MEMBERS PRESENT: ☒Glenn Adams, Cumberland County Commissioner, JD (via phone; entered at 4:23 pm; exited at 4:52 pm), ☐Cynthia Binanay, Chair, MA, BSN, ☒Christopher Bostock, BSIM (exitd at 6:14 pm), ☒Tony Braswell, Johnston County Commissioner (via phone; exitd at 4:50 pm), ☒Heidi Carter, Durham County Commissioner, MPH, MS (via phone), ☒George Corvin, Vice-Chair, MD, ☒David Curro, BS, ☒Greg Ford, Wake County Commissioner, MA (via phone), ☐Lodies Gloston, MA, ☒David Hancock, MBA, MPAff, ☐Duane Holder, MPA, ☐D. Lee Jackson, BA, ☐Donald McDonald, MSW, ☒Lynne Nelson, BS, ☒Gino Pazzaglini, MSW LFACHE, ☒Pam Silberman, JD, DrPH, ☒Lascel Webley, Jr., MBA, MHA, and ☐McKinley Wooten, Jr., JD

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

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Michael Bollini, Executive Vice-President/Chief Operating Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Amanda Graham, Senior Vice-President/Operational Effectiveness; Veronica Ingram, Executive Assistant II; Beth Melcher, Senior Director of Clinical Innovation; Sara Pacholke, Senior Vice-President/Financial Operations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Sean Schreiber, Executive Vice-President/Network and Community Health; Tammy Thomas, Director of Project Portfolio Management; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

1. CALL TO ORDER: Chair George Corvin called the meeting to order at 4:06 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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<tbody>
<tr>
<td>2. Announcements</td>
<td>2A. Commemorative Plaque: Chair Corvin presented a commemorative plaque to Chris Bostock; this is Mr. Bostock’s final meeting as an Alliance Board member. Mr. Bostock expressed appreciation for his time on the Board.</td>
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<td></td>
<td>2B. Hurricane Dorian Update: Ms. Graham shared about the agency’s preparation for pending inclement weather; this is a dual process including work with providers to provide services for the people Alliance serves and as well as the agency’s operational processes to continually provide services during inclement weather.</td>
</tr>
<tr>
<td></td>
<td>2C. CareforNC (<a href="https://CareForNC.org">CareForNC.org</a>): Mr. Robinson shared about this collaborative effort among NC MCOs (managed care organizations) to share the benefits of public managed care in North Carolina. Mr. Robinson encouraged Board members to review the website and share it on their social media platforms.</td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
</tr>
<tr>
<td>4. Public Comment</td>
<td>There were no public comments.</td>
</tr>
<tr>
<td>5. Committee Reports</td>
<td>A. Consumer and Family Advisory Committee – page 4 The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes and supporting documents from the August Cumberland, Durham, Wake, Johnston, and Steering committee meetings.</td>
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</table>
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
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<tr>
<td>Dave Curro, CFAC Chair, presented the report; he mentioned topics in recent meetings, the upcoming showing of &quot;The Anonymous People&quot; in October, the impact of the State budget on CFAC, affordable housing needs, and September recovery month events. He also mentioned upcoming CFAC events. The CFAC report is attached to and made part of these minutes.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**

The Board received the report.

**B. Finance Committee – page 183**

The Finance Committee's function is to review financial statements and recommend policies/practices on fiscal matters to the Board. This month's report included the draft minutes from the August 1, 2019, meeting, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending July 31, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

David Hancock, Committee Chair, presented the report. Mr. Hancock mentioned that revenues exceeded expenses. Additionally, he mentioned a proposed policy revision, which will be forwarded to the Board Policy Committee for review. Ms. Pacholke and Mr. Hancock mentioned two contracts that were reviewed by the Finance Committee and brought to the Board for approval. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. Hancock to 1) authorize the CEO to enter into a contract with Southlight Healthcare, Inc. to build infrastructure and system capacity for a clinically integrated network (Network for Advancing Behavioral Health) in an amount not to exceed $1,720,720 using Federal block grant allocation #20-A-24 and 2) authorize the CEO to execute a contract with American United Life Insurance (as part of employee benefits) in an amount not to exceed $345,000; motion seconded by Dr. Silberman. Motion passed unanimously.

6. Consent Agenda

A. Draft Minutes from August 1, 2019, Board Meeting – page 190
B. By-Laws/Policy Committee Report – page 195
C. Executive Committee Report – page 323
D. Quality Management Committee Report – page 326

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

**BOARD ACTION**

A motion was made by Ms. Nelson to approve/adopt the consent agenda; motion seconded by Mr. Curro. Motion passed unanimously.
### AGENDA ITEMS:

#### 7. Reappointment Recommendation – page 331

In accordance with the By-Laws of the Board, the terms of some Board members expire September 30, 2019. The matter before the Board is to recommend to the Cumberland Board of County Commissioners the reappointment of Lodies Gloston, whose term expires September 30, 2019; this would be for an additional three-year term.

**BOARD ACTION**

A motion was made by Dr. Silberman to recommend to the Cumberland Board of County Commissioners the reappointment of Lodies Gloston to Alliance’s Board. Motion seconded by Mr. Bostock. Motion passed unanimously.

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#### 8. Legislative Update

Sara Wilson, Government Relations Director, presented the legislative update. She shared about NC General Assembly still not having an approved budget. Ms. Wilson reviewed the impact of the State’s budget delay on the go-live dates for the State’s Standard Plan.

**BOARD ACTION**

The Board received the update.

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#### 9. Chair’s Report

Chair Corvin mentioned receipt of applications for vacant Board seats. An update will be provided at upcoming Board meetings.

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#### 10. Closed Session(s)

**BOARD ACTION**

A motion was made by Mr. Curro to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1.; motion seconded by Dr. Silberman. Motion passed unanimously.

The Board returned to open session.

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#### 11. Adjournment

All business was completed; the meeting adjourned at 6:33 p.m.

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**Next Board Meeting**

**Thursday, October 03, 2019**

4:00 – 6:00 pm

Minutes approved by Board on October 3, 2019.
ITEM:  Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING:  September 5, 2019

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

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

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

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

REQUEST FOR BOARD ACTION:  Receive draft minutes and supporting documents from the August Cumberland, Durham, Wake, Johnston, and the steering committee meetings.

CEO RECOMMENDATION:  Accept the report.

RESOURCE PERSON(S):  David Curro, CFAC Chair; Doug Wright, Director of Community and Member Engagement
MEMBERS PRESENT: ☒Michael McGuire ☒Ellen Gibson ☒Dorothy Johnson ☐Carrie Morrisy ☒Jackie Blue ☐Jamille Blue ☒Sharon Harris ☒Briana Harris ☒Shirley Francis ☒Tekeyon Lloyd ☒Tracey Glenn-Thomas ☒Renee Lloyd ☒Carson Lloyd Jr.

BOARD MEMBERS PRESENT:

GUEST(S): ☒Rosa Barns, ☒Alexandro Vasquez, ☒Valencia Handy, ☒Jason Francis, ☒Steheria Nicholson, ☐Andrea Clementine

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

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

1. WELCOME AND INTRODUCTIONS: Michael McGuire

2. REVIEW OF THE MINUTES – The minutes from the July 25, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by [Click here to enter text] and seconded by [Click here to enter text] to approve the minutes. Choose an item.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>Michael and Starlett Community events and resources have been provided via flyers/calendar. Committee members gave events that would be going on in August and September. Most were back to school drives.</td>
<td>Please see Doug, Starlett, or Terrasine for any questions.</td>
<td>September 26, 2019</td>
</tr>
<tr>
<td>4. Call ins to Meetings</td>
<td>Doug went over the flow chart of how CFAC was organized and how stipends work per the committee guidelines set originally. He explained the significance of the Steering Committee meeting and how the flow of information works. He explained that at the Steering committee meeting the Chair, Co-chair and one other member of the chair’s choosing can be in attendance and receive the stipend. He also explained that initially CFAC had decided to not pay stipends to those that called in as it was to cover things that may be needed in order to attend such as a sitter or mileage. The committee will be going back to that policy as of the September meeting. There were no questions or comments about this agenda item.</td>
<td>Please see Doug, Starlett, or Terrasine for any questions.</td>
<td>September 2, 2019</td>
</tr>
<tr>
<td>5. Roxie Letter</td>
<td>Terrasine Gardner- Roxie Update Terrasine went over the Roxie letter that was release on August 19, 2019. The screening, triage, and referral services at Roxie will no longer be a service rendered there due to low utilization effective August 30, 2019.</td>
<td>Please see Doug, Starlett, or Terrasine for any questions.</td>
<td>August 30, 2019</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
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</table>
| 6. MCO/ State Updates                | Doug Wright State and MCO Updates  
August State Updates- Doug went over the Community Engagement and Empowerment Team update for August. He pointed out the #CareForNC and what it entails.  
Perception of Care Survey- Doug went over the survey and explained the results. He explained that it was a very broad overview of the perception of the quality of care in MHSIP.  
Consumer experience with LME-MCO providers, and adult physical health. He went over the domains, what the survey entails and how the results are processed.  
Behavioral Health I/DD TP memo Appendix- Doug explained that the Appendix showed all of the services that the Tailored plans would include. It was a document for their information.  
Doug also explained the Frequently asked Questions document provided. This document could assist when members of the public ask questions about Medicaid Transformation. He also explained that there was information to contact the Enrollment Broker for additional questions.  
LME/MCO Admin Functions Monitoring- This was provided electronically to the committee.  
Medicaid Transformation Response- Doug explained that this document was about the immediate issues affecting beneficiaries during this transformation. He went over what has been identified.  
NC Association of County Commissioners- Doug explained that this document was about the recommendation of the county commissioners to leave the regions as is. It also showed the representatives that spoke on this matter from the Alliance catchment area.  
NC Medicaid Direct Tran- Beneficiary and Provider Form- This is the Raise Your Hand form. Doug explained that this form would allow individuals who were put on the standard plans to have the option to apply to be put on the Tailored plans. It was originally 17 pages and not user friendly. Concerns were sent to the state and it is now a 2 pager front and back. It has more white space so it is more user friendly. There is also a provider form for individuals who needs their assistance.  
SCFAC Annual Report- This report was sent electronically to the committee.                                                                                                                                                                                                                                                                                                                                                                                                  | Please see Doug, Starlett, or Terrasine for any questions.                                                                                     | Ongoing     |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 7. Upcoming Community Events/ Community Outreach event | Starlett Davis  
Reminder: Anonymous People Viewing room reservation update.  
October 17th, the Thursday has been approved, Flyer will be out by the September meeting.  
Member Activity Log- Updates on activities and events the members have been a part of. Starlett explained that the calendar would be going away and a spreadsheet/ document would be used starting September. It would list activities and events for the present and upcoming months so that members would know in advance what they could sign up for. This will also document who participated in what as a CFAC representative. The members are to email me this information. | The members are to email me this information.  
Starlett will provide flyers for the movie viewing at the September meeting. | Ongoing  
September 26, 2019 |
| 8. Membership Discussion                        | Michael McGuire- Benefits of CFAC and becoming a member.  
Three members were voted in at the last meeting. Starlett will schedule meetings over the phone/ via email. Michael brought up that a guest that has been coming regularly would like to join, Valencia Handy. The last meeting it was realized that we may be at capacity for the three categories for the committee. Starlett will look at membership to see the vacant spots. | Starlett will get back with the committee at the September meeting about capacity with membership. | September 26, 2019 |
| 9. Prep for next meeting                        | Discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting. Starlett asked that each member bring a friend. | Each member is to invite someone to the meeting. | September 26, 2019 |
| 10. Appreciation                                | Everyone gave their appreciation.                                                                    | N/A                                  | N/A                 |

ADJOURNMENT: the next meeting will be September 26, 2019. The next Steering Committee Meeting is telephonic on September 2, 2019.

Respectfully Submitted by:
Starlett Davis, Individual and Family Engagement Specialist

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
August 19, 2019

Dear Stakeholder,

As you are aware, crisis and assessment services, along with facility-based crisis services and detoxification services, were temporarily discontinued at the Roxie Avenue facility in early May as we began the process of transitioning to a new provider, RI International.

Since that time Cape Fear Valley Health and Alliance Health have worked together to ensure that individuals are able to obtain crisis services when needed. To this end Cape Fear Valley has been providing a screening, triage and referral service at Roxie, Carolina Outreach has provided access to behavioral health urgent care services as well as a Saturday morning weekend clinic, and as always, mobile crisis services and the Cape Fear Valley Medical Center emergency department have been available for those experiencing a behavioral health crisis.

Since the closing of the Roxie facility, Alliance has worked with RI, Cape Fear Valley, and Cumberland County to address the multiple steps required to reopen the facility under RI’s management. Also, during this time we have been monitoring the utilization of the services referenced above for individuals experiencing a behavioral health crisis. A thorough joint review by Alliance and Cape Fear Valley has revealed very low utilization of the screening, triage and referral services at Roxie and the decision has been made to curtail that service effective August 30, 2019.

Together, we are confident that the remaining crisis services in the community will be able to effectively handle the needs characteristic of individuals who have presented at Roxie over the past several months. We are working diligently to complete renovations to the facility that will allow RI to begin operations, including the resumption of STR services. In the meantime, Alliance and Cape Fear Valley will continue to monitor the situation to ensure that the citizens of Cumberland County are receiving an appropriate level of care.

Please feel free to contact Janet Conway at (910) 615-4748 at Cape Fear Valley Medical Center or Sean Schreiber at Alliance at (919) 651-8973 if you have any questions or concerns.
APPENDIX B — BH I/DD TAILORED PLAN CRITERIA

UPDATED: July 16, 2019

Pursuant to Session Law 2015-245, as amended by Session Law 2018-48\(^1\), populations meeting eligibility requirements for the BH I/DD Tailored Plan shall be exempt from Medicaid Managed Care until such point that BH I/DD Tailored Plans are available. Prior to implementation of the BH I/DD Tailored Plan, beneficiaries meeting BH I/DD Tailored Plan eligibility criteria and not otherwise excluded from Standard Plans will continue to receive coverage through their current delivery system (fee-for-service [FFS] and the Local Management Entity/Managed Care Organizations [LME/MCOs] for most beneficiaries).

Per Session Law 2018-48, beneficiaries eligible for the BH I/DD Tailored Plan include those with a serious mental illness (SMI), a serious emotional disturbance (SED), a severe substance use disorder (SUD), an I/DD, or who have survived a traumatic brain injury (TBI) and who are receiving TBI services, who are on the waiting list for the TBI waiver, or whose TBI otherwise is a knowable fact. DHHS identified specific data criteria, as outlined in this document, for populations described in Session Law 2018-48 that will be used to identify beneficiaries eligible for the BH I/DD Tailored Plan. Additionally, new Medicaid beneficiaries and Standard Plan beneficiaries who are not identified as eligible for BH I/DD Tailored Plans based on data reviews will be able to request a review to be exempt from mandatory enrollment in Standard Plans.

Along with meeting BH I/DD Tailored Plan eligibility criteria, beneficiaries must also be eligible for Medicaid Managed Care through the BH I/DD Tailored Plan. The following populations will be eligible to enroll and receive services through the BH I/DD Tailored Plan if they also meet one of the eligibility criteria defined later in this document.

- Populations eligible for the Standard Plan, as outlined in RFP 30-190029-DHB Section V.B.1(d).2
- Beneficiaries enrolled in both Medicare and Medicaid (dual eligible) for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing will only be eligible to receive BH, I/DD and TBI services through the BH I/DD Tailored Plan. Note that dual eligible beneficiaries otherwise excluded from managed care, such as beneficiaries served through the CAP/DA waiver, would not be eligible for the BH I/DD Tailored Plan.
- Non-dual eligible beneficiaries enrolled in the foster care system, formerly enrolled in foster care system up to age 26, or receiving Title IV-E adoption assistance, will have a choice between a Specialized Foster Care Plan and the BH I/DD Tailored Plan.

BH I/DD Tailored Plan Criteria

This section outlines the criteria used prior to Standard Plan implementation to identify beneficiaries eligible for the BH I/DD Tailored Plan. The BH I/DD Tailored Plan criteria below will be used to determine BH I/DD Tailored Plan eligibility based on application to the FFS claims, LME/MCO encounters, State eligibility system, and/or other sources. DHHS will evaluate data based on dates of service from January 2018 forward to determine the population meeting the BH I/DD Tailored Plan criteria. Beneficiaries who are not identified based on one of the criteria below but need the services or level of care available only through the BH I/DD Tailored Plans can request a review for BH I/DD Tailored Plan eligibility.

\(^1\) [https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf](https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf)

\(^2\) [https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf](https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf)
1. Innovations Waiver — Beneficiaries with a Special Coverage Code of “IN” or “CM.” Although the “IN” Special Coverage Code is the predominant indicator of Innovations Waiver enrollment, since this exercise evaluates a historical study period, the data logic also leverages the historical “CM” Special Coverage Code to identify Innovations Waiver participants. Innovations Waiver beneficiaries are excluded from Standard Plan enrollment.

2. TBI Waiver — Beneficiaries with a Special Coverage Code of “BH” or “BN.” DHHS maintains a list of these beneficiaries as reported by Alliance. TBI Waiver beneficiaries are excluded from Standard Plan enrollment.

3. Transition to Community Living Initiative (TCLI) — DHHS maintains a list of all beneficiaries targeted per the TCLI as reported by the LME-MCOs. Certain beneficiaries on the TCLI list have an applicant status indicating that they were “removed” from TCLI, and thus these beneficiaries will not be considered eligible for the BH I/DD Tailored Plan per the TCLI criteria.

4. Innovations Waiver Waitlist — DHHS maintains a list of beneficiaries on the Innovations Waiver Waitlist as reported by the LME-MCOs.

5. TBI Waiver Waitlist — This is not currently applicable as there are no individuals on the TBI Waiver Waitlist.

6. Utilization of Medicaid service only available in BH I/DD Tailored Plan — Utilization within the historical FFS claims and/or LME/MCO encounters of a service listed in Table 1.

7. Utilization of BH, I/DD or TBI Services Funded with State, Local, Federal or Other Non-Medicaid Funds — Identification logic leveraged State-funded claims experience based on data available through NCTracks.

8. Children with Complex Needs (CWCN) — DHHS maintains a list of all beneficiaries identified as CWCN as reported by the LME-MCOs.

9. I/DD Diagnosis — FFS claim or LME/MCO encounter with a qualifying I/DD diagnosis code(s) (all diagnosis positions) as listed in Table 2.

10. SMI/SED— The following logic was utilized to identify beneficiaries with an SMI or SED:
    a. FFS claim or LME/MCO encounter with a qualifying SMI/SED diagnosis code(s) as listed in Table 3 (SED) or Table 4 (SMI).
       i. SMI diagnosis list is applied to the primary diagnosis position only for beneficiaries ages 18 and older. Beneficiaries must also have utilization within the FFS and LME/MCO encounter information of an enhanced BH service as listed in Table 6. The diagnosis and enhanced BH utilization qualifying event do not need to occur on the same claim.
       ii. SED diagnosis list is applied to beneficiaries under age 18. Diagnoses denoted with an asterisk in Table 3 do not require the beneficiary to have also accessed an enhanced BH service (schizophrenia and schizophrenia spectrum diagnoses, in any diagnosis position). Beneficiaries with remaining diagnoses on the list in Table 3 must have a claim with a qualifying diagnosis in the primary diagnosis position only and also have utilization of an enhanced BH service in Table 6. The diagnosis and enhanced BH utilization qualifying event do not need to occur on the same claim.
    b. Electroconvulsive Therapy — Identified in both the FFS claims or LME/MCO encounters based on utilization of CPT code 90870 or revenue code 0901.
    c. Use of clozapine or long-acting injectable antipsychotics — Identified in the FFS claims based on utilization of one of the products listed in Table 7.

11. SUD Diagnosis + Enhanced BH Service — FFS claim or LME/MCO encounter with a qualifying SUD diagnosis code(s) (primary diagnosis position only) as listed in Table 5 along with utilization within the FFS and LME/Encounter information of an enhanced BH service as listed in Table 6.
The diagnosis and enhanced BH utilization qualifying event do not need to occur on the same claim.

12. Two or More Psychiatric Hospitalizations or Readmissions — Identified in the FFS claims based on DRGs 876, 880-887, 894–897, and in the LME/MCO encounters based on Revenue Codes 101–182,184–219.

13. Admission to State Psychiatric Hospitals or Alcohol and Drug Abuse Treatment Centers (ADATCs) — This includes, but is not limited to, individuals known to DHHS to have had one or more involuntary treatment episode in a State-owned facility.

14. Two or More Visits to the Emergency Department for a Psychiatric Problem — Identified in the FFS claims based on Revenue Code 450 and a qualifying diagnosis in the primary position per Tables 3–5 (on the same claim), and in the LME/MCO encounters based on Revenue Code 450 alone.

15. Two or More Episodes using BH Crisis Services — Identified in both the FFS claims and LME/MCO encounters based on utilization of the procedure codes listed below.
   - 90839 and 90840 (psychotherapy for crisis)
   - H0010 (non-hospital medical detox)
   - H2011 (mobile crisis management)
   - H2036 (medically supervised detox crisis stabilization)
   - S9484 (facility based crisis service)

Table 1: Services Only Available in the BH I/DD Tailored Plan

<table>
<thead>
<tr>
<th>Description</th>
<th>Code(s)</th>
<th>Applicable Dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid State Plan Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse (SA) Non-Medical Community</td>
<td>H0012</td>
<td>FFS Claims and/or LME/MCO Encounters</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA Medically Monitored Community Residential</td>
<td>H0013</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk Intervention (HRI) Residential</td>
<td>H0019</td>
<td></td>
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<tr>
<td>Assertive Community Treatment Team</td>
<td>H0040</td>
<td></td>
</tr>
<tr>
<td>HRI Residential</td>
<td>H0046</td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent Day Treatment</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Community Support</td>
<td>H2015</td>
<td></td>
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<tr>
<td>Psychosocial Rehabilitation</td>
<td>H2017</td>
<td></td>
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<tr>
<td>HRI Residential</td>
<td>H2020</td>
<td></td>
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<tr>
<td>Intensive In-Home Services</td>
<td>H2022</td>
<td></td>
</tr>
<tr>
<td>Multi-Systemic Therapy</td>
<td>H2033</td>
<td></td>
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<tr>
<td>HRI Residential</td>
<td>S5145</td>
<td></td>
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<tr>
<td>ICF/IID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Category of Service (SCOS) ^5 0021 OR 0047</td>
<td></td>
<td>FFS Claims</td>
</tr>
<tr>
<td>Revenue Code 100 OR 183</td>
<td></td>
<td>LME/MCO Encounters</td>
</tr>
</tbody>
</table>

^3 Unless otherwise noted, identification logic does not leverage the modifier field.
^4 In some instances, the BH I/DD Tailored Plan service criteria was only run against the LME/MCO encounters (and not the FFS claims) as certain services are only offered through the LME/MCOs and procedure code detail may double as another State Plan/1915(c) waiver service in the FFS claims.
^5 The State-defined SCOS field is based on provider taxonomy.
### Description of 1915(b)(3) Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Applicable Dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Living Skills (Cardinal Only)</td>
<td>H2022</td>
<td>LME/MCO Encounters</td>
</tr>
<tr>
<td>Intensive Recovery Supports</td>
<td>T1012</td>
<td></td>
</tr>
<tr>
<td>Personal Care/Individual Support</td>
<td>T1019</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
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<tr>
<td>One Time Transitional Cost</td>
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<tr>
<td>Supported Employment</td>
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<tr>
<td>Supported Employment Maintenance</td>
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<tr>
<td>Innovations Waiver Services</td>
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<tr>
<td>Crisis Intervention &amp; Stabilization Supports</td>
<td>H2011</td>
<td>LME/MCO Encounters</td>
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<tr>
<td>Community Networking</td>
<td>H2015</td>
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</tr>
<tr>
<td>Residential Supports (modifier differentiates Levels 1 and 4)</td>
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<td>Supported Employment</td>
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<tr>
<td>Natural Supports Education</td>
<td>S5110</td>
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<tr>
<td>Natural Supports Education — Conference</td>
<td>S5111</td>
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<tr>
<td>Personal Care</td>
<td>S5125</td>
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<tr>
<td>Respite Care</td>
<td>S5150</td>
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<tr>
<td>Home Modifications</td>
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<tr>
<td>Respite Care Nursing</td>
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<tr>
<td>In-Home Intensive Supports</td>
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<tr>
<td>Individual Goods and Services</td>
<td>T1999</td>
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</tr>
<tr>
<td>Community Living and Supports</td>
<td>T2013</td>
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</tr>
<tr>
<td>Residential Support Level 2</td>
<td>T2014</td>
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<td>Residential Support Level 3</td>
<td>T2020</td>
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<tr>
<td>Day Supports</td>
<td>T2021</td>
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<tr>
<td>Specialized Consultative Services</td>
<td>T2025</td>
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<tr>
<td>Day Supports — Developmental Day</td>
<td>T2027</td>
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<tr>
<td>Assistive Technology — Equipment and Supplies</td>
<td>T2029</td>
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<tr>
<td>Supported Living</td>
<td>T2033</td>
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<tr>
<td>Crisis Services — Out of Home</td>
<td>T2034</td>
<td></td>
</tr>
<tr>
<td>Community Transition Supports</td>
<td>T2038</td>
<td></td>
</tr>
<tr>
<td>Vehicle Adaptations</td>
<td>T2039</td>
<td></td>
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<tr>
<td>Community Navigator</td>
<td>T2041</td>
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### Innovations Waiver Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Applicable Dataset</th>
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<tbody>
<tr>
<td>Crisis Intervention &amp; Stabilization Supports</td>
<td>H2011</td>
<td>LME/MCO Encounters</td>
</tr>
</tbody>
</table>

---

Note that DHHS will submit a State Plan Amendment to add Peer Supports (currently a 1915(b)(3) service) to the State Plan. Once approved, this service will be offered via the Standard and BH I/DD Tailored Plans. As such, this service was not used to qualify beneficiaries as eligible for the BH I/DD Tailored Plan.
In-Lieu-Of Services (ILOS)³

ILOS utilization was included in the eligibility criteria, with exceptions for the following ILOS that were not included in the BH I/DD Tailored Plan eligibility criteria as DHHS has pre-approved these ILOS to be offered through the Standard Plan:

- Behavioral Health Urgent Care
- Outpatient Plus
- Rapid Care Services
- Behavioral Health Crisis Assessment and Intervention
- Child First Outpatient

Table 2: I/DD Diagnosis Code List

The following diagnosis code list was applied to both the FFS claims and LME/MCO encounters.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D82.1</td>
<td>Di George's syndrome</td>
<td>F84.0</td>
<td>Autistic Disorder</td>
</tr>
<tr>
<td>E70.0</td>
<td>Classical phenylketonuria</td>
<td>F84.2</td>
<td>Rett’s Syndrome</td>
</tr>
<tr>
<td>E75.02</td>
<td>Tay-Sachs disease</td>
<td>F84.3</td>
<td>Other childhood disintegrative disorder</td>
</tr>
<tr>
<td>E75.19</td>
<td>Other Gangliosidosis</td>
<td>G31.81</td>
<td>Alpers disease</td>
</tr>
<tr>
<td>E75.23</td>
<td>Krabbe disease</td>
<td>G31.82</td>
<td>Leigh’s Disease</td>
</tr>
<tr>
<td>E75.25</td>
<td>Metachromatic Leukodystrophy</td>
<td>Q05.4</td>
<td>Unspecified Spina Bifida With Hydrocephalus</td>
</tr>
<tr>
<td>E75.29</td>
<td>Other Sphingolipidosis</td>
<td>Q05.8</td>
<td>Sacral spina bifida without hydrocephalus</td>
</tr>
<tr>
<td>E75.4</td>
<td>Neuronal ceroid lipofuscinosis</td>
<td>Q07.02</td>
<td>Arnold-Chiari Syndrome with Hydrocephalus</td>
</tr>
<tr>
<td>E76.01</td>
<td>Hurler’s syndrome</td>
<td>Q07.03</td>
<td>Arnold-Chiari Syndrome With Spina Bifida And Hydrocephalus</td>
</tr>
<tr>
<td>E76.1</td>
<td>Mucopolysaccharidosis, type II</td>
<td>Q85.1</td>
<td>Tuberous sclerosis</td>
</tr>
<tr>
<td>E76.22</td>
<td>Sanfilippo Mucopolysaccharidoses</td>
<td>Q86.0</td>
<td>Fetal Alcohol Syndrome</td>
</tr>
<tr>
<td>E76.29</td>
<td>Other Mucopolysaccharidoses</td>
<td>Q87.1</td>
<td>Congenital malformation syndromes predominantly associated with short stature (includes Prader-Willi)</td>
</tr>
<tr>
<td>E76.3</td>
<td>Mucopolysaccharidosis, unspecified</td>
<td>Q90.9</td>
<td>Down Syndrome, Unspecified</td>
</tr>
<tr>
<td>E77.1</td>
<td>Defects In Glycoprotein Degradation</td>
<td>Q91.3</td>
<td>Trisomy 18, unspecified</td>
</tr>
<tr>
<td>E78.71</td>
<td>Barth syndrome</td>
<td>Q91.7</td>
<td>Trisomy 13, unspecified</td>
</tr>
<tr>
<td>E78.72</td>
<td>Smith-Lemli-Opitz Syndrome</td>
<td>Q93.4</td>
<td>Deletion of short arm of chromosome S</td>
</tr>
<tr>
<td>F70</td>
<td>Mild intellectual disabilities</td>
<td>Q93.82</td>
<td>Williams syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(code as of 1/1/2019, previously Q89.8)</td>
</tr>
<tr>
<td>F71</td>
<td>Moderate intellectual disabilities</td>
<td>Q93.51</td>
<td>Angelman syndrome</td>
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<tr>
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<td></td>
<td></td>
<td>(code as of 1/1/2019, previously Q93.5)</td>
</tr>
<tr>
<td>F72</td>
<td>Severe intellectual disabilities</td>
<td>Q98.4</td>
<td>Klinefelter syndrome, unspecified</td>
</tr>
<tr>
<td>F73</td>
<td>Profound intellectual disabilities</td>
<td>Q99.2</td>
<td>Fragile X Chromosome</td>
</tr>
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</table>

Please refer to the various LME/MCO rate schedules for a list of ILOS and corresponding procedure codes as this varies by LME/MCO.
### Table 3: SED Diagnosis Code List

The following diagnosis code list was applied to both the FFS claims and LME/MCO encounters. Codes denoted with an asterisk do not require enhanced BH service utilization, and meet the criteria when the diagnosis is found in any diagnosis position. All other codes apply to primary diagnosis code position only.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.30</td>
<td>Mood disorder due to known physiological condition, unspecified</td>
<td>F32.3</td>
<td>Major depressive disorder, single episode, severe with psychotic features</td>
</tr>
<tr>
<td>F06.31</td>
<td>Mood disorder due to known physiological condition with depressive features</td>
<td>F32.4</td>
<td>Major depressive disorder, single episode, in partial remission</td>
</tr>
<tr>
<td>F06.32</td>
<td>Mood disorder due to physiological condition with major depressive-like episode</td>
<td>F32.5</td>
<td>Major depressive disorder, single episode, in full remission</td>
</tr>
<tr>
<td>F06.8</td>
<td>Other mental disorders due to known physiological condition</td>
<td>F32.8</td>
<td>Other depressive episodes</td>
</tr>
<tr>
<td>F09</td>
<td>Unspecified mental disorder due to known physiological condition</td>
<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
</tr>
<tr>
<td>F20.0*</td>
<td>Paranoid schizophrenia</td>
<td>F33.0</td>
<td>Major depressive disorder, recurrent, mild</td>
</tr>
<tr>
<td>F20.1*</td>
<td>Disorganized schizophrenia</td>
<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
</tr>
<tr>
<td>F20.2*</td>
<td>Catatonic schizophrenia</td>
<td>F33.2</td>
<td>Major depressive disorder, recurrent severe without psychotic features</td>
</tr>
<tr>
<td>F20.3*</td>
<td>Undifferentiated schizophrenia</td>
<td>F33.3</td>
<td>Major depressive disorder, recurrent, severe with psychotic symptoms</td>
</tr>
<tr>
<td>F20.5*</td>
<td>Residual schizophrenia</td>
<td>F33.40</td>
<td>Major depressive disorder, recurrent, in remission, unspecified</td>
</tr>
<tr>
<td>F20.81*</td>
<td>Schizophreniform disorder</td>
<td>F33.41</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
</tr>
<tr>
<td>F20.89*</td>
<td>Other schizophrenia</td>
<td>F33.42</td>
<td>Major depressive disorder, recurrent, in full remission</td>
</tr>
<tr>
<td>F20.9*</td>
<td>Schizophrenia, unspecified</td>
<td>F33.8</td>
<td>Other recurrent depressive disorders</td>
</tr>
<tr>
<td>F22*</td>
<td>Delusional disorders</td>
<td>F33.9</td>
<td>Major depressive disorder, recurrent, unspecified</td>
</tr>
<tr>
<td>F23*</td>
<td>Brief psychotic disorder</td>
<td>F34.1</td>
<td>Dysthymic disorder</td>
</tr>
<tr>
<td>F24*</td>
<td>Shared psychotic disorder</td>
<td>F34.8</td>
<td>Other persistent mood [affective] disorders</td>
</tr>
<tr>
<td>F25.0*</td>
<td>Schizoaffective disorder, bipolar type</td>
<td>F34.9</td>
<td>Persistent mood [affective] disorder, unspecified</td>
</tr>
<tr>
<td>F25.1*</td>
<td>Schizoaffective disorder, depressive type</td>
<td>F39</td>
<td>Unspecified mood [affective] disorder</td>
</tr>
<tr>
<td>F25.8*</td>
<td>Other schizoaffective disorders</td>
<td>F40.00</td>
<td>Agoraphobia, unspecified</td>
</tr>
<tr>
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<td>Schizoaffective disorder, unspecified</td>
<td>F40.01</td>
<td>Agoraphobia with panic disorder</td>
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<tr>
<td>F28</td>
<td>Other psychotic disorder not due to a substance or known physiological condition</td>
<td>F40.02</td>
<td>Agoraphobia without panic disorder</td>
</tr>
<tr>
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<td>Unspecified psychosis not due to a substance or known physiological condition</td>
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<td>Social phobia, unspecified</td>
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<tr>
<td>F30.10</td>
<td>Manic episode without psychotic symptoms, unspecified</td>
<td>F40.11</td>
<td>Social phobia, generalized</td>
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<tr>
<td>F30.11</td>
<td>Manic episode without psychotic symptoms, mild</td>
<td>F40.8</td>
<td>Other phobic anxiety disorders</td>
</tr>
<tr>
<td>F30.12</td>
<td>Manic episode without psychotic symptoms, moderate</td>
<td>F41.0</td>
<td>Panic disorder without agoraphobia</td>
</tr>
<tr>
<td>F30.13</td>
<td>Manic episode, severe, without psychotic symptoms</td>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
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<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
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<tr>
<td>------</td>
<td>-------------------------------------------------------</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td>F30.2</td>
<td>Manic episode, severe with psychotic symptoms</td>
<td>F41.3</td>
<td>Other mixed anxiety disorders</td>
</tr>
<tr>
<td>F30.3</td>
<td>Manic episode in partial remission</td>
<td>F41.8</td>
<td>Other specified anxiety disorders</td>
</tr>
<tr>
<td>F30.4</td>
<td>Manic episode in full remission</td>
<td>F41.9</td>
<td>Anxiety disorder, unspecified</td>
</tr>
<tr>
<td>F30.8</td>
<td>Other manic episodes</td>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>F30.9</td>
<td>Manic episode, unspecified</td>
<td>F43.10</td>
<td>Post-traumatic stress disorder, unspecified</td>
</tr>
<tr>
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<td>Bipolar disorder, current episode hypomanic</td>
<td>F43.12</td>
<td>Post-traumatic stress disorder, chronic</td>
</tr>
<tr>
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<td>Bipolar disorder, current episode manic without psychotic features, unspecified</td>
<td>F44.89</td>
<td>Other dissociative and conversion disorders</td>
</tr>
<tr>
<td>F31.11</td>
<td>Bipolar disorder, current episode manic without psychotic features, mild</td>
<td>F50.00</td>
<td>Anorexia nervosa, unspecified</td>
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<tr>
<td>F31.12</td>
<td>Bipolar disorder, current episode manic without psychotic features, mod</td>
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<td>Anorexia nervosa, restricting type</td>
</tr>
<tr>
<td>F31.13</td>
<td>Bipolar disorder, current episode manic without psychotic features, severe</td>
<td>F50.02</td>
<td>Anorexia nervosa, binge eating/purging type</td>
</tr>
<tr>
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<td>F50.2</td>
<td>Bulimia nervosa</td>
</tr>
<tr>
<td>F31.30</td>
<td>Bipolar disorder, current episode depressed, mild or mod severity, unspecified</td>
<td>F50.8</td>
<td>Other eating disorders</td>
</tr>
<tr>
<td>F31.31</td>
<td>Bipolar disorder, current episode depressed, mild</td>
<td>F50.82</td>
<td>Avoidant/restrictive food intake disorder</td>
</tr>
<tr>
<td>F31.32</td>
<td>Bipolar disorder, current episode depressed, moderate</td>
<td>F50.9</td>
<td>Eating disorder, unspecified</td>
</tr>
<tr>
<td>F31.4</td>
<td>Bipolar disorder, current episode depressed, severe, without psychotic features</td>
<td>F63.1</td>
<td>Pyromania</td>
</tr>
<tr>
<td>F31.5</td>
<td>Bipolar disorder, current episode depressed, severe, with psychotic features</td>
<td>F63.3</td>
<td>Trichotillomania</td>
</tr>
<tr>
<td>F31.60</td>
<td>Bipolar disorder, current episode mixed, unspecified</td>
<td>F63.81</td>
<td>Intermittent explosive disorder</td>
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<tr>
<td>F31.61</td>
<td>Bipolar disorder, current episode mixed, mild</td>
<td>F63.89</td>
<td>Other impulse disorders</td>
</tr>
<tr>
<td>F31.62</td>
<td>Bipolar disorder, current episode mixed, moderate</td>
<td>F84.0</td>
<td>Autistic disorder</td>
</tr>
<tr>
<td>F31.63</td>
<td>Bipolar disorder, current episode mixed, severe, without psychotic features</td>
<td>F84.5</td>
<td>Asperger's syndrome</td>
</tr>
<tr>
<td>F31.64</td>
<td>Bipolar disorder, current episode mixed, severe, with psychotic features</td>
<td>F90.0</td>
<td>Attention-deficit hyperactivity disorder, predominantly inattentive type</td>
</tr>
<tr>
<td>F31.70</td>
<td>Bipolar disorder, currently in remission, most recent episode unspecified</td>
<td>F90.1</td>
<td>Attention-deficit hyperactivity disorder, predominantly hyperactive type</td>
</tr>
<tr>
<td>F31.71</td>
<td>Bipolar disorder, in partial remission, most recent episode hypomanic</td>
<td>F90.2</td>
<td>Attention-deficit hyperactivity disorder, combined type</td>
</tr>
<tr>
<td>F31.72</td>
<td>Bipolar disorder, in full remission, most recent episode hypomanic</td>
<td>F90.8</td>
<td>Attention-deficit hyperactivity disorder, other type</td>
</tr>
<tr>
<td>F31.73</td>
<td>Bipolar disorder, in partial remission, most recent episode manic</td>
<td>F90.9</td>
<td>Attention-deficit hyperactivity disorder, unspecified type</td>
</tr>
<tr>
<td>F31.74</td>
<td>Bipolar disorder, in full remission, most recent episode manic</td>
<td>F91.0</td>
<td>Conduct disorder confined to family context</td>
</tr>
</tbody>
</table>
North Carolina Medicaid Managed Care
Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F31.75</td>
<td>Bipolar disorder, in partial remission, most</td>
<td>F91.1</td>
<td>Conduct disorder, childhood-onset type</td>
</tr>
<tr>
<td></td>
<td>recent episode depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F31.76</td>
<td>Bipolar disorder, in full remission, most</td>
<td>F91.2</td>
<td>Conduct disorder, adolescent-onset type</td>
</tr>
<tr>
<td></td>
<td>recent episode depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F31.77</td>
<td>Bipolar disorder, in partial remission, most</td>
<td>F91.3</td>
<td>Oppositional defiant disorder</td>
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<tr>
<td></td>
<td>recent episode mixed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F31.78</td>
<td>Bipolar disorder, in full remission, most</td>
<td>F91.8</td>
<td>Other conduct disorders</td>
</tr>
<tr>
<td></td>
<td>recent episode mixed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F31.81</td>
<td>Bipolar II disorder</td>
<td>F91.9</td>
<td>Conduct disorder, unspecified</td>
</tr>
<tr>
<td>F31.89</td>
<td>Other bipolar disorder</td>
<td>F94.1</td>
<td>Reactive attachment disorder of childhood</td>
</tr>
<tr>
<td>F31.9</td>
<td>Bipolar disorder, unspecified</td>
<td>F94.2</td>
<td>Disinhibited attachment disorder of childhood</td>
</tr>
<tr>
<td>F32.0</td>
<td>Major depressive disorder, single episode, mild</td>
<td>F98.8</td>
<td>Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence</td>
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<tr>
<td>F32.1</td>
<td>Major depressive disorder, single episode,</td>
<td>F99</td>
<td>Mental disorder, not otherwise specified</td>
</tr>
<tr>
<td></td>
<td>moderate</td>
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<td></td>
</tr>
<tr>
<td>F32.2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>severe without psychotic features</td>
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<td></td>
</tr>
</tbody>
</table>

