MEMBERS PRESENT: ☒ Glenn Adams, ☒ Cynthia Binanay, Chair, ☒ Christopher Bostock, ☒ Heidi Carter, ☒ George Corvin, MD, Vice-Chair, ☒ David Curro, ☒ James Edgerton, ☒ Greg Ford, ☒ Lodies Gloston, ☒ Duane Holder, ☒ Curtis Massey (via phone; entered at 4:32 pm), ☒ Donald McDonald, ☒ Gino Pazzaglini, ☒ Pam Silberman, ☒ Lascel Webley, Jr., and ☒ McKinley Wooten, Jr. (entered at 4:08 pm; via phone after 5:38 pm)

GUEST(S) PRESENT: Carol Choate, A Caring Heart Case Management, Inc.; Janet Conner-Knox, A Caring Heart Case Management, Inc.; Yvonne French, NC DHHS/DMH,DD,SAS (Department of Health and Human Services/Division of Mental Health, Developmental Disabilities, and Substance Abuse Services); Mary Hutchings, Wake County Finance Department; and Israel Pattison, CFAC (Consumer and Family Advisory Committee) Chairperson

ALLIANCE STAFF PRESENT: James Allen, Assistant General Counsel; Michael Bollini, Executive Vice-President/Chief Operating Officer; Margaret Brunson, Hospital Relations Director; Denise Dirks, Administrative Assistant II; Joey Dorsett, Senior Vice-President/Chief Information Officer; Doug Fuller, Director of Communications; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Cheala Garland-Downey, Senior Vice-President/Human Resources; Amanda Graham, Senior Vice-President/Organizational Effectiveness; Kimberly Harrer, I/DD (Intellectual/Developmental Disability) Care Coordinator; Veronica Ingram, Executive Assistant II; Katherine Hobs-Knutson, Chief Medical Officer; Susan Lugones, Project Manager; Ken Marsh, Medicaid Program Manager; Beth Melcher, Executive Vice-President/Care Management; Ann Oshel, Senior Vice-President/Community Relations; 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; Matthew Ruppel, Director of Program Integrity; Tammy Thomas, Director of Portfolio Management; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Individual and Family Affairs

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

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Oath of Office</td>
<td>Chair Binanay mentioned that oaths were administered to new members prior to today’s meeting; she introduced the following new Board members: Pam Silberman, Gino Pazzaglini and Commissioner Greg Ford. She also mentioned that the remaining two vacant Wake seats may be filled soon.</td>
</tr>
<tr>
<td>3. Announcements</td>
<td>Vice-Chair Corvin encouraged Board members to complete the Board survey.</td>
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<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
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<tr>
<td>Mr. Robinson presented a hard copy of Alliance’s 2017 annual report. Additionally, he mentioned that NC DHHS (Department of Health and Human Services) Secretary Mandy Cohen was unable to attend today’s meeting as expected; she will attend the September meeting instead.</td>
<td></td>
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<tr>
<td>4. Agenda Adjustments</td>
<td>There were no adjustments.</td>
</tr>
<tr>
<td>5. Public Comment</td>
<td>There were no public comments.</td>
</tr>
<tr>
<td>6. Committee Reports</td>
<td>A. Consumer and Family Advisory Committee – page 9</td>
</tr>
<tr>
<td>The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes and documents from recent Steering, Wake, Durham and Cumberland subcommittee meetings.</td>
<td>Chair Binanay mentioned that the committee reports were part of the Board packet.</td>
</tr>
<tr>
<td>Israel Pattison, CFAC Chair, presented the CFAC report; he provided an update from the recent meeting, including Mr. Robinson sharing an update from the NC General Assembly’s budget. Mr. Pattison mentioned recent CFAC officer elections and state CFAC legislature meeting, including support for NC MCO (managed care organizations) to best manage care for persons with behavioral health concerns. Mr. Curro shared about his conversations with NC legislators at the State CFAC advocacy day. Mr. Pattison mentioned that the CFAC annual report is expected soon. The CFAC report is attached to and made part of these minutes.</td>
<td></td>
</tr>
<tr>
<td>BOARD ACTION</td>
<td>The Board accepted the report; no additional action required.</td>
</tr>
<tr>
<td>B. Finance Committee – page 46</td>
<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 May 3, 2018, meeting, the Summary of Savings/(Loss) by Funding Source, Statement of Revenue and Expenses (Budget to Actual) report and ratios for the period ending April 30, 2018.</td>
</tr>
</tbody>
</table>
James Edgerton, Committee Chair, presented the report. He mentioned that expenditures exceeded revenues due to delay in funding receipt and reduction in State Single Stream funding. He mentioned that Alliance met or exceeded all State mandated ratios. Additionally, Mr. Edgerton mentioned that the Finance Committee recommends approval of the following agenda items: item 7) Supportive Housing Investment, item 8E) Fiscal Year 2018-2019 Property and Liability Insurance, and item 9) FY19 budget and FY19 reinvestment plan, including the Wake Crisis Center.

**BOARD ACTION**

A motion was made by Mr. McKinley Wooten to amend the FY18 budget by $13,123,338; motion seconded by Vice-Chair George Corvin. Motion passed unanimously.

A motion was made by Mr. James Edgerton to approve property and liability insurance as specified in agenda item 8E: Fiscal Year 2018-2019 Property and Liability Insurance; motion seconded by Vice-Chair George Corvin. Motion passed unanimously.

The Finance Committee report is attached to and made part of these minutes.

C. Policy Committee – page 54

Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board reviews all policies annually. The Policy Committee reviews a number of policies each quarter in order to meet this requirement. This month’s report included minutes from the February Committee meeting, the following policies for continued use: HR1: Equal Employment Opportunity/Affirmative Action Policy; HR2: Recruitment and Selection Policy; HR4: Conditions of Employment Policy; HR5: Classification and Compensation Policy; HR6: Employee Benefits Policy; HR7: Alcohol and Drug Free Workplace Policy; HR8: Time and Attendance Policy; HR9: Sexual Harassment Policy; HR10: Leave Policy; HR11: Family and Medical Leave Act Policy; HR12: Clinical Staff Credentialing Policy; HR14: Disciplinary Action; HR15: Performance Management Policy; HR16: Separation Policy; HR17: Employee Complaint Policy; HR18: Employee Grievance Policy; and HR19: Reduction in Force Policy. The report also included policies with recommended changes: UM6: Eligibility for Services and By-Laws; proposed By-Laws revisions were presented to the May 3, 2018, meeting.

Curtis Massey, Committee Chair, presented the revised by-laws after the resolution in item 10A was approved by the Board. He also requested an update of Policy G-12: Area Authority Relations with Catchment Area County Boards of
<table>
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<tr>
<th>AGENDA ITEMS:</th>
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<tbody>
<tr>
<td><strong>Commissioners</strong> to include language that reflects the pending consolidation with Johnston County LME (local management entity).</td>
<td></td>
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</table>

**BOArd Action**
A motion was made by Commissioner Heidi Carter to approve *BO-20: Financial Eligibility* as included in the March agenda packet and the HR Policies as listed in item 6C: Policy Committee Report of the June agenda packet; motion seconded by Vice-Chair George Corvin. Motion passed unanimously.

A motion was made by Ms. Lodies Gloston to approve the recommended revisions to the by-laws; motion seconded by Mr. David Curro. Motion passed unanimously.

A motion was made by Vice-Chair Corvin to adopt the changes to *G-12: Area Authority Relations with Catchment Area County Boards of Commissioners* to reflect the pending merger with Johnston County; seconded by Mr. McKinley Wooten. Motion passed unanimously.

The Policy Committee report is attached to and made part of these minutes.

<table>
<thead>
<tr>
<th>7. Supportive Housing Capital Investment – page 99</th>
<th>Alliance approved $500,000 in the current budget to make capital investment grants with local housing developers to create access to supportive housing. A request was presented for approval of the final $200,000 to partner with Reinvest Partners for four units (20% set aside) for a property located at 2733 Holloway Street in Durham.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Ann Oshel, Senior Vice-President/Community Relations, presented the proposal, which was previously presented to the Executive and Finance Committees. Ms. Oshel provided an update on Alliance’s housing efforts, which includes a 97% retention rate for one project.</td>
</tr>
</tbody>
</table>

**BOArd Action**
A motion was made by Mr. Pazzaglini to approve the $200,000 investment with Reinvest Partners for four units at 2733 Holloway Street in Durham; motion seconded by Mr. Curro. Motion passed unanimously.

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<tbody>
<tr>
<td></td>
<td>B. Audit and Compliance Committee Report – page 106</td>
</tr>
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<td>C. Executive Committee Report – page 132</td>
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<td>D. Quality Management Committee Report – page 135</td>
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### AGENDA ITEMS:

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<tr>
<th>AGENDA ITEMS:</th>
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<tbody>
<tr>
<td><strong>E. Fiscal Year 2018-2019 Property and Liability Insurance – page 211</strong></td>
<td></td>
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<tr>
<td><strong>F. HR Classification and Grade Schedule – page 212</strong></td>
<td></td>
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<tr>
<td>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</td>
<td></td>
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</table>

**BOARD ACTION**

A motion was made by Mr. McKinley Wooten to approve the consent agenda; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

9. **FY19 Public Hearing and Budget Approval – page 219**

As required by Local Government Budget Fiscal Control Act, § 159-12 (b), the Board shall hold a public hearing before adopting the budget ordinance for the fiscal year. Chair Binanay opened the public hearing; there were no speakers. Chair Binanay closed the public hearing.

Ms. Goodfellow presented the FY19 (fiscal year 2018-2019) budget for approval and adoption per GS (general statute) 15-13. Mr. Edgerton provided an overview of Alliance’s fund balance and the impact of State Single Stream funding cuts for all NC MCOs. The budget presentation is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. James Edgerton to approve the FY19 budget of $500,329,015; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

A motion was made by Mr. James Edgerton to approve the FY19 reinvestment plan, the June 30, 2018, committed funds including Wake Adult Crisis Facility (implementation of facility start-up will be suspended until additional resources are identified to ensure long-term sustainability), and to direct staff to include $11 million for facility start-up in the June 30, 2018, committed funds; motion seconded by Mr. Gino Pazzaglini. Motion passed unanimously.

10. **Johnston Consolidation**

A. **Resolution to Add Johnston County into the Alliance Catchment Area – page 263**

N.C. Gen. Stat. §122C-115(c1) allows an area authority to add one or more counties to its catchment area upon the adoption of a resolution to that effect by a majority of the members of the Area Board and the approval of the Secretary of the NC Department of Health and Human Services. As required by statute, the Board of Directors is requested to approve the consolidation by resolution.
Ms. Wolff, General Counsel, read the resolution, which is attached to and made part of these minutes. There were no questions or discussion about the resolution.

**BOARD ACTION**
A motion was made by Mr. Lascel Webley to approve the resolution; motion seconded by Mr. Gino Pazzaglini. Motion passed unanimously.

B. Johnston County Lease Agreement – page 266
Johnston County is the owner of the office space currently occupied by Johnston County LME staff at 521 North Brightleaf Boulevard, Smithfield, NC 27577. NC General Statue §160A-274 authorizes governmental units to enter into leases with each other upon such terms and conditions as the parties deem wise. Ms. Wolff provided a brief overview of the lease; the lease is attached to and made part of these minutes.

**BOARD ACTION**
A motion was made by Mr. James Edgerton to approve the lease agreement for 521 North Brightleaf Boulevard in Smithfield; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.

11. Legislative Update
Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Government Relations Director, presented the legislative update. They reviewed the current NC General Assembly budget, the impact on NC MCOs, LME/MCO solvency standards, school and public safety, and Medicaid coverage for ambulance transports to address emergency department crowding (so ambulances can bill for taking persons to facilities other than emergency departments).

Additionally, Mr. Perkins mentioned additional bills that may impact NC MCOs, such as HB403, DHHS Medicaid transformation short session package, and IVC (involuntary commitment) reform bill.

The presentation is attached to and made part of these minutes.

**BOARD ACTION**
The Board received the update.
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<tr>
<td>12. FY19 Board Officer Election – page 273</td>
<td>As stated in the by-laws officers of the Area Board, officers shall be chosen for a one-year term at the final meeting of the fiscal year and shall be as follows: Chairperson and Vice-Chairperson.</td>
</tr>
</tbody>
</table>

Nominations were opened for FY19 Board Chair.

**BOARD ACTION**
A motion was made by Vice-Chair George Corvin to nominate Cynthia Binanay for FY19 Board Chair; motion seconded by Mr. Duane Holder. Motion passed unanimously.

A motion was made by Mr. Duane Holder to close nominations for FY19 Board Chair; motion seconded by Mr. David Curro. Motion passed unanimously.

By unanimous show of hands and/or verbal consent, the Board elected Cynthia Binanay as FY19 Board Chair.

Nominations were opened for FY19 Board Vice-Chair.

**BOARD ACTION**
A motion was made by Mr. Duane Holder to nominate George Corvin for FY19 Board Vice-Chair; motion seconded by Mr. David Curro. Motion passed unanimously.

A motion was made by Mr. James Edgerton to close the nominations for Vice-Chair; motion seconded by Mr. Duane Holder. Motion passed unanimously.

By unanimous show of hands and/or verbal consent, the Board elected George Corvin as FY19 Board Vice-Chair.
Thursday, June 07, 2018  
4600 Emperor Boulevard, Durham, NC, 27703  
4:00-6:00 p.m.

**AGENDA ITEMS:**

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<tr>
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<tbody>
<tr>
<td>13. Chairman’s Report</td>
<td>Chair Binanay mentioned that the next meeting is scheduled for Thursday, July 5; the Board has typically not met in July as this is near the July 4 holiday. She also mentioned that if the July meeting is cancelled, the next meeting will be August 2 in Cumberland County.</td>
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<tr>
<td></td>
<td><strong>BOARD ACTION</strong></td>
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<td></td>
<td>By unanimous show of hands and/or verbal consent, the board decided to cancel the July 5, 2018, Board meeting.</td>
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<td></td>
<td>Chair Binanay mentioned another tentative meeting scheduled for June 28 at 8 am. She mentioned that staff will confirm if the meeting is needed; she directed Ms. Ingram to contact Board members and confirm a new date for this potential meeting.</td>
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<tr>
<td></td>
<td><strong>BOARD ACTION</strong></td>
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<td></td>
<td>A motion was made by Vice-Chair George Corvin to enter closed session pursuant to NCGS 143-318.11 (a) (6), (a) (1), and (a) (3) to consider the qualifications, competence, and performance of an employee; to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; and to consult with General Counsel regarding civil action; motion seconded by Ms. Lodies Gloston. Motion passed unanimously.</td>
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<td></td>
<td>The Board returned to open session.</td>
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<td>15. Adjournment</td>
<td>With all business being completed the meeting adjourned at 7:02 p.m.</td>
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</table>

**Next Board Meeting**

**Thursday, August 02, 2018**

4:00 – 6:00 pm

Robert Robinson, Chief Executive Officer  
8/2/2018  
Date Approved
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: June 7, 2018

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 Steering Committee meets at 5:30pm on the first Monday each month, rotating face to face meetings at the Alliance Home Office, 4600 Emperor Boulevard, Durham, with telephonic meetings every other month. Local committee meetings are held in individual counties monthly, 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 AREA BOARD ACTION: Receive draft minutes and documents from May for the Steering, Wake and the Durham subcommittees and April for the Cumberland subcommittee.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Israel Pattison, CFAC Chair; Doug Wright, Director of Individual and Family Affairs.
### 1. WELCOME AND INTRODUCTIONS

**2. REVIEW OF THE MINUTES – 4-2-2018 – minutes approved by consensus**

<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 Comment</td>
<td>No Public Comments</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Individual/Family Challenges and Solutions</td>
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<tr>
<td>Nominating Committee</td>
<td>Officers to be elected at June meeting – Jason Phipps, Cynthia Daniels-Hall, and Tracy Glen-Thomas agreed to be the nominating committee.</td>
<td>Inquire about willingness to serve and develop a ballot for the June 4 meeting.</td>
<td>6/4/2018</td>
</tr>
<tr>
<td>SWOT Analysis</td>
<td>Doug introduced the SWOT analysis process being used by the state to help CFACs measure their effectiveness at meeting their legislative responsibilities. Members were asked to review at the local CFACs and be ready to participate in the SWOT analysis on June 4th.</td>
<td>Review at local meetings and prepare for the June 4th Steering committee.</td>
<td>6/4/2018</td>
</tr>
<tr>
<td>LME/MCO updates</td>
<td>By the numbers - Doug spent some time reviewing the LME/MCO monthly report. He showed how Alliance compared with other LME/MCOs and how to read the data and know when there may be a challenge. Members were encouraged to review the data on their own and ask questions for verification. Needs and Gaps Analysis - Carlyle to attend June meeting and introduce the process for this year; After receiving that information, members will be asked to go back to their local groups and gather feedback on needs and gaps in the</td>
<td>Continue reviewing the report monthly – ask questions when you do not understand or just need some clarification or additional information. Start discussing and noting needs and gaps in your community, prepare for the June meeting at local committees to have this as a discussion topic.</td>
<td>6/4/2018</td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
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<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<td>SCFAC Advocacy Day</td>
<td>May 22nd - Members were reminded about the SCFAC advocacy day and encouraged to attend.</td>
<td>Attend and advocate</td>
<td>5/22/2018</td>
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<tr>
<td>Subcommittees</td>
<td></td>
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<td>N/A</td>
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<tr>
<td>• Wake</td>
<td>Carole gave a brief update on Wake County.</td>
<td></td>
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<tr>
<td>• Durham</td>
<td>Dave gave a brief update on Durham County – Movie event!</td>
<td></td>
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<td>• Cumberland</td>
<td>Star gave a brief update on Cumberland County.</td>
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<tr>
<td>• Johnston</td>
<td>Jason gave a brief update on Johnston County – merger effective July 1st.</td>
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<td>• Area Board</td>
<td>Dave and Israel gave an update on the board meeting – Dave is now a member of the Board of Directors.</td>
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<td>• Human Rights</td>
<td>Human Rights Committee received annual training. Still looking for additional members.</td>
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<td>• Quality Management</td>
<td>Quality Management discussed the closure of QIPs and the introduction of new ones.</td>
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<tr>
<td>State Updates</td>
<td>SCFAC meeting scheduled for the 10th, the SCFAC call is scheduled for the 17th.</td>
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<td>N/A</td>
</tr>
<tr>
<td>Announcements</td>
<td>None</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

5. ADJOURNMENT
MEMBERS PRESENT: Cynthia Daniels-Hall, Annette Smith, Ben Smith, Israel Pattison, Carole Johnson, Gregory Schweitzer

GUEST(S) PRESENT: Anna Cunningham, Dave Mullen, Doug Wright, Stacy Guse, Karen McKinnon, Megan Mason, Connie King-Jerome

Dial +1 (605) 472-5464
Access Code: 289674
Pin: 8803

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES. Approved at 5:50

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<tbody>
<tr>
<td>Wake Network of Care</td>
<td>Dave Mullin-Will answer questions presented to him by the CFAC members.</td>
<td>Anna asked how she can provide feedback. Dave said send him the feedback. Anna also asked if the site can convert to different languages. Dave instruction step-by-step where to click to change to 118 different languages. Dave suggested everyone look at the site to find varying resources. Dave also informed how to update or correct information on the website. Annette asked if there are any restrictions on the website. Dave stated only providers or agencies, not individuals on the site. Anna suggested the large print icon be in larger print so anyone can find it. Anna also suggested adding a</td>
<td>30 minutes</td>
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<tr>
<td>Agenda Item</td>
<td>Presenter</td>
<td>Notes</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Link to Ready to NC for disaster preparedness.</td>
<td>Dave</td>
<td>Dave stated he will see if the link is already on the site. Dave provided his email address for those with questions or updates. Dave also provided a few new updates since last time he spoke 6 months ago. Dave handed out Alliance Behavioral Healthcare new opioid website cards.</td>
<td></td>
</tr>
<tr>
<td>SWOT MCO Updates</td>
<td>Doug</td>
<td>Doug asked to have the SWOT returned by June 4, 2018 for the Steering Committee. Stacy will email the SWOT analysis forms tomorrow.</td>
<td></td>
</tr>
<tr>
<td>Wake CFAC Subcommittee Community Event</td>
<td>Discuss</td>
<td>Annette asked if the event could be at the same time as another event. Doug suggested September since it is Recovery month. It is suggested we piggy back with the RCNC rally in September. Stacy will call Teri at RCNC to see if we can show Generation Found at the RCNC rally.</td>
<td></td>
</tr>
<tr>
<td>State Updates</td>
<td>Doug</td>
<td>Unable to discuss state updates due to time constraints.</td>
<td></td>
</tr>
<tr>
<td>Public Comment/challenges/solutions</td>
<td></td>
<td>No comments.</td>
<td></td>
</tr>
<tr>
<td>Training: CFAC Advisory SOC</td>
<td>Stacy</td>
<td>Unable to present training, but did pass out PowerPoint.</td>
<td></td>
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<tr>
<td>Changing rooms</td>
<td>Stacy</td>
<td>Doug stated we will be moving our conference room to 310 due Next meeting.</td>
<td></td>
</tr>
</tbody>
</table>
5. ADJOURNMENT
Carole adjourned and Israel seconded at 7:00.
CFAC Responsibilities, Tips On Self-Advocacy, System of Care
Duties of Alliance CFAC

• Review, comment on and monitor the implementation of the local business plan to Alliance, stakeholders, and DMH

• Identify service gaps and underserved populations and make recommendations on areas of service eligibility and service array to Alliance and the Board

• Make recommendations regarding the service array and monitor development of services
Duties of Alliance CFAC

• Review and comment on the Alliance program budget

• Participate in all quality improvement measures and performance indicators

• Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/IDD/SUD services
Conflict of Interest & Confidentiality

- Committee members must disclose a conflict or the appearance of a conflict of interest depending on the circumstances
  - May be prohibited from serving or restricted in voting based on the disclosure

- Members may not represent themselves as independent representatives of or acting independently on behalf of the Committee
  - Noncompliance may result in removal
State CFAC

• 21-member self-governing and self-directed advisory organization, composed entirely of individuals and family members of individuals

• Provides input and conduct oversight of the Division’s operations and efforts to accomplish the strategic outcomes of the State Plan

• Advises DHHS and the General Assembly on the planning and management of the State’s public MH/DD/SA services system
Five Components of Self-Advocacy

• Personal responsibility
• Knowledge of the law and other rules
• Fact finding and documentation
• Negotiating
• Believing in oneself
Tips for the Self-Advocate

- Realize you have rights and are entitled to equality under the law
- Keep informed and ask questions
- Take advantage of resources
  - Peer-run, family and community support programs, referral/crisis hotlines, advocacy groups, informative classes, assertiveness training groups
- When contacting a resource insist that explanations are clear and understandable
Responsibilities of the Self-Advocate

- Be clear about what you need and want
- Always go to meetings
- Ask who is at your meetings and why
- Keeping all your papers
- Never sign blank copies of forms
- Document what happens; taking notes or have someone else do it
Responsibilities of the Self-Advocate

• If you need help, taking someone along
• Know the laws that regulate your services
### State and Federal Laws

- Most services provided because of state or federal laws
- Laws have regulations that provide guidance about how that law should be implemented
- There are always rules about how to spend money, sometimes in regulation or policy
- Laws include definitions for eligibility and services
Working With Providers

• Many professionals have standards which must be met to be licensed or certified

• Find out if your provider has the needed specialized training (CPR, CFT, etc.)

• Best practices help to justify requests for services

• Request clear written information on your grievances/appeal rights within an agency and outside an agency
Fact Finding and Documentation

• Keep good records and document what happens – this will become your proof

• Keep notes about times, dates and who you talked to and what you were told

• If required services are not being provided when promised, write it down
Figure Out if it’s Working

• Ask questions about when where and how often the service is going to happen

• Keep a log – write down when services happen

• If services don’t happen, know whom to call

• Evaluate happiness with services provided

• Always ask for any decision or change to be put in writing and wait for it
Figure Out if it’s Working

• Use communication skills

• Use the telephone to gather information, to keep track of progress and to let people know what one wants
Expressing Dissatisfaction

• Before expressing dissatisfaction, write down the essential points
• Stay calm
• Make the conversation brief and clear
• Be willing to listen
• Ask for the name and position of the person one is talking with
Expressing Dissatisfaction

• Ask when to expect action
• If this person can’t help, ask who can
• If necessary ask to speak to a supervisor
• Thank the person for being helpful
• Keep a record of the call and follow-up
Tips for Negotiating

• Pay attention, do not frown
• Use good listening skills
• Ask for what you want and say why
• If the other person agrees, thank them; if not, suggest a compromise
• If they agree with the compromise, thank them
• Believe in yourself and do not give up
Self-Determination

• Principle of self-determination based on the recognition of the right and need of individuals and their families to have the freedom to make their own choices and decisions

• Alliance supports its individuals and families in those decisions and works to help them attain their goals and independence

• Everyone deserves to live happily and usefully whole
Recovery

• Recovery is holistic and is defined by individuals who have reclaimed their lives and are productive and active members of society.

• Alliance supports and encourages them as they embark upon their personal journeys.
The Alliance Service System

• Alliance is a managed care organization for public MH/DD/SA services
  o Allows greater flexibility to shape the service delivery system to ensure access to quality care that results in better consumer outcomes

• Services delivered by a network of private providers who contract with Alliance

• Serving the citizens of Durham, Wake, Cumberland and Johnston counties
The Alliance Service System

• Goal to ensure that individuals who seek help receive the quality services and supports they are eligible for to help them achieve their goals and live as independently as possible
The Alliance Service System

• Services that respect and support individuals
  o Build on strengths, promote recovery
  o Flexible to respond to unique and changing needs

• Services that respond to real life needs
  o Array of services provided by choice of provider
  o Connections to housing, social support, etc.

• Services that are effective
  o Based in research about what works and measured by best-practice quality standards
The Alliance Service System

• Based on a System of Care philosophy
  o A continuum of effective, community-based services and supports for individuals, children and families who have mental health issues and other life challenges
  o Organized into a coordinated network and built on partnerships and collaboration
SOC Core Values

• Culturally-competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve

• Community-based, with the focus of services, as well as the management and decision making responsibility, resting at the community level
SOC Core Values

• Person-centered and family-focused, with the strengths and needs of the individual, child and family determining the types and mix of services

• Evidence-based to help ensure positive treatment outcomes
NC DHHS
State Consumer & Family Advisory Committee

Invites you to
Legislative Advocacy Day

Tuesday, May 22, 2018
Beginning at 8 AM at the Legislature
16 W. Jones Street

This event is an opportunity to come to Raleigh to meet with your Senators and House of Representative members, and attend a DHHS-related legislative committee meeting.

State CFAC will facilitate the event. The purpose is to get a large group of folks from local CFACs across the state and from partner organizations to ADVOCATE for improved and expanded services under Medicaid Transformation. This is your opportunity to be heard!

You will receive more information soon by email including maps and bullet-point issue summaries from the Community Engagement and Empowerment Team, North Carolina Department of Health & Human Services.

SAVE the DATE!

STATE CFAC
c/o Suzanne Thompson
Email: CEandE.Staff@dhhs.nc.gov
Raleigh, NC
Toll Free: 1-855-262-1946
**DURHAM CFAC SUBCOMMITTEE MEETING**

**MEMBERS PRESENT:** ☑ Steve Hill, ☐ Tammy Harrington, ☐ Joe Kilsheimer, ☐ James Henry, ☐ Latasha Jordan, ☑ Dave Curro, ☐ Amelia Thorpe, ☑ Kyle Reece, ☑ Trulia Miles  
**GUEST(S) PRESENT:** ☑ Brenda Solomon ☑ Chris Dale  
**ALLIANCE STAFF:** ☐ Doug Wright, Director of Consumer Affairs; ☑ Ramona Branch, Individual and Family Engagement Specialist  

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

1. WELCOME AND INTRODUCTIONS
2. REVIEW OF THE MINUTES- Minutes approved and accepted as is.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Comments</td>
<td>Dave Curro announced that he spent some time at the Durham VA and engaged in conversation about the new opioid website from Alliance. The link for the website is: <a href="https://allianceforaction.org/">https://allianceforaction.org/</a></td>
<td>Ramona will follow up with Doug once he returns from vacation and advise Steve.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Steve Hill commented about the Durham CFAC Subcommittee Recovery Event/Movie night and stated that it has was a success despite the blustery conditions.</td>
<td>Ramona will follow up with Doug on this and we will address at the June meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steve Hill requested a copy of the movie “Generation Found” so that he can incorporate it into the programs at TROSA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steve Hill would like to know how long he has been the CFAC Chair for the Durham Subcommittee, and when elections will take place.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest in Membership/Outreach</td>
<td>Chris Dale will be eligible for CFAC membership during the next meeting in June.</td>
<td>June 11, 2018</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>CFAC Steering Committee</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFAC Steering Committee</td>
<td>Dave Curro gave an update on the telephonic Steering Committee meeting on 05.07.2018. Topics included:</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• Alliance award for opioid website</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DHHS to keep LME/MCO model</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ongoing recruitment for CFAC’s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CFAC, Advocacy, and SOC</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFAC, Advocacy, and SOC</td>
<td>Ramona went over the CFAC responsibilities, Tips on Self-Advocacy, System of Care training. Members were encouraged to reach out to her or Doug for any questions or concerns.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LME/MCO Updates</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCO Updates</td>
<td>Ramona went over the SWOT Analysis handout and encouraged everyone to have this completed for the next Steering Committee meeting that will take place on June 4, 2018 at Alliance’s corporate office. It was mentioned that Carlyle would be in attendance during the meeting to begin the discussion on needs and gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Announcements/Opportunities</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Announcements/Opportunities</td>
<td>State Advocacy Day: Tuesday 05.22.2018- Ramona went over ticketing information online and the cost is free. Everyone is encouraged to attend.</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 5. ADJOURNMENT:

6:40pm
MEMBERS PRESENT: Lotta Fisher (on the phone), Dr. Michael McGuire, Ellen Gibson, Dorothy Johnson, Tracey-Glenn Thomas (on the phone), Jackie Blue, Sharon Harris, Brianna Harris, and Shirley Francis.

