on Netflix discussing the effects on family and loved ones of individuals who have successfully completed suicide</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4. LME/MCO Updates</td>
<td>Doug went over the Complete Care Implementation update. In summary: Over the next 6-9 months Alliance will be making some changes in how Care Coordination is offered to our members. These changes are part of an agency-wide effort to prepare for the transition to a Tailored Plan. The team will be led by a Care Navigator who will be the point of contact for members and families. Among the additional expertise that may be added are nurses, pharmacist, community health workers, and senior clinicians. Implementation of the team approach to Care Coordination for IDD will begin July 1, 2019. Transition of the team approach for Care Coordination for MH/SUD will occur between July-December 2019. Additional information regarding that transition and listening sessions will be provided at a later date. A listening session has been set for Johnston County at the Johnston Medical Mall on May 16th from 6:00pm to 7:30pm.</td>
<td>Noah will invite Mr. Braswell and Mr. Jackson to a Johnston County CFAC meeting. CFAC’s responses on needs and gaps and member engagement will be reviewed.</td>
<td>Ongoing</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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<tr>
<td>ASL, pediatric ICF beds, school collaboration, respite care, facility based crisis and detox, summer camps and care, supportive housing/independent living opportunities, shelter care and promotion of mobile crisis promotion.</td>
<td></td>
<td>CFAC members will RSVP for state CFAC call if they wish to participate.</td>
<td>None</td>
</tr>
<tr>
<td>It was suggested to invite Mr. Braswell and Mr. Jackson from the Alliance Health board to a Johnston County CFAC general meeting to discuss needs and gaps in Johnston County.</td>
<td></td>
<td>CFAC members will RSVP for state CFAC call if they wish to participate.</td>
<td>None</td>
</tr>
<tr>
<td>5. State Updates</td>
<td>CJ Lewis discussed the upcoming State CFAC call on April 17, 2019. CJ encouraged members to RSVP with Kate Borrow if they would like to participate on the call. CJ discussed upcoming events throughout the state including Family Fest on April 27th in Iredell County, NC Tide on April 28th in Wilmington, and Disability Rights Advocacy Day on May 1st in Durham.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6. Events</td>
<td>SSSStrong Day due to inclement weather was moved to May 18th from 1pm to 3pm. CFAC members were encouraged to attend however the event also is the same day as the NAMI walk. The CFAC wishes to proceed with the proposed dates for the guardianship event June 8th or 15th. Currently waiting to hear back from proposed speakers and Johnston County Public Schools about possibly utilizing space on campus.</td>
<td>CFAC members will check their schedules and let Noah know if they will be able to attend SSSStrong Day. Noah will follow up with Jason next week to check on space for event.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>7. State CFAC Advocacy Day</td>
<td>May 16, 2019 in Raleigh from 10am to 12pm once the logistics of the event are known they will be shared with the CFAC.</td>
<td>Noah will share legislative day specifics with CFAC as soon as they are known.</td>
<td>ASAP</td>
</tr>
</tbody>
</table>

8. **ADJOURNMENT:** the next meeting will be May 21, 2019, at 5:30 p.m.

Respectfully Submitted by:

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
SAVE THE DATE
State CFAC Legislative Day
May 16, 2019
10:00am to Noon
Question 1: Best member experience?
“Been with LME/MCO; started a meeting in the community with people first”
“Where the doctors are engaged with me about my health”
“Being part of community outreach events and providing input to the behavioral health system”
“Serenity Transition from PATH program at Murdoch back to home. Good communication between all parties involved in planning and execution.”
“Communication with board members and becoming a certified peer support specialist and trained in peer to peer”

Question 2: Worst member experience?
“Not being heard and lack of use of peer supports”
“When people involved in my health act like I am just a member”
“Having to constantly change goals as system constantly changes”
“Lack of support in locating reliable direct service for HC based services”

Question 3: What does it mean to participate in your healthcare?
“To be treated as an equal partner in determining services and treatments for my family member”
“Important to be part of decision making process, for self and dependent”
“Is very important to be educated about my health”
“Means a lot to me to learn things from people and how to be independent! Need more money and help at sometimes. Would need more help if something happened to my mother”
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the February 4, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Jason Phipps and seconded by Jerry Dodson to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<tbody>
<tr>
<td>3. Public Comment</td>
<td>Important Announcement – Statewide CFAC Meeting (how did it go?) Members that attended expressed that they enjoyed the event, it was good to put faces to some of the people they saw in emails. The information presented was informative, they were glad they had been educated over the past year around Medicaid transformation so that they could understand and follow the conversation. Rob and Sara discussed transformation briefly and ask if anyone had any questions about the process. Multiple concerns were brought up about how members will get the information and will it be confusing and challenging for people to understand. Rob asks for suggestions about how to best inform members, the website, community forums and other options should all be considered.</td>
<td>Continue to educate ourselves and the members and communities about Medicaid transformation.</td>
<td>On-Going</td>
</tr>
<tr>
<td>4. Tailored Plan Care Management</td>
<td>Doug presented on Care Management. We discussed the three options for members, Advanced Medical Homes, Care Management Agencies, and BH I/DD Tailored Plans. Concerns were raised about stand-alone care management organizations. The importance of integrated care management was stressed.</td>
<td>Continue to educate ourselves and communities about Care Management and the options members will have.</td>
<td>On-Going</td>
</tr>
<tr>
<td>5. LME/MCO Updates</td>
<td>Healthy Opportunities Pilots – discussed the fact that there is $650,000,000.00 available for 2-4 pilots in NC through the 1115 N/A</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.
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>ITEM</th>
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<th>NEXT STEPS</th>
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<tbody>
<tr>
<td>6.</td>
<td>State Updates</td>
<td>State CFAC meeting on the 10th.</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Subcommittees</td>
<td>Consent agenda approved.</td>
<td>N/A</td>
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<td></td>
<td>Wake</td>
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<td>Human Rights</td>
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<td></td>
<td>Quality Management</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>Announcements</td>
<td>Wake CFAC showing of Resilience this Saturday, April 6th at RCNC</td>
<td></td>
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</tbody>
</table>

9. **ADJOURNMENT:** the next meeting will be May 6, 2019, at 5:30 p.m.

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

Click here to enter text. Date Approved

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

BH I/DD Tailored Plan Care Management Update

Kelsi Knick
Senior Program Manager, Population Health

March 13, 2019
Agenda

- Care Management Under Managed Care
- Overview of BH I/DD TP Care Management Model
- Discussion of Current LME-MCO Practices and Future State Capabilities
- Next Steps
Key Principles for Medicaid Transformation

- Deliver **integrated, whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy services and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden
Overview of Managed Care Transition

Under managed care, approximately 8 out of 10 Medicaid/NC Health Choice* beneficiaries will receive health coverage through integrated managed care products

There will be two types of integrated managed care products available to Medicaid beneficiaries under managed care:

1. Standard Plans (SPs) for most beneficiaries (approx. 1.6 million)
2. Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD TPs) for populations with significant behavioral health, I/DD and TBI needs (approx. 115,000)

Both products will offer robust services across the continuum of care, including physical health, behavioral health, pharmacy, and long-term services and supports (LTSS)

Only BH I/DD TPs will provide more intensive behavioral health services, I/DD and TBI services (including Innovations and TBI waiver services), 1915(b)(3) services, and State-funded services

* Note: References to “Medicaid” hereafter are intended to encompass both Medicaid and NC Health Choice.
Both managed care products will offer robust care management. BH I/DD TP care management will build on SP care management design to provide services customized to individuals with behavioral health, I/DD, and TBI needs.

**SP care management** will be available to certain “priority populations.” Primary care practices certified as Tier 3 Advanced Medical Homes (AMHs) will take the lead on care management for their patients in SPs.

**BH I/DD TP care management** will be available to all BH I/DD TP enrollees and will be provided through:

1. Tier 3 AMHs certified by DHHS to provide care management to the BH I/DD TP population
2. Care management agencies (CMAs)—community-based organizations (e.g., behavioral health or I/DD providers) certified by DHHS to provide care management to the BH I/DD TP population
3. BH I/DD TPs
Introduction to the AMH Program

The AMH program is a key vehicle for achieving integrated, whole-person care and local care management in North Carolina.

Vision for AMH in Managed Care

Build on the Carolina ACCESS program to preserve broad access to primary care services for Medicaid enrollees and strengthen the role of primary care in care management, care coordination, and quality improvement as the state transitions to managed care.

Today’s Carolina ACCESS primary care practices* have options:

• Current primary care practices in Carolina ACCESS program may continue into AMH with few changes (“Tier 1” and “Tier 2”)
• Practices ready to take on more advanced care management functions may attest into AMH “Tier 3”**
  • Tier 3 practices may rely on in-house care management capacity or contract with a Clinically Integrated Network (CIN) or other partner of their choice
  • Unlike in Carolina ACCESS, practices ARE NOT be required to contract with Community Care of North Carolina (CCNC) to participate in AMH

*Eligibility for AMH mirrors the legacy Carolina ACCESS program and includes general practice, family practice, internal medicine, pediatrics, OB/GYN, psychiatry and neurology
AMH Tiers Compared

Tiers 1 and 2

- **SP retains** primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple SPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

Tier 3

- **PHP delegates** primary responsibility for delivering care management to the practice level (see next slide)
- **Single, consistent care management approach:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 SP contracts
- **Initial attestation process closed 1/31:** based on attestation data, majority of SP beneficiaries are expected to be attributed to Tier 3 practices

Tier 4: To launch at a later date
Deep Dive on Tier 3 AMHs

Tier 3 AMHs are responsible for delivering care management at the practice level, including:

**Tier 3 Responsibilities**

- Risk stratify all empaneled patients
- Provide care management to high-need patients, which includes (but is not limited to):
  - Conducting a comprehensive assessment of enrollees’ needs
  - Establishing a multi-disciplinary care team for each enrollee
  - Developing a care plan for each enrollee
  - Coordinating all needed services (physical health, behavioral health, social services, etc.)
  - Providing in-person assistance securing unmet resource needs (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing transitional care management as enrollees change clinical settings
- Receive claims data feeds (directly or via a CIN/other partner) and meet state-designated security standards for their storage and use
Guiding Principles for BH I/DD TP Care Management

In alignment with the broader goals for Medicaid transformation, the Department is using following guiding principles in the design of the BH I/DD TP care management model.

- **All enrollees will be eligible for care management.** BH I/DD TP care management will be available to all BH I/DD TP enrollees continuously throughout an individual’s enrollment.

- **An integrated, whole-person approach.** BH I/DD TP enrollees will receive integrated, whole-person care management from care managers with expertise and training in addressing BH, I/DD, and/or TBI needs in addition to physical health needs.

- **Community-based care management.** Care management will be provided at the site of care, in the home or community, to enable frequent face-to-face interaction between care managers, providers, and enrollees.

- **Choice of care management providers.** BH I/DD TP enrollees may choose among care management providers and may change care managers at any time.

- **Community inclusion.** BH I/DD TP care managers will support enrollees in living meaningful, productive lives in the community.

