MINUTES

PLACE: Alliance Behavioral Healthcare, 4600 Emperor Blvd. Room 208, Durham, NC 27703.

MEMBERS PRESENT: Ann Akland, Dr. George Corvin, Jim Edgerton, Phillip Golden, Dr. Nancy Henley, Ellen Holliman, Michael Page, George Quick, William Stanford, Amelia Thorpe, John Griffin, Vicki Shore, Cynthia Binaynay, and Lascel Webley, Jr., Chairman.

MEMBERS ABSENT: Scott Taylor

GUESTS PRESENT: Yvonne French from DMH/DD/SAS, Denise Foreman from Wake County, Dan Shaw-Durham CFAC, and Frederick Aikers from Heartfelt Alternatives. Also present were the following Cumberland Board Applicants: Robin Berg, Christopher Bostock, Commissioner Kenneth Edge, Lodies Gloston, M. Beth Hogan, Reverend Floyd Johnson, Kaye Lewis, Evelyn Shaw, Pamela Suggs Story, and Angie Vorholt

STAFF PRESENT: Lorrie Beal, Doug Fuller, Kelly Goodfellow, Amanda Graham, Tracy Hayes, Carlyle Johnson, Lena Klumper, Beth Melcher, Monica Portugal, Sean Schreiber, Al Ragland, Hank Debnam, Dr. Janis Nutt and Dr. Khalil Tanas.

1. **CALL TO ORDER:**
   Chairman Lascel Webley, Jr. called the meeting to order at 4:07 pm.

2. **RECOGNITION OF RETIRING BOARD MEMBERS**
   Chairman Webley spoke with mixed emotions is saying thank you and so long to two former board members, John Barry and Barbara Gardner.

3. **ANNOUNCEMENTS**
   A. Introductions of applicants for Cumberland board seats
      Chairman Webley and the Board were gratified by the outstanding response to the three open Board seats for Cumberland County. Seventeen individuals have applied for membership and a number of them were in attendance. The board applicants will be joining Alliance board members at the Executive Committee meeting next Tuesday for short interviews.
   B. Introduction of new HR Director
      Ellen Holliman was pleased to introduce Al Ragland, Alliance’s new Director of Human Resources. Al comes to Alliance with years of extremely valuable private and public experience and he has hit the ground running.
3. **ANNOUNCEMENTS (continued)**

**C. Board Committees**

Chairman Lascel emailed a list of different board committees to all board members. If board members are interested in serving on a committee please email Chairman Webley. Jim Edgerton will chair the Policy Committee also on that committee is Cynthia Binaynay. Dr. Nancy Henley will chair the Quality and Management Committee also on the Committee is Dr. George Corvin and John Griffin. Dr. George Corvin asked that Chairman Webley resend the email with the list of different board committees. Mr. George Quick reminded the board that the Finance Committee meets an hour before the monthly board meetings; also Ann Akland, Jim Edgerton and Phil Golden serve on the Finance Committee. The Human Rights Committee will be chaired Scott Taylor and Cynthia Binaynay will also serve on that Committee.

Ellen Holliman stated that the September Executive Committee is scheduled for Tuesday, September 10, 2013 beginning at 8:30 am with the Cumberland Board applicant interviews starting at 9:30 am. Additionally Ellen Holliman reminded the board that the October Board meeting will include the annual training for the Board and that will begin at 3:00 on Thursday, October 3, 2013. Tracy Hayes, general counsel, will cover the legislation affecting Chapter 122 and all the new legislation that has been passed this year.

**D. Staff Training Event on September 27, 2013**

Chairman Webley reminded the Board that the Staff Training Event is scheduled for September 27, 2013. Staff from all offices will gather in Cary for this off-site event that will include important orientation in preparation for Alliance’s upcoming URAC visit, as well as a variety of team-building activities.

4. **AGENDA ADJUSTMENTS**

Chairman Webley stated that the Board should have received a revised agenda stating that agenda items 11 through 14 will be deferred to the October 2013 meeting. Mr. Dave Richard, DMH Director, will join the Alliance Board meeting for a short discussion.

5. **PUBLIC COMMENT**

There was no public comment.

6. **FINANCE COMMITTEE REPORT**

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. The Finance Committee met at 3:00 pm prior to the regular Board meeting. Draft minutes and financial information from the August 1, 2013 meeting were attached. Reviewed financial statements and ratios meeting the minimum requirements numbers in line for July; scheduled for December auditors will present audit to board members

**CEO RECOMMENDATION**

The Finance Committee Minutes were accepted as presented.
7. **COMMITTEE REPORTS**
   A. Human Rights Committee Report
   B. Consumer and Family Advisory Committee Report
   C. Executive Committee Report
   D. Policy Committee Report

   Chairman Webley stated that the Board received a number of Committee Reports in the Board Packets. There were no questions and the Board accepted as presented.

**CEO RECOMMENDATION**

The Committee Reports were accepted as presented.

8. **CONSENT AGENDA**
   A. Draft Board minutes from the June 6, 2013 Board Meeting
   B. Draft Board minutes from the August 1, 2013 Board Meeting
   C. Annual Review of Board Policies

   A Motion was made by Phil Golden to approve draft board minutes from the June 6, 2013 Board Meeting, draft board minutes from the August 1, 2013 meeting and the Annual Review of Board Policies; seconded by William Stanford. Motion passed.

9. **BOARD POLICIES**

   Monica Portugal, Corporate Compliance Officer, presented to the Board new and revised Board Policies.

   Chairman Webley stated that the Board received the new and revised Board Policies in the Board Packet; he asked if there were any questions regarding the policies; having none, Chairman Webley asked for a Motion.

   A Motion was made by William Stanford to accept the Board Policies as presented; seconded by Dr. Nancy Henley. Motion passed.

10. **CONVERSATION WITH DAVE RICHARD**

    Ellen Holliman welcomed Dave Richard, Director, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and expressed her appreciation that Mr. Richard took the time to discuss the status of the Secretary’s Medicaid reform plan.

    Mr. Richard stated that the state wants to have a different relationship with LME/MCO; no more show and tell meetings, the state wants to have more conversation and dialogue and be on the same page with LME/MCO. He states the Secretary is unwavering in terms of her desire that Medicaid and Division of Mental Health is working together on everything they do. She is engaged in the LME/MCO world having meetings and discussing the performance of systems and to exchange information.

    Mr. Richard feels fortunate that he has been able to meet with state CFACS and providers and has expressed the interest of the State to treat consumers holistically. Because of so many changes he’s been told that the state has a fragile provider network which results in a fragile consumer community.