GUEST(S) PRESENT: Renee Lloyd, Sharalyn Shelton, Starlett Davis (Alliance), Doug Wright (Alliance), Tyrone Fields, Tamekia Bartee, Lillie Henderson, Carmen G. Perez- Molina, Vincent Francis, Hank Debnam and Jamille Blue,

1. WELCOME AND INTRODUCTIONS- Lotta and Michael welcomed everyone and introductions were made.

2. REVIEW OF THE MINUTES – Minutes from March2018 were approved.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</thead>
<tbody>
<tr>
<td>Public Comment-Consumer/Family challenges and solutions</td>
<td>Starlett Davis has provided community events and resources. We went over those events. Ellen spoke about her fundraising community event on May 19th at E&amp;E Circle of Care Fish Fry, 603 Murchinson Rd. Dorothy let the committee and guest know that the walk was great and they were still taking donation.</td>
<td>See Doug or Star for any questions</td>
<td>May 19, 2018</td>
</tr>
<tr>
<td>CFAC Advocacy SOC Training</td>
<td>Doug Wright present the CFAC Advocacy SOC training to the committee. The purpose was to make sure that the committee understood their rights as an individual seeking services or a family member of the individual. He discussed how to advocate for yourself and family members and what System of Care is.</td>
<td>See Doug or Star for any questions</td>
<td>Ongoing</td>
</tr>
<tr>
<td>State Update</td>
<td>Doug Wright explained that the legislature research committee on I/DD is putting forward 4 pieces of legislation in the short session in May. One of the bill will be a new position in Health and Human Services being an administrator and coordinator of education across the state. The other proposal was to establish a task force for the collection of data for education and employment outcomes for I/DD. Also to allow savings from parental trust funds to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please see State Website for updates</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<tr>
<td>be rolled over to an able action account with the funds being considered income. Governor Cooper has put in some request for behavioral heath providers and 20 million dollars for public schools. He wants to hire nurses and psychologist for the schools. State CFAC Meeting is the 2nd Wednesday of the month.</td>
<td></td>
<td>State CFAC Meeting May 9th</td>
<td>May 9, 2018</td>
</tr>
<tr>
<td>MCO Updates</td>
<td>Doug Wright explained that we are moving forward with the Johnston County consolidation that will happen on July 1st. Doug gave more information on what that means and what that will look like. The Advocacy for State CFAC is May 22, 2018. Flyers have been sent out.</td>
<td>For any questions on consolidation with Johnston County, See Doug. See Doug or Star for additional information on Advocacy Day</td>
<td>July 1, 2018 May 22, 2018</td>
</tr>
<tr>
<td>Membership Discussion</td>
<td>Starlett Davis talked about Event Planning/ Membership Recruitment for Public event. The small group that was responsible for looking into venues for the Generations found viewing reported out. We discussed our findings. Doug added what Durham CFAC was doing and some of his ideas as well. We agreed on looking at doing this right before school starts again. Michael explained to the guest what CFAC is and being open to new members. We obtained a new member, Jamille Blue. She was voted in by the committee members. Starlett will get her situation with membership.</td>
<td>We will continue to discuss plans for the event at the next meeting.</td>
<td>Ongoing until July August</td>
</tr>
<tr>
<td>Prep for the next meeting</td>
<td>We discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting</td>
<td>Contact Starlett and Doug with questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Appreciation</td>
<td>Everyone gave their appreciation.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
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<th>TIME FRAME:</th>
</tr>
</thead>
</table>

### 5. ADJOURNMENT

Adjourned at 7:10pm
ITEM: Finance Committee Report

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. The Finance Committee meets monthly at 2:30/3:00 p.m. prior to the regular Area Board Meeting. This month’s report includes the draft minutes from the May 3, 2018, meeting, the Summary of Savings/(Loss) by Funding Source, Statement of Revenue and Expenses (Budget to Actual) report and ratios for the period ending April 30, 2018.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

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

1. Review of the Minutes

2. Monthly Financial Reports as of April 30, 2018
   a. Summary of Savings/(Loss) by Funding Source
   b. Statement of Revenue and Expenses (Budget & Actual)
   c. Senate Bill 208 Ratios
   d. DMA Contractual Ratios

3. Holloway Investment - Carol

4. Insurance Contract Approvals

5. Budget Approval for Fiscal Year 2019

6. Adjournment
## 1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the April 5, 2018, meeting were reviewed; a motion was made by Mr. Bostock and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Monthly Financial Reports</td>
<td>The monthly financial reports were discussed which includes the Statement of Net Position, the Statement of Revenue and Expenses, the Summary of Savings/(Loss) by Funding Source, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of March 31, 2018. a) Ms. Pacholke discussed the monthly reports. We have assets totaling $174,705,854 with approximately $119,000,000 being current. We have liabilities totaling $54,204,019 with approximately $43,600,000 being current. Net position is $120,501,835. We have a loss of $1,089,913 year to date which is expected. This is due to a combination of a smaller Medicaid savings than prior years and a higher state loss due to legislative reductions. As of March 31, 2018, we need approximately $11,750,000 from fund balance to offset the state loss. Alliance is meeting all SB208 and DMA contractual ratios.</td>
<td></td>
</tr>
<tr>
<td>4. Non-Medicaid Report</td>
<td>Ms. Goodfellow reviewed the Quarter Ending March 31, 2018 non-Medicaid report. Kelly Goodfellow discussed the third quarter non-Medicaid report. She highlighted some of the differences between budget and actual. The budget cap removal in March has helped and we are moving in the right direction to ensure we spend as much of State and Federal spending as possible.</td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. FY19 Recommended Budget</td>
<td>Ms. Goodfellow went over the FY19 recommended budget presentation. The presentation focused on the different funding sources (Medicaid, Non-Medicaid, and Administrative). The total recommended budget is $499,869,631. Ms. Goodfellow noted that there would be changes to the budget presented in June for approval due to possible County budget changes and due to a small PMPM change received after the recommended budget was prepared. The recommended budget will be presented to the full Board for discussion.</td>
<td>The final FY19 budget will be presented at the June 7th meeting for approval</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. **ADJOURNMENT:** The next meeting will be June 7, 2018, from 2:30 p.m. to 4:00 p.m.
<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$</td>
<td>$312,189,733</td>
<td>$300,167,747</td>
</tr>
<tr>
<td>Federal &amp; State Grants</td>
<td>12,682,686</td>
<td>34,237,864</td>
<td>46,920,550</td>
</tr>
<tr>
<td>Local Grants</td>
<td>-</td>
<td>22,940,190</td>
<td>24,479,007</td>
</tr>
<tr>
<td>Administrative</td>
<td>-</td>
<td>45,186,426</td>
<td>44,801,009</td>
</tr>
<tr>
<td>Total</td>
<td>$12,682,686</td>
<td>$414,554,213</td>
<td>$416,368,313</td>
</tr>
</tbody>
</table>

Less Amount from Fund Balance $12,682,686

Net Savings/(Loss) $1,814,100

### Fund Balance as of April 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2017</th>
<th>Change</th>
<th>April 30, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>3,233,623</td>
<td>1,187,723</td>
<td>4,421,345</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>34,509,071</td>
<td>7,091,029</td>
<td>41,600,100</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>11,414,200</td>
<td>(972,376)</td>
<td>10,441,824</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>35,531,214</td>
<td>(12,682,686)</td>
<td>22,848,528</td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>6,038,577</td>
<td>(2,495,586)</td>
<td>3,542,991</td>
</tr>
<tr>
<td>Reinvestment</td>
<td>15,773,126</td>
<td>(1,778,925)</td>
<td>13,994,201</td>
</tr>
<tr>
<td>Total Committed</td>
<td>57,342,917</td>
<td>(16,957,196)</td>
<td>40,385,721</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>15,091,936</td>
<td>7,836,721</td>
<td>22,928,657</td>
</tr>
<tr>
<td>Total Fund Balance</td>
<td>121,591,747</td>
<td>(1,814,100)</td>
<td>119,777,647</td>
</tr>
</tbody>
</table>
### Amended Budget 2018-01

#### Statement of Revenue and Expenses (Budget and Actual) - As of April 30, 2018

<table>
<thead>
<tr>
<th>Amended Budget</th>
<th>Current Period</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Year to Date</th>
<th>Balance</th>
<th>Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVENUES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$37,861,390.00</td>
<td>$2,979,743.54</td>
<td>$3,971,095.36</td>
<td>$6,961,134.11</td>
<td>$9,128,217.25</td>
<td>$22,940,190.26</td>
<td>$14,921,199.74</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>77,881,018.00</td>
<td>3,307,580.24</td>
<td>8,500,889.73</td>
<td>11,406,120.48</td>
<td>11,023,273.17</td>
<td>34,237,663.62</td>
<td>43,643,154.38</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>367,691,243.00</td>
<td>31,449,397.61</td>
<td>90,576,459.90</td>
<td>96,278,191.66</td>
<td>93,885,683.53</td>
<td>312,189,732.70</td>
<td>55,501,510.30</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$483,433,651.00</td>
<td>37,736,721.39</td>
<td>102,948,444.99</td>
<td>114,645,446.25</td>
<td>114,037,173.95</td>
<td>369,367,786.58</td>
<td>114,065,864.42</td>
</tr>
</tbody>
</table>

| Administrative |                |    |    |    |              |         |          |
| Local Administration | 369,054.00 | 30,754.50 | 92,383.65 | 92,263.50 | 92,265.55 | 307,667.20 | 61,386.80 |
| LME Administrative Grant | 4,359,385.00 | 363,283.00 | 1,089,848.99 | 1,089,848.99 | 1,089,849.00 | 3,632,829.98 | 726,555.02 |
| Medicaid Waiver Administration | 50,773,791.00 | 4,085,642.33 | 11,854,098.58 | 12,390,094.13 | 12,262,638.95 | 40,592,473.99 | 10,113,017.01 |
| Total Administrative Revenue | 56,257,230.00 | 4,566,311.25 | 13,197,160.86 | 13,754,204.49 | 13,668,233.72 | 45,186,426.32 | 11,070,803.68 |

| Total Revenues | $539,690,881.00 | 42,303,032.64 | 116,145,605.85 | 128,400,166.74 | 127,705,407.67 | 414,554,212.90 | 125,136,668.10 |

| EXPENSES       |                |    |    |    |              |         |          |
| Local Services | $37,861,390.00 | $2,979,743.54 | $3,971,095.36 | $6,961,134.11 | $9,128,217.25 | $22,940,190.26 | $14,921,199.74 |
| State & Federal Services | 77,881,018.00 | 3,307,580.24 | 8,500,889.73 | 11,406,120.48 | 11,023,273.17 | 34,237,663.62 | 43,643,154.38 |
| Medicaid Waiver Services | 367,691,243.00 | 31,449,397.61 | 90,576,459.90 | 96,278,191.66 | 93,885,683.53 | 312,189,732.70 | 55,501,510.30 |
| Total Service Expenses | 483,433,651.00 | 38,717,962.98 | 105,920,486.45 | 111,289,784.11 | 115,639,070.39 | 371,567,303.93 | 111,866,347.07 |

| Administrative |                |    |    |    |              |         |          |
| Operational | 7,184,040.85 | 701,250.14 | 1,336,008.44 | 2,731,350.03 | 2,122,458.76 | 6,891,067.37 | 292,973.48 |
| Salaries, Benefits, and Fringe | 41,195,953.14 | 3,302,974.37 | 9,823,667.13 | 9,834,221.70 | 9,199,200.19 | 32,880,783.39 | 8,315,169.75 |
| Professional Services | 7,122,236.00 | 305,032.48 | 1,321,201.60 | 1,723,171.69 | 1,679,752.34 | 5,029,158.11 | 2,093,077.89 |
| Miscellaneous Expense | 755,000.00 | - | - | - | - | 755,000.00 | 0.00% |
| Total Administrative Expenses | 56,257,230.00 | 4,309,256.99 | 12,480,877.17 | 14,288,743.42 | 13,722,131.29 | 44,601,008.87 | 11,456,221.13 |

| Total Expenses | $539,690,881.00 | 43,027,219.97 | 118,401,363.62 | 125,578,527.53 | 129,361,201.68 | 416,386,312.80 | 123,322,568.20 |

| CHANGE IN NET POSITION | ($724,187.33) | ($2,255,757.77) | $2,821,639.21 | ($1,655,794.01) | ($1,814,099.90) |
**Current Ratio**

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 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: Policy Committee Report

DATE OF BOARD MEETING: June 7, 2018

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

Policies reviewed at the February 8, 2018, Policy Committee meeting and ready for Board approval without revisions: HR1: Equal Employment Opportunity/Affirmative Action Policy; HR2: Recruitment and Selection Policy; HR4: Conditions of Employment Policy; HR5: Classification and Compensation Policy; HR 6: Employee Benefits Policy; HR 7: Alcohol and Drug Free Workplace Policy; HR 8: Time and Attendance Policy; HR 9: Sexual Harassment Policy; HR 10: Leave Policy; HR 11: Family and Medical Leave Act Policy; HR 12: Clinical Staff Credentialing Policy; HR 14: Disciplinary Action; HR 15: Performance Management Policy; HR 16: Separation Policy; HR 17: Employee Complaint Policy; HR 18: Employee Grievance Policy; HR 19: Reduction in Force Policy

Policies reviewed with suggested revisions: UM6: Eligibility for Services: Note that this policy was reviewed at the November 7, 2017 meeting of the Policy Committee.

By-Laws with suggested revisions: The Board Policy Committee presents the revisions to the By-Laws for consideration and approval. The proposed revisions were provided to Board members on May 3, 2018, for review. Pursuant to the By-Laws of the Board of Directors, this action requires a super-majority vote.

REQUEST FOR AREA BOARD ACTION: Accept the report. Accept Board Policy Committee minutes from the February meeting as submitted. As part of the annual review process approve the above listed policies for continued use. Approve and ratify the recommended changes to the above listed policy UM6 effective March 1, 2018. Consider and approve the proposed revisions to the By-Laws.

CEO RECOMMENDATION: Accept the report. Approve the reviewed policies for continued use. Approve and ratify the proposed revised policy UM6 effective March 1, 2018. Approve the proposed revisions to the By-Laws.

RESOURCE PERSON(S): Curtis Massey, Committee Chair; Monica Portugal, Chief Compliance Officer
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: The minutes from the November 9, 2017, meetings were reviewed; a motion was made by Ms. Gloston and seconded by Mr. Golden to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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</thead>
<tbody>
<tr>
<td>Documents Provided</td>
<td>Agenda, Minutes from the November 9, 2017 meeting, Human Resources Policies, Governance Policy # G-10.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Annual Review of Policies | **Human Resources Policies reviewed and considered for continued use without revisions requiring Board approval:**  
HR1: Equal Employment Opportunity/Affirmative Action Policy  
A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.  

HR2: Recruitment and Selection Policy  
A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.  

HR4: Conditions of Employment Policy - non-substantive, grammatical edits were made and approved by the Committee.  
A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as amended. Motion carried. | Draft minutes, reviewed policies and Agenda Action Form will be provided to the Board Clerk for inclusion in the Board Packet | |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
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<tbody>
<tr>
<td>HR5: Classification and Compensation Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
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<tr>
<td>HR 6: Employee Benefits Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
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<tr>
<td>HR 7: Alcohol and Drug Free Workplace Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>HR 8: Time and Attendance Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
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<tr>
<td>HR 9: Sexual Harassment Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR 10: Leave Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>HR 11: Family and Medical Leave Act Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
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</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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</thead>
<tbody>
<tr>
<td>HR 12: Clinical Staff Credentialing Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR 14: Disciplinary Action</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR 15: Performance Management Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>HR 16: Separation Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>HR 17: Employee Complaint Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
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<tr>
<td>HR 18: Employee Grievance Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR 19: Reduction in Force Policy</td>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to accept the policy as presented. Motion carried.</td>
<td></td>
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</tr>
<tr>
<td>Human Resources Policies reviewed with suggested revisions:</td>
<td>None</td>
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<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
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</tr>
<tr>
<td>Governance Policy reviewed with suggested revisions:</td>
<td>G10: Delegation of Authority to the Chief Executive Officer - The Committee proposed revisions to Governance Policy 10</td>
<td>The revisions proposed by the Board Policy Committee will be presented to the Finance Committee for review. If the Finance Committee assents to the revisions, then the revised Policy will be presented to the Board of Directors.</td>
<td>The next meeting of the Finance Committee is scheduled for March 1, 2018.</td>
</tr>
<tr>
<td>A motion was made by Ms. Gloston and seconded by Mr. Golden to present the revised policy language to the Finance Committee for review before submitting the re-revised policy to the Board of Directors. Motion carried.</td>
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3. ADJOURNMENT: @ 5:17 pm
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: The minutes from the September 21, 2017, meetings were reviewed; a motion was made by Mr. Golden and seconded by Mr. Massey to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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</thead>
<tbody>
<tr>
<td>Documents Provided</td>
<td>Agenda, Minutes from the September 21, 2017 meeting, Care Coordination Policies, Client Rights Policies, Customer Services Policies, Provider Network Policies, Quality Management Policies and Utilization Management Policies</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Review of Policies</td>
<td>Care Coordination Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
<td>Draft minutes, reviewed policies and Agenda Action Form will be provided to the Board Clerk for inclusion in the Board Packet</td>
<td></td>
</tr>
</tbody>
</table>
|                       | CC1: Coordination of Care for Special Health Care Population Policy  
|                       | A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.                  |             |             |
|                       | Care Coordination Policies reviewed with suggested revisions:  
|                       | None                                                              |             |             |
|                       | Client Rights Policies reviewed and considered for continued use without revisions requiring Board approval:                |             |             |
|                       | CR1: Client’s Rights to Dignity Privacy and Humane Care  
<p>|                       | A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy with non-substantive change. Motion carried. |             |             |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>CR2: Client’s Right to Confidentiality Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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</tr>
<tr>
<td>CR3: Consumer Choice Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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</tr>
<tr>
<td>CR4: Advanced Directives Advanced Instructions Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>Client Rights Policies reviewed with suggested revisions</td>
<td>None</td>
<td></td>
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</tr>
<tr>
<td>Customer Services Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
<td></td>
<td></td>
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<tr>
<td>CS1: Customer Services Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>Customer Services Policies reviewed with suggested revisions:</td>
<td>None</td>
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<tr>
<td>Provider Network Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
<td></td>
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<tr>
<td>PNI1: Selection and Retention of Providers Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
PN2: Letters of Support Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.

PN3: Provision of Services by Relatives-Legal Guardians Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.

PN5: Rule Waiver Requests Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.

Provider Network Policies reviewed with suggested revisions:
None

Quality Management Policies reviewed and considered for continued use without revisions requiring Board approval:

QM1: Consumer, Provider and Stakeholder Satisfaction Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.

QM2: Management and Investigation of Grievances Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.

QM3: Management of Incidents Policy
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.
<table>
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<tbody>
<tr>
<td>Quality Management Policies reviewed with suggested revisions: None</td>
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<tr>
<td>Utilization Management Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
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<tr>
<td>UM1: Accessibility of UR-UM Process Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>UM2: Pre-Review Screening for Certification Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>UM3: Utilization Review Criteria Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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</tr>
<tr>
<td>UM4: Utilization Review Process Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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</tr>
<tr>
<td>UM5: Appealing Clinical Utilization Management Decisions Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>Utilization Management Policies reviewed with suggested revisions:</td>
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<tr>
<td>UM6: Eligibility for Services</td>
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<tr>
<td>AGENDA ITEMS:</td>
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</table>
| Board Finance Committee submitted proposed changes to move UM6 to Business Operations and proposed changes to the purpose and policy statements.  
* A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as amended. Motion carried. | | | |
| Proposed Amendment to By-laws | Committee discussed a proposed change related to quorum and suggested to review one year of data to assist in evaluating how often lack of quorum impacts committee meetings.  
Committee decided to present the proposed revision to the by-laws to the Board Executive Committee before presenting it to the Board of Directors.  
The committee also added a provision stating that a non-Board member having a conflict of interest appointed to a committee shall be a non-voting member and shall not count towards establishing quorum.  
* A motion was made by Mr. Golden and seconded by Mr. Massey to move forward with this proposal. Motion carried. | Executive Assistant will be asked to provide one year of data on how often lack of quorum impacts meetings. | Data and proposed revisions will be presented to Executive Committee 11/21/17, to Board of Directors in December. |
| Proposed Amendment to By-Laws: QM Committee Composition | Ms. Binanay asked whether additional QM committee members – non-voting provider reps – are permitted. Ms. Wolff explained that more voting members than non-voting members still would be required.  
The committee added a provision increasing the number of provider reps to *plus at least 2*.  
* A motion was made by Mr. Golden and seconded by Mr. Massey to move forward with this proposal. Motion carried. | The committee will move forward with recommendation to present this revision of the by-laws to the Board of Directors. The committee will present the revision to the Executive Committee before presenting it to the Board of Directors. | Data to be presented to Executive Committee 11/21/17, to Board of Directors in December. |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
3. ADJOURNMENT: @ 5:30 pm
I. PURPOSE

The purpose of this policy is to acknowledge the enrollment and coverage of Medicaid-eligible consumers enrolled in the Prepaid Inpatient Health Plan (PIHP) of Alliance as well as to establish financial-eligibility criteria for individuals not eligible for Medicaid and who are seeking treatment in the Alliance Provider Network. Eligibility for non-Medicaid funded services is not an entitlement and is contingent upon availability of funding/coverage.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to comply with the DHHS Division of Medical Assistance contract in that all Medicaid categories listed as eligible in the contract are covered by Alliance as part of the 1915 (b)(c) Waiver operations.

It is the policy of Alliance Behavioral Healthcare to establish financial-eligibility criteria by which consumers/individuals may be eligible for the use of state funds as payment for behavioral health services to a non-Medicaid eligible individual in the Alliance area. For an individual to receive state funded treatment services, the following basic criteria must be met:

1. There must be funding available to pay for such treatment;
2. The individual must be a resident of a county in the Alliance catchment area;
3. There must be no other payer to cover the cost of care; and
4. The individual or minor individual’s parent or legal guardian are deemed financially eligible for services, as defined below.

An individual meets financial eligibility if the household income is at or below 300% of the federal poverty level and they have no assets or third party funding or insurance available to pay for services.

Residents of the Alliance counties are eligible for crisis assessment and crisis services through the Alliance Provider Network when no other payer source is available. Under this policy, acute inpatient psychiatric services that require prior authorization are not considered crisis services.

III. PROCEDURES
The Area Director/Chief Executive Officer shall develop procedures to implement the provisions of this policy.
BOARD OF DIRECTORS BY-LAWS

ARTICLE I

PURPOSE

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

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

ARTICLE II

STRUCTURE
A. AUTHORITY

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

B. COMPOSITION

1. The Board of Directors shall consist of nineteen-twenty (1920) members.
2. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland County Commissioners.
3. The Durham and Wake County Commissioners shall appoint seven (7) members respectively, and the Cumberland County Board of Commissioners will appoint four (4) members, and the Johnston County Board of Commissioners will appoint two (2) members. During the effective period of the Interlocal Agreement between the Board of Directors and the Johnston County Area Authority, the Alliance Board of Directors will appoint one member from Johnston County. All seats will be appointed at large.
4. The appointment process shall be consistent with the process outlined in the Joint Resolution between Cumberland, Durham and Wake Counties effective July 8, 2013. The Board of Directors will advertise, accept applications, interview and recommend appointments to the respective Boards of Commissioners.
5. Board of Directors membership may consist of the following:
   a. Consumer or family member representing the interest of individuals with mental illness, 
      intellectual or other developmental disabilities or substance abuse
   b. CFAC member
   c. An individual with health care expertise and experience in the fields of mental health, 
      intellectual or other developmental disabilities or substance abuse services.
   d. Individual with financial expertise
   e. Individual with provider experience in a managed care environment.
6. The Board of Directors shall assure that there is at least one representative of each of the three 
   disability categories, i.e., mental illness, intellectual/developmental disabilities and substance 
   abuse, on the board.
7. No individual who contracts with the Board of Directors for the delivery of mental health, 
   intellectual/developmental disabilities, or substance abuse services may serve on the Board of 
   Directors during the period in which the contract for services is in effect.

C. TERMS AND CONDITIONS OF OFFICE

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

D. OFFICERS
1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
   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.
   c. Executive Secretary – The CEO (or his/her designee) shall serve as the Executive Secretary. The CEO shall not be an official member of the Board of Directors nor have a vote. As Executive Secretary, the CEO shall:
      i. Send Board of Directors packets of information.
      ii. Maintain a true and accurate account of all proceedings at Board of Directors meetings.
      iii. Maintain custody of Board of Directors minutes and other records.
      iv. Notify the County Commissioners of any vacancies on the Board of Directors or attendance compliance issues.

E. COMMITTEES

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

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

b. **Client Rights/Human Rights Committee (DMH/DD/SAS contract and NCGS 122C-64, 10A NCAC 27G.0504)**
   
i. The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board members. Members should include consumers and family members representing mental health, developmental disabilities and substance abuse. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area.
   
ii. The Client Rights/Human Rights Committee functions include:
   
   1) Reviewing and evaluating Alliance’s Client Rights policies at least annually and recommending needed revisions to the Board of Directors.
   2) Overseeing the protection of client rights and identifying and reporting to the Board of Directors issues which negatively impact the rights of persons served.
   3) Reporting to the full Board of Directors at least quarterly.
   4) Submitting an annual report to the Board of Directors which includes, among other things, a review of Alliance’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).

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

c. **Quality Management Committee (URAC)**
   
i. The Quality Management (QM) Committee shall consist of at least 5 members to include consumers or their family members plus at least 2 non-voting provider representatives. The QM Committee will meet at least 6 times a year.
   
ii. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees.
   
iii. The QM Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

d. **Executive Committee** - The Board of Directors shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Board of Directors at the next scheduled meeting.
   
i. The Executive Committee shall be composed of the current Officers of the Board of Directors, Chairpersons of standing committees (who are Board of Directors members), the immediate past Board chairperson or an at-large member in the event the immediate past Board Chairperson is not available.
   
ii. The Board of Directors Chairperson shall serve as the Chairperson of the Executive Committee.
iii. The Chairperson shall call the meetings of the Executive Committee. Any member of the Board of Directors may request that the Chairperson call an Executive Committee meeting.

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

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

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

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

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

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

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

**ARTICLE III**
MEETINGS

A. REGULAR MEETINGS

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

B. SPECIAL MEETINGS

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

C. EMERGENCY MEETINGS

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

D. NOTICE OF MEETINGS

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

E. CONDUCT OF MEETINGS

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

The following guidelines should be followed at all Board and committee meetings:

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

F. QUORUM

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

G. APPROVAL OF CERTAIN ITEMS BY A SUPER MAJORITY

Significant actions by the Board of Directors require fifteen (15) affirmative votes, or a 75% majority in the event the number of board members changes or there are vacant seats on the Board. Significant actions shall include: (1) policy decisions which affect consumer benefit plans, admit or exclude providers, or set provider rates, (2) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159), (3) personnel policies, (4) employee benefit plans, (5) the selection and dismissal of the Chief Executive Officer, (6) changes to the Board of Directors structure, (7) execution of contracts or leases for real or personal property including accepting any assignment thereof, (8) acceptance of grants, (9) settlement of liability claims against the Area Authority or its officers or employees, (10) approval or amendment of the Area Authority’s by-laws, and, (11) any other matter so designated by the Area Authority Board.

H. ABSENCES

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

ARTICLE IV

GENERAL PROVISIONS

A. AMENDMENTS

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

B. SUSPENSION OF BY-LAWS

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

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

These By-Laws and all Board of Directors governance policies shall be reviewed at least annually.
I. PURPOSE

The purpose of this policy is to ensure the fair treatment of applicants and employees in all aspects of personnel administration without regard to race, color, religion, sex, sexual orientation, national origin, political affiliations, age, or disability and with proper regard for their privacy and constitutional rights as citizens. This “fair treatment” principle includes compliance with the federal employment opportunity and nondiscrimination laws.