- **Consistency across the state.** Regardless of geography or type of entity providing care management, all BH I/DD TP enrollees will have access to consistent, high-quality care management.

- **Leverage existing resources.** BH I/DD TP care management will build on existing, high-functioning care management infrastructure in the state to the extent it aligns with DHHS’s vision for care management.
Overview of BH I/DD TP Care Management Approach

**NC DHHS**

Establishes care management standards for BH I/DD TPs aligning with federal Health Home requirements

The BH I/DD TP will act as the Health Home and will be responsible for meeting federal Health Home requirements

**BH I/DD TP Health Home**

All approaches will be subject to one set of requirements and will provide care management across physical health, behavioral health, I/DD, and other services and the enrollee’s unmet health-related resource needs.

**Care Management Approaches**

BH I/DD TPs have flexibility in how they provide care management, as long as the approach meets DHHS standards and care management is provided in the community to the maximum extent possible.

**Approach 1: Tier 3 AMH with BH and/or I/DD Certification***

- DHHS will create specialized BH and I/DD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD TP enrollees and have experience serving these populations

**Approach 2: Care Management Agencies (CMAs)**

- BH I/DD TPs contract with agencies such as those that provide BH or I/DD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain CMA certification

**Approach 3: BH I/DD TP-Employed Care Managers**

- BH I/DD TPs may provide care management in certain circumstances that will be outlined in more detail by DHHS.

*Tier 3 AMHs or CMAs may contract with a clinically integrated network (CIN) for certain care management and data sharing functions*
Integrated, Community-Based Care Management

At its core, the BH I/DD TP care management model aims to promote integrated, community-based care management.

- **Integrated care management** places the person at the center of a multidisciplinary care team and recognizes interactions across all of their needs—ranging across physical health, behavioral health, I/DD, and TBI—developing a holistic approach to serve the whole person.

- **Community-based care management** ensures that care managers are physically located in settings that enable frequent face-to-face interaction between care managers, providers, and enrollees.
Coordinate a comprehensive set of services addressing all of the enrollee’s needs; enrollees will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.

Provide holistic, person-centered planning. Enrollees receive a care management assessment that evaluates all of their needs—from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drive the development of a care plan that identifies the goals and strategies to achieve them.

Connect enrollees to programs and services that address unmet health-related resource needs (e.g. housing, food, transportation, interpersonal safety, employment, etc.), including through healthy opportunity pilots in regions where available.

Are part of multidisciplinary care teams made up of clinicians and service providers (e.g. primary care providers, behavioral health and I/DD or TBI providers, pharmacists, nutritionists, community health workers, peer supports, etc.) that communicate and collaborate closely to efficiently address all of the enrollee’s needs.

Have access to technology that bridges data silos across providers and plans, and facilitate the timely and secure exchange of information to support and inform integrated care management.
Community-Based Care Management Means that Care Managers...

- **Primarily use face-to-face meetings**, supplemented by telephone, text message, and email, to engage and support the client whether in the home or a treatment setting. They speak the client’s language or have easy access to interpreters.

- **Are local**, and live in and/or have experience working in the geographic region where their panel lives. They:
  - Understand local culture and how it impacts the physical and behavioral health of clients
  - Conduct regular assessments of community health assets and needs and use the results to plan/implement services that respond to cultural and linguistic diversity

- **Are embedded within or assigned to a designated group of primary care practices or behavioral health or I/DD providers**

- **Have professional working relationships in the community** with residential and outpatient treatment facilities, home health and housing agencies, community-based social service agencies, schools, police, correctional facilities, and other service providers that their clients may come in contact with on a regular basis

- **Leverage their community-based connections** to facilitate/fast track services needed to stabilize clients in community settings or transition to other settings to gain most favorable outcome for the client

- **Build effective relationships with family and other caregivers** to guide them in supporting the client through transitions and ongoing treatment
Appendix
**Definitions**

*Adults with Special Health Care Needs* is defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis; or receiving 1915(b)(3), Innovations or TBI Waiver services.

**Children with Special Health Care Needs** is defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child’s age. This includes, but is not limited to, children: in foster care; receiving Early Intervention; with an SMI, SED, I/DD or SUD diagnosis, and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.

**High Unmet Resource Needs** is defined as enrollees who are homeless; witnessing domestic violence or lack of personal safety; or showing unmet needs in three or more social determinants of health domains (i.e., housing, food, transportation, and interpersonal violence/toxic stress) on the care needs screening.
Healthy Opportunities Pilots to Further Whole Person Care

As a part of the Medicaid 1115 waiver application, NC DHHS submitted a “Healthy Opportunities” pilot. The pilot was approved along with the Medicaid 1115 waiver. This pilot brings an exciting prospect for achieving an important aspect of whole person care because it allows for Medicaid/Health Choice reimbursement in four areas of Social Determinants of Health (SDOH): housing, transportation, food insecurity and interpersonal violence/toxic stress. Very limited Medicaid reimbursement is currently available for these types of services, yet studies have proven that addressing health disparities including social determinants of health can save money and improve outcomes. A 2011 study by The Joint Center for Political and Economic Studies found that $230 billion in direct medical care expenditures between 2003 and 2006 were excess costs due to socially determined health inequalities for minorities.

NC DHHS will identify two to four geographic areas of the state “to test evidence-based interventions designed to improve health and reduce costs by directly addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid enrollees.”

Framework for Pilot

NC DHHS unveiled the framework for the Healthy Opportunities pilot in a recent webinar. NC DHHS will contract with a limited number (up to 4) of Lead Pilot Entities. These organizations are expected to have (a) experience directly providing relevant non-medical services or working closely with organizations that provide such services; (b) strong, longstanding relationships in the proposed Pilot geographic area with a variety of human service organizations; (c) expertise in providing services in a culturally competent manner; and (d) the commitment and expertise to strengthen the capacity of human service organizations to work effectively with healthcare systems and providers.

The Lead Pilot Entities will then develop networks of Human Service Organizations (HSOs). The HSOs are community-based and social service agencies. Care Managers will play a key role in identifying Medicaid/Health Choice beneficiaries who can benefit from participating in the pilot. They will look for the following physical/behavioral health risk factors (varies by population):

- Adults (such as two or more chronic conditions).
- Pregnant women (such as multifetal gestation).
- Children, age 0-3 (such as a baby that was in a neonatal intensive care unit).
- Children, age 0-21 (such as experiencing three or adverse childhood experiences).

The State is collaborating with the Foundation for Health Leadership and Innovation to implement a statewide tool, NCCARE360, to serve as a platform to (i) directly connect patients to community resources, and (ii) track and monitor referrals. They have also contracted with the UNC Cecil B. Sheps Center to conduct an evaluation of the pilot.

New service definitions will be developed. Below is a list of the federally-approved pilot services by category of SDOH:
**Housing:**
- Housing and Tenancy Supports
- Housing Quality and Safety Improvement Services
- Legal Assistance
- Securing Housing Payments
- Short-Term Post-Hospitalization

**Food Insecurity:**
- Food Support Services
- Meal Delivery Services

**Transportation:**
- Non-emergency health-related transportation

**Interpersonal Violence (IPV)/Toxic Stress:**
- Interpersonal violence-related transportation
- IPV and parenting support resources
- Legal Assistance
- Child Parenting Support

**Request for Information (RFI) Published**
The webinar also kicked off a [Request for Information (RFI)](#) in which NC DHHS is seeking design feedback and quantitative data for the pilot. Comments are due to NC DHHS by 2 p.m. EST on March 15, 2019.

Most of the services listed above are already being provided in North Carolina in some way. Much of it is through non-profit organizations that receive private funding and that create structures for the service. This formal process of the RFI is partially focused on obtaining accurate qualitative and quantitative data on who likely Human Service Organizations are, what is currently being offered and the cost related to that service. NC DHHS also uses the RFI process to seek feedback from Medicaid beneficiaries and other interested stakeholders. They noted in the recent webinar that organizations do not have to answer every question in the RFI. NC DHHS will use the feedback they receive to design the full pilot that they anticipate beginning by the end of 2020. NC DHHS anticipates publishing the Request for Proposals to identify the Lead Pilot Entities by mid-2019 and awarding those contracts by the end of 2019.

**Life Expectancy by Zip Code**
Robert Wood Johnson Foundation provides an [interactive tool](#) that will tell you the average life expectancy in your zip code. The RWJF site states, “…where we live can have an even greater impact. Improving health and longevity in communities starts with ensuring access to healthy food, good schools, affordable housing, and jobs that provide us the resources necessary to care for ourselves and our families—in essence, the types of conditions that can help keep us from getting sick in the first place.
Alliance Health 2019 Legislative Priority:  
Stop Reductions in Funding for NC Behavioral Healthcare

Request to the General Assembly
Stop the cuts to State Single-Stream Funding that are severely restricting North Carolinians’ access to healthcare services for mental health, intellectual/developmental disabilities, and substance use disorder (MH/IDD/SUD) needs.

- Single-Stream Funding is the State appropriation for the MH/IDD/SUD service needs of uninsured and underinsured North Carolinians. Single-Stream Funding is separate from Medicaid funding.
- State Single-Stream Funding has been cut for four consecutive years. The State’s two most recent biennium budgets have cut nearly half a billion dollars from NC’s public behavioral health system.
- These Single-Stream cuts continue to negatively impact our State’s ability to address the behavioral health needs of the uninsured and underinsured.

Background
- The current State budget included cuts to Single-Stream Funding of almost $200 million over two years. This nearly $200 million cut is in addition to $262 million in Single-Stream cuts included in the previous budget. The table below breaks down the cuts by year. Alliance’s share of this cut has been nearly $67 million during this period.

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Single-Stream Cut (in millions)</td>
<td>$110</td>
<td>$152</td>
<td>$87</td>
<td>$107.6</td>
<td>$458.3</td>
</tr>
<tr>
<td>Alliance’s Share of Cuts (in millions)</td>
<td>$11</td>
<td>$15.2</td>
<td>$15.9</td>
<td>$25.1</td>
<td>$67.2</td>
</tr>
</tbody>
</table>

- Despite these drastic reductions, current law requires LME-MCOs to continue offering the same level of State-funded services as before the reductions.
- LME-MCOs are forced to make up this State funding shortfall by using their Medicaid savings otherwise designated for reinvestment initiatives that target specific unmet behavioral health and social determinant needs of individuals living in our communities. This severely restricts investments in initiatives to reduce unnecessary emergency department admissions and divert people with behavioral health issues from the criminal justice system.

Cutting State funds in this manner contradicts the original intent in creating the public behavioral health managed care system in NC – for LME/MCOs to use savings derived from effective management of the system to build infrastructure to address unmet community needs. Alliance has been forced to halt planned reinvestment projects. For example, we have had to stop work on:

- Opening a new Adult Crisis Facility to respond to rapidly-growing demand in Wake County.
- Expanding Behavioral Health Urgent Care Centers in several communities throughout our catchment area.