Table 4: SMI Diagnosis Code List
The following diagnosis code list was applied to both the FFS claims and LME/MCO encounters.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F20.0</td>
<td>Paranoid schizophrenia</td>
<td>F31.74</td>
<td>Bipolar disorder, in full remission, most recent episode manic</td>
</tr>
<tr>
<td>F20.1</td>
<td>Disorganized schizophrenia</td>
<td>F31.75</td>
<td>Bipolar disorder, in partial remission, most recent episode depressed</td>
</tr>
<tr>
<td>F20.2</td>
<td>Catatonic schizophrenia</td>
<td>F31.76</td>
<td>Bipolar disorder, in full remission, most recent episode depressed</td>
</tr>
<tr>
<td>F20.3</td>
<td>Undifferentiated schizophrenia</td>
<td>F31.77</td>
<td>Bipolar disorder, in partial remission, most recent episode depressed</td>
</tr>
<tr>
<td>F20.5</td>
<td>Residual schizophrenia</td>
<td>F31.78</td>
<td>Bipolar disorder, in full remission, most recent episode mixed</td>
</tr>
<tr>
<td>F20.8</td>
<td>Other schizophrenia</td>
<td>F31.81</td>
<td>Bipolar II disorder</td>
</tr>
<tr>
<td>F20.81</td>
<td>Schizophreniform disorder</td>
<td>F31.89</td>
<td>Other bipolar disorder</td>
</tr>
<tr>
<td>F20.89</td>
<td>Other schizophrenia</td>
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<td>Bipolar disorder, unspecified</td>
</tr>
<tr>
<td>F20.9</td>
<td>Schizophrenia, unspecified</td>
<td>F32.0</td>
<td>Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td>F21</td>
<td>Schizotypal disorder</td>
<td>F32.1</td>
<td>Major depressive disorder, single episode, moderate</td>
</tr>
<tr>
<td>F22</td>
<td>Delusional Disorder Unspecified</td>
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<td>Major depressive disorder, single episode, severe without psychotic features</td>
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<tr>
<td>F25.0</td>
<td>Schizoaffective disorder, bipolar type</td>
<td>F32.3</td>
<td>Major depressive disorder, single episode, severe with psychotic features</td>
</tr>
<tr>
<td>F25.1</td>
<td>Schizoaffective disorder, depressive type</td>
<td>F32.4</td>
<td>Major depressive disorder, single episode, in partial remission</td>
</tr>
<tr>
<td>F25.8</td>
<td>Other schizoaffective disorders</td>
<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
</tr>
<tr>
<td>F25.9</td>
<td>Schizoaffective disorder, unspecified</td>
<td>F33.0</td>
<td>Major depressive disorder, recurrent, mild</td>
</tr>
</tbody>
</table>
### Table 5: SUD Diagnosis Code List

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F29</td>
<td>Unspecified psychosis not due to a substance or known physiological condition</td>
<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
</tr>
<tr>
<td>F30.13</td>
<td>Manic episode, severe, without psychotic symptoms</td>
<td>F33.2</td>
<td>Major depressive disorder, recurrent severe without psychotic features</td>
</tr>
<tr>
<td>F30.2</td>
<td>Manic episode, severe with psychotic symptoms</td>
<td>F33.3</td>
<td>Major depressive disorder, recurrent, severe with psychotic symptoms</td>
</tr>
<tr>
<td>F31.0</td>
<td>Bipolar disorder, current episode hypomanic</td>
<td>F33.41</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
</tr>
<tr>
<td>F31.10</td>
<td>Bipolar disorder, current episode manic without psychotic features, unspecified</td>
<td>F33.9</td>
<td>Major depressive disorder, recurrent, unspecified</td>
</tr>
<tr>
<td>F31.11</td>
<td>Bipolar disorder, current episode manic without psychotic features, mild</td>
<td>F40.00</td>
<td>Agoraphobia, unspecified</td>
</tr>
<tr>
<td>F31.12</td>
<td>Bipolar disorder, current episode manic without psychotic features, moderate</td>
<td>F40.01</td>
<td>Agoraphobia with panic disorder</td>
</tr>
<tr>
<td>F31.13</td>
<td>Bipolar disorder, current episode manic without psychotic features, severe</td>
<td>F41.0</td>
<td>Panic disorder without agoraphobia</td>
</tr>
<tr>
<td>F31.2</td>
<td>Bipolar disorder, current episode manic severe with psychotic features</td>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>F31.30</td>
<td>Bipolar disorder, current episode depressed, mild or mod severity, unspecified</td>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
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<tr>
<td>F31.31</td>
<td>Bipolar disorder, current episode depressed, mild</td>
<td>F42.3</td>
<td>Hoarding disorder</td>
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<td>Bipolar disorder, current episode depressed, moderate</td>
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<td>Post-traumatic stress disorder, unspecified</td>
</tr>
<tr>
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<td>Post-traumatic stress disorder, acute</td>
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<tr>
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<td>F43.12</td>
<td>Post-traumatic stress disorder, chronic</td>
</tr>
<tr>
<td>F31.60</td>
<td>Bipolar disorder, current episode mixed, unspecified</td>
<td>F44.2</td>
<td>Dissociative stupor</td>
</tr>
<tr>
<td>F31.61</td>
<td>Bipolar disorder, current episode mixed, mild</td>
<td>F44.81</td>
<td>Dissociative identity disorder</td>
</tr>
<tr>
<td>F31.62</td>
<td>Bipolar disorder, current episode mixed, moderate</td>
<td>F44.9</td>
<td>Dissociative and conversion disorder, unspecified</td>
</tr>
<tr>
<td>F31.63</td>
<td>Bipolar disorder, current episode mixed, severe, without psychotic features</td>
<td>F50.00</td>
<td>Anorexia nervosa, unspecified</td>
</tr>
<tr>
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<td>Anorexia nervosa, restricting type</td>
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<td>F31.70</td>
<td>Bipolar disorder, currently in remission, most recent episode unspecified</td>
<td>F50.02</td>
<td>Anorexia nervosa, binge eating/purging type</td>
</tr>
<tr>
<td>F31.71</td>
<td>Bipolar disorder, in partial remission, most recent episode hypomanic</td>
<td>F50.2</td>
<td>Bulimia nervosa</td>
</tr>
<tr>
<td>F31.72</td>
<td>Bipolar disorder, in full remission, most recent episode hypomanic</td>
<td>F53</td>
<td>Puerperal psychosis</td>
</tr>
<tr>
<td>F31.73</td>
<td>Bipolar disorder, in partial remission, most recent episode manic</td>
<td>F60.3</td>
<td>Borderline Personality Disorder</td>
</tr>
</tbody>
</table>

*Note: SUD stands for Substance Use Disorder.*
The following diagnosis code list was applied to both the FFS claims and LME/MCO encounters.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.10</td>
<td>Alcohol abuse, uncomplicated</td>
<td>F14.220</td>
<td>Cocaine dependence with intoxication, uncomplicated</td>
</tr>
<tr>
<td>F10.121</td>
<td>Alcohol abuse with intoxication delirium</td>
<td>F14.23</td>
<td>Cocaine dependence with withdrawal</td>
</tr>
<tr>
<td>F10.20</td>
<td>Alcohol dependence, uncomplicated</td>
<td>F14.250</td>
<td>Cocaine dependence with cocaine-induced psychotic disorder with delusions</td>
</tr>
<tr>
<td>F10.22</td>
<td>Alcohol dependence with intoxication, uncomplicated</td>
<td>F14.251</td>
<td>Cocaine dependence with cocaine-induced psychotic disorder with hallucinations</td>
</tr>
<tr>
<td>F10.221</td>
<td>Alcohol dependence with intoxication delirium</td>
<td>F14.29</td>
<td>Cocaine dependence with unspecified cocaine-induced disorder</td>
</tr>
<tr>
<td>F10.23</td>
<td>Alcohol dependence with withdrawal, uncomplicated</td>
<td>F15.10</td>
<td>Other stimulant abuse, uncomplicated</td>
</tr>
<tr>
<td>F10.231</td>
<td>Alcohol dependence with withdrawal delirium</td>
<td>F15.20</td>
<td>Other stimulant dependence, uncomplicated</td>
</tr>
<tr>
<td>F10.232</td>
<td>Alcohol dependence with withdrawal with perceptual disturbance</td>
<td>F15.220</td>
<td>Other stimulant dependence with intoxication, uncomplicated</td>
</tr>
<tr>
<td>F10.239</td>
<td>Alcohol dependence with withdrawal, unspecified</td>
<td>F15.23</td>
<td>Other stimulant dependence with withdrawal</td>
</tr>
<tr>
<td>F10.25</td>
<td>Alcohol dependence with alcohol-induced psychotic disorder with delusions</td>
<td>F15.250</td>
<td>Other stimulant dependence with stimulant-induced psychotic disorder with delusions</td>
</tr>
<tr>
<td>F10.251</td>
<td>Alcohol dependence with alcohol-induced psychotic disorder with hallucinations</td>
<td>F15.251</td>
<td>Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations</td>
</tr>
<tr>
<td>F10.29</td>
<td>Alcohol dependence with unspecified alcohol-induced disorder</td>
<td>F15.29</td>
<td>Other stimulant dependence with unspecified stimulant-induced disorder</td>
</tr>
<tr>
<td>F10.921</td>
<td>Alcohol use, unspecified with intoxication delirium</td>
<td>F15.929</td>
<td>Other stimulant use, unspecified with intoxication, unspecified</td>
</tr>
<tr>
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<td>F15.93</td>
<td>Other stimulant use, unspecified with withdrawal</td>
</tr>
<tr>
<td>F11.120</td>
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<td>F16.10</td>
<td>Hallucinogen abuse, uncomplicated</td>
</tr>
<tr>
<td>F11.129</td>
<td>Opioid abuse with intoxication, unspecified</td>
<td>F16.20</td>
<td>Hallucinogen dependence, uncomplicated</td>
</tr>
<tr>
<td>F11.20</td>
<td>Opioid dependence, uncomplicated</td>
<td>F16.220</td>
<td>Hallucinogen dependence with intoxication, uncomplicated</td>
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<td>Opioid dependence with intoxication, uncomplicated</td>
<td>F16.250</td>
<td>Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions</td>
</tr>
<tr>
<td>F11.23</td>
<td>Opioid dependence with withdrawal</td>
<td>F16.251</td>
<td>Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations</td>
</tr>
<tr>
<td>F11.25</td>
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<td>Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)</td>
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<tr>
<td>F11.251</td>
<td>Opioid dependence with opioid-induced psychotic disorder with hallucinations</td>
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<td>Hallucinogen dependence with other hallucinogen-induced disorder</td>
</tr>
<tr>
<td>F11.259</td>
<td>Opioid dependence with opioid-induced psychotic disorder, unspecified</td>
<td>F16.29</td>
<td>Hallucinogen dependence with unspecified hallucinogen-induced disorder</td>
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<tr>
<td>F11.29</td>
<td>Opioid dependence with unspecified opioid-induced disorder</td>
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<td>Inhalant abuse, uncomplicated</td>
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<td>Inhalant dependence, uncomplicated</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
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<td>--------------------------------------------------</td>
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<td>Opioid use, unspecified with withdrawal</td>
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<td>Inhalant dependence with intoxication, uncomplicated</td>
</tr>
<tr>
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<td>Cannabis abuse, uncomplicated</td>
<td>F18.250</td>
<td>Inhalant dependence with inhalant-induced psychotic disorder with delusions</td>
</tr>
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<td>F12.20</td>
<td>Cannabis dependence, uncomplicated</td>
<td>F18.251</td>
<td>Inhalant dependence with inhalant-induced psychotic disorder with hallucinations</td>
</tr>
<tr>
<td>F12.220</td>
<td>Cannabis dependence with intoxication, uncomplicated</td>
<td>F18.29</td>
<td>Inhalant dependence with unspecified inhalant-induced disorder</td>
</tr>
<tr>
<td>F12.250</td>
<td>Cannabis dependence with psychotic disorder with delusions</td>
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<td>Other psychoactive substance abuse, uncomplicated</td>
</tr>
<tr>
<td>F12.251</td>
<td>Cannabis dependence with psychotic disorder with hallucinations</td>
<td>F19.20</td>
<td>Other psychoactive substance dependence, uncomplicated</td>
</tr>
<tr>
<td>F12.288</td>
<td>Cannabis dependence with other cannabis-induced disorder</td>
<td>F19.220</td>
<td>Other psychoactive substance dependence with intoxication, uncomplicated</td>
</tr>
<tr>
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<td>Cannabis dependence with unspecified cannabis-induced disorder</td>
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<td>Other psychoactive substance dependence with intoxication with perceptual disturbance</td>
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<td>Other psychoactive substance dependence with withdrawal, uncomplicated</td>
</tr>
<tr>
<td>F13.10</td>
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<td>F19.231</td>
<td>Other psychoactive substance dependence with withdrawal delirium</td>
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<tr>
<td>F13.20</td>
<td>Sedative, hypnotic or anxiolytic dependence, uncomplicated</td>
<td>F19.232</td>
<td>Other psychoactive substance dependence with withdrawal with perceptual disturbance</td>
</tr>
<tr>
<td>F13.220</td>
<td>Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated</td>
<td>F19.239</td>
<td>Other psychoactive substance dependence with withdrawal, unspecified</td>
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<td>Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations</td>
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<td>Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified</td>
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<td>Other psychoactive substance dependence with psychotic disorder, unspecified</td>
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<td>Other psychoactive substance dependence with anxiety disorder</td>
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<tr>
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<td>F19.281</td>
<td>Other psychoactive substance dependence with sexual dysfunction</td>
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</table>
North Carolina Medicaid Managed Care
Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment

<table>
<thead>
<tr>
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<th>Description</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td>F13.29</td>
<td>Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder</td>
<td>F19.282</td>
<td>Other psychoactive substance dependence with sleep disorder</td>
</tr>
<tr>
<td>F14.10</td>
<td>Cocaine abuse, uncomplicated</td>
<td>F19.288</td>
<td>Other psychoactive substance dependence with other disorder</td>
</tr>
<tr>
<td>F14.20</td>
<td>Cocaine dependence, uncomplicated</td>
<td>F19.29</td>
<td>Other psychoactive substance dependence with unspecified disorder</td>
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</tbody>
</table>

Table 6: Enhanced BH Services
The following service code list was applied to both the FFS claims and LME/MCO encounters.

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
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<tbody>
<tr>
<td>Non-Hospital Medical Detoxification</td>
<td>H0010</td>
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<tr>
<td>SA Non-Medical Community Residential Treatment</td>
<td>H0012</td>
</tr>
<tr>
<td>SA Medically Monitored Community Residential Treatment</td>
<td>H0013</td>
</tr>
<tr>
<td>Ambulatory Detoxification</td>
<td>H0014</td>
</tr>
<tr>
<td>SA Intensive Outpatient Program</td>
<td>H0015</td>
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<tr>
<td>HRI Residential</td>
<td>H0019</td>
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<tr>
<td>Opioid Treatment</td>
<td>H0020</td>
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<tr>
<td>Partial Hospital</td>
<td>H0035</td>
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<tr>
<td>Assertive Community Treatment Team</td>
<td>H0040</td>
</tr>
<tr>
<td>HRI Residential</td>
<td>H0046</td>
</tr>
<tr>
<td>Mobile Crisis Management</td>
<td>H2011</td>
</tr>
<tr>
<td>Child/Adolescent Day Treatment</td>
<td>H2012</td>
</tr>
<tr>
<td>Community Support</td>
<td>H2015</td>
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<tr>
<td>Psychosocial Rehabilitation</td>
<td>H2017</td>
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<tr>
<td>HRI Residential</td>
<td>H2020</td>
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<tr>
<td>Intensive In-Home Services</td>
<td>H2022</td>
</tr>
<tr>
<td>Multi-Systemic Therapy</td>
<td>H2033</td>
</tr>
<tr>
<td>SA Comprehensive Outpatient Treatment Program</td>
<td>H2035</td>
</tr>
<tr>
<td>Medically Monitored or ADATC Detoxification/Crisis Stabilization</td>
<td>H2036</td>
</tr>
<tr>
<td>HRI Residential</td>
<td>S5145</td>
</tr>
<tr>
<td>Facility-Based Crisis</td>
<td>S9484</td>
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</table>

Table 7: Clozapine and Long-Acting Injectable Antipsychotics
The following products were used in the identification of clozapine and long-acting injectable antipsychotics.

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<thead>
<tr>
<th>Description</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ABILIFY MAINTENA ER 300 MG SYR</td>
<td>HALOPERIDOL DEC 100 MG/ML AMP</td>
</tr>
<tr>
<td>ABILIFY MAINTENA ER 300 MG VL</td>
<td>HALOPERIDOL DEC 100 MG/ML VIAL</td>
</tr>
<tr>
<td>ABILIFY MAINTENA ER 400 MG SYR</td>
<td>HALOPERIDOL DEC 50 MG/ML VIAL</td>
</tr>
<tr>
<td>ABILIFY MAINTENA ER 400 MG VL</td>
<td>HALOPERIDOL DEC 500 MG/5 ML VL</td>
</tr>
<tr>
<td>ARISTADA ER 1064 MG/3.9 ML SYR</td>
<td>HALOPERIDOL DECAN 50 MG/ML AMP</td>
</tr>
<tr>
<td>ARISTADA ER 441 MG/1.6 ML SYRN</td>
<td>INVEGA SUSTENNA 117 MG/0.75 ML</td>
</tr>
<tr>
<td>ARISTADA ER 662 MG/2.4 ML SYRN</td>
<td>INVEGA SUSTENNA 156 MG/ML SYRG</td>
</tr>
<tr>
<td>ARISTADA ER 882 MG/3.2 ML SYRN</td>
<td>INVEGA SUSTENNA 234 MG/1.5 ML</td>
</tr>
<tr>
<td>ARISTADA INITIO ER 675 MG/2.4</td>
<td>INVEGA SUSTENNA 39 MG/0.25 ML</td>
</tr>
</tbody>
</table>

8 BH I/DD Tailored Plan data logic did not rely on the modifier field.
<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLOZAPINE 100 MG TABLET</td>
<td>INVEGA SUSTENNA 78 MG/0.5 ML</td>
</tr>
<tr>
<td>CLOZAPINE 25 MG TABLET</td>
<td>INVEGA TRINZA 273 MG/0.875 ML</td>
</tr>
<tr>
<td>CLOZAPINE 50 MG TABLET</td>
<td>INVEGA TRINZA 410 MG/1.315 ML</td>
</tr>
<tr>
<td>CLOZAPINE ODT 100 MG TABLET</td>
<td>INVEGA TRINZA 546 MG/1.75 ML</td>
</tr>
<tr>
<td>CLOZAPINE ODT 12.5 MG TABLET</td>
<td>INVEGA TRINZA 819 MG/2.625 ML</td>
</tr>
<tr>
<td>CLOZAPINE ODT 150 MG TABLET</td>
<td>PERSERIS ER 120 MG SYRINE KIT</td>
</tr>
<tr>
<td>CLOZAPINE ODT 200 MG TABLET</td>
<td>PERSERIS ER 90 MG SYRINE KIT</td>
</tr>
<tr>
<td>CLOZAPINE ODT 25 MG TABLET</td>
<td>RISPERDAL CONSTA 12.5 MG SYR</td>
</tr>
<tr>
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<td>RISPERDAL CONSTA 25 MG SYR</td>
</tr>
<tr>
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<td>RISPERDAL CONSTA 37.5 MG SYR</td>
</tr>
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<td>RISPERDAL CONSTA 50 MG SYR</td>
</tr>
<tr>
<td>FAZACLO 12.5 MG ODT</td>
<td>VERSACLOZ 50 MG/ML SUSPENSION</td>
</tr>
<tr>
<td>FAZACLO 150 MG ODT</td>
<td>ZYPREXA RELPREVV 210 MG VIAL</td>
</tr>
<tr>
<td>FAZACLO 200 MG ODT</td>
<td>ZYPREXA RELPREVV 210 MG VL KIT</td>
</tr>
<tr>
<td>FAZACLO 25 MG ODT</td>
<td>ZYPREXA RELPREVV 300 MG VIAL</td>
</tr>
<tr>
<td>FLUPHENAZINE DECANOATE LIQUID</td>
<td>ZYPREXA RELPREVV 300 MG VL KIT</td>
</tr>
<tr>
<td>FLUPHENAZINE DECANOATE OIL</td>
<td>ZYPREXA RELPREVV 405 MG VIAL</td>
</tr>
<tr>
<td>HALDOL DECANOATE 100 AMPUL</td>
<td>ZYPREXA RELPREVV 405 MG VIAL KIT</td>
</tr>
<tr>
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Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment Updates
July 16, 2019

Purpose of This Memo
In March 2019, the North Carolina Department of Health and Human Services (DHHS) released policy guidance outlining its approach to Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan Eligibility and Enrollment.¹ This memo outlines several updates to both processes in response to stakeholder feedback and considerations in operationalizing efficient and effective processes for Behavioral Health I/DD Tailored Plan eligibility and enrollment. This memo also provides an update to the substance use disorder service packages for Standard Plans.

Overview of Behavioral Health I/DD Tailored Plans
North Carolina is transforming its Medicaid program to managed care. Beginning in November 2019, DHHS will enroll most Medicaid beneficiaries into integrated managed care products called Standard Plans that will cover physical health, behavioral health and pharmacy services.

Behavioral Health I/DD Tailored Plans are specialized managed care products targeting the needs of individuals with significant behavioral health disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI). These plans are scheduled to begin in July 2021.

Prior to launch, beneficiaries meeting eligibility for the Behavioral Health I/DD Tailored Plans will continue to be covered through the current Medicaid fee-for-service/local management entity – managed care organization (LME-MCO) system, also referred to as NC Medicaid Direct.

Core to DHHS’ approach to Medicaid managed care eligibility and enrollment is an ongoing commitment to ensuring that beneficiaries are enrolled in and transitioned as seamlessly as possible to the managed care plan or delivery system that is best suited to meet their needs.

DHHS will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans and new Medicaid beneficiaries who meet Behavioral Health I/DD Tailored Plan eligibility criteria. Additionally, new Medicaid beneficiaries and Standard Plan beneficiaries who are not identified as eligible for Behavioral Health I/DD Tailored Plans will able to request a review to determine whether they are eligible.

Topics Addressed in this Memo
This memo contains updates and clarifications on four topics:

I. Behavioral Health I/DD Tailored Plan Eligibility Criteria Used for Claims/Encounter Data Reviews
   II. Process for Requesting Behavioral Health I/DD Tailored Plan Eligibility
   III. Process for Enrolling in a Behavioral Health I/DD Tailored Plan After Start of Standard Plan Enrollment
   IV. Benefits Covered in Behavioral Health I/DD Tailored Plans

I. Behavioral Health I/DD Tailored Plan Eligibility Criteria Used for Claims/Encounter Data Reviews
DHHS has held ongoing discussions with a variety of stakeholders to refine the Behavioral Health I/DD Tailored Plan eligibility criteria used in claims/encounter data reviews. DHHS’ consistent approach is to

¹ https://files.nc.gov/ncdhhs/BH-IDD-TP-FinalPolicyGuidance-Final-20190318.pdf
use encounter/claims data as a proxy for determining whether Medicaid beneficiaries with qualifying diagnoses of serious mental illness (SMI) or serious emotional disturbance (SED) are functionally impaired. Through these discussions and with consultation from DHHS clinical leadership, additional encounter/claims data markers were identified as being indicative of functional impairment and have been added to the criteria used for identifying beneficiaries as eligible for Behavioral Health I/DD Tailored Plans.

**Additional Eligibility Criteria Indicative of Functional Impairment for SMI/SED**
DHHS has added the following criteria to those outlined in the March 2019 guidance to identify beneficiaries eligible for the Behavioral Health I/DD Tailored Plans based on claims/encounter data reviews:

- Beneficiaries under 18 years of age with a claim or encounter since January 1, 2018, that includes a schizophrenia or schizoaffective disorder, regardless of service utilization.
- Beneficiaries with a claim/encounter demonstrating use of electroconvulsive therapy since January 1, 2018, regardless of diagnosis.
- Beneficiaries who have used clozapine or long acting injectable anti-psychotics since January 1, 2018, regardless of diagnosis.

**Additional Eligibility Criteria for I/DD**
Additionally, DHHS has expanded the list of I/DD diagnoses included in its claim/encounter data reviews to include Williams Syndrome, Angelman Syndrome and Prader-Willi Syndrome.

**Other Clarifications**
DHHS has clarified several criteria used for data reviews to ease the transition for Standard Plan beneficiaries to Behavioral Health I/DD Tailored Plans. DHHS will use two emergency visit claims (primarily related to behavioral health problems) or crisis services as evidence of functional impairment for beneficiaries with SMI and Behavioral Health I/DD Tailored Plan eligibility.

In addition to flagging beneficiaries with two crisis episodes as noted above, DHHS has also clarified that beneficiaries with any claim for an enhanced crisis service (e.g., facility-based crisis, mobile crisis) during the look-back period is a qualifier for Behavioral Health I/DD Tailored Plan eligibility if the beneficiary has a qualifying primary mental health or substance use disorder diagnosis as outlined in the March 2019 guidance.

**II. Process for Requesting Behavioral Health I/DD Tailored Plan Eligibility**

As noted in the March 2019 guidance, DHHS recognizes that data reviews will not identify all beneficiaries eligible for enrollment in the Behavioral Health I/DD Tailored Plans, including some with behavioral health diagnoses causing significant functional impairment. To address this concern, DHHS has developed a request process as an alternative pathway for determining Behavioral Health I/DD Tailored Plan eligibility.

Beneficiaries who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility criteria as part of the DHHS data review process but meet one of the criteria outlined in legislation can submit to DHHS a request to stay in NC Medicaid Direct/LME-MCO. The request can be made using one of the following forms:
1) Request to Stay in NC Medicaid Direct and LME-MCO: Beneficiary Form - The beneficiary (or guardian/legally responsible person) can submit a form that indicates whether the beneficiary has needs related to developmental disability, mental illness, traumatic brain injury and/or substance use disorder. The beneficiary must provide either documentation of their needs or contact information for their provider. The beneficiary must sign the form providing permission for DHHS to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to NC Medicaid Direct/LME-MCO.

2) Request to Stay in NC Medicaid Direct and LME-MCO: Provider Form - The beneficiary (or guardian/legally responsible person) can work with their provider to complete a form indicating the reason(s) the beneficiary is believed to be eligible for the Behavioral Health I/DD Tailored Plan. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary. The beneficiary must also sign the form providing permission for DHHS to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to NC Medicaid Direct/LME-MCO.

DHHS has developed the forms in collaboration with stakeholders. For reference, the forms are attached.

Once received, DHHS (or its contractors) will review the forms and follow up with the beneficiary and/or their provider for more information as needed. If the request is approved, DHHS will send a letter to the beneficiary to let them know that they will continue getting, or begin getting, their Medicaid services through NC Medicaid Direct/LME-MCO. If the request is not approved, DHHS will send a letter to the beneficiary to let them know that they will continue to be enrolled in their Standard Plan. The letter will also tell them how they can appeal if they do not agree with the decision.

Prior to July 2021, the forms will be updated to reflect the launch of Behavioral Health I/DD Tailored Plans.

III. Process for Enrolling in a Behavioral Health I/DD Tailored Plan After Start of Standard Plan Enrollment

DHHS has updated the enrollment pathways for Standard Plan enrollees to better ensure that those who urgently need a service covered only by Behavioral Health I/DD Tailored Plans (or only by NC Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch) are transitioned as quickly and smoothly as possible.

Updated Policy: Automatic Enrollment for All Beneficiaries
DHHS will auto-enroll all Standard Plan beneficiaries who are identified as eligible into Behavioral Health I/DD Tailored Plans (or NC Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch) on the first of the month following the date they are identified as eligible.

DHHS will notify these beneficiaries that they are being transferred, and that they can request to transfer back to any Standard Plan at any point during the coverage year (effective the first of the next month). Standard Plan beneficiaries with an urgent need for a service available only in Behavioral Health I/DD Tailored Plans (or LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch) will have an expedited path to enrolling in a Behavioral Health I/DD Tailored Plan, as described in the next section.
New Policy: Urgent Transfer Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Only Available in the Behavioral Health I/DD Tailored Plans (NC Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch)

DHHS has clarified the process for beneficiaries enrolled in a Standard Plan who have an urgent need for a service only available in the Behavioral Health I/DD Tailored Plans (or NC Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plans). Transfers can be requested as follows:

- Provider submits request for an urgent transfer to DHHS on behalf of the Standard Plan beneficiary.
- Standard Plan beneficiary must sign the urgent request, which acknowledges the request and that approval will lead to immediate disenrollment from Standard Plan and enrollment in a Behavioral Health I/DD Tailored Plan (or NC Medicaid Direct/LME-MCO prior to Behavioral Health I/DD Tailored Plan launch).
- DHHS will review and enroll the Standard Plan beneficiary in Behavioral Health I/DD Tailored Plans (or NC Medicaid Direct/LME-MCO prior to Behavioral Health I/DD Tailored Plan launch) effective retroactive to the date of the request.

More details on this process and the applicable form will be available prior to November 1, 2019, when Standard Plan coverage will begin for beneficiaries in the first two of six regions in the state.

IV. Benefits Covered in Behavioral Health I/DD Tailored Plans

Original Policy
 DHHS had proposed that both substance abuse intensive outpatient program (SAIOP) and substance abuse comprehensive outpatient treatment program (SACOT) would be covered by both Standard Plans and Behavioral Health I/DD Tailored Plans.

Updated Policy
 Both SAIOP and SACOT services will only be covered by the Behavioral Health I/DD Tailored Plans (or Medicaid Direct/LME-MCOs prior to Behavioral Health I/DD Tailored Plan launch). Standard Plan beneficiaries who urgently require SAIOP or SACOT will be transferred to a Behavioral Health I/DD Tailored Plan immediately following DHHS’ review and approval of the request for an urgent transfer as described in Section III above.

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More Information
For more information about Behavioral Health I/DD Tailored Plans, please visit medicaid.ncdhhs.gov/behavioral-health-idd-tailored-plans.

For more information about North Carolina’s Medicaid Transformation, please visit ncdhhs.gov/medicaid-transformation.

About the Appendix
DHHS also updated “Appendix B. Behavioral Health I/DD Tailored Plan Population Identification of the Policy Guidance” to reflect the updates outlined in this memo.
North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Local Management Entities/Managed Care Organizations
Administrative Functions Monitoring

Report
May 2019

Prepared by:

Quality Management Section
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services North Carolina Department of Health and Human Services
3004 Mail Services Center, Raleigh, NC 27699-3004
(919) 733-0696
ContactDMHQuality@dhhs.nc.gov

Version: 07/02/19
### DMA Performance Measures

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### Combined Performance Measures

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<td>% Answered within 30 seconds</td>
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Yellow Shading indicates the MCO did not meet the Standard for one or two consecutive months.
Pink Shading indicates the MCO did not meet the Standard for 3 or more consecutive months.
Gray Shading indicates not applicable this report period.
EXPLANATIONS

**Note:** When reviewing the data, please note that the highlighted outliers may be considered as a positive or negative indicator. The highlighted outlier indicates a value that is numerically distant from the other data points in the set of data.
## LME/MCO Monthly Monitoring Report
### Medicaid and State Combined

**May 2019 Report**

### Call Center

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<th>Trillium</th>
<th>Vaya</th>
<th>NC Total</th>
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### IDD Wait List

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<tr>
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### Service Status of Persons on the Waiting List

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<td><strong># of Persons on Waitlist receiving State Services</strong></td>
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<td><strong>% of Persons on Waitlist receiving State and/or B3 Services</strong></td>
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### Incidents

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### Transitions to Community Living Initiative

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<td><strong>Individuals in In-reach</strong></td>
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### Claim/Encounter Processing in NCTracks

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<th>Standard</th>
<th>LME-MCO:</th>
<th>Alliance</th>
<th>Cardinal</th>
<th>Eastpointe</th>
<th>Partners</th>
<th>Sandhills</th>
<th>Trillium</th>
<th>Vaya</th>
<th>NC Total</th>
<th>STD DEV</th>
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<tbody>
<tr>
<td><strong>DMH- % of Claims $ Value Denied by Date of Service FY16</strong></td>
<td></td>
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<tr>
<td><strong>DMH- % of Claims $ Value Denied by Date of Service FY17</strong></td>
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<tr>
<td><strong>DMH- % of Claims $ Value Denied by Date of Service FY18</strong></td>
<td></td>
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<tr>
<td><strong>DMH- % of Claims $ Value Denied by Date of Service FY19 YTD</strong></td>
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</tbody>
</table>

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1 Please be aware that April 2019 data is used in this section.

Note: All Level 3 Critical Incidents are reviewed by the LME/MCO to ensure Providers conduct internal investigation.

Yellow Highlights indicate the MCO did not meet the Standard
Pink Highlights indicate the MCO did not meet the Standard for 3 consecutive months.
Blue highlights indicate possible outliers (>1.5 Std Dev above or below the LME/MCO Avg).
### MCO Monthly Monitoring Report

**Medicaid Only**

**May 2019 Report**

**LME/MCO:**

<table>
<thead>
<tr>
<th>Monitoring Area</th>
<th>Standard</th>
<th>Alliance</th>
<th>Cardinal</th>
<th>Eastpointe</th>
<th>Partners</th>
<th>Sandhills</th>
<th>Trillium</th>
<th>Vaya</th>
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<th>STD DEV</th>
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<tbody>
<tr>
<td><strong>Persons Served</strong></td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
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<td>May-19</td>
<td>May-19</td>
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<tr>
<td>Unduplicated Count of Medicaid Members</td>
<td>220,927</td>
<td>420,858</td>
<td>149,542</td>
<td>137,553</td>
<td>166,081</td>
<td>201,334</td>
<td>154,035</td>
<td>1,450,330</td>
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<tr>
<td># Persons Receiving MH Services</td>
<td>12,591</td>
<td>23,623</td>
<td>5,185</td>
<td>9,253</td>
<td>8,649</td>
<td>10,888</td>
<td>9,591</td>
<td>79,780</td>
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<tr>
<td>% of Members Receiving MH Services</td>
<td>5.7%</td>
<td>5.6%</td>
<td>3.5%</td>
<td>6.7%</td>
<td>5.2%</td>
<td>5.4%</td>
<td>6.2%</td>
<td>5.9%</td>
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<tr>
<td># Persons Receiving SA Services</td>
<td>1,405</td>
<td>3,073</td>
<td>1,097</td>
<td>1,385</td>
<td>1,557</td>
<td>1,692</td>
<td>1,695</td>
<td>11,904</td>
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<tr>
<td>% of Members Receiving SA Services</td>
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<td>0.7%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>0.9%</td>
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<tr>
<td># Persons Receiving DD Services</td>
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<td>6,624</td>
<td>1,230</td>
<td>2,149</td>
<td>1,920</td>
<td>2,932</td>
<td>2,152</td>
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<td>% of Members Receiving DD Services</td>
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<td>1.6%</td>
<td>0.8%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>1.5%</td>
<td>1.4%</td>
<td>0.2%</td>
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<td>Unduplicated # that received MH/DD/SA Services</td>
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<td>30,740</td>
<td>6,905</td>
<td>11,883</td>
<td>12,126</td>
<td>13,868</td>
<td>13,076</td>
<td>104,422</td>
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<td>% of Members Receiving MH/DD/SA Services</td>
<td>7.2%</td>
<td>7.3%</td>
<td>4.6%</td>
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<td>7.3%</td>
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<td><strong>Community Psychiatric Hospitalization</strong></td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
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<tr>
<td># of MH Admissions to Community Psychiatric Inpatient</td>
<td>138</td>
<td>453</td>
<td>124</td>
<td>110</td>
<td>147</td>
<td>242</td>
<td>214</td>
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<td>Rate of MH Admissions per 1,000 Medicaid Members</td>
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<td>1.08</td>
<td>0.83</td>
<td>0.80</td>
<td>0.89</td>
<td>1.20</td>
<td>1.39</td>
<td>0.98</td>
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<tr>
<td>% of MH Admissions that were Readmissions within 30 days</td>
<td>12</td>
<td>26</td>
<td>21</td>
<td>12</td>
<td>15</td>
<td>35</td>
<td>18</td>
<td>139</td>
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<tr>
<td>% of MH Admissions that were Readmissions within 30 days</td>
<td>8.7%</td>
<td>5.7%</td>
<td>16.9%</td>
<td>10.9%</td>
<td>10.2%</td>
<td>14.5%</td>
<td>8.4%</td>
<td>9.7%</td>
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<tr>
<td>MH Inpt Average Length of Stay (days)</td>
<td>11.0</td>
<td>9.6</td>
<td>7.1</td>
<td>8.0</td>
<td>4.3</td>
<td>7.8</td>
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<tr>
<td># of SA Admissions to Community Psychiatric Inpatient</td>
<td>6</td>
<td>37</td>
<td>12</td>
<td>9</td>
<td>19</td>
<td>10</td>
<td>20</td>
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<td>Rate of SA Admissions per 1,000 Medicaid Members</td>
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<td>0.09</td>
<td>0.08</td>
<td>0.07</td>
<td>0.11</td>
<td>0.05</td>
<td>0.13</td>
<td>0.08</td>
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<tr>
<td>% of SA Admissions that were Readmissions within 30 days</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>12</td>
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<tr>
<td>% of SA Admissions that were Readmissions within 30 days</td>
<td>50%</td>
<td>5%</td>
<td>8%</td>
<td>11%</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>14.4%</td>
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<tr>
<td># of SA Inpatient Discharges</td>
<td>6</td>
<td>28</td>
<td>12</td>
<td>11</td>
<td>22</td>
<td>10</td>
<td>21</td>
<td>110</td>
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<tr>
<td>SA Inpt Average Length of Stay (days)</td>
<td>9.5</td>
<td>6.4</td>
<td>5.9</td>
<td>4.8</td>
<td>6.2</td>
<td>6.3</td>
<td>5.8</td>
<td>6.2</td>
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<tr>
<td><strong>Care Coordination</strong></td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
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<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
</tr>
<tr>
<td># of MH and SA Readmits assigned to a Care Coordinator</td>
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<td>27</td>
<td>22</td>
<td>13</td>
<td>17</td>
<td>34</td>
<td>19</td>
<td>147</td>
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<tr>
<td>% of Readmits assigned to Care Coordination</td>
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<td>100.0%</td>
<td>96.4%</td>
<td>100.0%</td>
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<td>100.0%</td>
<td>94.4%</td>
<td>95.0%</td>
<td>97.4%</td>
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<td><strong>Emergency Dept Utilization (3 month lag)</strong></td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
<td>Feb-19</td>
</tr>
<tr>
<td># of ED Admits for persons with MH/DDSA diagnoses</td>
<td>310</td>
<td>1016</td>
<td>210</td>
<td>280</td>
<td>302</td>
<td>351</td>
<td>217</td>
<td>2,686</td>
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<tr>
<td>Rate of ED Admits per 1,000 Medicaid Members</td>
<td>1.40</td>
<td>2.28</td>
<td>1.36</td>
<td>1.92</td>
<td>1.83</td>
<td>1.64</td>
<td>1.37</td>
<td>1.9</td>
<td>0.32</td>
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</tr>
<tr>
<td>% of ED Admits for persons who are active consumers</td>
<td>106</td>
<td>573</td>
<td>70</td>
<td>138</td>
<td>98</td>
<td>175</td>
<td>64</td>
<td>1,224</td>
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<tr>
<td>% of ED Admits that were for active consumers</td>
<td>34%</td>
<td>56%</td>
<td>33%</td>
<td>49%</td>
<td>32%</td>
<td>50%</td>
<td>29%</td>
<td>46%</td>
<td>10.0%</td>
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<tr>
<td># of ED Admits which were readmissions within 30 days</td>
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<td>213</td>
<td>33</td>
<td>36</td>
<td>39</td>
<td>21</td>
<td>31</td>
<td>417</td>
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<tr>
<td>% of ED Admissions Readmitted within 30 days</td>
<td>14%</td>
<td>21%</td>
<td>16%</td>
<td>13%</td>
<td>13%</td>
<td>6%</td>
<td>14%</td>
<td>15.5%</td>
<td>4.1%</td>
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</tr>
<tr>
<td><strong>Authorization Requests</strong></td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
<td>May-19</td>
</tr>
<tr>
<td>Total Number of Auth Requests Received</td>
<td>4,980</td>
<td>8,037</td>
<td>2,226</td>
<td>3,962</td>
<td>3,457</td>
<td>3,159</td>
<td>3,122</td>
<td>28,943</td>
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<tr>
<td># Standard Auth. Request Decisions</td>
<td>4,342</td>
<td>6,782</td>
<td>1,822</td>
<td>3,738</td>
<td>2,951</td>
<td>2,042</td>
<td>2,306</td>
<td>23,983</td>
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</tr>
<tr>
<td>% Processed in 14 Days</td>
<td>95.0%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.9%</td>
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</tr>
<tr>
<td># Standard Auth Requests Processed in 14 Days</td>
<td>4,336</td>
<td>6,776</td>
<td>1,822</td>
<td>3,738</td>
<td>2,951</td>
<td>2,041</td>
<td>2,303</td>
<td>23,967</td>
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<tr>
<td># Auth Requests requiring Expedited Decisions, inclusive of Inpatient</td>
<td>638</td>
<td>1,255</td>
<td>404</td>
<td>224</td>
<td>506</td>
<td>1,117</td>
<td>816</td>
<td>4,960</td>
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<tr>
<td>% Processed in 3 Days</td>
<td>95.0%</td>
<td>100.0%</td>
<td>99.2%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.8%</td>
<td></td>
</tr>
<tr>
<td>% of ED Admissions Readmitted within 30 days</td>
<td>14%</td>
<td>21%</td>
<td>16%</td>
<td>13%</td>
<td>13%</td>
<td>6%</td>
<td>14%</td>
<td>15.5%</td>
<td>4.1%</td>
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<tr>
<td>Total % of Auth Requests Processed in Required Timeframes</td>
<td>95.0%</td>
<td>99.9%</td>
<td>99.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.9%</td>
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### MCO Monthly Monitoring Report
**Medicaid Only**