II. POLICY STATEMENT

1. Equal Employment Opportunity:

Alliance Behavioral Healthcare is committed to equal employment opportunity for all who seek employment with the organization as well as those employed by the organization. Discrimination in all forms is prohibited. As a means of carrying out its commitment, the Area Board shall enforce the relevant provisions of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967 as amended, the Rehabilitation Act of 1973 as amended and all other statutes or regulations governing equal employment opportunity.

In furtherance of this policy, the Area Board prohibits retaliatory action of any kind taken by any employee of Alliance Behavioral Healthcare against any other employee, client, or applicant for employment because that person filed a complaint or charge; or assisted, testified, or participated in any manner in a hearing, proceeding, or investigation of a complaint charge.

2. Affirmative Action:

Alliance Behavioral Healthcare is committed to ensuring utilization of women, minorities, and the disabled as part of its workforce. The Area Director shall develop and implement a program of affirmative action to assure that all personnel policies and practices facilitate employment opportunities for women, minorities and the disabled. Annually, the Area Director shall provide a report on the distribution of the gender, minorities and disabled employees to the Board.
III. PROCEDURES

The Area Director will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide a standard for the staff recruitment and selection process.

II. POLICY STATEMENT

Alliance Behavioral Healthcare is committed to systematic recruitment and selection programs that are designed to identify, attract, and select from the most qualified applicants for employment. The Board strives for diverse representation at all levels of the workforce while engaging in recruitment and selection practices that are in compliance with all applicable employment laws. It is the policy of Alliance Behavioral Healthcare to provide equal employment opportunities for employment to all applicants and employees.

III. PROCEDURES

The Area Director will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to define certain terms and conditions that individuals must meet to be hired by Alliance Behavioral Healthcare. The contents of this policy are not intended to serve as an exhaustive list of requirements or conditions of employment, and some or all of the requirements and conditions described in this policy may not apply to every individual who is hired.

II. PERSONS AFFECTED

This policy primarily impacts newly hired, transferred, or promoted employees in all employee classifications. It also requires all current employees to report felony convictions that occur at any time during their employment.

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare that all employees satisfy job-related eligibility conditions including but not limited to licensure, certification and/or credentialing and satisfactory criminal background checks and e-verify employment verification. Alliance shall not employ anyone who is excluded from participation in federal healthcare programs or federal procurement activities and has been identified on the list of excluded individuals/entities maintained by the Office of Inspector General of the US Department of Health and Human Services (DHHS) or the Excluded Parties List System maintained by the federal System for Award Management (SAM).

IV. PROCEDURES

The Area Director shall develop procedures to implement this Policy.
I. PURPOSE

The purpose of this policy is to establish and maintain a classification and compensation plan in order to attract, motivate, and retain highly qualified employees. The plan shall provide a structure to administer salaries fairly and equitably.

All employees shall be covered under the classification and compensation plan, except for the Area Director whose compensation is set by the Board of Directors.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to ensure that its system of compensation is internally equitable, market competitive and administered without regard to age, sex, race, color, creed, religion, national origin, physical or mental condition, sexual orientation, non-job related disability, political affiliation, marital status, or other non-merit factors.

A. The Classification and Compensation Plan

The Classification and Compensation Plan shall consist of a system for identifying all types and levels of positions together with standards and procedures for maintaining the plan. Each position in Alliance Behavioral Healthcare is grouped with similar positions. This grouping is called a “Classification.” Job classifications shall be established to reflect the type of work performed, level of difficulty, and responsibilities associated with a position. Annually, the Board shall review and approve the Classification and Compensation plan.

The Classification and Compensation Plan shall provide a salary rate structure that may be revised in response to labor market trends. Each classification shall be assigned to a grade level with a designated salary range. No beginning pay rate will be below the federal or state minimum wage.

B. Minimum Qualification Standards

It shall be the policy of Alliance Behavioral Healthcare to establish job related minimum qualification standards wherever practical for each class of work in the classification and compensation plan. The
standards shall be based on the required skills, knowledge, and abilities common to each classification. The qualification standards and job related skills, knowledge and abilities shall serve as guides for the selection and placement of individuals.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to set forth the basis for providing benefits for the employees of Alliance Behavioral Healthcare.

II. POLICY STATEMENT

Alliance Behavioral Healthcare shall offer a comprehensive benefits plan for employees and their eligible dependents as outlined below.

A. Eligibility

1. All probationary, provisional, trainee and regular employees who work a minimum of 50% of a regular work schedule per week are eligible.

2. Employees may also cover a legally recognized spouse and/or children, including legally adopted children, step children, children placed for adoption, children for whom legal guardianship has been awarded to the employee, and children whose coverage is court-ordered.

B. Benefits

The following Employee Benefits Plans shall be offered by Alliance:

1. Health Insurance
2. Dental Insurance
3. Vision Insurance
4. Life Insurance and Accidental Death and Dismemberment
5. Short Term Disability
6. Long Term Disability
7. Voluntary Life Insurance
8. Voluntary Long Term Care
9. Voluntary Hospital Confinement
10. Voluntary Section 125-Flexible Spending Account
11. Voluntary NC 529 College Savings Plan
12. Local Government Employee Retirement System participation
13. NC 401K Plan
14. NC 457 Plan-Voluntary
15. Employee Assistance Program (EAP)

C. Availability of Funding

Benefit offerings are subject to change based on funding availability and Alliance Behavioral Healthcare directives. Deletion or addition to the Benefits listed in B above shall be subject to Board approval pursuant to the Alliance by-laws, however changes to employee benefit offerings (i.e. deductibles and co-pays) may be approved by the Area Director.

D. COBRA Rights

Employees who separate from Alliance Behavioral Healthcare for reasons other than gross misconduct may elect to continue their health, dental and vision benefits under COBRA (Consolidated Omnibus Budget Reconciliation Act).

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to affirm the Area Board’s prohibition against the use, distribution, dispensation and possession of controlled substances and the use of alcohol and abuse of prescription drugs by employees and contractors at the workplace. This policy is also meant to comply with the requirements of the Drug Free Workplace Act of 1988 and Attachment H of the NC Department of Health and Human Services, Division of Medical Assistance 1915(b)(c) waiver.

II. POLICY STATEMENT

It shall be the policy of Alliance Behavioral Healthcare to maintain an alcohol and drug free workplace. The unlawful manufacture, distribution, dispensation, possession or use of nonprescription controlled substance or alcohol in the workplace by Alliance Behavioral Healthcare employees or contractors is prohibited. Employees and contractors may not report to work under the influence of a nonprescription controlled substance or alcohol and may not use any such substance during work hours. Also prohibited is the misuse of prescription or nonprescription medication which results in impaired behavior on the job. Violation of this policy shall constitute inappropriate personal conduct which will subject the employee or contractor to disciplinary action up to and including dismissal.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

Alliance Behavioral Healthcare maintains work hours that ensure optimal productivity and customer service levels and which are compatible with state law, agency functions, and the maintenance of effective work schedules.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to comply with the Fair Labor Standards Act. The normal work week for nonexempt full-time employees is 40 hours per week. The normal work schedule for exempt full-time employees may average more than 40 hours per week in order to complete work assignments. Employment with Alliance Behavioral Healthcare is based on the following principles:

i. Employees are expected to report for each and every scheduled working day or shift, to report on time and to complete all scheduled hours.

ii. Being absent from or reporting to work after the scheduled beginning time requires the employee to properly notify the supervisor in advance and to utilize appropriate leaves or to lose payment for time not worked.

iii. Employees scheduled to work are expected to remain on the job until completion of the last hour of the scheduled work day or shift.

iv. Arrival any time after the beginning of the scheduled work day or shift is considered late or tardy for performance purposes.

III. PROCEDURES

The Area Director will develop procedures to implement this policy.
I. PURPOSE

The Area Board believes that all employees are entitled to work in an environment that is free of sexual harassment. To this end, the Board shall establish a policy to govern the behavior of all its employees, consultants, contractors, vendors, and suppliers regarding the prohibition of sexual harassment.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to provide a work environment that is free of sexual harassment. For purposes of this policy, sexual harassment is defined as deliberate, unsolicited and unwelcomed verbal or physical conduct of a sexual nature or with sexual implications which:

i. has or may have a direct bearing on a selection decision;
ii. creates an offensive, intimidating, or hostile work environment;
iii. interferes with a person’s job or job seeking performance.

Sexual harassment is herein deemed a form of sex discrimination prohibited by Title VII of the Civil Rights Act of 1964 and NC G.S. 126-16.

In furtherance of this policy, the Area Board prohibits retaliatory action of any kind taken by any employee of Alliance Behavioral Healthcare against any other employee, client, or applicant for employment because that person filed a complaint or charge; or assisted, testified, or participated in any manner in a hearing, proceeding, or investigation of a sexual harassment complaint charge.

III. PROCEDURES

All complaints of sexual harassment shall be promptly and thoroughly investigated. The Area Director shall develop procedures for handling sexual harassment complaints.
I. PURPOSE

The purpose of this policy is to establish a consistent system of leave for Alliance Behavioral Healthcare staff.

II. POLICY STATEMENT

Alliance Behavioral Healthcare recognizes the importance of balancing work and time away from the workplace and shall provide leave to employees as a privilege when approved by a supervisor according to applicable procedures.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to set forth the conditions and process for implementing the provisions of the Family and Medical Leave Act of 1993, as amended.

II. POLICY STATEMENT

In compliance with the Family and Medical Leave Act (FMLA) of 1993, as amended, Alliance Behavioral Healthcare shall provide leave to eligible employees who have worked for Alliance for at least 12 months and at least 1,250 hours in the 12 calendar months immediately preceding the request for leave or otherwise deemed eligible under the FMLA Act.

III. PROCEDURES

The Area Director will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that clinical staff of Alliance Behavioral Healthcare is appropriately credentialed to perform clinical functions.

II. DEFINITIONS

Credential: Attestation of qualification, competence or authority issued to an individual by an organization or entity of competent jurisdiction

Credentialing: The process of establishing the qualifications of licensed/certified professionals

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to ensure that only those persons with appropriate training, education, credentials and/or experience perform clinical functions. In order to accomplish this, Alliance Behavioral Healthcare shall verify the clinical license and/or certification of applicable personnel at the time of employment or contract and no less than every three years thereafter.

Licensed and or certified employees and consultants shall notify Alliance Behavioral Healthcare management in writing of an adverse change in licensure or certification status immediately (within 24 hours) upon learning of the status change. Each employee or consultant shall attest to knowledge of this requirement by signing an attestation at the time of employment or beginning of a contract.

IV. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare develops a clear and consistent process for equitable disciplinary actions.

II. POLICY STATEMENT

It is the Policy of Alliance to provide employees and supervisors a clear and consistent process for implementing and evaluating the fair and just delivery of appropriate disciplinary actions, promote efficient and equitable treatment for all employees. Alliance shall ensure that disciplinary actions, including dismissal, are administered in as near a uniform manner as possible, allow for the prompt, orderly and efficient resolution of problems and differences arising between the supervisor and employee, and ensure compliance with applicable federal and state laws, rules and regulations. It is the intent of Alliance to provide any employee, supervisors and management with a fair, clear and useful tool for correcting and improving performance issues, as well as to provide a process to assist management in addressing instances of unacceptable personal conduct.

III. PROCEDURES

The Area Director shall develop procedures to implement this Policy.
I. PURPOSE

The purpose of this policy is to establish a formal assessment program in which each staff member’s performance is evaluated on an annual basis.

II. POLICY STATEMENT

Alliance Behavioral Healthcare believes that employees need and deserve an opportunity to receive feedback from their supervisor relating to performance. In addition, a regular evaluation of employees’ performance supports the concept of ‘employee accountability’.

The performance appraisal:
1. Provides employees direction in their jobs and an opportunity to discuss any job problems and interests with his or her supervisor;
2. Enhances the likelihood of achieving both the organization’s and the department’s objectives by providing periodic feedback and coaching;
3. Provides an objective, consistent, and uniform way to gauge and improve each employee’s on-the-job performance using objective criteria; and,
4. Correlates the job-performance evaluation directly to the recommended merit increases.

A. Requirements

The appraisal policy requires managers and supervisors to develop a work plan with individual performance objectives with employees for the year within 30 days of hire. It also requires managers and supervisors to hold periodic review and coaching sessions with employees prior to completion of the probationary period or annual performance evaluation session.

Performance reviews are prepared annually. Probationary reviews are given to newly hired employees at the completion of the probationary period to determine performance level and determine regular status eligibility.
III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide guidelines for separation of employment with Alliance Behavioral Healthcare.

II. POLICY STATEMENT

Separation from employment may result from either voluntary or involuntary termination. For the purpose of this policy, voluntary termination means separation is initiated by the employee (examples: resignation or retirement). Involuntary termination means separation occurs when the separation is not initiated by the employee (examples: appointment ended, dismissal, probationary dismissal, reduction-in-force, and unavailability of leave).

An employee is considered to have resigned in “good standing” if he/she provides written notice within at least fourteen calendar days of his/her separation date. Failure to give fourteen calendar days’ written notice may be cause for denial of consideration for reemployment, and the employee may be deemed to have resigned ‘not in good standing”. Unauthorized absences from work for a period of three or more days may be considered a voluntary resignation. The Area Director has the authority to set the time and conditions of employment separation.

Regular employees who separate from Alliance and return within 30 calendar days will be reinstated with no break in service.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide a mechanism for employees to address unfair and/or poor employment practices that are not covered by the grievance policy.

II. DEFINITION

**Complaint**: Any written employee concern or dissatisfaction for which redress is sought, that is not otherwise covered under the Grievance Policy (see Policy HR-18).

**Employee**: Any permanent, temporary or contractual employee of Alliance Behavioral Healthcare.

III. POLICY STATEMENT

Alliance Behavioral Healthcare is committed to a consistent, equitable, and legally defensible process for the resolution of employee complaints. Employees shall have the right to file a complaint via the employee complaint procedure to address employment conditions other than disciplinary, reduction-in-force, or discriminatory actions.

An employee that files a complaint shall not be subject to retaliation for filing a complaint.

IV. PROCEDURES

The Area Director shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to provide a grievance process for certain employees of Alliance Behavioral Healthcare contesting a disciplinary action, Reduction in Force, alleged illegal discrimination or harassment based on race, religion, color, national origin, sex (including pregnancy, childbirth, and related medical conditions), age, disability (physical or mental including AIDS/HIV status), genetic information (i.e. Sickle cell or hemoglobin C trait), citizenship status, military status or service, or political affiliation, or other issue grievable under state law. This policy applies to Alliance career status and permanent employees. Career status employees are eligible for appeal rights through the internal Alliance grievance process and the State Human Resources Commission and Office of Administrative Hearings. Permanent employees who have not yet attained career status have appeal rights through the Alliance grievance process, but not outside Alliance unless they allege the employment action is being imposed on the basis of illegal discrimination. This policy does not apply to probationary, intern, temporary or trainee employees, except for grievances on the basis of alleged illegal discrimination or harassment or as otherwise provided under state law. It is the intent of this policy to encourage employees to resolve their grievance at the lowest level possible.

II. DEFINITION

Career status employee – A permanent employee who has been continuously (without break) employed in a position subject to the State Personnel Act for the immediate preceding 12 months.

Permanent employee – An employee who has been appointed to a permanently established position following the satisfactory completion of a probationary period in accordance with 25 NCAC 01I .2002(c).

Probationary employee – An employee serving a probationary appointment of not less than 3 months but not more than 9 months in accordance with 25 NCAC 01I .2002(a).

Reduction in Force (RIF) – Separation of employment with Alliance based on reductions in the workforce due to shortages of funds or work and/or changes in organizational objectives and policies.
which cause the consolidation, reorganization, or elimination of programs, functions, positions, or organizational work units.

III. POLICY STATEMENT

Alliance Behavioral Healthcare is committed to a consistent, equitable, and legally defensible process for the resolution of employee grievances regarding hiring, separation, disciplinary, reduction-in-force, or alleged discriminatory actions that are grievable under state law.

Permanent employees have the right to grieve when they disagree with certain disciplinary actions (suspension, demotion, or dismissal) taken against them. All employees also have the right to grieve if they believe they have been subject to illegal discrimination or harassment. Permanent employees subject to a reduction-in-force may also grieve as permitted under state law. Written warnings, placement on investigatory status with pay, and extensions of disciplinary actions are not grievable and are not appealable to the State Office of Administrative Hearings (OAH). Employees may file a complaint for all employment issues not covered by this policy.

No action involving demotion, suspension, or dismissal is to be taken against an employee for disciplinary reasons until such action has been approved by the CEO/Area Director or designee except when, in the judgment of the manager the immediate suspension is necessary to protect the safety of persons or property. In no case, however, shall an employee be dismissed without the written approval of the Area Director/CEO or designee.

Employees seeking redress under the grievance policy shall not suffer retaliation for filing a grievance.

IV. PROCEDURES

The Area Director/CEO shall develop procedures to implement the provisions of this policy. The procedures shall comply with all relevant Federal, State and local requirements. If any provision of this policy conflicts with duly promulgated Federal or State laws, rules or regulations, the provision of the law, rule or regulation shall govern.
I. PURPOSE

The purpose of this policy is to provide guidance for executing reductions in the workforce due to shortages of funds or work and/or changes in organizational objectives and policies which cause the consolidation, reorganization, or elimination of programs, functions, positions, or organizational work units.

II. POLICY STATEMENT

Alliance Behavioral Healthcare will make every effort to consider all feasible alternatives to involuntary separation of employees through reduction-in-force (RIF). Factors that will be considered in determining which employee(s) will be separated include: (1) applicable laws and regulations; (2) impact on overall program objectives; (3) departmental organization structure; (4) funding sources and budgetary guidelines; (5) possible re-distribution of staff and other resources; (6) appointment type (regular, provisional, probationary, temporary, emergency, seasonal); (7) seniority; and (8) employee job performance.

The Area Director will present the circumstances of an impending RIF to the Area Board for approval. This notification should be in the form of a proposed reduction plan, which will document the reason(s) for the reduction in the workforce; the effective date of the reduction; the proposed course of action and associated factors considered; the specific classifications of positions scheduled for reallocation, reassignment and/or abolishment, along with before and after RIF organization charts.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
ITEM: Supportive Housing Capital Investment

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: Alliance approved $500,000 in the current budget to make capital investment grants with local housing developers to create access to supportive housing. We are requesting approval for the final $200,000 to partner with Reinvest Partners for four units (20% set aside) for a property located at 2733 Holloway street in Durham.

REQUEST FOR AREA BOARD ACTION: Approve the request.

CEO RECOMMENDATION: Approve the request.

RESOURCE PERSON(S): Ann Oshel, Senior Vice-President/Community Relations; Carol Wolff, General Counsel
May 8, 2018

Ann K. Oshel, MS
Sr VP, Community Relations Officer
Alliance Behavioral Healthcare
4600 Emperor Boulevard, Suite 200
Durham, NC 27703

Dear Ann,

Reinvestment Partners is a nonprofit advocacy and community development agency promoting healthy and just communities by providing direct services to people, place based improvements and policy advocacy.

Reinvestment Partners respectfully requests a grant of $200,000 for our sixteen unit property at 2733 Holloway Street, Durham, North Carolina. These funds will be used as equity and for renovations to maintain the apartment complex as affordable, quality housing. In return, Reinvestment Partners agrees to reserve four units exclusively for your referred clients.

We are glad to work with Behavioral Health to comply with all related regulations and glad to share our financial records and programmatic accomplishments to demonstrate the capacity to partner on this and other future housing partnerships.

Sincerely,

Peter Skillern
Executive Director
ITEM: Draft Minutes from the May 3, 2018, Board Meeting

DATE OF BOARD MEETING: June 7, 2018

REQUEST FOR AREA BOARD ACTION: Approve the draft minutes from the May 3, 2018 meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
MEMBERS PRESENT: ☒Glenn Adams, ☒Cynthia Binanay, Chair (via phone), ☒Christopher Bostock (exited at 5:35 pm), ☒Heidi Carter, ☒George Corvin, MD, Vice-Chair, ☒David Curro, ☒James Edgerton, ☒Lodies Gloston, ☒Duane Holder, ☒Curtis Massey (entered at 4:16 pm), ☐Donald McDonald, ☒Erv Portman (entered at 4:06 pm), ☒Lascel Webley, Jr., and ☐McKinley Wooten, Jr.

GUEST(S) PRESENT: Lori Caviness, Cumberland Site Director; Janet Conner-Knox, A Caring Heart; Yvonne French, NC DHHS-DMH (Department of Health and Human Services - Department of Mental Health); Denise Foreman, Assistant Wake County Manager; Mary Hutchins, Wake County Finance Department; Israel Pattison, CFAC (Consumer and Family Advisory Committee) Chair; and Gregory Schweizer, CFAC

ALLIANCE STAFF PRESENT: Joey Dorsett, Senior Vice-President/Chief Information Officer; Doug Fuller, Director of Communications; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Davida Jones, Appeals Coordinator; Ken Marsh, Medicaid Program Manager; Ann Oshel, Senior Vice-President/Community Relations; 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; Matthew Ruppel, Director of Program Integrity; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Individual and Family Affairs

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

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<th>AGENDA ITEMS</th>
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<tr>
<td>2. Oath of Office</td>
<td>3. Vice-Chair Corvin mentioned that Pam Silberman was appointed by the Durham Board of County Commissioners; Dr. Silberman will join the Board at the June Board meeting.</td>
</tr>
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</table>
| 4. Announcements | A. Vice-Chair Corvin mentioned the following:  
• May is Mental Health Awareness Month: a schedule of community events was sent to Board members. If additional information is needed, members may contact Ms. Ingram.  
• The annual board survey was sent last week. He mentioned that the Board’s input is vital and requested that surveys be completed by May 25, 2018.  
B. Mr. Robinson mentioned the following:  
• Alliance surpassed its goal to help 88 individuals receive supportive housing this year. The 100th move occurred this week. Mr. Robinson invited Board members to join the celebration tomorrow, May 4, 2018, from 11:30 to 1:00 at Alliance’s Home Office at 4600 Emperor Boulevard in Durham.  
• The i2i Conference, formerly NC Council, is June 11 and 12 in Raleigh. If Board members are interested in attending, they may contact Ms. Ingram.  
• Alliance was selected by the NC DHHS to operate a pilot waiver for traumatic brain injury (TBI) within our four-county service region. Waiver services begin August 2018.  
• Mr. Robinson mentioned that Alliance won a gold award for the internal branding poster series. The national Aster Awards for Marketing Healthcare Today Magazine entries are judged by a panel of industry experts; John Hopkins and Blue Cross Blue Shield were additional entries in this category. |
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<th>AGENDA ITEMS:</th>
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<tr>
<td>5. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
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<td>6. Public Comment</td>
<td>There are no public comments.</td>
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</table>
| 7. Committee Reports | A. Consumer and Family Advisory Committee – page 3  
The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services.  
This month’s report included draft minutes and documents from the April Steering, Wake and Durham subcommittee meetings.  
The committee reports were part of the Board packet; Israel Pattison, CFAC Chair presented the report. Mr. Pattison mentioned recent events that CFAC sponsored in the community, an increase in membership for the local CFAC subcommittees, and CFAC participation in the NAMI Walk in Raleigh. Mr. Pattison also reminded Board members of upcoming CFAC meetings. The CFAC report is attached to and made part of these minutes. |

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

B. Finance Committee – page 15  
The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included the draft minutes from the April 5, 2018, meeting, the Statement of Net Position, 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, 2018.  
James Edgerton, Committee Chair, presented the report. Mr. Edgerton mentioned that expenditures exceeded revenue due to NC General Assembly funding cuts that require MCOs (managed care organizations) to maintain the same level of services. He mentioned that today’s Committee meeting included looking at funding from Counties and will include quarterly updates to review State Single Stream funding, which affects how County funds are utilized. The Finance Committee report is attached to and made part of these minutes. |

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

C. Policy Committee Report – page 24  
Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board reviews all policies annually. The Policy Committee reviews a number of policies each quarter in order to meet this requirement. This month’s report included draft revisions to the by-laws. |
**AGENDA ITEMS:**

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<td><strong>Mr. Massey provided an update from the Policy Committee noting proposed changes to the by-laws. As stated in the by-laws, changes must be presented thirty-days before they are approved. This item is on the agenda for the June Board meeting for approval.</strong></td>
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**BOARD ACTION**
The Board received the report.

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<tr>
<td><strong>8. Consent Agenda</strong></td>
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<tr>
<td>A. Draft Minutes from April 5, 2018, Board Meeting – page 35</td>
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<tr>
<td>B. Executive Committee Report – page 41</td>
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<tr>
<td>C. Human Rights Committee Report – page 44</td>
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<td>D. Draft Minutes from the March 27, 2018, Budget Retreat – page 139</td>
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The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.

**BOARD ACTION**
A motion was made by Mr. Christopher Bostock to approve the consent agenda; motion seconded by Commissioner Glenn Adams. Motion passed unanimously.

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<td><strong>9. FY19 Recommended Budget - page 216</strong></td>
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<tr>
<td>Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, presented the Fiscal Year (FY) 2018-2019 recommended budget for consideration; approval of the budget will be part of the June Board meeting.</td>
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<td>Ms. Goodfellow also provided an update from the March budget retreat, specifically how funds from the Counties will be utilized per respective County requests and recommendations for optimal utilization of State Single Stream funding. Ms. Goodfellow shared potential, prospective impact of this budget proposal and next steps. The budget presentation is attached to and made part of these minutes.</td>
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**BOARD ACTION**
The Board received the presentation.

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<td><strong>10. Appointment Recommendation –page 252</strong></td>
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<td>In accordance with NC General Statute 122C-118.1.d and the By-Laws of the Alliance Board, the initial terms of Alliance Board members were staggered with each initial term being considered a full term. A seat representing Durham County is currently vacant. Vice-Chair Corvin mentioned that the Executive Committee recommends Gino Pazzaglini for this seat, with a term ending March 31, 2021.</td>
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**BOARD ACTION**
A motion was made by Commissioner Heidi Carter to recommend that the Durham Board of County Commissioners appoints Gino Pazzaglini to Alliance’s Board; motion seconded by Mr. Curtis Massey. Motion passed unanimously.

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<td><strong>11. Legislative Update</strong></td>
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<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Director of Government Relations, presented an update. Mr. Perkins mentioned that the upcoming NC General Assembly session begins May 16, 2018, which may include key items that affect NC MCOs. He also mentioned a recent Alliance CARES (Community, Awareness, Resources, Education,</td>
<td></td>
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</table>
AGENDA ITEMS: DISCUSSION:

Services) event that included a number of law enforcement CIT (critical intervention team) officers trained by Alliance and Alliance staff.

Ms. Wilson provided an update on MCAC (Medicaid Care Advisory Committee) subcommittees. This included the State’s transition from DMA (Division of Medical Assistance) to DHB (Division of Healthcare Benefits); the transition is expected to be complete by August 1, 2018, with the goal of no interruption of services.

BOARD ACTION
The Board received the update.

12. Chair’s Report
Vice-Chair Corvin reminded Board members that the selection of FY19 Chair and Vice-Chair will occur at the June Board meeting; the terms for these offices begins July 1, 2018.

13. Adjournment
With all business being completed the meeting adjourned at 5:42 p.m.

Next Board Meeting
Thursday, June 07, 2018
4:00 – 6:00 pm

Robert Robinson, Chief Executive Officer

Date Approved
ITEM: Audit and Compliance Committee Report

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: The purpose of the Audit and Compliance Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions and to assist the Area Board in fulfilling its oversight responsibilities.

This report includes: notes for January 30, 2018 meeting; minutes for April 24, 2018 and May 23, 2018 meetings; proposed revisions to Employee Code of Ethics and Conduct reviewed by the Committee May 23, 2018; Corporate Compliance Plan reviewed by Committee May 23, 2018.

The Employee Code of Ethics and Conduct was approved by the Board of Directors in 2012. In accordance with Alliance Policy, the Board shall approve any modifications to the content of the Code.

The Alliance Corporate Compliance Plan includes the following elements: 1) the designation of a compliance officer and a compliance committee that are accountable to senior management; 2) written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards; 3) effective training and education for the compliance officer and the organization's employees; 4) effective lines of communication between the compliance officer and the organization's employees; 5) enforcement of standards through well-publicized disciplinary guidelines; 6) provision for internal monitoring and auditing; 7) provision for prompt response to detected offenses, and for development of corrective action initiatives.

The Alliance Board approved the Corporate Compliance Plan in 2012 and annually since then in accordance with the Board Corporate Compliance Plan Policy. The Audit and Compliance Committee reviewed proposed revisions to the Plan and is recommending approval.

REQUEST FOR AREA BOARD ACTION: Accept the report and approve the Code and Plan.