- Because the crisis facility and urgent care centers would serve a high proportion of uninsured and underinsured individuals, lack of current and future State Single-Stream Funding makes operating these much-needed facilities unsustainable.
ITEM: Finance Committee Report

DATE OF BOARD MEETING: May 2, 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 April 4, 2019, meeting, Statement of Net Position, the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending March 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): Chris Bostock, Committee Chair; and Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
AGENDA

1. Review of the Minutes – April 4, 2019

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

3. Approval of Contract(s)

4. Quarterly Updates
   a. Reinvestment Plan
   b. Solvency Standards
   c. PMPM
   d. Non-Medicaid Reporting

5. FY20 Recommended Budget

6. Adjournment
1. **WELCOME AND INTRODUCTIONS**

2. **REVIEW OF THE MINUTES** – The minutes from the March 7, 2019, meeting were reviewed; a motion was made by Mr. Gino Pazzaglini and seconded by Chair Cynthia Binanay to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 3. Monthly Financial Reports | The monthly financial reports were discussed which includes the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of February 28, 2019. Ms. Sara Pacholke discussed the monthly reports.  
  - As of 2/28/19, we have a loss of $22.3M and need $15M from fund balance to offset legislative reductions. The loss will continue to grow during FY19 due to legislative cuts.  
  - As of 2/28/19, we have unrestricted net position of $2.07M.  
  - The Committee discussed the impact of the declining unrestricted net position and the impact on reinvestments. The PMPM rate we receive for FY20 is critical.  
  a) We are meeting all SB208 and DMA contract ratios. |  |  |
| 4. Medicaid Recoupments | Ms. Kelly Goodfellow discussed the continued impact of Medicaid recoupments. We are still waiting on information from the State and IT to go through the data. Recoupments happened in July, August, and September. We were paid back for some in December and then additional recoupments happened in February. We are working to resolve the issue before year-end close. |  |  |

5. **ADJOURNMENT**: next meeting will be May 2, 2019, from 2:30 p.m. to 4:00 p.m.
Respectfully Submitted by:

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

#### Current Assets
- Cash and cash equivalents: $28,361,205.34
- Short term investments: 50,044,706.22
- Due from other governments: 18,280,439.09
- Accounts receivable, net of allowance for uncollectible accounts: 589,895.37
- Sales tax refund receivable: 126,447.92
- Prepaid expenses: 1,250,211.36
- **Total Current Assets**: 98,652,905.30

#### Noncurrent Assets
- Restricted Cash: 49,443,773.76
- Other assets: 406,495.47
- Capital assets, net of accumulated depreciation: 4,671,227.81
- Deferred Outflows of Resources: 6,347,979.30
- **Total Other Assets**: 60,869,476.34

#### Total Assets
- **Total Assets**: 159,522,381.64

### LIABILITIES

#### Current Liabilities
- Accounts Payable and Other Current Liabilities: 4,168,531.58
- Claims and other service liabilities: 40,273,241.88
- Unearned Revenue: 12,048,817.54
- Current portion of accrued vacation: 624,208.01
- Other Current Liabilities: 2,482,942.00
- **Total Current Liabilities**: 59,597,741.01

#### Noncurrent Liabilities
- Net Pension Liability: 7,133,553.00
- Accrued Vacation: 1,168,450.77
- Deferred Inflows of Resources: 201,921.00
- **Total Long-Term Liabilities**: 8,503,924.77

#### Total Liabilities
- **Total Liabilities**: 68,101,665.78

### NET POSITION

- Capital Assets at Beginning of Year: 4,409,429.01
- Restricted: 43,027,793.18
- Unrestricted: 65,498,716.79
- **Net Revenue over Expenses:** (21,515,223.12)

#### Current Year Change in Net Position
- **Total Net Position**: 91,420,715.86
- **Total Liabilities and Net Position**: $159,522,381.64
### Summary of Savings/(Loss) by Funding Source as of March 31, 2019

<table>
<thead>
<tr>
<th>Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$281,918,474</td>
<td>$284,987,080</td>
<td>$(3,068,607)</td>
</tr>
<tr>
<td>Federal &amp; State Grants</td>
<td>29,889,754</td>
<td>47,088,081</td>
<td>$(17,198,328)</td>
</tr>
<tr>
<td>Local Grants</td>
<td>20,917,968</td>
<td>20,949,943</td>
<td>$(31,975)</td>
</tr>
<tr>
<td>Administrative</td>
<td>42,958,452</td>
<td>44,174,766</td>
<td>$(1,216,314)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$375,684,648</td>
<td>$397,199,871</td>
<td>$(21,515,223)</td>
</tr>
</tbody>
</table>

Amount to be used from Fund Balance $ (21,515,223)

### Fund Balance as of March 31, 2019

<table>
<thead>
<tr>
<th>Description</th>
<th>June 30, 2018</th>
<th>Change</th>
<th>March 31, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,409,429</td>
<td>261,799</td>
<td>4,671,228</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>43,027,793</td>
<td>6,415,980</td>
<td>49,443,774</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statues</td>
<td>5,217,343</td>
<td>(0)</td>
<td>5,217,343</td>
</tr>
<tr>
<td>Prepaids</td>
<td>639,095</td>
<td>611,117</td>
<td>1,250,211</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>5,856,438</td>
<td>611,116</td>
<td>6,467,554</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>25,141,196</td>
<td>(17,198,328)</td>
<td>7,942,866</td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>3,007,817</td>
<td>(2,255,863)</td>
<td>751,954</td>
</tr>
<tr>
<td>Reinvestment</td>
<td>18,769,500</td>
<td>(1,909,320)</td>
<td>16,860,180</td>
</tr>
<tr>
<td>Total Committed</td>
<td>46,918,513</td>
<td>(21,363,511)</td>
<td>25,555,002</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>12,723,765</td>
<td>(7,440,608)</td>
<td>5,283,157</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td>112,935,938</td>
<td>(21,515,223)</td>
<td>91,420,715</td>
</tr>
</tbody>
</table>
### Statement of Revenue and Expenses (Budget and Actual) - As of March 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Current Period</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$37,931,390.00</td>
<td>$265,850.78</td>
<td>$8,466,791.72</td>
<td>$6,389,890.21</td>
<td>$6,061,286.29</td>
<td>$20,917,968.22</td>
<td>$17,013,421.78</td>
<td>55.15%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>77,881,018.00</td>
<td>4,276,614.83</td>
<td>8,846,485.71</td>
<td>9,319,173.06</td>
<td>11,724,094.98</td>
<td>29,889,753.75</td>
<td>47,991,264.25</td>
<td>38.38%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>379,107,645.00</td>
<td>33,350,585.18</td>
<td>93,458,622.95</td>
<td>98,804,150.03</td>
<td>99,655,700.53</td>
<td>281,918,473.51</td>
<td>97,189,171.49</td>
<td>74.36%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$494,920,053.00</td>
<td>37,893,050.79</td>
<td>110,771,900.38</td>
<td>114,513,213.30</td>
<td>107,441,081.80</td>
<td>332,726,195.48</td>
<td>162,193,857.52</td>
<td>67.23%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>369,054.00</td>
<td>33,273.33</td>
<td>99,820.71</td>
<td>99,822.00</td>
<td>99,819.99</td>
<td>299,462.70</td>
<td>69,591.30</td>
<td>81.14%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,359,385.00</td>
<td>363,283.00</td>
<td>1,089,849.08</td>
<td>1,089,849.00</td>
<td>1,089,849.00</td>
<td>3,269,547.08</td>
<td>1,089,837.92</td>
<td>75.00%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>55,780,727.00</td>
<td>4,539,162.53</td>
<td>12,741,941.97</td>
<td>13,478,617.67</td>
<td>12,217,026.62</td>
<td>38,437,586.26</td>
<td>17,343,140.74</td>
<td>68.91%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>885,000.00</td>
<td>105,989.00</td>
<td>309,706.87</td>
<td>331,327.12</td>
<td>310,822.08</td>
<td>951,856.07</td>
<td>(66,856.07)</td>
<td>107.55%</td>
</tr>
<tr>
<td>Total Administrative Revenue</td>
<td>61,394,166.00</td>
<td>5,041,707.86</td>
<td>14,241,318.63</td>
<td>14,999,615.79</td>
<td>13,717,517.69</td>
<td>42,958,452.11</td>
<td>18,435,713.89</td>
<td>69.97%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$556,314,219.00</td>
<td>42,934,758.65</td>
<td>125,013,219.01</td>
<td>129,512,829.09</td>
<td>121,158,599.49</td>
<td>375,684,647.59</td>
<td>180,629,571.41</td>
<td>67.53%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>37,931,390.00</td>
<td>297,825.32</td>
<td>8,472,799.62</td>
<td>6,386,899.29</td>
<td>6,090,243.85</td>
<td>20,949,942.76</td>
<td>16,981,447.24</td>
<td>55.23%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>77,881,018.00</td>
<td>6,409,862.28</td>
<td>12,903,916.54</td>
<td>17,101,285.30</td>
<td>17,082,879.58</td>
<td>47,088,081.42</td>
<td>30,792,936.58</td>
<td>60.46%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>379,107,645.00</td>
<td>303,233,890.02</td>
<td>97,116,301.36</td>
<td>91,972,251.07</td>
<td>95,298,527.93</td>
<td>284,987,080.36</td>
<td>94,120,564.63</td>
<td>75.17%</td>
</tr>
<tr>
<td>Total Service Expenses</td>
<td>494,920,053.00</td>
<td>36,941,577.62</td>
<td>119,093,017.52</td>
<td>115,460,435.66</td>
<td>118,471,651.36</td>
<td>353,025,104.54</td>
<td>141,894,948.46</td>
<td>71.33%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>7,832,123.51</td>
<td>758,680.09</td>
<td>1,974,721.02</td>
<td>2,390,060.51</td>
<td>2,845,908.37</td>
<td>7,210,689.90</td>
<td>621,433.61</td>
<td>92.07%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>44,912,299.33</td>
<td>3,722,829.88</td>
<td>11,353,127.34</td>
<td>10,593,784.98</td>
<td>11,605,495.00</td>
<td>33,552,407.32</td>
<td>11,359,892.01</td>
<td>74.71%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>7,764,743.16</td>
<td>629,518.25</td>
<td>795,698.68</td>
<td>1,038,533.10</td>
<td>1,577,437.17</td>
<td>3,411,668.95</td>
<td>4,353,074.21</td>
<td>43.94%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>885,000.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>885,000.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>61,394,166.00</td>
<td>5,111,028.22</td>
<td>14,123,547.04</td>
<td>14,022,378.59</td>
<td>16,028,840.54</td>
<td>44,174,766.17</td>
<td>17,219,399.83</td>
<td>71.95%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>556,314,219.00</td>
<td>42,052,605.84</td>
<td>133,216,564.56</td>
<td>129,482,814.25</td>
<td>134,500,491.90</td>
<td>397,199,870.71</td>
<td>159,114,348.29</td>
<td>71.40%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td><strong>$882,152.81</strong></td>
<td><strong>($8,203,345.55)</strong></td>
<td><strong>$30,014.84</strong></td>
<td><strong>($13,341,892.41)</strong></td>
<td><strong>($21,515,223.12)</strong></td>
<td><strong>$141,894,948.46</strong></td>
<td><strong>159,114,348.29</strong></td>
<td><strong>71.40%</strong></td>
</tr>
</tbody>
</table>
**Current Ratio** = Compares current assets to current liabilities. Liquidity ratio that measures an organization's ability to pay short term obligations. The requirement is 1.0 or greater.