    Where is the state headed – putting meat to the bones proposal and presenting it to the general assembly? There is an understanding that you can’t dismantle a Mental Health,
Substance Abuse and IDD system without providing a transition plan that provides some stability.

At the end of the day, the State cannot sustain 10 MCOs; it will be less than 5 perhaps 3 or 4. Although there has been LME/MCO mergers that are not contiguous the State is not looking to go forward in that direction. The State will be looking at a more regional system.

11. UM ACTIVITIES AND TRENDS
Sean Schreiber, Chief Clinical Officer, presented to the Board a review of Utilization Management trends and activities.

CEO RECOMMENDATION
The Reports were accepted as presented.

12. PROVIDER NETWORK DEVELOPMENT PLAN
Beth Melcher, Chief of Network Development and Evaluation, presented to the Board the Provider Network Development Plan. The focus of the Plan at Alliance is the development and maintenance of a robust provider network that will respond to the needs of our communities for a wide array of high-quality services. Communication, performance issues and a process to review service network needs.

CEO RECOMMENDATION
The Provider Network Development Plan was accepted as presented.

13. LOCAL BUSINESS PLAN
Lena Klumper, Director of Quality Management, presented to the Board the Local Business Plan.

A Motion was made by Dr. George Corvin to approve the Local Business Plan as presented; seconded by Dr. Nancy Henley. Motion passed.

14. FINAL LEGISLATION REPORT
Tracy Hayes, General Counsel, will present to the Board an overview of Legislative updates.
This agenda item was tabled for the October 3, 2013 meeting.

15. CHAIRMAN'S REPORT
Chairman Webley encouraged all board member to attend the Executive Committee meeting slated for Tuesday, September 10th at 8:05am to engage in a discussion prior to the Cumberland board seat interviews
16. **ADJOURNMENT**
With all business being completed the meeting adjourned at 6:05 pm.

Next Board Meeting
Thursday, October 3, 2013
3:00 – 6:00

Respectfully submitted:


[Signature]

Ellen S. Holliman, Chief Executive Officer

Date Approved

10/3/13
### CUMBERLAND COUNTY BOARD APPLICANTS

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<tr>
<th>Schedule 9/10/13</th>
<th>Name</th>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<td>Eric Ditmore</td>
<td>3686 Linden Road</td>
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<td>28356</td>
<td>910-658-1823</td>
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<td>Kenneth Rogers</td>
<td>Laurel Oak Drive</td>
<td>Fayetteville</td>
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<td>28314</td>
<td>910-384-6659</td>
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<td>Evelyn Shaw</td>
<td>3315 Lake Bend Drive</td>
<td>Fayetteville</td>
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<td>28311</td>
<td>910-476-8179</td>
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<td>Lodies Gloston</td>
<td>2000 Greendale Drive</td>
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<td>28304</td>
<td>910-624-9878</td>
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<td>Robin Berg</td>
<td>9728 Gooden Drive</td>
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<td>910-717-9015</td>
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<td>Sharon Henderson</td>
<td>6208 Castlebrooke Lane</td>
<td>Linden</td>
<td>NC</td>
<td>28356</td>
<td>936-577-7044</td>
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<td>11:00</td>
<td>Kaye Lewis</td>
<td>P.O. Box 40831</td>
<td>Fayetteville</td>
<td>NC</td>
<td>28309</td>
<td>910-425-8786</td>
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<td>Beth Hogan</td>
<td>6200 Falkland Court</td>
<td>Fayetteville</td>
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<td>910-426-5977</td>
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<td>Angie Vorholt</td>
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<td>910-489-8446</td>
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<td>Pamela Suggs Story</td>
<td>631 West Cochran Avenue</td>
<td>Fayetteville</td>
<td>NC</td>
<td>28301</td>
<td>910-286-0783</td>
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<td>Debbie Faircloth</td>
<td>137 E. First Street</td>
<td>Stedman</td>
<td>NC</td>
<td>28391</td>
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<td>Stanley Dodson</td>
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<td>910-486-8143</td>
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<td>Commissioner Kenneth Edge</td>
<td>6874 Towbridge Road</td>
<td>Fayetteville</td>
<td>NC</td>
<td>28306</td>
<td>910-425-0918</td>
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<td>Rev. Floyd Johnson</td>
<td>448 Hallmark Road</td>
<td>Fayetteville</td>
<td>NC</td>
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<td>910-822-0457</td>
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<td>Dr. Martin Chipman</td>
<td>413 Brightwood Drive</td>
<td>Fayetteville</td>
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<td>Nickkia McIntyre</td>
<td>6501 Foxberry Drive</td>
<td>Fayetteville</td>
<td>NC</td>
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<td>910-527-0439</td>
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</table>

* All applications are located on the B drive
Executive Committee
Lascel Webley, Jr., Chairman
Committee meets the 2nd Tuesday of each month.

Finance Committee
George Quick, Chairman
Committee meets 30 minutes prior to the monthly Board Meeting.

Human Rights Committee
Scott Taylor, Chairman
Committee meets every other month. Further details will be provided.

Quality Management Committee
Dr. Nancy Henley, Chairman
Committee schedule may be altered. Further details will be provided.

Policy Committee
TBD, Chairman
The committee will meet November 14, 2013; February 13, 2014; and April 24, 2014.

E. COMMITTEES

1. STANDING COMMITTEES - Annually, the Area Board Chairperson shall appoint committees that are required by law, regulation, accrediting bodies or contract as well as other committees, at the discretion of the Area Board. These committees shall have the responsibility of making policy recommendations to the Area Board regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the relevant statute, regulation or contract requirements. These standing committees shall be as follows:

   a. Finance Committee (NCGS 122C-119 (d))

      i. This committee shall be composed of the Finance member designees of the Area Board plus three other Area Board members. (The Finance Officers of Durham and Wake Counties may serve as ex-officio members)

      ii. The Committee’s functions include:

          1) Recommending policies/practices on fiscal matters to the full Area Board.
          2) Reviewing and recommending budgets to the entire Area Board.
          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. Human Rights Committee (Contract with DMH/DD/SAS)

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

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

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

c. Quality Management Committee (Contract with DMHDDSAS)

i. The Committee shall review statistical data and provider monitoring reports and make recommendations to the full Area Board or other Area Board committees.

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

ii. The Executive Committee shall be composed of the officers of the Area Board, Chairpersons of standing committees (who are Area Board members), the past Board chairperson or at-large members.

iii. The Area Board Chairperson shall serve as the Chairperson of the Executive Committee.

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

iv. 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 Area Board meetings.