CEO RECOMMENDATION: Accept the report and approve the Code and Plan.

RESOURCE PERSON(S): Lascel Webley, Committee Chair; Monica Portugal, Chief Compliance Officer
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – Quorum was not present and therefore minutes were not reviewed.

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<tr>
<td>3. Follow-Up DMH Block Grant Audit: Mr. Marsh provided an update on the status of the Plan of Correction. Questions were answered regarding findings.</td>
<td>No follow up required</td>
<td>N/A</td>
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<td>External Quality Review (EQR): Mr. Marsh provided an update from the recent EQR and preliminary results presented by the EQRO at the closing of the review. A detailed presentation will be provided at the next meeting.</td>
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<td>4. Outstanding Overpayments</td>
<td>Committee reviewed a proposal to contract with collection agency for debt owed to Alliance by providers leaving the Alliance Network. Committee had questions related to providers with debt owed to Alliance that are still in the Network.</td>
<td>Follow-up at the next meeting related to providers in the Network.</td>
<td>Next meeting</td>
</tr>
<tr>
<td>5. Annual OCR Report</td>
<td>Ms. Perkins presented data related to HIPAA breaches and the annual report to the Office of Civil Rights (OCR). Questions related to operational procedures were answered.</td>
<td>OCR report will be filed in February.</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Internal Audits</td>
<td>Security Risk Assessment: Ms. Perkins presented the scope, methodology and results of the annual Security Risk Assessment. A third party vendor conducted the assessment in three main areas – HIPAA privacy/security; social engineering; external penetration testing. Questions were answered in all areas, except penetration testing.</td>
<td>Network Security Department will be present at the next meeting to answer questions related to the penetration testing.</td>
<td>Next meeting</td>
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</table>
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
---|---|---|---|
Simple Audits: Ms. Perkins and Ms. Portugal presented the scope, methodology and findings from six different simple audits in the areas of IDD Care Coordination, Hotline, Continuity of Care, Credentialing Access, Credentialing Agreements, and Unencrypted Email. Questions related to the various audits were answered. | No follow up required | N/A |

7. **ADJOURNMENT:** next meeting will be April 24, 2018, from 4:00 p.m. to 6:00 p.m.
APPOINTED MEMBERS PRESENT: ☒ Chris Bostock, BSIM, (phone) ☒ Duane Holder, MPA,(phone) ☒ Lascel Webley, Jr., M.B.A., M.H.A. (Committee Chair) (phone)

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT: None

STAFF PRESENT: Monica Portugal, Chief Compliance Officer; Ken Marsh, Medicaid Program Director; Joel York, Senior Network Security Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the May 24, 2017, meeting were reviewed; a motion was made by Mr. Bostock and seconded by Mr. Holder to approve the minutes. Motion passed unanimously.

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<tr>
<td>3. Follow-Up</td>
<td>Security Risk Assessment: External Penetration Testing: Mr. York explained the methodology and findings of the testing, including the level of risk involved in each finding. In addition to the vendor’s testing, Alliance does its own internal scans throughout the year. York provided answers to specific questions related to the testing. Outstanding Overpayments: Committee received an update related to the proposal to contract with collection agency for debt owed to Alliance and challenges with budgeting such administrative expenses. The Office of Legal Affairs is exploring options for managing debt in-house.</td>
<td>Follow up regarding outstanding overpayments</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Board Member Conflict of Interest</td>
<td>All Board Members except one have submitted the annual conflict of interest disclosure form. New conflict will be discussed with individual board members in order to allow opportunities for resolution before reported to the Committee.</td>
<td>New conflict, if any, will be presented at the next meeting.</td>
<td>Next meeting</td>
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<tr>
<td>5. Review and Approval of Independent Auditor Contract</td>
<td>Committee was reminded of the independent audit firm’s peer review conducted through American Institute of CPAs last year. The peer review report, which examines the system of quality control for the accounting and auditing practice, was accepted by the National Peer Review Committee on</td>
<td>Lascel will sign the Engagement Letter on behalf of the Audit &amp; Compliance Committee.</td>
<td>5/3/2018</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
### AGENDA ITEMS:

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<td>January 12, 2017 with a passing score. Firms can receive a rating of pass, pass with deficiencies, or fail. The FY19 Contract and Scope of Work between Alliance and the audit firm was reviewed. Relationships between Alliance and the firm were disclosed. A motion was made by Mr. Bostock to approve the contract. The motion was seconded by Mr. Holder. Motion passed.</td>
<td>No follow up required</td>
<td>N/A</td>
</tr>
<tr>
<td>6. <strong>External Quality Review</strong></td>
<td>Mr. Marsh reviewed this year’s scores compared to previous years’ and explained the scope of the review and findings in areas of Administration, Provider Services, Enrollee Services, Quality Improvement, Grievances and Appeals. Corrective Action Plan was approved by EQRO and closed out. Alliance is working on completing Best Practice Recommendations.</td>
<td>No follow up required</td>
</tr>
<tr>
<td>7. <strong>Quarterly Report</strong></td>
<td>Committee reviewed the quarterly Compliance dashboard for the first three quarters of FY18, including Network Compliance, Program Integrity and Corporate Compliance.</td>
<td>No follow up required</td>
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8. **ADJOURNMENT:** next meeting will be May 23, 2018, from 4:00 p.m. to 6:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
APPOINTED MEMBERS PRESENT: ☒Chris Bostock, BSIM (phone) ☐ Duane Holder, MPA (phone) ☒ Lascel Webley, Jr., M.B.A., M.H.A. (Committee Chair) (phone)

BOARD MEMBERS PRESENT: Cynthia Binanay, Board Chair (phone)
GUEST(S) PRESENT: Eddie Burke, CPA, Partner Cherry Bekaert
STAFF PRESENT: Monica Portugal, Chief Compliance Officer; Ken Marsh, Medicaid Program Director

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the April 24, 2018, meeting were reviewed; a motion was made by Mr. Bostock and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

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<tr>
<td>3. Annual Single Audit and Audit of Financial Statements</td>
<td>Eddie Burke of Cherry Bekaert presented the plan for this year’s audit, including an introduction of the audit team and timeline. The presentation included details of the audit scope such as testing of internal controls, significant audit areas to include assets/revenues, liabilities/expenditures, and others, and the single audit plan including audit risks and planned responses. Committee was in agreement with the audit plan. Members asked questions, answered by Mr. Burke.</td>
<td>Committee will receive a report out from the Audit Team before presented to the full Board.</td>
<td>December</td>
</tr>
<tr>
<td>4. Annual Review of Corporate Compliance Plan</td>
<td>Ms. Portugal reviewed proposed revisions which included changes in responsibilities between the two compliance committees and the Chief Compliance Officer and other non-substantive changes.</td>
<td>The Plan will be submitted to the Board consent agenda.</td>
<td>June Board meeting</td>
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<td>Mr. Bostock made a motion to approve the revisions to the Corporate Compliance Plan. The motion was seconded by Ms. Binanay. Motion passed unanimously.</td>
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<td>5. Employee Code of Ethics and Conduct</td>
<td>Ms. Portugal reviewed proposed revisions to the Board approved Employee Code of Ethics and Conduct adding emphasis to employee responsibility to know and comply with the Alliance approved Policies and Procedures and clarification to avoid discrimination in compliance with URAC Core</td>
<td>The Code will be submitted to the Board consent agenda.</td>
<td>June Board meeting</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>v. 4.0. Committee asked clarifying questions and was in agreement with the revisions.</td>
<td>New conflict, if any, will be presented at the next meeting.</td>
<td>Next meeting</td>
<td></td>
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<tr>
<td><strong>6. Board Member Conflict of Interest</strong></td>
<td>All Board Members have submitted the annual conflict of interest disclosure form. New conflict is being discussed with individual board member/s in order to allow them an opportunity to resolve it before reported to the Committee.</td>
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<td><strong>7. Internal Audits</strong></td>
<td>Committee reviewed the scope, methodology and findings from two internal audits in the areas of privacy and security. Questions related to the audits were answered.</td>
<td>No follow up required</td>
<td>N/A</td>
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**8. ADJOURNMENT:** next meeting will be August 22, 2018, from 4:00 p.m. to 6:00 p.m.
Corporate Compliance Plan

FY198

Adopted by the Area Board: October 4th, 2012
Reviewed and Approved by the Area Board: June 11, 2013
Reviewed and Approved by the Area Board: June 5, 2014
Reviewed and Approved by the Area Board: June 4, 2015
Reviewed and Approved by the Area Board: June 2, 2016
Reviewed and Approved by the Area Board: June 1, 2017
Reviewed and Approved by the Area Board: June 7, 2018
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I. Introduction and Statement of Purpose

It is the policy of Alliance Behavioral Healthcare (Alliance) to follow ethical standards of business practice established by Alliance Behavioral Healthcare’s Area Board and Management Team, by oversight agencies, and state and federal law. Alliance Behavioral Healthcare has an ongoing commitment to ensure that its affairs are conducted in accordance with applicable law and sound ethical business practice. Alliance Area Board of Directors, employees, and Provider Network are fully informed of applicable laws and regulations to which Alliance Behavioral Healthcare is obligated so that they do not inadvertently engage in conduct that may raise compliance issues. Alliance Behavioral Healthcare recognizes that its business relationships with contracted providers and vendors, Medicaid enrollees, and recipients of behavioral healthcare services are subject to legal requirements and accountability standards.

To further its commitment to compliance and to protect its employees and contracted providers, Alliance Behavioral Healthcare places emphasis on its Compliance Plan to address regulatory issues likely to be of most consequences to Alliance operations. The Compliance Plan establishes the following framework for corporate compliance by Alliance Area Board of Directors, management, employees and providers:

A. Designation of a Chief Compliance Officer, a Board Audit & Compliance Committee and Corporate Compliance Committee charged with directing the effort to enhance compliance and implement the Compliance Plan;

B. Incorporation of standards, policies, and administrative guidelines directing Alliance Behavioral Healthcare personnel and others involved with operational practices;

C. Prevention and identification of criminal and unethical conduct and legal issues that may apply to business relationships and methods of conducting business;

D. Effective education and training for the Chief Compliance Officer, Area Board of Directors, management and employees addressing obligations for adherence to applicable compliance requirements;

E. Development and implementation of informational materials and training for employees, subcontractors, providers, and enrollees addressing obligations for adherence to applicable compliance requirements and information to prevent dishonest behavior which results in fraud, waste of public funding, and program abuse;

F. Implementation of mechanism for employees to raise questions and receive appropriate guidance concerning regulatory and operational compliance issues;
G. Development and implementation of an ongoing monitoring and auditing process identifying potential risk areas and operational issues requiring remediation;

H. Development and implementation of a process for employees, subcontractors, providers and recipients to report possible compliance issues, such as legal and ethical violations, or to report fraud, waste, and abuse, including a process for such reports to be fully and independently reviewed;

I. Enforcement of standards through documented disciplinary guidelines, policies and training addressing expectations and consequences;

J. Formulation of plans for corrective action or remediation plans to address identified areas of noncompliance;

K. Evaluation of the effectiveness of the overall compliance efforts of Alliance Behavioral Healthcare to ensure that operational practices reflect current compliance requirements and address strategic goals to improve Alliance Behavioral Healthcare operations.

This Compliance Plan is not intended to set forth all of the substantive programs and practices of Alliance Behavioral Healthcare that are designed to achieve compliance and integrity. In addition to this Plan, Alliance Behavioral Healthcare has developed and implemented a variety of monitoring processes for providers. The compliance practices included in those efforts will be coordinated with this Plan to direct Alliance’s overall compliance efforts.

It is intended that the scope of all compliance activities promotes integrity, ensures objectivity, fosters trust and supports the stated values of Alliance Behavioral Healthcare.
II. Compliance Infrastructure

A. Chief Compliance Officer (CCO)

The Chief Compliance Officer has been delegated day-to-day operational responsibility for the Alliance Behavioral Healthcare compliance program. The CCO will report compliance efforts and identified issues directly to the Chief Executive Officer (CEO) who has overall responsibility to ensure that Alliance has an effective compliance program. The CCO will report directly as necessary and required to the Area Board of Directors. The Alliance Area Board of Directors is accountable for governing Alliance Behavioral Healthcare as a knowledgeable body regarding the scope and operations of the compliance program, including expectations, practices, identified risk issues and compliance remediation.

The Chief Compliance Officer is responsible for the following activities:

1. Formulate, review, and revise policies and procedures to guide all activities and functions of Alliance Behavioral Healthcare that involve issues of compliance, with assistance from the Compliance Committee;

2. Ensure processes for compliance integrate with and support Alliance Behavioral Healthcare quality management and provider network monitoring processes;

3. Develop, in conjunction with the Audit & Compliance Committee and other relevant parties, the Code of Ethics and Conduct for Alliance employees and providers;

4. Develop, in conjunction with the Compliance Committee and other relevant parties, methods to ensure that employees and providers are aware of Alliance Behavioral Healthcare’s Code of Ethics and Conduct and understand the importance of compliance;
5. Develop and deliver, in conjunction with the Compliance Committee, educational and training programs;

6. Develop and monitor internal systems and controls to carry out Alliance standards, policies and procedures as part of Alliance’s daily operations;

6.7. Receive, review, and investigate instances of suspected internal and external compliance issues, communicate findings and develop action plans with the program suspected of noncompliance and as appropriate with the assistance of the Compliance Committee;

7.8. Oversee program integrity activities, such as claims audits, data analytics, and special investigations to detect and resolve instances of provider and enrollee fraud and abuse;

8.9. Refer to Division of Medical Assistance (DMA) Office of Compliance and Program Integrity Behavioral Health Section suspected cases of fraud for determination of credible allegation;

9.10. Prepare annual compliance summary for evaluation by for the Corporate Compliance Committee and Board Audit and Compliance Committee to evaluate the effectiveness of compliance efforts, as set forth in this Plan;

10.11. Conduct an annual risk assessment, as set forth in this Plan, with the Corporate Compliance Committee, Alliance leadership and the Board Audit and Compliance Committee;

11.12. Prepare the annual compliance work plan, as set forth in this Plan, with the Corporate Compliance Committee and the Board Audit and Compliance Committee;

12.13. Prepare revisions to Alliance Behavioral Healthcare Compliance Plan together with the Corporate Compliance Committee and Board Audit and Compliance Committee, as set forth in this plan;

13.14. Report to and assist the Board of Directors and assist them in fulfilling their oversight responsibilities through its Audit and Compliance Committee to fulfill its oversight responsibilities; and

14.15. Provide other assistance with compliance initiatives regarding compliance as directed by the CEO and/or Board of Directors.

B. Board Audit and Compliance Committee (ACC)
The purpose of the Audit and Compliance Committee (ACC) is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. To assist the Board of Directors in fulfilling its oversight responsibilities for:

1. The integrity of the organization’s annual financial statements;

2. The system of risk assessment and internal controls by, among other things, approving the annual risk assessment methodology and the annual compliance work plan;

3. The organization’s compliance with legal and regulatory requirements by reviewing results of external and internal audits and monitoring;

4. The independent auditor's qualifications and independence;

5. The performance of the organization’s internal audit function; and

6. To provide an avenue of communication between management, the independent auditors, and the Board of Directors.

C. Corporate Compliance Committee (CCC)
To assist the Chief Compliance Officer (CCO) with the development and implementation of compliance efforts, a Corporate Compliance Committee has been formed representative of the clinical and administrative services of Alliance Behavioral Healthcare. The CCO will serve as the chair of the Committee and will not vote on any matters, unless the vote is required to break a tie. Committee members will serve one-year terms with no limitations on the number of terms to serve. The make-up of the committee will be re-evaluated at the end of each fiscal year. For the sake of maintaining the integrity of the Committee no more than 50% of committee members may resign from the Committee in the same year. New members will be nominated by their Department Head and will be selected by majority vote by the current Committee. The CCO must be consulted on the selection of membership.

The role of the CCC is to advise the CCO, to assist in the implementation of the compliance program, and to evaluate the effectiveness of Compliance efforts. The Committee’s responsibilities include:

1. Analyzing the organization’s regulatory obligations;

2. Working with employees and providers to develop standards of conduct and policies and procedures that promote compliance;

3.1 Developing and monitoring internal systems and controls to carry out Alliance Behavioral Healthcare standards, policies and procedures as part of Alliance Behavioral Healthcare’s daily operations;
4.3. Determining the appropriate strategy and approach to promote compliance and detection of potential risk areas through various reporting mechanisms;

5.4. Determining methodology to conduct the annual risk assessment, overseeing the process and determining the levels of risk as part of formulating the annual Compliance Work Plan;

6. Overseeing the implementation of the annual Compliance Work Plan in order to evaluate the effectiveness of compliance efforts;

7.5. Assisting, as appropriate, with the development of preventive and remediation plans;

8.6. Reviewing provider compliance violations and oversee enforcement of disciplinary guidelines, including making determinations regarding the approval of corrective actions and other sanctions as appropriate and per Alliance policies and procedures;

9.7. Developing a system to solicit, evaluate and respond to compliance issues, grievances, and other problems;

10.8. Monitoring findings of internal and external reviews for the purpose of identifying risk areas or deficiencies requiring further monitoring or preventive and corrective action; and

11.9. Reviewing and analyzing trends such as results from exclusions checks, internal and external monitoring and auditing efforts, fraud, waste and abuse investigations, billing audits, enforcement actions, and final disposition.

III. Policy Guidelines and Standards of Conduct

Alliance Behavioral Healthcare has adopted policies and procedures specific to Alliance Behavioral Healthcare’s operational practices. These policies and procedures are reviewed at least annually and revisions are made, as necessary. The policies and procedures specific to Alliance Behavioral Healthcare’s compliance efforts are intended to support and further define the operational practices and responsibilities and, when possible, are integrated within existing policies and procedures.

Alliance Behavioral Healthcare has also adopted an Employee Code of Ethics and Conduct to guide all business activity. This code reflects a common sense approach to ensuring legal and ethical behavior. All new employees receive training and provide acknowledgement of receipt of the Alliance Code of Ethics and Conduct. As a condition of employment the Code of Ethics and Conduct is reviewed and acknowledged annually thereafter.
It is the intent of Alliance Behavioral Healthcare to adopt and implement a Code of Ethics specific to the Alliance Provider Network. The Network Provider Code of Ethics will guide business activities of Providers who contract with Alliance.

IV. Effective Education and Training

It is essential to the Alliance Compliance Program to ensure that the Chief Compliance Officer receives effective training and education on an ongoing basis. The CCO shall seek out opportunities to receive Continuous Education Credits in order to maintain Compliance Certification and to enhance job related skills.

The CCO and CCC are responsible for ensuring Alliance Behavioral Healthcare policies regarding compliance are disseminated and understood by employees. To accomplish this objective, the CCO will assist with the development of a systematic and ongoing training program that enhances and maintains awareness of Alliance Behavioral Healthcare policies. Training materials directed to clinical, administrative or other regulatory compliance issues will be submitted to the CCO for review with the CCC.

Upon hire and annually thereafter, all Alliance employees will participate in compliance training whereby a system is in place to document that such training has occurred. Employees will be required to take a post-test in order to measure the effectiveness of training efforts. Training materials will identify Alliance Behavioral Healthcare’s CCO as available to respond to questions specific to compliance training or regulatory issues. Employees are made aware of their compliance obligations as a condition of employment.

Adherence to policies will be addressed within the New Employee Orientation and ongoing training programs, and employee job descriptions. Employees will be expected to demonstrate a sufficient level of understanding as a result of compliance training. If a particular compliance or risk issue develops, the CCO and/or CCC may recommend that identified persons attend training addressing the risk issue.

The CCO and CCC will develop compliance training opportunities for Providers in the Alliance Network. Such training may include an overview of Alliance policies and procedures, Provider Network Code of Ethics and Conduct, Compliance Program requirements, and healthcare fraud, waste, and abuse.

To ensure compliance throughout the Alliance Network, the CCO and CCC will develop and offer training to Enrollees. Such training may include Client Rights and healthcare fraud, waste, and abuse.

V. Effective Lines of Communication

A. Reporting Compliance Issues
In keeping with Alliance policies, all employees are required to report promptly all known or suspected violations of an applicable law or regulation, the Code of Ethics and Conduct, breach of privacy or security or any Alliance policies to their supervisor, the Chief Compliance Officer (CCO), or the confidential Compliance Line. As a general practice, employees are directed to address questions about operational issues to persons having supervisory responsibility of that function. Supervisors are responsible for ensuring that issues or violations of which they are aware are immediately reported to the CCO.

As another reporting option, training materials will inform employees that they may report directly to the Alliance CCO or to a confidential third party 24 hour Hotline, Compliance Line. The training materials will provide a contact method(s) to address compliance issues to the CCO and to the Compliance Line. The CCO will use various communication methods, including electronic, web based and telephonic communication methods, to ensure timely communication of the elements of this compliance program. The various communication methods will be available 24 hours a day. The intent of publicizing various methods of communication is to ensure both convenience and confidentiality for employees and enable immediate response to submitted issues. All reports will be investigated unless the information provided contains insufficient information to permit a meaningful investigation.

Failing to report violations may result in disciplinary action. Employees reporting in good faith possible compliance issues will not be subjected to retaliation or harassment as a result of the report. Concerns about possible retaliation or harassment should be reported to the CCO or the CEO.

The Compliance Program will also include a confidential third party 24 hour Fraud and Abuse Line, as a means to offer providers, enrollees, or other persons in the community an opportunity to report suspected fraud, waste of program funding, or abuse of services anonymously. The Fraud and Abuse Line will be advertised on the Alliance website, in Consumer Handbooks, Provider Manual, and other informational and training materials. The Alliance Access and Information line is another option for placing reports of this nature.

Reported compliance concerns related to providers will be logged in the Alliance Behavioral Healthcare grievance database. Concerns regarding fraud, waste, and abuse will be tracked in a separate compliance software by the CCO, Director of Program Integrity and/or Special Investigations Unit. Compliance concerns related to Alliance employees will be treated as a confidential document whereby access will be limited to the CCO and designated Compliance employee/s as requested by the reporter and as allowed by law. Internal compliance matters will be tracked using a confidential compliance software available to the CCO and designated Compliance employee/s.

B. Investigating Compliance Issues

When conduct is reported that is determined to be inconsistent with regulations, rules or laws or Alliance Behavioral Healthcare policy, the CCO will determine the level of potential risk and respond accordingly. If this preliminary review indicates that a problem may exist, the CCO will
promptly report the risk issue to the CEO and inquiry into the matter will be undertaken. This inquiry may include appropriate assistance from Legal Counsel. Alliance employees and providers will be expected to cooperate fully with any inquiries undertaken. The CCO shall report any compliance issues that may result in negative publicity and risk to Alliance Behavioral Healthcare to the Area Board of Directors.

Responsibility for conducting the investigation will be decided on a case-by-case basis by the CCO. The CCO will delegate investigations of suspected provider or recipient abuse or fraud to the Director of Program Integrity and Special Investigations Unit. The findings will be reviewed by the CCO to ensure consistency in the investigative process. All investigations will be documented in a confidential compliance software. Suspected cases of provider or enrollee fraud will be referred to DMA Office of Compliance and Program Integrity Behavioral Health Section for determination of credible allegation of fraud. Alliance will cooperate with DMA and/or the Department of Justice Medicaid Investigations Division on all fraud investigations.

When the compliance issue concerns an Alliance employee, the investigative process will adhere to Alliance policies and procedures regarding internal investigations and applicable Human Resources policies. To the extent practical and appropriate, efforts will be made to maintain the confidentiality of such inquiries and the information gathered. Consequences for conduct inconsistent with Alliance Behavioral Healthcare’s policy will be addressed according to the provisions identified in the applicable policies.

VI. Enforcement of Standards and Disciplinary Guidelines

Compliance standards will be consistently enforced through appropriate disciplinary actions, up to and including termination of employment. For providers in the Alliance Network compliance with standards will be enforced through sanctions up to and including termination of contract.

The following guidelines will be used. Discipline must be:
1. documented and well-publicized;
2. consistent;
3. dependent on the severity of the violation;
4. enforced for those who commit a violation; and
5. enforced for those who fail to report a known violation

The CCO and CCC, in collaboration with Human Resources, will develop policies and procedures to guide disciplinary actions. The CCO will ensure that such policies and procedures are made available to employees and providers through electronic means as well as incorporated into manuals and training materials. Disciplinary procedures will be approved by the CEO. The CCO will monitor to ensure consistent implementation of disciplinary guidelines.

VII. Internal Auditing and Monitoring
Audits and monitoring are preventative and detective compliance measures which assist Alliance Behavioral Healthcare in identifying and acting on real or potential issues before they become larger compliance risks. Audits are objective and independent planned activities determined by the annual risk assessment and included in the annual compliance work plan. Monitoring is a subjective, detective control done as a self-review within a Department or by the Office of Compliance. Monitoring may be planned and part of the annual compliance work plan or may be conducted as a reaction to concerning trends identified as part of the Continuous Quality Improvement process, or based on concerns from within a Department, etc.

Internal audits and monitoring will be completed using tools as appropriate and will be documented in the Compliance Audit or Monitoring Report. At a minimum, the following components will be included in all audits and monitoring:
1. Sample selection
2. Data review and collection
3. Data analysis; and
4. Reporting

Techniques may vary depending on the nature of the area reviewed and may be a combination of two or more of the following:
1. On-site visits;
2. Unannounced mock audits;
3. Interviews;
4. Questionnaires;
5. Trend analysis;
6. Review and tracking of work flow and processes;
7. Reviews of written materials and documentation prepared by the different departments; and
8. Other

The CEO delegates authority to the CCO to seek consultation with legal counsel when expert review is necessary to analyze the risk issue. If a review identifies risk issues for Alliance Behavioral Healthcare, the CCO will report the facts to the CEO. In consultation with legal counsel, as appropriate, the CCO will review the situation to determine whether there appears to have been activity inconsistent with federal and state rules and regulations, Alliance policies, procedures or the Code of Ethics and Conduct.

In addition to internal audits and monitoring, the Provider Network Operations Department will conduct ongoing provider monitoring and billing audits according to Alliance Behavioral Healthcare’s policies and procedures on provider monitoring. Results of these reviews will be communicated to the CCC by the Provider Network Evaluators and/or Quality Management Department.

All audit and monitoring activities will be reviewed by the CCC, CEO and ACC and summarized for Alliance Behavioral Healthcare Area Board of Directors, including sufficient information to
evaluate the appropriateness of responses to identified violations of Alliance’s policies and Federal or State laws.

**VIII. Response and Remediation**

When an internal compliance issue has been identified through an audit or monitoring activity, the CCO will ensure the issue is reported to the CEO and will facilitate the process to develop corrective action initiatives or to enforce standards through disciplinary actions promptly as required by policies and law.

As appropriate, the CCO will develop a remediation plan. Plans may include:

1. additional or modified training and education;
2. corrective action;
3. development of new policies and procedures;
4. revision to existing policies and procedures;
5. revision to the Compliance Plan;
6. additional monitoring and auditing; or
7. reporting to outside agencies

The CCO must be involved in the development of all remediation plans that:

1. result from a significant compliance violation;
2. affect multiple departments; or
3. involve revisions or additions to the Compliance Plan or policies and procedures.

Reporting a compliance violation to an outside agency must be coordinated through the CCO prior to reporting. The Office of Compliance monitors settlement of issues reported to outside authorities.

Remediation plans, including any reporting to an external agency, should be attached to the investigative documentation in the confidential compliance software, or to the Compliance Audit/Monitoring Report. Remediation plans that require further monitoring are considered “open” and are not resolved and closed until the monitoring period is successfully completed.

In accordance with Alliance’s policies and procedures, providers who have engaged in legal or ethical misconduct will be subject to consideration of penalties, sanctions, termination of contract for services and/or excluded from providing local, state, grant, and/or Medicaid funded services in the Alliance Provider Network, and/or other sanctions and penalties as required by law or state policy.

All providers’ corrective action plans will be maintained electronically and will be used as historical reference tools whereby identified issues may be included in Alliance Behavioral Healthcare’s provider profiling and review processes.

**IX. Effectiveness of the Compliance Program**
A. Annual Compliance Report

The Chief Compliance Officer (CCO) will ensure a review of Alliance Behavioral Healthcare’s status with current compliance and regulatory operations. The purpose of the review is to ascertain whether the compliance operations of Alliance Behavioral Healthcare are of sufficient scope and within substantial compliance with Alliance’s policy and regulatory requirements. The results of the self-assessment process along with a report of compliance efforts during the preceding year will be prepared by the CCO. With review and comments provided by the Corporate Compliance Committee (CCC) and Board Audit and Compliance Committee, the Annual Report will be presented to the Alliance Behavioral Healthcare Area Board of Directors.