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

**Medical Loss Ratio (MLR)** = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue. The requirement is 85% or greater cumulative for the rating period (7/1/17-6/30/18).
ITEM: Draft Minutes from the April 4, 2019, Board Meeting

DATE OF BOARD MEETING: May 2, 2019

REQUEST FOR BOARD ACTION: Approve the draft minutes from the April 4, 2019, meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; and Veronica Ingram, Executive Assistant II
MEMBERS PRESENT: ☒Glenn Adams, Cumberland County Commissioner, JD (via phone; exited at 5:21 pm), ☒Cynthia Binanay, Chair, MA, BSN, ☒Tony Braswell, Johnston County Commissioner (via phone), ☒Christopher Bostock, BSIM, ☒Heidi Carter, Durham County Commissioner, MPH, MS (via phone; entered at 4:57 pm), ☒George Corvin, Vice-Chair, MD (via phone), ☒David Curro, BS, ☒Greg Ford, Wake County Commissioner, MA, ☒Lodies Gloston, MA, ☒David Hancock, MBA, Puff, ☒Duane Holder, MPA, ☐D. Lee Jackson, BA, ☒Donald McDonald, MSW (entered at 4:06 pm), ☒Lynne Nelson, BS, ☒Gino Pazzaglini, MSW LFACHE, ☒Pam Silberman, JD, D.Ph., ☐Lascel Webley, Jr., MBA, MHA, and ☒McKinley Wooten, Jr., JD (via phone)

GUEST(S) PRESENT: Janet Conner-Knox, A Caring Heart; Denise Foreman, Wake County Manager's office; Yvonne French, NC DHHS/DMH/IDD/SAS (Department of Health and Human Services/Division of Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services); Mary Hutchings, Wake County Finance office; and Curtis Massey

ALLIANCE STAFF PRESENT: Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Operating Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Don Fowls, Chief Medical Officer (interim); Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Operational Effectiveness; Veronica Ingram, Executive Assistant II; Ken Marsh, Medicaid Program Manager; Beth Melcher, Senior Director/Clinical Innovations; 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; Tammy Thomas, Director of Project Management Portfolio; Sara Wilson, Director of Government Relations; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:02 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td>A. Chair Binanay shared that Curtis Massey’s term ended March 31; he is not pursuing an additional term. She presented a commemorative plaque to Mr. Massey and thanked him for his service on the Board.</td>
</tr>
<tr>
<td></td>
<td>B. BHUC: Mr. Robinson shared about the launch of the behavioral health urgent care (BHUC) in Wake County, which opened at the end of March. This was also featured in Triangle Business Journal (<a href="https://www.bizjournals.com/triangle/news/2019/03/26/wake-to-helpcreate-countys-first-behavioral-health.html?iana=hpmvp_trig_news_headline">https://www.bizjournals.com/triangle/news/2019/03/26/wake-to-helpcreate-countys-first-behavioral-health.html?iana=hpmvp_trig_news_headline</a>).</td>
</tr>
<tr>
<td></td>
<td>C. Mr. Robinson introduced staff who transitioned to new positions: Beth Melcher, Senior Director/Clinical Innovations, and Sean Schreiber, Executive Vice-President/Network and Community Health.</td>
</tr>
<tr>
<td></td>
<td>D. Crisis Services Update: Mr. Schreiber provided an update and timeline on the transition of crisis services in Cumberland County, which is anticipated to be operational in August 2019; he also shared about the history and progress on the child crisis facility in Wake County, which is expected to open in March 2020.</td>
</tr>
<tr>
<td></td>
<td>E. Chair Binanay reminded board members to submit their biographies for the agency’s website.</td>
</tr>
</tbody>
</table>
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Mr. Robinson reminded board members of an upcoming orientation for new board members on Wednesday, April 17 from 2:00-4:00 pm.</td>
</tr>
<tr>
<td>G. Chair Binanay shared that she and CEO, Rob Robinson, will participate in a meeting with a workgroup of the NCACC (NC Association of County Commissioners) on April 24 to provide feedback to the workgroup about the design of Tailored Plan regions. NC DHHS has asked NCACC to provide input in the development of regions for the Tailored Plan. Chair Binanay encouraged Board members to share input with her, Mr. Robinson, or Commissioner Glenn Adams, who represents Alliance on this NCACC committee.</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

<table>
<thead>
<tr>
<th>A. Consumer and Family Advisory Committee – page 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 Cumberland, Durham, Johnston, and Wake subcommittee meetings.</td>
</tr>
</tbody>
</table>

Dave Curro, CFAC Chair, presented the report. Mr. Curro mentioned recent events in the CFAC subcommittee meetings, including a presentation on the transportation pilot and the development of a calendar to include upcoming CFAC events, forms and presentations by Alliance in the catchment area. Mr. Curro encouraged Board members to attend local CFAC meetings. The CFAC report is attached to and made part of these minutes.

**BOARD ACTION**

The Board received the report.

<table>
<thead>
<tr>
<th>B. Finance Committee – page 43</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 draft minutes from the March meeting, the Summary of Savings/ (Loss) by Funding Source, and the Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending February 28, 2019.</td>
</tr>
</tbody>
</table>

Chris Bostock, Committee Chair, presented the report. Mr. Bostock mentioned that expenses exceeded revenues; this is due to the reduction in State Single Stream funding, the current PMPM (per member, per month) rate and large unresolved Medicaid recruitments, all of which impact the agency’s financial position. Mr. Bostock also shared that all contract and State mandated ratios were met. He mentioned that a recommended budget for the next fiscal year will be presented at the next board meeting. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

The Board accepted the report.
Thursday, April 04, 2019

AREA BOARD REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Consent Agenda</td>
<td>A. Draft Minutes from March 7, 2019, Board Meeting – page 51</td>
</tr>
<tr>
<td></td>
<td>B. Audit and Compliance Committee Report – page 55</td>
</tr>
<tr>
<td></td>
<td>C. Executive Committee Report – page 58</td>
</tr>
<tr>
<td></td>
<td>D. Quality Management Committee Report – page 61</td>
</tr>
<tr>
<td></td>
<td>E. Records Retention Schedule – page 129</td>
</tr>
<tr>
<td></td>
<td>F. Draft Minutes from March 19, 2019, Board Budget Retreat – page 131</td>
</tr>
</tbody>
</table>

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

**BOARD ACTION**
A motion was made by Mr. Pazzaglini to adopt the consent agenda (approve the board minutes and adopt the records retention schedule); motion seconded by Mr. Bostock. Motion passed unanimously.

<table>
<thead>
<tr>
<th>7. Presentation: Change Management – page 134</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Management is defined as “the process, tools, and techniques to manage the people side of change to achieve the required business results”. Alliance began developing its Change Management plan for Alliance’s transition to a Tailored Plan in October 2018.</td>
</tr>
<tr>
<td>Amanda Graham, Senior Vice-President/Operational Effectiveness, provided an overview of the Prosci model of Change Management, which included three phases: preparing for change, managing change, and reinforcing change. Ms. Graham shared specifics and effectiveness of Alliance’s implementation for effective organizational and individual change.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**
The Board accepted the presentation.

<table>
<thead>
<tr>
<th>8. Legislative Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, provided the legislative update, which included an overview of the NC General Assembly’s budget proposals, and bills that could affect NC MCOs and the people Alliance serves. Board members discussed the potential impact on the people Alliance serves.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**
The Board accepted the update.

<table>
<thead>
<tr>
<th>9. Closed Session(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BOARD ACTION</strong> A motion was made by Mr. Curro to enter closed session pursuant to NC § 143-318.11 (a) (1) and (a) (3) to prevent the disclosure of information that is confidential and not a public record under NC § 122C-126.1 and to consult with General Counsel regarding current litigation; motion seconded by Commissioner Carter. Motion passed unanimously.</td>
</tr>
</tbody>
</table>

The Board returned to open session.

<table>
<thead>
<tr>
<th>10. Adjournment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All business was completed; the meeting adjourned at 6:14 p.m.</td>
</tr>
</tbody>
</table>

**Next Board Meeting**
Thursday, May 02, 2019
4:00 – 6:00 pm
ITEM: Executive Committee Report

DATE OF BOARD MEETING: May 2, 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 April 16, 2019, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; and Robert Robinson, CEO
**BOARD EXECUTIVE COMMITTEE REGULAR MEETING**

5200 W. Paramount Parkway, Morrisville, NC 27560

4:00-6:00 p.m.

**APPOINTED MEMBERS PRESENT:** ☒Cynthia Binanay, MA (Board Chair); ☑Christopher Bostock, BSIM (Previous Board Chair, Finance Committee Chair); ☒George Corvin, MD (Board Vice-Chair); ☒Dave Curro, BS (Quality Management Committee Chair);
☑Lodies Gloston, MA (Policy Committee Chair); ☒Donald McDonald, MSW (Network Development and Services Committee Chair);
☒Lascel Webley, Jr., MBA, MHA (Audit and Compliance Committee Chair) – via phone; and ☒Lynne Nelson, BS (Human Rights Committee Chair)

**APPOINTED, NON-VOTING BOARD MEMBERS PRESENT:** Gino Pazzaglini

**BOARD MEMBERS PRESENT:** None

**GUEST(S):** Denise Foreman, Wake County Manager’s office; and Mary Hutchings, Wake County Finance Department

**STAFF PRESENT:** Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

1. **WELCOME AND INTRODUCTIONS**

2. **REVIEW OF THE MINUTES** – The minutes from the March 19, 2019, Executive Committee meeting were reviewed; a motion was made by Vice-Chair George Corvin and seconded by Ms. Nelson to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Updates</td>
<td>a) LEGISLATIVE UPDATE: Ms. Wilson shared about the State Auditor’s presentation at yesterday’s monthly John Locke Foundation meeting (<a href="https://www.johnlocke.org/event/state-auditor-beth-wood-discusses-report-on-north-carolinas-administration-of-medicaid/">https://www.johnlocke.org/event/state-auditor-beth-wood-discusses-report-on-north-carolinas-administration-of-medicaid/</a>), which included information from previously released reports that were mentioned at earlier Board and Executive Committee meetings. The auditor’s presentation also included the topics for her upcoming reports, including Medicaid eligibility.</td>
<td>a) None specified.</td>
<td>a) N/A</td>
</tr>
<tr>
<td></td>
<td>b) ALLIANCE CARES: Ms. Wolff shared about a current service project that Alliance is sponsoring and in which Alliance employees may participate; the flyer is attached to and made part of these minutes. Chair Binanay encouraged Committee members who are Durham residents to also participate in this event.</td>
<td>b) None specified.</td>
<td>b) N/A</td>
</tr>
<tr>
<td></td>
<td>c) BOARD BIOS/WEBSITE PHOTOS: Chair Binanay encouraged Committee members to submit their biographies for the website.</td>
<td>c) None specified.</td>
<td>c) N/A</td>
</tr>
</tbody>
</table>

4. **Benefit Review**

Ms. Goodfellow provided a brief update related to next year’s recommended budget, which will be presented in detail at the May Board meeting and submitted for approval at the June Board meeting.