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 Area Board.
2) Establish agendas for full Area Board meetings.
3) Act on matters that are time-sensitive between regularly scheduled board meetings
4) Provide feedback to the Area Director concerning current issues related to services, providers, staff, etc.
5) Fulfill other duties as directed by the full Area Board.
2. AD HOC COMMITTEES

   a. Ad hoc committees, may be appointed by the Area Board Chairperson with the approval of a
      majority of the Area 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 Area Board and shall report
      their findings to the Area Board or its committees.

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

NEW COMMITTEE
Policy Committee

This committee shall be composed of up to 6 members of the Area Board and the Corporate Compliance Officer. A chairperson shall be appointed by the Chair of the Area Board.

The Committee’s functions include:
1. Developing, reviewing and revising Area Board By-Laws and Policies that Govern the LME-MCO.
2. Recommending policies to the full Area Board to include all functions and lines of business of the LME-MCO.
3. Reviewing Area Board Policies at least annually, within 12 months of policies’ approval.
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.
ITEM: Finance Committee Minutes from August 1, 2013 meeting

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND:

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. The Finance Committee meets monthly at 3:00 PM prior to the regular Area Board Meeting. The financial statements for the period ending May 31, 2013 and the draft minutes of the August Finance Committee are attached.

REQUEST FOR AREA BOARD ACTION: None

CEO RECOMMENDATION: None

RESOURCE PERSON(S): Ellen Holliman, Kelly Goodfellow, Sara Pacholke
Alliance Behavioral Healthcare
Finance Committee Minutes
August 1, 2013

Members Present: Phillip Golden, BS, Lascel Webley, Jr, MBA, MHA, George Quick, MBA, Jim Edgerton, BS

Members Absent: N/A

Staff Present: Ellen Holliman, BS, Sara Pacholke, BS, CPA, Rob Robinson, LCAS, Doug Fuller

Staff Absent: Kelly Goodfellow, MBA

Opening: Meeting opened by George Quick at 1:08 at Alliance Behavioral Healthcare’s corporate office

Approval of Minutes: Phillip Golden made a motion to approve the minutes from the June 6, 2013 meetings with a second from Jim Edgerton.

Agenda Items

Sara Pacholke presented the May 2013 financial statements and ratios. Explanations were provided for unusual items. Net assets increased compared to the prior month. Alliance currently meets the financial ratios required by Senate Bill 208.

Doug Fuller presented the AV proposal and discussed the different options. The Finance Committee approved the AV items for the Board Room and digital signage.

The year end close and audit were discussed. June financial statements will not be presented until the year is closed and in draft format (unaudited). It was also discussed that going forward Sara Pacholke will present revenue and expenditures compared to budget on a monthly basis along with ratios. On a quarterly basis the balance sheet, income state and cash flows statement will be presented.

The results of the HMS audit were presented: 99.95% of claims were paid within 0-30 days, .05% of claims were paid within 31-60 days, claims processing accuracy is 99.85%, financial accuracy is 99.73%

Meeting adjourned at 2:00 pm.

Respectfully submitted,

Sara Pacholke
Finance Director
### Alliance Behavioral Healthcare

Statement of Revenue, Expenditures and Changes in Net Assets Full Accrual - Budget to Actual

For the Month Ended May 31, 2013

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<th>Original Budget</th>
<th>Q1 Budget</th>
<th>Amendment</th>
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<td>Miscellaneous Revenue</td>
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<td>Medicaid Waiver</td>
<td>165,548,747.00</td>
<td>26,659,178.23</td>
<td>104,355,681.72</td>
<td>59,193,128.28</td>
<td>63.81%</td>
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<td>Total Service Expenditures</td>
<td>219,613,619.20</td>
<td>238,273,113.00</td>
<td>24,983,372.33</td>
<td>164,094,471.49</td>
<td>74,178,641.51</td>
<td>68.87%</td>
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<tr>
<td>Administrative</td>
<td></td>
<td></td>
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<td>Operational</td>
<td>4,534,754.41</td>
<td>12,096,507.00</td>
<td>360,474.08</td>
<td>4,490,181.79</td>
<td>7,606,325.21</td>
<td>37.12%</td>
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<td>Salaries, Benefits, and Fringe</td>
<td>21,768,495.12</td>
<td>19,039,993.00</td>
<td>1,597,166.00</td>
<td>13,790,080.14</td>
<td>5,249,912.86</td>
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<td>Professional Services</td>
<td>5,203,692.32</td>
<td>8,565,255.00</td>
<td>593,079.67</td>
<td>4,438,211.14</td>
<td>4,127,043.86</td>
<td>51.82%</td>
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<td>In Kind Expenses</td>
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<td></td>
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<tr>
<td>Total Administrative Expenditures</td>
<td>31,506,941.85</td>
<td>39,701,755.00</td>
<td>2,922,875.83</td>
<td>23,090,629.15</td>
<td>16,611,125.85</td>
<td>58.16%</td>
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<tr>
<td>Total Expenditures</td>
<td>251,120,561.05</td>
<td>277,974,868.00</td>
<td>27,906,248.16</td>
<td>187,185,100.64</td>
<td>90,789,767.36</td>
<td>67.34%</td>
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<tr>
<td><strong>REVENUES OVER EXPENDITURES</strong></td>
<td>(137,641,846.32)</td>
<td>(165,680,614.00)</td>
<td>6,407,829.85</td>
<td>7,986,195.94</td>
<td>(173,666,809.94)</td>
<td>(4.82%)</td>
<td></td>
</tr>
<tr>
<td><strong>CHANGE IN NET ASSETS</strong></td>
<td>(137,641,846.32)</td>
<td>(165,680,614.00)</td>
<td>6,407,829.85</td>
<td>7,986,195.94</td>
<td>(173,666,809.94)</td>
<td>(4.82%)</td>
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</tbody>
</table>
### ASSETS

**Current Assets**
- Cash and Cash Equivalents: $39,486,354.25
- Due from Other Governments: 16,347,596.32
- Accounts Receivable, Net of Allowance for Uncollectible Accounts: 16,664.96
- Sales Tax Refund Receivable: 67,312.61
- Prepaid Expenses: 51,057.14

**Total Current Assets**: 55,968,985.28

**Property and Equipment**
- Furniture and Fixtures: 615,694.39
- Computer Equipment: 42,932.43
- Vehicles: 21,963.00
- Software: 137,560.00

Less Accumulated Depreciation and Amortization: (117,782.20)

**Property and Equipment - Net**: 700,367.62

**Other Assets**
- Restricted Cash: 2,301,403.00
- Security Deposits: 93,934.99

**Total Other Assets**: 2,395,337.99

**Total Assets**: $59,064,690.89

### LIABILITIES

**Current Liabilities**
- Notes Payable - Current Portion: $800,000.00
- Accounts Payable and Other Current Liabilities: 11,321,077.10
- Accrued Liabilities: 15,370,169.28
- Accrued IBNR: 16,199,338.43
- Deferred Revenue: 187,910.14