B. Annual Risk Assessment and Compliance Work Plan

Annually, the CCO and CCC in collaboration with leadership will conduct a compliance risk assessment using an approved Risk Assessment tool. Risk will be identified through interviews with department heads, document reviews with input from management, results from previous audits and investigations, and review of the annual Office of Inspector General work plan, Fraud Alerts, Special Advisory Bulletins, and advice and guidance by Division of Medical Assistance. The level of risk will be assessed based on legal, reputational and financial risk to Alliance. Based on the assessment, CCC the CCO will prioritize the highest scored risk areas and will include at a minimum the top 5 to 10 areas that relate to Compliance in the annual compliance work plan.

C. Revisions to the Compliance Plan

This Compliance Plan is intended to be flexible and readily adaptable to changes in regulatory requirements and in the health care system as a whole. The plan will be regularly reviewed by the CCO and the CCC to assess the viability of the Plan and the inclusion of all appropriate Alliance policies and regulatory requirements. The Plan will be revised as experience demonstrates that a certain approach is not effective or suggests a better alternative. The Area Board of Directors will review and approve the Compliance Plan annually.
APENDIX A
Federal Criminal and Civil Statutes Related to Fraud and Abuse in the Context of Health care

Criminal Statutes
This section contains references to criminal statutes related to fraud and abuse in the context of health care. It is not intended to be a compilation of all federal statutes related to health care fraud and abuse. It is merely a summary of some of the more frequently cited federal statutes.

- **Health Care Fraud** *(18 U.S.C. 1347)*
- **Theft of Embezzlement in Connection with Health Care** *(18 U.S.C. 669)*
- **False Statements Relating to Health Care Matters** *(18 U.S.C. 1035)*
- **Obstruction of Criminal Investigations of Health Care Offenses** *(18 U.S.C. 1518)*
- **Mail and Wire Fraud** *(18 U.S.C. 1341 and 1343)*
- **Anti-Kickback law/Criminal Penalties for Acts Involving Federal Health Care Programs** *(Section 1128B of the Social Security Act/42 U.S.C. 1320a-7b)*

Civil and Administrative Statutes
This section contains a description of civil and administrative statutes related to fraud and abuse in the context of health care. It is not intended to be a compilation of all federal statutes related to health care fraud and abuse. It is merely a summary of some of the more frequently cited federal statutes.

- **The False Claims Act** *(31 U.S.C. 3829-3733)*
- **Civil Monetary Penalties Law** *(Section 1128A of the Social Security Act/42 U.S.C. 1320a-7aa)*
- **Stark/Self-Referral Law/Limitations on Certain Physician Referrals** *(Section 1877 of the Social Security Act/42 U.S.C. 1395nn)*
- **Exclusion From Federal Health Care Programs** *(Section 1128(a), (b) and (c) of the Social Security Act/42 U.S.C. 1320a-7a)*
REFERENCES


42 CFR § 438.608 Program Integrity Requirements.

The Alliance Behavioral Healthcare Code of Ethics and Conduct (the “Code”) sets out basic principles which all of the Alliance management and employees must follow. This Code applies to all business operations and personnel. Non-personnel, such as contractors, consultants, temporary staff and interns must also conduct themselves in a manner consistent with this Code when acting on behalf of Alliance Behavioral Healthcare.

**Standards of Conduct**

1. One of Alliance’s most important resources is a reputation for integrity and honesty. Alliance will conduct its business in full compliance with applicable laws and with sound ethical standards.

   All personnel shall act in compliance with the requirements of applicable law, [Alliance policies and procedures](#) and this Code and in a sound ethical manner when conducting business and operations. It is the responsibility of all personnel to know and comply with all Alliance policies and procedures.

2. Each supervisor and manager is responsible for ensuring that the employees within their supervision are acting ethically and in compliance with applicable law, [Alliance policies and procedures](#) and the Code. All employees are responsible for obtaining sufficient knowledge to recognize potential compliance issues applicable to their duties and for appropriately seeking advice regarding such issues.

3. Personnel shall not offer or give any bribe, payment, gift or item of value to any person or entity with which Alliance has or is seeking any business or regulatory relationship.

4. Personnel shall not accept any bribe, payment, gift, or item from any person or entity with which Alliance has or is seeking any business or regulatory relationship. Employees must promptly report the offering or receipt of gifts above a nominal value to their supervisor.

5. Other than compensation from Alliance, and as consistent with the conflict of interest policies, personnel shall not have a financial or other personal interest in any of its service providers or vendors.

6. Personnel shall not use Alliance resources for personal needs.

7. Records, whether financial, clinical, or administrative, shall be created, maintained, retained, or destroyed in accordance with Alliance records management policies and procedures.

8. All personnel shall maintain the confidentiality of Alliance’s business information and of information relating to Alliance’s service providers and vendors. Personnel shall not use any such confidential or proprietary information except as is appropriate for business.
9. Personnel shall uphold the legal and ethical commitment to the privacy and confidentiality of consumers served. Confidentiality will only be waived to prevent harm to the consumer or to comply with legal requirements.

10. Alliance personnel shall honor the rights of consumers to file grievances and shall assist them in the process.

11. All of Alliance business dealings shall be carried out in accordance with management’s general or specific directives. Information recorded and submitted to other persons must not be used to mislead those who receive the information or to conceal anything that is improper. This includes all transactions, payments, utilization decisions, contracts, credentialing and monitoring results, quality of care evaluations, grievances and appeals.

12. It is against the law to knowingly submit false, fraudulent or misleading claims, including claims for services not rendered, or claims which do not otherwise comply with applicable program contractual requirements. No payment shall be approved or made with the intention or understanding that it will be used for any purpose other than that described in the supporting documentation for the payment.

13. Personnel shall be completely honest in all dealings with government or oversight agencies and representatives. No misrepresentations shall be made. Personnel certifying the correctness of records, reports, and other documents shall have the knowledge that the information is accurate and complete before giving such certification.

14. Personnel must neither claim nor imply professional qualifications which exceed those possessed, and are responsible for correcting any misrepresentations of these qualifications by others. As applicable, personnel must abide by their professional discipline’s code of ethics and maintain licensing and educational requirements of their professional discipline.

15. Alliance shall not employ or contract with providers excluded from participation in federal healthcare programs.

16. Materials used to describe and promote Alliance services and programs shall be accurate, truthful, fully informative and non-deceptive.

17. Alliance shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, and no incentives, monetary or otherwise, shall be given for withholding medically necessary services.

18. All personnel are responsible for ensuring that the work environment is free of discrimination or harassment due to age, race, gender, color, religion, national origin, disability, sex, genetic information, pregnancy or sexual orientation. Any form of harassment, including the creation of a hostile working environment, is completely prohibited. Personnel shall treat all coworkers, other professionals, visitors and consumers with courtesy, sensitivity, and respect.
**Reporting of Violations**

1. Employees who believe or become aware of any violation of this Code, Alliance policies, or applicable law, shall promptly report the violation to their supervisor, management, Compliance Officer, or by calling the Compliance Line (855-727-6721) or file a report through the Compliance Portal (www.alliancebhc.ethicspoint.com).

2. It is the policy of Alliance to promptly and thoroughly investigate reports of violations of this Code, Alliance policies, or applicable law. Personnel must comply with these investigations.

3. No reprisals or disciplinary action will be taken against personnel for good faith reporting of, or cooperating in the investigation of violations of this Code, Alliance policies, and applicable law.

4. Personnel who violate the Code, Alliance policies and procedures, or applicable law are subject to discipline up to and including dismissal. Personnel are responsible for knowing and complying with Alliance policies and procedures. Personnel who report their own violations or improper conduct will have such self-reporting taken into account in determining the appropriate disciplinary action.

**ATTESTATION:**

As an employee/contractor/intern with Alliance Behavioral Healthcare, I acknowledge that I have read and understand the Alliance Code of Ethics and Conduct. I also acknowledge that I have been given an opportunity to have any questions clarified. Furthermore, I agree to abide by the Code of Ethics and Conduct established by Alliance Behavioral Healthcare and to promote ethical and legal actions in my performance as an employee/contractor/intern.

Signature:

_____________________________________________  ________________________
Employee/Contractor/Intern      Date
ITEM: Executive Committee Report

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Minutes from the May 15, 2018, meeting are attached.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; Robert Robinson, CEO
**Board Executive Committee Meeting - Regular Meeting**

4600 Emperor Boulevard, Durham, NC 27703
4:00-6:00 p.m.

**Tuesday, May 15, 2018**

**Board Members Present:** None

**Guest(s):** None

**Staff Present:** Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Ann Oshel, Senior Vice-President/Community Relations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

**APPOINTED MEMBERS PRESENT:** ☒ Cynthia Binanay, M.A., Board Chair; ☒ Christopher Bostock, B.S.I.M., Previous Board Chair (via phone); ☒ George Corvin, M.D., Board Vice-Chair/Quality Management Committee Chair; ☒ James Edgerton, B.S., Finance Committee Chair; ☐ Lodies Gloston, M.A., Human Rights Committee Chair; ☒ Curtis Massey, J.D., Policy Committee Chair (via phone; entered at 4:15 pm); ☐ Lascel Webley, Jr., M.B.A., M.H.A, Audit and Compliance Committee Chair; and ☒ McKinley Wooten, Jr., J.D., Network Development and Services Committee Chair

**Guest(s):** None

**Staff Present:** Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Ann Oshel, Senior Vice-President/Community Relations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

### 1. Welcome and Introductions

### 2. Review of the Minutes

The minutes from the April 17, 2018, Executive Committee meeting were reviewed; a motion was made by Mr. Edgerton and seconded by Vice-Chair Corvin to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>Agenda Items</th>
<th>Discussion</th>
<th>Next Steps</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>3. Housing Grant Request</td>
<td>Ann Oshel, Senior Vice-President/Community Relations, mentioned a proposal that would be part of the current fiscal year’s budget. This proposal would provide additional housing for the people Alliance serves and would be similar to another housing grant the Board approved earlier this year.</td>
<td>The proposal will be forwarded to the Board’s Finance Committee meeting for review.</td>
<td>6/7/18</td>
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**Committee Action:**

The Committee agreed to recommend that the Board approves the grant pending review/approval by the Board’s Finance Committee.

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<tr>
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<th>Next Steps</th>
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<tr>
<td>4. Updates</td>
<td>a) Medicaid Reform/NC Legislation: Mr. Robinson mentioned that the next session of the North Carolina General Assembly starts May 16, 2018; he also mentioned potential topics. b) Board Vacancies: Chair Binanay provided an update on pending applications; two applicants will interview at next month’s meeting. c) Wake Crisis Facility: Mr. Robinson and Ms. Goodfellow provided an update and recommendations. The Committee discussed potential next steps.</td>
<td>a) None specified. b) None specified. c) None specified. d) Ms. Wolff will present this topic at the June Board meeting.</td>
<td>a) N/A b) N/A c) N/A d) 6/8/18</td>
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**Committee Action:**

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

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<tr>
<td>A motion was made by Vice-Chair Corvin to include the Wake Adult Crisis Facility in the FY19 reinvestment plan to be presented for approval at the June Board meeting, but note that the implementation of the facility shall be suspended until additional resources for long term sustainability are identified, single stream cuts are suspended by the General Assembly and a third party partner is identified to assist with the ongoing operating cost. Motion seconded by Mr. Edgerton; motion passed unanimously.</td>
<td>Committee will interview two additional applicants at the June Committee meeting.</td>
<td>6/21/18</td>
</tr>
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<td>d) JOHNSTON CONSOLIDATION: Ms. Wolfe provided a preliminary review of documents scheduled to be presented to the full Board at the June Board meeting. Additionally, she mentioned an upcoming community forum in Johnston County on May 30 at 4:00 p.m.</td>
<td></td>
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<td>5. Applicant Interview Committee members interviewed an applicant for a vacant seat representing Wake County. <strong>COMMITTEE ACTION:</strong> The Committee agreed to postpone a decision until the remaining applicants are interviewed at the next Committee meeting.</td>
<td>Committee will interview two additional applicants at the June Committee meeting.</td>
<td>6/21/18</td>
</tr>
<tr>
<td>6. June 7, 2018, Area Board Draft Agenda The Committee reviewed the agenda and provided input.</td>
<td>Ms. Ingram will add cancellation of the July meeting to the agenda and forward the revised agenda to staff.</td>
<td>5/15/18</td>
</tr>
<tr>
<td>7. Closed Session <strong>COMMITTEE ACTION:</strong> A motion was made by Vice-Chair Corvin to enter closed session pursuant to NCGS 143-318.11 (a) (6), (a) (1), and (a) (3) to consider the qualifications, competence, and performance of an employee; to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; and to consult with General Counsel regarding civil action. Motion seconded by Mr. Wooten. Motion passed unanimously. The Committee returned to open session.</td>
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</table>

**8. ADJOURNMENT:** the next Committee meeting will be June 19, 2018, at 4:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: June 7, 2018

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 consisting of Board members and consumers and/or their family members. Other non-voting members include at least one MCO employee and at least two provider representatives. 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 Chief Medical Officer, who has ultimate responsibility of oversight of quality management; the Quality Review Manager, who staffs the committee; and other staff as designated.

The Global QMC meets at least six times 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 QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees. The QM Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

The draft minutes and materials from the May 2018 meeting are attached. The committee did not meet in April. Old business consisted of an update on committee membership. The committee filled one of the Board member vacancies, is actively recruiting and interviewing for the other Board vacancy, and is recruiting another CFAC member. The committee was reminded about the Board survey, typically due at this time of year. Like last year, we are hoping for a 100% response rate.
QM talked briefly about ABLE accounts, at the request of the committee. These accounts allow family members to save money for individuals with IDD that do not negatively impact disability benefits. Alliance is attending training in a few weeks on the NC Treasurer’s plans for outreach and education. Information will be brought back to the committee after this training.

The committee reviewed results from two statewide surveys—consumer (called ECHO) and provider satisfaction. The ECHO survey noted some slight decreases in satisfaction, while the provider survey indicated continued high satisfaction. It is important to note the very small sample size with the ECHO survey. Data from these surveys, along with another survey expected to be received in the next month or two will be combined with quantitative data to create an action plan. The committee also looked at performance data.

Finally, QM presented updated on Quality Improvement Projects, including proposals for new projects. The committee approved the two new UM projects so that they can get started and will review data and recommendations for other projects in order to be prepared to vote on them at their June meeting.

**REQUEST FOR AREA BOARD ACTION:** Accept the report.

**CEO RECOMMENDATION:** Accept the report.

**RESOURCE PERSON(S):** George Corvin, Committee Chair; Wes Knepper, Quality Management Director
VOTING MEMBERS PRESENT: ☒ George Corvin, MD, Chair (Area Board); ☒ Duane Holder (Area Board); ☐ Vacant (Area Board); ☒ Joe Kilsheimer, MBA (CFAC); ☐ Vacant (CFAC)

NON-VOTING MEMBERS PRESENT: ☐ Cynthia Binanay (Area Board Chair); ☒ Tim Ferreira, BA (Provider Representative, I/DD)-via Phone; and ☒ Jeremy Reed (Provider Representative, MH/SA)

STAFF PRESENT: ☒ Tina Howard, MA (Quality Review Manager); ☒ Wes Knepper, LPC (Quality Management Director); ☐ Damali Alston, Director of Network Evaluation; ☐ Katherine Knutson (Chief Medical Officer); ☒ Doug Wright (Director Individual & Family Affairs); ☒ Linda Losiniecki, (Executive Assistant)

GUEST(S) PRESENT: Yvonne French, Director & Liaison DMH/DD/SAS; Mary Hutchings, Wake Co. Internal Audit;

REVIEW OF THE MINUTES: Motion made by Joe Kilsheimer to approve the February 1, 2018 and March 1, 2018 meeting minutes, seconded by Duane Holder, minutes were approved.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome &amp; Introductions:</td>
<td>Welcome: Dr. Corvin opened the meeting and welcomed new Global QMC member Duane Holder, other committee member and guests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Old Business:</td>
<td>Update on Membership (Dr. Corvin) Board Committee membership across the organization is down. The Board leadership is actively recruiting and screening members to the Board, which will bring new members to the board committees. The process of being on the Board of Directors is quite extensive, selecting new members takes time but brings very qualified and dedicated individuals. Eventually these new members will be actively involved with the board committees. Doug Wright has requested but has not received interest from CFAC members for this Global QMC.</td>
<td>Report on progress</td>
<td>Next meeting</td>
</tr>
<tr>
<td>3. New Business:</td>
<td>Area Board Survey (Dr. Corvin)</td>
<td>Tina will send out the non-board committee member survey.</td>
<td></td>
</tr>
</tbody>
</table>
Everyone should have received the letter and link to the Annual Board Survey. If you haven’t completed the survey, you are strongly encouraged to do so. It is still available on-line. There is also a non-board committee member survey available.

**ABLE Accounts (Tina)**
Similar to an HSA, I/DD consumers/parents can load an account with monies for services. Information was distributed that was obtained from the State Treasurer. There will be training on May 16, 2018 with additional information coming soon.

**ECHO & Provider Satisfaction Survey Results (Wes)**
Wes provided an overview of the Experience and Care Health Outcomes (ECHO) and Provider Satisfaction surveys and summarized results for Alliance. Both surveys are required by the state.

The Providers Satisfaction Survey is sent annually to providers working with LME/MCOs. The data obtained from this survey included improvement in Access to Care, Appeals and Authorizations. Alliance scored above average in all areas except claims (although agreement with statements are in 80%).

The ECHO survey is sent to consumers who received services through the MCO. This is conducted by an external survey company to obtain the information by phone or mail. Because of consumers changing address and phone numbers it hard to get a good amount of data.

For the adult survey, Alliance is ranked first on how well Clinicians communicate and ranked lower on getting treatment quickly and perceived improvement for 2017 from 2016. For the child survey, Alliance rank dropped in areas of: getting treatment quickly and how well clinicians communicate. Wes cautioned about results: sample sizes are very small and have a high margin of error.

Full, detailed results available on Alliance’s website: [https://www.alliancebhc.org/providers/quality-management/](https://www.alliancebhc.org/providers/quality-management/)

<table>
<thead>
<tr>
<th>Bring additional information from training to committee</th>
<th>Next meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Performance Dashboard (LME/MCO Operations) (Wes)**
Wes briefed the group of what type of data is reported through the dashboard. Alliance continues to work with the Providers to ensure the data being submitted is accurate and meets the required benchmarks.

**QIP Updates & Proposals for FY19 QIPs (Tina)**
There are 7 active QIPs and 2 were closed in February.

**Successes:**
- **TCLI Project-Private Housing** - Met the housing placement by doubling the goal within the first 6 months.
- **First Responder Project** - Alliance conducts test calls to the providers offering enhanced services after regular business hours. Performance is the highest since the start of the project. QM staff have implemented new interventions for quicker referrals to Compliance, when necessary.

**Red Flags:**
- **Crisis QIP** – The intervention in Wake County (extended hours for Open Access clinic) does not appear to impact closures of WakeBrook CAS. The Project Advisory Team reviewed other potential interventions, but none seem to impact measure in the near future. Recommending closure of project.
- **Access to Care-Routine/Urgent** – Maintained improvement with Routine callers, however, performance has not reached benchmark. There has been no improvement with Urgent callers. Team started several new interventions for Urgent population, although it is too early to determine impact. Recommending continuation of project to start new intervention for Routine and continue interventions for Urgent.

**Continuing Projects:**
QM is recommending continuing Care Coordination QIP, because new measures are being proposed; Intensive In-Home, because analysis is nearly complete; and Access to Care – Emergent due to change in Emergent definition.
**New Projects:**

- **UM Turn Around Time** – Reduce turn around time for Innovation requests.

- **UM Expedite Care Requests** – Expedite care requests for individuals discharging from inpatient and ED services.

- **TCLI Timeliness of Housing** – Contract with state requires a QI project every year. With successful closure of private housing project, QM is requesting approval for a new project with the goal of reducing the time from approval to moving into housing.

While the committee is not required to formally vote on all of the recommendations until June, Tina asked the committee if they would consider voting on the two new UM projects because URAC requires two active projects at any given time (the other projects were successfully closed in February). The committee agreed and took a vote on the 2 New UM QIPs. Motion by Duane to approve the two UM QIPs, seconded by Joe. Motion carried to approve the two new UM QIPs.

**Transportation Pilot (Doug)**

An exciting innovative pilot is being planned for the Access to Care-Urgent project for transportation services through LogistiCare. They would contract with ride share companies to transport Urgent Callers to their first appointment. This has been used in other areas of the country and has been successful. Doug is working with Care Coordination to see if any of the other populations we serve would benefit from this as well.

**Tina send Duane the TCLI Housing placement breakdowns by County.**

---

**Upcoming Meeting:**

Next meeting is scheduled for June 7, 2018 *(Time: 2:00 – 3:30 pm) Location: Alliance Home Office.*

Attendance encouraged for the upcoming June meeting, have many action items.

**Adjournment:**

Meeting adjourned at 3:20 p.m.
Categories

- **Global Rating**: An overall rating of the quality of counseling and treatment received.

- **Composite Measures**: Aggregates of multiple questions that measure similar dimensions of care and tx.

- **Priority Matrices**: Compares scores on composite measures to questions that predict overall satisfaction.

- **Care Coordination Measure**: Measures satisfaction with MCO Care Coordination functions.

- **Single-Item Measure**: Single question measures that have been selected as key topics.
Concerns About Interpretation

Very small sample size (n=79 adult, n=100 child)

Due to this sample, high margin of error

High/Low benchmarks are the range between all NC MCOs, not national standards

Care Coordination responses were too low to compare, especially for adult survey (need >= 30 observations)
*The margin of error ranged between 12-15% above and below the reported score for each MCO.*
• Ranked 7th overall for Rating of Counseling and Treatment

• ABH scored above the other MCOs on: How Well Clinicians Communicate (composite) and “Told about side effects of medication” (single item; statistically significant)

<table>
<thead>
<tr>
<th>Composite</th>
<th>MCO Avg.</th>
<th>Alliance</th>
<th>Rank</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Treatment Quickly</td>
<td>61.6%</td>
<td>56.5%</td>
<td>6</td>
<td>Ranked 1 in 2016</td>
</tr>
<tr>
<td>How Well Clinicians Communicate</td>
<td>89.2%</td>
<td>92.3%</td>
<td>1</td>
<td>Ranked 2 in 2016</td>
</tr>
<tr>
<td>Getting Treatment, Information</td>
<td>52.6%</td>
<td>32.2%</td>
<td>6</td>
<td>Ranked 3 in 2016</td>
</tr>
<tr>
<td>Perceived Improvement</td>
<td>55.2%</td>
<td>52.1%</td>
<td>7</td>
<td>Ranked 4 in 2016</td>
</tr>
<tr>
<td>Information About Treatment Options</td>
<td>54.9%</td>
<td>57.4%</td>
<td>3</td>
<td>Ranked 4 in 2016</td>
</tr>
</tbody>
</table>

• The priority matrices did not indicate areas of high priority. 4 of 5 composite areas resulted in medium priority categorization. How well clinicians communicate was low priority.
Adult Composite Areas

- Getting Treatment Quickly
- How Well Clinicians Communicate
- Getting Treatment, Information
- Perceived Improvement
- Information About Treatment Options

Legend:
- Alliance 2016
- Alliance 2017
- MCO Avg.
Child ECHO Survey

• Ranked 4\textsuperscript{th} overall for Rating of Counseling and Treatment

• ABH did not score significantly higher in any area or single item

• In 2016, Alliance ranked 1\textsuperscript{st} in 3 of the 4 composite areas. In 2017, these rankings declined (below).

<table>
<thead>
<tr>
<th>Composite</th>
<th>MCO Avg.</th>
<th>Alliance</th>
<th>Rank</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Treatment Quickly</td>
<td>64.1%</td>
<td>67.5%</td>
<td>3</td>
<td>Ranked 1 in 2016</td>
</tr>
<tr>
<td>How Well Clinicians Communicate</td>
<td>90.2%</td>
<td>89.0%</td>
<td>6</td>
<td>Ranked 1 in 2016</td>
</tr>
<tr>
<td>Getting Treatment, Information</td>
<td>48.9%</td>
<td>55.5%</td>
<td>3</td>
<td>Ranked 1 in 2016</td>
</tr>
<tr>
<td>Perceived Improvement</td>
<td>62.3%</td>
<td>60.7%</td>
<td>6</td>
<td>Ranked 7 in 2016</td>
</tr>
</tbody>
</table>
Child ECHO – Areas of Focus

Top Priority
- Perceived Improvement
- Getting Treatment and Information from the Plan

High Priority
- How Well Clinicians Communicate (Maintain high performance)

Medium Priority
- Getting Treatment Quickly
Provider Satisfaction Survey

March 28, 2018
Alliance improved in the areas of access, appeals, communications, and compliance from the 2016 survey.

Scores declined in authorizations, claims, provider networks, and training.

Alliance scored above the state average in all areas except Claims.

Training Needs

• There were considerable decreases in the number of providers requesting trainings on Clinical Coverage Policies and Audit Reimbursement from the 2016 survey.  
• Despite the decrease, Clinical Coverage Policies and Quality Management/Reporting remain the two highest areas of training requested from providers in 2017.
Access

Alliance Access Over Time

- LME/MCO staff is easily accessible for information, referrals, and scheduling of appointments
- LME/MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.

Alliance vs State

<table>
<thead>
<tr>
<th>LME/MCO staff is easily accessible for information, referrals, and scheduling of appointments</th>
<th>LME/MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance 2017</td>
<td>87.9</td>
</tr>
<tr>
<td>State 2017</td>
<td>85.6</td>
</tr>
<tr>
<td>Alliance 2017</td>
<td>86.0</td>
</tr>
<tr>
<td>State 2017</td>
<td>78.4</td>
</tr>
</tbody>
</table>
Appeals

Alliance Appeals Over Time

- My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).

Alliance vs State

- My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).

- Alliance 2017: 80.8
- State 2017: 77.5
Authorizations

Alliance Authorizations Over Time

- Blue line: Authorizations for treatment and services made within the required timeframes.
- Orange line: Denials for treatment and services explained.
- Green line: The authorizations issued are accurate.

Alliance vs State

- Blue bars: Alliance 2017
- Red bars: State 2017
- Top bar: Authorizations for treatment and services made within the required timeframes.
- Middle bar: Denials for treatment and services explained.
- Bottom bar: The authorizations issued are accurate.

<table>
<thead>
<tr>
<th>Year</th>
<th>Alliance 2017</th>
<th>State 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td></td>
<td></td>
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<tr>
<td>2015</td>
<td></td>
<td></td>
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<tr>
<td>2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

91.5 90.6
85.1 83.6
95.3 94.8
Claims

Alliance Claims Over Time

- Blue line: When I speak with staff about claims issues I am given consistent and accurate information. Our claims are processed in a timely and accurate manner.
- Green line: Our claims are processed in a timely and accurate manner.

Alliance vs State

- Blue bar: When I speak with staff about claims issues I am given consistent and accurate information.
- Red bar: Our claims are processed in a timely and accurate manner.

- Alliance 2017: 82.2
- State 2017: 84.3
- Alliance 2017: 88.6
- State 2017: 91.6
The LME/MCOs website has been a useful tool for helping my agency find the tools and materials needed to provide services.
The LME/MCO staff conducts fair and thorough investigations. After the audit or investigation, LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable.

<table>
<thead>
<tr>
<th>Year</th>
<th>Alliance</th>
<th>State</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td></td>
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<td>2016</td>
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<td></td>
</tr>
<tr>
<td>2017</td>
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</table>

The LME/MCO staff conducts fair and thorough investigations. After the audit or investigation, LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable.
Provider Networks

Alliance Provider Networks Over Time

- Provider Network meetings are informative and helpful.
- Provider Network keeps providers informed of changes that affect my local Provider Network.
- Provider Network staff are knowledgeable and answer questions consistently and accurately.

Alliance vs State

- Provider Network meetings are informative and helpful.
- Provider Network keeps providers informed of changes that affect my local Provider Network.
- Provider Network staff are knowledgeable and answer questions consistently and accurately.
- How would you rate your overall satisfaction with Provider Network?

Alliance 2017 vs State 2017

Provider Network meetings are informative and helpful: 90.3 vs 87.8
Provider Network keeps providers informed of changes that affect my local Provider Network: 86.8 vs 85.6
Provider Network staff are knowledgeable and answer questions consistently and accurately: 85.4 vs 83.5
How would you rate your overall satisfaction with Provider Network?: 87.8 vs 85.1
Stakeholders

Alliance Stakeholders Over Time

- Customer Service is responsive to local community stakeholders.
- Our interests as a network provider are being adequately addressed in the local Provider Council.

Alliance vs State

- Customer Service is responsive to local community stakeholders.
- Our interests as a network provider are being adequately addressed in the local Provider Council.

Alliance 2017: 87.7
State 2017: 84.7

Alliance 2017: 81.1
State 2017: 80.1
Training

Alliance Training Over Time

Alliance vs State

Claims trainings meet my needs. Information Technology trainings are informative and meet my agency's needs. Trainings are informative and meet our needs as a provider/agency.

Information Technology trainings are informative and meet my agency's needs.