**May 2019 Report**

#### LME/MCO:

<table>
<thead>
<tr>
<th>Monitoring Area</th>
<th>Standard</th>
<th>Alliance</th>
<th>Cardinal</th>
<th>Eastpointe</th>
<th>Partners</th>
<th>Sandhills</th>
<th>Trillium</th>
<th>Vaya</th>
<th>Statewide</th>
<th>STD DEV</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Auth Requests Denied for Clinical Reasons</td>
<td>□</td>
<td>54</td>
<td>223</td>
<td>132</td>
<td>148</td>
<td>42</td>
<td>45</td>
<td>42</td>
<td>686</td>
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</tr>
<tr>
<td>% of Total Auth Requests Denied for Clinical Reasons</td>
<td>□</td>
<td>1.1%</td>
<td>2.8%</td>
<td>5.9%</td>
<td>3.7%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>2.4%</td>
<td>1.7%</td>
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<tr>
<td># of Administrative Denials</td>
<td>□</td>
<td>40</td>
<td>1</td>
<td>15</td>
<td>34</td>
<td>-</td>
<td>29</td>
<td>12</td>
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<tr>
<td>% of Total Auth Requests Denied for Admin Reasons</td>
<td>□</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total # of Auth Requests Denied</td>
<td>□</td>
<td>94</td>
<td>224</td>
<td>147</td>
<td>182</td>
<td>42</td>
<td>74</td>
<td>54</td>
<td>817</td>
<td></td>
</tr>
<tr>
<td>% of Total Auth Requests Approved</td>
<td>□</td>
<td>98.1%</td>
<td>97.2%</td>
<td>93.4%</td>
<td>95.4%</td>
<td>98.8%</td>
<td>97.7%</td>
<td>98.3%</td>
<td>97.2%</td>
<td>1.8%</td>
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<tr>
<td>Number of Consumer Authorization Appeals received</td>
<td>□</td>
<td>13</td>
<td>29</td>
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<td>25</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>102</td>
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<tr>
<td>Rate of Consumer Auth. Appeals per 1,000 persons svd</td>
<td>□</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.9%</td>
<td>0.4%</td>
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<tr>
<td># of Administrative Denials</td>
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<td>1</td>
<td>16</td>
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<td>0</td>
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<tr>
<td>% of Total Auth Requests Denied for Admin Reasons</td>
<td>□</td>
<td>1.1%</td>
<td>2.8%</td>
<td>5.9%</td>
<td>3.7%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>2.4%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total # of Auth Requests Denied</td>
<td>□</td>
<td>54</td>
<td>223</td>
<td>132</td>
<td>148</td>
<td>42</td>
<td>45</td>
<td>42</td>
<td>686</td>
<td></td>
</tr>
<tr>
<td>% of Total Auth Requests Approved</td>
<td>□</td>
<td>98.1%</td>
<td>97.2%</td>
<td>93.4%</td>
<td>95.4%</td>
<td>98.8%</td>
<td>97.7%</td>
<td>98.3%</td>
<td>97.2%</td>
<td>1.8%</td>
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<tr>
<td>Number of Authorizations overturned due to Consumer Appeals</td>
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<td>4</td>
<td>5</td>
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<td>2</td>
<td>6</td>
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<td>27</td>
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#### Claims

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<tbody>
<tr>
<td>Total # Clean Claim Received during Month (detail lines)</td>
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<td>224,107</td>
<td>61,769</td>
<td>95,887</td>
<td>58,161</td>
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<td>105,449</td>
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<td>Rate of Claims Rcpt per Person Served</td>
<td>7,4</td>
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<td>8,9</td>
<td>8,1</td>
<td>4,8</td>
<td>7,3</td>
<td>8,1</td>
</tr>
<tr>
<td>% of Total Auth Requests Denied for Clinical Reasons</td>
<td>□</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Number of Administrative Denials</td>
<td>□</td>
<td>1</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% of Total Auth Requests Denied for Admin Reasons</td>
<td>□</td>
<td>1.1%</td>
<td>2.8%</td>
<td>5.9%</td>
<td>3.7%</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total # of Auth Requests Denied</td>
<td>□</td>
<td>54</td>
<td>223</td>
<td>132</td>
<td>148</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>% of Total Auth Requests Approved</td>
<td>□</td>
<td>98.1%</td>
<td>97.2%</td>
<td>93.4%</td>
<td>95.4%</td>
<td>98.8%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Number of Consumer Authorization Appeals received</td>
<td>□</td>
<td>13</td>
<td>29</td>
<td>14</td>
<td>25</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Rate of Consumer Auth. Appeals per 1,000 persons svd</td>
<td>□</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td># of Administrative Denials</td>
<td>□</td>
<td>1</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% of Total Auth Requests Denied for Admin Reasons</td>
<td>□</td>
<td>1.1%</td>
<td>2.8%</td>
<td>5.9%</td>
<td>3.7%</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total # of Auth Requests Denied</td>
<td>□</td>
<td>54</td>
<td>223</td>
<td>132</td>
<td>148</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>% of Total Auth Requests Approved</td>
<td>□</td>
<td>98.1%</td>
<td>97.2%</td>
<td>93.4%</td>
<td>95.4%</td>
<td>98.8%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Number of Authorizations overturned due to Consumer Appeals</td>
<td>□</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>-</td>
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<td>6</td>
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</tbody>
</table>

#### Complaints/Grievances

<table>
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<tr>
<th>Apr-19</th>
<th>Apr-19</th>
<th>Apr-19</th>
<th>Apr-19</th>
<th>Apr-19</th>
<th>Apr-19</th>
<th>Apr-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of complaints received (1 month prior)</td>
<td>30</td>
<td>34</td>
<td>12</td>
<td>10</td>
<td>17</td>
<td>5</td>
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<tr>
<td>Rate of Complaints per 1,000 Persons Served</td>
<td>1.56</td>
<td>1.01</td>
<td>1.20</td>
<td>0.73</td>
<td>1.28</td>
<td>0.28</td>
</tr>
<tr>
<td>% Consumer complaints against provider</td>
<td>□</td>
<td>60%</td>
<td>68%</td>
<td>42%</td>
<td>60%</td>
<td>71%</td>
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<tr>
<td>% Consumer complaints against LME/MCO</td>
<td>□</td>
<td>3%</td>
<td>11%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
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<tr>
<td>% Provider complaints against LME/MCO</td>
<td>□</td>
<td>0%</td>
<td>0%</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
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</table>
| Program Integrity--Fraud, Waste and Abuse

#### Program Integrity--Fraud, Waste and Abuse

<table>
<thead>
<tr>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Provider fraud and abuse cases under investigation by LME/MCO-New</td>
<td>16</td>
<td>19</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Number of Provider fraud and abuse cases under investigation by LME/MCO-Ongoing from previous month</td>
<td>60</td>
<td>19</td>
<td>19</td>
<td>4</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Number of Enrollee fraud and abuse cases investigated by LME/MCO</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Cases Referred to DMA Program Integrity</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>3</td>
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</tbody>
</table>

**Pink Highlights indicate the MCO did not meet the Standard for 3 consecutive months.**

**Blue highlights indicate possible outliers (>1.5 Std Dev above or below the LME/MCO Avg).**

---

Yellow Highlights indicate the MCO did not meet the Standard for 3 consecutive months.

---

Blue highlights indicate possible outliers (>1.5 Std Dev above or below the LME/MCO Avg).

---

Pink Highlights indicate the MCO did not meet the Standard for 3 consecutive months.
## LME/MCO Monthly Monitoring Report

### May 2019 Report

#### State/Federal Block Grant Only

**LME/MCO:**

### Monitoring Areas

<table>
<thead>
<tr>
<th>Persons Served</th>
<th>Standard</th>
<th>Alliance</th>
<th>Cardinal</th>
<th>Eastpointe</th>
<th>Partners</th>
<th>Sandhills</th>
<th>Trillium</th>
<th>Vaya</th>
<th>Statewide</th>
<th>STD DEV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of Uninsured in Catchment Area</td>
<td>167,581</td>
<td>311,096</td>
<td>84,198</td>
<td>93,680</td>
<td>113,741</td>
<td>137,401</td>
<td>114,321</td>
<td>1,022,018</td>
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<tr>
<td># Persons Receiving MH Services</td>
<td>2,848</td>
<td>3,511</td>
<td>1,090</td>
<td>1,424</td>
<td>2,111</td>
<td>2,798</td>
<td>2,366</td>
<td>16,148</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Uninsured Receiving MH Services</td>
<td>1.7%</td>
<td>1.1%</td>
<td>1.3%</td>
<td>1.5%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.1%</td>
<td>0.33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Persons Receiving SA Services</td>
<td>1,477</td>
<td>2,418</td>
<td>658</td>
<td>1,294</td>
<td>905</td>
<td>2,212</td>
<td>1,890</td>
<td>10,894</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Uninsured Receiving SA Services</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>1.4%</td>
<td>0.8%</td>
<td>1.6%</td>
<td>1.7%</td>
<td>1.37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Persons Receiving DD Services</td>
<td>685</td>
<td>808</td>
<td>252</td>
<td>361</td>
<td>548</td>
<td>500</td>
<td>216</td>
<td>3,370</td>
<td></td>
<td></td>
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<tr>
<td>% of Uninsured Receiving DD Services</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.09%</td>
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<td></td>
</tr>
<tr>
<td>Unduplicated # Persons Receiving MH/DD/SA Services</td>
<td>4,747</td>
<td>6,297</td>
<td>1,897</td>
<td>2,906</td>
<td>3,564</td>
<td>4,586</td>
<td>4,350</td>
<td>28,347</td>
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<tr>
<td>Community Psychiatric Hospitalization (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of MH Admissions to Community Psychiatric Inpatient Area</td>
<td>57</td>
<td>332</td>
<td>8</td>
<td>48</td>
<td>114</td>
<td>176</td>
<td>56</td>
<td>791</td>
<td></td>
<td></td>
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<tr>
<td>Rate of MH Admissions per 1,000 Uninsured</td>
<td>0.34</td>
<td>1.07</td>
<td>0.10</td>
<td>0.51</td>
<td>1.00</td>
<td>1.28</td>
<td>0.49</td>
<td>0.77</td>
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<td></td>
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<tr>
<td>% of MH Admissions that were Readmissions within 30 days</td>
<td>14%</td>
<td>1%</td>
<td>0%</td>
<td>6%</td>
<td>10%</td>
<td>11%</td>
<td>9%</td>
<td>4.92%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of MH Inpatient Discharges</td>
<td>70</td>
<td>97</td>
<td>8</td>
<td>48</td>
<td>114</td>
<td>186</td>
<td>61</td>
<td>596</td>
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<tr>
<td>MH Inpt Average Length of Stay (days)</td>
<td>6.8</td>
<td>8.7</td>
<td>3.9</td>
<td>5.6</td>
<td>2.5</td>
<td>7.5</td>
<td>5.7</td>
<td>6.2</td>
<td>1.96</td>
<td></td>
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<tr>
<td>Community Psychiatric Hospitalization (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of SA Admissions to Community Psychiatric Inpatient Area</td>
<td>15</td>
<td>46</td>
<td>-</td>
<td>23</td>
<td>20</td>
<td>17</td>
<td>43</td>
<td>164</td>
<td></td>
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<tr>
<td>Rate of SA Admissions per 1,000 Uninsured</td>
<td>0.09</td>
<td>0.15</td>
<td>-</td>
<td>0.25</td>
<td>0.18</td>
<td>0.12</td>
<td>0.38</td>
<td>0.16</td>
<td>0.11</td>
<td></td>
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<tr>
<td># of SA Admissions that were Readmissions within 30 days</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td></td>
<td></td>
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<tr>
<td>% of SA Admissions that were Readmissions within 30 days</td>
<td>7%</td>
<td>2%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>9%</td>
<td>4%</td>
<td>3.4%</td>
<td></td>
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</tr>
<tr>
<td># of SA Inpatient Discharges</td>
<td>16</td>
<td>36</td>
<td>0</td>
<td>22</td>
<td>20</td>
<td>11</td>
<td>41</td>
<td>146</td>
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<tr>
<td>SA Inpt Average Length of Stay (days)</td>
<td>5.6</td>
<td>5.8</td>
<td>-</td>
<td>4.4</td>
<td>3.8</td>
<td>5.8</td>
<td>4.0</td>
<td>4.8</td>
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### Authorizations

<table>
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<tr>
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<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
<th>May-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Auth Requests Received</td>
<td>1,261</td>
<td>2,758</td>
<td>645</td>
<td>2,314</td>
<td>1,409</td>
<td>923</td>
<td>749</td>
<td>10,059</td>
<td></td>
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<tr>
<td># Standard Auth. Request Decisions</td>
<td>968</td>
<td>1,785</td>
<td>503</td>
<td>2,106</td>
<td>924</td>
<td>330</td>
<td>307</td>
<td>6,923</td>
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</tr>
<tr>
<td># Standard Auth Requests Processed in 14 Days</td>
<td>967</td>
<td>1,783</td>
<td>503</td>
<td>2,106</td>
<td>924</td>
<td>330</td>
<td>307</td>
<td>6,920</td>
<td></td>
</tr>
<tr>
<td>% Processed in 14 Days</td>
<td>95.0%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td># Auth Requests requiring Expedited Decisions, inclusive of Inpatient</td>
<td>293</td>
<td>973</td>
<td>142</td>
<td>208</td>
<td>485</td>
<td>593</td>
<td>442</td>
<td>3,136</td>
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</tr>
<tr>
<td># Expedited and Inpatient Auth Requests Processed in 3 Days</td>
<td>293</td>
<td>968</td>
<td>142</td>
<td>208</td>
<td>485</td>
<td>593</td>
<td>442</td>
<td>3,131</td>
<td></td>
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<tr>
<td>% Processed in 3 Days</td>
<td>95.0%</td>
<td>100.0%</td>
<td>99.5%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.8%</td>
</tr>
<tr>
<td>Total % of Auth Requests Processed in Required Timeframes</td>
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<td>99.9%</td>
<td>99.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>0.00</td>
</tr>
<tr>
<td># of Auth Requests Denied for Clinical Reasons</td>
<td>5</td>
<td>36</td>
<td>15</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>77</td>
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</tr>
<tr>
<td>% of Total Auth Requests Denied for Clinical Reasons</td>
<td>0.4%</td>
<td>1.3%</td>
<td>2.3%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.8%</td>
<td>0.7%</td>
</tr>
<tr>
<td># of Administrative Denials</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>-</td>
<td>6</td>
<td>3</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Total Auth Requests Denied for Admin Reasons</td>
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<td>0.1%</td>
<td>0.8%</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total # of Auth Requests Denied</td>
<td>5</td>
<td>39</td>
<td>20</td>
<td>18</td>
<td>6</td>
<td>12</td>
<td>6</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>% of Total Auth Requests Approved</td>
<td>100%</td>
<td>99%</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Number of Consumer Authorization Appeals received</td>
<td>-</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Rate of Consumer Auth. Appeals per 1,000 persons svd</td>
<td>0.0</td>
<td>0.6</td>
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<td>0.0</td>
<td>0.5</td>
<td>0.3</td>
<td>0.25</td>
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<tr>
<td>Number of Authorizations overturned due to Consumer Appeals</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
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</tr>
</tbody>
</table>
# LME/MCO Monthly Monitoring Report

## State/Federal Block Grant Only

### May 2019 Report

**Date:** 6/20/2019

### Claims

<table>
<thead>
<tr>
<th>Monitoring Areas</th>
<th>Standard</th>
<th>Alliance</th>
<th>Cardinal</th>
<th>Eastpointe</th>
<th>Partners</th>
<th>Sandhills</th>
<th>Trillium</th>
<th>Vaya</th>
<th>Statewide</th>
<th>STD DEV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Clean Claim Received during Month (header)</td>
<td></td>
<td>30,047</td>
<td>32,758</td>
<td>12,974</td>
<td>26,295</td>
<td>7,250</td>
<td>29,878</td>
<td>24,978</td>
<td>164,180</td>
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</tr>
<tr>
<td>Rate of Claims Rcpt per Person Served</td>
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<td>6.33</td>
<td>5.20</td>
<td>6.84</td>
<td>9.05</td>
<td>2.03</td>
<td>6.52</td>
<td>5.74</td>
<td>5.79</td>
<td>1.96</td>
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<tr>
<td># Paid</td>
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<td>29,585</td>
<td>11,628</td>
<td>23,720</td>
<td>7,149</td>
<td>27,523</td>
<td>19,948</td>
<td>146,581</td>
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<tr>
<td># Denied</td>
<td></td>
<td>3,019</td>
<td>3,173</td>
<td>1,346</td>
<td>2,575</td>
<td>101</td>
<td>2,355</td>
<td>5,029</td>
<td>17,598</td>
<td></td>
</tr>
<tr>
<td># Pended or in Process</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Percent Denied</td>
<td></td>
<td>10.0%</td>
<td>9.7%</td>
<td>10.4%</td>
<td>9.8%</td>
<td>1.4%</td>
<td>7.9%</td>
<td>20.1%</td>
<td>10.7%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Percent Processed within 30 Days</td>
<td></td>
<td>90.0%</td>
<td>98.9%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>96.3%</td>
<td>99.2%</td>
<td>0.01</td>
</tr>
<tr>
<td>Avg # days for Processing (from Receipt to Payment )</td>
<td></td>
<td>7.0</td>
<td>8.3</td>
<td>8.3</td>
<td>9.1</td>
<td>9.2</td>
<td>7.3</td>
<td>10.0</td>
<td>8.2</td>
<td>0.99</td>
</tr>
<tr>
<td>Total number of complaints received (1 month prior)</td>
<td></td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Rate of Complaints per 1,000 Persons Served</td>
<td></td>
<td>0.51</td>
<td>0.86</td>
<td>1.51</td>
<td>0.29</td>
<td>0.82</td>
<td>1.81</td>
<td>0.41</td>
<td>1.02</td>
<td>0.53</td>
</tr>
<tr>
<td># Consumer complaints against provider</td>
<td></td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>% Consumer complaints against provider</td>
<td></td>
<td>33%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>40%</td>
<td>100%</td>
<td>45%</td>
<td>34.5%</td>
</tr>
<tr>
<td># Consumer complaints against LME/MCO</td>
<td></td>
<td>-</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>% Consumer complaints against LME/MCO</td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>20%</td>
<td>0%</td>
<td>10%</td>
<td>12.6%</td>
</tr>
<tr>
<td># Provider complaints against LME/MCO</td>
<td></td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Provider complaints against LME/MCO</td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td># of Other Types of Complaints</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td># of Complaints Resolved in 30 Days</td>
<td></td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Percent of Complaints resolved in 30 days</td>
<td></td>
<td>90.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>-</td>
</tr>
</tbody>
</table>

**Yellow Highlights indicate the MCO did not meet the Standard**

**Pink Highlights indicate the MCO did not meet the Standard for 3 consecutive months.**

**Blue highlights indicate possible outliers (>1.5 Std Dev above or below the LME/MCO Avg).**

---

(1) **Community Psychiatric Hospitalization includes 3-Way Contract funded beds, which are not distributed evenly across LME-MCO catchment areas, and may impact utilization rates.**
Monday, August 12, 2019
CFAC MEETING - REGULAR MEETING
Trosa, 1820 James St., Durham, NC  27707
5:30-7:00 p.m.

MEMBERS PRESENT: ☒ Steve Hill, ☒ Tammy Shaw, ☐ Joe Kilsheimer, ☐ James Henry, ☐ Latasha Jordan, ☒ Dave Curro, ☒ Trula Miles, ☒ Brenda Solomon, ☒ Chris Dale, ☒ Dan Shaw, ☒ Pinkey Dunston
BOARD MEMBERS PRESENT: None
GUEST(S): ☐ Susan Hertz, ☐ Tina Barnes, ☒ Regina Mays, ☒ Charlitta Burruss, ☒ Bryan Cheek
STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Engagement, ☒ Terrasine Gardner, Member Engagement Manager, ☒ Ramona Branch, Individual & Family Engagement Specialist
Dial-In Number: (605) 472-5464
Access Code: 289674

1. WELCOME AND INTRODUCTIONS

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

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>The group was asked a question from a guest (Charlitta Burruss) on what drives them to stay in recovery. Various members chimed in and shared on what keeps them on track.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interest in Membership/Outreach</td>
<td>N/A</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>5. LME/MCO and State Updates</td>
<td>CE&amp;E August Updates; Enrollment Eligibility Updates; Transformation Forms; Perception of Care; SCFAC Annual Report: Doug gave the LME/MCO updates. • Alliance is in the process of finalizing working relationships for us to provide behavioral health call center services for three of the companies who will be operating Standard Plans in North Carolina – AmeriHealth Caritas, United HealthCare, and WellCare. It was also noted that Alliance also won a bid from Blue Cross Blue Shield but they have since decided to perform this function internally. • CQI- Continual Quality Improvement update: revising by adding member experience and provider input. This group makes recommendations to the Global Quality Improvement Team, and with the revision, opportunities will become available for individuals/members to participate in committees. • State Budget FY 2019-21: It is nearly a month into the new fiscal year, but North Carolina still does not have a budget. Democratic N.C. Gov. Roy Cooper vetoed the General Assembly's budget</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Monday, August 12, 2019

CFAC MEETING - REGULAR MEETING
Trosa, 1820 James St., Durham, NC  27707
5:30-7:00 p.m.

AGENDA ITEMS: DISCUSSION: NEXT STEPS: TIME FRAME:

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>proposal on June 28. A vote to</td>
<td>A vote to override Cooper’s budget veto has remained on the House calendar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>override Cooper’s budget veto</td>
<td>since July 8, but Speaker Tim Moore, R-Cleveland, has yet to call for a vote.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members were asked to review the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>documents that were sent out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>electronically and to email any</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>questions or concerns to Ramona,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doug, or Terrasine.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Community Forum Brainstorming

Revisiting Ideas for future forum topics:
The group brainstormed on the next topic for Community Forums. Affordable housing has been chosen. Because of the broadness of this topic, Doug, Terrasine and Ramona will meet together and come up with some ideas to present to the group during the next meeting. The group has agreed that the target date for this event will try to be early November.
Doug, Terrasine, and Ramona to meet and come up with ideas before next meeting: 09.09.2019. 30 days

7. Event Planning

RCOD Event: 09.14.2019 2-6pm: Steve Hill, Pinkey Dunston, Dave Curro, and Trula Miles have stated they will be in attendance for this event.
Tailored Plan Transition Webinar 08.20.2019 2:15-3:15: Link will be sent out for webinar instructions once it has been given by the state.
Ongoing N/A

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

Respectfully Submitted by:

Ramona Branch, Individual & Family Engagement Specialist 08.13.2019

Click here to enter text. Date Approved

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
**CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING**

**5200 W. Paramount Parkway, Morrisville, NC 27560**

**5:30 p.m. – 7:00 p.m.**

**APPOINTED MEMBERS PRESENT:** ☒ Carole Johnson, ☒ Megan Mason, ☒ Karen McKinnon, ☒ Connie King-Jerome, ☒ Israel Pattison, ☒ Annette Smith, ☒ Ben Smith, ☒ Wanda (Faye) Griffin, ☒ Gregory Schweitzer, ☒ Vicki Bass, ☒ Anthony Saracena, ☒ Jessica Larrison, ☒ Bradley Garlik, ☒ Dave Curro

**BOARD MEMBERS PRESENT:** None

**GUEST(S):** Marqueshe Chaven, Dianne Morris

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

***Call-in 1 (919) 838-9800 Meeting ID# 3304 PW #3304***

1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 5:36

2. **REVIEW OF THE MINUTES** – The minutes from the July 9, 2019, meeting were reviewed; a motion was made by Annette Smith and seconded by Jessica Larrison to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public Comments</td>
<td>Welcome Bradley Garlik as a new member</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Interest on Membership/Outreach</td>
<td>Dave Curro has asked our CFAC members to attend the I/DD Next Step meeting Sept 21st at Millbrook Exchange Park Community Center 1905 Spring Forest Rd, Raleigh, NC 27615 9:30 am. Alliance Health CEO Rob Robinson will be at the meeting discussing Publicity for Providers. A light breakfast will be served. Please look at Save the Date August 20, 2019</td>
<td>Jessica and Israel plans to attend</td>
<td>None</td>
</tr>
<tr>
<td>3. LME/MCO and State Updates</td>
<td>2018 PoC for SFAC 07/02/2019; August 2019 Update 08/02/2019; BH-IDD-Eligibility Enrollment Update; BH-IDD-Update Appendix; Medicaid Transformation Response; NC Association of County Commissioner; NC Medicaid Direct Transformation Benefits, NC Medicaid Direct Transformation Provider; SFAC Annual Report.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4. Community Forum Brainstorming</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Event Planning.</td>
<td>Karen McKinnon, Carole Johnson, and Stacy Guse will attend RCNC Rally September 21,2019 @Mordecaie Historic Park 1 Mimosa St. Raleigh</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>6. Acronyms Training</td>
<td>Stacy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on Click or tap to enter a date.
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Next meeting</td>
<td>James Osborne will be presenting a training on Bullying at our Sept 10th meeting</td>
<td>N/a</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 10. ADJOURNMENT:

The meeting adjourned at Jessica Larrison; the next meeting will be September 10, 2019, from 5:30 p.m. to 7:00 p.m.
MH/SA Consumer Perception of Care Survey

• Annual survey about quality of care
• SAMHSA reporting requirement for Community MHBG
• Adult, Youth, Child Family respondents
• Three sections:
  - Mental Health Statistics Improvement Program (MHSIP) Survey
  - Consumer experiences with LME-MCO and providers
  - Adult physical health

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
**Survey Format**

Please answer the following questions based on the services you have received so far in the past year. Indicate if you **Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree** with each statement. If the question is about something you have not experienced, please fill in the circle for Not Applicable (N/A) to indicate that this item does not apply to you.

### II. YOUR SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>I am Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like the services that I received here.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. If I had other choices, I would still get services from this agency.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I would recommend this agency to a friend or family member.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. The location of services was convenient (parking, public transportation, distance, etc.).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Staff were willing to see me as often as I felt it was necessary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Staff returned my call within 24 hours.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Services were available at times that were good for me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. I was able to get all the services I thought I needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Staff here believe that I can grow, change and recover.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I felt free to complain.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE: 2018 NC DHHS Division of MH/DD/SA Services Adult Survey**
Survey Domains

- General Satisfaction
- Outcomes/ Functioning/ Social Connectedness
- Quality and Appropriateness/ Cultural Sensitivity
- Treatment Planning
- Access to Services

**SOURCE:** 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
### Survey Items (Examples)

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Services</strong></td>
<td>• Services were available at times that were good for me.</td>
</tr>
<tr>
<td></td>
<td>• Staff were willing to see me as often as I felt it was necessary.</td>
</tr>
<tr>
<td><strong>Treatment Planning</strong></td>
<td>• I, not staff, decided my treatment goals.</td>
</tr>
<tr>
<td></td>
<td>• I helped to choose my child’s services.</td>
</tr>
<tr>
<td><strong>Quality &amp; Appropriateness</strong></td>
<td>• I was given information about my rights.</td>
</tr>
<tr>
<td></td>
<td>• Staff were sensitive to my cultural background.</td>
</tr>
<tr>
<td><strong>Cultural Sensitivity</strong></td>
<td>• Staff treated me with respect.</td>
</tr>
<tr>
<td></td>
<td>• Staff spoke with me in a way that I understand.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>• I am better able to deal with crisis.</td>
</tr>
<tr>
<td></td>
<td>• My child is doing better in school and/or work.</td>
</tr>
<tr>
<td><strong>Functioning</strong></td>
<td>• I do things that are more meaningful to me.</td>
</tr>
<tr>
<td></td>
<td>• My child is better able to do things he or she wants.</td>
</tr>
<tr>
<td><strong>Social Connectedness</strong></td>
<td>• I feel I belong in my community.</td>
</tr>
<tr>
<td></td>
<td>• In a crisis, I would have the support I need from family or friends.</td>
</tr>
<tr>
<td><strong>General Satisfaction</strong></td>
<td>• Overall, I am satisfied with the services I received here.</td>
</tr>
<tr>
<td></td>
<td>• I received services that were right with me.</td>
</tr>
</tbody>
</table>

SOURCE: 2018 NC DHHS Division of MH/DD/SA Services Adult, Youth, and Parent Surveys
Survey Administration

• May 7 — June 5, 2018 survey period
• Distributed by service providers
• 6700+ respondents, 500+ Provider NPIs
• Standard survey administration guidelines, e.g.,
  – Survey is voluntary, confidential, no right or wrong answers
  – Provide private area to complete and secure method to return
  – Enlist help of peers/advocates to assist

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
2018 Survey Sample (N = 6,713)

- Adult (18+ years): 65%
- Youth (12-17): 18%
- Child (3-11): 17%

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
N.C. LME-MCOs

- Reflects LME-MCOs as of 7/1/18.
- Includes the realignment of Columbus County to Trillium Health Resources on 7/1/18.
2018 Survey Sample (N = 6,713)

Cardinal, 22%

Alliance, 13%

Partners, 12%

Trillium, 22%

Eastpointe, 11%

Sandhills, 10%

Vaya, 9%

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Primary Reason for Services

**Adults**
- MH, Male: 24%
- MH, Female: 42%
- SU, Male: 15%
- SU, Female: 18%

**Youth**
- MH, Male: 50%
- MH, Female: 44%
- SU, Male: 4%
- SU, Female: 2%

**Child Family**
- MH, Male: 62%
- MH, Female: 38%

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Survey Results

- Annual Trends
- Demographic Groups
- National Data
- LME-MCO Patterns
Adult Survey: 2010-2018

SOURCE 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Youth Survey: 2010-2018

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Child Family Survey: 2010-2018

Access
Outcomes
Cultural Sensitivity
Treatment Planning
Functioning
Social Connectedness
General Satisfaction

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Annual Trends

Survey Populations

Child Family   Adult   Youth
### Annual Trends

#### Survey Domains

<table>
<thead>
<tr>
<th>Quality/ Cultural Sensitivity</th>
<th>Treatment Planning</th>
<th>Outcomes/ Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Satisfaction</td>
<td>Access</td>
<td>Social Connectedness (Adult)</td>
</tr>
<tr>
<td>Social Connectedness (Child Family)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2018 MHSIP Domains by Child Consumer Gender

<table>
<thead>
<tr>
<th>Domain</th>
<th>Male Children</th>
<th>Female Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>TREATMENT PLANNING</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>CULTURAL APPROPRIATENESS</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>OUTCOMES*</td>
<td>66%</td>
<td>76%</td>
</tr>
<tr>
<td>FUNCTIONING</td>
<td>68%</td>
<td>75%</td>
</tr>
<tr>
<td>SOCIAL CONNECTEDNESS*</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>GENERAL SATISFACTION</td>
<td>92%</td>
<td>95%</td>
</tr>
</tbody>
</table>

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
2018 MHSIP Domains by Adult Primary Service Type

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
### 2017 Mental Health National Outcomes Measures (NOMS): SAMHSA Uniform Reporting System*

<table>
<thead>
<tr>
<th>Adult Consumer Survey Measures</th>
<th>N.C. Rate</th>
<th>U.S. Rate**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Services</td>
<td>91%</td>
<td>88%</td>
</tr>
<tr>
<td>Participation in Treatment Planning</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Quality/Appropriateness</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Outcomes from Services</td>
<td>78%</td>
<td>79%</td>
</tr>
<tr>
<td>Improved Social Connectedness</td>
<td>75%</td>
<td>79%</td>
</tr>
<tr>
<td>General Satisfaction with Care</td>
<td>93%</td>
<td>90%</td>
</tr>
</tbody>
</table>

SOURCE: samhsa.gov
# 2017 Mental Health National Outcomes Measures (NOMS): SAMHSA Uniform Reporting System

<table>
<thead>
<tr>
<th>Youth/Child Family Survey Measures</th>
<th>N.C. Rate</th>
<th>U.S. Rate**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Services</td>
<td>84%</td>
<td>88%</td>
</tr>
<tr>
<td>Participation in Treatment Planning</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>Cultural Sensitivity of Providers</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Outcomes from Services</td>
<td>68%</td>
<td>73%</td>
</tr>
<tr>
<td>Child Family Improved Social Connectedness</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>General Satisfaction with Care</td>
<td>87%</td>
<td>88%</td>
</tr>
</tbody>
</table>

*SOURCE: samhsa.gov*
CHILD FAMILY SURVEY TREATMENT PLANNING

SOURCE: 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
### Youth Treatment Planning

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>77%</td>
</tr>
<tr>
<td>Cardinal</td>
<td>74%</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>80%</td>
</tr>
<tr>
<td>Partners</td>
<td>68%</td>
</tr>
<tr>
<td>Sandhills</td>
<td>79%</td>
</tr>
<tr>
<td>Trillium</td>
<td>79%</td>
</tr>
<tr>
<td>Vaya</td>
<td>87%</td>
</tr>
<tr>
<td>State Total</td>
<td>77%</td>
</tr>
</tbody>
</table>

**Source:** 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
## LME-MCO Network

### Adult Survey: Have any of the following problems interfered with your ability to receive the services you need from any of your LME/MCO’s providers?

<table>
<thead>
<tr>
<th>LME-MCO</th>
<th>Transportation</th>
<th>Difficulty reaching provider</th>
<th>Service location</th>
<th>Cost of meds</th>
<th>Service cost</th>
<th>Hours services available</th>
<th>Other</th>
<th>None of the above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>13%</td>
<td>4%</td>
<td>6%</td>
<td>10%</td>
<td>4%</td>
<td>6%</td>
<td>2%</td>
<td>75%</td>
</tr>
<tr>
<td>Cardinal</td>
<td>16%</td>
<td>6%</td>
<td>6%</td>
<td>13%</td>
<td>7%</td>
<td>5%</td>
<td>4%</td>
<td>70%</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>13%</td>
<td>3%</td>
<td>4%</td>
<td>10%</td>
<td>3%</td>
<td>6%</td>
<td>3%</td>
<td>78%</td>
</tr>
<tr>
<td>Partners</td>
<td>12%</td>
<td>3%</td>
<td>4%</td>
<td>11%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>75%</td>
</tr>
<tr>
<td>Sandhills</td>
<td>15%</td>
<td>4%</td>
<td>5%</td>
<td>9%</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
<td>77%</td>
</tr>
<tr>
<td>Trillium</td>
<td>17%</td>
<td>5%</td>
<td>6%</td>
<td>12%</td>
<td>7%</td>
<td>5%</td>
<td>4%</td>
<td>71%</td>
</tr>
<tr>
<td>Vaya</td>
<td>16%</td>
<td>5%</td>
<td>5%</td>
<td>11%</td>
<td>6%</td>
<td>7%</td>
<td>6%</td>
<td>68%</td>
</tr>
<tr>
<td>State</td>
<td>15%</td>
<td>4%</td>
<td>5%</td>
<td>11%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>73%</td>
</tr>
</tbody>
</table>

**SOURCE:** 2018 Mental Health and Substance Use Services Consumer Perception of Care Report
Questions?

Karen Feasel
DMH/DD/SAS Quality Management
Karen.Feasel@dhhs.nc.gov
(919) 715-2270
June 28, 2019

Kody H. Kinsley
Deputy Secretary for Behavioral Health and
Intellectual and Developmental Disabilities
3001 Mail Service Center
Raleigh, North Carolina 27699-3001

Dear Kody:

This submission is the response of the North Carolina Consumer and Family Advisory Committee (SCFAC) to the Concept Paper “North Carolina’s Care Management Strategy of Behavior Health and Intellectual/Developmental Disability Tailored Plans” dated May 29, 2019.

First, SCFAC recognizes and appreciates the willingness expressed by many NCDHHS personnel to include the thoughts and concerns of consumers and family statewide as this important transformation unfolds in North Carolina, both within the NC General Assembly and as designed and implemented by NCDHHS. Outreach to consumers and to advocacy and advisory groups, as well as the availability of DHHS staff to inform and address concerns, has been extremely beneficial and most appreciated.

Second, although SCFAC recognizes the many benefits that individuals in North Carolina have the potential to receive with the overall design and the implementation of the proposed Care Management Design for Tailored Plans, there are several areas that SCFAC recommends be considered.

**Immediate Issues Affecting Beneficiaries**

- Most importantly, will the proposed Care Management Design for Tailored Plans be adequately communicate to all consumers and families who are currently receiving, or who are eligible to receive services covered by the proposed Tailored Plans? In order that they can make decisions best suited for their futures, individuals must be given adequate and accurate information about the services they need and how they will be provided those services.

- Will local support agencies, such as county DSS and their corresponding health departments, be given adequate training to provide meaningful information to beneficiaries with concerns/questions about how they will continue to receive services until the Tailored Plans are implemented in 2021?

- Although the great majority of the Care Management Design appears conceptually sound, will there be enough oversight to make certain that it all happens as planned, particularly as the 3 proposed Care Management Organizational Structures are chosen and implemented as the Tailored Plans are rolled out in 2021? Consumers and their families must know, as far in advance as possible, whom they will be working with in the management of their care and the responsible individual they can contact directly with any questions or concerns.
The move to Integrated Care for many individuals with complex medical, behavioral, and/or IDD needs may be difficult to effectively understand, especially after most have a familiarity with a system of differentiated providers and case management. Direct one-on-one contact with consumers and families will be critical to the success of the transformation process.

Finally, although this Concept Paper specifically addresses the implementation process for Care Management in Tailored Plans over the next 2 years, we continue to keep in mind broader, long-term issues that will significantly impact individuals receiving services in both Standard and Tailored Plans:

- Will funding continue for current and future individuals who will require supports within both Standard and Tailored Plans?

- What provisions will be made to adequately provide services to individuals in rural areas with low population density and relatively higher percentages of poorer citizens as this “access-disparity” becomes increasingly acute?

- How will all agencies and organizations involved in providing effective services address the issue of adequate compensation for Direct Service Personnel so that all beneficiaries can receive the supports they need?