**Total Current Liabilities**: 43,878,494.95

**Long-Term Liabilities**
- Notes Payable: 7,200,000.00

**Total Long-Term Liabilities**: 7,200,000.00

**Total Liabilities**: 51,078,494.95

### NET ASSETS

**Invested in capital assets, net of related debt**: 700,367.62

Restricted for:
- Risk Reserve: 2,301,403.00
- Services: 6,724,912.52

Unrestricted: (1,740,487.20)

**Total Net Assets**: 7,986,195.94

**Total Liabilities and Net Assets**: $59,064,690.89
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND:
The Human Rights Committee shall include consumers and family members representing mental health, developmental disabilities and substance abuse.
The Human Rights Committee functions include:
1) Reviewing and evaluating the Area Authority’s Client Rights policies at least annually and recommending needed revisions to the Area Board.
2) Overseeing the protection of client rights and identifying and reporting to the Area Board issues which negatively impact the rights of persons served.
3) Reporting to the full Area Board at least quarterly.
4) Submitting an annual report to the Area Board which includes, among other things, a review of the Area Authority’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).
The Human Rights Committee shall meet at least quarterly.

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

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. The Committee is currently chaired by Mr. Scott Taylor.

REQUEST FOR AREA BOARD ACTION:
Receive the minutes from the June 4, 2013 meeting. Attached to the minutes are the 3rd quarter reports for grievances and incidents.

AREA DIRECTOR RECOMMENDATION:
Receive the minutes.

RESOURCE PERSON(S):
Doug Wright, Scott Taylor, May Alexander
# Human Rights Committee

<table>
<thead>
<tr>
<th>Date/time of meeting:</th>
<th>6/4/2013  4:00pm until 6:00pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Corporate Office</td>
</tr>
<tr>
<td>Members:</td>
<td>Bill Stanford, Scott Taylor, Maribel Rivera-Elias, Marc Jacques, Amelia Thorpe, David Smith, Lascel Webley</td>
</tr>
<tr>
<td>Staff Present:</td>
<td>May Alexander, Doug Wright</td>
</tr>
<tr>
<td>Staff Absent:</td>
<td></td>
</tr>
<tr>
<td>Guest(s):</td>
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</table>

**Approve Minutes from (Date)**

**Follow up Items**

**Documents Provided**
- Agenda, Human Rights Committee Procedures(draft), 3rd Quarter grievance power point, 3rd Quarter incidents power point

**Topic:** Cumberland Merger

**Discussion:**
Mr. Stanford asks Mr. Webley to give his thoughts about the Cumberland County merger and how that related to the committee’s membership. Mr. Webley stated that the Cumberland Commissioners had made a decision to move forward with a merger with Alliance. The process to make that happen has begun with a hopeful finish date of July 1 or as soon as possible after that. That being said, consideration of Cumberland representation on the committee should be given when recommending potential members to him for appointment.
### Human Rights Committee Procedures

**Discussion:**
The previous discussion flowed directly into a discussion about the procedures being presented. There was significant discussion about what the make-up of the committee should be and how it should be defined in the procedures. It was agreed that the membership should be 12 with at least 6 of those not Area Board members and we should have at least 3 Board Members, hopefully one from each county. The membership should be similar to population and we would strive to have at least one member from any county that we have an inter local agreement with. A quorum was defined as the chairman plus 50% of members. A motion to approve the procedures was made by Marc Jacques, seconded by Scott Taylor and approved unanimously.

**Suggestions/Comments:**
Clean up the copy with approved suggestions and send it back out to the membership to review and comment on. A one week window for any additional comments or concerns after the clean copy was sent out was agreed upon.

**Next steps:**
Formally recommend Dan Shaw to the Board Chair.

**Person Responsible:**
Doug Wright

### Membership

**Discussion:**
After agreeing upon what the committee should look like and what it looked like at the present time, a motion was made by Scott Taylor to recommend Dan Shaw from Durham as a potential member to the Board Chair Lascel Webley, the motion was seconded by Marc Jacques, and approved unanimously.

**Suggestions/Comments:**

**Next steps:**

**Person Responsible:**
Bill Stanford

### 3rd Quarter Grievances

**Discussion:**
May Alexander presented the 3rd quarter grievance power point presentation to the committee. (attached) She gave some background information, and then discussed the total number and type of grievances. She explained that we will be
changing the categories to give a more accurate look at the types. She discussed who complained and what it was they complained about. How the complaints were resolved and how long it took to resolve the complaints. We talked about unresolved complaints, why we would have them and that some (anonymous) could never be resolved completely because we don’t have a person to go back to with the resolution. We looked at the top five providers with complaints. Concerns about Alliance being a top five was expressed. We were reminded that many times providers are actually complaining about us and that all complaints were taken seriously and dealt with, many times with training and or supervision. Training opportunities were identified for staff on how to enter a complaint into our system and webinar training is being developed. Trends by population were looked at with an opportunity for training being identified. Lastly we reviewed the nature of grievances.

**Suggestions/Comments:** Continue to fine tune information and data.

**Next steps:** Prepare next quarter report for presentation.

**Person Responsible:** May Alexander

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**Topic:** 3rd Quarter Incidences

**Discussion:** May Alexander presented the 3rd Quarter Incidents Report. (attached) The number of incidents, how many children versus adults and other pertinent statistics were presented. Level 2 and level 3 incidents by population were presented. The additional need for raw numbers was expressed. The definitions of level 2 and 3 incidents were presented.

**Suggestions/Comments:** Add raw numbers as well.

**Next steps:** Prepare next quarter report.

**Person Responsible:** May Alexander

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Next meeting: August 27th  
Meeting room: TBD  
4:00pm – 6:00pm
The grievance process underwent several changes

- Beginning in February, Cumberland and Johnston grievances were handled through the Corporate office.
- The Innovations Waiver began in February.
- Clarification was given by Alliance General Counsel regarding the definition of a grievance (concerns from a consumer or legally responsible person) which significantly changed the response process. Beginning March 19, QM staff followed the statute-defined timeline for issues filed by consumers, their legally responsible person, providers, MCO’s and State agencies. Prior to that they were applying the process to all complaints, even those submitted from MCO staff.
- Supervision of the grievance staff changed in March.
Background:
At the time a grievance is logged, it is placed in the category that best describes the nature of the concern.

Analysis and Trends:
The majority of grievances were logged as complaints, followed by Quality of Care concerns.