Claims trainings meet my needs.
Information Technology trainings are informative and meet my agency's needs.
Trainings are informative and meet our needs as a provider/agency.

Alliance 2017  State 2017
Overall

Alliance Overall Over Time

- LME/MCO staff responds quickly to provider needs. Technical assistance and information provided by staff is accurate and helpful. Please rate your overall satisfaction with the LME/MCO.
- Technical assistance and information provided by staff is accurate and helpful.
- Please rate your overall satisfaction with the LME/MCO.

Alliance vs State

- LME/MCO staff responds quickly to provider needs.
- Technical assistance and information provided by staff is accurate and helpful.
- Please rate your overall satisfaction with the LME/MCO.

Alliance 2017: 82.3, 80.1, 91.0, 88.8, 87.7
State 2017: 85.4
Quality Improvement Projects

Presentation to the
Global Quality Management Committee
(May 2018)
Quality Improvement Projects

Summary:
- Open/Active: 7 projects
- Closed (in 2018): 2 projects (IDD Timeliness, PCP Quality)

Successes:
- TCLI Private Housing Project – 15 individuals in private housing in Wake County (as of March 2018), exceeding benchmark of 11
- First Responder – 82% successful test calls (nearly reaching benchmark of 85%), best result since start of project, implemented new interventions (quicker referral to compliance, training, outreach)
Quality Improvement Projects

Red Flags:

- Crisis QIP: Wake County – while closures of CAS have decreased, it is highly doubtful that it was due to the intervention of Open Access clinic opening after regular business hours; considered other interventions with no success

- Access to Care Routine/Urgent QIP: Continued poor show rate of individuals identified as Urgent showing for care within 2 days, even worse for individuals releasing from incarceration
Quality Improvement Projects

Recommendations (existing projects):

- Close Crisis QIP: Wake County – Project Advisory Team & CQI have recommended closure
- Access to Care Routine/Urgent QIP: Implement new intervention for Routine callers; Urgent: continue new interventions for another quarter to determine efficacy, focus on highest risk individuals (consumer safety)
- MH/SUD Care Coordination – Identify new measures and interventions
- TCLI Private Housing – Close due to success
Quality Improvement Projects

Recommendations (existing projects):
Still being measured (continue until analysis complete)
  o  IIH – Analysis being finalized
  o  Access to Care – Emergent – Urgency level being revised, performance may change substantially
Quality Improvement Projects

Recommendations:

New Projects

- UM Turn-Around Time (TAT) for Innovations requests – Reduce average TAT for Innovations requests, meets URAC requirement for UM project
- UM Expedite Care Requests – Expedite requests for services following acute stabilization (ED, inpatient, crisis), clinical, Meets URAC requirement for consumer safety project
- TCLI Timeliness of Housing – Reduce days from housing slot to housing and % housed in 90 days, meets contract requirement for at least one TCLI QIP/year
Detailed Results for QIPs
Access to Care - Emergent

Goal:

- 77% of callers identified as needing Emergent Care show for the care within 2:15 hours (state benchmark, which we feel is unreasonable, is 97%)

Interventions:

- Revised Mobile Crisis services (start: July 2017, delayed start); Centralized Dispatch started December 1, 2017 (delayed)
- Improve internal coding and data entry (start: January 2017)
- Conducted another barrier analysis to identify any other interventions that may improve performance (none identified within Alliance’s control)
Access to Care - Emergent

Results (Baseline – 67%):

<table>
<thead>
<tr>
<th>FY 17, Q1: Jul-Sep 2016*</th>
<th>FY 17, Q2: Oct-Dec 2016</th>
<th>FY 17, Q3: Jan-Mar 2017</th>
<th>FY 17, Q4: Apr-Jun 2017</th>
<th>FY 18, Q1: Jul-Sept 2017</th>
<th>FY 18, Q2: Oct-Dec 2017</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>69%</td>
<td>67%</td>
<td>54%</td>
<td>53%</td>
<td>52%</td>
<td>52%</td>
<td>77%</td>
</tr>
</tbody>
</table>

- Mobile Crisis Team response time improved to 73% through FY 17, Q2, then started to decrease to 50% in FY 18, Q1
- Centralized Dispatch delayed until December 1, 2017
- Medical team considering revising definition
- Project Advisory met in December: Provider Network Clinical Evaluation follow up with Teams re: response times, monitor for another quarter (Quarter 3) after start of Central Dispatch

*Percent met revised after error detected.
Goals:

- Increase consumer initiation in services after phone call based on need—63% within 14 days for Routine and 62% in 2 days for Urgent callers

Methodology changes for FY 17 & FY 18

- Use only claims submitted to calculate measure due to inaccuracy of Alpha report
- Revised baselines-Routine: FY 16, Q1; Urgent: FY 16, Q4

*All claims for Q2 most likely not submitted, yet.*
Access to Care – Urgent/Routine

Interventions-Routine:

- Reminder calls a few days before appointment (started: January 2016)
- Feedback letters to providers (started: February 2017)
- Provider meetings – Alliance met with providers in Durham and Johnston to discuss barriers/solutions; reviewing suggestions (started: Spring 2017)
## Routine Callers: Results

### Percent Met

- The table below illustrates performance based on claims:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 14</th>
<th>% show in 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q1 (Jul-Sep 2015)</td>
<td>1,051</td>
<td>424</td>
<td>40%</td>
</tr>
<tr>
<td>FY 16, Q2 (Oct-Dec 2015)</td>
<td>959</td>
<td>430</td>
<td>45%</td>
</tr>
<tr>
<td>FY 16, Q3 (Jan-Mar 2016)</td>
<td>778</td>
<td>370</td>
<td>48%</td>
</tr>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>806</td>
<td>361</td>
<td>45%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>753</td>
<td>370</td>
<td>49%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)</td>
<td>700</td>
<td>309</td>
<td>44%</td>
</tr>
<tr>
<td>FY 17, Q3 (Jan-Mar 2017)</td>
<td>697</td>
<td>357</td>
<td>51%</td>
</tr>
<tr>
<td>FY 17, Q4 (Apr-Jun 2017)</td>
<td>665</td>
<td>316</td>
<td>48%</td>
</tr>
<tr>
<td>FY 18, Q1 (Jul-Sep 2017)*</td>
<td>563</td>
<td>262</td>
<td>47%</td>
</tr>
<tr>
<td>FY 18, Q2 (Oct-Dec 2017)**</td>
<td>617</td>
<td>281</td>
<td>46%</td>
</tr>
</tbody>
</table>

*Data re-run and validated in January 2018.*

**Initial analysis, data on claims incomplete due to lag in submitting claims.**

---

**Intervention:** Reminder Calls
At Baseline (FY 16, Quarters 1 & 2), 42% of individuals who called Alliance’s Access & Information Center requesting services received those services within 14 days of the call. The percent increased significantly to 46% of callers in the 1st post-intervention time period (FY 16, Quarters 3 & 4) and 47% in the 2nd post-intervention time period received services in 14 days*. **Best outcomes were detected from individuals/guardians who talked directly to Call Center staff, second best: message left on voicemail.**

* A Chi-Square statistic was used to calculate significance of difference. In both post-tests, results were found to be statistically significant, FY 16 Q3-4: $X^2 (1, n=3,593) = 5.41, p=0.20$; FY 17 Q1-2: $X^2 (1, n=3,461) = 5.62, p=0.18$. Significance was also found using the Fisher’s Exact Test (FY 16 Q3-4: $p=.021$ (two tailed); FY 17 Q1-2: $p=.018$ (two tailed)). **Initial analysis, data on claims incomplete due to lag in submitting claims.
This graph clearly shows a difference in results by insurance type. Individuals with Medicaid are more likely to show for care within 14 days of the call than those without the benefit. This difference has increased from 16% and 8% in FY 17 Q1 and Q2, respectively, to 20% and 19% in FY 18 Q1 and Q2, respectively. The non-Medicaid show rate has continued to decline for two quarters since the beginning of FY 18. This decline does not appear to be related to availability of appointments because approximately 94% of callers receive appointments within 14 days (similar to Medicaid).

*Data re-run and validated in January 2018.
**Initial analysis; data on claims incomplete due to lag in submitting claims.
Routine Callers: Interventions

Reminder calls:

- Reminder calls started in the beginning of FY 16, Q3
- Calls are continuing to be made by Access Center staff about 1 – 3 days before appointments
- Challenge: not all callers receive reminders (report not pulling all data, report pulling data on appointments not in the Access to Care report, unable to reach callers)
  - Update: Reminder Call Report migration to MicroStrategy (to resolve issue of missing data on appointments) is 91% complete
Routine/Urgent Callers: Interventions

Provider feedback letters

• In February 2017, all provider receiving more than one referral from the Access Center received a letter on performance (from FY 16, Q4)

One example of a success story: A provider reported that, after receiving our letter, the number of days between referral and assessment in two Durham programs was reduced by as much as 10-21 days.

• QM sent another round of letters in January 2018 regarding performance in FY 17, Q4

• QM provided technical assistance to providers who requested it
Routine/Urgent Callers: Interventions

Provider feedback letters

• Barriers identified:
  • Callers not scheduled in specified timeframe (Caller selected date outside of 2 days: 4 Routine; 24, 7%, Urgent) or rescheduling
  • Callers were seen, but billing was not submitted/counted because:
    • Caller was not enrolled in our system, provider needed to complete enrollment for person in order to submit claim
    • Clinicians who completed CCA were not fully credentialed in our network (process can take up to 180 days, avg: 4-6 months)
    • Caller presented for crisis services after the call (if crisis facility billed for service)-not counted if caller was coded as Routine (15, 2% of, cases in FY18, Q1)
    • Caller has Medicare (outpatient not billed to Alliance)-3% of callers*

*The percent of Routine and Urgent callers with private insurance is even smaller: approximately 0.65% and 1%, respectively.
Above is a list of the providers that receive more than 20 referrals from the Call Center. The chart compares performance in FY 16 (before letter was sent) to performance in FY 17 (after letter was sent). Additionally, providers received a presentation on this QIP which included difference in provider performance (no provider names were used on presentation) and the five providers receiving the most referrals were invited to a meeting with Alliance. 6 of the 10 agencies improved performance (only 2 of the 4 who attended the meetings improved, although the difference in performance is very slight, -3%).
Urgent Callers: Results

Percent Met

- The table below illustrates performance based on claims:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 2</th>
<th>% show in 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>452</td>
<td>101</td>
<td>22%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>479</td>
<td>100</td>
<td>21%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)</td>
<td>448</td>
<td>72</td>
<td>16%</td>
</tr>
<tr>
<td>FY 17, Q3 (Jan-Mar 2017)</td>
<td>422</td>
<td>87</td>
<td>21%</td>
</tr>
<tr>
<td>FY 17, Q4 (Apr-Jun 2017)</td>
<td>421</td>
<td>60</td>
<td>14%</td>
</tr>
<tr>
<td>FY 18, Q1 (Jul-Sep 2017)*</td>
<td>406</td>
<td>80</td>
<td>20%</td>
</tr>
<tr>
<td>FY 18, Q2 (Oct-Dec 2017)**</td>
<td>341</td>
<td>61</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Data re-run and validated in January 2018.
**Initial analysis, data on claims incomplete due to lag in submitting claims.
Urgent Callers: Results

This graph clearly shows a difference in results by insurance type. With the exception of FY 17, Quarter 1, individuals with Medicaid are more likely to show for care within 2 days of the call than those without the benefit. The difference may be due, in part, to the large percent of individuals releasing from prison (80%-90% do not have Medicaid) who have very low show rates (FY18, Q2=7%). Interestingly, there is little difference between the percent of callers with timely appointments—an average of 61% for individuals with Medicaid and 64% for individuals without Medicaid (from FY17Q1-FY18Q2).
Urgent Callers: Interventions

- Letters to inmates – recently started in July, letters sent to home addresses, no letters sent if person is releasing to homeless shelter

- Results:
  - Overall: 7% showed in 2, 33 (40% of total) letters sent in FY18, Q2
  - Higher % showing in cases in which letter sent, data analysis does not take into account other factors influencing show rate

*Percent calculated as individuals showing for care over number of individuals in each category (letter sent vs. letter not sent). For example, 4 individuals of the 33 cases in which letters were sent showed for care in 2 days. All who showed had appointments within timeframe (either 2 or 7 days), with the exception of one person.*
Urgent Callers: Interventions

• Increase appointments:
  • Reminder about putting appointments into Slot Scheduler emailed to providers in Provider Newsletter

• Targeted outreach to providers in Wake County:
  • One provider: Researching internal data, developing initiative to expand availability and access
  • Another provider: Starting April 2, filled dedicated intake coordinator position, adding appointments to Slot Scheduler, improved phone call system to allow any caller to talk to live person
  • Another provider: Working with Call Center and Provider Network Specialist to resolve issues regarding assessment appointments
Urgent Callers: Interventions

• Transportation Pilot:
  • Existing projects: Community Relations working with Johnston County Walk In Clinic to offer funding for transportation, contract for Wake County provider to offer peer support to increase engagement
  • New idea: Community Relations, Call Center, Provider Operations, QM developed proposal to use Rideshare company (who contracts with individual drivers, cabs, or Lyft drivers) to transport individuals (discharged from inpatient or Access Center callers) to/from initial appointments; combining efforts with 7-Day Challenge initiative
 Improve MH/SUD Care Coordination

Goal:

- 80% of individuals assigned to Care Coordinator, and recently discharged from inpatient, receive contact within 2 business days of discharge

Interventions:

- Clarification of “First Contact” definition
- Additional drop-down boxes to define contact attempts
- Training all Care Coordination staff-Supervisors and direct care
Improve MH/SUD Care Coordination

Next Steps:

- Completed training
- Additional measurements taken, performance still poor due to confusion about changes
- Consider changing measures/interventions due to changing business practices
Goals:

- Reduce ED admissions of youth in best practice pilot programs (FCT and Enhanced TFC) in Cumberland County
- Increase the number of consumers utilizing Same Day/Open Access (Tier II) after 3:00 PM by 20%
- Reduce percentage of time that WakeBrook CAS in Wake County is on diversion by 2%

Interventions:

- (Cumberland) Family Centered Treatment (FCT) and Enhanced Therapeutic Foster Care (TFC) pilots
- (Wake) Encourage a provider offering Open Access (Tier II) to open after regular business hours
1. **Reduction in ED Admits for youth in FCT & ETFC (Cumberland County)**

Goal: Less than 5% (consider closing measure)

- **Baseline (April 2015-February 2016): 25%**
  *Data measures the number of youth in these services who had an Emergency Department admission during the 90 days prior to their initial service authorization effective date*

- **Measure #1 (Sept 2015 – Aug 2016): 10%**
  *Data measures the number of youth in these services who had an Emergency Department admission 90 days after their last claim date of service (90 days post discharge from the program)*
2. Increase # of consumers using Open Access after 3 PM (Wake County)

Goal: At least 8% of total served

Intent behind measure: More individuals, not needing crisis services, are diverted to Open Access clinic instead of going to WakeBrook CAS

- Baseline (Feb - April 2016): Less than 10/831 (.24%)
- Measure #1 (May – Jul 2016): 32/719 (4.45%)
- Measure #2 (Aug – Oct 2016): 14/757 (1.85%)
- Measure #3 (Nov 2016 – Jan 2017): 33/609 (5.42%)
- Measure #4 (Feb – April 2017): Less than 10/189 (3.70%)
- Measure #5 (May – July 2017): 43/374 (11.49%)
- Measure #6 (Aug – Oct 2017): 41/343 (11.95%)
2. **Increase # of consumers using Open Access after 3 PM (Wake County)**

Even though Open Access has continued to expand hours, the number of individuals presenting during those hours, after the initial three months, decreased through May. This provider switched to an “Advanced Access” model in which individuals seeking services can call the clinic to be screened, then given an appointment time. This change resulted in a **69% decrease** (from Nov-Jan to Feb-April) of individuals being served. Even though the number served began to increase in May, the clinic is still serving half of the individuals they served in early 2016.
**Improve Crisis Services**

**Crisis QIP Measures: 3. Reduce % of operating hours that CAS’ back door (IVC) is closed** (Wake County)

Goal: 21%; Baseline (Jan-June 2014): 23%

Measurements:
- #1 (Jan – June 2015): 44%
- #2 (Jan – June 2016): 43%
- #3 (Jan – June 2017): 23%
Crisis QIP Measures: 4. Reduce % of operating hours that CAS’ front door (“full diversion”) is closed (Wake County)

Goal: 13%; Baseline (Jan-June 2014): 15%
Conclusions:

- Measure #2 (% of individuals served in Open Access after regular business hours) met goal for two reporting periods
- With that said, there is no evidence suggesting that intervention (Open Access offering later hours) had an impact on closures—question asking individuals if they would have presented to CAS was not administered
- Plus, data suggests that other factors influenced reduction in closures:
  - Additional inpatient beds - average length of stay for individuals disposed to the WBIPU decreased significantly from 46:27 hours (1.94 days) in 2016 to 23:41 hours (0.99 days) in 201*

*Significance based on T Test: t (229) = 5.07, p<.001
Conclusions, continued:

- Data suggests that other factors influenced reduction in closures:
  - Administrative changes - Beginning of October, there were sharp decreases in closures (avg % closed):
  - PAT recommended closure due to failure

Next steps: Present recommendation to UM Committee, CQI, and Global Quality Management Committee
First Responder

Test crisis lines of providers after business hours

**Goals:** 85% of calls meet standard for satisfactory (call goes through successfully and it is answered live or returned within 1 hour)

**Interventions:**

- Providers assigned to “Tiers” based on previous performance (some called more frequently, others less)
- Written feedback to all providers after calls
- Refer to Compliance the providers who continue to score “unsatisfactory”, issue Plan of Correction if poor performance continues
- Compare test results with actual data of consumers, open to enhanced services, using crisis services
Results:

- Performance continues to improve, nearly meeting benchmark

- Interventions: added outreach calls to providers with 2 consecutive unsatisfactory performances prior to 5th measure

- Since benchmark still not met, barrier analysis conducted. PAT recommended (based on analysis): Outreach calls, in addition to emails, after every unsatisfactory call; referral to Compliance after 2 unsatisfactory calls (from 3); training for targeted providers; validate tier methodology by calling all providers at same frequency for one year

### Measurements

<table>
<thead>
<tr>
<th>Call Cycle</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>6th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>65% (N=17)</td>
<td>81% (N=34)</td>
<td>79% (N=22)</td>
<td>64% (N=9)</td>
<td>72% (N=18)</td>
<td>82% (N=18)</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>35% (N=9)</td>
<td>19% (N=8)</td>
<td>21% (N=6)</td>
<td>36% (N=5)</td>
<td>28% (N=7)</td>
<td>18% (N=4)</td>
</tr>
<tr>
<td>Total calls made</td>
<td>26</td>
<td>42</td>
<td>27</td>
<td>14</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>
Goals: Reduce use of crisis services, reduce behavioral health interference with daily activities, and decrease severity of mental health symptoms.

Interventions:

- IIH providers to implement specific, family-focused EBP with external fidelity monitoring
- Training and technical assistance to providers
Update:

- Evidence based practice models selected, Alliance offered subsidized trainings in June 2016
- Implementation plans included in FY17 contracts, implementation deadline March 2017
- Collected post-intervention data
- Analysis being finalized
TCLI-Increase private housing

Goal:
- Increase the # of individuals (in TCLI population) housed in private housing to 11 (in Wake County)

Baseline: Only 6 individuals were housed privately in all FY 17 (Wake county)

Interventions:
- Standardized internal process for housing placements
- Training to property owners on Alliance, housing program, anti-stigma and recovery oriented system of care (measure change in owners’ perception and willingness to rent to our population)
- Centralize/Simplify internal data collection/analysis
- Created marketing campaign
TCLI-Increase private housing

Update:

- Internal process for housing placements standardized
- IT creating a SharePoint site to centralize internal data, new database will include additional data validation controls, allows for simplified data analysis
- Small sub-group created brochure, landlord packet, revamped website, created videos, and presenting program at conferences
- Outreach to landlords – landlords in “preferred” zip codes of Raleigh identified, received marketing blast and invitation to attend training, incentives approved for new landlords, smaller training took place in September, larger training took place in December (6 participants), training to partners in March
TCLI-Increase private housing

Results:

- Goal exceeded!

Private - FY17 vs FY18

- Wake: FY17: 6, FY18: 15
- Durham: FY17: 7, FY18: 26
- Cumberland: FY17: 7, FY18: 8
- Johnston: FY17: 0, FY18: 1
- Out of Catchment: FY17: 2, FY18: 1
### Alliance Behavioral HealthCare

**Proposed Quality Improvement Projects for FY19**

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Description</th>
<th>Data Source(s)</th>
<th>Duration</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>[TCLI Housing TAT]</td>
<td><strong>Concern:</strong> LME-MCOs are required, under provisions of the DOJ Settlement Agreement and DMA contractual obligations, to report performance measures monthly for the percentage of individuals transitioned to supportive housing within 90 days of housing slot issue date. During Fiscal Year 2017 (July 1, 2016 through June 30, 2017), Alliance housed 27.1% of individuals within 90 days of slot issue date. This is significantly below the established State performance target of 80%. As of January 2018, Alliance’s average remains below the State target for Fiscal Year 2018 and the average number of days from housing slot issue to transition is 255.</td>
<td>LME-MCO State Performance Dashboards (provided by DMA); Internal Sharepoint TCLI Database</td>
<td>February 2018 through February 2019</td>
<td>LME/MCO POC: QR Coordinator II Additional Resources: CC Director, TCL Supervisors, DOJ Program Manager, Exec. VP Care Management</td>
</tr>
</tbody>
</table>

#### Alliance Behavioral Healthcare

<table>
<thead>
<tr>
<th>Month</th>
<th>Target</th>
<th>Stretch</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>3</td>
<td>9</td>
<td>33.3%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>1</td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>3</td>
<td>11</td>
<td>27.3%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>80.0%</td>
<td>85.0%</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>80.0%</td>
<td>85.0%</td>
<td>3</td>
<td>11</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

Research Question: Would standardizing TCL workflows and improving provider engagement increase the percentage of individuals who transitioned to supportive housing within 90 days of housing slot issue date.

Data will be pulled and analyzed on a quarterly basis.
### QI Project:

**Goals:**

- Increase percentage of individuals who transition within 90 days of housing slot issue date to at least 60%.

**Proposed Interventions:**

- Address provider delays related to submission of person-centered plans.
- Implement internal process improvements to strengthen TCL standardization of workflows.
- Strengthen provider engagement and collaboration by improving lines of communication, clarifying procedures, and increasing level of TCL technical assistance.

Specific interventions around internal process improvements have begun as of March 2018:

- Adding enhancements to Sharepoint database to streamline workflows for TCL staff (i.e. tracking and auto alerts)
- Visual management utilization to highlight problems areas for quick action.
- Review of ACTT & TMS Scopes of Work to outline provider responsibility. Contingency plan if interventions are not working would be to conduct root cause analyses to identify process bottlenecks or barriers to housing.
## Project Name
(Areas of Focus, Clinical vs. Non-Clinical, Requirements Met)

### UM-Expedite Post-Acute Care
(Clinical, MCO-wide, URAC-UM, Consumer Safety)

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Description</th>
<th>Data Source(s)</th>
<th>Duration</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM-Expedite Post-Acute Care</td>
<td>Concern: Connection with post-discharge services is critical to reduce readmissions to inpatient and crisis services. In 2017, the 30-day readmission rate for Alliance consumers was an average of 8% for individuals with Medicaid. Additionally, the percent of individuals with a primary mental health disorder showing for care within 7 days after inpatient discharges is 52%, the same as the percent for individuals with primary substance use disorders (September 2017 data, Division of Medical Assistance). Filtering for only children, the percent engaged in services within 7 days increases to 71%. While many factors influence timely engagement, this proposal is offering to remove or reduce authorization review time as a barrier to timely care. Most intensive adult services allow for short-term pass throughs, while child services do not. In a sample of youth who were admitted to EDs in September 2017, 41 received enhanced or residential services following the admission. The average turn-around time for authorization requests was 9 days, above the average for all non-expedited or Innovations requests (average is 8 days). Research Question: Do UM actions reduce the time between post-acute stabilization and engagement in ongoing care?</td>
<td></td>
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</tr>
</tbody>
</table>
| QI Project              | Goal: Reduce the amount of time between discharge from acute stabilization (admissions to inpatient, crisis, and Emergency Departments) and start of ongoing care for pilot population (children). Measures:  
- Reduce average turn-around time for expedited authorization requests for post-acute care to 3 days.  
- Increase number of expedited requests for post-acute ongoing care submitted by providers (outpatient or inpatient/ED) by 10%                                                                                      | Alpha, MS      | July 1, 2018 – June 30, 2019 | LME/MCO POC: QR Coordinator II  
Additional Resources: UM Director, Care Coordination, Senior Medical Staff, Senior VP-Clinical Operations |
<table>
<thead>
<tr>
<th>Project Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Areas of Focus, Clinical vs. Non-Clinical, Requirements Met)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce average days between acute care and ongoing care to 7 days</td>
</tr>
<tr>
<td>Proposed interventions:</td>
</tr>
<tr>
<td>• Change benefit package for children’s post-acute stabilization services: Allow 2 week pass-through for enhanced community based services (MST, IIH, Day Treatment)</td>
</tr>
<tr>
<td>• Allow providers to request expedited review for residential services following post-acute stabilization for children</td>
</tr>
<tr>
<td>• Provide training to Hospital/Crisis Liaisons on expedited requests, who will, in turn, educate providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source(s)</th>
<th>Duration</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

See Driver Diagram below to illustrate how these interventions would be helpful:

```
Reduce days between discharge from acute stabilization to ongoing care

Make decision on authorization requests within 3 days

Remove authorization review requirement

Allow requests to be identified as “Expedited” in Alpha system

Allow 2-week pass through
```
## Project Name
(Areas of Focus, Status, Requirements Met)

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Description</th>
<th>Data Source(s)</th>
<th>Duration</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Turn Around Time</td>
<td>Concern: The turn-around time (TAT) for UM decisions (the amount of time it takes to make a decision on a service request) is an important quality element for UM and a URAC standard. Overall, the average TAT has remained well within the requirement of 14 days. However, there has been an increase in average TAT for Innovations reviews—from 7.59 days (Jan-Mar 2017) and 7.29 days (Apr-Jun 2017) to 8.25 days (Jul-Sept 2017). The longest TAT for Innovations authorizations are those that are denied—14.5 days for administrative denials and 10.54 for clinical denials. 11% of all Innovations authorizations are deemed unable to process, an increase from 6% in Jan-Jun 2017. Additionally, this decision took an average of 8.23 days, an increase of 1.2-1.4 days from Jan-Jun 2017. The average TAT for approved authorizations (those expected to take the least amount of time) was 8.13 days. Additionally, 89% of reviews that exceed 14 days involve Innovations services. Additionally, Alliance has received allocation for increased waiver slots however, this did not result in new IDD UM Care Manager positions. This requires the department to improve in efficiencies to meet the demands of the increase in waiver reviews anticipated. IDD UM reviewers reported that missing documentation is a key reason for longer TAT and coding reviews as unable to process. Research Question: Would standardizing the Care Coordination process reduce TAT for Innovations reviews?</td>
<td>Alpha, MS (SAR Decision Date &amp; IDD ISP Submission Reports)</td>
<td>October 2017 – June 30, 2019</td>
<td>LME/MCO POC: QR Coordinator II</td>
</tr>
<tr>
<td>(Non-Clinical, MCO-wide, URAC-UM)</td>
<td></td>
<td></td>
<td></td>
<td>Additional Resources: UM Director, Care Coordination-IDD Director, Exec. VP-Care Management</td>
</tr>
</tbody>
</table>
**QI Project:**

**Goals:**
- Reduce average TAT for Innovations authorizations to 8 days or less
- 100% of administrative denials reviewed within 10 days or less
- Reduce average TAT for approved authorizations to 6 days or less

**Proposed interventions:**
- Transition IPRS and B3 requests to licensed staff working in MH/SUD UM to reduce IDD workload and improve quality of clinical reviews
- Implement checklist for Care Coordinators to ensure all needed paperwork is included with request
- Monthly data analysis (as automated as possible)

**Real-time feedback** (by UM Administrative Staff) to Care Coordinators & their Supervisors regarding presence and timeliness of checklist submission. Backup Interventions:

If performance has not improved within 3 months after start of QIP, the PAT will consider the following additional interventions:
- UM create a reminder system, several days prior to deadline, for Care Coordinators and their Supervisors when information is missing or not yet received
<table>
<thead>
<tr>
<th><strong>Project Name</strong></th>
<th><strong>Project Description</strong></th>
<th><strong>Data Source(s)</strong></th>
<th><strong>Duration</strong></th>
<th><strong>Resources Needed</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Areas of Focus, Status, Requirements Met)</td>
<td>- Share checklist with individuals, their families, and providers in notice of administrative denial letters</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ITEM: Fiscal Year 2018-2019 Property & Liability Insurance

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: Revised Delegation of Authority Policy (Policy G-10) requires non-provider contracts $250,000 or over (within one fiscal year) shall be presented to the Board Finance Committee for consideration and authorization for approval by the Board. Documents for the FY18/19 property & liability insurance and costs to bind coverage are attached.