Ms. Goodfellow will present the recommended budget for next fiscal year.

5/2/19

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. May 2, 2019, Area Board Draft Agenda</td>
<td>The Committee reviewed the draft agenda and provided input.</td>
<td>Ms. Ingram will forward the agenda to staff.</td>
<td>4/16/19</td>
</tr>
<tr>
<td>6. Closed Session</td>
<td>COMMITTEE ACTION: A motion was made by Vice-Chair George Corvin and seconded by Ms. Lodies Gloston to enter closed session pursuant to NC § 143-318.11 (a) (6) to consider the qualifications, competence, and performance of an employee. Motion passed unanimously. All staff and quests were excused from the closed session. The Committee returned to open session.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **ADJOURNMENT:** the next Committee meeting will be May 21, 2019, at 4:00 p.m.

Respectfully Submitted by:

Veronica Ingram, Executive Assistant II

Date Approved
Important Things To Know About Disasters and Other Traumatic Events

If you were involved in a disaster such as a hurricane, flood, or even terrorism, or another traumatic event like a car crash, you may be affected personally regardless of whether you were hurt or lost a loved one. You can be affected just by witnessing a disaster or other traumatic event. It is common to show signs of stress after exposure to a disaster or other traumatic event, and it is important to monitor your physical and emotional health.

You may experience reactions such as:

- Having trouble falling asleep, staying asleep, sleeping too much, or trouble relaxing.
- Noticing an increase or decrease in your energy and activity levels.
- Feeling sad or crying frequently.
- Using alcohol, tobacco, illegal drugs or even prescription medication in an attempt to reduce distressing feelings or to forget.
- Having outbursts of anger, feeling really irritated and blaming other people for everything.
- Having difficulty accepting help or helping others.
- Wanting to be alone most of the time and isolating yourself.
- Having trouble remembering things or thinking clearly and concentrating.
- Feeling confused.
- Worrying a lot.
- Having difficulty making decisions.
- Having difficulty talking about what happened or listening to others.

Community Conversation
Thursday, April 18, 2019
6 pm
Duke Memorial
United Methodist Church
504 W Chapel Hill St.

www.AllianceHealthPlan.org
It’s common to experience stress following a disaster or other tragic event regardless of whether you were hurt or lost a loved one.

There are many things you can do to cope with traumatic events:

• Understand that your symptoms may be normal, especially right after the trauma.
• Keep to your usual routine.
• Take the time to resolve day-to-day conflicts so they do not add to your stress.
• Do not shy away from situations, people and places that remind you of the trauma.
• Find ways to relax and be kind to yourself.

• Turn to family, friends, and clergy for support, and talk about your experiences and feelings with them.
• Participate in leisure and recreational activities.
• Recognize that you cannot control everything.
• Recognize the need for trained help, and call the Alliance Access and Information Center.

If you or someone you care about continues to show signs of stress and you are becoming concerned, you may want to reach out for help.

Call the Alliance Access and Information Center 24 hours a day at (800) 510-9132 and a licensed clinician will assist you in finding the right kind of help.

Community Conversation
Thursday, April 18, 2019
6 pm
Duke Memorial
United Methodist Church
504 W Chapel Hill St.
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: May 2, 2019

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

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

The Human Rights Committee shall meet at least quarterly.

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

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. Draft minutes for the April 16, 2019, meeting are attached.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Lynne Nelson, Committee Chair; Doug Wright, Director of Individual and Family Affairs; and Todd Parker, QM Incident and Grievance Manager
**APPOINTED MEMBERS PRESENT:** ☒ Lodies Gloston, MA, Board member, ☒ Sally Hunter, ☐ Donald McDonald, MSW, Board member, ☐ Dr. Michael Teague, ☒ Patricia Wells, ☐ Ira Wolfe, ☐ McKinley Wooten, Jr., JD, Board member, ☒ Lynne Nelson (Committee Chair)

**APPOINTED, NON-VOTING MEMBERS PRESENT:**

**BOARD MEMBERS PRESENT:** Cynthia Binanay

**GUEST(S) PRESENT:**

**STAFF PRESENT:** Doug Wright, Director of Community and Member Engagement, Todd Parker, Star Davis, Stacy Guse

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES - The minutes from the January 10, 2019, meeting were reviewed; a motion was made by Cynthia Binanay and seconded by Sally Hunter to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Grievance Review</td>
<td>Todd Parker presented the grievance presentation. He discussed the nature of issues, sources, Alliance concerns, service breakdown, human rights concerns, and resolution status of complaints received. In the discussion we talked about how we count internal concerns when reporting to the state and that stands out on their monthly report because no other MCO includes those numbers. HRC members felt like tracking those concerns and acting on the information was good but thought we may want to consider reporting the same way other MCOs report because of perception.</td>
<td>Todd will get with his director and review the procedure, the why it is done this way and see what we need to do to possibly change the way we report it. He will report back to the committee at the next meeting.</td>
<td>7/11/2019</td>
</tr>
<tr>
<td>4. Incident Review</td>
<td>Todd presented the quarterly review of incidents, 777 reports, 539 for children and 238 for adults. He explained the NC IRIS system to members as well as the difference between level 2 and 3 incidents. We looked at comparisons by county, quarters service breakdown, and incident category. He reviewed the incident report compliance process and the improvements made by providers. Todd took a moment to explain how several things had happened with one provider such as not filing incidents, complaints, the re-credentialing process, all brought to light some challenges that the provider was unable to overcome and that they were no longer in the network. Doug explained the provider’s right to a reconsideration and how that process worked. Cynthia brought up a challenge presented to her by a community member in the Transition to Community Living program. There</td>
<td>Doug will get with Aimee Izawa and schedule a presentation for the next meeting.</td>
<td>7/11/2019</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>was interest in understanding the TCL process and how members’ rights might be violated or at least how the process might be perceived as challenging by members. The group ask for a presentation about the TCL program for the next meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Appeals</td>
<td>Doug did an overview of the appeals process for members and reviewed the 3rd quarter data for appeals; looking at numbers received, by population, and resolution.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Medicaid Plan Changes</td>
<td>Doug reviewed the Medicaid Plan changes with the committee so that they were aware of the reasoning. (attached)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Future agenda items</td>
<td>The meeting time will not change, this month’s change was just so Lynne could be sure to attend her first meeting as chair of the committee. Future topics will be determined at each meeting with the exception of the annual training (Required by statute annually).</td>
<td>Continue to raise issues of concern or interest.</td>
<td>On-Going</td>
</tr>
</tbody>
</table>

8. **ADJOURNMENT**: next meeting will be July 11, 2019 from 4:00 p.m. to 5:30 p.m.

Respectfully Submitted by:

Doug Wright

Click here to enter text.
Q2 Complaint Analysis
QM Quality Assurance
Overview

• 2Q FY19 yielded 174 entries
• 13 were regarding ABH
• Topics discussed in this report:
  • Nature of Issue
  • Source
  • Alliance Concerns
  • Service Breakdown
  • Human Rights Concerns
  • Resolution Status
<table>
<thead>
<tr>
<th>Reporting Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse, Neglect and Exploitation</strong></td>
<td>Any allegation regarding the abuse, neglect and/or exploitation of a child or adult as defined in APSM 95-2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td><strong>Access to Services</strong></td>
<td>Access to Services as any complaint where an individual is reporting that he/she has not been able to obtain services</td>
</tr>
<tr>
<td><strong>Administrative Issues</strong></td>
<td>Any complaint regarding a Provider’s managerial or organizational issues, deadlines, payroll, staffing, facilities, etc.</td>
</tr>
<tr>
<td><strong>Authorization/Payment Issues/Billing</strong></td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices regarding providers</td>
</tr>
<tr>
<td><strong>Basic Needs</strong></td>
<td>Any complaint regarding the ability to obtain food, shelter, support, SSI, medication, transportation, etc.</td>
</tr>
<tr>
<td><strong>Clients Rights</strong></td>
<td>Any allegation regarding the violation of the rights of any consumer of mental health/developmental disabilities/substance abuse services. Clients Rights include the rights and privileges as defined in General Statutes 122C and APSM 95-2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td><strong>Confidentiality/HIPAA</strong></td>
<td>Any breach of a consumer’s confidentiality and/or HIPAA regulations.</td>
</tr>
<tr>
<td><strong>LME/MCO Functions</strong></td>
<td>Any complaint regarding LME functions such as Governance/Administration, Care Coordination, Utilization Management, Customer Services, etc.</td>
</tr>
<tr>
<td><strong>LME/MCO Authorization/Payment/Billing</strong></td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices of the LME/MCO</td>
</tr>
<tr>
<td><strong>Provider Choice</strong></td>
<td>Complaint that a consumer or legally responsible person was not given information regarding available service providers.</td>
</tr>
<tr>
<td><strong>Quality of Care – PROVIDER ONLY</strong></td>
<td>Any complaint regarding inappropriate and/or inadequate provision of services, customer services and services including medication issues regarding the administration or prescribing of medication, including the wrong time, side effects, overmedication, refills, etc.</td>
</tr>
<tr>
<td><strong>Service Coordination between Providers</strong></td>
<td>Any complaint regarding the ability of providers to coordinate services in the best interest of the consumer.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Any complaint that does not fit the above areas.</td>
</tr>
</tbody>
</table>
Nature of Issue
(Top 3)

- Quality of Services: 43
- Access to Services: 41
- Administrative Issues: 25
Source: Who submitted concerns?