Follow up:
Upon review of the nature of concern, from Q2, several adjustments were made to properly categorize items. Also, an additional category of UM quality of care concerns was added to help differentiate between internal and external issues.

Next Steps:
Upon review of these categories, it was determined that no current definitions exist for these terms (they were pre-populated by the Alpha system). Currently, work is being completed to define more applicable categories. It is expected that these will be in use at the beginning of FY 14.
Background:
Alliance Behavioral Healthcare is responsible for addressing grievances related to publicly-funded, behavioral health services. Grievances are logged from consumers, providers, or service team members when dissatisfaction with services is reported.

Analysis and Trends:
Complainant detail is similar to Q2, with consumers filing 50% (Q2) and 49% (Q3) of grievances and MCO staff accounting for 23 and 26%, respectively. It is anticipated that MCO staff reporting may increase as they engage with more providers in the network.

Follow up:
- QM completed work with IDD Care Coordination during the transition to MCO; there was no significant increase in IDD grievances.
- General Counsel has worked with QM staff and grievance procedure changes are underway.
- Alliance departments are addressing concerns as they are able when addressing or filing a complaint.

Next Steps:
Finalize grievance changes in procedures, Alpha and record webinar for staff training.
**Background:**
Detail of areas of concern expressed by consumers*

**Analysis and Trends:**
The majority of complaints were centered on quality of services (29) followed by access to services (12).

**Next Steps:**
Upon review of these categories, it was determined that no current definitions exist for these terms (they were pre-populated by the Alpha system). Currently, work is being done to define more applicable categories. It is expected that these will be in use at the beginning of FY 14.

* included are consumer, consumer advocate, family member, and guardian
**Background:**
Detail of areas of concern expressed by MCO staff

**Analysis and Trends:**
The largest area of concern was care quality specifically quality of services (24), Complaints were also focused on quality of services.

**Next Steps:**
Upon review of these categories, it was determined that no current definitions exist for these terms (they were pre-populated by the Alpha system). Currently work is being done to define more applicable categories. It is expected that these will be in use at the beginning of FY 14.
**Background:**
Previously, this graph looked at each individual service. To present a more comprehensive picture, services were grouped by type.

**Analysis and Trends:**
Of the Enhanced Benefit services the vast majority were related to residential care (37). ACTT was second (15) followed by IIH (13). This breakdown was similar to Q2.

**Follow up:**
QM continues to work with Provider Network to educate providers about quality of care standards.

**Next Steps:**
Based on Committee preference, QM will continue to analyze service type in the manner most useful to MCO departments.
**Background:**
QM staff use various methods to resolve issues.

**Analysis and Trends:**
Ninety (90)% of grievances were resolved by providing technical assistance to complainant or working with the provider for a resolution. This is slightly up from Q2 (85%); unresolved grievances were down from 12 to 7%. Unresolved grievances are predominantly due to lack of accurate contact information for complainants.

**Next Steps:**
Monitor potential trends of agencies receiving repeat technical assistance on similar grievance issues.
**Background:**
Grievances must be resolved within 15 working days (of the date filed), but may be extended if issues require additional attention, or the grievance requires the attention of an external regulatory agency. Frequently QM staff work to resolve the issue within 5 days.

**Analysis and Trends:**
This quarter there was a slight increase from 73 to 77% of issues resolved in 15 days. Those resolved over 30 days were referred out to other agencies. Unresolved grievances decreased from 12% to 7%.

**Follow up:**
Unresolved grievances were reviewed and the majority were unresolved due to the inability to communicate with the complainant.

**Next Steps:**
Monitor resolution trends in Q4 in preparation for system changes in Q1 FY14.
**Background:**
Grievances were reviewed to begin baseline data for the top providers against whom grievances/complaints were filed.

**Analysis and Trends:**
Q3 is the first time that this information has been reviewed.

**Next Steps:**
Currently, no next steps other than to monitor trends.
**Background:**
Previously demographic and population data has not been included; it is now being included because of comments/requests made by several committees during the review of Q2 data.

**Analysis and Trends:**
Baseline information indicates that in half of the cases, target population or age is not reported. Both categories have a “not applicable” or “unknown” option and, therefore, should be completed by staff entering the information.

**Next Steps:**
A webinar training is scheduled to be recorded for staff in Q4. It will address missing information that these reports highlight.
**Background:**
In February 2013 Alliance began serving 4 counties.

**Analysis and Trends:**
Rate of reporting has been graphed based on number of consumers served in each county. If all counties were reporting at the same rate, the line would be flat. Information presented is for 98 of the grievances filed. The other 112 were either not indicated (108) or another county (4). Although in some cases data could have been corrected to show the county, this step was not taken because it could not be applied to all missing information.

**Next Steps:**
This information presents the opportunity for training and education in all of the counties about grievance reporting.
**Background:**
Quality of Services comprised the majority of grievances.

**Analysis and Trends:**
During Q3, issues with available categories in Alpha was resolved. There was a significant increase in quality of services issues. This is not surprising given the transition to four counties, the beginning of the Innovations Waiver, and the number of providers now in the Alliance catchment area. There was a 57% increase between Q2 and Q3 in total grievances.

**Next Steps:**
Nature of grievances will continue to be monitored as part of both DMA and DMH contract reporting. Education and training will continue to be provided to Alliance staff about the definitions of each category to ensure proper categorization. Volume of grievances will continue to be monitored to determine optimal staffing patterns.
Q3 Incident Statistics

- There were 715 incidents occurring for 514 consumers. 417 involved children, 298 adults.
- The highest number of incidents for one consumer was 12.
- Of the consumers with the highest number of incidents (over 5) 8 are children one is an adult.
  - 1 child has changed placements, 1 is no longer receiving services, 1 is receiving a higher level of service, 5 are being addressed within the current service. For the adult the PCP was modified to better support the consumer.
Background: Level 2 incidents are monitored to ensure consumer and community safety.

Trend and Analysis: Q3 data is being presented by population. The lower trend line indicates those types of incidents that occurred in more than .2% of that county’s population served. The upper trend line is only for Consumer Behavior incidents. Those typically occur at a high rate than all others. The percentage used is .4% of that county’s population served. The majority of the Wake County restrictive interventions (75%) are from one day treatment provider. This same provider accounts for 25% of the consumer behaviors. In Durham County, no one provider stood out.

Next Steps: Review incident trends to determine if referral to Provider Account specialists is needed.
**Background:** Level 3 incidents are monitored to ensure consumer and community safety. Information is shared with necessary members of management to ensure a comprehensive clinical and administrative response. 

**Trend and Analysis:** Q3 data is being presented by population. The trend line indicates those types of incidents that occurred in more than .25% of that county’s population served. There are no provider trends related to unknown deaths or abuse/neglect/exploitation in Durham County. In Johnston County one provider stands out related to Staff Abuse with three reported cases. They involved three different staff and two were dismissed. 