REQUEST FOR AREA BOARD ACTION: Approve the proposal.

CEO RECOMMENDATION: Accept the proposal.

RESOURCE PERSON(S): Sara Pacholke, Senior Vice-President/Financial Operations and Finance Committee Liaison
ITEM: FY19 Classification and Grade Plan

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: Annually in July, Alliance is required to report its classification and grade plan to the North Carolina Office of State Human Resources (OSHR). This report requires that the Alliance Board review and approve this Annual Plan. In addition, a compensation survey was conducted to ensure our classification grades are competitive within the current market. The resultant changes to the classification grade levels are highlighted on the attached document.

REQUEST FOR AREA BOARD ACTION: Approve the report.

CEO RECOMMENDATION: Approve the report.

RESOURCE PERSON(S): Cheala Garland-Downey, Senior Vice-President/Human Resources
<table>
<thead>
<tr>
<th>Working Title</th>
<th>Classification</th>
<th>Salary Grade</th>
<th>Min</th>
<th>Mid</th>
<th>Max</th>
</tr>
</thead>
<tbody>
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ITEM: FY19 Public Hearing and Budget Approval

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: Per GS 159-12 (b), a public hearing shall be held to allow any persons who wish to be heard on the budget to appear. The FY 2018-2019 Budget is also being presented to the Board for approval and adoption per GS 159-13.

REQUEST FOR AREA BOARD ACTION: Approve the proposal.

CEO RECOMMENDATION: Approve the proposal.

RESOURCE PERSON(S): Robert Robinson, Chief Executive Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
Alliance Behavioral Healthcare
Annual Budget
FY 2018-2019

Board of Directors

Cynthia Binanay, Chair

George Corvin, Vice Chair

**Durham County**

Cynthia Binanay

Commissioner Heidi Carter

David Curro

Curtis Massey

Pam Silberman

Lascel Webley, Jr.

Vacancy

**Wake County**

George Corvin, MD

James Edgerton

Donald McDonald

Commissioner Erv Portman

McKinley Wooten, Jr.

Vacancy

**Cumberland County**

Commissioner Glenn Adams

Christopher Bostock

Lodies Gloston

Duane Holder

**Johnston County**

Vacancy

Robert Robinson, CEO
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June 7, 2018

Alliance Board Members,

We are pleased to share with you our FY19 budget for your approval.

The approved budget reflects a few changes from the recommended budget that was presented to you on May 4th. To summarize, increases were made in the following areas:

- Medicaid by over $400K due to the final PMPM
- Local funding by $46,000 due to the final budget amount from Durham County

As I mentioned in my introduction to the recommended budget document, this budget that we are presenting for your approval reflects our focus for the upcoming year on reassessing and redesigning how we manage State funding. We believe that it will allow Alliance to serve as many people as possible with quality services and a focus on best practice services, to reduce reliance on our fund balance for ongoing commitments to uninsured individuals, and very importantly, to ensure our future sustainability in a changing healthcare landscape.

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

Best Regards,

Rob Robinson
Chief Executive Officer
Reader’s Guide

FY 2018 - 2019 is the seventh annual budget presented for Alliance Behavioral Healthcare (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 2018-2019 for Alliance’s administrative and service operations covering Cumberland, Durham, Johnston, and Wake counties. The budget year begins July 1, 2018 and ends June 30, 2019. The document will show how the funds are allocated and how they will be spent.

Alliance Behavioral Healthcare LME/MCO will have one fund called the General Enterprise Fund. The General Enterprise 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 Behavioral Healthcare 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 1% of the county dollars in administrative support for the management of their dollars in serving individuals 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 Administration budget.

Medicaid Services
Alliance Behavioral Healthcare 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 use 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 use 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 budgeting for Alliance Behavioral Healthcare is modified accrual per G.S. 159. The basis of accounting for Alliance Behavioral Healthcare is full accrual.

This document was prepared by Alliance Behavioral Healthcare Business Operations and is available online at www.alliancebhc.org. If further information is needed, please contact Kelly Goodfellow, Executive Vice President/CFO, at 4600 Emperor Blvd, Durham, North Carolina 27703 or by email at kgoodfellow@alliancebhc.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>
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<tbody>
<tr>
<td>Cumberland</td>
<td>327,127</td>
<td>77,515</td>
<td>23.70%</td>
<td>12,172</td>
<td>3,387</td>
<td>15,559</td>
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<tr>
<td>Durham</td>
<td>306,212</td>
<td>50,557</td>
<td>16.51%</td>
<td>8,288</td>
<td>3,404</td>
<td>11,692</td>
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<tr>
<td>Johnston</td>
<td>191,450</td>
<td>38,277</td>
<td>19.99%</td>
<td>5,588</td>
<td>1,705</td>
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<td>Wake</td>
<td>1,046,791</td>
<td>120,267</td>
<td>11.49%</td>
<td>16,285</td>
<td>8,215</td>
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<td><strong>Total</strong></td>
<td><strong>1,817,580</strong></td>
<td><strong>286,616</strong></td>
<td><strong>15.77%</strong></td>
<td><strong>42,333</strong></td>
<td><strong>16,711</strong></td>
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Based on 2016 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>
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<td>5,363</td>
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<td>2,398</td>
<td>48</td>
<td>376</td>
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<td></td>
<td>Wake</td>
<td>7,637</td>
<td>201</td>
<td>1,073</td>
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<td><strong>Total</strong></td>
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#### PROVIDER BREAKDOWN

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<td>Outpatient Practices</td>
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<tr>
<td><strong>Total</strong></td>
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Departmental Information

Care Management Division
Care Management at Alliance Behavioral Healthcare 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 and person-directed care.

Clinical Operations

Brief Description of Department and Units
The Clinical Operations Department is comprised of three units and receives clinical oversight from the Alliance Senior VP for Clinical Operations and the Chief Medical Director.

- 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.

Accomplishments for FY18

- New Care Management Software (Jiva) is currently being configured and is on schedule to go live in July 2018. The tool standardizes efforts, promotes increased quality, and offers enhanced tracking of cases, efforts and outcomes in care coordination.

- Formation of Complex Integrated Care team, the pilot model for Care Teams for Alliance Complete Care’s Individuals with Complex Needs initiative.

- Predictive Analytics Rounds successfully implemented during November 2017 in Cumberland County. The purpose is to reduce Out of Home Placements for youth with mental health disorders. Similar Predictive Analytics-based clinical rounds are ongoing in Durham County to decrease hospitalizations and ED utilization.
• Clinical Operations met all waiver performance standards for the year and scored 100% for EQR.
• Continued downward trend in Intensive In-Home utilization; met target utilization goal for the end of the year and continues to trend downward, keeping individuals in less restrictive, more successful levels of treatment.
• New MH/SUD Care Coordination Philosophy is being implemented – Care Coordination focuses on engaging members, removing barriers to quality treatment, and facilitating the care exchange to providers with support from Care Coordination through information and care plan sharing.
• TCLI Program continues to exceed the state target for the number of individuals transitioned into supportive housing. The state has commended us on our significant progress.
• MH/SUD CC Program expansion – Three new MH/SUD CC supervisors were added (one in Cumberland, one in Durham and one Wake) to create manageable direct report numbers for supervisors. Assistant Director was hired for the department to focus on standardization of practice among MH/SUD CC supervisors and improve quality.
• Opening of the Remote Monitoring Home. One member successfully completed first stay with at least seven other referrals in process.
• Thirty-one staff completed and passed their national exam for NACCM certification. The certification enhances the quality of IDD care coordination professionals.
• Advanced analytics are being used to stratify and proactively intervene for children who have both IDD and complex behavioral health needs.
• Organizational expansion - Four new IDD CC staff were added to address new slot allocations for Innovations. Two new supervisors were added (one in Cumberland and one in Durham) to create manageable direct report numbers for supervisors. An Assistant Director was hired for the department to focus on standardization of practice among IDD CC supervisors.
• Integration of physical health Registered Nurses (RNs) into several IDD and MH/SUD care coordination teams. We will further develop this integration as we move toward changes with Medicaid reform.

Summary of Goals and Objectives for FY19

• Complete implementation of Jiva, the care management tool that provides the platform for our care coordination transformations.
• Full implementation of interdisciplinary care teams in IDD, new, more standardized focus of interventions and connecting people to treatment for MH/SUD, and new stratification to help make care coordination more proactive.
• Implement care teams across IDD using innovative population health principles in order to improve overall healthcare for individuals.
• 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 the services based on data review, including outcome measures.
• Decrease number of individuals with stays beyond expected ranges for highly utilized services.
• Expand use of predictive analytics to other counties and other populations.
• Implement standard assessments and care plans across the organization’s care coordination staff.
• Decrease average length of stay (ALOS) of children in Therapeutic Foster Care.
• Increase use of Family Partners, peers, and community health workers for our care teams. These members will help execute care plans developed by licensed clinicians, and they are often most effective at engaging our members.
• Increase the number of physical health RNs to support transition toward integrated care coordination.

Medical Team

Brief Description of Department and Units

The Medical Team provides guidance and oversight of clinical services including authorization of services, clinical operations and overall clinical direction. The 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 Medical Team is comprised of the Chief Medical Officer, two Associate Medical Directors, a Pharmacist, a Senior Psychologist, the Director of Integrated Care, and two Registered Nurses.

Accomplishments for FY18

• Implemented/continued four integrated care pilot programs, collecting data on health and service utilization outcomes. The most successful pilot programs were those that incorporated physical health providers within the behavioral health home. In these pilots:
  o Substantially improved routine physical health screening rates for individuals with serious mental illness (SMI), to levels expected for populations without SMI.
  o Improved rate of metabolic screening for individuals receiving psychotropic medications.
• Pharmacy was focused on opiate use disorders and worked closely with providers to communicate and educate on pharmacy prescribing limits for opiate drugs developed by the state.
• Supported implementation and dissemination of medication assisted treatment (MAT) for opiate use disorders.
• Organized efforts to distribute Naloxone kits to treat opiate overdose throughout our catchment area.
• Support and communication with providers on changes in prescribing limits and monitoring for opiate drugs from NC DMA.
Summary of Goals and Objectives for FY19

- Implement integrated care pilot and evaluate physical and behavioral health data sharing capacity with one integrated provider.
- Invest in one robust integrated care program, with plans to incorporate value based contracting with upside risk sharing.
- Develop the Community Pharmacy network at Alliance to support use and adherence to including Clozapine and long acting injectable drugs.
- Support Alliance’s transition to, as it relates to Medicaid reform, gaining new responsibility for management of the pharmacy benefit.

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 units:

- 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 FY18

- Expansion of provider collaboratives to provide technical assistance and improve quality
- Implementation of multiple evidence based practice service models
- Implementation of 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.
- Creation of Remote Monitoring Home
- Development of new Behavioral Health Urgent Care service model to address gaps in the crisis continuum
- Expand capacity of opioid treatment services
- Streamline process for new service development

Summary of Goals and Objectives for FY19

- Expand network crisis services capacity
- Implement psychiatric rehabilitation service model within Psychosocial Rehabilitation programs
- 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 Relations

Brief Description of Department and Units

Community Relations 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 Relations 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 Relations 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 Relations 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 FY18

- Continued short-term rental assistance programs (ILI) in each community and longer term rental assistance program for a higher risk population
- 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
- Convened a cross departmental Social Determinant Think Tank and beginning to implement a standardized SDOH screening tool
- Participated on a statewide social determinant advisory group
- Convened a cross departmental Member Engagement Think Tank and 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
- 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 with plans to expand into Cumberland
- Expanded Mental Health First Aid (MHFA) trainers and now have a Community Relations staff trained on almost every module. Trained the Raleigh and Durham Police Department’s on MHFA with over 1,000 participants
- Completed significant enhancements to Wake and Durham Network of Care
- Continued 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 FY19

- 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 Relations (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 FY18**

- Alliance claims staff continue to provide weekly claims training for providers to ensure that updated knowledge of systems and claim information is shared with all providers.
- Through the Accounts Receivable (AR) system, staff are able to research and resolve denials more efficiently. This has prevented AR numbers from growing and has enabled Alliance to meet contractual requirements.
- Alliance has met the required 95% encounter success rate this fiscal year and even going further with achieving 100% in some weeks.
- Claims Staff continues to collaborate with IT/Report Development to create reports that provide analysts with paid claims in different categories. Some of the reports include: retro authorizations for claims, Out of Network provider claims, claims outside of our covered age range, claims where Medicaid has changed, and invalid living arrangements.
- The HMS audit for March 2017 through August 2017 resulted in high scores of 99.88% in timeliness of provider payment, 99.77% in claims processing accuracy, and 99.37% in financial accuracy.
Summary of Goals and Objectives for FY19

- Maintain focus on maintaining the encounter requirement to have 95% approved claims.
- Develop new reports to analyze paid and denied claims to ensure we are maximizing our payments to providers. Reports such as review of National Correct Coding Initiative (NCCI) edits, and contract diagnosis codes will help prepare staff for future onsite reviews, as well as ensure correct processing of claims.
- Work with IT to continue to make improvements in the AR system so that we can maintain accurate accounting of all outstanding submitted claims and validate our files sent to the State, as well as those sent to us.
- Continue to enhance customer service, training and development so that staff are fully trained and have the tools they need to do their job. We will focus on building a unified team with the help of updated procedures and process flows, mutual understanding of work, cross departmental training, and most importantly, adhering to our mission and values.
- Continue to work with claims vendor to do enhancements of system to improve efficiency in processing of claims in the areas of coordination of benefits and hospital claims.

Financial Operations

Brief Description of Department and Units

- Finance and Accounting - responsible for the agency's financial transactions, financial reporting, adherence to Generally Accepted Accounting Principles (GAAP), ensuring adequate and effective internal controls, purchasing in accordance with general statutes, timely payment to providers and vendors, completion of all annual and ad hoc audits
- 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.

Accomplishments for FY18

- Implemented budget software that works in conjunction with the accounting software to streamline budget efforts and improve reporting.
- Implemented a new feature in the accounting software that allows us to better account and report by program, provider, and funding source.
- Combined the Medicaid Services Committee with the Budget and Finance Committee to allow for a more unified approach in discussing service detail, compare financial perspective with the clinical team, and discuss initiatives in cases of over or under spending.
- Worked with consultants to develop a new financial reporting model
- Implemented a non-Medicaid Incurred But Not Reported (IBNR) model to improve the accuracy of estimating the outstanding non-Medicaid claims. These efforts support our Continuous Quality Improvement focus.
- Collaborated with the IT team to improve non-Medicaid reporting
- Continue to monitor the Organization’s Medical Loss Ratio (MLR) performance.
- Created Frequently Asked Questions for Transition to Community Living (TCLI) funding to assist TCLI team members with the complexity of the funding source.
- Completed another successful independent financial statement audit and compliance audit receiving no material weaknesses, significant deficiencies, and no required adjustments.
- Collaborated with the IDD Care Coordination team to revise the purchasing process for special Innovation purchases. These changes will make these purchases more efficient.
- Exceeded all legislative and contractual financial ratios.
- Completed External Quality Review (EQR) with a score of 100%.
- 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 FY19

- Implement a new Human Capital Management (includes payroll) system in collaboration with the Human Resources team.
- 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 evaluation and revision of higher level reporting and forecasting.
- Implement paperless vendor files related to the Accounts Payable function.
- 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 building a unified team with the help of updated procedures and process flows, mutual understanding of work, cross departmental training, and most importantly, adhering to our mission and values.

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

Organizational Effectiveness is achieved at the highest level by integrating our organization’s work projects, our people, our systems, and our leadership, and aligning all with our organizational strategy. The Organizational Effectiveness Department was created a year and a half ago to do just that, and includes the Communications unit, the Facilities unit, Organizational Project Portfolio Management Office (OPPMO), and the Organizational Development and Learning (ODL) team. OED’s purpose is 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 that is in alignment with our values. All four of OED’s units contribute toward this mission, and the impact on the organization’s effectiveness is greater because of this synergy and collaboration.

- 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.
- Facilities is currently a one-person unit responsible for the management of multiple construction projects, property management, renovations, and day-to-day facility management of the Alliance sites. Health and Safety also falls within this unit, as does the Emergency Action Plan.

**Accomplishments for FY18**

- Developed a Thought Leadership Marketing Plan designed to enhance the Alliance profile within the behavioral health industry by highlighting the expertise and innovation of our subject matter experts.
- Created and launched a robust website called “Alliance For Action on Opioids”, offering resources and tangible, straightforward strategies allowing individuals and healthcare providers to take action to help stem the tide of the opioid epidemic.
- Launched and implemented new Project Portfolio Management System – “PortfolioPedia”. This implementation allows leadership to review data illustrating staff capacity and demand for the strategic initiatives, and more easily ensure adequate resources and success for large scale, impactful organizational initiatives.
- Created and developed a Leadership Development Academy that consists of Aspiring Leaders (high potentials), Emerging Leaders (middle management), and Strategic Leaders (executive leadership) to retain staff and prepare them for growth and opportunity.
- Created and produced the first annual All Alliance Leadership conference that provided professional development for all leaders throughout the organization.
- Provided Spanish Language training for all employees to better meet the needs of the communities we serve.
- Collaborated weekly with the Government Relations team to ensure access to targeted strategic messaging for high-value stakeholders, particularly in the General Assembly.
• Collaborated with vendor to execute creation of our “Alliance: Powered by People” brand messaging and a variety of collateral products including posters, a brand video and a brand book celebrating Alliance staff to enhance engagement and improve culture.

• Created and expanded ODL team, building infrastructure, talent, and 3 year plan to expand the services available to the organization.

• Created and implemented 9 Affinity Groups to assist employees in navigating Diversity, Equity & Inclusion within the organization.

• Developed and implemented phase 1 of the Strategic Facilities plan to identify and lease appropriate property for consolidation of three Alliance office sites to manage growth and unify the organization as leases expired. FY19 will be phase 2, which is the actual transition plan.

• Everbridge has been launched and proven successful for employee safety and security. This is a secure, scalable and reliable critical communications platform that enables rapid delivery of critical communications with near real-time verification over numerous devices and contact paths. It has saved hours of staff time communicating during interruption of services due to weather or other adverse event.

Summary of Goals and Objectives for FY19

• Implement year 2 plan of Organizational and Development and Learning plan which includes expanding Diversity and Cultural Competence learning, development of Strategic Leaders curriculum, and development of needed training modules to prepare Alliance staff for the future evolution in Medicaid reform.

• Continue to implement and refine the Thought Leadership Marketing Plan developed in FY18.

• Continue to utilize Project Portfolio Management system to educate leaders in the fundamentals of 1) project intake and prioritization model, 2) project budgets, 3) project dashboards and reports, and 4) project level of effort estimation and forecasting to prepare for the future.

• Expand use of Project Portfolio Management to include management, monitoring, and reporting for all Strategic Initiatives 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 implementation of Facilities plan to consolidate Home, Durham, and Call Center offices into one building. Target move in date: December/January 2019.

• Continue Evolutionary Website Redesign by identifying, analyzing, and fine-tuning a variety of performance and Search Engine Optimization issues.

• Develop and launch Alliance Brand Ambassadors program, which will serve as a key component of our internal communications efforts.
Access Center

Brief Description of Department and Units

The Access and Information Center (the Alliance 24/7 call center) links individuals 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 individuals needing routine services or during an after-hours crisis. It handles general information requests for Alliance as well.

Accomplishments for FY18

- Maintained URAC Health Call Center accreditation.
- Met State contractual requirements for time of answer and abandonment rate. Speed of answer improved from 7 seconds to 6.
- Positive External Quality Review (EQR) that is reflected in Enrollee Services and Delegation Section.
- Completed over 150 referrals from Primary Care offices.
- Filled all the IDD Innovations slots in a timely manner.
- Improved coordination of care with NC Start for children.
- Held a successful Resource Fair for stakeholders, members and families seeking services for IDD.
- Promoted Open Access model of care to decrease the time between appointments.
- Collaborated with Provider Networks and providers on increasing choice for members.
- Implemented the use of MicroStrategy to predict staffing coverage, training needs, and overall better reporting capability.
- Collaborated with other Alliance Departments on “Complete Care” project.
- Worked collaboratively with Network development on rolling out new service definitions, and assessing the needs and gaps in our service continuum.
- Collaborated with Duke and Durham Public Schools to create a Suicide Prevention Training.
- Streamlined IDD eligibility to lessen the wait for services.
- Positive NC DHHS review of our IDD wait list procedures.

Summary of Goals and Objectives for FY19

- Maintain URAC accreditation.
- Increase our knowledge of Population Health Management and explore ways to serve the “whole person” in the Access and Information Center.
- Continue to improve access to care for routine and urgent appointments.
- Continue to streamline workflows to decrease call length, staff onboarding, and improve customer service.
- Work collaboratively to implement TBI waiver.
- Continue to meet our call center contractual requirements.
• Increase the number of calls monitored with innovative technologies.
• Challenge the way in which we have approached member’s access to care. Use creative ways to increase the number of members seeking services to obtain the services in a timely manner.
• Fill all the Innovations slots for the year.
• Continue to find new and innovative ways to serve more individuals within our budgetary constraints.

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 Alliance’s 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 FY18

• Created a third team with Quality Management dedicated to ensuring Alliance is using data well to monitor operations.
• Staff completed training in the MicroStrategy analytics tool and are now Power Users.
• Continued to evaluate provider compliance with key Alliance-approved clinical guidelines;
• Successfully led a Quality Improvement Project to increase the number of individuals, involved in the Transition to Community Living Initiative, who found housing in private units; goal was met just 6 months after start of project;
• Successfully improved the quality of person-centered plans for individuals with MH/SUD diagnoses;
• Successfully led a large and multi-disciplinary project team to increase the percent of individuals who received new Innovations services in a timely manner.
• Evaluation of internal program, School Based Care Coordination Program, was used to win the 2017 Program of Excellence Award by the NC Council of Community Programs.
• Created automated dashboards that allow staff to track their work progress daily and ensure that obligations are met within deadlines.
- Facilitated the creation of a Provider Quality subcommittee of the Continuous Quality Improvement committee to give network providers a voice in determining how Alliance measures the quality of providers.
- Created an organization wide tracking system for external reports to catalog reports that have been submitted and to provide reminders about upcoming due dates to individuals responsible for creating and submitted reports.

**Summary of Goals and Objectives for FY19**

- Provide department-level support and general oversight of Alliance’s response to contract performance measures.
- Improve Quality Management’s internal reporting capabilities through advanced MicroStrategy training.
- Improve the dissemination of quality data across the organization to ensure a consistent awareness of interdepartmental performance.
- Support departmental efforts to show the impact of internal improvement efforts.

**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 serve 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. In addition, there are two organization-wide committees which represent and support key HR initiatives in the areas of employee health and wellness (Wellness Committee), and employee recognition (Rewards and Recognition Committee). 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 FY18**

- Posted 119 vacancies; Hired 94 (36 Internal 38%, 58 external 62%) candidates
- Created 37 new positions
- On boarded two Senior Business Partners in the areas of Benefits Administration, and Employee Relations and Policy Administration
- Outsourced the administration of FMLA leaves for continuous and intermittent usage
- Implemented Employee Navigator, an online benefits enrollment portal; eliminating manual entry of benefit election data into 7 databases by Senior Business Partner – Benefits Administration
- Launched the Employee Health Assessment campaign in December 2017
• Launched use of ‘recruiter’ phone and offered candidates the option of communicating via text
• Rewards and Recognition Committee hosted first 5 year service awards in the Fall 2017 and employee art displays in the Spring 2018
• Posted RFP to enter into contract for the Human Capital Management system
• Completed Phase 2 of Compensation Survey
• Implemented SharePoint solution to automate position management, onboarding and off boarding processes
• Wellness Committee host the walking challenge, mindfulness sessions, and focused monthly activities (e.g. hand sanitizers etc.)
• Released an Employee Engagement Survey in April 2018
• Completion of 2017-18 Performance Appraisal cycle

Summary of Goals and Objectives for FY19

• Enhance HR technology – implement HCM for HR and Payroll functions, improve automation capabilities
• Implement process improvements – onboarding/off boarding, new employee orientation, expand recruitment sources
• Improve HR communications – incorporate compensation meetings prior to job posting, analyze and report workforce data

Information Technology

Brief Description of Department and Units

The IT department is comprised of three 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. Manage database security, file downloads, and IT Project management. Manage User Acceptance Testing (UAT) for all Alpha releases for the organization.
• Data Analytics/Business Intelligence – Comprised of the business intelligence and data science teams, this group 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, Teradata Aster 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.
• IT Infrastructure and Support - Installs and supports all business data and voice networks within the Alliance sites. They are responsible for maintaining network and data security, HIPAA compliancy, email security, network and server performance, administration and the IT Helpdesk.
Accomplishments for FY18

- Created the Alliance Data Science Team comprised of a Director of Data Science and a Data Scientist 1 position. These roles will allow us to develop and address the advanced analytic initiatives within the organization. Added a Director of Product Management and Support as the IT product owner for major outsourced software applications, such as AlphaMCS and the Jiva product from ZeOmega. This position will serve as the conduit between the business community, the IT support teams, the vendor customer support and vendor developmental services teams.

- Continued development of Alliance Enterprise Data Warehouse by adding multiple new data domains.

- Continued to expand Alliance’s reporting and dashboard capabilities using the MicroStrategy Reporting Tool. We currently have over 100 reports, dashboards and datasets available for use in the MicroStrategy Production System.

- Deployed Teradata Aster Advanced Analytics Platform. Developed multiple use cases and proof of concepts including support for Therapeutic Foster Care, Call Center use of Text Analytics and Compliance Provider/Claims review.

- Implemented a Power Users Training Program which successfully trained 40 Power Users from all of the major departments at Alliance utilizing 21 custom datasets. These datasets allow the Power Users to develop their own data grids for Self Service Reporting.

- Continued to support growth in the data analytics usage by training and adding a total of 104 MicroStrategy users in all major departments.

- Implemented the required data interfaces and support structure for the Jiva – Care Coordination project.

- The Advanced Analytics team, in collaboration with the Clinical Department, has developed 2 predictive models aimed at identifying and providing enhanced services to the following populations:
  - a. Children at risk of entering Therapeutic Foster Care: 68 Children Identified since October 2017, and
  - c. Both models are currently being used by multidisciplinary teams to address gaps in care for children at risk.
  - d. The data is run monthly to deliver new individuals at risk each month to the interdisciplinary teams.

- Implemented a Security Awareness Testing and Training program to make all Alliance employees aware of the risks of phishing and other high risk issues.

- Recycle 4,800 pounds of electronic hardware.

- Improved Helpdesk Support Ticket resolution times closing tickets within 8 hours 65% of the time.

- Supported the development of SharePoint apps and forms to replace the excel spreadsheets by various teams within the organization. SharePoint lists allow Alliance to standardize information, to more effectively communicate and share data with team members, to track critical interventions to ensure members are receiving enhanced
services based on recommendations, and to allow the various departments to manage their project information.

- Developed various enhancements to the Alliance Intranet, such as the Video library. Additional Sites were developed and introduced such as the OPPMO department site, the Organizational Development and Learning (ODL) site, the Diversity, Equity, & Inclusion Council (DEIC) site, and the Alliance Complete Care (ACC) site.
- Developed a Provider Portal to allow internal ABH staff and external providers to access the ABH suite of applications.
- Modified the Provider Search website to include mobile access as well as languages, clinician search, and provider referral status.
- Updated the Incident Reporting System (IRIS) application to meet new business requirements.

Summary of Goals and Objectives for FY19

- Support the Advancing NC Whole Health Coalition as we strive to change the Alliance Business Model to support the Medicaid reform changes as being discussed by DHHS.
- Develop a training plan to support the Data Fluency Initiatives at Alliance. These include the Power Analysts program, the Power Users, as well as the Data Analytics Team.
- Redesign the current ETL processes to eliminate Alliance’s dependence on the Alpha Data Warehouse databases.
- Implement a replication process of the Mediware production databases to the Alliance infrastructure. This will provide Alliance with near real time access to the AlphaMCS databases in order to update the Enterprise Data Warehouse and the Jiva databases in a more timely fashion.
- Provide Enhanced Analytic capabilities for the Alliance Geo-Spatial and Social Determinants of Health initiatives.
- Continue support for the Jiva project to allow timely implementation of the UM module, the provider and member portals, and the Call Center Module.
- Support the relocation of the home site, the call center, and the Durham office into the new Alliance corporate headquarters.
- Explore additional Disaster Recovery systems and test plans to provide the needed levels of redundancy for all critical Alliance systems and servers.
- Create an Accreditation module for Providers in our network to communicate and verify their accreditation status online.
- Implement a Provider Maintenance application that will house various modules that providers will use to communicate with Alliance.
- Develop an internal Provider Search website that will allow Alliance staff access to additional information on provider clinician languages, specialties, and accurate referral information.
- Develop EDI Statistics that will allow Alliance to monitor statistics relevant to the EQR audit and encounter claims processing.
Office of Compliance
The Alliance Office of Compliance focuses on the prevention, detection and correction of identified violations of federal and state laws and regulations, fraud control and unethical conduct, and encourages an environment where employees can report compliance concerns without fear of retaliation.