SCFAC fully understands that many of these issues may not be able to be addressed at this time and require detailed analysis as further design and implementation of the new managed care structure proceeds. We certainly desire that the plan of integrated care together with quality care management be successful and ultimately benefits those in need of system supports. SCFAC members, together with their statewide individual and organizational partners welcome the opportunity to work with NCDHHS as the plan proceeds.
Recommendations to NC Department of Health and Human Services Secretary Mandy Cohen

MAY 2019
Section I: Executive Summary

At the request of the NC Department of Health and Human Services (NCDHHS) Secretary, the North Carolina Association of County Commissioners (NCACC) convened a committee of 15 county commissioners and four ex-officio subject matter experts to develop recommendations for the map for the Tailored Plan regions under Medicaid Transformation. The Committee met between March and May to discuss this matter and has determined its recommendations for the Secretary’s consideration.

NCDHHS Deputy Secretary for NC Medicaid Dave Richard issued a letter in February 2019 stating that “The Secretary of NCDHHS requests that NCACC will coordinate and facilitate a process, including consultation with LME-MCOs, to develop recommendations to NCDHHS related to the establishment of regions for Tailored Plans.”

After deliberative meetings, data analysis and extensive input from LME-MCOs and stakeholders, the Committee presents these recommendations:

- The seven current LME-MCO regions remain the same leading up to 2021 and through 2025 with two conditions:
  - If the LME-MCO is deemed not viable as it relates to finances or any other condition, then each county may appeal to the NCDHHS Secretary to move to another LME-MCO.
  - Current LME-MCOs should not be prohibited from voluntarily merging with another LME-MCO between 2019-2025. However, a merger should not be mandated.

- Once these regions are set for the 2019-2025 cycle, the Committee recommends a moratorium on a county’s ability to move LME-MCOs, unless a condition as described above occurs.

Other recommendations not specific to the LME-MCO region question are as follows:

- Restoring funding and avoiding additional cuts would support the financial viability of the public behavioral health system to more adequately provide services to vulnerable populations.

- The determination as to the individuals covered by the Standard plan or the Tailored plan should be a collaborative process that includes input from all stakeholders including LME-MCOs and affected county departments.

- The Committee recognizes that Medicaid eligible children in certain circumstances, such as the foster care system, children of incarcerated parents, children in the public adoption assistance program, should either be included in the Tailored plan or consideration be given to creating a specialized statewide plan.

- In the event the regions for Tailored plans are reconsidered in the future, the Committee recommends that a similar process to this one is followed to ensure county representation in the process is preserved.
• The Committee requests guidance on how these regions affect a county’s ability to participate in healthy opportunity pilots and pursue that funding if the pilot region includes multiple Tailored Plan regions. *(more information about this included in the appendix)*

**Section III: Supporting Documentation of the Committee Process**

**Formation of Committee:** After receiving the letter from NCDHHS in February 2019, NCACC President-Elect Kevin Austin, in consultation with NCACC staff, assembled a committee that ensured broad perspectives and representation from across the state. President-Elect Austin appointed Macon County Commissioner Ronnie Beale and Moore County Commissioner Catherine Graham to Co-Chair the Committee. Each LME-MCO was given an opportunity to appoint a county commissioner to serve as its representative. The remainder of the Committee included the NCACC Health and Human Services Steering Committee Chair, Transylvania County Commissioner Page Lemel, and at-large appointees. There were 15 voting members and four ex-officio members of the Committee.

**Full Committee Membership:**

Cumberland County Commissioner Glenn Adams - Alliance Health appointee  
Randolph County Commissioner David Allen - Sandhills appointee  
Catawba County Commissioner Kitty Barnes - NCACC appointee  
Macon County Commissioner Ronnie Beale - Vaya appointee / Committee Co-Chair  
Wilson County Commissioner Rob Boyette - Eastpointe appointee  
Vance County Commissioner Dan Brummitt - Cardinal appointee  
Guilford County Commissioner Kay Cashion - NCACC appointee  
Moore County Commissioner Catherine Graham - Committee Co-Chair  
Beaufort County Commissioner Jerry Langley - NCACC appointee  
Transylvania County Commissioner Page Lemel - NCACC HHS SC Chair  
Bladen County Commissioner Ophelia Munn-Goins - NCACC appointee  
Durham County Commissioner Ellen Reckhow - NCACC appointee  
Mecklenburg County Commissioner Susan Rodriguez-McDowell - NCACC appointee  
Dare County Commissioner Wally Overman - Trillium appointee  
Yadkin County Commissioner Frank Zachary - Partners appointee

NCACC President-Elect and Yadkin County Commissioner Kevin Austin (ex-officio)  
NC DSS Director Association President Kim Harrell (ex-officio)  
Wake County Assistant County Manager Denise Foreman (ex-officio)  
NC Public Health Directors Association President Steve Smith (ex-officio)

**Committee Schedule:** The Committee met three times—April 8; April 26; May 13. These meetings were held in person. This report was finalized at the third and final meeting of the committee on May 13 in Guilford County and will be submitted to the NCDHHS Secretary by or before the June 1, 2019 requested deadline.
Appendix: Reference Materials for the Committee

i. *Health Opportunity Pilot: The Healthy Opportunities Pilots an opportunity to test the impact of providing selected evidence-based interventions to Medicaid enrollees. Over the next five years, the Pilots will provide up to $650 million in Medicaid funding to cover the cost of select Pilot services related to housing, food, transportation and interpersonal safety that directly impact the health outcomes and health care costs of enrollees in two to four geographic areas of the state. The Pilots have been authorized by the federal Centers for Medicare & Medicaid Services (CMS) for a five-year period, from Nov. 1, 2019 through Oct. 31, 2024, as part of North Carolina’s 1115 demonstration waiver, which also provides North Carolina federal authority to transition its fee-for service delivery system to Managed Care. Funding will be given to a lead pilot entity, which can be include county-based agencies as partners in these initiatives, allowing them to use funding for these initiatives. The current guidelines for lead pilot entities are defined by geographic regions they service, but under current guidelines cannot cross over more than one Medicaid PHP region. With this guidance, it remains unclear how a county that wants to partner with an LME, among other community based organizations, might be able to harness this funding given that LME regions and PHP regions do not align.

ii. Presentation on History of LMEs by Mark Botts (PowerPoint presentation)

iii. Presentation on Medicaid by Dave Richard (PowerPoint presentation)

iv. Meeting Agendas

v. Public Comment Input *(compiled by LME region A-Z; then county A-Z)*

**Alliance Region**
- Alliance Health Input
- Cumberland County Input
- Durham County Input
- Wake County Input (2)

**Cardinal Region**
- Cardinal Input
- Orange County Input
- Rowan County Input
- Stanly County Input

**Eastpointe Region**
- Eastpointe Input
- Bladen County Input
- Edgecombe County Input
- Greene County Input
- Robeson County Input
- Scotland County Input
- Wayne County Input
- Wilson County Input

**Partners Region**
- Burke County Input
- Iredell County Input
Dear Secretary Cohen,

Members of NC Consumer and Family Advisory Committee (NC CFAC) have worked diligently with members of your staff as well as members of the General Assembly to ensure the changes to the Medicaid System make sense both for our state and for our citizens being served. The focus of NC CFAC this year has been the Medicaid Transformation which is the largest transformation the state has undertaken. NC SCFAC recognizes that this is a massive project for the state and one that cannot fail. We have been committed to uphold our mandated responsibilities which include advising the Department of Health and Human Services (DHHS) and the General Assembly (GA) on the planning and management of the state’s public mental health, developmental disabilities and substance use services.

We would like to thank you for your commitment to both the state and local CFAC’s. Under your leadership NC SCFAC has received policy papers for our input prior to them being released. Please find attached our annual report. We would invite you to attend meetings as your schedule permits.

Sincerely,

Benita Purcell, Chairman
State Consumer & Family Advisory Committee
STATE CFAC: MISSION & PURPOSE

Mission
The mission of the State CFAC is to:

- Support the development of consumer services by identifying needs and gaps in services and promoting services that are effective and meet high quality standards.
- Support CFAC growth and development at state and local level.
- Support individual consumer and family participation at state and local level.

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

The State CFAC shall undertake all of the following:

- Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.
- Review and comment on the State budget for mental health, developmental disabilities, and substance abuse services.
- Participate in all quality improvement measures and performance indicators.
- Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
- Provide technical assistance to local CFACs in implementing their duties.
North Carolina Consumer and Family Committee

Annual Report for 2018-2019

Members of this committee work many hours to ensure our tasks are completed. It is more than coming to Raleigh one time a month to ensure the citizens we represent have a voice and that their voice is heard. First, I would like to recognize all members of this committee

Members on NC SCFAC:

Benita Purcell, Chair       Mark Fuhrmann, Vice Chair
Kenneth Brown             Angelena Kearney-Dunlap
John Duncan               Jonathan Ellis
Catreta Flowers           Jean Andersen
Pat McGinnis              Brandon Tankersley
Deborah Page              Wayne Petteway
Ron Rau                   Lori Richardson
Patty Schaeffer           Brandon Wilson
April DeSelms             Susan Stevens

The following is a summary of this past year’s accomplishments of NC SCFAC:

At the start of the fiscal year, there were some internal concerns that NC SCFAC needed to resolve in order to be a more cohesive body. We worked on being more aware of each member’s perspective and honoring the differences. The by-laws were reviewed this fiscal year and some changes were made and finalized November 14, 2018. The main
changes in the by-laws were around meeting attendance and the election of officers. While members believed face-to-face meetings were more productive, we understood that attending in person may not always be an option to some members and did not want to have barriers to participation.

The major focus of NC SCFAC this past year has been on Medicaid Transformation. At each meeting we have addressed issues and concerns related to this major challenge the state is undertaking. Secretary Cohen stressed at the beginning of our fiscal year that both local and state CFAC’s are important and would be part of the system as Medicaid reform moved forward.

Kody Kinsley was appointed Deputy Secretary of the Division of MH/IDD/SAS and has continued to be very supportive of CFAC’s. He has attended most meetings and presented on the Tailored Plans and Standard Plans at our August meeting. During that meeting there were several members of the General Assembly (GA) present to learn more about the changes. NC SCFAC has been active in reaching out to members of the GA though out the year.

NC SCFAC dedicated time at each meeting this year to committee work in order to ensure we covered all the areas we are mandated to cover in GS-122 C-171. This year the main committees included the Legislative Committee, Gaps and Needs Committee (which the Veterans Committee merged into) and the State to Local Committee. Each committee accomplished major tasks this year.
Legislative Committee

The committee decided early on that the Legislative Day needed to occur due to the massive transformation occurring with Managed Care. This was the second Legislative event NC CFAC has organized and while we did not have as many attendees this year, we had more contact with members of the GA. The event occurred on May 16, 2019. NC SCFAC members and members of all local CFAC’s were invited to participate. Talking points were sent out to all local CFAC’s and we had a meeting on May 15th to address the talking points, discuss key bills and discuss the flow of events for the following day. The talking points are attached.

Senator Woodard (District 22) secured the press room for us and he, together with Representative Insko (District 56), attended and spoke at the press conference. This press conference was taped and can be found on YOUTUBE.com “NC CFAC Press May 16, 2019”. NC SCFAC believes this is one of the most significant ways to advise the GA on the planning and management of the State’s public mental health, developmental disabilities, and substance abuse service system (NC GS 122C-171).

Gaps and Needs Committee

This committee worked diligently and compiled a detailed report identifying needs and gaps throughout the state. Members of this committee used reports and data submitted by each LME/MCO and from NCServes. Their detailed report is attached. This complied information made it easier for the committee to make recommendations which can be found at the end of the report. This report will be sent to members of the GA.
**State to Local Committee**

This committee continued to have monthly phone calls with members of state CFAC and local CFAC members participating. These calls focus on a specific topic of interest each month, but then are open for reports of local happenings and events as well as collective brainstorming. As would be expected, many discussions this past year focused on the elements of Standard and Tailored Plans as well as plan rollout and the role of the Enrollment Broker. These calls allow CFAC members statewide to share information with as we work to ensure voices of individuals and families we represent are heard. Members of this committee also sent out a comprehensive survey this year to ascertain what local CFAC’s may want or need from the State CFAC. This committee also developed a form for local CFAC’s to use to get their concerns to the State CFAC. Local CFAC’s are not required to use the form but it is expected to be an effective method to ensure their concerns reach us.

**Other tasks completed by SCFAC**

NC SCFAC has 2 members representing the committee on the North Carolina Medical Care Advisory Committee (NC MCAC) Sub-Committee on Tailored Plans. Federal law requires that states have this committee to advise about health and medical care services that may be covered by their local Medicaid programs. With all the changes occurring in our state, this sub-committee is doing considerable work and it was a benefit to have SCFAC members invited to participate.

NC SCFAC also supported the proposed amendment to HB 250 which would allow 6 additional members to State CFAC representing traumatic brain injury. SCFAC wanted to more inclusive in its membership, not exclusive. We also spoke out against HB 963.
because while it provided a budget to SCFAC it also put restrictions to membership. We reached out to members of the GA who were sponsoring the bill and shared out concerns. We were pleased to receive a response back from Representative Insko (bill sponsor).

Many SCFAC members attended the statewide CFAC collaborative meeting hosted by Sandhills CFAC on April 1, 2019. SCFAC members recommend these meetings occur more frequently if possible (2 times a year), as this is a great way to provide training to members and get input to share with DHHS staff and members of the GA.

The NC Association of County Commissioners also reached out to us to provide input regarding the regions for Tailored Plans. The concern of this committee was that consumers and family members needed to have some continuity of care in order to feel comfortable with the system. Our recommendation was to leave the regions aligned as they currently are with the LME/MCO’s. Change for the sake of change is not always going to provide the positive outcomes desired.

We have received much training this past year, both by DHHS staff and outside individuals. Mark Botts, UNC School of Government came and spoke with us on the laws concerning State CFAC and what it could look like under the new Medicaid Plan. While we recognize that GS 122-C must be updated to reflect the current system, we must be diligent in ensuring this committee remains in law. The language in the statue will need to address the role of CFAC’s in the Tailored Plans in addition to the role of LME/MCO’s.

Glenda Stokes and her team from Consumer Service and Community Rights Team attended several of our monthly meetings and presented proposed fact sheets for input from our committee on language. Many suggestions were shared with her and her team.
We will continue to work with her team this upcoming year as they update all develop new fact sheets.

This coming year, we will be watching very closely how the rollout of Standard Plans and seeking consumer reactions. We are concerned that Enrollment Brokers will not be as available as we were once told they were going to be (they are not stationed in each county which could be a barrier to individuals). We will remain focused on trainings that occur around both the Standard and Tailored Plans. SCFAC will also continue to look at barriers to services as well as needs and gaps and provide comment to DHHS and members of the GA.
Legislative Day Talking Points

**NC Consumer and Family Advisory Committee Legislative Day**

**Talking Points**

**May 16, 2019**

- Expand Medicaid (this would increase services for substance use with NC experiencing an opioid epidemic as well as increase Innovations Waiver Slots).

- Protect and strengthen the voice of consumers-Any revisions to NC GS 122 C must include appropriate measures for consumer and family input through the NC SCFAC and local CFAC's.

- Support efforts to increase rates for direct support professionals. There is a national shortage of direct support professionals. The House has put forth a budget that contains provisions aimed at addressing this issue.

- Any "re-mapping" of the organizational structure of LME/MCO's throughout the state for purposes of implementing Tailored Plans must prioritize consumer and family service needs and stability in those providing direct services.

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**State Statute 122C Section 171 enacted in 2006.**

https://www4.ncleg.net/enactedlegislation/statutes/html/bychapter/chapter_122c.html

§ 122C-171. **State Consumer and Family Advisory Committee.**

(a) There is established the State Consumer and Family Advisory Committee (State CFAC). The State CFAC shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

(b) The State CFAC shall be composed of 21 members. The members shall be composed exclusively of adult consumers of mental health, developmental disabilities, and substance abuse services; and family members of consumers of mental health, developmental disabilities, and substance abuse services. The terms of members shall be three years.
Gaps and Needs Subcommittee Report

NC State Consumer and Family Advisory Committee
Gaps and Barriers/Veterans Subcommittee

2019 Report and Recommendations

NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Foreword

This report is respectfully submitted by the Gaps and Barriers/Veterans Subcommittee to the North Carolina State Consumer and Family Advisory Committee, in order to appropriately request Legislative action from General Assembly and the North Carolinas Secretary of the Department of Health and Human Services. The findings and research conducted, as well as the voices of the consumers of MH/IDD in North Carolina has impacted these recommendations. It is with great confidence that these recommendations will support the LME/MCO’s and communities with the identified gaps in service delivery.

Ronald Rau  
Chairperson

Lori Richardson  
Chairperson

Brandon Wilson

Wayne Petteway

Pat McGinnis

Deborah Page

Catreta Flowers

*Special thanks to Ms. Megan Brewer UNCA work intern with Veterans Services of the Carolinas for her contributions of research and insight for this report.*
Table of Contents

Page 5..........................Subcommittee Charter
Page 7............................Social Determinants of Health
Page 8............................Background
Page 9............................Gaps and Analysis Report
Page 12.........................NCServes Gaps and Analysis Report on Veterans
Page 13.........................LME/MCO Network Adequacy Reports
Page 16.........................LME/MCO Performance Improvement Projects
Page 20.........................Transportation
Page 21.........................Recommendations
State Consumer and Family Member Advisory Committee
Service Gaps & Needs/Veterans Subcommittee Charter

Purpose
The purpose of the Services Gaps & Needs/Veterans Subcommittee of the State Consumer and Family Members Advisory Committee (SCFAC) is to assist in assuring adequate services for North Carolina citizens, including veterans, who require Mental Health (MH), Intellectual Developmental Disabilities (IDD), and Substance Abuse (SA) Services by means of recommendations regarding any gaps and needs according to North Carolina General Statute §122C-171.

Authority
The authority for the specific responsibilities of the Services Gaps & Needs/Veterans Subcommittee is found in NC General Statute § 122C-171 (2014) as follows:

1. Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
2. Identify service gaps and underserved populations.
3. Make recommendations regarding the service array and monitor the development of additional services.
4. Review and comment on the State Budget for mental health (MH), intellectual developmental disabilities (IDD), and substance abuse (SA) services.
5. Participate in all quality improvement measures and performance indicators.
6. Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
7. Provide technical assistance to local CFACs in implementing their duties.
Meetings

Meetings of the subcommittee will be conducted in the following manner:

- The chair will set up meetings monthly or as appropriate
- The chair is responsible for setting the agenda.
- The chair will assign a subcommittee member the responsibility to take minutes.
- The chair or designee will report out and make recommendations to the full SCFAC.
- Communication needs (letters written, research, follow-up information, etc.) will be conveyed to SCFAC for assistance and resolution.

Specific Activities of the Service Gaps & Needs Subcommittee

Subcommittee member will review gaps and needs analyses:

- Collect gaps and needs from NC Department of Health and Human Services and/or LME/MCO’s
- Collect gaps and needs information from NC Department of Military & Veterans Affairs
- Look for state-wide trends for consumers and veterans
- Communicate state-wide gaps and needs to other subcommittees as appropriate

Subcommittee members will participate in the development of the State Plan:

- Participate in SCFAC conference calls and any agency meetings or conference calls regarding the State Plan
- Make recommendations regarding the substance and implementation of the State Plan using info from gaps and needs work including veterans
- Stay abreast of agency regulations and legislation regarding the substance or implementation of the State Plan
- Coordinate subcommittee activity with the SCFAC and make recommendations through communications with appropriate individuals and committees

Subcommittee members will receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, intellectual developmental disabilities, and substance abuse services

- Participate in the State-to-Local CFAC conference calls and any agency meetings or conference calls regarding service gaps and needs within the local service areas
- Coordinate subcommittee activity with the SCFAC and make recommendations through communications with appropriate individuals and committees
- Participate with the local CFAC’s regarding the annual DHHS report to CMS on service gaps & needs
Social Determinants of Health

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH). We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. This also can impact children during their youth, and we know this from the Adverse Childhood Experiences Study (ACES). We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. Social determinants carry a lot more influence on a person’s health than we know. With the movement to transform Medicaid, social determinants are necessary to consider because of the major effects they have on one’s health. Recent studies will show that toxic stress has detrimental effects on one’s neuro chemistry resulting in poor overall health. Housing, employment, transportation, education, clothing, adequate food are all social needs that lead to challenges in demographics, economic stability, education which are known as social determinants that cause some level of stress. A lot of social determinants can manifest to eventually cause toxic stress. If social determinants have a negative correlation with overall health then medical professionals need to be looking at patients holistically. As a society we need to first examine the quality of life and the stresses one patient may be under before trying to examine their health. Resources that enhance the quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, educational opportunities, adequate transportation, and public safety, availability of healthy foods, local emergency/health services and environments free of life-threatening toxins.

If we can focus on the social determinants and try to relieve some of the stresses then it is possible that a person’s overall health will improve. This is why social determinants are at the forefront of discussion during both Medicaid expansion and reform and are now driving decisions at all levels of communities.
Background

Both the NC Medicaid and the DMH/DD/SAS contract require the LME/MCO to conduct and maintain a minimum of three (3) performance improvement projects. These performance improvement projects shall be based on the following criteria, indicated by the Quality Improvement Office from DHHS.

- Topics for performance improvement projects shall be identified through consumer, family, provider, and stakeholder surveys, performance measures, quality improvement studies, and continuous data collection and analysis.

- The LME/MCO shall give priority to projects that address initiatives of the NC General Assembly and DHHS.

- Any projects developed and implemented in accordance with this Contract may also be used to meet the requirements of LME/MCO’s accreditation body and NC Medicaid.

- Reports on all performance improvement projects shall be submitted to DMH/DD/SAS and NC Medicaid no later than August 31 of each year.

DMH/DD/SAS and NC Medicaid monitor the LME/MCO performance improvement projects on a quarterly basis as a part of the Interdepartmental Monitoring team reviews. Quarterly review monitoring includes: Updated measurement results and trend data (baseline, trend and current)

1. Progress made
2. Barriers
3. Interventions
4. Next steps
### Gaps and Analysis Report

<table>
<thead>
<tr>
<th></th>
<th>Transportation</th>
<th>Housing</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alliance Behavioral Healthcare (Members)</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Vaya Health (Members)</strong></td>
<td>11% (29 members)</td>
<td>18.6% (40 members)</td>
<td>17.2% (37 members)</td>
</tr>
<tr>
<td><strong>Cardinals (Members)</strong></td>
<td>30.76%</td>
<td>26.66%</td>
<td>36.76%</td>
</tr>
<tr>
<td><strong>Partners (Members)</strong></td>
<td>14.6% (24 members)</td>
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</tr>
<tr>
<td><strong>Sandhills (Members)</strong></td>
<td>15.9% (66 members)</td>
<td>13.97% (58 members)</td>
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</tr>
<tr>
<td><strong>Eastpointe (Members)</strong></td>
<td>33.59% (86 members)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Trillium (Members)</strong></td>
<td>11.35%</td>
<td>6.03%</td>
<td>10.56%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>Average = 19.5%</td>
<td>Average = 14.7%</td>
<td>Average = 20.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Transportation</th>
<th>Housing</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alliance Behavioral Healthcare (stakeholders)</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Vaya Health (stakeholders)</strong></td>
<td>49.5% (283 members)</td>
<td>19% (109 members)</td>
<td>16.6% (95 members)</td>
</tr>
<tr>
<td><strong>Cardinals (stakeholders)</strong></td>
<td>69.09%</td>
<td>54.10%</td>
<td>45.43%</td>
</tr>
<tr>
<td><strong>Partners (stakeholders)</strong></td>
<td>73.5% (25 members)</td>
<td>67.6% (23 members)</td>
<td>55.9% (19 members)</td>
</tr>
<tr>
<td><strong>Sandhills (stakeholders)</strong></td>
<td>16.3% (259 members)</td>
<td>22.69% (395 members)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Eastpointe (stakeholders)</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>Trillium (stakeholders)</strong></td>
<td>8.21%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>Average = 43.3%</td>
<td>Average = 40.8%</td>
<td>Average = 39.3%</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Transportation</th>
<th>Housing</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCserves</strong></td>
<td>2% (215 members)</td>
<td>25% (2249 members)</td>
<td>19% (1747 members)</td>
</tr>
<tr>
<td><strong>Averages for both members and stakeholders</strong></td>
<td>31.40%</td>
<td>27.75%</td>
<td>29.90%</td>
</tr>
</tbody>
</table>

*Vaya Health also had supported employment long term follow up stats showing that 35 members had gaps/barriers making that a 16.2% gap/barrier.

Vaya also had supported living stats showing 37 members reported gaps/barriers making it 17.2%

*Vaya Health also had supported employment long term follow up stats showing that 94 stakeholders reported gaps/barriers making a 16.4%

Vaya also had supported living stats showing 109 stakeholders reported gaps/barriers making it 19%.

*Sandhills has data for lack of transportation and housing gaps/barriers; For members, 66 responded having transportation gaps/barriers for a 15.9% total. 259 stakeholders responded having transportation gaps/barriers for a 16.3% total. 58 members responded having housing/homelessness gaps/barriers for a 13.97% total (5.78% are completely homeless). 395 stakeholders responded for housing/homelessness gaps/barriers for a 22.69% total (10.74%...
Alliance BH on pages 19 and 22 (parts 2 and 4) list both transportation and housing as barriers for consumers, family members, and stakeholders, however, there was no data presented in adequacy report.
Average Gaps/Barriers for Consumers:

Average Gaps/Barriers for Stakeholders:
The following graph’s data was calculated from the preceding two graphs (consumers and stakeholders. It is an average of the consumers and stakeholders surveys for employment, housing, and transportation.

Average Gaps/Barriers for Consumers & Stakeholders:
NCServes Gaps and Analysis Report on Veterans

NCServes is the state’s first coordinated network of public, private and non-profit organizations serving Veterans, Service Members and their families. NCServes uses a web based platform (Unite Us) to guide and collaborate with local, state, and national partners in order to both enhance service delivery and track outcomes of the services. NCServes operates four networks across North Carolina and currently provides services in 64 counties. NCServes Western (Buncombe) NCServes Metrolina (Mecklenburg), NCServes Central (Wake) and NCServes Coastal (Jacksonville), although each network operates independently, they often work together and are able to collaborate through inter-network referrals.

Unlike the Network Adequacy Reports, which are solely based on participation in surveys from both members and stakeholders, the following graph is derived on actual outcomes based on service needs being requested by our Veterans, Service Members and their families. The outcomes measured are calculated in aggregate by both resolved and unresolved.

Average Gaps/Barriers for NCServes in Comparison to Needs:

- Employment, 19%
- Housing, 25%
- Transportation, 2%
Network Adequacy Reports

The Subcommittees reviewed all LME/MCO Network Adequacy reports (formerly known as Gaps/Analysis Report). The Subcommittee is highlighting both the top 3 needs indicated by both the stakeholder and consumer surveys. The committee however is focusing on three pertinent needs also indicated by the surveys and local CFAC feedback. These needs are housing, transportation, and employment. All of which can be considered social needs categorized in the Social Determinants of Health.

Top 3 Gaps and Barriers from LME/MCO Network Adequacy 2018

The following data was retrieved from adequacy reports from the 2018 year. There was no standard report among the providers making it difficult to retrieve the correct data. According to the following data, transportation and the inability to pay for services were the two most common gaps/barriers to care. Other gaps/barriers include housing, employment, lack of insurance, location of providers, and lack of adequate food.

Unfortunately, there were a couple of providers that failed to present all the data in their adequacy report. This makes it harder to compare and contrast; ultimately affecting the efficiency of compiling the necessary data. In order to ensure a more concise data collection, providers should follow a standardized format that has common language and data. If there was common formatting it would make it easier and faster to be able to find the appropriate data. This will be a recommendation for DHHS moving forward.
Citations: The adequacy reports data was retrieved from the following pages from each respected LME/MCO individual report. Due to the complexity of these reports and the unique reporting from each region, some of this data’s interpretation may have discrepancies.

Alliance- found pgs. 19 & 22 (parts 2&4); Cardinal- found on pgs. 8 & 103; Eastpointe- found on pg. 16; Partners- found on pgs. 89 & 122; Sandhills- found on pgs. 29-30; Trillium- found on pgs. 33-34; Vaya Health- found on pgs. 24-25;
Network Adequacy Reports

*There were no specific numbers/data on report, however, Alliance stated that both housing and transportation were barriers for consumers. They also reported that housing was a barrier reported by stakeholders.

Members*
1. Employment- 36.76%
2. Transportation- 30.76%
3. Medical issues- 29.03%

Stakeholders*
1. Transportation- 69.09%
2. Cannot pay for services/medications- 62.30%
3. No insurance- 55.50%

Members*
1. Transportation- 33.59%
2. Service not available close to my home-17.58%
3. There are no providers available in my community- 14.06%

Stakeholders*
1. Transportation- 73.5%

Members*
1. Medical/health issues- 26.2%
2. Cannot pay for services- 23.2%
3. Mental health/substance use- 18.3%

Stakeholders*
1. Transportation- 73.5%
2. Cannot pay for services- 70.6%
3. Homeless/housing issues- 67.6%

**SANDHILLS CENTER**

Members*

1. Transportation- 15.90%
2. Housing- 8.19%
3. Lack of adequate food- 6.02%

Stakeholders*

1. Transportation- 16.30%
2. Cannot pay for services- 13.47%
3. Lack of adequate food- 9.06%

**Trillium Health Resources**

Members*

1. Transportation- 26.38%
2. Wait too long for appointments- 17.32%
3. Cost of medication- 13.32%

Stakeholders*

Are concerned that Trillium does not provide services that are available for all their members’ cultural and ethnic needs, why?

1. Gaps or limited services- 18.33%
2. Establish or improve partnership with Trillium- 15.56%
3. Mental health services/support – 15.00%

**VayaHealth**

Members*

1. Availability of qualified staff- 63 members
2. Quality of service provider- 55 members
3. Availability of specialized services- 53 members
Stakeholders*

1. Transportation - 283 stakeholders
2. Availability of service providers who accept insurance - 223 stakeholders
3. Availability of psychiatric services - 236 stakeholders
LME/MCO Performance Improvement Projects

(Performance improvement projects were last submitted to the state on August 31, 2018.)

The following was reported by the DHHS Quality Improvement Team during the monthly State CFAC meeting on January 9, 2019. All LME/MCO’s are required to report the priorities being addressed in each respected Performance Improvement Projects. The highlighted areas indicate an area on improvement being addressed from the top three identified areas of improvement of Housing, Employment, and Transportation.

*Note that only Housing is being addressed by an existing program which was expanded; TCLI (Transitions to Community Living).

Access to Care: To improve the number of Emergent callers who show for care within the 2:15 hour timeframe, as calculated by Alliance

Access to Care: Increase in consumers needing urgent care who show for care within 2 calendar days

Access to Care: Increase in consumers needing routine care who show for care within 14 calendar days

First Responder: Increase providers with a test call rated as Satisfactory (Live Answer by Staff or Answering Service, or Message Returned Within 1 Hour)

**TCLI: Increase members housed during the measurement period within 90 days of housing slot assignment**

UM Expedite Care: Decrease average authorization decision turn-around time for youth discharging from local emergency departments to 3 days or less

UM Innovations Requests Turnaround Times: Decrease average authorization decision turn-around time for Innovations service requests to 8 days or less

Show how providers benefit from technical assistance and education through PCM resolutions with the goal of improving quality of care

Increase follow up with outpatient provider 7 and 30 days after hospitalization and FBC admission for mental health concern

Increase follow up with outpatient provider 7 and 30 days after hospitalization and FBC admission for substance use concern
Increase the percentage of members (age 6 and up with a principle diagnosis of mental illness who had a follow-up visit for mental health at 7 and 30 days following an emergency department visit.

Increase the percentage of members (age 6 and up with a principle diagnosis of substance use disorder who had a follow-up visit for mental health at 7 and 30 days following an emergency department visit.

Quality of grievance resolution (decreasing the types of grievances which occur most often)

IDD adherence to monitoring requirements

Timely submission of Quality of Life surveys

Decrease the number of members who experience three or more crisis services in a 12-month period

Improved Recovery Assessment Scores consequent of Peer Support provision

Increase the percentage of members in an ACH or at risk of ACH admission who have a claim for Supported Employment provided by a fidelity provider

Increase percentage of children 1-17 with two or more prescriptions for antipsychotics who receive metabolic monitoring

Increase percentage of members who received a face to face service within 48 hours.

Decrease state psychiatric hospital 30-day readmissions for high risk members.

Decrease Emergency Department(ED) admissions for Active Members

Increase Percent of members discharged who were admitted for mental health treatment that received a follow-up visit within 7 days after discharge from inpatient treatment facility

Increase Total dollar amount of Approved Encounter Claims

Increase the percent of individuals who receive a 2nd service within ≤ 14 days.

Increase percentage of individuals served in the Priority Population by a Fidelity Provider to fifty percent (50%) monthly.

Increase Physical Health/Primary Care Physician (PCP) referrals to Behavioral Health

Increase the Percentage of Consumers Completing an Episode of Treatment via NC-TOPPS

Increase Initial NC-TOPPS Interviews
Increase Utilization Rate of B3 Supported Employment Services by the IDD Population of Consumers

Promoting follow-up within seven (7) days of discharge from a Community Hospital, State Psychiatric Hospital, and Facility Based Crisis Service for Mental Health Treatment.

Promoting follow-up within seven (7) days of discharge from Community Hospital, State Psychiatric Hospital, State ADACTs and Detox/Facility Based Crisis Services for SUD Treatment.

Transition to Community Living Initiative (TCLI) - Individuals Transitioned within 90 days of House Slot Issue Date

Ensure that members have access to routine behavioral health assessments in a timely and appropriate manner

Shaping the Network to improve provider choice and ensure members access to quality services

Increase the Evidenced Based Best Practices employed by our provider network, and increase the documentation supporting the use of those practices.

Maximize the benefit of Child Mental Health Level III

Decrease the number of days from when a housing slot is issued to the actual transition date

Improving access to behavioral health information and services for Hispanic members by improving content available to members of this population seeking such services

Increase the number of members authorized for Psychosocial Rehabilitation Services with correct diagnosis or sufficient clinical information

Increase timely completion and submission of Quality of Life Surveys

Increase number and percentage of members with routine appointments who keep their appointment within 14 calendar days of contacting with the Call Center

Increase and maintain a minimum number of ten (10) participants in the Project SEARCH program so it can be self-sustaining

Assure consistent connection to community services following Facility Based Crisis Services

Improve member’s access to care by ensuring follow through with routine and urgent scheduled appointments
Enhance Network Provider Directory; improve the accuracy of provider information in the Network Provider Directory

Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)

DMA and DMH Mental Health 7 Day Follow-Up

DMA and DMH Substance Use Disorder 7 Day Follow-Up

Improving the percentage of timely contacts with members in In-reach status

Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion

Inpatient Rapid Readmission

Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants

Follow-Up After Discharge from Inpatient Mental Health Treatment

Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment

Increase housing placements through the Transitions to Community Living Initiative
Transportation

Limited access to reliable transportation causes millions of Americans to forgo important medical care every year. Transportation barriers are most prominent among the poor, elderly, and chronically ill—populations for whom routine access to ambulatory and preventive care is most important. As identified in all Network Adequacy Reports transportation continues to be a large barrier for consumers across North Carolina. Some MCO’s are working to address this barrier in small pilot projects. An example of such a project is with Vaya Health in their Complex Case Management Program. They are in partnership with RHA and Mission Hospital; and provide Bus Passes to people leaving the hospital with MH and SU issues, so that they can access community services and make follow-up appointments. It is important to keep in mind that a large majority of consumers in NC live in rural areas where mass transit options are nonexistent. However, supporting and funding these types of initiatives will lead to a success’s with consumers.

Some states have taken steps to address transportation barriers by providing non-emergency medical transportation (NEMT) benefits to select beneficiaries. A majority of Medicare Advantage (MA) plans and state Medicaid programs currently provide NEMT benefits, North Carolina being one of these states. Currently in North Carolina the Division of Social Services arranges NEMT, however under the new tailored plan design our MCO’s will arrange NEMT in the future.

An approach that has attracted considerable attention is the use of transportation network companies (TNCs)—such as Uber or Lyft—to provide NEMT services. Recently both Lyft and Uber have been authorized transport consumers and receive payment from Medicaid sources. Both companies are working to train drivers to work with people who use wheelchairs, walkers and scooters. Both Lyft and Uber are contracting directly with health plans and delivery organizations to provide NEMT services.

In Texas and Florida there are bills that would allow Medicaid Managed Care Companies to use Uber, Lyft and others transportation networks to transport patients to appointments. Through our recommendations, it is our hope that DHHS and the LME/MCO’s will work with communities to create projects that will enhance this SDOH. We understand that each community is different and that a vast array of creative ideas must be approached and implemented to assure we are addressing this need across North Carolina.
Recommendations

1.) That the Department of Health and Human Services specifically fund the LME/MCO’s for Transportation needs for consumers receiving services from each LME/MCO. Funding to be $250,000 for transportation projects for each LME/MCO. (this would be a $1.75 million dollar investment)

2.) NCDHHS to give authorization for LME/MCO’s to utilize transportation funds in any innovative means to support access to care. This includes formal partnerships with transportation networks such as Uber and Lyft.

3.) That NCDHHS mandate that top tiered needs identified in Network Adequacy reports be addressed in each Performance Improvement Project from LME/MCO’s.

4.) SCFAC would like to have a comprehensive report from NC Quality Improvement Team on all Network Adequacy Reports each year; in order to best gauge both gaps and barriers and the performance improvement projects being submitted.

5.) That NCDHHS mandate the correct question for LME/MCO’s on initial assessments and follow ups for Veterans. ‘Have you or an immediate family member ever served in the active Military, Guard or Reserve?’