**Next Steps:** Review incident trends to determine if referral to Provider Account specialists is needed.
Level 2 & 3 Incident Definitions

- **Level 2 incident categories and behaviors**
  - Consumer Death – Terminal Illness or Natural Cause
  - Restrictive Intervention – Emergency/Unplanned use or planned use that has exceeded authorized limits
  - Consumer Injuries – Any injury that requires treatment by a licensed health professional
  - Allegations of Abuse – Any allegations of abuse, neglect or exploitation including domestic violence
  - Medication Errors – Any error that threatens the consumer’s health or safety
  - Consumer Behavior – Suicidal behavior, sexual behavior (exhibited by the consumer), consumer act (involves aggressive, destructive or illegal act that results in a report to law enforcement that is potentially harmful to the consumer or others), consumer absence (greater than 3 hours over what is specified in the consumer’s plan or requires police contact)
  - Other – Suspension, Expulsion and Fire

- **Level 3 incident categories and behaviors** – all are categorized as any that results in permanent physical or psychological impairment or if there is perceived to be a significant danger to the community
  - Death – Suicide, Accident, Homicide, Unknown
  - Restrictive Intervention
  - Consumer Injury
  - Abuse/Neglect/Exploitation – includes all sexual assaults
  - Medication Error
  - Behavior
  - Other
ITEM: Consumer and Family Advisory Committee (CFAC)  Report

DATE OF BOARD MEETING: September 5, 2013

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, 4600 Emperor Boulevard, Durham. 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.

The Alliance CFAC is currently chaired by Dan Shaw while Maribel Rivera-Elias serves as vice-chair.
REQUEST FOR AREA BOARD ACTION:
Receive the minutes from August, 2013 as well as our recommendations surrounding needs and gaps and the Local Business Plan.

We take very seriously our responsibility to advise you regarding needs and gaps and the Local Business Plan. We have compiled a list of items we hope you will consider as you move forward with your planning process. We have shared this list with Senior Management at Alliance as well. Thank you for your genuine consideration of our concerns.

AREA DIRECTOR RECOMMENDATION:
Receive the minutes and feedback about needs and gaps and the Local Business Plan.

RESOURCE PERSON(S):
Doug Wright, Dan Shaw, Maribel Rivera-Elias
<table>
<thead>
<tr>
<th>Start Time</th>
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<tbody>
<tr>
<td>CFAC Agenda Item</td>
</tr>
<tr>
<td>Welcome</td>
</tr>
<tr>
<td>Minutes approved</td>
</tr>
<tr>
<td>Election of new officers</td>
</tr>
<tr>
<td>Alliance Behavioral HealthCare CFAC held a ballot election for new chair, vice chair, secretary and treasurer. After the collection of ballots it was determined: Chair: J. Dan Shaw Vice Chair: Maribel Rivera-Elias Secretary: Caroline Ambrose Treasurer: Kurtis Taylor</td>
</tr>
<tr>
<td>By Laws</td>
</tr>
<tr>
<td>The bylaws were reviewed and a change on Page 4 Section 8 max number of voting CFAC members was changed to 36 due to the merger of Cumberland with Alliance Behavioral Healthcare was made. The bylaws were then adopted into practice by a unanimous vote.</td>
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<tr>
<td>Community Relations/Crisis and Incarcerations</td>
</tr>
<tr>
<td>James Osborn provided an overview of the Community Relations Department and his current role. Cumberland introduced their only civilian CTI trained community member. James will share Mental Health First Aid and</td>
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<tr>
<td><strong>Mental Health 101 training opportunities with each subcommittee. CFAC members expressed concern that the emergency services dispatchers need to CIT trained in a timelier manner due to staff turnover.</strong></td>
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<td><strong>DMA Director Dave Richards</strong></td>
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</table>
| **Local Business Plan** | Alliance Behavioral HealthCare has begun working on GAPS Analysis, the 2013 Provider Network Profile. The new Business Plan is due to the state by October 31, 2013. CFAC is asked to participate in this process. The plan must be approved by CFAC, ABHC board as well as the local community government. There are five areas that the state requires be addressed:
   1. Assertive community treatment and fidelity to the process
   2. Transition to Community Living (DJJ Settlement)
   3. Enhancement of Crisis Services
   4. Provide services closer to home (PRTFs)
   5. Reduce Wait Lists for IDD-checklist and or provide appropriate B-3 Services
   Alliance Behavioral HealthCare has added three more areas:
   1. Improve Care for complex medical needs
   2. Open Access
   3. Improve diversion from jail and enhance post-jail linkage
   Please send Doug any suggestions/concerns by 8/19/13. |
| **Consumer Empowerment Update** | Roanna Newton shared the Consumer Empowerment update. |
| **Announcements** | 1. Doug shared the Annual report
2. Is ABHC CFAC interested in hosting a Regional/Statewide CFAC meeting? ABHC CFAC endorsed this proposal. The Executive team will begin working on this. Please let Doug or one of the Executive team members know if you are willing to help plan this. |
3. The Durham Subcommittee will meet at the TROSA site on James Street on September 16, 2013—5:30-7:15.
4. September is National Recovery Month.

Subcommittees Report

Next meeting August 6, 2012
Local Business Plan, Needs and Gaps Feedback from CFAC  
August 21, 2013

Needs and Gaps

- Peer Support Services – this was an area that was mentioned over and over again, consumers believe in this service, are trained to provide the service, but the real opportunities are not there.
- Peer Respite
- Preventive Services
- Family Dynamics Training
- Housing First – Residential options come up often regardless of disability, especially in rural areas, but not limited to rural.
- Recovery Oriented Services
- Child Inpatient – Cumberland
- Substance Use Disorder Services/Engagement
- Training and Education – How do people advocate for themselves especially when it seems they hit brick walls.
- Children Services (Johnston) – local crisis placements as well as effective therapy
- I/DD Transition Services for Children/Adults – no real hope or services or places to live coming out of hospital
- I/DD Support Groups
- Transportation – especially rural, the little things make such a big difference, getting medicine or food or making appointments, a whole lot cheaper than serving someone in crisis.
- Detox – Johnston County
- Daily Living Supports – similar to tenancy supports
- Wards of the State – How is their voice heard, could and should CFAC engage DSS and other agencies that are guardians to get input in general about needs and services.
- Crisis Services – Johnston County
- 3-Way Beds
- Options other than Holly Hill in Wake County
- Monitoring of Providers

Local Business Plan

**Recovery Oriented** – as an organization you get that recovery happens, is real, but the services are still for the most part aimed at crisis and maintenance. Recovery Oriented System of Care is more about living life to the fullest not just surviving. Help people stay well!