- MCO Staff: 82
- Guardian: 34
- Consumer: 32
# Complaints Against Alliance

<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10</strong> LME/MCO Functions</td>
<td>Complaints related to Care Coordination, housing, gaps in services, contracts</td>
</tr>
<tr>
<td><strong>3</strong> Authorization/Payment/Billing</td>
<td>Provider complaints related to denials for services, guardian’s concerns for budget letter reductions</td>
</tr>
</tbody>
</table>
Service Breakdown

- 16% from Outpatient Services
- 10% from Innovations Services (Non-Residential)
- 6% from Psychiatric Services
  - All others represented 5% or less or were non-service related or
Service Breakdown

- 10% from NC Innovations Waiver Services
- 2% IDD Care Coordination
- 1% from ICF
Service Breakdown

- 45% from Enhanced Services
- 30% from Basic Services
- 6% from Substance Use Service
- 5% from Crisis Services
- 1% from MH/SA Care Coordination
Human Rights Complaints

- Client Rights: 0
- Basic Needs: 1
- Confidentiality/HIPAA: 3
- Abuse: 19

Neglect/Exploitation
<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Description</th>
<th>Resolutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse/Neglect/Exploitation</td>
<td>10- Staff abuse in licensed facilities</td>
<td>Referred to DHSR (NC Division of Health Services Regulations) for investigation</td>
</tr>
<tr>
<td></td>
<td>9 – Primarily involved inappropriate supervision of staff.</td>
<td>Provider initiated corrective action</td>
</tr>
<tr>
<td>Confidentiality/HIPAA</td>
<td>2 - Individuals participating in plan development that were not authorized</td>
<td>Provider initiated corrective action</td>
</tr>
<tr>
<td></td>
<td>1 – Individual alleged to have access to member information they should not have access to</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>Issues with water damage to apartment after hurricane Florence</td>
<td>Member moved to another apartment</td>
</tr>
</tbody>
</table>
HR Grievances - Service Breakdown

Abuse/Neglect/Exploitation

- Adult Day Vocational Program: 1
- Psychosocial Rehabilitation (PSR): 1
- Multi-Systemic Therapy (MST): 1
- Intermediate Care Facility (ICF): 2
- Innovations Services (Non Residential): 4
- Residential Services (Including Innovations): 10
## HR Grievances - Service Breakdown

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Confidentiality/HIPAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Services (Including Innovations)</td>
<td>1</td>
</tr>
<tr>
<td>Innovations Services (Non Residential)</td>
<td>1</td>
</tr>
<tr>
<td>Community Support Team (CST)</td>
<td>1</td>
</tr>
<tr>
<td>\</td>
<td>Basic Needs</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1</td>
</tr>
</tbody>
</table>
About Alliance

- 777 Reports were entered into NC-IRIS for 463 members
- 539 reports involved children, 238 involved adults

**LEVELS**

- 697 Level 2 reports
- 80 Level 3
Wake County submitted the largest number of Level 2 (437) and Level 3 (46) reports in the 2nd quarter of FY19.
A total of 539 Incidents were reported for children: (510 L2 and 29 L3)
A total of 238 Incidents were reported for Adults: (187 L2 and 51 L3)
This chart represents services reporting more than 10 incidents during Q2.

The large number of L2 reports in the PRTF service category was due to a provider submitting a large number of late reports from several months past.
REPORTS BY INCIDENT CATEGORY
The large number of Physical Restraints is due to late incidents reported by a PRTF provider.
All Member Injury reports were Level II Incidents
A total of 78 incidents were reported in this category
One (1) of the Exploitation incidents also involved Staff Abuse which rendered it a Level III report
All Level III reports are reviewed by the Clinical Quality Review Committee
• Member Deaths due to Terminal Illness are generally considered Level II Incidents
• Terminal Illness reports for members receiving OMT (Opioid Maintenance Therapy) are considered Level III incidents
Incident Report Compliance
New Incident Report Compliance Process
(Implemented during the 2nd Quarter FY2019)

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

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

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

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

• For the 2^nd^ Quarter, an average of 16% of reports entered into NC IRIS were entered late

• The PRTF provider entering a larger number of reports late during Q2 was not re-credentialed as an Alliance network provider
Late Incident Submissions

Oct-18: 30%
Nov-18: 9%
Dec-18: 9%
AVERAGE: 16%
“The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize… The court has nothing but sympathy for officials who must interpret or administer the Act.”

Appeals Department

• Oversees the Service Denial Appeals Due process

  • Ensure that all steps follow within accordance with general statutes governing Medicaid, URAC accreditation, and Alliance policies and procedures.

• Back up staff is trained within the Office of Individual and Family Affairs to offer assistance and back up when needed.

• 85-90% of the appeals received are for Medicaid service denials.
Utilization Review Decision

- Any decision by Alliance to deny or reduce a service authorization request requires that Alliance send a written notification to the member.

- This notification is mailed within one business day of Alliance’s decision.

- Each notification includes required information:
  - What was denied
  - The reason it was denied
  - How to appeal.
Utilization Review Decision

- Medicaid members have **60 calendar days** from the mailing date of the notification to file an appeal.
- State Funded members have **15 working days** to file an appeal.
- The notification includes a form that can be used to initiate the appeal along with detailed information and instructions.
Appeals Process

- Alliance has 30 calendar days to review and decide a Medicaid appeal (called a “LME/MCO Level Appeal”) and 7 working days to decide an State Funded appeal (called a “Local Appeal”), once received.

- 1st level appeals are a desk review by a clinician not involved in the original decision and with the appropriate expertise to review the member’s case.

- The member can submit additional documentation or information for the appeal.
Appeals Process

• If the appeal is upheld, the member has the right to request a second level appeal.

• The second level of appeal is managed outside of Alliance by Office of Administrative Hearings (OAH) for Medicaid and the Division of Mental Health for IPRS.
Medicaid 2\textsuperscript{nd} Level Appeal Process

• Must be filed within 120 days of the appeal outcome notification.

• Mediation is scheduled with a NC mediation network provider.

• Mediations are informal, confidential, and aimed at resolving the appeal prior to a court hearing.
Medicaid 2nd Level Appeal Process

• The court hearing is called a “State Fair Hearing”, can be attended by members in person or phone, and is heard by an Administrative Law Judge.

• If they disagree with the ALJ’s decision, members can continue to appeal through the NC court system (e.g., NC Superior Court).
State Funded 2nd Level Appeal Process

• For State Funded appeals, a hearing is held with the Division of Mental Health/Substance Abuse/Developmental Disabilities (or “DMH”).

• Alliance, the appellant and a hearing officer also make every effort to resolve the appeal.

• For State Funded second level appeals, Alliance’s CEO makes the final decision based on the information presented in that hearing. That decision is final and there are no more appeal rights beyond this hearing.
Ways the Appeals Department helps Members:

- Appeals education and assistance
- Preventing safety risks and gaps in service
Appeals education and assistance:

- Calls every member that files an appeal
- Outreach to help guide them through the appeals process.
- We assist members with submitting additional information for the appeal, communicating with involved stakeholders, and filing grievances.
- Provided training and written materials explaining “Due Process” rights and procedures.
Preventing Safety Risks and Service Gaps:

• Each appeal is reviewed and processed within a timeframe that is most appropriate for the appeal.

• If risks or gaps in services are identified a reach out to the Provider is done and coordination with UM Clinical Staff for clinical recommendations are made.
Appeals Quarterly Data:

- The Appeals Department received 53 written requests for LME/MCO Level Appeal for Medicaid members within the quarter.
- Not all requests are clinically reviewed within the same month of receipt.
- A total of 19 appeals were reviewed in FY19 Q3.
Appeals Quarterly Data:

- Of the Requests for LME/MCO Level Appeals received,
  - 32% were MH/SA and
  - 26% were I/DD.
  - 42% were invalid appeal request.
  - 95% of appeals are UPHELD
ITEM: Network Development and Services Committee Report

DATE OF BOARD MEETING: May 2, 2019

BACKGROUND: The Network Develop and Services Committee met on March 13, 2019; the minutes from this meeting are attached. Minutes from the November 14, 2018, meeting were reviewed and approved. Dr. Carlyle Johnson provided an update on the plan to gather greater stakeholder feedback for the upcoming Network Adequacy and Accessibility analysis. Dr. Johnson also provided the Committee with a summary of Alliance activities aimed at addressing opioid misuse, including a summary of how opioid specific funding is being deployed.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Donald McDonald, Committee Chair; and Sean Schreiber, Executive Vice-President/ Network and Community Health
APPOINTED MEMBERS PRESENT: ☒ Donald McDonald (Committee Chair), ☐ Cynthia Bianay (Board Chair), ☒ Heidi Carter, ☐ George Corvin, ☐ Sally Hunter, ☐ Marilyn Avalia, ☒ Yvonne French (DMH Liaison), ☒ Lynne Nelson, ☐ Beth Melcher, ☒ Sean Schreiber
GUEST(S) PRESENT: Carlyle Johnson

1. WELCOME, INTRODUCTIONS and CALL TO ORDER

2. REVIEW OF THE MINUTES – The minutes from the November 14, 2018 meeting were reviewed. A motion to Approve was made by Donald McDonald and second by Commissioner Carter. The Motion unanimously passed.

AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME:
---|---|---|---
3. Network Adequacy and Accessibility Analysis: Increasing provider, member and stakeholder engagement - Carlyle Johnson | State and Federal requirements for each LME/MCO to submit annual report of community needs and gaps.  
- Assessment of adequacy and accessibility of provider network.  
- Results in plan for addressing needs and gaps.  
- Plans for 2019 Network Analysis indicating service gaps  
- Recommendations and discussion | Discuss ways to solicit a greater level of member input into the next Adequacy and Accessibility analysis. | May 8, 2019
4. Opioid Treatment Expansion: Use of State Opioid Response Funds - Carlyle Johnson | Opioid Treatment Expansion and Use of State Opioid Response Funds  
- Overview  
- Impact to Alliance  
- NC Opioid Action Plan 2017 – 2021  
- Future Opportunities and Challenges  
- Tailored Plan Implications | | |
5. Next Meeting: | May 8, 2019 – 4:00 – 5:00pm | | |
6. Adjournment | 5:00pm | | |
ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: May 2, 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(s) are attached.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, Committee Chair; and Wes Knepper, Quality Management Director
APPOINTED MEMBERS PRESENT: ☒Dave Curro, BS, Committee Chair, (Area Board); ☒ Duane Holder, MPA, (Area Board), ☐ Israel Pattison (CFAC); ☐Joe Kilsheimer, MBA (CFAC); ☒ Pam Silberman (Area Board)

APPOINTED, NON-VOTING MEMBERS PRESENT: ☒ Diane Murphy (Provider Representative, I/DD) by phone; ☐ Dava Muserallo (Provider Representative, MH/SUD)

BOARD MEMBERS PRESENT: 

GUEST(S) PRESENT:

STAFF PRESENT: ☒ Wes Knepper, LPC (Quality Management Director); ☒ Tina Howard (Quality Review Manager); ☒ Doug Wright (Director Individual & Family Affairs); ☒ Diane Fening, (Executive Assistant)

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The March meeting minutes will be reviewed at the May meeting.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. New Business: (Wes)</td>
<td>We have an abbreviated meeting today. There is an accreditation obligation to maintain two active QIPs per accredited module. We only have one for the Call Center. The QIP being proposed is focused on the timeliness of responses to requests about innovation services. There is a URAC standard around following up; we have to have a procedure. Our procedure says that the response has to be within one business day. We looked at data and saw room for improvement. About 64% of calls were returned within one business day. We want to do better than one business day. All of the staff that were handling these calls have historically been sitting in the Call Center as kind of their own team. Now we will be integrating them into IDD Care Coordination. Calls will still go to the Call Center first. The response will be handled now by staff that are</td>
<td></td>
<td></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.
### 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></td>
<td>moving over to IDD Care Coordination team. These are not calls for services, but request for information, status, general customer service. The team is going from team of 5 to 2. We are hoping to automate some of it. Pam made a motion to accept the proposed new QIP. Duane seconded the motion. All were in favor. The motion carried. We don’t think it will take a very long time to reach 85%. The team is moving from the Call Center to IDD Care Coordination now and should be up and running soon. Dave Curro won’t be here for June meeting. Pam will substitute for him.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **ADJOURNMENT**: next meeting will be May 2, 2019 from 2:00 p.m. to 3:30 p.m.