6.) That DHHS and General Assembly allocate funding for the NCServes networks to enhance service delivery and track outcomes for Veterans and families across North Carolina; and that these networks work with the NCCares 360 project in unison.
A
ABC – Attachment Bio-Behavioral Catch-up
ACA – Affordable Care Act (Obama Care)
ACT – Assertive Community Team
ADA – American Disabilities Act
ADATC – Alcohol and Drug Abuse Treatment Center ADD – Attention Deficit Disorder
ADETS – Alcohol and Drug Education Traffic School ADHD – Attention Deficit Hyperactive Disorder
AG – Academically Gifted
AHCA – American Health Care Act (Trump Care)
AHEC – Area Health Education Center AOC – Administrative Office of the Courts AMI – Alliance for the Mentally Ill
ARC – Association for Retarded Citizens
ASAM – American Society of Addictive Medicine
B
BIP – Behavioral Intervention Plan
BED – Behavioral/Emotional Disorder (public schools)
C
CAP – Community Alternatives Program
CAFAS – Child and Adolescent Functional Assessment Scale
CASSP – Child and Adolescent Service System Program CBT – Cognitive Behavioral Therapy
CC – Community Collaborative
CCNC – Community Care of North Carolina
CCSW – Certified Clinical Social Worker
CDFA – Children’s Development Services Agency CEC – Council for Exceptional Children
CFAC – Consumer and Family Advisory Committee CFP – Child and Family Plan
CFT – Child and Family Team
CHIP – Children’s Health Insurance Program
CIS – Community in Schools
CIT – Crisis Intervention Team
CJO – Criminal Justice Offender – Child or Adult Population CMH – Child Mental Health
CMS – Centers for Medicare/Medicaid Services
CPSP – Certified Parent Support Provider
CSAT – Center for Substance Abuse Treatmen
D
DACJ – Division of Adult Correction & Juvenile Justice
DCD – Division of Child Development DD – Developmental Disabilities
DHHS – Division of Health and Human Services
DJJDP – Division of Juvenile Justice and Delinquency Prevention DMA – Division of Medical Assistance
DMH/DD/SA – Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DOC – Department of Correction (State) DOH – Department of Health (County) DPH – Department of Public Health
DPI – Department of Public Instruction (State)
DSDHH – Division of Services for the Death and Hard of Hearing (State) DSM-IV – Diagnostic and Statistics Manual
DSS – Division of Social Services (State)
DWI – Driving While Impaired
DUI – Driving Under Influence
DX – Diagnosis
EBD – Emotionally or Behaviorally Disturbed
EBP – Evidence Based Practice
ECAC – Exceptional Children’s Assistance Center
ED – Emotionally Disturbed
EOC – End of Course (DPI)
EOG – End of Grade (DPI)
EPSDT – Early Periodic Screening, Diagnosis and Treatment
ESEA – Elementary and Secondary Education Act
ESL – English as a Second Language
FPC – Family Partner Coordinator
FAPE – Free and Appropriate Public Education
FFT – Family Functional Therapy
FAN – Family Advocacy Network
FCT – Family Centered Treatment
FFCMH – Federation Families Children’s Mental Health
FES – Family Empowerment Scale
FFS – Fee for Service
FSN – Family Support Network
FSP – Family Support Partner
FREDLA – Family Run Executive Director Leadership Association
GAL – Guardian ad Litem
G.S. – General Statute
GAF – Global Assessment of Functioning
HC – Health Check
HCBS – Home and Community Based Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HMO – Health Maintenance Organization
HOM – Homeless Child or Adult Substance Abuse Population
HUD – Housing and Urban Development
ICC – Interagency Coordinating Council
ICD – International Classification of Diseases codes
ICF – Intermediate Care Facility
ICF- I/DD– Intermediate Care Facility – Intellectual Developmental Disability
I/DD – Intellectual Developmental Disability
IDEA – Individuals with Disabilities Education Act
IEP – Individualized Education Program
IFSP – Individual Family Services Plan
IIH – Intensive In-Home
IPRS – Integrated Payment and Reporting System
IT – Information Technology
I & R – Information and Referral
IY – Incredible Years
JCAHO – Joint Commission for Accreditation of Healthcare Organizations
JJ- Juvenile Justice
JCP – Juvenile Crime Prevention Council
JSAMHP – Juvenile Justice Substance Abuse Mental Health Partnership
LCSW – Licensed Clinical Social Worker
RFA – Request for application
RFI – Request for information RFP – Request for Proposal
RRC – Regional Resource Centers (Special Education)
RX – Prescription
S
SAD – Substance Abuse Disorder – Child
SAMHSA – Substance Abuse and Mental Health Services Administration
SA – Substance Use
SAYSO – Strong Able Youth Speaking Out
SBI – State Bureau of Investigation
SCFAC – State Consumer and Family Advisory Committee SCS – Standard Course of Study (DPI)
SED – Seriously Emotionally Disturbed SIP – School Improvement Plan
SIMS – Student Information Management System (DPI) SMHRCY – State Mental Health Representatives for Children and Youth
SNAP – Support Needs Assessment Profile
SNAP – Supplemental Nutrition Assistance Program
SIS – Supports Intensity Scale
SOC – System of Care
SOC-EX – System of Care Expansion
SOS – State Operated Services
SOW – Scope of Work
SPMI – Sever and Persistent Mental Illness SS – Social Security
SSI – Supplemental Security Income
T
TANF – Temporary Assistance for Needy Families
TEACCH – Treatment and Education of Autistic and Related Communication Handicapped Children
TMH – Trainable Mentally Handicapped (also TMR)
TF-CBT – Trauma Focused-Cognitive Behavior Therapy
Title IV-E – Foster Care and Adoption Assistance Programs (section of Social Security Act)
Title XIX – Medicaid (Section of the Social Security Act)
Title XVIII – Medicare (Section of the Social Security Act)
TPR – Termination of Parental Rights
Triple P – Positive Parenting Practice
TTY – Text Telephones
TX – Treatment
U
UM – Utilization Management
V
VI – Visually Impaired (also VH)
MEMBERS PRESENT: Jason Phipps, Cassandra Herbert, Leanna George, Albert Dixon, Jerry Dodson, Bobby Dixon  
BOARD MEMBERS PRESENT: None  
GUEST(S): Anthony Navarro  
STAFF PRESENT: Doug Wright, Director of Community & Member Engagement, Terrasine Gardner, Member Engagement Manager, Noah Swabe, Individual and Family Engagement Specialist  

1. WELCOME AND INTRODUCTIONS  

2. REVIEW OF THE MINUTES – The minutes from the June 18, 2019, Consumer and Family Advisory Committee (CFAC) meeting reviewed; a motion made by Jerry Dodson and seconded by Bobby Dixon to pass the minutes. Motion passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comment</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4. LME/MCO Updates</td>
<td>Doug Wright gave the LME/MCO update informing CFAC members that Alliance has reached an agreement with AmeriHealth Caritas, Well Care, and United Healthcare which are three of the four standard plans that will be operating within NC. Alliance will be providing behavioral health call-in services.</td>
<td>Alliance staff will continue to update the CFAC with information and opportunities as it becomes available.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Doug provided an update to the current Continued Quality Improvement (CQI) process which is changing from departments to functions. This will open up opportunities for CFAC members to offer feedback that will be given to the Global Quality Improvement Team.</td>
<td></td>
<td></td>
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<tr>
<td>5. State Updates</td>
<td>Doug gave an update on the current state budget situation. DHHS said in today’s webinar that if there is no state budget by early September they will be forced to delay Medicaid Transformation from the November 1st go live date. Doug discussed the webinar that was given this afternoon on Medicaid Transformation. Members were encouraged to ask questions and review the slides from the webinar if they were unable to view the webinar this afternoon. Several documents were sent out through email; printed versions were made available at the CFAC meeting. Documents included the County Commissioners Report, Request to Stay form, Perception of Care, and the SCFAC report. Members were encouraged to review the documents and ask Noah, Terrasine, or Doug if they had any questions.</td>
<td>Alliance staff will continue to follow developments at the state level and update the CFAC.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6. Guardianship Event</td>
<td>The Johnston CFAC hosted a guardianship event in 2017 focusing on what guardianship is, why to consider guardianship, and alternatives to</td>
<td>Noah will reach out to the Medical Mall and reserve the space for</td>
<td>September 17, 2019</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
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<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>7. Events</td>
<td>Noah discussed upcoming events within the community and provided a handout with dates, times, and locations of community events both locally and regionally.</td>
<td>Continue to update CFAC members with community events and trainings.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>8. Call In and Stipends</td>
<td>Doug discussed the current process for CFAC members calling into the Alliance CFAC steering committee. Doug commended the Johnston CFAC on how well they represent the Johnston CFAC at the steering committee by sending the co-chairs and one to two members to the Alliance CFAC. The concern is folks who are calling into the meetings are then leaving before the meeting is over or not participating during the meeting. It was suggested that the topic be brought up at the next Alliance CFAC steering committee. One possibility would be considering keeping the call-in an option for listening but, stipends would only be issued for in-person participation.</td>
<td>Discuss call-in stipends at the Alliance CFAC steering committee.</td>
<td>October 7, 2019</td>
</tr>
</tbody>
</table>

9. **ADJOURNMENT:** the next meeting will be September 17, 2019, at 5:30 p.m.

Respectfully Submitted by:

**Noah Swabe, Individual and Family Engagement Specialist**

[Click here to enter text.]
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the July 1, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dr. McGuire and seconded by Steve Hill to approve the minutes. Motion passed.

<table>
<thead>
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<tr>
<td>3. Public Comment Individual/Family Challenges and Solutions</td>
<td>Israel Patterson commented on the challenges with adult guardianship and the group commented. A moment of silence was requested for the victims of this past weekend’s shootings by Trula Miles. Doug Wright pointed out in wake of the shootings that have affected our communities that evil and hate are not mental illness. The group also spent some time discussing grievance procedures.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Tailored Plans</td>
<td>Medicaid – Managed Care – Open Enrollment: Sara Perkins delivered a presentation on Medicaid Transformation; Managed Care and Open Enrollment. The main focus points of this presentation were: Open Enrollment, and Beneficiary Support.</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>5. LME/MCO Updates</td>
<td>By The Numbers Annual Report:</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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</thead>
<tbody>
<tr>
<td>6. Gaps and Needs</td>
<td>The LME/MCO Administrative Functions Monitoring Report was given to all members and they were asked to review and submit any questions or concern to Doug. The FY 2019 Annual Report was given to all members.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7. State Updates</td>
<td>Network Adequacy and Accessibility: Carlyle Johnson presented on the 2019 Network Adequacy and Accessibility Analysis. The main focus points on this presentation were the findings of the needs and gaps surveys that were completed earlier this year.</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Subcommittees • Wake • Durham • Cumberland • Johnston • Area Board • Human Rights • Quality Management</td>
<td>There were no updates at this time.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Announcements</td>
<td>The September Steering Committee meeting will not take place due to the Labor Day holiday.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

10. **ADJOURNMENT:** the next meeting will be October 7, 2019, at 5:30 p.m.

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

Ramona Branch, Individual & Family Engagement Specialist

Click here to enter text.

Date Approved

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
There is a lot of information about changes to Medicaid in North Carolina. Some people who use Medicaid will choose a health plan soon; some people will not. Everyone who is eligible to get Medicaid will still get Medicaid.

This document provides answers to some common questions. It covers the changes to Medicaid, how they affect you, and who you can contact for help.

What is happening in NC?

How is NC Medicaid changing in 2019 and 2020?

• North Carolina is changing how most people receive Medicaid services.
• Most people will get the same Medicaid services but in a new way—through health plans.
• A health plan coordinates your health care with a group of doctors, hospitals, and other providers. They will work together to provide you with health care. Almost everything will come from the same plan. This includes physical health services, behavioral health services, and medicine your doctor prescribes for you. Some health plans will provide added services like gym memberships.

Is everyone going to receive Medicaid health care through health plans?

• Most people will receive Medicaid health care through health plans. People who do not get Medicaid health care through health plans will get the same Medicaid services through “NC Medicaid Direct” and their current Local Management Entity/Managed Care Organization (LME/MCO).

What is “NC Medicaid Direct”?

• NC Medicaid Direct is one way for people to get Medicaid health care. It is the new name for the current Medicaid fee-for-service program. It is how people get physical health services and some behavioral health services today.
• NC Medicaid Direct has many of the same services that are in health plans.
• LME-MCOs will continue to provide some services for people in NC Medicaid Direct who have a mental illness, substance use disorder, I/DD, or TBI; some of these services are not available in NC Medicaid Managed Care.

How do I know if I will get Medicaid health care through a health plan or through NC Medicaid Direct?

• In June, DHHS began sending letters to many people who get Medicaid health care today. Your letter has information about you and your family. Your letter explains what the changes mean for you. If you have questions about your letter, call 1-833-870-550 (TTY: 1-833-870-5588).
When will people start getting Medicaid health care through a health plan?

- Most people will start their new health plans in November 2019 or February 2020. When you start depends on where in the State you live and what types of health care services or treatment you need.

How do changes in Medicaid health care impact me?

I got a letter saying that I need to choose a primary care provider and health plan by September 13, 2019. What does this mean?

- This means that you need to choose a primary care provider (PCP). Your PCP could be your family doctor, clinic, or other health care provider. Your PCP will help you with your health care needs.
- You also need to enroll in a health plan. Not all doctors work with every health plan. Choose a health plan that works with your PCP.
- If you do not choose a health plan or PCP by September 13, Medicaid will choose one for you. If you do not choose a PCP, Medicaid will try to keep you with your current PCP.
- Call 1-833-870-5500 (TTY: 1-833-870-5588) for help choosing a health plan that works with your PCP.

I got a letter saying I will stay in NC Medicaid Direct. What does this mean?

- You do not need to choose a health plan. You will continue to have access to all the same Medicaid services you do now.
- You will continue to get services for your I/DD, mental illness, substance use disorder, or TBI through your current LME/MCO if that is how you access those services today.

I got a letter saying that only some members of my household need to enroll in a Medicaid health plan while others will stay in NC Medicaid Direct. Why?

- Some people with certain health care needs – such as people with a serious mental illness, severe substance use disorder, I/DD, or TBI—will continue getting their Medicaid services in NC Medicaid Direct through their LME/MCOs. Others will get all their health care needs met by enrolling in a health plan.

I get both Medicaid and Medicare. Do I need to pick a Medicaid health plan?

- No. You do not need to pick a new health plan. The way you receive services isn’t going to change.

Why did my friend or neighbor get a different letter than what I got?

- Everyone got a letter specific to his or her personal situation. You and your friend may have different health care needs.
• Most, but not all, people will start getting Medicaid services from a health plan. However, some people with certain health care needs will stay in NC Medicaid Direct and access certain services through their LME/MCOs.

**I got a letter to enroll in a health plan, but need a service for my I/DD, TBI, serious mental illness, or severe substance use disorder. What should I do?**

• You can request a review of your case.
• You or your doctor can submit this request using the Request to Stay in NC Medicaid Direct and LME/MCO form.
• You or your doctor can fill out the form. To get the form, call 1-833-870-5500 (TTY: 1-833-870-5588).

**Will I still be able to see my doctor?**

• Call 1-833-870-5500 (TTY: 1-833-870-5588) to learn if your doctor works with your health plan. The staff at this phone number can help you find a health plan that works with your doctor.

**Will it cost more for me to get my Medicaid through a health plan?**

• No. Your costs will **not** change if you get Medicaid through a health plan.
• Like today, you may need to pay a copay for certain services, but you will not need to pay a monthly fee (premium).

**What if I did not get a letter?**

• Some people who have Medicaid health care got letters in June; other people who have Medicaid health care will get letters in October. When you get your letter depends where in the State you live.
• However, some people who currently have Medicaid health care will not get a letter at all. They will continue to receive their health care services as they do today. They do not need to do anything at this time.
• For example, people who have Medicaid **and** Medicare, as well as some other special groups, will not receive a letter at all.
• If you have questions about whether you are getting a letter, call 1-833-870-5500 (TTY: 1-833-870-5588) for help.

**Who can I contact for help?**

The Enrollment Broker can:

• Help you understand your options related to the Medicaid changes;
• Explain the enrollment process and help you pick a health plan and PCP; and
• Explain why you do or do not need to enroll.
• The help is **FREE**.

Contact the Enrollment Broker:

- By phone at 1-833-870-5500
- Online at [www.ncmedicaidplans.gov](http://www.ncmedicaidplans.gov)
Medicaid Managed Care
Phase 1 Open Enrollment

Department of Health and Human Services
Secretary Mandy Cohen, M.D.

July 15, 2019
Medicaid Transformation Hits New Milestones

☑ **ON**
   NC Medicaid Managed Care call center (833-870-5500)

☑ **ON**
   NC Medicaid Managed Care website, ncmedicaidplans.gov

☑ **ON**
   Enrollment packets mailed in Phase 1 counties
In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services to transition North Carolina Medicaid and NC Health Choice from fee-for-service to managed care.
North Carolina’s Vision for Medicaid Transformation

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”
Features of Managed Care

• Medicaid services paid for differently
  – DHHS contracts with insurance companies (Health Plans)
  – DHHS pays predetermined set rate per person (capitated rate)
  – Minimum rate floors are set for certain providers
  – Health Plans accountable for managing care

• Beneficiaries choose a health plan
  – Enrollment Broker helps beneficiaries choose
Medicaid Transformation Phases 1 and 2
Standard Plan Rollout

- Region 1
- Region 3
- Region 5
- Region 6

- Region 2
- Region 4
# Medicaid Transformation Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Phase 1*</th>
<th>Phase 2*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Packets mailed; Enrollment Broker phone, chat, website and mobile app go live</td>
<td>Began 6/28/2019</td>
<td>Begins 9/2/2019</td>
</tr>
<tr>
<td>Open Enrollment (postcard reminders will be sent)</td>
<td>TODAY! 7/15/2019 - 9/13/2019</td>
<td>10/14/2019 – 12/13/2019</td>
</tr>
<tr>
<td>Auto-Assignment (for beneficiaries who have not selected a plan)</td>
<td>9/16/2019</td>
<td>12/16/2019</td>
</tr>
<tr>
<td>Day 1 – Health Plan effective date</td>
<td>11/1/2019</td>
<td>2/1/2020</td>
</tr>
</tbody>
</table>

*Dates are approximate and subject to change.*
Successes To-Date

Enrollment Broker Call Center
1,120 Calls Handled

NCmedicaidplans.gov
2,754 Website Visits

NC Medicaid Managed Care Mobile App
160 Downloads
296 Sessions

All information for the period of June 28, 2019 to July 9, 2019
Managing Change

• Transitioning to managed care is most significant change that NC Medicaid has ever undertaken.

• With any rollout of this magnitude, there will be issues and questions that arise.

• We are committed to doing everything possible to resolve problems quickly
Managing Change - Contact Us

• We want to hear from you. What is working? What is not?

• START HERE FIRST
  – Providers: NCTracks: 800-688-6696
  – Beneficiaries: Medicaid Contact Center: 833-870-5500
  – Counties: NC FAST: 919-813-5400

• Staff can escalate issues to internal SWAT team focused on problem identification and resolution

• When needed, issues can be escalated to our SWAT team by calling (919) 527-7460 or emailing MedicaidSWAT@dhhs.nc.gov
We Are Supporting Beneficiaries

WHAT YOU NEED TO DO

1. Choose a primary care provider (PCP):
   - To keep your doctor, clinic or other health care provider as your PCP, find out which health plans they work with. You can also choose a new PCP.
   - For a list of doctors for each health plan, visit the mobile app or call us toll free.

2. Choose a health plan in NC Medicaid Managed Care:
   - A health plan is a group of doctors, hospitals and other providers. They work together to give you the health care you need. There are several health plans to choose from. Learn more:
     - nmedicaidplans.gov/choose/compareplans

3. Enroll in one of these ways:
   - Go to nmedicaidplans.gov
   - Use the NC Medicaid Managed Care mobile app
   - Call us toll free at 1-833-870-5500 (TTY: 1-833-870-5508)
   - When you receive an enrollment form, fill it out and mail or fax it back

IF YOU HAVE MORE QUESTIONS

- About your eligibility: Contact your local Department of Social Services (DSS) office. Find contact information here: ncmedicaid.gov/local
- About choosing a provider: Call the health plan directly at nmedicaidplans.com

There is a New Way to Get Medicaid Health Care

Most people will get the same Medicaid services in a new way – through health plans. You will be able to choose the plan that is best for you. You will also choose a primary care provider (PCP).

GET ANSWERS

We’re here to help you understand your primary care provider (PCP) and health plan choices. Here are answers to questions you may have.

- If you have other questions, call us toll free at 1-833-870-5500 (TTY: 1-833-870-5508), or use the chat tool to talk with us online.
We Are Supporting Providers

• Information
  – Releasing a Provider Playbook Training
  – AHEC-supported training /Face-to-face events /Webinars

• Connections to PHPs
  – Ensuring providers are paid
  – Meet and Greets with Health Plans

• Connection to DHHS
  – Virtual office hours /FAQs
  – Engagement with providers, practices and associations
  – Targeted Medicaid bulletins
We Are Supporting Counties

- Managed Care on-boarding sessions (Feb-Mar 2019)
- Health Plan cross functional training (April 2019)
- Monthly webinars (ongoing)
- Virtual office hours (ongoing)
- Enrollment Broker onsite for in-person support (begins July 2019)
- DHHS staff onsite for in-person support (begins July 2019)
- County Playbook
- 1,504 DSS staff in ALL 27 Phase 1 counties trained as of June 14
The playbook is a resource for learning about Medicaid Transformation.

Medicaid Transformation is changing the way most people receive Medicaid services. In 2016, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid and NC Health Choice from fee-for-service to managed care.

The NC Medicaid 2019 County Playbook provides resources for county leaders to prepare for the local impact of Medicaid Transformation. It is designed to support local Departments of Social Services, Local Health Departments, county commissioners and managers, and community organizations.

The Playbook will be released in phases and existing materials will be updated as needed. Topics and content addressed are informed by county leaders. DHHS will continue to provide updates and support through the transformation.

All materials are posted online at https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care.

The table of contents will be updated with each release. Please note:
- The materials posted in the most recent release of the playbook will be marked “NEW.”
- Any materials that are updated (e.g. corrections made or information added) will be marked “UPDATED.”

### TABLE OF CONTENTS

- Introduction to Medicaid Transformation Part 1: Overview
- Introduction to Medicaid Transformation Part 2: Enrollment and Timelines
- Increase in Beneficiary Contact
- Non-Emergency Medical Transportation (NEMT): Part 1
- Warm Transfers and Referrals
- Managed Care Populations and Enrollment Notices
- Instructional Guide for Managed Care Status Estimates by County Report
- Instructional Guide for Beneficiary Outreach Materials
- **NEW**: Medicaid Transformation County DSS Readiness Considerations Workbook
- **NEW**: Reference Guide for NC Medicaid Contacts

https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
We Are Supporting Legislators

- SWAT team to address questions rapidly
- Conference call during open enrollment
- DHHS presentations to priority stakeholders for legislators
- Calls with legislators during “Go Live”
- Resources on transformation
  - County Playbook Fact Sheets
DHHS’ Priorities for Day 1 of Managed Care

• A person with a scheduled appointment is seen by provider

• A person’s prescription is filled by the pharmacist

• A provider enrolled in Medicaid prior to Nov 1, is still enrolled

• A provider is paid for care delivered to members
Enrollment Broker
About the Enrollment Broker

The Enrollment Broker is responsible for choice counseling for Health Plan and PCP selection; as part of this, the Enrollment Broker is also responsible for mailing all notices and handling enrollment.

“An Enrollment Broker is an entity that performs choice counseling or enrollment activities, or both. Eligibility services are completed by NC Medicaid, not by the Enrollment Broker. Enrollment Brokers and subcontractors must not have direct or indirect financial ties to any Health Plan or healthcare provider that furnishes services in the same state where the Enrollment Broker work is performed.”

Mailing of Notices

DSS updates beneficiary information in NC Fast

Enrollment Broker mails notices based on information in NC FAST

Beneficiaries receive notice and can begin choice counseling and enrollment
Options for Beneficiaries

1. Direct them to [ncmedicaidplans.gov](http://ncmedicaidplans.gov) to learn more
2. Direct them to [ncmedicaidplans.gov](http://ncmedicaidplans.gov) to chat with an Enrollment Specialist
3. Direct them to download and use the NC Medicaid Managed Care mobile app
4. Tell them to call 1-833-870-5500 to speak with an Enrollment Specialist. The call is free.
5. Individuals with hearing impairments may contact an Enrollment Specialist via the TTY line 1-833-870-5588.
6. Beneficiaries can also enroll by mailing or faxing their completed enrollment form
Enrollment Packet: Sample Transition Notice

There are 3 steps to enroll:

① Choose a primary care provider (PCP) for these members
   • Your PCP could be your family doctor, clinic or other health care provider. Your PCP will help you with your health care needs. You can choose a new PCP.
   • You can choose a different PCP for each member.
   • Remember, health plans work with different PCPs. To leave your doctor, clinic or other provider as your PCP, find out which plans they work with. Then choose one of those plans.
   • You can ask your provider which plans they work with. Or you can call us at 1-833-970-5500 (TTY: 1-833-970-5588).
   • You can also find a list of doctors and other specialists for each plan at medicaid.necdhs.gov.

② Choose a health plan in NC Medicaid Managed Care
   • If you want to keep your provider as your PCP, choose a health plan your primary care provider works with.
   • Read the Health Plan Comparison Chart that came with this letter. It tells you about the plans and services they offer.
   • Compare the plans and choose the best one for you.

③ Enroll in one of these ways
   • Visit medicaid.necdhs.gov.
   • Use the NC Medicaid Managed Care mobile app. To get the free app, search for NC Medicaid Managed Care in Google Play or the App Store.
   • Call us at 1-833-970-5500 (TTY: 1-833-970-5588).
   • Mail the enrollment form in the envelope that came with this letter. Or fax it to 1-833-970-9555.

More on page 2

We will choose a health plan for you if you don’t choose by September 13, 2019.

It’s better if you choose because you know your health care needs best.

If you decide later that you want to change your health plan

You will be able to change your health plan until January 31, 2020. After that, unless you have a special reason, you cannot change your health plan until your Medicaid re-certification date.

If you think you should not be enrolled in a health plan because you need a certain service to address needs related to developmental disability, mental illness, traumatic brain injury, or substance use disorder, you can request a reconsideration. This is a review of the decision. To ask for a reconsideration call us at 1-833-970-5500 (TTY: 1-833-970-5588).

What happens next

After you enroll, your health plan will send you information and a new ID card. You will use your ID card to get health care services. If you have questions, call your health plan’s member services number on your ID card.

You can start using your new health plan on November 1, 2019. Until then, get care and services the way you do now.

Questions?

We can help. Go to medicaid.necdhs.gov. You can also use the “chat” tool on the website. Or call us at 1-833-970-5500 (TTY: 1-833-970-5588), 7 a.m. to 5 p.m., 7 days a week. After September 12, 2019 we are open from 7 a.m. to 5 p.m., Monday through Saturday. The call is free. You may need your Medicaid ID number when you call us or go to the website.

Thank you,
NC Medicaid Team

To get this information in other languages or formats such as large print or audio, call 1-833-970-5500.

Download at medicaid.necdhs.gov/county-playbook-medicaid-managed-care
Sample Mandatory Notice

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Sample Excluded Notice

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Sample Exempt Notice

Dear Patricia A. Jones:

You now have more choices

The people below are in the NC Medicaid Managed Care health plans listed. You can choose a new plan at anytime. If you choose a primary care provider (PCP), your PCP is listed below.

There are more choices for Patricia A. Jones because of the services they need.

<table>
<thead>
<tr>
<th>Name</th>
<th>I.D. Number</th>
<th>Plan / Start Date</th>
<th>Phone</th>
<th>Address / Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia A. Jones</td>
<td>123-45-6789</td>
<td>Wellcare</td>
<td>1-800-739-5318</td>
<td>Dr. Betty Phillips</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>101 Blair Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Raleigh, NC 27609</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>919-985-6200</td>
</tr>
</tbody>
</table>

Do you want to change to NC Medicaid Direct?

- If you need certain services to address needs related to developmental disability, mental illness, traumatic brain injury, or substance abuse disorder you may want to change to NC Medicaid Direct.
- To learn more or to change to NC Medicaid Direct, call us at 1-833-670-6500 (TTY: 1-833-670-5588). You do not need to send an enrollment form.

June 28, 2019

If you want to keep your NC Medicaid Managed Care health plan

You do not have to do anything if you want to keep the health plan listed above.

If you want to stay in NC Medicaid Managed Care, but want to change your plan:

- Go to medicaid.ncdhhs.gov.
- Use the NC Medicaid Managed Care mobile app. To get the free app, search for NC Medicaid Managed Care in the Apple App or the Google Play.
- Read the Health Plan Comparison Chart in the welcome packet mailed to you.

To change your plan, go to medicaid.ncdhhs.gov or use the NC Medicaid Managed Care mobile app. Or call us at 1-833-670-6500 (TTY: 1-833-670-5588). You can change your plan at any time.

If you change your health plan before October 31, 2019, the new plan will start on November 1, 2019.

After you enroll, your health plan will send you information and a new ID card. You will use your ID card to get health care services. If you have questions, call your health plan at the number listed on your ID card.

Questions:

We can help. Go to medicaid.ncdhhs.gov. You can also use the “chat” tool on the website. Or call us at 1-833-670-6500 (TTY: 1-833-670-5588). Our extended hours are from 7 a.m. to 8 p.m., 7 days a week. The call is free. You may need your Medicaid ID number when you call or go to the website.

Thank you,

NC Medicaid Team

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Enrollment Packet: Informational Flyer

In NC Medicaid Managed Care, you choose a doctor for most of your Medicaid-covered services. You also choose a health plan that is right for you. All plans offer the same Medicaid services you have today. Each plan offers additional services.

Here are steps to help you choose a primary care provider and health plan

Step 1: Choose a primary care provider (PCP)
Health plans work with different PCPs. To keep your family doctor, clinic or other health care provider as your PCP, first find out which plans they work with. Then choose one of those plans.

Here are three ways you can find out which plans your PCP works with:
- Ask your PCP
- Call us at 1-800-600-0000 (TTY: 1-800-637-0417)
- Visit the NC Medicaid website at ncmedicaid.com and find a provider inside your family medical group.

Step 2: Choose a health plan in NC Medicaid Managed Care
Choose a plan that covers the care you need. Each plan has doctors and specialists you can choose. Follow the steps below to pick a health plan:
- Do you want to keep your current doctor or clinic? Or do you want a new one?
- Does the plan have the doctors, hospitals and specialists you need?
- Does anyone in your family have special health needs?
- What additional services does the plan have?
- To see which care and services your plan provides, visit the NC Medicaid website at ncmedicaid.com.

Step 3: Enroll in one of these ways
- Go to ncmedicaid.com
- Use the NC Medicaid Managed Care mobile app
- Call us at 1-800-600-0000 (TTY: 1-800-637-0417)
- Fill out the enrollment form and mail it in the envelope that came with this welcome packet.

Questions and answers

Who must choose a health plan?
Most people in NC Medicaid must choose a health plan in the NC Medicaid Managed Care program. Some people can choose to stay in NC Medicaid Direct. They will not need to choose a plan. To find out which group you are in, read the letter that came with this welcome packet. To learn more about NC Medicaid Direct, go to ncmedicaid.com/playbook.

What is a health plan?
A health plan is a group of doctors, hospitals and other providers. They work together to give you the health services you need.

All health plans are required to have the same Medicaid services, such as office visits, blood tests and X-rays. To see the full list of NC Medicaid-covered services provided by the plans, go to ncmedicaid.com.

Health plans also have additional services such as programs to help you quit smoking, eat healthier and have a healthy pregnancy.

What is a primary care provider (PCP)?
Your PCP is your family doctor, clinic or other health-care provider. Your PCP will help you with your health care needs. Your PCP will also coordinate your care with other health providers.

Can I keep my doctor as my PCP?
Yes, if your doctor is in the health plan you choose. Ask your doctor what health plans they are in. Or, go to ncmedicaid.com or use the mobile app.

Will I lose any services?
No. You will not lose any services. Some plans have added services.

To get this information in other languages or formats such as large print or audio, call 1-800-600-0000.

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Enrollment Packet: Enrollment Form

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Enrollment Packet: Comparison Chart

Health Plan Comparison Chart

All plans are required to have the same type of Medicaid services you get now. These include:
- Doctor visits
- Hospital visits
- Behavioral health care
- Prescriptions
- Eye care
- Medical supplies
- Lab tests and X-rays
- Therapies
- Hospice

To see the full list of NC Medicaid covered services provided by the plans, go to ncmедicaidplans.gov. Use this chart to learn more about your plan choices.

Questions? Go to ncmедicaidplans.gov or call us at 1-833-870-5560 (TTY: 1-833-870-5588). We can speak with you in other languages. You can get this information in other languages or formats, such as large print or audio.

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Enrollment Packet: Comparison Chart

Health Plan Comparison Chart (Phase 2)

All plans are required to have the same type of Medicaid services you get now. These include:
- Doctor visits
- Hospital visits
- Behavioral health care
- Prescriptions
- Eye care
- Medical supplies
- Lab tests and X-rays
- Therapies
- Hospice

To see the full list of NC Medicaid covered services provided by the health plans, go to ncmedicaidplans.gov.

Use this chart to learn more about your health plan choices.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Contact Information</th>
<th>Statewide Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellCare</td>
<td>1-866-799-5318 TTY 711&lt;br&gt;wellcare.com nc</td>
<td>(all 100 counties)</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>1-800-349-1855 TTY 711&lt;br&gt;uchcommunityplan.com nc</td>
<td>(all 100 counties)</td>
</tr>
<tr>
<td>HealthyBlue</td>
<td>1-844-594-5070 TTY 711&lt;br&gt;healthyblue.com</td>
<td>(all 100 counties)</td>
</tr>
<tr>
<td>AmeriHealth Care North Carolina</td>
<td>1-855-375-8811 TTY 711 or 1-866-209-6421&lt;br&gt;amerihealthcarenc.com</td>
<td>(all 100 counties)</td>
</tr>
<tr>
<td>Carolina Complete Health</td>
<td>1-833-552-3876 TTY 711 or 1-800-735-2962&lt;br&gt;carolinacompletehealth.com</td>
<td>(all 100 counties)</td>
</tr>
</tbody>
</table>

Questions? Go to ncmedicaidplans.gov. Or call us at 1-833-870-5500 (TTY: 1-833-870-5588). The call is free. We can speak with you in other languages.

You can get this information in other languages or formats, such as large print or audio.

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Enrollment Packet: Additional Information

Notice of Non-Discrimination
NC Medicaid complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. NC Medicaid does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

NC Medicaid provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

NC Medicaid provides free language services to people whose primary language is not English, such as:
- Qualified Interpreters
- Information written in other languages

If you need these services, contact NC Medicaid at 1-833-870-5500 (TTY: 1-833-870-5588)
If you believe that NC Medicaid has failed to provide these services, or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

DHHS ADA/RA Complaints
Office of Legal Affairs
2001 Mail Service Center
Raleigh, NC 27695-2001

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Legal Affairs is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
• Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
• By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F
  H-H Building
  Washington, DC 20201
• By phone at 1-800-666-0290 (TDD: 1-800-877-8339) or

Completed forms are available at www.hhs.gov/ocr/office/file/index.html.
Reminder Postcard

It’s time to choose a health plan!

Choose a health plan by [Date]

In the new way to get Medicaid, you need to choose a health plan. We sent you a packet in the mail. If you don’t choose a plan, we will choose one for you.

Choose a plan in one of these ways:
1. Online at ncmedicaidplans.gov
2. Use the NC Medicaid Managed Care mobile app
3. Call us at 1-833-870-5500 (TTY: 1-833-870-5588)
4. Mail the Enrollment Form we sent you

Outreach and Education
Partner Engagement & Member Outreach

**Partner Engagement Events**

**Types of Events**
- Onboarding sessions
- Cross-functional trainings
- Monthly webinars
- Readiness

**Types of Materials**
- Managed care toolkit
- Presentations
- Recordings
- Systems training

**Member Outreach Events**

**Types of Events**
- Member education:
  - Enrollment events
  - Community events
  - Meet & greet
  - Informational booth

**Types of Materials**
- Media campaigns
- Marketing materials
- Flyers, fact sheets, etc.
Outreach Materials

POSTER

FACT SHEET

Q&A

PALM CARD

Download at medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
Introductory Video

The NC Medicaid Managed Care Introductory Video addresses:

• What is a primary care provider (PCP)
• What is a Health Plan
• The Health Plans available
• What beneficiaries need to do
• What happens after beneficiaries enroll
• The phases for enrollment and key dates
• How to get answers to additional questions
ABOUT ELIGIBILITY
Contact their local DSS
Find contact information at ncdhhs.gov/localdss

ABOUT NC MEDICAID DIRECT BENEFITS AND CLAIMS
Call the Medicaid Contact Center toll free:
1-888-245-0179

ABOUT CHOOSING A PLAN OR PCP AND ENROLLING
Go to ncmedicaidplans.gov (chat available)
Use the NC Medicaid Managed Care mobile app
Call 1-833-870-5500 (the call is free)
TTY: 1-833-870-5588

ABOUT NC MEDICAID DIRECT BENEFITS AND CLAIMS
Call the Medicaid Contact Center toll free:
1-888-245-0179

ABOUT NC MEDICAID DIRECT BENEFITS AND CLAIMS
Call their Health Plan
Questions
Medicaid Managed Care
Phase 1 Open Enrollment

Department of Health and Human Services
Secretary Mandy Cohen, M.D.

July 15, 2019

NC Medicaid Managed Care call center: 833-870-5500

NC Medicaid Managed Care website: ncmedicaidplans.gov

Enrollment materials: medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care

Webinar recordings and presentations: ncdhhs.gov/medicaid-transformation
Medicaid Transformation Phases 1 and 2: Standard Plan Rollout

- Region 1
- Region 3
- Region 5
- Region 6

- Region 2
- Region 4
## Medicaid Transformation Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Phase 1*</th>
<th>Phase 2*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Packets mailed; Enrollment Broker phone, chat, website and mobile app go live</td>
<td>Began 6/28/2019</td>
<td>Begins 10/1/2019</td>
</tr>
<tr>
<td>Open Enrollment (postcard reminders will be sent)</td>
<td>7/15/2019 - 9/13/2019</td>
<td>10/14/2019 - 12/13/2019</td>
</tr>
<tr>
<td>Auto-Assignment (for beneficiaries who have not selected a plan)</td>
<td>9/16/2019</td>
<td>12/16/2019</td>
</tr>
<tr>
<td>Day 1 – Health Plan effective date</td>
<td>11/1/2019</td>
<td>2/1/2020</td>
</tr>
</tbody>
</table>

*Dates approximate and subject to change*
Open Enrollment for Standard Plans

Enrollment Broker Call Center
1,120 Calls Handled

NCmedicaidplans.gov
2,754 Website Visits

NC Medicaid Managed Care Mobile App
160 Downloads
296 Sessions

All information for the period June 28-July 9, 2019
An entity experienced in working with State Medicaid agencies will serve as an Ombudsman to support the goals of the North Carolina Medicaid Managed Care Program.