**Peer Support Supervisor Training** – DOJ, ACTT, SE all have a peer component that is not done well in most cases, not because of desire, but people are not trained to value and respect peer roles.

**Providers** – continue our work towards standardization and continue to work hard on building a sustainable network of quality providers as well as recognizing the importance of those open and supportive relationships with our providers.

**Housing First** – This is certainly not a new issue but one that was heard loud and clear, when people don’t have housing options available, they usually continue to cycle through our system.
**Peer Support** - Would like to see the implementation of more peer support specialists in all aspects of care in the mental health industry. This would help with making more informed and consumer driven decisions about care versus clinical decisions that may or may not have the clients' best interests at heart.

**DOJ** - To be clearer if you are including only what is required by the DOJ Mandate (aka those living in IMDs) or if you are thinking more expansively to include other people who have other types of disabilities (IDD/ SA/ other sub-categories)

**Family Inclusion** - Due to needs in Family Dynamic Training across the region and disabilities and throughout the initiatives listed, it would be nice to more specifically address either here or in another document how to meet this need so families can see their role and know which initiatives involve them more clearly and benchmarks can be created in the timelines of each.

**Measurement** - Sounds like new measures will be established and so it would be helpful if more detail was provided on this process.

**Military** - Due to the large military and veteran family presence in Cumberland County, it may be helpful to increase communications with military leadership to determine how Alliance BHC and military/VA BH systems can work together to address BH crises in military/veteran families that occur outside of the installation. One Example: A clear cut method, outside of bogging down the emergency room at CFVMC, for referral or access to substance abuse detoxification services for members of the community that are not indigent or Medicaid recipients.

**Providers** – Concerns have been expressed that good providers may go by the wayside if we aren’t careful in the way we right size our network and if we don’t work hard to standardize and work with the providers, then services may not be available or at least not the quality of service we need.

**Access** – Can bed utilization be enhanced by using out of county consumers to fill empty beds, ex. Johnston County consumer going to Durham Center Access for detox?

**I/DD Registry of Unmet Needs** – How can it be cleaned up, the need for emergency slots.
ITEM: Executive Committee Report

DATE OF BOARD MEETING: September 5, 2013

REQUEST FOR AREA BOARD ACTION:
The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Attached is the Executive Committee Report from the July 9, 2013 meeting.

CEO RECOMMENDATION:
Accept this report.

RESOURCE PERSON(S):
Ellen Holliman
## Executive Committee Report

**Date:** July 9, 2013  
**Present:** Lascel Webley, Phil Golden, Bill Stanford, Scott Taylor, Barbara Gardner  
**Staff:** Ellen Holliman, Rob Robinson,

<table>
<thead>
<tr>
<th>Topic:</th>
<th>Data:</th>
<th>Action Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Items:</td>
<td>Meeting was called to order by Lascel Webley.</td>
<td></td>
</tr>
<tr>
<td>Approve Minutes:</td>
<td>Bill Stanford made the motion to approve the June 11, 2013 minutes. Scott Taylor seconded. Motion passed.</td>
<td></td>
</tr>
<tr>
<td>Cumberland County merger</td>
<td>Ms. Holliman reported the Cumberland County merger went smoothly as all the Cumberland staff participated in the staff orientation. The Secretary’s approval has not been received as of this date. Note: the approval letter was received on Wednesday, July 10, 2013.</td>
<td></td>
</tr>
<tr>
<td>Interview of applicant to fill the Johnston County seat</td>
<td>Board members had the opportunity to interview Ms. Vicki Shore from Johnston County. Ms. Shore recently retired after working over 37 years from a Johnston County non-profit that served individuals with IDD. Ms. Shore will be recommended for appointment at the August meeting.</td>
<td></td>
</tr>
<tr>
<td>Board selection process</td>
<td>The merger agreement states that Alliance will advertise, interview and make recommendations to the respective boards of commissioners for board appointments. Ms. Holliman will contact the county managers in Wake and Cumberland to inquire about any commissioner appointments before moving forward on advertising.</td>
<td></td>
</tr>
<tr>
<td>Mecklenburg request</td>
<td>Ms. Holliman told the EC that there have been no new developments with Mecklenburg. At this point, it appears that Mecklenburg may move forward with developing an area authority and separating from the county.</td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td>Notes</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UNC Certificate of Need</td>
<td>Rob Robinson presented a request from UNC for a Letter of Support for the addition of 16 Residential Treatment beds on the WakeBrook Campus in Wake County. The Board previously agreed to provide a Letter of Support for UNC for the same service just at a different location within WakeBrook campus. The change of location, even though it is within the same location/facility, requires a Letter of Support from Alliance.</td>
<td>This item will be placed on the consent agenda for the August meeting.</td>
</tr>
<tr>
<td>FY 14 Board Retreat</td>
<td>Amanda Graham joined the committee to discuss the Board Retreat that is scheduled for August 1, from 2:00-5:00 prior to the regular board meeting. The purpose of the retreat is to strengthen the board effectiveness to better position Alliance for the future. An email will be sent to the members asking them to rate the items from the 2013 Board Survey. The 3-5 highest priorities will be discussed at the retreat. The members also discussed board orientation and how we need to plan for the School of Government to provide board training for new members and a refresher for the current members. Ms. Holliman will follow-up.</td>
<td></td>
</tr>
<tr>
<td>August 1, 2013 board agenda</td>
<td>The board approved the agenda to include the following items: vote on the Johnston board seat, oath of office for Ms. Shore, staff survey, overview of the service system and updates on new legislation and the Wake divestiture. Ms. Holliman requested input from board members on any agenda items for FY 14 board meetings. This request will be sent to all board members.</td>
<td></td>
</tr>
</tbody>
</table>
June 28, 2013

Tammie Stanton
Post Acute Services, UNC Healthcare
101 Manning Drive
Chapel Hill, NC 27514

Re: LME Letter of Support
University of North Carolina Hospitals at Chapel Hill d/b/a UNC Health Care Addiction
Treatment Center at WakeBrook
107 Sunnybrook Road, Suite A, Raleigh, NC 27610
10A N.C. Admin. Code § 27G.3400 (residential rehabilitation facility)

Dear University of North Carolina Hospitals at Chapel Hill:

N.C.G.S. §122C-23.1 requires prospective providers of residential services to submit a letter of support from the Local Management Entity in whose catchment area the facility will be located with their license application to the Division of Health Service Regulation.