Respectfully Submitted by:

Click here to enter text. Date Approved
**Rationale for Project:**
URAC (HCC #20) requires accredited organizations to "document all follow-up communications (at the consumer’s agreement) according to policies and procedures and has a mechanism to retrieve these records of communication". Alliance meets that requirement through Procedure #4005 (Documentation of Triage Process). The procedure, though, does not include timeliness of follow up responses (calls not answered live by IDD/TBI Eligibility staff). Alliance’s Access & Information Center maintains a desk reference for following up with requests from members and family (typically regarding IDD or TBI services), which includes a timeliness standard of responding within 1 business day. Baseline data indicate that 64% of calls receive a response within one business day. Additionally, IDD Access staff are transitioning to the IDD/TBI Care Coordination team (from 5 to 2 staff dedicated to eligibility), while the oversight for this process will remain with Access. It is critically important to ensure process continues during the transition of staff.

**Opportunity Statement:**
Alliance Access & Information Center has an opportunity to improve the timeliness of responses to requests about IDD and TBI Eligibility. While the desk reference does not specify a benchmark for timeliness, it is assumed that the procedure intended to apply to most cases.

**Focused Goal Statement:**
The goal of the project is to improve the percent of follow up responses about IDD/TBI eligibility within the timeliness standard in the desk reference.

**Process Start Point:**
Date the communication was received by an Alliance staff person.

**Process End Point:**
Date that Alliance staff responded to person (as per Alliance definition) sending request.

**In Scope:**
All follow up communication requests received by Alliance’s Access & Information staff.

**Out of Scope:**
Non-telephonic requests for health education, requests that come to other departments, telephonic requests that involve immediate health/safety issues

<table>
<thead>
<tr>
<th>Key Performance Indicators</th>
<th>Baseline</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of communications with response within one business day</td>
<td>64%</td>
<td>85%</td>
</tr>
</tbody>
</table>

**Targeted Intervention(s):**
Project Team identified several root causes: lack of consistent tracking, manual tracking of emails, limited oversight, lack of training for staff, and unclear expectations. The team will prioritize the following interventions: a system of consistent tracking of responses, requesting an automated report of calls and their responses, regular monitoring of performance, and training to staff on expectations.

**Data Sources (reliability & validity):**
Excel spreadsheet for tracking, emails

**Potential Barriers to Success:**
Cumbersome data tracking (i.e. multiple staff receiving communications, lack of centralized data tracking), transition of staff
### Project Plan Overview

<table>
<thead>
<tr>
<th>Task/Phase</th>
<th>Start Date</th>
<th>End Date</th>
<th>Actual End</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzanne Davis-Marens</td>
<td>Project Champion (Dir Access &amp; Information Center)</td>
</tr>
<tr>
<td>Nancy Kent</td>
<td>SME (Supervisor, Access &amp; Information Center)</td>
</tr>
<tr>
<td>QM</td>
<td>Facilitator</td>
</tr>
<tr>
<td>Community &amp; Member Engagement</td>
<td>SME</td>
</tr>
<tr>
<td>Care Coordination-IDD/TBI Eligibility (Kristy Meyers)</td>
<td>SME</td>
</tr>
</tbody>
</table>

### Data Analysis Plan

Data will be pulled and analyzed on a monthly basis starting with the month that the Global Quality Management Committee approved the project. Data will continue to be monitored by Access Supervisor assigned to task. Sampling will not be used. Supervisor will ensure all data fields are completed thoroughly and accurately. Assigned staff will be responsible for entering raw data into centralized spreadsheet. A formula is entered on spreadsheet to calculate difference between date of request and date of response. Total days and percent receiving a response according to standard in desk reference will be calculated by creating a Pivot Table. Project Advisory Team, CQI, and GQMC will receive regular updates of progress.

### Stakeholders/Potential Partners

- Call Center, Community & Member engagement, QM, Care Coordination

---
ITEM: FY 2019-2020 Recommended Budget

DATE OF BOARD MEETING: May 2, 2019

BACKGROUND: The FY 2019-2020 recommended budget is being presented to the Board for consideration. The board will vote on the FY 2019-2020 budget on June 6, 2019.

REQUEST FOR AREA BOARD ACTION: Review the report.

CEO RECOMMENDATION: Review the report.

RESOURCE PERSON(S): Robert Robinson, Chief Executive Officer; and Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
## Alliance Health
### Annual Budget
#### FY 2019-2020

### Board of Directors

Cynthia Binanay, Chair
George Corvin, Vice Chair

### Durham County
- Cynthia Binanay
- Commissioner Heidi Carter
- David Curro
- Gino Pazzaglini
- Pam Silberman
- Lascel Webley, Jr.
- *Vacancy*

### Wake County
- George Corvin, MD
- Commissioner Greg Ford
- David Hancock
- Donald McDonald
- Lynne Nelson
- McKinley Wooten, Jr.
- *Vacancy*

### Cumberland County
- Commissioner Glenn Adams
- Christopher Bostock
- Duane Holder
- Lodies Gloston

### Johnston County
- Commissioner Tony Braswell
- Lee Jackson
- *Vacancy*

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Robert Robinson, CEO
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May 2, 2019

Alliance Board Members,

On behalf of the entire organization I thank each of you for your expertise, guidance and support during the past year of continued organizational growth. We are pleased to share with you our FY20 budget proposal.

As part of our budget retreat you received a thorough update on our financial picture, including an overview of risks we face, including loss of Medicaid lives, additional single-stream funding cuts, and the need to retain talented staff during a period of significant operational transition.

We reviewed Medicaid spending trends and our medical budget and savings plan, as well as the potential advantages of value-based contracting with our providers. We reviewed areas of overspending and anticipated changes for the coming year.

As you know, we are moving full-steam ahead in our preparations to operate as a Tailored Plan as part of our state’s Medicaid transformation. Our leadership updated you on the implementation project plan and highlights – including a progress report on the integration of our Complete Care model across the organization.

We look forward to working closely with you all during this budget process to take this important step towards making Alliance an even stronger, more viable organization better able to meet the needs of the people we serve.

Best Regards,

Rob Robinson
Chief Executive Officer
Reader’s Guide

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

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

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

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

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

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

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

Miscellaneous
This category is to account for any funds received during the fiscal year that do not fall into one of the above mentioned categories and are not significant enough to require their own category. The funds roll up into the Administrative budget.

Medicaid Services
Alliance Health began the management of Medicaid services under a waiver according to Session Law 2011-264 House Bill 916 on February 1, 2013. These funds refer to the dollars allocated under the contract with the NC Division of Medical Assistance to provide services to Medicaid enrollees of Cumberland, Durham, Johnston, and Wake counties.
**State Services**
These funds represent state allocated dollars for Cumberland, Durham, Johnston, and Wake communities to provide services for non-Medicaid citizens with mental health, intellectual/developmental disabilities and substance abuse needs. The funds include Federal Block Grant dollars as allocated from the NC DMH.

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

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

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

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

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

## Alliance Regional Population Data

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

Based on 2017 Statistics, US Census Bureau

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>County</th>
<th>MH</th>
<th>SA</th>
<th>IDD</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth (ages 3-17)</td>
<td>Cumberland</td>
<td>5,488</td>
<td>92</td>
<td>623</td>
<td>6,203</td>
</tr>
<tr>
<td></td>
<td>Durham</td>
<td>3,706</td>
<td>75</td>
<td>368</td>
<td>4,149</td>
</tr>
<tr>
<td></td>
<td>Johnston</td>
<td>2,331</td>
<td>27</td>
<td>328</td>
<td>2,686</td>
</tr>
<tr>
<td></td>
<td>Wake</td>
<td>7,697</td>
<td>127</td>
<td>941</td>
<td>8,765</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>19,222</td>
<td>321</td>
<td>2,260</td>
<td>21,803</td>
</tr>
<tr>
<td>Adult (ages 18+)</td>
<td>Cumberland</td>
<td>8,056</td>
<td>2,435</td>
<td>774</td>
<td>11,265</td>
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<tr>
<td></td>
<td>Durham</td>
<td>6,149</td>
<td>2,343</td>
<td>838</td>
<td>9,330</td>
</tr>
<tr>
<td></td>
<td>Johnston</td>
<td>3,690</td>
<td>1,055</td>
<td>380</td>
<td>5,125</td>
</tr>
<tr>
<td></td>
<td>Wake</td>
<td>12,325</td>
<td>3,362</td>
<td>2,014</td>
<td>17,701</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>30,220</td>
<td>9,195</td>
<td>4,006</td>
<td>43,421</td>
</tr>
</tbody>
</table>

## Provider Breakdown

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

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

Care Management/Care Coordination

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

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

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

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

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

Provider Network and Evaluation

Brief Description of Department and Units

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

The Department is comprised of three sections:

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

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

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

Accomplishments for FY19

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

Summary of Goals and Objectives for FY20
• Expand network crisis services capacity
• Implement psychiatric rehabilitation service model within Psychosocial Rehabilitation programs
• Implement provider scorecards
• Establish practice transformation unit within the Strategic Initiatives and Special Projects section of the department
• Develop and pilot behavioral health home model
• Evaluate effectiveness of incentive based contracts
• Pilot a shared risk service contract
• Improve processes for data sharing with providers
• Implementation of HEDIS data analysis at the MCO level and provider level
• Improve relationships with and contract management of hospitals/health systems, including identifying opportunities to improve billing
• Address provider network needs and gaps as specified in network development plan
• Focus provider collaborative efforts on implementation of evidence based practices

Community Health and Well-Being

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

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

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

Accomplishments for FY19
• Realignment of department functions to that included a name change from Community Relations to Community Health and Well-Being
• Implemented short-term rental assistance program (ILI) in each community. Also created a longer term rental assistance program for a higher risk population. On track to expend full allotment of ILI funds
• Implemented a comprehensive landlord recruitment strategy that has almost tripled our housing placements in private units for TCLI participants
• Enterprise Consulting completed an assessment of all affordable housing properties in our counties to increase access to safe and affordable housing
• Implemented a Staying Well initiative with Care Coordination and the Office of Individual and Family Affairs to conduct follow up for persons discharged from Care Coordination
• Successfully implemented a FEMA crisis outreach program in Cumberland County.
• Implemented a standardized SDOH screening tool with Jiva
• Participated on a statewide social determinant advisory group
• Beginning to implement a variety of health literacy strategies
• Implemented a supportive housing pilot with Duke Healthcare
• Implemented the first Bridge Housing Program in Wake County
• In partnership with Durham Housing Authority and the City of Durham secured funding for 2 supportive housing positions and 20 vouchers to implement a Justice Involved Supportive Housing Program
• Partnered with the Durham Housing Authority to apply for HUD Mainstream vouchers specifically designated for permanent housing for persons with disabilities. Received almost 15 vouchers
• Implemented transportation pilot program
• Durham, Johnston and Wake have highly successful Crisis Intervention Training (CIT) training programs with designated CIT Coordinators. The CIT Veterans training started in Wake has now expanded to Johnston Co with plans to expand into Cumberland.
• Expanded Mental Health First Aid (MHFA) trainers and now have a CR staff trained on almost every module. Trained the Raleigh and Durham PD’s on MHFA with over 1000 participants.
• Completed significant enhancements to Wake and Durham Network of Care
• Implemented Care Review in each community and expanded to include a Homeless Care Review Team in each county
• Funding renewed for two HUD-funded supportive housing programs in Durham
• All Community Collaborative completed strategic plans outlining SOC priorities

Summary of Goals and Objectives for FY20

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

The Business Operations Division is responsible for the oversight and management of Alliance’s financial accountability relating to budgeting, claims, auditing and financial analysis.