- **“No Wrong Door”**
- **Central Resource**
- **Referrals & Collaboration**
- **Identifying Trends**
- **Supporting DHHS Vision**
Beneficiary Support

**About Eligibility**
Contact their local DSS
Find contact information at ncdhhs.gov/localdss

**About NC Medicaid Direct Benefits and Claims**
Call the Medicaid Contact Center toll free:
1-888-245-0179

**About Choosing a Plan or PCP and Enrolling**
Go to ncmedicaidplans.gov (chat available)
Use the NC Medicaid Managed Care mobile app
Call 1-833-870-5500 (the call is free)
TTY: 1-833-870-5588

**About NC Medicaid Managed Care Plan or Benefits**
Call their Health Plan
2019 Network Adequacy & Accessibility Analysis

Alliance CFAC
August 5, 2019
Community Needs and Gaps Survey

• State and Federal requirement for each LME/MCO to submit annual report of community needs and gaps
• Assessment of adequacy and accessibility of provider network
• Reflects feedback from:
  • Members and families
  • Stakeholders
  • Providers
  • Alliance staff
• Results in plan for addressing needs and gaps
Community Demographics

- Variability in racial/ethnic composition
- Spanish language use highest in Durham and Johnston counties
- Educational attainment lowest in Cumberland and Johnston
- Income and poverty challenges highest for Cumberland, followed by Durham and Johnston
- Uninsured rates higher than state average in Johnston and Durham counties
- Rates of disability highest in Cumberland and Johnston counties

- Total population: 1,994,049
- Projected population growth: Higher than average for all but Cumberland
- Highest Veteran/Military % in Cumberland
## Community Health Disparities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes</td>
<td>73</td>
<td>12</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Length of Life</td>
<td>63</td>
<td>6</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>74</td>
<td>25</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Health Factors</td>
<td>65</td>
<td>16</td>
<td>39</td>
<td>2</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>67</td>
<td>14</td>
<td>41</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>40</td>
<td>7</td>
<td>71</td>
<td>3</td>
</tr>
<tr>
<td>Social &amp; Economic Factors</td>
<td>71</td>
<td>46</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>36</td>
<td>31</td>
<td>92</td>
<td>79</td>
</tr>
</tbody>
</table>
Community Needs and Gaps Survey

- Access to needed services
- Barriers to accessing services
- Populations with limited access or difficulty accessing services
- Specific services not available within each community
- Social Determinants of Health
- Age and disability specific gaps
- Results sortable by respondent type, county, workgroup
<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Two (2) within 30 miles or minutes (m/m)</td>
<td>Two (2) within 30 m/m</td>
</tr>
<tr>
<td>Location-Based</td>
<td>Two (2) within 30 m/m</td>
<td>One (1) within 30 m/m</td>
</tr>
<tr>
<td>Community / Mobile</td>
<td>Two (2) within Alliance Health catchment (AHC)</td>
<td>One (1) within AHC</td>
</tr>
<tr>
<td>Crisis</td>
<td>One (1) within AHC</td>
<td>One (1) within AHC</td>
</tr>
<tr>
<td>Inpatient</td>
<td>One (1) within AHC</td>
<td>One (1) within AHC</td>
</tr>
<tr>
<td>Specialized</td>
<td>Two (2) in NC</td>
<td>One (1) in NC</td>
</tr>
<tr>
<td>C-Waiver-Group 1</td>
<td>Two (2) within AHC</td>
<td>N/A</td>
</tr>
<tr>
<td>C-Waiver-Group 2</td>
<td>One (1) within AHC</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Geographic Access Results

Areas in full compliance with geographic access requirements:

- Outpatient
- Community-based / mobile
- Crisis
- Inpatient
- C-Waiver
Geographic Access Gaps & Waiver Requests

- Location-based
  - Child & Adolescent Day Treatment (M,S)
  - SA Comprehensive Outpatient Tx (S)
  - *Opioid Treatment (M)*
  - Day Supports (S)

- Specialized Services
  - Medicaid: (b)(3) I/DD Facility-Based Respite
  - State: Residential Treatment Level 2, IDD Supported Living, ICF/IDD
<table>
<thead>
<tr>
<th></th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members &amp; Family</td>
<td>16</td>
<td>10</td>
<td>17</td>
<td>37</td>
<td>84</td>
</tr>
<tr>
<td>Providers</td>
<td>65</td>
<td>87</td>
<td>69</td>
<td>140</td>
<td>235</td>
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<tr>
<td>Stakeholders</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>18</td>
<td>44</td>
</tr>
<tr>
<td>ABH Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>128</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>91</strong></td>
<td><strong>108</strong></td>
<td><strong>96</strong></td>
<td><strong>194</strong></td>
<td><strong>491</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Dually Diagnosed (IDD/MI, SUD/MI or SUD/IDD)</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>IDD on Innovations waiver waitlist</td>
<td>2</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Traumatic Brain Injuries</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice system involvement (including individuals being discharged from jails and prisons)</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex or chronic medical problems</td>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Youth in juvenile justice system</td>
<td>6</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans/military</td>
<td>7</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Access Barriers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited transportation</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lack of funding / insurance coverage</td>
<td>2</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Access to safe and affordable housing</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Services not available nearby</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Limited information about how to access services</td>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Shortage of qualified direct care workers</td>
<td>6</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Cost of medication for uninsured</td>
<td>7</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Service Gaps

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential treatment options</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced crisis services continuum</td>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Structured daily activity programs / programs to develop living skills</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vocational and educational services</td>
<td>5</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Comprehensive array of SUD services</td>
<td>6</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Case management services and services between outpatient and</td>
<td>7</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
FY20 Planning Considerations

• Preparation for Tailored Plan
• FY19 objectives that continue into FY20
• Other Alliance initiatives that align with identified gaps, barriers and underserved populations
• Staff resource availability for any new objectives
• Impact of State budget reductions
• Traumatic Brain Injury Waiver
• Other state priorities (e.g., TCLI, Children with Complex Needs)
FY20 Network Access Priorities

- Tailored Plan Implementation
- TBI Waiver
- Crisis and hospital diversion
- Services/supports for individuals with complex needs
- Recovery-oriented system of care
- Social Determinants of Health
- Public awareness of Alliance and its network
- SUD service continuum
Tailored Plan Implementation

• Develop Tailored Plan population profile and identify provider network design and development priorities
• Implement new Care Team Model
• Initiate pilot projects with Care Management Agencies
• Begin network development efforts in preparation for management of medical and behavioral health care of tailored plan population
• Implement additional alternative payment models
Traumatic Brain Injury Waiver

• Continue network development, training and outreach efforts required for implementation of TBI waiver
Crisis and Hospital Diversion

• Continue implementation and evaluation of Enhanced Mobile Crisis Pilot in Wake County

• Improve timely access to aftercare appointments following inpatient, facility-based crisis or non-hospital detoxification treatment
Services/Supports for Individuals with Complex Needs

- Evaluate residential treatment service needs and implement network changes to address identified gaps
- Improve service capacity to address needs of dually diagnosed individuals
- Implement Family Engagement Services Pilot to improve appropriate utilization of PRTF services
- Implement ICF Mid-Step initiative to reduce ED utilization and reduce utilization of ICF facilities
Recovery-Oriented System of Care

- Transition PSR programs to recovery-oriented psychiatric rehabilitation models
- Improve quality and consistency of Peer Support services
- Identify and implement other initiative(s) to improve services to promote independence, social connections, independent living skills, personal care and self-help needs
Social Determinants of Health

- Housing initiatives, including Supportive Housing and Group Living Step Down projects
- Social Determinants pilot initiatives
- Services to address transportation challenges
- Implement Health Literacy initiatives
Public Awareness of Alliance & Services

• Improve availability of information to the public about service availability and access
• Develop plans for improving member engagement
SUD Continuum of Care

- Expand opioid treatment availability
- Provide technical assistance, training and support for SUD providers to enhance quality, outcomes and accessibility of care
Questions for Next Year

1. How will network adequacy assessments change for LME-MCOs after implementation of Standard Plans?
2. What network adequacy requirements are in place for Standard Plans?
3. How can we improve member engagement in future surveys of network adequacy and accessibility?
4. When should we begin evaluating network adequacy from a whole person perspective?
5. What other sources of data can we prepare to use as a TP?
Questions & Discussion

Additional questions or feedback:
Carlyle Johnson, Ph.D.
Director of Provider Network Strategic Initiatives

cjohnson@alliancehealthplan.org
ITEM: Finance Committee Report

DATE OF BOARD MEETING: September 5, 2019

BACKGROUND: The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Board Meeting. This month’s report includes the draft minutes from the August 1, 2019 meeting, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending July 31, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

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

1. Review of the Minutes – August 1, 2019

2. Monthly Financial Reports as of July 31, 2019
   a. Summary of Savings/(Loss) by Funding Source
   b. Senate Bill 208 Ratios
   c. DMA Contractual Ratios

3. 6/30/19 Close Update

4. Approval of Contract(s)
   a. A motion to authorize the CEO to enter into a contract with Southlight Healthcare, Inc. to build infrastructure and system capacity for a clinically integrated network (Network for Advancing Behavioral Health) in an amount not to exceed $1,171,720 using Federal block grant allocation letter #20-A-24.
   
   b. A motion to authorize the CEO to enter into a contract with American United Life Insurance (OneAmerica) to offer life insurance, accidental death and dismemberment (AD&D), short-term disability and long-term disability options to employees including employer paid basic life and basic AD&D for an estimated amount of $345,000.

5. Closed Session
   a. The Finance Committee will hold a closed session pursuant to NC General Statute 143-318.11 (a) 1 to prevent the disclosure of information that is privileged or confidential pursuant to the law of this State or of the United States, or not considered a public record within the meaning of Chapter 132 of General Statutes.

6. Adjournment
1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 3:10 PM

2. REVIEW OF THE MINUTES – The minutes from the June 6, 2019, meeting were reviewed; a motion was made by Mr. Bostock and seconded by Mr. Pazzaglini to approve the minutes. Motion passed unanimously.

AGENDA ITEMS: DISCUSSION: NEXT STEPS: TIME FRAME:


The monthly financial reports were discussed which includes the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of May 31, 2019. Ms. Sara Pacholke discussed the monthly reports.

- As of 5/31/19, we have a loss of $24.5M and need $20.1M from fund balance to offset legislative reductions.
- As of 6/30/19, Alliance is projecting a loss of $25.8M with $25.5M previously committed by the Board to cover legislative reductions, the required intergovernmental transfer, and reinvestment into the community.

We are meeting all SB208 and DMA contract ratios.

4. Approval of Contracts

The following motions were made related to contract approvals.

- A motion to authorize the CEO to enter into a contract with Pharmaceutical Strategies Group, LLC to assist with the future Pharmacy Benefit Management in an amount not to exceed $256,641.
- A motion to authorize the CEO to enter into a contract with BCBS for employee health insurance for an estimated amount of $699,577.20.
- A motion to authorize the CEO to enter into a contract with RTI International to study the efficacy of virtual reality as an evaluation and treatment aid for Veterans with PTSD in an amount not to exceed $900,000 using Federal block grant allocation letter #20-A-15.
- A motion to authorize the CEO to enter into a contract with The Menges Group, LLC to provide Tailored Plan Design and Development Consulting Services in an amount not to exceed $250,000.
- A motion to authorize the CEO to enter into a contract with Arthur J. Gallagher & Co. to have annual insurance coverage for professional and

Take the motions to the Board for approval. 8/1/19 Meeting
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>general liability, directors and officers, cyber, property, fiduciary bonds, builders risk insurance in an amount not to exceed $508,000. A motion was made by Mr. Gino Pazzaglini and seconded by Mr. Chris Bostock to recommend to the Board to approval all contracts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Tailor Plan</td>
<td>Discussed various aspects of the tailor plan including budget considerations and timeline.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **ADJOURNMENT:** the meeting adjourned at 3:54 pm; the next meeting will be September 5, 2019, from 2:30 p.m. to 4:00 p.m.
### Summary of Savings/(Loss) by Funding Source as of July 31, 2019

<table>
<thead>
<tr>
<th>Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Adjustments*</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$31,540,359</td>
<td>$29,670,417</td>
<td></td>
<td>$1,869,942</td>
</tr>
<tr>
<td>Medicaid Waiver Risk Reserve</td>
<td>$693,038</td>
<td></td>
<td></td>
<td>$693,038</td>
</tr>
<tr>
<td>Federal Grants &amp; State Funds</td>
<td>$3,135,930</td>
<td>$5,140,264</td>
<td>(1,642,498)</td>
<td>$ (361,836)</td>
</tr>
<tr>
<td>Local Funds</td>
<td>$1,895,061</td>
<td>$1,871,779</td>
<td></td>
<td>$23,282</td>
</tr>
<tr>
<td>Administrative</td>
<td>$4,881,020</td>
<td>$5,262,873</td>
<td></td>
<td>$ (381,853)</td>
</tr>
<tr>
<td>Total</td>
<td>$42,145,407</td>
<td>$41,945,333</td>
<td>(1,642,498)</td>
<td>$1,842,572</td>
</tr>
</tbody>
</table>

### Committed

- Legislative Reductions: (361,836)
- Intergovernmental Transfers: -
- Reinvestments-Service: -
- Reinvestments-Administrative: -
- Total Committed: (361,836)

### Unrestricted

Total Amount to be Appropriated - Fund Balance: $2,204,408

*Adjustments based on approval of State Budget.

### Fund Balance as of July 31, 2019

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2019</th>
<th>Change</th>
<th>July 31, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,488,050</td>
<td>(73,248)</td>
<td>4,414,802</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>51,602,006</td>
<td>693,038</td>
<td>52,295,044</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statutes</td>
<td>5,217,343</td>
<td>-</td>
<td>5,217,343</td>
</tr>
<tr>
<td>Prepaids</td>
<td>858,436</td>
<td>1,271,186</td>
<td>2,129,621</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>6,075,779</td>
<td>1,271,186</td>
<td>7,346,964</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>4,342,029</td>
<td>(361,836)</td>
<td>3,980,193</td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>3,007,817</td>
<td>-</td>
<td>3,007,817</td>
</tr>
<tr>
<td>Reinvestments-Service</td>
<td>500,000</td>
<td>-</td>
<td>500,000</td>
</tr>
<tr>
<td>Reinvestments-Administrative</td>
<td>5,000,000</td>
<td>-</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Total Committed</td>
<td>12,849,848</td>
<td>(361,836)</td>
<td>12,488,010</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>11,827,907</td>
<td>313,433</td>
<td>12,141,340</td>
</tr>
<tr>
<td>Total Fund Balance</td>
<td>86,843,588</td>
<td>1,842,571</td>
<td>88,686,159</td>
</tr>
</tbody>
</table>
Senate Bill 208 Ratios - As of July 31, 2019

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 (7/1/17-6/30/19).
ITEM: Draft Minutes from the August 1, 2019, Board Meeting

DATE OF BOARD MEETING: September 5, 2019

REQUEST FOR BOARD ACTION: Approve the draft minutes from the August 1, 2019, Board meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
**AREA BOARD REGULAR MEETING**  
711 Executive Place, Fayetteville, NC 28305  
4:00-6:00 p.m.

**MEMBERS PRESENT:** ☒Glenn Adams, Cumberland County Commissioner, JD (exited at 6:36 pm), ☒Cynthia Binanay, Chair, MA, BSN (via phone), ☒Christopher Bostock, BSIM, ☐Tony Braswell, Johnston County Commissioner, ☐Heidi Carter, Durham County Commissioner, MPH, MS, ☒George Corvin, Vice-Chair, MD, ☐David Curro, BS, ☐Greg Ford, Wake County Commissioner, MA (via phone; exited at 5:26pm), ☐Lodies Gloston, MA, ☐David Hancock, MBA, MAff, ☐Duane Holder, MPA (via phone; entered at 4:35 pm; exited at 4:40 pm), ☒D. Lee Jackson, BA, ☐Donald McDonald, MSW, ☐Lynne Nelson, BS (entered at 4:30 pm), ☒Gino Pazzaglini, MSW LFACHE, ☐Pam Silberman, JD, DrPh, ☐Lascel Webley, Jr., MBA, MHA, and ☐McKinley Wooten, Jr., JD (via phone)

**GUEST(S) PRESENT:** Jackie Blue; Carson Lloyd, Jr., Alliance CFAC; Renee Lloyd, Alliance CFAC; Tekeyyon Lloyd, Alliance CFAC; Ellen Gibson, Cumberland CFAC Co-Chair; Shirley Francis, Cumberland CFAC; Yvonne French, NC DHHS DMH/DD/SAS (Department of Health and Human Services (Division of Mental Health/Developmental Disability/Substance Abuse Services)); Dr. Michael McGuire; Cumberland CFAC Chair; and Sally Shutt, Cumberland County Manager’s office

**ALLIANCE STAFF PRESENT:** Michael Bollini, Executive Vice-President/Chief Operating Officer; Terrasine Gardner, Engagement Manager; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Nathania Headley, Post Transition Engagement Specialist; Veronica Ingram, Executive Assistant II; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Sean Schreiber, Executive Vice-President/Network and Community Health; Tammy Thomas, Director of Project Portfolio Management; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

1. **CALL TO ORDER:** Chair George Corvin called the meeting to order at 4:02 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td>Chair Corvin greeted guests from the Cumberland County area. Mr. Robinson reminded Commissioners of the next quarterly Commissioner meeting on Thursday, September 5, 2019, at 3:00 pm. Commissioners may contact Ms. Ingram to confirm attendance. Mr. Robinson reminded Board members of two upcoming orientation sessions for new Board members: part one on Thursday, August 8, 2019, at 2:00 pm and part two on Tuesday, September 17, 2019, at 2:00 pm. Board members may contact Ms. Ingram to RSVP. Mr. Robinson introduced a video detailing the importance of housing as an integral part of whole person care; the video is available at <a href="https://youtu.be/oSOXrbu36bQ">https://youtu.be/oSOXrbu36bQ</a>.</td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
</tr>
<tr>
<td>4. Public Comment</td>
<td>There were no public comments.</td>
</tr>
</tbody>
</table>
5. Committee Reports

**A. Consumer and Family Advisory Committee – page 3**

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

The committee reports were sent as part of the Board packet; David Curro, CFAC Chair, presented the CFAC report. Mr. Curro recognized Cumberland CFAC members who were present and commended them for their work in the community. Additionally, Mr. Curro mentioned CFAC’s annual report, which was provided to the Board. He also mentioned discussion in recent CFAC meetings regarding transitioning to Tailored Plan and upcoming CFAC events.

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

**B. Finance Committee – page 90**

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

David Hancock, Committee Chair, presented the Finance Committee report. Mr. Hancock stated that expenses exceeded revenues due to reduction in State Single Stream funding. He also stated that all contractual ratios were met.

Mr. Hancock mentioned the following contracts that were reviewed by the Finance Committee and submitted to the Board for approval:
- Pharmaceutical Strategies Group, LLC, to assist with the future pharmacy benefit management in an amount not to exceed $256,241.00
- Blue Cross Blue Shield for employee health insurance in an estimated amount of $699,577.00
- RTI International to study the efficacy of virtual reality as an evaluation and treatment aid for veterans with PTSD in an amount not to exceed $900,000.00 per block grant allocation letter #20-A-15
- The Menges Group, LLC, to provide Tailored Plan Design and Development Consulting Services in an amount not to exceed $250,000.00
- Arthur J. Gallagher and Company to have annual insurance coverage for professional and general liability, directors and officers, property, fiduciary bonds, and builders risk insurance in an amount not to exceed $508,000.00

**BOARD ACTION**
A motion was made by Ms. Gloston to authorize the CEO to enter the contracts as presented; motion seconded by Mr. Bostock. Motion passed unanimously.
C. By-Laws/Policy Committee Report – page 99

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

Ladies Gloston, Committee Chair, mentioned that the proposed revisions to the by-laws were sent to the Board on July 1, 2019, and were also part of the packet. Ms. Gloston mentioned that the Executive Committee reviewed the proposed revisions at its July meeting and recommended additional revisions, which Carol Wolff, General Counsel, presented. Ms. Wolff reviewed the proposed revisions to the by-laws; she included the Executive Committee’s input in her presentation.

**BOARD ACTION**

A motion was made by Mr. Jackson to approve revisions to the by-laws as presented; motion seconded by Mr. Hancock. Motion passed unanimously.

6. Consent Agenda

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

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

**BOARD ACTION**

A motion was made by Ms. Nelson to adopt the consent agenda; motion seconded by Commissioner Adams. Motion passed unanimously.

7. Presentation/Training: Crisis Services for Alliance’s Catchment Area – page 170

Alliance has developed and continues to improve upon crisis services available to citizens in the catchment area. Sean Schreiber, Executive Vice-President/Network and Community Health, provided an overview of the following programs/services: Alliance’s 24/7 toll-free Access and Information Center, Crisis Intervention Team (CIT) training/Mental Health First Aid training, advanced para-medicine, NC START, mobile crisis, rapid response beds/crisis respite, behavioral health urgent care, crisis and assessment centers, and the LEAP (Learning Enriched Autism Program).

Mr. Schreiber mentioned partnerships within each community with service responders, school officials, DSS (Department of Social Services) staff, and first responders. He also shared high-level overviews of crisis system utilization by category. Mr. Schreiber shared a video depicting the benefit of first responders, service providers and Alliance working in partnership to provide care in a potential crisis situation ([https://www.wral.com/law-enforcement-mental-health-experts-learn-together-to-de-escalate-crises/18253512/](https://www.wral.com/law-enforcement-mental-health-experts-learn-together-to-de-escalate-crises/18253512/)). He also provided an update on specific crisis services in Cumberland County.

**BOARD ACTION**

The Board accepted the training/presentation.
8. Legislative Update

Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Director of Government Relations, provided the update. Mr. Perkins mentioned the current progress of the NC General Assembly’s budget, which was vetoed by Governor Roy Cooper. Mr. Perkins also mentioned proposed new recurring cuts in the Conference budgets, which is drafted from the NC House and Senate’s budgets. He mentioned the potential short and long term impact of the current budget standoff, specifically how this may impact the people Alliance serves and how it may impact the State’s implementation of the Tailored Plan.

Ms. Wilson reviewed current progress with Tailored Plan implementation. She reviewed the State’s map of both phases for the go-live dates: phase 1 goes live November 1, 2019, and phase 2 goes live February 1, 2020. Additional deadlines were adjusted due to the delay in finalizing the State budget.

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

9. Chair’s Report

Chair Corvin shared that annually, the Board has chosen to have the Executive Committee serve as the ad hoc committee to provide preliminary review of the CEO and make recommendations to the Board.

**BOARD ACTION**
A motion was made by Mr. Bostock to appoint the Executive Committee as the FY20 ad hoc committee to provide preliminary review of the CEO and make recommendations to the Board; motion seconded by Ms. Gloston. Motion passed unanimously.

Chair Corvin reminded Board members that the September 5, 2019, Board meeting is at Alliance’s Home Office in Morrisville.

10. Closed Session(s)

**BOARD ACTION**
A motion was made by Ms. Nelson to enter closed session pursuant to NC General Statute (NCGS) 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence and performance of an employee; motion seconded by Mr. Curro. Motion passed unanimously.

The Board returned to open session.

11. Adjournment

All business was completed; the meeting adjourned at 6:43 p.m.

Next Board Meeting

Thursday, September 05, 2019

4:00 – 6:00 pm

Minutes approved by the Board on Click or tap to enter a date..
ITEM: By-Laws/Policy Committee Report

DATE OF BOARD MEETING: September 5, 2019

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

Policies reviewed at the June 19, 2019, and the August 14, 2019, Policy Committee meetings and ready for Board approval without revisions:
B1 By-Laws
BO1 Compliance with Local Government Budget and Fiscal Control Act; BO2 Risk Management; BO4 Travel and Employee Expense Reimbursement; BO5 Cellular Communication Devices; BO6 Paybacks BO8 Management of Financial Risk; BO9 Fund Balance; BO10 Financial Stability; BO11 Accounting Manual; BO12 Accounting by Funding Source; BO13 Coordination of Benefits; BO14 Cyclical Financial Reporting; BO15 Claims Adjudication; BO16 Purchasing; BO17 Investments; BO18 Service Codes in Alpha; BO19 Budget Transfers; BO20 Eligibility for Services
C1 Corporate Compliance Plan; C2 Guarding against Fraud and Abuse; C3 Financial Incentives; C4 Employee Conflict of Interest; C5 Employee Code of Ethics and Conduct; C6 Records Retention; C7 Legal Proceedings Involving Service Records
CC1 Coordination of Care for Special Health Care Populations
CR1 Members’ Rights to Dignity, Privacy and Humane Care; CR2 Member’s Right to Confidentiality; CR3 Member Choice; CR4 Advanced Directives/Advanced Instructions
CS1 Customer Services
G2 Board of Directors Member Meeting Attendance Compensation; G4 Development of Policies and Procedures; G6 Chief Executive Officer Compensation; G8 Board of Directors Code of Ethics; G9 Consumer, Family Advisory Committee; G10 Delegation of Authority to the Chief Executive Officer; G11 Guidelines for Public Comment at Board of Directors Meetings; G12 Area Authority Relations with Catchment Area County Boards of Commissioners; G13 Board of Directors Media Policy; G14 Dispute Resolution
GA1 Management of Service Delivery; GA2 Strategic Planning; GA3 Reporting of Abuse, Neglect, Dependency and Exploitation; GA4 Health and Safety Policy; GA5 Emergency Management Plan; GA6 Internal Control; GA7 Business Continuity Plan; GA8 Corporate Communications
HR1 Equal Employment Opportunity/Affirmative Action; HR2 Recruitment and Selection; HR4 Conditions of Employment; HR5 Classification and Compensation; HR6 Employee Benefits; HR7 Alcohol and Drug Free Workplace; HR8 Employee Time and Attendance; HR9 Sexual Harassment; HR10 Leave Policy; HR11 Family and Medical Leave Act; HR12 Clinical Staff Credentialing; HR14 Disciplinary Action; HR15 Performance Management; HR16 Separation; HR17 Employee Complaint; HR18 Employee Grievance; HR19 Reduction-in-Force

(Back to agenda)
IT1 General Computer Use; IT4 Eligibility Load, Error Handling and Reconciliation; IT5 IT System Backup

PN1 Selection and Retention of Providers; PN2 Letters of Support; PN3 Provision of Services by Relatives/Legal Guardians; PN5 Rule Waiver Requests

QM1 Member, Provider and Stakeholder Satisfaction; QM2 Management and Investigation of Member Grievances; QM3 Management of Incidents

UM1 Accessibility of Utilization Review/Utilization Management Process; UM2 Pre-Review Screening for Certification; UM3 Utilization Review Criteria; UM4 Utilization Review Process; UM5 Appealing Utilization Management Decisions

Policies reviewed with recommended revisions: 
G1 Board of Directors Conflict of Interest; G3 Board of Directors Processes; G7 Evaluation of Chief Executive Officer

Policies reviewed and recommended to repeal: None

REQUEST FOR BOARD ACTION: Accept the report. Accept Board Policy Committee minutes from the June and August meetings as submitted. As part of the annual review process approve the above listed policies for continued use. Approve the recommended changes to the above listed policies.

CEO RECOMMENDATION: Accept the report. Approve the reviewed policies for continued use and approve the proposed revised policies.

RESOURCE PERSON(S): Lodies Gloston, Committee Chair; Monica Portugal, Chief Compliance Officer
APPOINTED MEMBERS PRESENT: ☒ Dave Curro, BS (via teleconference), ☒ Lodies Gloston, MA (Committee Chair), ☐ Lee Jackson (via teleconference)

BOARD MEMBERS PRESENT: Cynthia Binanay (via teleconference)

GUESTS PRESENT: 

STAFF PRESENT: Monica Portugal, Chief Compliance Officer; Carol Wolff, General Counsel, Kathy Dempsey, Compliance Analyst

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: The minutes from the March 25, 2019, meeting were reviewed; a motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Administrative and Governance Policies</td>
<td>GA1 Management of Service Delivery - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>GA2 Strategic Planning - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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</tr>
<tr>
<td></td>
<td>GA3 Reporting of Abuse, Neglect, Dependency and Exploitation - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td></td>
<td>GA4 Health and Safety Policy - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
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<tr>
<td></td>
<td>GA5 Emergency Management Plan - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GA6 Internal Control - A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
</tr>
<tr>
<td>--------------</td>
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<tr>
<td>GA7 Business Continuity Plan</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA8 Corporate Communications</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G1 Board of Directors Conflict of Interest</td>
<td>The Committee members discussed review of proposed revisions. The Committee decided to approve the policy as presented for purposes of annual review and continue review of proposed revisions at a later meeting. A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td>The Committee will review the proposed revisions at a special meeting in August.</td>
<td>8/14/19</td>
</tr>
<tr>
<td>G2 Board of Directors Member Meeting Attendance Compensation</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 Board of Directors Processes</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as revised. Motion passed unanimously.</td>
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</tr>
<tr>
<td>G4 Development of Policies and Procedures</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<td></td>
</tr>
<tr>
<td>G6 Chief Executive Officer Compensation</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
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</tr>
<tr>
<td>G7 Evaluation of Chief Executive Officer</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as revised. Motion passed unanimously.</td>
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</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8 Board of Directors Code of Ethics</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G9 Consumer, Family Advisory Committee</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>G10 Delegation of Authority to the Chief Executive Officer</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>G11 Guidelines for Public Comment at Board of Directors Meetings</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>G12 Area Authority Relations with Catchment Area County Boards of Commissioners</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>G13 Board of Directors Media Policy</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>G14 Dispute Resolution</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as presented. Motion passed unanimously.</td>
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<tr>
<td>B1 Bylaws</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to approve the policy as revised. Motion passed unanimously.</td>
<td></td>
<td>6/20/19</td>
</tr>
</tbody>
</table>

The revised bylaws will be sent out June 20 in order to give 30 days’ notice to Board of Directors. A supermajority is required to change.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other: Board Policies</td>
<td>A motion was made by Mr. Dave Curro and seconded by Ms. Lodies Gloston to</td>
<td>bylaws. Discussion of changes will take place at a meeting of the Executive Committee.</td>
<td>9/5/19</td>
</tr>
<tr>
<td>approval schedule</td>
<td>send all policies to the September Board meeting for approval.</td>
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</tbody>
</table>

2. **ADJOURNMENT**: next regular meeting will be September 12, 2019, from 4:00 p.m. to 5:30 p.m.

Respectfully Submitted by:

**Kathy Dempsey**

Kathy Dempsey               Date Approved

8.14.2019
1. **WELCOME AND INTRODUCTIONS** – The meeting was called to order at 2:29 p.m.

2. **REVIEW OF THE MINUTES** – The minutes from the June 19, 2019, meeting were reviewed; a motion was made by Mr. Wooten and seconded by Ms. Gloston 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><strong>3.</strong> G1 Board of Directors Conflict of Interest Policy</td>
<td>The Committee reviewed and discussed proposed revisions to the policy. A motion was made by Mr. Wooten and seconded by Ms. Gloston to approve the revised policy. Motion passed unanimously.</td>
<td>The revisions will be presented to the Board Executive Committee on August 20th before submission to the Sept. Board meeting.</td>
<td>August 20, 2019.</td>
</tr>
<tr>
<td><strong>4.</strong> Review of Board Policy Committee Meeting Schedule</td>
<td>The Committee discussed if a change in the regular meeting schedule was necessary. It was determined that the schedule will remain the same.</td>
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</table>

5. **ADJOURNMENT**: the meeting adjourned at 2:53 p.m.; The next meeting will be September 12, 2019, from 4:00 p.m. to 5:30 p.m.
I. PURPOSE

The purpose of this policy is to establish standards and guidelines to prevent conflict of interest on the part of members of the Alliance Health (“Alliance”) Board of Directors (hereinafter “Board”). The policy is intended to supplement, but not replace any applicable federal or state laws, rules and regulations governing conflict of interest. This policy is also intended to meet the requirements of the North Carolina Department of Health and Human Services, Division of Health Benefits regarding conflict of interest under the Medicaid 1915 (b)/(c) waiver.

II. POLICY STATEMENT

It is the policy of Alliance to ensure that none of its Board members have conflicts of interest with any of the provider agencies with which Alliance has a contractual or a consumer referral relationship.

Each Board of Directors member shall fulfill his or her responsibilities consistent with all Federal and State laws and regulations, Board of Directors and Alliance policies, and Board of Directors By-Laws regarding avoidance of conflict of interest. This includes the avoidance of the perception of conflict of interest which might undermine the efforts of the Board of Directors to maintain public confidence and trust in Alliance.

III. DEFINITIONS

**Provider agency**: Agency, organization or individual that is contracted with Alliance to deliver publicly-funded mental health, intellectual/ developmental disability, substance abuse or other treatment, habilitation, rehabilitation, educational, training and/or recovery related services to consumers.

**Publicly-funded**: Funded with State, County, Medicaid or Federal Block Grant Funds.

**Vendor**: Company or other entity that provides goods and services needed to develop, maintain or operate the corporation.
Conflict of Interest: Situations in which financial or personal interests may adversely affect, or have the appearance of adversely affecting, an individual’s professional judgment in performing any activity or duty in connection with his/her role as a Board member.

IV. RESTRICTIONS AND REPORTING

1. Identification

Board of Directors will be educated on conflict of interests. Each Board member is responsible for identifying potential, perceived and prohibited conflict of interests.

2. Prohibited Conflicts

Certain activities are deemed a conflict of interest and are therefore prohibited; specifically Board members are prohibited from the following:

a. Receiving reimbursement as consultant or employee from Alliance or being employed by Alliance during the time they serve as board member.

b. No member of the Board of Directors may be a ‘family member’, as defined in Section IV-2.b. of this policy, of any employee of Alliance.

c. Representing him or herself to be an independent agent of the Board of Directors representing any potential Board of Directors action or position.

d. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the Board of Directors (NCGS 122C -118.1).

e. Having a personal interest, direct or indirect financial investment, an ownership interest (whether by stock ownership, partnership, or otherwise), any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit, board membership, or employment with any Provider Agencies with which Alliance has a current contractual or referral relationship. Exempt that Membership of a Board of County Commissioners who is also a member of the Board of Directors of any nonprofit hospital due to his/her status as a County Commissioner shall not be prohibited from serving on the Board of Directors even if the nonprofit hospital is contracted with Alliance. Any such member must recuse themselves from any Board of Directors votes that may impact the nonprofit hospital, and must likewise recuse themselves from any hospital Board votes that may impact Alliance.

A list of the provider agencies with which Alliance has contractual or referral relationships is available on the Alliance website. A list of vendors shall be provided to Board members upon request.

f. Serving on the Consumer and Family Advisory Committee, unless as the appointed member as reflected in the bylaws.

g. Having any interest in an Alliance vendor as follows:

1. The Board member is a director, officer, partner, or direct or indirect owner of the beneficial interest in more than 5% of the equity in the vendor.
ii. The Board member has a family member who is a director, officer, partner, or direct or indirect owner of the beneficial interest in more than 5% of the equity in the vendor.

h. Personally having, or having a family member who has, any interest in any mortgage, deed of trust, note, or other financial interest in a vendor where the value of such interest equals more than 5% of the value of the assets of the vendor.

i. Employment with the State of North Carolina, the Federal government, or the fiscal intermediary in any position that exercises any authority or control over Alliance, its contracts, or its performance.

j. Serving on the Board if:
   i. debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or
   ii. being an affiliate, as defined in the Federal Acquisition Regulation, of a person described in i.

k. No Board member may have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

l. A person representing or potentially representing a vendor, a Provider, or a funder in an adversarial role to Alliance (e.g. attorney for provider).

3. Potential and Perceived Conflicts

To ensure accurate disclosure and consideration of potential and perceived conflicts of interest, the following relationships must also be reported and may be deemed a conflict of interest:

a. Having a family member who has a financial investment, an ownership interest (whether by stock ownership, partnership, or otherwise), any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit, board membership, or employment with any provider agencies with which Alliance has a contractual or referral relationship.

For purposes of this policy, “family members” include:

i. The Board member’s spouse;

ii. The Board member’s parents, children, and siblings;

iii. The Board member’s stepparents, stepchildren, stepbrothers, and stepsisters;

iv. The Board member’s father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;

v. The Board member’s grandparents and grandchildren;

vi. A spouse of any of the Board member’s grandparents or grandchildren.

V. REQUIREMENTS

Certain actions are required on the part of Board members for effective implementation of this policy:
1. Board members must observe the highest moral and ethical standards in any dealings in which they represent the Board of Directors.

2. Board members must disclose on an ongoing basis any conflict or the appearance of a conflict of interest and depending on the circumstances, may be prohibited from serving or restricted in voting based on the disclosure.

3. All Board members are required to update the information on the disclosure form whenever a potential conflict arises.

4. Board members who are aware of any violations by any board members of this policy are required to report them to the Board of Directors Chair. The Board Chair shall notify the Chief Executive Officer of the reported violation.

VII. CONFLICT OF INTEREST DISCLOSURE AND RESOLUTION PROCESS

1. The Conflict of Interest (COI) Disclosure form will be distributed no later than the February Board meeting.

2. Board members are required to submit COI Disclosure forms by March 31 each fiscal year.

3. Board members who do not submit COI Disclosure forms by the due date will have their membership on the Board suspended to include eligibility for stipends and financial reimbursement until such time the form is submitted. Board members who do not fully comply with the provisions in this Policy may be subject to removal from the Board.

4. Compliance Officer and Legal Counsel review forms and make recommendation to the CEO. Recommendations may include prohibition from voting to resignation from the Board.

5. Compliance Officer and Legal Counsel notifies Audit & Compliance Committee (Committee) Chair of the conflict and the recommendation to remove/avoid the conflict prior to Committee meeting.

6. Committee Chair calls Board member with identified conflict to discuss conflict and recommendation prior to the Committee meeting. Board member is offered the opportunity to remove the conflict prior to presenting to the Committee:
   a. If Board member removes the conflict, a new disclosure form is filled out reflecting no conflict
   b. If Board member does not remove conflict, it is presented to the Committee
   c. While conflict of interest issues are being reviewed, the Board member and subject of the potential conflict may be prohibited from serving or restricted from voting.

7. Committee hears the conflict and makes a final recommendation to the Board. The Committee will invite the Board member to be present when the matter is considered by the Committee.

8. Committee submits recommendation to the full Board as consent agenda item using Agenda Action Form (AAF) and a separate document identifying the Board Member, his/her conflict, and proposed solution.
9. The Board of Directors shall make the final decision regarding the disposition of all conflict of interest issues.
I. PURPOSE

To identify activities necessary for the orderly planning and implementation of Board of Directors processes.

II. DEFINITIONS

Processes: Activities associated with Board of Directors meetings including agenda planning, developing and distributing meeting materials, overseeing committee work, compiling meeting minutes, etc.

III. POLICY STATEMENT

The Board of Directors shall utilize processes required for effective and efficient meetings, to execute Board business and to carry out Area Authority responsibilities for service delivery and operations.

IV. PROCEDURES

A. Agenda Planning

Each Board of Directors meeting shall utilize an agenda developed by the Board of Directors Executive Committee with assistance from the Chief Executive Officer. Meeting agendas shall conform to the following principles:

1. The agenda shall have continuity from the previous meeting.
2. Agenda items may sometimes include special issues such as election of new members, attention to crisis situations, goal setting, etc.
3. The agenda shall indicate the beginning and ending times for each Board meeting.
4. The agenda shall be sent to Board of Directors members at least four (4) working days prior to each meeting.
B. Developing and Distributing Meeting Materials

The Chief Executive Officer (or designee) is responsible for the following:

1. Sending notices to Board of Directors members regarding meetings

2. Preparing “Board Packets” to be available to Board members for (4) working days prior to each regularly scheduled board meeting. The packets shall include but not be limited to:
   a. The meeting agenda
   b. Agenda Action Form and supporting documentation
   c. Minutes from the previous Board of Directors meeting
   d. Minutes from committee meetings, as applicable

3. Posting agenda on website

Deleted: five (5)
I. PURPOSE

The purpose of this policy is to set forth the requirement that the Board of Directors conduct an annual performance evaluation of the Chief Executive Officer.

II. POLICY STATEMENT

The Board of Directors shall complete a formal review (at least annually or more often if necessary) of the Chief Executive Officer using a method that encompasses areas of operation that are important to the Board of Directors and required by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (State). This method shall be used at the Board’s discretion and shall minimally include: the major categories described in the State rules for evaluating the Chief Executive Officer and additional priorities as mutually agreed to by the Board of Directors and the Chief Executive Officer. Among other things, the Board shall use the performance evaluation to (1) assure that the Chief Executive Officer meets performance expectations as established by the Board and (2) to identify or verify information that may be used to determine or justify a change in the Chief Executive Officer’s compensation package.

III. PROCEDURES

The Board Chair may appoint an ad hoc committee to conduct the annual performance evaluation. The committee shall bring its recommendation to the full board for final action.
The Alliance Health 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 Division for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.
   i. Delegating to the Chief Executive Officer authority to execute contracts and agreements, where appropriate.
   j. Maintaining open communication with the Consumer and Family Advisory Committee (CFAC).
   k. Participate in strategic planning, including consideration of local priorities as determined by the County Commissioner Advisory Board;
   l. Government affairs and advocacy.

B. COMPOSITION

1. The Board of Directors shall consist of twenty (20) members.
2. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland County Commissioners.
3. The Durham and Wake County Commissioners shall appoint seven (7) members respectively, the Cumberland County Board of Commissioners will appoint four (4) members, and the Johnston County Board of Commissioners will appoint two (2) members.
4. The Board of Directors will advertise, accept applications, interview and recommend appointments to the respective Boards of Commissioners.

5. Board of Directors membership may consist of the following:
   a. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse
   b. CFAC member
   c. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
   d. Individual with financial expertise
   e. Individual with provider experience in a managed care environment.

6. The Board of Directors shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board.

7. No individual who contracts with the Board of Directors for the delivery of mental health, intellectual/developmental disabilities, or substance abuse services may serve on the Board of Directors during the period in which the contract for services is in effect.

C. TERMS AND CONDITIONS OF OFFICE

1. Terms of membership shall be for three years except any member of the Board of Directors who is a county commissioner serves on the Board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a County Commissioner.

2. Members shall not be appointed for more than three consecutive terms.

3. Members may be removed with or without cause by the appointing authority, upon recommendation by the Executive Committee.

4. Board of Directors members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Board of Directors.

5. Vacancies on the Board of Directors shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.

6. Board of Directors members are responsible for disclosing and may not vote on any issue in which they have a direct or indirect financial interest or personal gain. All Board members are expected to exhibit high standards of ethical conduct, avoiding both actual conflict of interest and the appearance of a conflict of interest.

7. Neither Board of Directors members nor members of their families will receive preferential treatment through the Area Authority’s services or operations.

8. Board of Directors members must be current with all property taxes in their respective counties.

9. Membership is based on the rules and regulations of the Board of Directors policies and all applicable North Carolina General Statutes.

10. Board of Directors members are required to comply with the Board of Directors Code of Ethics, policies and all applicable North Carolina General Statutes.

11. While Board members may be appointed because they represent a certain community, once on the Board, their responsibility is to all individuals served by Alliance.
D. OFFICERS

1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
   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 Chief Financial Officer or CEO designee will serve as staff liaison to the Committee.
      iii. The Committee’s functions include:
1) Recommending policies/practices on fiscal matters to the full Board of Directors.
2) Reviewing and recommending budgets to the entire Board of Directors.
3) Reviewing and recommending approval of audit reports (following a meeting by a
designee of this committee with the auditor and receipt of the management letter) and
assure corrective actions are taken as needed.
4) Reviewing and recommending policies and procedures for managing contracts and
other purchase of service arrangements.
5) Reviewing financial statements at least quarterly.
6) Reviewing the financial strength of the Area Authority.

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

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

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

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

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

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

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

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

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

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

iii. The Chief Executive Officer, or designee will be the staff liaison to the Committee.

iv. The Chairperson shall call the meetings of the Executive Committee. Any member of the Board of Directors may request that the Chairperson call an Executive Committee meeting.

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

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

f. Audit and Compliance Committee
   i. The Audit and Compliance Committee will consist of at least three members of the Board of Directors. At least one member shall have financial expertise. The Chairperson of the Audit and Compliance Committee may not also be the Chairperson of the Finance Committee.
   ii. The Chief Compliance Officer or CEO designee 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 Executive Vice President of Network & Community Health or CEO 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, Alliance shall have a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC). The Consumer and Family Advisory Committee shall be self-governing and self-directed. The CFAC shall advise the Board of Directors on the planning and management of the local mental health, intellectual/developmental disabilities and substance abuse services system.

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

A. REGULAR MEETINGS

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

B. SPECIAL MEETINGS

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

C. EMERGENCY MEETINGS

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

D. NOTICE OF MEETINGS

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

E. CONDUCT OF MEETINGS

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

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

A majority of the actual membership of the 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 affirmative votes, from two-thirds of the actual membership of the Board, excluding vacant seats. Significant actions shall include:

1. any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159),
2. the selection and dismissal of the Chief Executive Officer,
3. changes to the Board of Directors structure,
4. execution of contracts for sale, purchase or leases of real property,
5. approval or amendment of the Board of Director’s by-laws, and,
6. any other matter so designated by the Board of Directors.