Brief Description of Department and Units

The Department and Units is comprised of seventeen 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 FY18

- Opened 71 fraud and abuse investigations in the first 6 months of FY18 (136 total in FY17) and referred 9 full investigations to DMA Program Integrity for determination of credible allegation of fraud (18 total in FY17).
- 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 83 actions and sanctions to providers in response to Network compliance issues in the first 6 months of FY18 (196 total in FY17).
- Issued over $213,000 in overpayments through the Corporate Compliance Committee process in the first 6 months of FY18 ($425,000 total in FY17).
- Managed 3 requests for reconsideration of actions against providers in the first 6 months of FY18 (21 total in FY17).
- Audited 3% of adjudicated claims weekly.
- Audited 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.
- Hired two Compliance Analysts and filled vacant Special Investigator and Claims Auditor positions.

Summary of Goals and Objectives for FY19

- 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 significant risk (legal, financial, reputation) to Alliance. The updated plan is implemented in November each year and is reflective of the current risk environment in which Alliance operates.

- Provide specialized training to department staff to promote professional growth and to achieve and maintain nationally recognized certifications in the areas of responsibility.
# General Fund Revenues

**FY2018-2019 Recommended Budget**

**Total General Fund Revenues: $500,329,015**

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**Total** $500,329,015
General Fund Revenues
FY2018-2019 Recommended Budget
Total General Fund Revenues: $500,329,015
General Fund Expenditures
FY2018-2019 Recommended Budget

Total General Fund Expenditures: $500,329,015

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General Fund Expenditures
FY2018-2019 Recommended Budget
Total General Fund Expenditures: $500,329,015

$445,663,599
89%

$54,665,416
11%

Administrative
Services
# Budget Comparison

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<td>Johnston</td>
<td></td>
<td></td>
<td>State</td>
<td>2,066,301</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Federal</td>
<td>193,990</td>
</tr>
<tr>
<td>Wake</td>
<td></td>
<td></td>
<td>State</td>
<td>4,146,347</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Federal</td>
<td>3,739,414</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Local</td>
<td>27,038,871</td>
</tr>
<tr>
<td>Grant Services</td>
<td>158,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>755,000</td>
<td>500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund Balance</td>
<td>21,581,842</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 539,690,881</strong></td>
<td><strong>$ 500,329,015</strong></td>
<td><strong>$ 539,690,881</strong></td>
<td><strong>$500,329,015</strong></td>
</tr>
</tbody>
</table>

Fund balance appropriation in FY18 is contributing to administrative and service expenses.

Medicaid services decreased slightly as a result of less Medicaid eligible lives. Administration increased slight due to a change in administrative budget for FY19. Retro-active Medicaid will be factored in at year-end.

State dollars reflect a decrease due to one-time allocations received in the prior year. In addition, the budget is not adjusted for the legislative reduction. That is done at the end of the year with a fund balance appropriation for the reduction.

Local funds have increased due to an increase of county commitment.

Administration accounts for 10.5% percent of the overall budget. Administration expenses are reflected as 8.66% when including Care Coordination activities under Medicaid Services.
ANNUAL BUDGET ORDINANCE
ALLIANCE BEHAVIORAL HEALTHCARE
FY 2018 - 2019

WHEREAS, the proposed budget and budget message for FY 2018 - 2019 was submitted to the Alliance Behavioral Healthcare Area Board on May 3, 2018 by the Budget Officer; was filed with the Executive Secretary to the Board;

WHEREAS, on June 7, 2018, the Alliance Behavioral Healthcare 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 Behavioral Healthcare Area Board that for the purpose of financing the operations of Alliance Behavioral Healthcare, for the fiscal year beginning July 1, 2018 and ending June 30, 2019, there is hereby appropriated funds the following by function:

**Section 1: General Enterprise Fund Appropriations**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$54,665,416</td>
</tr>
<tr>
<td>Medicaid Services</td>
<td>$362,034,029</td>
</tr>
<tr>
<td>State Services</td>
<td>$43,802,180</td>
</tr>
<tr>
<td>County Services</td>
<td>$39,827,390</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$500,329,015</strong></td>
</tr>
</tbody>
</table>

**Section 2: General Enterprise Fund Revenue**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$54,665,416</td>
</tr>
<tr>
<td>Medicaid Services</td>
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<tr>
<td>State Services</td>
<td>$43,802,180</td>
</tr>
<tr>
<td>County Services</td>
<td>$39,827,390</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$500,329,015</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 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 use needs. Through the budget, Alliance Behavioral Healthcare aims to fulfill its mission as granted by NC G.S. 122-C.

Governing Statutes
Alliance Behavioral Healthcare 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 to 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 2018-2019 is the seventh recommended budget representing Alliance Behavioral Healthcare 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, FY19 projected costs, FTE positions, Department of Health and Human Services contract requirements, and costs related to 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 FY19 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**

Thursday, May 3, 2018  
FY 2018-2019 recommended budget presented at LME/MCO Board meeting

By Friday, May 11, 2018  
Notice of June 1, 2018 Public Hearing published

Thursday, June 2, 2018  
Public Hearing

By Friday, June 29, 2018  
LME/MCO Board adoption of FY 2018-2019 Budget Ordinance

Monday, July 2, 2018  
Budget is available in the General Ledger system

**Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</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 individuals, 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 individual to continue living in his or her home, rather than a group home.</td>
</tr>
</tbody>
</table>
Recommended vs. Approved

- Total budget increase - $459,384
  - $500,329,015
- Increase in Medicaid PMPM
  - Adjustments made between Medicaid service and administration
  - Adjustment in TBI revenue
- Increase in Local funds
  - Service (Durham) and admin (Cumberland)
## Approved Budget

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$54,165,416</td>
</tr>
<tr>
<td>Medicaid Services</td>
<td>362,034,029</td>
</tr>
<tr>
<td>Non-Medicaid</td>
<td></td>
</tr>
<tr>
<td>Alliance</td>
<td>34,166,467</td>
</tr>
<tr>
<td>Cumberland</td>
<td>5,609,831</td>
</tr>
<tr>
<td>Durham</td>
<td>9,273,518</td>
</tr>
<tr>
<td>Johnston</td>
<td>1,617,431</td>
</tr>
<tr>
<td>Wake</td>
<td>32,962,323</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$500,329,015</strong></td>
</tr>
</tbody>
</table>
## Medicaid

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>PMPM</th>
<th>Budget Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$</td>
<td>$ 26,765,629</td>
</tr>
<tr>
<td>Community Support</td>
<td>1.28</td>
<td>3,574,207</td>
</tr>
<tr>
<td>BH Long Term Residential</td>
<td>7.58</td>
<td>21,117,835</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility (PRTF)</td>
<td>5.22</td>
<td>14,542,385</td>
</tr>
<tr>
<td>Outpatient</td>
<td>15.36</td>
<td>42,781,351</td>
</tr>
<tr>
<td>Assertive Community Treatment Team (ACTT)</td>
<td>4.38</td>
<td>12,195,959</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>1.81</td>
<td>5,047,545</td>
</tr>
<tr>
<td>Intensive In Home</td>
<td>9.42</td>
<td>26,247,232</td>
</tr>
<tr>
<td>Partial Hospitalization / Day Treatment</td>
<td>0.89</td>
<td>2,482,846</td>
</tr>
<tr>
<td>Psychosocial Rehab</td>
<td>2.63</td>
<td>7,312,119</td>
</tr>
<tr>
<td>Crisis</td>
<td>0.55</td>
<td>1,527,905</td>
</tr>
<tr>
<td>Innovations</td>
<td>32.75</td>
<td>91,210,496</td>
</tr>
<tr>
<td>Intermediate Care Facility (ICF)</td>
<td>31.74</td>
<td>88,400,241</td>
</tr>
<tr>
<td>B3</td>
<td>3.76</td>
<td>10,477,066</td>
</tr>
<tr>
<td><strong>Total Medicaid Service</strong></td>
<td>$</td>
<td>$ 353,682,816</td>
</tr>
</tbody>
</table>
Non-Medicaid

• Alliance Base Benefit Plan - $23,685,217
  • ACTT, Community Support Team, Developmental Therapy, Outpatient, Residential Services, Substance Use Treatment, etc.

• Alliance Community Funds - $3,298,300
  • ADVP, Assertive Engagement, Day Activity, Intensive In Home, PSR, MST, etc.

• Alliance Provider Ongoing Support - $2,443,556
  • Crisis Services, Behavioral Health Urgent Care
## FY19 Reinvestment Plan

<table>
<thead>
<tr>
<th>Crisis Services</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Urgent Care</td>
<td>$500,000</td>
</tr>
<tr>
<td>Child Facility Based Crisis</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Durham Crisis Facility</td>
<td>1,700,000</td>
</tr>
<tr>
<td>Crisis Diversion</td>
<td>350,000</td>
</tr>
<tr>
<td>NC START</td>
<td>650,000</td>
</tr>
<tr>
<td>Paramedicine</td>
<td>250,000</td>
</tr>
<tr>
<td>Wake Crisis Facility Renovations</td>
<td>5,500,000</td>
</tr>
<tr>
<td>Wake Crisis Facility Start-Up/Operations Y1</td>
<td>5,500,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$19,450,000</strong></td>
</tr>
</tbody>
</table>
## FY19 Reinvestment Plan

### Interventions and Supports

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>$500,000</td>
</tr>
<tr>
<td>Intensive Wrap Around</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$520,000</strong></td>
</tr>
</tbody>
</table>

### Social Determinants of Health

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>$55,000</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$555,000</strong></td>
</tr>
</tbody>
</table>
## FY19 Reinvestment Plan

### Engagement and Self-Management

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology Enabled Homes</td>
<td>$30,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$30,000</strong></td>
</tr>
</tbody>
</table>

### Administration

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Claims Processing System</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Care Coordination/JIVA Implementation</td>
<td>1,614,500</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$3,614,500</strong></td>
</tr>
</tbody>
</table>

**Total**                                                                                      **$24,169,500**
ITEM: Resolution to add Johnston County into the Alliance Catchment Area and Corresponding Termination of the Interlocal Agreement and Subcontract with Johnston County

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: N.C. Gen. Stat. §122C-115(c1) allows an area authority to add one or more counties to its catchment area upon the adoption of a resolution to that effect by a majority of the members of the Area Board and the approval of the Secretary of the NC Department of Health and Human Services. Alliance and the Johnston County Area Authority entered into an Interlocal Agreement dated February 1, 2013, pursuant to N.C. Gen. Stat. §122C-115.1 and N.C. Gen. Stat. Article 20 Chapter 160A, whereby Alliance was designated as the Lead LME for purposes of operating as a risk-based Medicaid Managed Care Organization and administering MH/I/DD/SA services in Johnston County. Alliance and the Johnston County Area Authority also entered into a Subcontract dated February 1, 2013, for Johnston Area Authority to perform certain functions of the 1915 b/c Medicaid Waiver Contract, those functions being Care Coordination and Community Relations in Johnston County.

Considering geographic proximity, historic working relationship, organizational values, advantages to providers and consumers, and cost efficiencies, Alliance and the Johnston County Board of County Commissioners believe that it is in the parties’ best interests to formally add Johnston County into the Alliance catchment area, and terminate the Interlocal Agreement and Subcontract. In March 2018, both parties approved deal points guiding the consolidation of Johnston County formally into the Alliance catchment area in lieu of the Interlocal and Subcontract agreements. As required by statute, the Board of Directors is requested to approve the consolidation by Resolution, which includes the following terms: (1) formally adds Johnston County to the Alliance Behavioral Healthcare catchment area effective July 1, 2018, subject to the dissolution of the Johnston County Area Authority and approval of said addition by the Secretary of the NC DHHS. (2) agrees to maintain a local office in Johnston County, located at 521 North Brightleaf Boulevard Smithfield, NC, for at least one year. Alliance will provide Johnston County ninety days’ notice if it no longer needs the Johnston County space and will not close or relocate the local site outside of Johnston County without the consent of the Johnston County Board of Commissioners. (3) pursuant to the revised Alliance By-Laws, effective July 1, 2018, the Johnston County Board of Commissioners will appoint two (2) individuals to the Alliance Board, creating a 20-member Alliance Board of Directors and (4) terminates the Interlocal Agreement with Johnston County and the Subcontract with the Johnston County Area Authority, effective midnight, June 30, 2018.

REQUEST FOR AREA BOARD ACTION: Approve the proposal.

CEO RECOMMENDATION: Approve the proposal.

RESOURCE PERSON(S): Carol Wolff, General Counsel
RESOLUTION

WHEREAS, N.C. Gen. Stat. §122C-115(c1) allows an area authority to add one or more counties to its catchment area upon the adoption of a resolution to that effect by a majority of the members of the Area Board and the approval of the Secretary of the NC Department of Health and Human Services; and

WHEREAS, Johnston County Area Authority remains a single-county Area Authority organized and operating in accordance with N.C. Gen. Stat. §122C-115.1; and

WHEREAS, Alliance and the Johnston County Area Authority entered into an Interlocal Agreement dated February 1, 2013 pursuant to N.C. Gen. Stat. §122C-115.1 and N.C. Gen. Stat. Article 20 Chapter 160A, whereby Alliance was designated as the Lead LME for purposes of operating as a risk-based Medicaid Managed Care Organization and administering MH/I-DD/SA services in Johnston County; and

WHEREAS, Alliance and the Johnston County Area Authority entered into a Subcontract dated February 1, 2013 for Johnston Area Authority to perform certain functions of the 1915 b/c Medicaid Waiver Contract, those functions being Care Coordination and Community Relations in Johnston County; and

WHEREAS, Considering geographic proximity, historic working relationship, organizational values, advantages to providers and consumers, and cost efficiencies, the Alliance Board of Directors and the Johnston County Board of County Commissioners believe that it is in the parties’ best interests to formally add Johnston County into the Alliance catchment area, and terminate the Interlocal Agreement and Subcontract; and

WHEREAS, In March 2018, both parties approved deal points guiding the consolidation of Johnston County formally into the Alliance catchment area in lieu of the Interlocal and Subcontract agreements; and

NOW THEREFORE, BE IT RESOLVED by the Board of Directors for Alliance Behavioral Healthcare:

1. The County of Johnston is hereby added to the Alliance Behavioral Healthcare catchment area effective July 1, 2018, subject to the dissolution of the Johnston County Area Authority and approval of said addition by the Secretary of the NC DHHS.

2. Alliance will continue to maintain a local office in Johnston County, located at
521 North Brightleaf Boulevard Smithfield, NC 27577, which is owned by Johnston County, for at least one year. Alliance will provide Johnston County ninety days’ notice if it no longer needs the Johnston County space. Alliance will not close or relocate the local site outside of Johnston County, NC without the consent of the Johnston County Board of Commissioners, which consent shall not be unreasonably withheld. Reasons for closing or relocating may include financial feasibility and efficiencies or staff or Medicaid transformation changes that no longer make it feasible to have all or some local sites.

3. Pursuant to the revised Alliance By-laws, effective July 1, 2018, the Johnston County Board of Commissioners will appoint two (2) individuals to the Alliance Board, creating a 20 member Alliance Board of Directors.

4. The Board hereby terminates the Interlocal Agreement with Johnston County and the Subcontract with the Johnston County Area Authority, effective midnight, June 30, 2018.

Adopted this the 7th day of June, 2018.

________________________________________
Chairman of the Board of Directors.

ATTEST:

________________________________________
Executive Secretary to the Board
ITEM:  Johnston County Lease Agreement

DATE OF BOARD MEETING:  June 7, 2018

BACKGROUND:  Johnston County is the owner of the office space currently occupied by Johnston County LME staff at 521 North Brightleaf Boulevard Smithfield, NC 27577. Alliance has committed to maintain our local office in the same location for at least 1 year after the consolidation, effective July 1, 2018.  NC General Statue §160A-274 authorizes governmental units to enter into leases with each other upon such terms and conditions as the parties deem wise. Johnston County has agreed to lease 5,895 square feet of exclusive space and 2,535 sq. ft. of shared space, totaling 8,430 combined square footage, to Alliance for our Johnston County local office. The leased space is only a portion of the total building space available, sharing the remainder of the premises with the Johnston County Public Health Department.  The term of the lease is for 1 year, for an annual rental amount of $1. Alliance will reimburse Johnston County for its pro-rata share of utilities. Johnston County is in the process of renovating the space to include separate, locked entrances for Alliance staff, as well as a separate reception space that will include Alliance signage directing people to the Alliance reception window. The proposed lease is attached for consideration and approval. Approval of this item requires a super majority vote pursuant to the Alliance By-laws.

REQUEST FOR AREA BOARD ACTION:  Approve the proposal.

CEO RECOMMENDATION:  Approve the proposal.

RESOURCE PERSON(S):  Carol Wolff, General Counsel
STATE OF NORTH CAROLINA                 LEASE AGREEMENT
COUNTY OF JOHNSTON

This Lease Agreement, is made and entered into the 1st day of July, 2018, by and between Alliance Behavioral Healthcare, a political subdivision of the state of North Carolina, having a principal office at 4600 Emperor Boulevard, Suite 200, Durham, North Carolina, hereinafter referred to as "LESSEE," and the County of Johnston, a body politic and corporate of the State of North Carolina, having a principal office at __________, Smithfield, North Carolina, hereinafter referred to as "LESSOR".

WITNESSETH:

WHEREAS, LESSOR, is the owner of that certain property located at 521 North Brightleaf Boulevard Smithfield, NC 27577 (the “County Property”); and

WHEREAS, LESSEE is the Local Management Entity/Managed Care Organization responsible for the management of public funds for individuals needing mental health, substance use, and development disability services in Johnston, Cumberland, Wake and Durham counties; and

WHEREAS, North Carolina General Statue §160A-610(7) authorizes LESSOR to enter into leases of real property as Lessor whenever such real property is no longer required for purposes of the LESSOR; and

WHEREAS, North Carolina General Statue §160A-274 authorizes LESSOR and LESSEE as governmental units to enter into leases with each other upon such terms and conditions as the Parties deem wise; and

WHEREAS, LESSEE desires to lease a portion of the County Property as more particularly described herein (the “Leased Premises”) and LESSOR is willing to lease said Premises to LESSEE, subject to the terms and conditions of this Lease for business purposes.

NOW THEREFORE, In consideration of the mutual promises and subject to the terms and conditions contained or referred to herein, the Parties hereby agree as follows:

1. LEASE OF THE PREMISES. LESSOR does hereby lease and demise to LESSEE and LESSEE hereby accepts and leases from LESSOR, together with those nonexclusive rights to use the Common Areas (as hereinafter defined), that certain office space located in the building at 521 North Brightleaf Boulevard Smithfield, NC 27577, as more fully described as follows (hereinafter referred to as the "Leased Premises"):

   5,895 sq. ft. of exclusive space and 2,535 sq. ft. of shared space, ingress and egress, totaling 8,430 combined sf. as shown on the Floor Plan included on Exhibit A, attached hereto and incorporated herein.

The Leased Premises is only a portion of the total building space available, sharing the remainder of the premises with the Johnston County Public Health Department. The shared conference room located in the lobby area, shown on Exhibit A is also utilized by court officials from time to time. LESSEE will establish a joint scheduling calendar with
Johnston County Public Health Department for the use of the shared conference rooms.

2. **TERM.** The Lease shall commence **July 1, 2018**, and unless sooner terminated, continue for a term of 1 year, expiring at midnight on **June 30, 2019**. Upon mutual agreement by LESSEE AND LESSOR, the term may be extended annually.

3. **RENT:** The annual rent for the Leased Space shall be $1.00.

4. **DEPOSIT:** LESSOR shall not require a security deposit from the LESSEE.

5. **CONDITION OF PREMISES:** The parties have agreed that LESSOR shall make certain renovations and improvements to the Leased Premises and that such improvement will be completed on or before the effective date of this Lease. The improvements include creating badge access entry ways into the Leased Premises, as shown on the Floor Plan included on Attachment A.

LESSEE shall return the Leased Premises to LESSOR at the termination or expiration hereof in as good condition and state of repair as the same was at the commencement of the Term hereof, except for loss, damage, or depreciation occasioned by reasonable wear and tear or damage by fire or other casualty.

6. **PARKING LOT:** The parking lot adjacent to the building shall be included in the Leased Premises for the shared use of LESSEE and its visitors and invitees with any other occupants and tenants of the building and their respective visitors and invitees.

7. **ASSIGNMENT OR SUB-LEASE:** The LESSEE shall not assign this Lease or sublet the Leased Premises or any part thereof, without the written consent of the LESSOR. Such written consent will not be unreasonably withheld by LESSOR.

8. **USE AND POSSESSION:** The Leased Premises are to be used by LESSEE exclusively for LESSEE's activities to conduct LME/MCO functions in Johnston County.

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

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

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

12. LESSOR'S RIGHT TO INSPECT: LESSOR shall have the right, at reasonable times
during the term of this lease, to enter the Leased Premises, for the purposes of examining
and inspecting same and of making such repairs or alterations therein as LESSOR shall
deem necessary.

13. INSURANCE: LESSOR will be responsible for insuring its interest in the building and
LESSEE will be responsible for insuring its personal property within the Leased Premises.
LESSEE shall at all times during the term hereof, at its own expense, maintain and keep
in force a policy or policies of general and premises liability insurance against claims for
bodily injury, death or property damage occurring in, on, or about the demised premises in
a coverage amount of no less than $1,000,000 per occurrence. LESSEE shall provide
current copies of all such policies of insurance to LESSOR'S Office of Risk Management.

14. LESSOR'S RESPONSIBILITY FOR MAINTENANCE: LESSOR shall be responsible
for the repair and maintenance of the roof, windows and exterior walls of the building, the
parking lot, landscaping (including trimming, mowing, planting, mulching and fertilizing
as needed), and the repair or replacement of electrical system, overhead lighting system,
including bulbs, plumbing system, fire suppression system, heating, air conditioning and
ventilation system components as well as maintenance and repair in the shared Leased
Premises. Further, LESSOR shall provide all services related to the landscaping and
grassed areas.

15. LESSEE'S RESPONSIBILITY FOR ALL OTHER MAINTENANCE: LESSEE shall
be responsible for all other maintenance of the exclusive Leased Premises not specified as
the responsibility of LESSOR above, or shared space. LESSEE shall be responsible for
the regular maintenance in good condition of all interior surfaces including floors, doors,
ceilings, walls and windows. LESSEE shall not be responsible for ordinary wear and tear
or for major damage or destruction caused by casualty or disaster for which there is
insurance coverage.

16. JANITORIAL SERVICES: LESSEE shall provide janitorial service and trash removal
from the exclusive Leased Premises. LESSOR shall provide janitorial service and trash
removal from the shared Leased Premises.
17. **PERSONAL PROPERTY AND IMPROVEMENTS**: Any additions, fixtures, or improvements placed or made by the LESSEE in or upon the leased premises, which are permanently affixed to the Leased Premises and which cannot be removed without unreasonable damage to said premises, shall become the property of the LESSOR and remain upon the premises as a part thereof upon the termination of this Lease. All other additions, fixtures, or improvements, to include trade fixtures, office furniture and equipment, and similar items, which can be removed without irreparable damage to the leased premises, shall be and remain as the property of the LESSEE and may be removed from the leased premises by the LESSEE upon the termination of this lease. LESSEE shall bear the expense of any repairs of the Leased Premises, other than reasonable wear and tear caused by such removal. LESSEE shall obtain LESSOR’S written consent before making any alterations or changes to the building or Leased Premises.

18. **TAXES**: LESSOR acknowledges that all business personal property owned by LESSEE is exempt from property taxation. Notwithstanding the foregoing, in the event any property of LESSEE becomes taxable, LESSEE will list and pay all business personal property taxes on its taxable personal property located within the Leased Premises.

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

For Johnston County:  Attn: County Manager

For Alliance BHC:  Attn: CEO
4600 Emperor Blvd. Suite 200
Durham, North Carolina 27713

20. **ADA / OSHA REQUIREMENTS**: LESSOR shall make such repairs and perform such maintenance as is necessary to keep the premises in compliance with all ADA and OSHA requirements. LESSEE shall keep the premises in good condition and repair and in a good, clean, and safe condition at all times during the term of this Lease Agreement.

21. **SUCCESSIONS AND ASSIGNS**: This lease shall bind and inure to the benefit of the successors and assigns of the parties hereto.

22. **UTILITIES**: Electrical power and water and sewer services are not metered. LESSEE shall reimburse LESSOR for LESSEE’S pro rata share of the cost of these services based on percentage of sq. ft of the Leased Premises to the whole building. LESSEE'S pro rata share shall be computed as the percentage of square feet leased exclusively by LESSOR of the total building sf. LESSOR shall invoice LESSEE for the reimbursement of the costs of these services not less than quarterly. LESSOR shall not be liable for any failure of any public utility to provide utility services over such connections and such failure shall not constitute a default by LESSOR in performance of this Lease. The installation, maintenance and service charges for any other utilities or services such as telephone, cable television, internet, or wireless connectivity shall be the sole responsibility of
23. **RISK OF LOSS:** As between the LESSOR and the LESSEE, any risk of loss of personal property placed by the LESSEE in or upon the Leased Premises shall be upon and the responsibility of the LESSEE, regardless of the cause of such loss.

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

25. **TERMINATION:** If LESSEE shall fail to perform any of the terms and conditions heretofore set forth and shall continue in such default for a period of thirty (30) days after written notice of default, LESSOR, at its discretion, may terminate this Lease and take possession of the Leased Premises without prejudice to any other remedies allowed by law. If LESSOR shall fail to perform any of the terms and conditions heretofore set forth and shall continue such default thirty (30) days after written notice of such default, LESSEE, at its discretion, may terminate this Lease and vacate the Leased Premises without further obligation to pay rent as theretofore provided from date of said termination, without prejudice to any other remedies provided by law. In the event LESSEE is unable or chooses not to use the Leased Premises for the intended uses, then LESSEE may terminate this Lease upon ninety (90) days prior written notice to LESSOR, and in such event pay rent to LESSOR through the end of the month which LESSEE vacates.

26. **OCCUPANCY AND QUIET ENJOYMENT:** LESSOR promises that LESSEE shall have quiet and peaceable possession and occupancy of the Leased Premises in accordance with the terms of this Lease, and that, to the extent permitted by law, LESSOR will defend and hold harmless the LESSEE against any and all claims or demands of others arising from LESSEE'S occupancy of the premises or in any manner interfering with the LESSEE'S use and enjoyment of said premises.

27. **MODIFICATION:** This Agreement may be modified only by an instrument duly executed by the parties or their respective successors.

28. **MERGER CLAUSE:** This instrument is intended by the parties as a final expression of their agreement and as a complete and exclusive statement of its terms. No course of prior dealings between the parties and no usage of trade shall be relevant or admissible to supplement, explain, or vary any of the terms of this Lease. Acceptance of, or acquiescence in, a course of performance rendered under this or any prior agreement shall not be relevant or admissible to determine the meaning of this Lease even though the accepting or acquiescing party has knowledge of the nature of the performance and an opportunity to make objection. No representations, understandings or agreements have been made or relied upon in the making of this Lease other than those specifically set forth herein.

IN WITNESS WHEREOF, LESSOR and LESSEE have caused this Lease Agreement to be executed in duplicate originals by their duly authorized officers, to be effective for the term as stated above.
Alliance Behavioral Healthcare
By:

Rob Robinson, CEO

LESSOR:
County of Johnston
By:

ITEM: Election of FY19 Board Officers: Chairperson and Vice-Chairperson

DATE OF BOARD MEETING: June 7, 2018

BACKGROUND: As stated in Article II, Section D of the by-laws, officers of the Area Board shall be chosen for a one-year term at the final meeting of the fiscal year in which the Area Board is serving, and shall be as follows: Chairperson and Vice-Chairperson.

With the exception of the Executive Secretary (which shall be filled by the CEO or the CEO’s designee), no officer shall serve in a particular office for more than two consecutive terms. Each Area Board member shall be eligible to serve as an officer. Duties of officers shall be as follows:

- Chairperson – this officer shall preside at all meetings and generally perform the duties of a presiding officer. The Chairperson shall appoint all Area Board committees.
- 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.

Nominations will be presented and Board members will elect officers at the June 7, 2018, Board meeting.

REQUEST FOR AREA BOARD ACTION: Elect FY19 Chairperson and Vice-Chairperson.

CEO RECOMMENDATION: Elect FY19 Chairperson and Vice-Chairperson.

RESOURCE PERSON(S): Robert Robinson, CEO