**Claims Processing**

**Brief Description of Department and Units**

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

**Accomplishments for FY19**

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

**Summary of Goals and Objectives for FY20**

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

**Financial Operations**

**Brief Description of Department and Units**

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

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

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

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

Organizational Effectiveness Department

Brief Description of Department and Units

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

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

Accomplishments for FY19

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

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

Access Center

Brief Description of Department and Units

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

Accomplishments for FY19

• Answered 57,009 calls. 98.1% of these calls were answered within 30 seconds. Average hold time was 1 minutes and 8 seconds.
• Met DHHS contractual requirements for time of answer and abandonment rate. Maintained low speed of answer of 6 seconds and 0.9% abandon rate.
• Call Center turnover rate is < 1%. Two staff returned to the Department.
• Maintained URAC Health Call Center accreditation.
• Redesigned our Clinical Decision Guide with the help of our CMO to better align with Emergency Medicine standards.
• Implemented the TBI waiver. 8 members successfully placed on the TBI waiver this year.
• Successfully closed out our Access to Care- Emergent QIP based on our higher rate of member engagement.
• IDD Access team participated in 10 IDD community events to inform more members and stakeholders about services and resources for people with IDD and TBI.
• New Training modules presented in multiple ways to support learning and increased retention.
• Pending- Positive EQR review that is reflected in Enrollee Services and Delegation Section.
• Collaborated with Primary Care offices to coordinate care for members. Over 500 assessment appointments set for members in 2018.
• Use technology to streamline the Innovations slot allocation process.
• Filled all the IDD Innovations available slots in a timely manner.
• Registry of Unmet Needs. Collaborated with Alliance report writers to address data discrepancies and move further away from the use of spreadsheets for tracking.
• Collaboration with IDD Care Coordination to expand their capacity to serve Alliance members by leveraging the untapped talented workforce in Customer Service.
• 4 trainings hosted at Alliance by IDD Access team on behalf of NC Start.
• Promoted Open Access model of care to decrease the time between appointments.
Collaborated with Provider Networks and providers to increase choice for members.

Increased the number of Saturday assessment appointments for all funding and ages.

Implemented the use of MicroStrategy to create a Provider Capacity Dashboard. Assists staff to locate appointments that most clearly meet the necessary timeframe and location for callers. Collaborated with other departments to gain access. Informs Alliance staff of gaps in the network.

Attempted to address language barriers for our members within our provider community. Piloting the use of our interpreter vendor for a single enhanced service provider serving a non-English speaking member. Alliance is funding the use of this telephonic interpreting service.

Successful physical move of department without service disruption.

Collaborated with other Alliance Departments on “Complete Care” project.

LogistiCare transportation pilot implementation to remove barriers to care.

Worked collaboratively with Network development on rolling out new service definitions, and assessing the needs and gaps in our service continuum. Increased the number of ABA providers for our membership.

Collaborated with Duke and Durham Public Schools to create a Suicide Prevention Training.

Improved departmental communication and integrated agency-wide communication strategy during inclement weather events to ensure timely access to emergency services.

Summary of Goals and Objectives for FY20

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

**Brief Description of Department and Units**

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

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

**Accomplishments for FY19**

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

**Summary of Goals and Objectives for FY20**

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

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

Accomplishments for FY19

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

Summary of Goals and Objectives for FY20

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

Brief Description of Department and Units

The IT department is comprised of five distinct teams:

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

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

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

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

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

Accomplishments for FY19

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

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

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

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

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

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

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

**Summary of Goals and Objectives for FY20**

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

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

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

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

FY2019-2020 Recommended Budget

**Total General Fund Revenues: $534,243,120**

<table>
<thead>
<tr>
<th>Region</th>
<th>Administrative</th>
<th>Medicaid Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 57,337,049</td>
<td>384,001,477</td>
</tr>
</tbody>
</table>

**Alliance**

- **State**: 38,881,499
- **Federal**: 4,408,173

**Cumberland**

- **State**: 777,708
- **Federal**: 145,228
- **Local**: 4,817,226

**Durham**

- **State**: 3,169,416
- **Federal**: 333,993
- **Local**: 6,548,666

**Johnston**

- **State**: 1,656,743
- **Federal**: 20,000

**Wake**

- **State**: 3,324,021
- **Federal**: 637,496
- **Local**: 27,684,425

**Miscellaneous**: 500,000

**Total**: $534,243,120
General Fund Revenues
FY2019-2020 Recommended Budget
Total General Fund Revenues: $534,243,120
## General Fund Expenditures

**FY2019-2020 Recommended Budget**

**Total General Fund Expenditures:** $534,243,120

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>$57,337,049</td>
</tr>
<tr>
<td>Medicaid</td>
<td>384,001,477</td>
</tr>
<tr>
<td>State</td>
<td>53,354,277</td>
</tr>
<tr>
<td>Local</td>
<td>39,050,317</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$534,243,120</strong></td>
</tr>
</tbody>
</table>

- Administrative: 11%
- Services: 89%

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*[This page is from the FY20 Recommended Budget document]*
<table>
<thead>
<tr>
<th></th>
<th>Budgeted Revenue</th>
<th></th>
<th>Budgeted Expenditures</th>
<th></th>
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<td>FY20</td>
<td>FY19 Approved</td>
<td>FY20</td>
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<tr>
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<td></td>
<td></td>
<td>Administration</td>
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<tr>
<td></td>
<td></td>
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<td>43,802,180</td>
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<tr>
<td>Cumberland</td>
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<td>Durham</td>
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<tr>
<td></td>
<td>455,323</td>
<td>333,993</td>
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<tr>
<td></td>
<td>6,116,519</td>
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<tr>
<td>Johnston</td>
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<td>20,000</td>
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<tr>
<td>Wake</td>
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<tr>
<td></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$500,329,015</strong></td>
<td><strong>$534,243,120</strong></td>
<td><strong>$500,329,015</strong></td>
<td><strong>$534,243,120</strong></td>
</tr>
</tbody>
</table>

Both Administrative and Medicaid services reflect an increase for FY20 as a result of a higher Medicaid lives count.

State dollars reflect an increase due to the State providing Alliance with estimated allocations for Cures, TCLI, and ADATC earlier than prior years.
Functional Organization Chart

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

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

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

### DRAFT

**Section 1: General Fund Appropriations**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$57,837,049</td>
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<td>Medicaid Services</td>
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</tr>
<tr>
<td>State Services</td>
<td>$53,354,277</td>
</tr>
<tr>
<td>County Services</td>
<td>$39,050,317</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$534,243,120</strong></td>
</tr>
</tbody>
</table>

**Section 2: General Fund Revenue**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
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<td>County Services</td>
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</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$534,243,120</strong></td>
</tr>
</tbody>
</table>

**Section 3: Authorities**

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

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

C. The CEO may enter into the following within budgeted funds:

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

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

Governing Statutes
Alliance Health abides by the North Carolina Local Government Budget and Fiscal Control Act. It is the legal framework in which all government agencies must conduct their budgetary processes. NC G.S. 159 provides the legislation which includes several key dates such as:

- 159-10 – by April 30, Departments must submit requests to the Budget Officer
- 159-11(b) – by June 1, the Recommended Budget must be submitted the Board
- 159-12(b) – a public hearing must be held
- 159-13(a) – from 10 days after submitting to the Board, but by July 1, a balanced budget must be adopted

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

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

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

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

Amendment Process
The budget ordinance is approved at a function/appropriation level. The Budget Officer is authorized to transfer budget amounts within an appropriation up to $100,000 cumulatively without reporting to the Board. The Budget Officer is authorized to transfer budget amounts between functions up to $100,000 with an official report of such transfer being noted at the next regular Board meeting.

Per G.S. 159-15, the governing board may amend the budget ordinance at any time after the ordinance's adoption in any manner, so long as the ordinance, as amended, continues to satisfy the requirements of G.S. 159-8 and 159-13.
## Budget Calendar

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

## Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME</td>
<td>Per G.S. 122C-3(20b), Local Management Entity or LME means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization; LMEs that have adopted the financial risk and service review functions of the 1915(b) and 1915(c) waivers. LME-MCOs carry out the function of an LME and also act as health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals.</td>
</tr>
<tr>
<td>Medicaid Waiver</td>
<td>States can submit applications to the federal Centers for Medicare and Medicaid Services, asking to be exempt from certain requirements. If granted a “1915(b)” waiver, a state can limit the number of providers allowed to serve consumers, easing the state’s administrative burden and saving money. If granted a “1915(c)” waiver, a state can offer more services focused on helping an intellectually or developmentally disabled consumer continue living in his or her home, rather than a group home.</td>
</tr>
</tbody>
</table>
ITEM: Review of FY20 Board Officer Selection Process

DATE OF BOARD MEETING: May 2, 2019

BACKGROUND: As stated in Article II, Section D of the by-laws:
1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
   a. Chairperson, and
   b. Vice-Chairperson.
2. No officer shall serve in a particular office for more than two consecutive terms.
3. Each Board of Directors member, other than County Commissioners, shall be eligible to serve as an officer.
4. Duties of officers shall be as follows:
   a. Chairperson – this officer shall preside at all meetings and generally perform the duties of a presiding officer. The Chairperson shall appoint all Board of Directors committees.
   b. Vice Chairperson – this officer shall be familiar with the duties of the Chairperson and be prepared to serve or preside at any meeting on any occasion where the Chairperson is unable to perform his/her duties.

Board Chair, Cynthia Binanay will review the process for determining next year’s officers. The selection of Board officers will occur at the June Board meeting. Board officer terms are concurrent with Alliance’s fiscal year.

REQUEST FOR AREA BOARD ACTION: Review the process for determining Board officers in preparation to vote for Board officers at the June 6, 2019, Board meeting.

CEO RECOMMENDATION: Review the process for determining Board officers in preparation to vote for Board officers at the June 6, 2019, Board meeting.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; and Robert Robinson, Chief Executive Officer