H. ABSENCES

1. Absence from three (3) consecutive Board meetings without notification to the Executive Secretary shall constitute resignation from the Board.
2. Absence from four (4) or more of the regularly scheduled Board 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 define a process by which the annual budget shall be prepared in accordance with Article 3 of Subchapter III of Chapter 159 of the General Statutes, the Local Government Budget and Fiscal Control Act.

II. DEFINITIONS

The Local Government Budget and Fiscal Control Act is the legal framework in which all local government agencies must conduct their budgetary process.

III. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to adhere to all applicable provisions in Article 3 of Subchapter III of Chapter 159 of the General Statutes, the Local Government Budget and Fiscal Control Act. The Board shall adopt procedures that ensure the financial stability of the Area Authority.

A. Provisions: Following are some of the relevant provisions in NC G.S. 159:

1. 159-8(b), the budget shall cover a fiscal year beginning July 1 and ending June 30.
2. 159-9, the board shall appoint a Budget Officer.
3. 159-10, all department requests for the following year shall be submitted to the Budget Officer. The Budget Officer shall create a mechanism for Department Head submissions and prepare summarized information for the budget proposal.
4. 159-11(b), the budget and budget message shall be submitted to the governing board not later than June 1. The budget message shall be concise and explain the goals, activities of the budget, changes from the previous year, and any major changes in fiscal policy.
5. 159-12(a), the Budget Officer shall submit a copy of the budget to the office of the clerk of each County of the catchment area. It will remain available until the budget ordinance is adopted. The budget shall be made available to news media and be available on all websites affiliated with Alliance.
6. 159-12(b), the board shall hold a public hearing to receive input on the budget.
7. 159-13(a), not earlier than ten (10) days after the day the budget is presented to the board and no later than July 1, the board shall adopt a budget ordinance.
8. 159-24, the board shall appoint a Finance Officer.
9. 159-31, the board shall designate its official depository.

**B. Budget Retreat**

The board shall hold an annual budget retreat in which the date of the public hearing will be established.
I. PURPOSE

The purpose is for Alliance Health (Alliance) to develop and implement a risk management plan that will enable the organization to successfully manage risk to the organization and its customers.

II. DEFINITIONS

Risk: The potential of harm to the organization, customers or key stakeholders.
Risk Assessment: An evaluation of the nature and magnitude of risk to the organization. The evaluation is based upon known or potential threats, as well as the likelihood of the threats being realized and the potential impact to the organization and its customers.
Risk Management: The process of evaluating and responding to risks for the purpose of reducing those risks to acceptable levels. Risk management is inclusive of the risk assessment process, and uses the results of risk assessments to make decisions on the acceptance of risks or on taking action to reduce those risks.

III. POLICY STATEMENT

Alliance shall have a comprehensive risk management plan to identify, analyze and manage threats to the organization’s ability to operate, including changes in service or business environment, as well as threats to employees, property, income, and community standing. For each risk identified, Alliance will develop a plan to address the risk and avoid exposure, or to manage and minimize the severity of the loss.

IV. PROCEDURES

The Chief Executive Officer will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide a consistent standard for employee expense reimbursement for authorized travel for the purpose of conducting business or obtaining training. It is the intent of Alliance Health (Alliance) that employees neither gain nor lose personal funds when engaging in Agency authorized travel and/or training. It is also the intent of Alliance that all employee expense reimbursements be approved, necessary and reasonable.

II. POLICY

Alliance is committed to developing an educated and skilled workforce and shall provide funding for employee training and travel whenever possible. Funding for this purpose may be established annually during the annual budget process. Available training funds may be used for training required for obtaining or maintaining professional licensure or to obtain necessary skills required for a position when approved by the Chief Executive Officer. Mileage is reimbursed for travel that is a part of an employee’s job responsibilities or for approved travel for training purposes.

III. ALLOWABLE EXPENSES

Reimbursement for the following travel and training related expenses, both within and outside the catchment area, are allowable under this policy:
A. Mileage in accordance with current IRS regulations.
B. Meals based on the IRS per diem rates.
C. Hotel charges incurred
D. Ancillary travel costs, e.g., tips, parking, vehicle rental, etc.
E. Tuition/Registration.

Any exceptions to the established rates shall require the prior approval of the Chief Executive Officer.
IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to authorize the Chief Executive Officer to issue cellular telephone and related devices to Alliance Health (Alliance) employees or to provide reimbursement to employees for the use of such devices.

II. POLICY STATEMENT

It is the policy of Alliance to provide staff with the tools/equipment necessary for the efficient operation of the Area Authority’s affairs. In recognition of the need for timely communication, Alliance may provide reimbursement to authorized employees for the use of personal cell phones for business purposes, including phone calls, emails, personal data assistant, etc. Alliance may also issue agency owned cellular phones to employees.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy. Those procedures shall address at a minimum:

A. Positions that qualify for cellular phone support
B. Reimbursement rates
C. Eligibility criteria to receive reimbursement
D. Criteria for issuance of an agency owned cellular device
I. PURPOSE

The purpose of this policy is to establish guidelines for collection of provider paybacks in accordance with standards set forth in Alliance Health’s (Alliance) agreements with the NC Department of Health and Human Services and as specified in the NC Department of Health and Human Services standardized provider agreements.

II. POLICY STATEMENT

It is the policy of Alliance to ensure that providers repay funds identified as requiring recoupment according to the funding source’s policy (Examples of funding source include: Medicaid, State funds, Federal Block Grants, County funds). Alliance shall comply with all established regulatory and statutory requirements of the funding agencies and shall comply with the provisions of the standardized provider contracts.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) will identify, reduce, and eliminate risk and to safeguard the financial integrity of the organization.

II. POLICY STATEMENT

It is the policy of Alliance to ensure that service and administrative costs not exceed the level of funding received. Risk indicators, which are overall factors of how the organization is operating from a financial perspective, shall be monitored. Financial results shall be reviewed monthly for possible savings or losses of revenues versus expenditures. Alliance shall emphasize capturing, analyzing and reporting accurate data as the foundation of financial risk management.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to ensure Alliance Health (Alliance) has a fund balance that contributes to the Organization’s fiscal health and is adequate to meet Alliance’s operational and service needs.

II. DEFINITIONS

**Fund Balance**: Difference between the assets and liabilities in a governmental fund

**Unassigned Fund Balance**: Amount of fund balance that does not have any specific purpose identified for the use of those net resources

III. POLICY STATEMENT

It is the policy of Alliance to have the Finance Committee of the Board of Directors review the fund balance annually. Fund balance designations shall be appropriated at year end while adhering to G.S. 159-8 (a).

The Local Government Commission (LGC) recommends that the fund balance available (unassigned fund balance) be an amount not less than eight percent (8%) of expenditures as presented in the most recent audited financial statements which should approximate expenditures for one month.

Based on the LGC recommendation and due to Alliance’s specific circumstances the Organization is working towards an unassigned fund balance of 8% of expenditures as presented in the most recent audited financial statements.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure the financial stability of Alliance Health (Alliance).

II. POLICY STATEMENT

It is the policy of Alliance to comply with all state and federal laws regarding the financial management of the organization. The Board of Directors of Alliance shall be responsible for the financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services. The Board of Directors shall establish a Finance Committee per G.S. 122C-119(d). The Finance Committee responsibilities shall include reviewing financial statements and making recommendations on financial matters to the Board of Directors.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to ensure that an up to date accounting manual is maintained by the Finance Department.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to maintain an up to date accounting manual that documents finance related processes. The accounting manual shall be developed and implemented to ensure that the department has adequate internal controls and procedures consistent with generally accepted accounting principles, in accordance with contractual requirements and to ensure the department is operated efficiently. The accounting manual shall be reviewed and revised as necessary and at a minimum annually.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I.  PURPOSE

The purpose of this policy is to ensure proper and adequate recording of financial transactions.

II.  POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to record all revenues and service expenses in the general ledger by funding source. Administrative expenses will be allocated based on the assigned cost allocation. This shall be done to ensure accurate accountability to all reporting entities and to ensure sound financial tracking and monitoring in accordance with contractual requirements.

III.  PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to establish guidelines for coordination of benefits (COB) to ensure that public funds are the payor of last resort.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to establish procedures to ensure that public funds are the payor of last resort. Alliance shall develop procedures to ensure that all third party coverage will be identified and that claims submitted to Alliance will include the net remaining amount to be paid.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) has consistent and accurate cyclical financial reporting.

II. POLICY STATEMENT

It is the policy of Alliance to reconcile and close the financial records on a monthly and annual basis in order to prepare accurate and timely financial statements. Financial statements shall be prepared according to generally accepted accounting principles and in accordance with contractual requirements.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure adherence with claims adjudication contractual requirements.

II. POLICY STATEMENT

Alliance Health (Alliance) shall establish general guidelines for the timely and accurate processing of claims submitted by providers for payment. Procedures shall ensure that Prompt Pay Guidelines will be met and that denied claims information will be returned to the Providers in a timely manner according to Department of Health and Human Services contractual requirements.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to establish a process for organization purchases.

II. POLICY STATEMENT

It is the policy of Alliance Health to ensure the cost effective, efficient and timely procurement of the necessary goods and services in compliance with applicable State and Federal laws and regulations.

III. PROCEDURES

The Chief Executive Officer will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to develop and implement procedures for the legal and proper investment of Alliance Health (Alliance) idle funds.

II. POLICY STATEMENT

It is the policy of Alliance to invest idle public funds in a manner which will provide the highest investment return with the maximum security while meeting the daily cash flow requirements of the Organization and conforming to all State statutes governing the investment of idle funds, specifically G.S. 159-30.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) follows established procedures for loading and maintaining service codes in AlphaMCS.

II. POLICY STATEMENT

It is the policy of Alliance that all service codes and descriptions are loaded and maintained in the AlphaMCS system by a qualified user. Consistent procedures shall be utilized to ensure that the quality and integrity of data in the system is maintained.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

Alliance Health (Alliance) is a political subdivision of the State of North Carolina that is subject to Article 3 of N.C.G.S. Chapter 159, the Local Government Budget and Fiscal Control Act. N.C.G.S. §159-9 requires the governing board to appoint a budget officer to serve at the will of the governing board. The Alliance Board has appointed the Chief Financial Officer as the Budget Officer. N.C.G.S. §159-15 allows the governing board to authorize the Budget Officer to transfer moneys from one appropriation to another within the same fund subject to such limitations and procedures as it may prescribe. The purpose of this Board Policy is to define the authority level at which the Chief Financial Officer as the board appointed Budget Officer, can transfer moneys within and between appropriations.

II. POLICY STATEMENT

The Annual Operating Budget for Alliance is supported by Federal and State Medicaid Funds, State Funds, Federal and Other Grant Funds and County funds. Throughout the fiscal year it may be necessary from time to time to transfer moneys between and within the funding sources (or “appropriations”) to maximize the most appropriate use of funding for services. It is the policy of Alliance to authorize the Chief Financial Officer, as the board appointed Budget Officer to transfer moneys as outlined below:

- Transfers of $25,000 or less between appropriations may be made by the Budget Officer without prior approval.
- Subject to the prior written approval from the Chief Executive Officer, transfers between appropriations of $25,001 - $100,000 per transaction, may be made if allowed by the funding source subject to a report to the Board Finance Committee at its next scheduled meeting. The report to the finance committee shall contain the reason and justification for the transfer. Consistent with N.C.G.S. §159-15, the Finance Committee will report these transfers to the Board at its next regular meeting for information and entry into the minutes.
- Transfers within an appropriation up to $100,000 cumulatively for the fiscal year may be made subject to a year-end report to the Finance Committee. This year-end report will be provided to the Board at its next regular meeting for information and entry into the minutes.
Amounts exceeding the limits above shall require Board approval. A request to transfer money in excess of the Budget Officer’s authority shall be brought to the Finance Committee first for prior consideration/recommendation. The Finance Committee shall report its recommendation to the Board at the next regular meeting for final approval or denial. The Board action shall be recorded in the minutes.

Funds allocated by the State for programs or services in a specific county may not be transferred between counties without the approval of the finance committee and the Board and/or direction from the State.

Notwithstanding the foregoing, the Year-end adjustments made in the year end close process (August of the following fiscal year) may be made without prior approval and reported to the Finance Committee and the Board at the next meeting after the year-end financial statements have been completed.

The transfer of county appropriations between counties is prohibited.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to acknowledge the enrollment and coverage of Medicaid consumers enrolled in the Prepaid Inpatient Health Plan (PIHP) of Alliance Health (Alliance) as well as to establish eligibility criteria for individuals not eligible for Medicaid coverage.

II. POLICY STATEMENT

It is the policy of Alliance to comply with the DHHS NC Medicaid 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.

Alliance shall establish criteria by which individuals may be eligible for state funds as payment for behavioral health services to a non-Medicaid eligible individual. For an individual to receive state funded 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.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is for Alliance Health (Alliance) to develop and implement a compliance plan and program. The program shall be designed to establish an organizational culture that promotes prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and federal, state and private payer health care program requirements, as well as Alliance’s ethical and operational policies and procedures.

II. POLICY STATEMENT

Alliance is committed to the development of an organizational culture where services are provided and business is conducted in a legal and ethical manner. Alliance also encourages employee and provider participation in achieving a culture of compliance through training, suggestions for improvement, questions, and reporting of violations without any fear of retaliation. Each report or question offers an opportunity to contribute positively to the quality of services at Alliance.

Ethical behavior and compliance with all pertinent laws, rules and other requirements are the responsibility of all employees and provider agencies.

III. PROCEDURES

Annually, the Chief Executive Officer shall present the Corporate Compliance Plan to the Board for approval.
I. PURPOSE

The purpose of this policy is to outline the scope, responsibilities, and activities conducted by Alliance Health (Alliance) to prevent, detect, and resolve instances of fraud and abuse.

II. POLICY STATEMENT

It is the policy of Alliance to comply with all local, state, and federal laws governing its operations. Alliance shall promote efforts to guard against fraud and abuse through prevention, detection and enforcement activities.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that any financial incentives provided by Alliance Health (Alliance) promote the provision of quality health care services.

II. DEFINITIONS

Delegated Entity: An entity that performs delegated activities on behalf of Alliance

III. POLICY STATEMENT

It is the policy of Alliance to not allow the payment of bonuses or other financial incentives to staff, contractors, consultants, or delegated entity based directly on consumer utilization of health care services.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to establish guidelines and procedures to prevent conflict of interest on the part of employees of Alliance Health (Alliance). The policy is intended to supplement, but not replace any applicable Federal or state laws governing conflict of interest.

II. POLICY STATEMENT

It is the policy of Alliance that employees shall disclose any actual or potential conflict of interest.

Each employee shall fulfill his or her responsibilities consistent with all Federal and State laws and regulations, and Alliance policies regarding avoidance of conflict of interest. This includes the avoidance of the perception of conflict of interest.

North Carolina General Statutes 126-4 prohibits an employee from holding any office or have other employment which may conflict with employment in an agency subject to the State Personnel Act.

Alliance employees shall not derive a direct benefit from a provider or contractor as covered by NC G.S. 14-234.

It is the responsibility of each employee to reveal a conflict or the appearance of a conflict of interest. Not reporting a conflict of interest constitutes unacceptable personal conduct which may result in disciplinary action up to and including dismissal.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

Alliance Health (Alliance) is committed to providing high quality services that comply with the regulations and laws that are applicable to behavioral healthcare and Managed Care Organizations. To support this commitment, Alliance shall develop a Code of Ethics and Conduct to provide guidance for staff on employee and organizational responsibilities. The code is not intended to be an exhaustive list of behavioral expectations. In areas the code does not cover, staff has a duty to determine how they should behave by consulting the regulations, speaking to a supervisor or contacting the Compliance Officer.

II. POLICY STATEMENT

It is the policy of Alliance to develop a Code of Ethics and Conduct to provide staff with guidance on requirements for conduct as established by Alliance and applicable laws and standards. Principles within the Code of Ethics and Conduct shall be grounded in Alliance policy.

All staff shall uphold Alliance’s adopted Code of Ethics and Conduct. Additionally all staff is required to report or seek guidance on any activity they believe is unethical or violates the law or any federal or state healthcare requirement. Individuals do not have to be certain that the violation occurred in order to report it. Staff seeking guidance or reporting violations may do so without fear of retaliation and their confidentiality will be protected to the fullest extent possible.

The Code of Ethics and Conduct shall be reviewed at least annually and the Board of Directors shall approve any modifications to the content of the code.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.

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<tr>
<th>TITLE:</th>
<th>Employee Code of Ethics and Conduct</th>
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<td>C-5</td>
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<td>RESPONSIBILITY:</td>
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<td>42 CFR § 438.608,</td>
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I. PURPOSE

The purpose of this policy is to assure that any records generated by the Area Authority are maintained as required by State and Federal rules and regulation.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to maintain all program records and service records in accordance with North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services Records Retention and Disposition Schedule for State and Area Facilities, APSM 10-5 to include all subsequent revisions. In the event that the Alliance is notified of any pending legal action or action involving federal or state audit or investigation of the program, the records shall be maintained until the date such matter is resolved and formally concluded in accordance with applicable federal and state laws and regulations.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provision of this policy.
I. PURPOSE

The purpose of this policy is to provide guidelines and requirements for Alliance Health (Alliance) employees regarding legal proceedings involving service records.

II. POLICY STATEMENT

It is the policy of Alliance to comply with any valid requests for service records issued by a court of competent jurisdiction in accordance with state and federal regulations.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) carries out its responsibility for providing care coordination to eligible individuals and families within the Alliance catchment area and to define the process of identifying and referring individuals to Care Coordination.

II. DEFINITIONS

Care Coordination: A collaborative process that links individuals and families with special healthcare needs and high risk/high cost individuals to services and resources in an effort to optimize clinical outcomes, decrease unnecessary utilization of services, and ensure delivery of quality care.

Special Health Care and High Risk Populations:
- Adult enrollees who are severely and persistently mentally ill and meet Level of Care Utilization System for Psychiatric Services (LOCUS) criteria
- Child enrollees who are severely emotionally disturbed and meet Child and Adolescent Level of Care Utilization System (CALOCUS) criteria
- Children under 21 years of age with a mental health or substance use diagnosis who are currently, or have been within the past thirty (30) days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the Department of Public Safety, or Division of Adult Correction and Juvenile Justice for whom Alliance has received notification of discharge.
- Enrollees with substance use diagnosis and current ASAM PPC Level of III.7 or II.2-D or higher.
- Enrollees with co-occurring diagnoses (SA/MH/I/DD)
- Opioid Dependent: Individuals with an opioid dependence diagnosis and who have reported to have used drugs by injection within the past thirty days
- CCNC/MCO (Community Care of North Carolina/Managed Care Organization) Priority List
- Consumers who meet criteria for the Transitions to Community Living Initiative
- Individuals on the NC Innovations Waiver
- Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past thirty (30) days, in a facility operated by the Division of Adult Correction and Juvenile Justice for whom Alliance has received notification of discharge
III. POLICY STATEMENT

It is the policy of Alliance to provide Care Coordination to individuals that meet the Special Health Care and High Risk Populations criteria delineated in part II. Alliance shall develop protocols to identify individuals who are high risk or who have special health care needs and ensure that those individuals identified receive care coordination as appropriate. Alliance shall employ qualified professionals who shall be located in the geographic areas covered by Alliance to provide care coordination.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that members’ rights are respected and protected by all providers in the Alliance Health (Alliance) Provider Network.

II. POLICY STATEMENT

It is the policy of Alliance that every person served has a right to dignity, privacy and humane care that must be respected and protected. Providers in the Alliance Provider Network shall assure basic human rights to each member. All programs operated by providers shall comply with the clients’ rights standards set forth in G.S. 122C, Article 3.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to protect each member’s right to privacy and to safeguard the confidentiality of identifiable health information.

II. POLICY STATEMENT

All members of Alliance Health (Alliance) shall be assured that their right to privacy and the confidentiality of their identifiable health information will be safeguarded. No staff member, volunteer, student or other person associated with Alliance shall use or disclose any information except as provided by these policies and procedures as authorized by the General Statutes of the State of North Carolina 122C Parts 52-56, Client Right to Confidentiality, the Federal Regulations 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and the Health Insurance Portability and Accountability Act (HIPAA) regulations in 45 CFR. Any violation of this policy shall be grounds for disciplinary action, including termination of employment or termination of other services with Alliance.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to advocate and support an individual’s right to make informed choices about service provision.

II. POLICY STATEMENT

It is the policy of the Area Authority to promote and encourage choice when members seek services from Alliance Health (Alliance). Alliance shall ensure that each member seeking services receives the following:

1. information necessary to make an informed choice about service;
2. information about the range of other services available and;
3. information about their right to receive services in a way that is non-coercive and protects their right to self-determination.

For Medicaid funded services, members shall be provided with a choice of at least two provider agencies from which they may elect to receive services. (May not apply to some highly specialized services)

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) complies with regulatory requirements surrounding Advanced Directives and Advanced Instructions for Mental Health Treatment.

II. POLICY STATEMENT

It is the policy of Alliance to distribute written information regarding Advance Directives and Advanced Instructions for Mental Health Treatment policies to adult Members, including a description of applicable State and Federal laws. Written information regarding Advance Directives and Advanced Instructions shall cover the following topics:

1. Member rights under State law;
2. Alliance policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives and Instructions as a matter of conscience;
3. Information on the Advance Directive and Instructions policies of Alliance; and
4. The Member's right to file a grievance with the State Certification and Survey Agency or the Division of MH/IDD/SA Services concerning any alleged noncompliance with the Advance Directive or Instructions laws.

In compliance with 42 CFR 438.3(j) and N C GS 122C Article 3, Part 2, the written information provided to Members shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to establish the expectation that Alliance Health (Alliance) shall operate a comprehensive customer services program.

II. POLICY STATEMENT

It is the policy of Alliance that its Customer Services Program will provide the following:

1. 24/7/365 access to services by providing screening, triage and referral through the Access and Information Line;
2. Crisis services authorization as needed; and
3. Information in response to questions and inquiries expressed through the Access and Information Line.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

To provide formal guidelines for compensation that Board of Directors Members are entitled to receive under G.S. 122C-120.

II. POLICY STATEMENT

All members of the Board of Directors are entitled to receive a payment of $50.00 per meeting for attendance at the following meeting(s):

- Regular Monthly Board of Directors Meetings
- Committee Meetings for appointed Committee members, or Board Members requested to attend, that occur on a day besides a Board of Directors Meeting

Each member has the right to decline this compensation by giving written notice to the Chief Executive Officer.

Members shall be entitled to reimbursement for travel to official meetings and functions of the Board of Directors or Committees in excess of 40 miles round trip, at the rate established by the current IRS regulations.

III. PROCEDURES

Compensation shall be made consistent with the fiscal procedures of the Area Authority.
I. PURPOSE

To provide a process for the Alliance Behavioral Healthcare Board of Directors (Board of Directors) to develop, revise, review, approve and monitor policies and procedures that govern the core business of the Area Authority.

II. DEFINITIONS

Approval authority: The party or parties authorized to approve Board of Directors and Area Authority policies and procedures. The Board of Directors approves Board of Directors policies and procedures and the Chief Executive Officer approves Area Authority operational procedures.

Approval date: The date on which the policy or procedures has been approved by all applicable parties and becomes effective for use. This approval date shall appear on all policies and procedures.

Board of Directors: Any use of the term Board of Directors in Board Policies shall be deemed to include the Area Board, Area Authority, LME and other such terms used in North Carolina General Statutes.

Chief Executive Officer (CEO): The CEO is hired and evaluated by the Board of Directors and is responsible for leading and conducting the Area Authority’s business and affairs. Any use of the term CEO in Board Policies shall be deemed to include the Area Director and other such terms used in North Carolina General Statutes.

Policy: Documents developed and approved by the Board of Directors that provide direction to guide the Area Authority’s decision making including the development of operating procedures.

Procedures: Documents developed and approved by the Chief Executive Officer that provides steps for employees to follow when performing a particular function.

Review date: The date the policy was reviewed and approved for continued use. Procedure review date is the date Alliance initiates the review of a procedure. Policies and procedures shall be reviewed at least annually (month year to month year) and revised as necessary.

Revision date: The date on which the policy or procedures were revised to reflect required changes in the organization’s decision making process. Revisions may be effected at any time and it is not necessary to await the scheduled review date.
III. POLICY STATEMENT

The Board of Directors shall be responsible for the development, revision, approval, and monitoring of Area Authority policies that govern the operation of the Area Authority’s programs and services. Among other things, these policies may relate to Federal or State statutes, NC DHHS rules or other regulatory or accreditation requirements affecting the provision of mental health, intellectual/developmental disabilities and substance abuse services.

IV. PROCEDURES

Policies for inclusion in the policy manual require Board of Directors action. Annually, the Board of Directors shall review its policies. These reviews may occur more often if required by rules, statutes, or outside accrediting bodies.

The Board Policy Committee shall develop, review and revise all Board of Directors policies before submission to the full Board of Directors for review and approval. Board of Directors policies affecting operations which come under the purview of other Board Committees shall be reviewed by those Committees and their input provided to the Board Policy Committee four weeks prior to their scheduled review. Non-substantive, grammatical revisions may be made with the approval of the Board Policy Committee.

The Chief Executive Officer (or designee) is responsible for developing a process for revising, approving and monitoring all procedures associated with the implementation of Board policies.
I. PURPOSE

The purpose of this policy is to establish a process for determining compensation for the Chief Executive Officer.

II. POLICY STATEMENT

The operational effectiveness of Alliance Behavioral Healthcare is dependent, in large part, on the leadership of its chief executive. As such, it is incumbent upon the Board of Directors to develop a compensation plan and process that (1) attracts and retains the best executive talent, (2) ensures compensation that is comparable to that of similar organizations and (3) is based on the Chief Executive Officer’s performance. The Board’s compensation plan shall comply with all relevant Federal, State and local requirements, including but not limited to NCGS 122C-121.

III. PROCEDURES

A. Total Compensation Mix

Total executive compensation shall include the following items:

1. Base pay – formal position salary structure plus any restructuring based on position reviews.
2. Benefits plan – health and medical insurance benefits, liability coverage and other benefits as approved by the board.
3. Incentives based on personal and professional performance.

B. Total Compensation References

The Board of Directors shall use comparability data in determining and approving an equitable compensation arrangement including:

1. Market comparator data – a review of compensation paid by other agencies of similar size and services.
2. Functionally comparable positions – a review of compensation paid to other executives of similar functions and responsibilities.
I. DEFINITIONS

As used in this article, the following terms shall have the meaning indicated:

**Business Entity:** Any business, proprietorship, firm, partnership, person in representative or fiduciary capacity, association, venture, trust or corporation which is organized for financial gain or profit.

**Area Authority Official:** A member of the Board of Directors.

**Immediate Family:** The Board of Directors member, his/her spouse, and minor children (including stepchildren and foster children).

**Interest:** Direct or indirect pecuniary or material benefit, as a result of an official act, a contract, or transaction with Alliance Behavioral Healthcare, accruing to:

i. A board member;

ii. Any person in his/her Immediate Family;

iii. Any business entity in which the board member, member of his/her immediate family, or is about to be, an officer or director; or

iv. Any business entity in which an excess of five (05) percent of the stock, or legal or beneficial ownership of, is controlled or owned directly or indirectly by the board member, or his/her immediate family member.

For the purposes of the above paragraphs, ii, iii, and iv, a board member is presumed to have knowledge of the financial affairs of his/her immediate family members. For the purpose of this policy, the board member only has an Interest in the affairs of other immediate family members if the board member has knowledge of or should have known of the Interest of the family member.

**Official Act or Action:** Any administrative, appointive, or discretionary act of any board member.

**Confidential Information:** Any information or knowledge which has not been made public through a governmental agency or official. Information that has become public knowledge, whether or not through a governmental agency or official, is not considered confidential information.
II. POLICY STATEMENT

The Proper Operation of a public authority requires that board members of the authority and its employees be independent, impartial, and responsible to the people; that decisions and policy be made publicly; that public offices not be used for personal gain; and that the public maintain confidence in the integrity of the authority.

In recognition of these goals, a code of ethics for the Board of Directors of Alliance Behavioral Healthcare is hereby adopted. The purpose of this policy statement is to set forth guidelines for ethical standards of conduct for all such officials by setting forth acts or actions that are incompatible with the best interests of the Area Authority.

III. STANDARDS OF CONDUCT

The stability and proper operation of Alliance Behavioral Healthcare depends upon the continuing public confidence in the integrity of the Area Authority and upon responsible exercise of the trust conferred by the people. Board decisions and policy must be made and implemented through proper channels and processes of the board’s structure. The purpose of this section is to establish additional guidelines for ethical standards of conduct for board members. It should not be considered a substitute for the law or a board member’s best judgment.

Board of Directors members must be able to act in a manner to maintain their integrity and independence, yet must be responsible to the interests and needs of those individuals served by Alliance. Board members serve in an important advocacy capacity in meeting the needs of the served communities in the Alliance Catchment Area and should recognize the legitimacy of this role as well as the importance of this function to the proper functioning of the Area Authority. At the same time, the Board must, at times, act in an administrative capacity and must, when doing so, act in a fair and impartial manner. Board of Directors members must know how to distinguish these roles and when each role is appropriate, and they must act accordingly. Board members must be aware of their obligation to conform their behavior to standards of ethical conduct that warrant the trust of their constituents.

A. A Board of Directors Member Shall Obey the Law. Board members shall support the Constitution of the United States, the Constitution of North Carolina and the laws enacted by the Congress of the United States and the General Assembly pursuant thereto.

B. A Board of Directors Member Shall Uphold the Integrity of His or Her Office. Board members shall demonstrate the highest standards of personal integrity, truthfulness, honesty, and fortitude in all their public activities in order to inspire public confidence and trust in Alliance Behavioral Healthcare. Board members shall participate in establishing, maintaining, and enforcing, and shall themselves observe, high standards of conduct so that the integrity of their office may be preserved. The provisions of this Code should be construed and applied to further these objectives.

C. A Board of Directors Member Shall Avoid Impropriety and the Appearance of Impropriety in All of His or Her Activities.

1. It is essential that Alliance Behavioral Healthcare attract those citizens best qualified and willing to serve. Board of Directors members have legitimate interests - economic,
professional and vocational - of a private nature. Board members shall not be denied, and shall not deny to other members or citizens, the opportunity to acquire, retain and pursue private interests, economic or otherwise, except when conflicts with their responsibility to the public cannot be avoided. Board of Directors members must exercise their best judgment to determine when this is the case and comply with the Board of Directors Conflict of Interest Policy.

2. Board of Directors members shall not allow family, social, or other relationships to unduly influence their conduct or judgment and shall not lend the prestige of the office to advance the private interests of others; nor shall they convey or permit others to convey the impression that they are in a special position to influence them.

D. A Board of Directors Member Shall Perform the Duties of the Office Diligently. Board members shall perform the duties of the office as prescribed by law. In the performance of these duties, the following standards shall apply:

1. Board members shall respect the legitimacy of the goals and interests of other members and shall respect the rights of others to pursue goals and policies different from their own.

2. Board members shall respect, support and abide by the decisions made by the board even in those instances when the member(s) is not on the prevailing side of an issue.

3. Board members shall demand and contribute to the maintenance of order and decorum in proceedings before the board.

4. Board members shall be honest, patient, dignified and courteous to those with whom they deal in their official capacity, and shall require similar conduct of the Area Authority’s staff.

5. Board members shall accord to every person who is legally interested in a proceeding before the board full right to be heard according to law.

E. A Board Member Shall Conduct the Affairs of the Board in an Open and Public Manner. Board members must be aware of the letter and intent of the State’s Open Meetings Law and conduct the affairs of the board consistent with the letter and spirit of that law and consistent with the need to inspire and maintain public confidence in the integrity and fairness of the Area Authority.

IV. ADDITIONAL STANDARDS OF CONDUCT

Board members shall be subject to and abide by the following standards of conduct.

A. Conflict of Interest. Board members shall comply with all provisions in the board’s policy on Conflict of Interest.

B. Use of official position. No board member shall use his/her official position or the Area Authority’s facilities for his/her private gain, or for the benefit of any individual, which benefit would not be available to any other member of the public in the same or similar circumstance.
C. Disclosure of information. No board member shall use or disclose confidential information gained in the course of or by reason of his/her official position on the board for purposes of advancing:

1. His/her financial or personal interest;
2. The interest of a business entity of which the member, an immediate family member, has an interest;
3. The financial or personal interest of a member of his/her immediate family; or
4. The financial or personal interest of any citizen beyond that which is available to every other citizen.

D. Incompatible service. No board member shall engage in, or accept private employment or render service for private interest, when such employment or service for private interest is incompatible with the proper discharge of his/her official duties with the Area Authority or would tend to impair his/her independent judgment or action in the performance of his/her official duties, unless otherwise permitted by law.

E. Gifts. No board member shall directly or indirectly solicit any gift, or accept or receive any gift, whether in the form of money, services, loan, travel, entertainment, hospitality, thing or promise, or any other form from any Alliance contractor, subcontractor, provider or supplier.

Exempted from the prohibition are reasonable honorariums for participating in meetings, advertising items or souvenirs of nominal value or meals furnished at banquets. Also exempted are customary gifts or favors between board members or officers and their friends or relatives. Board members must report in writing to the Chief Executive Officer all honorariums and gifts and favors from friends and relatives if made by a covered contractor, subcontractor, provider or supplier.

It shall not be a violation of this policy for any board member to solicit donations, contributions or support for any charitable activity which does not result in direct pecuniary benefit to the member, a member of his immediate family, or business entity with which he is associated.

F. Chief Executive Officer to Secure Advice. In any case where the circumstances make it unclear as to whether a thing constitutes a “gift” within the meaning of this provision, any board member shall consult with the Chief Executive Officer who will secure an advisory opinion from General Counsel.

V. VIOLATIONS OF THE CODE OF ETHICS; SCHEDULING OF HEARING BEFORE THE BOARD OF DIRECTORS; RIGHTS OF ACCUSED AT HEARINGS; SANCTIONS

A. The Board of Directors Chairperson, after receiving an allegation of a violation of the Code of Ethics, shall refer the matter to the Chief Executive Officer for further investigation and inform the Board’s Executive Committee of the alleged violation and the findings of the investigation.

B. If the Executive Committee finds sufficient evidence to believe a violation may have occurred, they shall report the matter to the full board which may schedule a hearing on the issue. The board member who is charged with the violation shall have the right to present evidence, including the
testimony of witnesses, and to question witnesses, including the complainant or complainants, at the hearing.

C. The hearing shall be conducted by the Board of Directors in open session. Any determination resulting from said hearing shall be made in open session of the Board. The Clerk to the Board shall be authorized to swear witnesses before the presentation of their testimony.

D. If the Board of Directors by majority vote of the remaining members finds that a violation has occurred, they may adopt a resolution of censure which shall be placed as a matter of record in the official minutes of the Board meeting or, if warranted, refer the matter to the appointing authority.

VI. ADVISORY OPINIONS

When any board member has a doubt as to the applicability of any provision of this policy to a particular situation involving that board member or as to the definition of terms used in this policy, he/she may apply to the Chief Executive Officer who shall obtain an advisory opinion from General Counsel. The board member shall have the opportunity to present his/her interpretation of the facts at issue and of the applicability of provisions of this policy before such advisory opinion is made.

CODE OF ETHICS FOR ALLIANCE BEHAVIORAL HEALTHCARE BOARD OF DIRECTORS

I, a member of the Alliance Behavioral Healthcare Board of Directors acknowledge that I have received and reviewed a copy of the Code of Ethics for the Board of Directors.

_________________________________________  ______________
Signature                                      Date

_________________________________________
Printed Name
I. PURPOSE

The purpose of this policy is to ensure the ongoing and meaningful involvement of consumers and family members, through the Consumer and Family Advisory Committee (CFAC), in the planning, management and oversight of the Area Authority.

II. POLICY

It is the policy of Alliance Behavioral Healthcare that a Consumer and Family Advisory Committee (CFAC) shall be established and operational. The CFAC shall be a self-governing and self-directed organization that advises the Board of Directors on the planning and management of the local public mental health, intellectual/developmental disabilities and substance abuse system. The CFAC shall be actively involved in all aspects of planning, development, implementation and evaluation of the Area Authority and its providers of services.

III. PROCEDURES

A. Alliance shall provide staff to assist CFAC in implementing its duties under NCGS 122C-170(c).
I. PURPOSE

The purpose of this policy is to define the relationship between the Alliance Behavioral Healthcare Board of Directors (Board of Directors) and the Chief Executive Officer.

II. DEFINITIONS

Chief Executive Officer: The Chief Executive Officer is the Area Authority’s chief executive officer. The Chief Executive Officer is hired and evaluated by the Board of Directors and is responsible for leading and managing the Area Authority’s business and affairs.

III. POLICY STATEMENT

The Board of Directors shall maintain an ongoing relationship with the Chief Executive Officer that will ensure the effective and efficient operation of the Area Authority’s programs and services.

IV. PROCEDURES

A. Delegation of Authority and Responsibility to the Chief Executive Officer

The Chief Executive Officer shall be employed by the Alliance Behavioral Healthcare Board of Directors (Board of Directors) to administer the affairs of the Area Authority within the policies and procedures adopted by the Board of Directors and applicable Federal, State and local laws and regulations. The duties of the Chief Executive Officer shall include but are not limited to:

1. Hire, suspend and dismiss employees as necessary.
2. Provide the Board of Directors with required reports, data and information regarding programs, services, finances and any other business areas as identified by the Board of Directors.
3. Assume overall responsibility for implementing programs and services, including the execution of Provider contracts pursuant thereto.
4. Develop procedures to implement the policies of the Board of Directors.
5. Administer and monitor the Area Authority budget and recommend changes.
6. Define duties and establish the compensation of the Area Authority employees.
7. Evaluate the Area Authority employees.
8. Serve as the primary liaison between the Board of Directors and the NC Department of Health and Human Services.
9. Assist the Board of Directors in understanding their legal responsibilities in performance of their assigned duties.
10. Meet with the Board of Directors or specific Board of Directors members, during regularly established, or impromptu, meetings as required.
11. Negotiate, approve and execute settlement agreements of provider and consumer appeals deemed necessary and in consultation with General Counsel.
12. Enter into all necessary non-Provider contracts (including but not limited to consultant, service contracts, and purchase of goods) and extensions and amendments thereto costing $250,000 or less cumulatively within one fiscal year. Requests for non-Provider contracts greater than this amount shall be presented to the Board Finance Committee for consideration and authorization for approval by the Board. Nothing herein delegates authority to the CEO for those matters set forth in the Board By-laws requiring approval by a super majority of the Board. The CEO may delegate his authority for non-Provider contracts costing $250,000 or less, as deemed necessary for the efficient operation of the organization.

B. Board of Directors Access to Area Authority Management and Employees

From time to time Board of Directors members may need to interact with staff of the Area Authority in order for the Board to fulfill its mission. The Chief Executive Officer shall develop the framework and procedures to facilitate Board/staff interaction.
I. PURPOSE

The purpose of this policy is to provide a framework to carry out the intent and desire of the Board of Directors to receive public comment at Board meetings.

II. POLICY STATEMENT

The Board of Directors considers public comment, within specific guidelines, an important and integral component of fulfilling its planning and decision-making responsibilities.

III. PROCEDURES

A. Persons must sign up for agenda items and identify any non-agenda items about which they wish to speak as they sign up.

B. Persons may sign up prior to the meeting and during the meeting up to the point that the Board recognizes opportunity for public comment to occur.

C. Guidelines shall be posted outside the Board Room and shall be made available to persons signing up for public comment.

D. The public comment period shall be slotted into the early part of the Board’s agenda.

E. Board of Directors members may ask clarifying questions at any time during the public comment period and staff may be asked by the Board Chair to provide clarification.

F. No individual staff shall be named during public comment.

G. The discussion of all items is to occur only among Board members.

H. If an organization or group wishes to be heard, one person shall serve as their spokesperson.
I. Two (2) minutes per speaker is the established time limit (apart from any comment that is made in response to a Board of Directors member’s request for clarifying information). (Note: Any individuals/groups seeking formal inclusion on a Board of Directors agenda will be considered by the Executive Committee when it sets the agenda at its monthly meeting).

J. Yielding time to others is not permitted.

K. The Chairperson shall have the discretion to conduct the public comment session in a manner that maintains good order and decorum.

L. Board will acknowledge the comment but further discussion will be at the discretion of the Chair.
I. PURPOSE

Alliance Behavioral Healthcare is a political subdivision of the State of North Carolina and organized under North Carolina General Statute §122C-115, to administer all publicly-funded mental health, intellectual/developmental disability, and substance abuse (“MH/ID/DD/SA”) services for the residents of Durham, Wake, Johnston, and Cumberland Counties. The purpose of this policy and accompanying procedures is to define the relationship between the Area Authority and the participating County Boards of Commissioners.

II. DEFINITIONS

**Area Authority:** The area mental health, developmental disabilities and substance abuse authority.

**Catchment Area:** The geographic part of the state served by the area authority.

**Boards of County Commissioners:** The participating boards of county commissioners for multicounty area authorities.

III. POLICY STATEMENT

In accordance with the “Purpose” as outlined above, the Area Authority shall develop and manage local mental health, intellectual/developmental disabilities, and substance abuse services in the multi-county area per contracts with the Department of Health and Human Services (DHHS), Inter-local Agreements and the powers and duties outlined in N.C.G.S. §122C-117. The Area Authority shall collaborate with all relevant local governmental agencies in the catchment area to coordinate and advance the development of mental health, intellectual/developmental disabilities and substance abuse services. The Area Authority shall also operate in accordance with all applicable federal and state laws, rules, regulations, executed contracts, agreements, and resolutions as promulgated by the Alliance Behavioral Healthcare Board of Directors.

IV. PROCEDURES
A. Alliance Behavioral Healthcare shall create and manage the provision of high quality cost-effective mental health, intellectual/developmental disabilities, and substance abuse services to residents of the catchment area.

B. Alliance Behavioral Healthcare shall adhere to the requirements of applicable Federal and State laws, rules and regulations including but not limited to Chapters 108A 108D and 122C of the North Carolina General Statutes, the NC State Plan for Medical Assistance, the 1915 b/c Medicaid Waivers, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services’ (DMH/DD/SAS) State Plan, Clinical Coverage Policies, State Service Definitions, executed contracts with the NC Department of Health and Human Services, agreements with catchment area counties or other funding sources, all as may be amended, updated or supplemented from time to time.

C. Annually, the Chief Executive Officer (CEO) shall negotiate and sign a Funding Agreement with the Board of Commissioners of each county in the catchment area. County funding allocated for local services annually shall be conveyed through this Agreement between the funding County and the Area Authority. The terms of the Agreement shall be mutually developed and in compliance with applicable County, State and Federal requirements.

D. The Chief Executive Officer (CEO) or designee may attend catchment area County Department Head meetings and provide information and reports as specified in the Agreement between the Area Authority and the respective county government.

E. Alliance Behavioral Healthcare shall provide a status report on operations and service delivery to the catchment area County Boards of Commissioners at least annually, or more often if specified in the County Agreement or if circumstances dictate. The report shall be presented in a format as agreed upon by each County and the Area Authority and shall include, but not be limited to the following:
   1. Financial report
   2. Risk-management report
   3. Service planning and delivery activities
   4. Quality improvement activities including program audits, surveys, and reports
   5. Provider network management activities
   6. Consumer activities including complaints and grievances
   7. Other reports as identified
I. PURPOSE

The purpose of this policy is to guide board members in their relations with the news media in such a way as to ensure the effective operation of the Alliance Behavioral Healthcare Board of Directors. This policy does not seek to be comprehensive but sets out to provide guidance on how to handle issues that may arise when dealing with news media organizations.

II. DEFINITION

Media: Generally accepted organizations that publish or broadcast information aimed at informing the public.

III. POLICY STATEMENT

The Board of Directors is accountable to the citizens in the Alliance multi-county area. The board is committed to providing timely and accurate information to the public through all available means, including the news media. Each board member serves as an ambassador for the Area Authority and as such may be called upon by various media outlets to field questions or provide information regarding Alliance Behavioral Healthcare. Each board member shall adhere to this policy as he or she interacts with the news media regarding the affairs of the Board of Directors.

IV. PROCEDURES

A. Procedures for Dealing with the Media:

1. Board members should advise the Area Authority’s Corporate Communications Office of any planned or unplanned activities involving the news media.

2. The board shall allow all reasonable access to news media organizations and shall make every effort to respond without delay to requests for information. The board shall attend to media requests promptly and with courtesy, honesty and respect.
3. The Board shall treat all media outlets equally and shall avoid giving one outlet preferential treatment. Media releases shall be distributed to all media outlets at the same time.

4. Board members shall not disclose information that is of a confidential nature. This includes consumer information as well as information that has been discussed as confidential items on the board’s agenda.

5. The Board of Directors Chairperson shall serve as the official spokesperson on all matters related to the Alliance Behavioral Healthcare Board of Directors.

6. In their role as appointed representative, each board member is free to talk with the media at any time. Board members may use these opportunities to enhance the community’s understanding of the work of the Area Authority. However, if the board has not taken a position on a particular issue, the board member must make it clear that they are speaking for themselves and not for the board.

7. In responding to media inquiries, board members have an obligation to respect board policy once a decision is made. While it may be legitimate for a board member to make clear that he or she disagreed with a policy and voted against it, if the vote took place in an open session, he or she shall not seek to undermine a board decision through the news media.

8. From time to time board members may be requested to contribute material for newspaper articles or participate in a broadcast interview. The Area Authority’s Corporate Communications Office shall be available, upon request, to provide assistance.

9. From time to time it may be necessary for a Letter to the Editor or other position statement to be written as an official board communication to inform the community about a particular matter. Such letters or statements shall be issued under the signature of the Board Chairperson.
I. PURPOSE

The purpose of this policy is to provide guidance to the Board and consumers, enrollees, providers, vendors, stakeholders, or other persons or entities that have a contractual or business relationship with Alliance Behavioral Healthcare (“Alliance”), as to how to resolve disputes concerning Alliance contract actions, service authorization decisions or other matters, including applicable appeal rights.

II. DEFINITIONS

**Consumer:** Means any consumer of mental health, intellectual/ developmental disability, and/or substance abuse (“MH/I-DD/SA”) services who is enrolled with Alliance, regardless of funding source.

**Enrollee:** Means any Medicaid-eligible beneficiary whose Medicaid eligibility is based in any of the counties included within the Alliance catchment area and who is enrolled in the Alliance Medicaid Prepaid Inpatient Health Plan.

**Network Provider:** Means as defined in N.C.G.S. §108D-1(13), i.e. an appropriately credentialed provider of MH/I-DD/SA services that has entered into a contract for participation in the Alliance Closed Network.

**Out of Network Provider:** Means any provider who has entered into an Out of Network Single Case Agreement in order to provide services to an Alliance Enrollee.

**Provider:** Means any provider who has a contract or agreement with Alliance for the delivery or reimbursement of publicly-funded MH/I-DD/SA services, regardless of funding source or type, and includes all Network Providers, Out of Network providers, and providers of emergency services.

**Provider of Emergency Services:** Means as defined in N.C.G.S. §108D-1(18), i.e. A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee’s emergency medical condition, and has submitted claims to or been reimbursed by Alliance for such services.

**Vendor:** Means any individual or entity contracted with Alliance to furnish goods or services to the organization, but does not include Providers.
III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to resolve disputes that arise over decisions made by the Board of Directors at the lowest level and in accordance with all applicable Federal and State laws, rules and regulations and accreditation requirements, including but not limited to Chapter 108D of the North Carolina General Statutes (for Medicaid enrollee appeals) and 10A NCAC Subchapter 27G (for State-funded service appeals). Alliance will attempt to informally resolve any and all disputes with consumers, enrollees, providers or vendors and will establish dispute resolution procedures. It is the position of Alliance that the NC Office of Administrative Hearings lacks jurisdiction over Alliance (a local unit of government) except for timely petitions contesting service authorization decisions filed by Medicaid enrollees or duly authorized representatives, as set forth in N.C.G.S. §150B-23(a3). Any formal action alleging breach of contract by Alliance should be filed in accordance with the terms and conditions of the provider’s or vendor’s contract and all applicable laws, rules and regulations, including but not limited to N.C.G.S. §1-52.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

To set forth policy that guides and directs the management and provision of public mental health, intellectual and developmental disabilities and substance abuse services in Alliance Behavioral Healthcare’s catchment area.

II. POLICY STATEMENT

Alliance Behavioral Healthcare (Alliance) is charged with management and oversight responsibility for the public mental health, intellectual and developmental disabilities and substance abuse service system in a multi-county area. It is the intent of the Board of Alliance Behavioral Healthcare that the service delivery system will be managed in a manner that is consistent and accountable to the citizens of the catchment area.

This policy will guide the Board as it carries out its responsibilities outlined in North Carolina General Statutes 122C-115.4 which assigns the following functions to the LME:

1. Access to services 24/7/365 basis;
2. Provider endorsement, monitoring, technical assistance, capacity development and quality control;
3. Authorization of services, utilization review and management;
4. Authorization of the utilization of state psychiatric hospitals, three-party contracted local hospitals and other state facilities;
5. Care coordination and quality management;
6. Community collaboration and consumer affairs;
7. Financial management and accountability; and
8. Management of waiting lists for consumers with intellectual and developmental disabilities.
III. PROCEDURES

Annually, the Board will review and approve the plan for managing and delivering services in the catchment area. The plan shall be presented to the Board as part of the budget development process and shall outline the process for assuring a consistent clinical model and best practices across the catchment area.
I. PURPOSE

The purpose of this policy is to enunciate the critical role the strategic planning process plays in guiding the Board of Directors as it carries out its mission of providing mental health, intellectual/developmental disabilities and substance abuse services to the residents in the Alliance multi-county area. Strategic planning is the foundation of organizational achievement and success.

II. POLICY STATEMENT

The Board shall develop a strategic plan to cover a period of no more than five years. The Board shall conduct a comprehensive review of its strategic plan every three years or more often as necessary. Annually, the Board shall review the plan’s goals and objectives to adjust the plan for changes in the operational environment.

Given the importance of the strategic planning process and its outcomes, the area authority shall involve the broader catchment area community in the development of the plan. Participants shall include, but are not limited to: Area Authority staff, Board of Directors members, consumers, community members, advocacy groups, and funding agencies. Special effort shall be made to ensure representation from various age groups, disabilities, and cultural backgrounds representative of the catchment area demographics.

All participants in the strategic planning process shall receive an orientation to strategic planning focused on its significance to Alliance Behavioral Healthcare’s operations, and training in the specific planning process that will be utilized.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.

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<table>
<thead>
<tr>
<th>TITLE:</th>
<th>Strategic Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOARD POLICY #:</td>
<td>GA-2</td>
</tr>
<tr>
<td>LINES OF BUSINESS:</td>
<td>Quality Management, All</td>
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<tr>
<td>RESPONSIBILITY:</td>
<td>Board of Directors, Chief Executive Officer</td>
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<tr>
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<td>NC G.S. § 122C-115.2</td>
</tr>
<tr>
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<td>CORE, v. 3.2, Standards 2, 17-21 &amp; 27</td>
</tr>
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<td>APPROVAL DATE:</td>
<td>8/2/2012</td>
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<tr>
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I. PURPOSE

The purpose of this policy is to ensure that all instances of alleged or suspected abuse, neglect, dependency, or exploitation of children or disabled adults, which come to the attention of the staff of Alliance Behavioral Healthcare, are reported to the County Department of Social Services in the county where the person is receiving services.

II. POLICY STATEMENT

Every employee shall immediately report to their immediate supervisor, any form of alleged or suspected abuse, neglect, dependency, or exploitation of a child or disabled adult that comes to their attention. In addition to the requirement to report to the immediate supervisor the employee shall make a report to the County Department of Social Services in the county where the child or disabled adult is receiving services.

Any employee who fails to report known or suspected abuse, neglect, dependency, or exploitation as required in this policy shall receive disciplinary action in accordance with Alliance Behavioral Healthcare policies for administering disciplinary action.

Pursuant to G.S. 7B-301 and G.S. 108A-102 the definition of duty to report and immunity shall prevail.

Aggregate data of abuse, neglect and/or exploitation reports to the Department of Social Services will be presented to the Board of Directors Human Rights Committee on a regular basis.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The Board of Directors strives to provide a healthy and safe environment for consumers, customers, staff personnel and other stakeholders who work in or visit Alliance Behavioral Healthcare facilities.

II. POLICY STATEMENT

It is the policy of the Board of Directors to provide services and programs in physical environments that are safe and free of health hazards. Alliance Behavioral Healthcare will comply with all Federal, state and local environmental/health and safety laws, regulations, and ordinances.
I. PURPOSE

The purpose of this policy is to set forth the requirement for the Area Authority to develop an Emergency Management Plan to be followed in the event of an emergency, including but not limited to fire, medical, natural disaster, violent/threatening person, utility failure or bomb threat.

II. POLICY STATEMENT

It is the policy of the Board of Directors to have an Emergency Management Plan to be followed by staff, consumers and visitors. Alliance Behavioral Healthcare will take every possible action to comply with all emergency regulations and protect employees, visitors and property in emergency situations.

III. PROCEDURES

The Chief Executive Officer shall develop a comprehensive emergency management plan and shall conduct periodic emergency drills or simulations. The Chief Executive Officer shall report to the Board of Directors on the results of those drills or simulations.
I. PURPOSE

The purpose of this policy is to establish proper internal control procedures.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to establish internal control procedures to provide reasonable assurance regarding the achievement of objectives in the following categories:

1. Effectiveness and efficiency of operations
2. Reliability of financial reporting
3. Compliance with applicable laws and regulations

III. PROCEDURES

The Chief Executive Officer shall be responsible for developing internal control procedures to ensure that internal controls are established, properly documented, maintained and adhered to in each department within Alliance Behavioral Healthcare.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare continue to operate during any natural and/or man-made disasters or other disruptions. The plan shall ensure minimal interruption of services to the citizens in the catchment area.

II. POLICY STATEMENT

Alliance Behavioral Healthcare shall develop a Business Continuity Plan, which shall include information and procedures for preparedness and response to natural and man-made disasters or disruptions to the daily operations. The plan shall include a Disaster Recovery Plan, to ensure timely and reliable access to critical computer systems, network services and phone system needed to support business operations. The Business Continuity Plan will be reviewed at least annually and updated as needed.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
The purpose of this policy is to ensure that Alliance Behavioral Healthcare has a set of procedures in place designed to ensure the prudent, efficient and effective dissemination of organizational information in its multiple forms via multiple platforms, as well as the appropriate utilization of graphic properties such as its corporate logo.

II. POLICY STATEMENT

Alliance Behavioral Healthcare shall develop a set of procedures that guide staff as well as select external stakeholders in the dissemination of organizational information and the utilization of the Alliance corporate logo and other graphic properties. These shall include but not be limited to procedures governing staff interaction with the media, staff use of social media, and review of core organizational informational materials.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
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 Health (Alliance) 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 Board of Directors 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 Board of Directors prohibits retaliatory action of any kind taken by any employee of Alliance 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 is committed to ensuring utilization of women, minorities, and the disabled as part of its workforce. The Chief Executive Officer 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 Chief Executive Officer shall provide a report on the distribution of the gender, minorities and disabled employees to the Board.
III. PROCEDURES

The Chief Executive Officer 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 Health (Alliance) 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 to provide equal employment opportunities for employment to all applicants and employees.

III. PROCEDURES

The Chief Executive Officer 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 Health (Alliance). 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 that all employees satisfy job-related eligibility conditions including but not limited to licensure, certification and/or credentialing and satisfactory criminal background checks when necessary 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 Chief Executive Officer 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 Chief Executive Officer whose compensation is set by the Board of Directors.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) 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 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 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 Chief Executive Officer 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 Health (Alliance).

II. POLICY STATEMENT

Alliance 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
15. Employee Assistance Program (EAP)

C. Availability of Funding

Benefit offerings are subject to change based on funding availability and Alliance 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 Chief Executive Officer.

D. COBRA Rights

Employees who separate from Alliance 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 Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to affirm the Board of Directors’ 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 intended to comply with the requirements of the Drug Free Workplace Act of 1988.

II. POLICY STATEMENT

It shall be the policy of Alliance Health (Alliance) 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 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 Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

Alliance Health (Alliance) 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 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 is based on the following principles:

1. Employees are expected to report for each and every scheduled working day or shift, to report on time and to complete all scheduled hours.
2. 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.
3. Employees scheduled to work are expected to remain on the job until completion of the last hour of the scheduled work day or shift.
4. Arrival any time after the beginning of the scheduled work day or shift is considered late or tardy for performance purposes.

III. PROCEDURES

The Chief Executive Officer will develop procedures to implement this policy.
I. PURPOSE

The Board of Directors 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 Health (Alliance) 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:

1. has or may have a direct bearing on a selection decision;
2. creates an offensive, intimidating, or hostile work environment;
3. 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 Board of Directors prohibits retaliatory action of any kind taken by any employee of Alliance 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 Chief Executive Officer 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 Health (Alliance) staff.

II. POLICY STATEMENT

Alliance 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 Chief Executive Officer 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 Health (Alliance) 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 Chief Executive Officer will develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that clinical staff of Alliance Health (Alliance) 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 to ensure that only those persons with appropriate training, education, credentials and/or experience perform clinical functions. In order to accomplish this, Alliance 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 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 Chief Executive Officer shall develop procedures to implement this policy.
## I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) 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 Chief Executive Officer 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 Health (Alliance) 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 Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide guidelines for separation of employment with Alliance Health (Alliance).

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 Chief Executive Officer 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 Chief Executive Officer 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 Health (Alliance).

III. POLICY STATEMENT

Alliance 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 Chief Executive Officer 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 Health (Alliance) 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 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/Chief Executive Officer 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 Chief Executive Officer/CEO or designee.

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

IV. PROCEDURES

The Chief Executive Officer/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 Health (Alliance) 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 Chief Executive Officer will present the circumstances of an impending RIF to the Board of Directors 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 Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to outline the acceptable use of computer and information technology resources provided by Alliance Health (Alliance) to employees, Board of Directors members, independent contractors, agents, authorized guests and authorized affiliates (hereinafter “Users”). Inappropriate use exposes Alliance to risks, including breach of personal computer security, exposure of restricted data, compromise of network systems/services, detriments to technology performance, and legal liability. Information Technology Services (hereinafter "IT") is committed to protecting employees, affiliates, and the Area Authority from illegal or damaging actions by individuals, either knowingly or unknowingly.

This policy applies to all equipment that is owned or leased by Alliance.

II. POLICY STATEMENT

It is the policy of Alliance that all computer resources that are the property of Alliance can be used only for legitimate business purposes. Users are permitted access to the computer resources to assist them in performance of their jobs. Use of the computer system is a privilege that may be revoked at any time. It is every employee's duty to use the Area Authority’s computer resources responsibly, professionally, ethically, and lawfully. Any abuse of this policy shall be grounds for disciplinary action which may include termination of employment.

All data created or received for work purposes and contained in the Area Authority’s electronic files, servers, or e-mail depositories are public records, unless otherwise deemed confidential or exempt under the public records act or other law or regulation. Public Records are available to the public unless specifically prohibited from general viewing by law. All public records are to be maintained and disposed of according to state approved records retention and disposition schedules.

III. PROCEDURES
The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) follows specific procedures related to loading, maintaining, and reconciling eligibility and enrollment data.

II. POLICY STATEMENT

It is the policy of Alliance to use accurate and current data to ensure compliance with federal and state laws and contractual requirements throughout its operations. Alliance shall use the Global Eligibility File (GEF) received daily from Department of Health and Human Services (DHHS) to ensure that recipients’ eligibility and enrollment status is correct. Alliance shall use the GEF, HIPAA 820 and HIPAA 834 transactions for reconciliation monthly.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to ensure that routine backup of information system servers occur in order to protect information required to continue business operations.

II. DEFINITIONS

Backup: A term used in the Information Technology environment to describe a process in which information is copied to a separate media. This process is used to ensure availability of information in the event that the original information is lost or compromised.

III. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to subscribe to a Data Backup Plan to ensure availability of information required to continue business operations. The Data Backup Plan shall be in compliance with the North Carolina Department of Health and Human Services (NC DHHS) and the Health Insurance Portability and Accountability Act (HIPAA) security and privacy requirements in order to protect the security of health information and the integrity of Alliance.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) complies with Federal and State laws, rules and regulations, contract requirements and national accreditation standards regarding the selection and retention of providers.

II. POLICY STATEMENT

It is the policy of Alliance to select and retain providers based on quality of care, quality of service, the service needs of the catchment area population and business needs of the organization. The goal of Alliance is to develop and maintain a sufficient network of high quality service providers that meets consumer and community needs within available resources and promotes efficiency and the economic viability of network providers. Selected providers must also meet the credentialing and re-credentialing requirements established by Alliance and the North Carolina Department of Health and Human Services.

The North Carolina Medicaid 1915 b/c Waiver permits Alliance to operate a closed network by waiving the provider “freedom of choice” provision in the Social Security Act. The closed network is balanced by Alliance’s responsibility to ensure accessibility of services.

In accordance with 42 CFR 438.214 and the terms and conditions of the Alliance contract with NCDHHS to operate a Prepaid Inpatient Health Plan, Alliance is required to implement provider selection and retention criteria that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Criteria may include provider performance and other factors. Alliance shall not employ or contract with providers who are excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act or who have been terminated by the NC State Medicaid program for any reason.

Alliance will establish a fair, impartial and consistent process for the enrollment and re-enrollment of mental health, intellectual/developmental disability and/or substance abuse (MH/I-DD/SA) service providers in the Alliance Closed Network that complies with 42 CFR §438.207 and §438.214.
III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide guidance on the issuance of letters of support/acknowledgment for community based projects for persons with mental illness, intellectual/developmental disabilities, and substance abuse disorders.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to support the development of community based MH/IDD/SA services. Pursuant to the development of these services, the Area Authority may, from time to time, be asked for a letter of support or acknowledgment for a specific project. Some of these requests may be precipitated by law or regulation which requires Area Authority involvement or knowledge of the project. Irrespective of the reason for the request, the decision to submit a letter of support/acknowledgement shall be based on the service needs of the residents of the catchment area as identified in the Area Authority’s comprehensive planning process.

III. PROCEDURES

The Chief Executive Officer shall develop procedures for the issuance of letters of support for the various types of projects that might arise. The guiding principle for these procedures shall be the identification of need as reflected in the Area Authority’s comprehensive plan.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) complies with the provisions of the NC Medicaid 1915(c) Innovations Waiver as Alliance reviews and processes requests to employ relatives as providers.

II. POLICY STATEMENT

It is the policy of Alliance to process requests:

1. From Network Providers to employ relatives/legal guardians (who live in the home of the Innovations Waiver participant) to provide Innovations Waiver services to adult family members; and,

2. From individuals who wish to participate in Individual and Family Directed Supports.

The process for handling such requests shall comply with the policy and regulatory provisions of the Innovations Waiver.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Health (Alliance) processes waiver of licensure rule requests made by contracted licensed facilities in a consistent manner. When recommending approval to waive a rule, Alliance must ensure the existence of safeguards to protect the consumers’ health and safety.

II. POLICY STATEMENT

It is the policy of Alliance to process all rule waiver requests submitted by licensed facilities in the Alliance Provider Network consistently and in compliance with the North Carolina Administrative Code. The Administrative Rule outlines that the decision to grant or deny the waiver request shall be based on the following:

1. The nature and extent of the request;
2. The existence of safeguards to ensure that the health, safety, or welfare of the clients residing in the facility will not be threatened;
3. The determination that the waiver will not affect the health, safety, or welfare of clients residing in the facility;
4. The existence of good cause; and
5. Documentation of LME-MCO governing body approval when requests are from an LME-MCO contract agency.

The Alliance Board of Directors has delegated authority to the Chief Executive Officer to approve and deny requests to waive a rule as authorized by Department of Health of Human Services.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to ensure a consistent approval process of rule waiver requests.
I. PURPOSE

Alliance Health (Alliance) endeavors to provide services to the community that are timely, high quality and effective. Alliance is committed to a process of continuous quality improvement and assessment of its relationships with its community partners.

II. POLICY STATEMENT

Alliance seeks to serve the community in a manner that is efficient, responsive, and effective. It is the policy of the Board to employ appropriate techniques to measure the extent to which the Board is meeting its objectives and the level of satisfaction among the Board’s many constituencies. The results of these measurements are to be used to promote improvement of members’, providers’ and other stakeholders’ satisfaction and to improve the quality of services and treatment outcomes.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this Policy.
I. PURPOSE

The purpose of this policy is to establish a process for receiving, investigating, resolving, and managing member grievances in a consistent manner.

II. DEFINITIONS

**Complainant:** Member, legally responsible person, or Providers, authorized in writing and acting on behalf of the member filing the grievance. Does not include providers, stakeholders or other individuals not acting on behalf of a member.

**Grievance:** an expression of dissatisfaction by a member, their legal guardian, or Provider, authorized in writing and acting on behalf of the member about any matter other than decisions regarding requests for Medicaid services.

**Provider:** an individual, agency or organization that provides mental health, developmental disabilities and/or substance abuse services to members and families.

III. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to respond to grievances received concerning the provision of publicly funded services in the Alliance catchment area. It is also the policy of Alliance to use the information gleaned from grievance proceedings as part of Alliance’s quality improvement process.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy. The procedures shall comply with all relevant state and Federal statutes and requirements of all regulatory, funding or accrediting bodies.
I. PURPOSE

The purpose of this policy is to define and establish a uniform and consistent approach for handling incidents which occur in the operations of a facility or service.

II. DEFINITIONS

Incidents: Events that are inconsistent with the routine operations of a service or care of a member that are likely to lead to adverse effects.

III. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to ensure member safety and quality of care within the Alliance Network. Alliance will require that Network Providers respond to all level I, II and III incidents according to 10A North Carolina Administrative Code 27G .0603-.0605 and that Alliance responds to all level III incidents in accordance with 10A North Carolina Administrative Code 27G .0605.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure timely reviews of oral or written requests for service authorization.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to ensure timely access to care. Utilization management personnel shall be available during regular business hours to process requests and to communicate with providers, consumers and other stakeholders. All communications and interactions with the affected parties shall be cordial and courteous.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to set forth policy regarding the use of licensed and non-licensed staff in the utilization management process.

II. DEFINITIONS

Certification – authorization for an individual to receive services from an Area Authority provider.

III. POLICY STATEMENT

Alliance Health (Alliance) shall employ licensed clinical staff as well as non-clinical, administrative personnel to perform the utilization management functions required to issue certifications. Alliance shall ensure that licensed clinical staff are available to provide oversight and follow-up of clinically related questions during initial screening activities.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to set forth the standards and criteria used by Alliance Health (Alliance) to determine the medical necessity of service requests submitted by network providers.

II. DEFINITIONS

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

III. POLICY STATEMENT

It is the policy of Alliance to implement objective clinical review criteria to govern all utilization management decisions regarding service authorization requests. These criteria have been developed by North Carolina Medicaid, and are documented in NC Medicaid Clinical Coverage Policies and the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services and are documented in the MH/DD/SA Services Definition manual. The Alliance Clinical Advisory Council is authorized to approve clinical guidelines that can be used during the utilization review process. All Clinical Coverage Policies, Service Definitions and clinical guidelines that are used in the utilization management process shall be made available to providers and consumers.

IV. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to clearly define the standards and procedures for authorizing Medicaid and State funded services.

II. POLICY STATEMENT

It is the policy of Alliance Health (Alliance) to make timely and accurate utilization management determinations and notifications regarding requests for certification of treatment. Determinations and notifications shall be made in accordance with the requirements of the North Carolina Division of Mental Health/Intellectual and Developmental Disability/Substance Abuse Services, North Carolina Medicaid and the external accrediting body, URAC.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

To establish a clear process to ensure that consumers’ federal and state due process rights are protected in regards to service reductions, suspensions, termination and denials.

II. POLICY STATEMENT

Alliance Health (Alliance) shall utilize a formal written process with concrete timeframes to govern appeals of denial, suspension, termination or reduction of service based on medical necessity determinations for all services. In accordance with applicable Federal and State laws, rules and regulations, the process shall make a distinction between appeals filed concerning Medicaid, state-funded and locally-funded services, standard appeals, i.e., cases involving non-urgent care, expedited appeals, and cases involving urgent care. The process shall clearly delineate the steps that may be taken by a consumer or the consumer’s legal representative, or a provider or facility rendering service when the appellant asserts their right to appeal, either in verbal or written form. Written directions on how to file an appeal shall be provided with the decision. The directions shall be written in a manner that meets the health, literacy and linguistic needs of the persons affected by the policy.

III. PROCEDURES

The Chief Executive Officer shall develop procedures to implement this policy.
ITEM: Executive Committee Report

DATE OF BOARD MEETING: September 5, 2019

BACKGROUND: The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. Attached are the draft minutes from the August 20, 2019, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dr. George Corvin, Board Chair; Robert Robinson, CEO
1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 4:04 pm

2. REVIEW OF THE MINUTES – The minutes from the July 16, 2019, meeting were reviewed; a motion was made by Mr. Webley and seconded by Ms. Nelson to approve the minutes. Motion passed unanimously.

### AGENDA ITEMS:

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<tr>
<th>AGENDA ITEMS:</th>
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<th>TIME FRAME:</th>
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<td>3. Finance Topic</td>
<td>Ms. Goodfellow shared about receipt of a recent allocation letter from the State to provide infrastructure and development as part of a partnership venture with Wake Med Hospital to serve individuals exiting the emergency department by creating software to track these individuals; the funds must be used by September 30, 2019. She also mentioned a proposed revision to the policy requiring Board approval of contracts over $250,000; this proposed revision would exclude future allocation letters.</td>
<td>Topic will be covered at the September Finance Committee and Board meetings.</td>
<td>9/5/19</td>
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<td>4. Updates</td>
<td>a) LEGISLATIVE UPDATE: Mr. Perkins and Ms. Wilson shared about recent events at the NC General Assembly and movement to finalize the NC budget. b) EXECUTIVE COMMITTEE MEETING DATES/TIMES: Chair Corvin provided an update from the previous meeting where the Committee discussed changing the date of this Committee’s meetings.</td>
<td>a) None specified. b) Ms. Ingram will post notice for the meeting change per NC Open Meetings Law. c) None specified.</td>
<td>a) N/A b) 8/23/19 c) N/A</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; minutes approved on Click or tap to enter a date.
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<td>A motion was made by Ms. Nelson to change future meetings of Alliance’s Executive Committee to the third Monday of each month starting September 16, 2019. Motion seconded by Mr. McDonald. Motion passed unanimously.</td>
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<td>c) BOARD APPLICANT: Chair Corvin mentioned that the applicant for the vacant Durham seat withdrew her application.</td>
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<td>5. Review Application</td>
<td>Chair Corvin mentioned the receipt of an application for the vacant Wake seat; Committee members reviewed the application and decided by consensus to interview the applicant.</td>
<td>Ms. Ingram will schedule two interviews for the September Committee meeting.</td>
<td>9/16/19</td>
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<td>6. Reappointment Recommendation</td>
<td>Chair Corvin mentioned that two Board members’ terms expire September 30, 2019. COMMITTEE ACTION A motion was made by Ms. Nelson to recommend that the Board requests that the Cumberland Commissioners reappoint Lodies Gloston to Alliance’s Board. Motion seconded by Mr. McDonald. Motion passed unanimously. Chair Corvin mentioned that Chris Bostock is not seeking an additional term; the Board will recognize Mr. Bostock at the September Board meeting.</td>
<td>Topic will be addressed at the September Board meeting.</td>
<td>9/5/19</td>
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<td>7. Review of Conflict of Interest Policy</td>
<td>Ms. Portugal provided a draft revision for the Conflict of Interest policy and requested the Committee’s input.</td>
<td>Topic will be addressed at the September Board meeting.</td>
<td>9/5/19</td>
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<td>8. Agenda for September Board Meeting</td>
<td>Ms. Goodfellow requested adding an additional closed session topic. Committee reviewed the draft agenda and provided input.</td>
<td>Ms. Ingram forwarded the agenda to staff.</td>
<td>8/20/19</td>
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<td>9. NC Open Meetings Law Training</td>
<td>Ms. Wolff provided a training on NC Open Meetings Law to Committee members.</td>
<td>None specified.</td>
<td>N/A</td>
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<td>10. Closed Session COMMITTEE ACTION: A motion was by Ms. Nelson to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1. Motion seconded by Mr. McDonald. Motion passed unanimously. Committee returned to open session.</td>
<td>None specified.</td>
<td>N/A</td>
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11. **ADJOURNMENT:** the meeting adjourned at 5:54 pm; the next meeting will be August 1, 2019, from 3:00 p.m. to 4:00 p.m.
ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: September 5, 2019

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

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

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

The draft minutes and materials from the previous meeting are attached

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Pam Silberman, Committee Chair; Wes Knepper, Director of Quality Management

(Back to agenda)
Thursday, August 01, 2019

BOARD QUALITY MANAGEMENT COMMITTEE - REGULAR MEETING
711 Executive Place, Fayetteville, NC 28305
2:00-3:30 p.m.

APPOINTED MEMBERS PRESENT: ☒Cynthia Binanay, MA, BSN (Board member) by phone, ☒David Curro, BS (Board member), ☒David Hancock, MBA, MPAff (Board member), ☐ Duane Holder, MPA (Board member), ☒Diane Murphy, by phone, ☒Dava Muserallo, by phone, ☒Pam Silberman, JD, DrPH (Board member; Committee Chair)

APPOINTED, NON-VOTING MEMBERS PRESENT: Israel Pattison (CFAC), by phone; Yvonne French, LME Liaison

BOARD MEMBERS PRESENT: George Corvin, M.D. (Board Member)

GUEST(S) PRESENT: None

STAFF PRESENT: Diane Fening, Executive Assistant I; Wes Knepper, Quality Management Director; Doug Wright, Director of Community and Member Engagement; Jose Lopez, Michael Bollini, Executive Vice-President, Chief Operating Officer

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 2:00 pm by Committee Chair Pam Silberman.

2. REVIEW OF THE MINUTES – The minutes from the July 10, 2019, meeting were reviewed and a couple of corrections were made. Diane Murphy was present in person not by phone, and Cynthia was present at last meeting. A motion was made by Cynthia and seconded by Israel to approve the minutes with the changes. The motion passed.

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<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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<td>3. Old Business</td>
<td>QIP Review and Approval (Vote Needed) – there is a requirement that once a year we get all of the QIP's approved. Want to review and get approval to keep moving forward with them.</td>
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<td>4. New Business</td>
<td>Access to Care – getting callers (to our call center) seen within two days for urgent callers and fourteen days for routine callers. We’ve been seeing that more of our members have been accessing care directly through providers. The number of people has gone down dramatically, and percentage has stayed same for routine and gone up for urgent. This is not appointment availability, but people showing up for their appointment. All based on claims data. This measure will probably change dramatically in November when the Standard Plan members leave. Since we can’t know how many routine calls we will get once that happens, we are hesitant to adopt new and different interventions given that this may change. If callers are connected to an existing provider and call us, we will redirect them to their provider. They won’t count towards this measure.</td>
<td>Wes will provide information on how we set the requirements to Pam and the committee.</td>
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<td>Care Coordination QIP- the current goal is for our hospital liaisons to see the consumers face to face while they are in crisis facility prior to discharge. This allows clinicians to strengthen consumer engagement as well as identify and address unmet needs. We switched to new care management platform and</td>
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Thursday, August 01, 2019

BOARD QUALITY MANAGEMENT COMMITTEE - REGULAR MEETING
711 Executive Place, Fayetteville, NC 28305
2:00-3:30 p.m.

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<td>missed some people, but education has been done and should be better now. Wes doesn’t anticipate this initiative changing with the Tailored Plan. Pam asked how we pick the goals. Wes said that some are based on what’s feasible, and some on state benchmarks or contract requirements.</td>
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<td>• Transition to Community Living Initiative – Committee voted to close this last time. We were able to speed up number of people who were housed. This is a dashboard requirement that the State put out that we were not hitting but now we are. Cynthia requested that Wes say whether he anticipates there will be changes due to the Standard Plan for each initiative. There will be another TCLI QIP that we are opening in the next month or so and Wes does not anticipate that one changing with the Tailored Plan.</td>
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<td>• Expedited Care QIP – focused on our utilization management process. Providers serving people coming out of ED or hospital weren’t requesting that as expedited. We process expedited much faster. Goal is to get people seen in less than three days coming out of these settings, so we can address their needs in the community rather than in the facility. This is entirely provider based. We are educating providers to submit as expedited requests. Dava suggested creating a check box through the Alpha portal asking if this person has been released from a hospital or inpatient setting in x amount of time. If it is checked, it would automatically get flagged as an expedited claim. Wes will look into this idea.</td>
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<td>• Upgrade Provider Profiles QIP – increase percent of contacted provider agencies who have a current profile. We have been pushing this, to have accurate provider profiles. This will populate our provider search tool. This may be indirectly impacted by the Standard Plan population leaving. Some providers may not remain in our network. We check on their information every three months to see if anything has changed. Providers can change their information more often than that.</td>
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<td>• Call Center and IDD and TBI Eligibility – this is going through some revisions. Call volume is different from what was expected. This is not a good intervention. What we thought was going to work isn’t. This will be brought back to the committee at a later time. Should have more information on this next month.</td>
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<td>• Improve adverse letters going out to members in a timely fashion QIP was approved at our last meeting. Improve quality of UM decision documentation of adverse letters sent to members.</td>
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<td>• Israel made a motion to keep these QIPs going with the understanding that the Call Center and IDD and TBI Eligibility one will be brought back to discuss at a future meeting. David seconded the motion. The motion passed.</td>
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<td>• <strong>Annual Confidentiality Agreements</strong> - all committee members need to sign these annually. The committee members present were given the forms to sign. Those members on the phone will be given the form at a future date.</td>
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<td>• <strong>Post Closure Analysis of QIPs</strong> – usually these are brought to the committee and the committee approves to close. Over the year following their closing, they are checked to be sure the level is being maintained. Two were checked and they are staying at same level. One was the First Responder QIP-are providers answering their crisis line when we call them. The other is last year's TCLI project-to increase number of people moving in with private landlords who are accepting housing vouchers. Continued to improve. Only two years are left on the DOJ settlement which includes FY20. Part of settlement intent is that the system changes and what has been created be maintained. But the State has to keep funding it to keep it going.</td>
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<td>• <strong>Draft Quality Program Evaluation</strong> – This is done yearly. All data has not been entered yet. It is being done a bit differently this year. We tried to condense it. The committee will be asked to vote on this at next meeting. There are notes now about corrective action (page 9). At the end is an appendix that gives you the call blockage rate for the Call Center. There was a suggestion to have the actual percentage in the columns so that we can see how close or far away we are from goal. This document will be brought back for a vote at the next meeting.</td>
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<td>• There will be a total of three documents that come out. The QM evaluation is the big evaluation of what was done and then the next steps are taken from that and turned into a workplan and a program description for next year. If there are other comments, please email Wes later.</td>
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<td>• <strong>Moving Meeting Time</strong> - the two suggestions were 1:00 on same board meeting date, or on same day of Executive Committee meeting. The Executive</td>
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**NEXT STEPS:**

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<td>• Wes will re-send Israel a copy of this.</td>
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<td>• Wes will add the actual percentage into the columns of the Performance Measures and a visual representation of compliance of measures in the table of contents.</td>
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<td>• After the Executive Committee meeting date is decided, a</td>
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<td>Committee date should be decided soon. Depending on public meeting notice rule, we may have to do it two months from now.</td>
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- **CQI Improvements** – we have to demonstrate that we have cross-departmental engagement to solve these issues. Two big changes have been implemented—the Medical Director has been added as co-chair, and subcommittees have been restructured, moving away from department subcommittees to functional subcommittees. This will allow providers and members to be added on subcommittees and help solve these problems. This is orienting us to position ourselves to NCQA accreditation. The Care Management subcommittee will have providers on it. We are identifying chairs of committees and have a rough sketch of what committees will be doing.

- On this month’s agenda, Wes posted a list of upcoming meetings and what we will be covering.

5. **ADJOURNMENT**: the meeting adjourned at 3:17 pm; the next meeting will be September 5, 2019, from 2:00 p.m. to 3:30 p.m. at the Home office.
ITEM: Reappointment Recommendation

DATE OF BOARD MEETING: September 5, 2019

BACKGROUND: In accordance with the By-Laws of the Board, the terms of some Board members expire September 30, 2019. The matter before the Board is to recommend to the Cumberland Board of County Commissioners the reappointment of Lodies Gloston, whose term expires September 30, 2019; this would be for an additional three-year term.

REQUEST FOR AREA BOARD ACTION: The Board is requested to recommend to the Cumberland Board of County Commissioners the reappointment of Lodies Gloston.

CEO RECOMMENDATION: The Board is requested to recommend to the Cumberland Board of County Commissioners the reappointment of Lodies Gloston.

RESOURCE PERSON(S): George Corvin, MD, Board Chair; Robert Robinson, CEO