The purpose of the provision is to protect the general welfare and lives, health, and property of the people of the State of North Carolina, to verify that additional beds are needed in the LME’s catchment area, to ensure that unnecessary costs to the State do not result, that residential treatment facility beds are available where needed, and that individuals who need care in residential treatment facilities may have access to quality care.

In accordance with N.C.G.S. 122C-23.1: Licensure of Residential Treatment Facilities, Alliance concludes the following:

<table>
<thead>
<tr>
<th>Number of Existing Beds for Same Type of Facility:</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Need for Additional Beds of Same Type:</td>
<td>Alliance has determined that there is a need for this type of facility in Wake County</td>
</tr>
</tbody>
</table>

Based on data available on this date, there is a need for additional residential rehabilitation beds under 10A N.C. Admin. Code § 27G.3400 for individuals of all disability groups who are age 18 and older in the Alliance Behavioral Healthcare (Wake County) catchment area.

This letter is not intended as an endorsement of the quality of the service nor is it to be interpreted as a guarantee of contract, referrals, business, or occupancy of the beds for the provider. Data utilized is current as of the date of the letter and subject to change.

Sincerely,

[Signature]

Robert Robinson, Chief Operations Officer
Alliance Behavioral Healthcare

cc: Ellen Holliman, CEO, Alliance Behavioral Healthcare
    Sandee Resnick, DMH/DD/SAS Accountability
    Stephanie Gilliam, DHSR, MH Licensure & Certification Section
ITEM: Policy Committee Minutes

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND:
The Committee’s functions include:
1. Developing, reviewing and revising Area Board By-Laws and Policies that Govern the LME/MCO.
2. Recommending policies to the full Area Board to include all functions and lines of business of the LME/MCO.
3. Reviewing Area Board Policies at least annually, within 12 months of policies’ approval. The 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.

REQUEST FOR AREA BOARD ACTION:

Review Board Policy Committee minutes from two meetings: 7/11/2013, 8/15/2013

AREA DIRECTOR RECOMMENDATION:

RESOURCE PERSON(S):
Lascel Webley Jr., Policy Committee member
Monica Portugal, Corporate Compliance Officer
<table>
<thead>
<tr>
<th>Committee name:</th>
<th>Board Policy Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting date:</td>
<td>7/11/13</td>
</tr>
<tr>
<td>Report submitted by:</td>
<td>Lascel Webley Jr., Board Chair on behalf of Barbara Gardner</td>
</tr>
<tr>
<td>Members:</td>
<td>Barbara Gardner (Chairperson, Policy Committee), Lascel Webley Jr. (Chairperson Area Board; Member, Board Policy Committee)</td>
</tr>
<tr>
<td>Members Present:</td>
<td>Barbara Gardner, Lascel Webley Jr.,</td>
</tr>
<tr>
<td>Members Absent:</td>
<td>N/A</td>
</tr>
<tr>
<td>Staff:</td>
<td>Monica Portugal (Corporate Compliance Officer, Staff Support, Board Policy Committee)</td>
</tr>
<tr>
<td>Minutes from (Date)</td>
<td>N/A</td>
</tr>
<tr>
<td>Follow up Items</td>
<td>N/A</td>
</tr>
<tr>
<td>Announcements</td>
<td>Welcome and Introductions conducted by Barbara Gardner</td>
</tr>
<tr>
<td>Documents Provided</td>
<td>Agenda, Board Policies, Board Policy Index,</td>
</tr>
</tbody>
</table>

### Non-Report Topic

<table>
<thead>
<tr>
<th>Discussion: role of Board Policy Committee (BPC); organization and meeting schedule; procedure for the BPC</th>
</tr>
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<tbody>
<tr>
<td>The Committee discussed the role and organization of the Board Policy Committee (BPC), meeting schedule and whether or not to have written procedures or a committee description to outline the membership and responsibilities of the Committee.</td>
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</table>

### Brief description of Topic

**A.** It was determined that the Committee’s function includes:

1. Developing, reviewing and revising Area Board By-Laws and Policies that Govern Alliance Behavioral Healthcare (Alliance).
2. Recommending policies to the full Area Board to include all functions and lines of business of Alliance.
3. Reviewing Area Board Policies at least annually, within 12 months of policies’ approval.
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.

**B.** Meetings will occur quarterly, with the understanding that additional meetings may be called if there are urgent requests for new policies or
revisions to existing policies. Examples of urgent requests may be changes in regulations or contractual requirements which necessitate timely revisions in order for Alliance to be in compliance with such changes.

C. A suggestion was made to increase the membership to 4-5 Board members with a reasonable effort to represent each county.

D. The Committee decided to develop a procedure or Committee description for the BPC outlining the responsibilities, membership, meeting schedule, etc.

**Next steps:**

Monica Portugal will draft a Committee Description and send to the Committee for review. Lascel Webley, Jr. will request volunteers for the Policy Committee at the next Board meeting.

<table>
<thead>
<tr>
<th>Non-Report Topic</th>
<th>Annual Review of Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief description of Topic</strong></td>
<td>Alliance Area Board Policy on <em>Development of Policies and Procedures</em> states that Policies must be reviewed by the Area Board at least annually. URAC Standards says the same and define annually as no longer than 12 months from the month of approval.</td>
</tr>
<tr>
<td><strong>Suggestions/Comments</strong></td>
<td>Meetings were scheduled for: August 15, 2013, November 14, 2013, February 13, 2014, and April 24, 2014. The quarterly meetings will allow the Committee to divide up all Board Policies into four equal groups of policies to review as part of the annual review. Reviewed policies will be reported to the full Area Board as part of the consent agenda. Policies that need revisions will be distributed as part of the Board Packet to the members of the Area Board, to be discussed at the next Area Board meeting. The same process will be implemented for new policies.</td>
</tr>
<tr>
<td><strong>Next steps:</strong></td>
<td>Monica Portugal will send to the Committee a proposed schedule for annual review, including a list of policies to be reviewed at each meeting for FY14.</td>
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</table>

<table>
<thead>
<tr>
<th>Non-Report Topic</th>
<th>Policies for Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief description of Topic</strong></td>
<td>The Committee reviewed and made suggested revisions to the <em>Development of Policies and Procedures</em> policy. Revisions included clarification of definitions.</td>
</tr>
<tr>
<td><strong>Suggestions/Comments</strong></td>
<td>The Committee will send suggested changes to the Area Board for review and discussion.</td>
</tr>
<tr>
<td><strong>Next steps:</strong></td>
<td>Using track-changes, Monica Portugal will make suggested revisions and send to the Committee for review before sending to the Board.</td>
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<table>
<thead>
<tr>
<th>Non-Report Topic</th>
<th>Meeting adjourned</th>
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<tbody>
<tr>
<td><strong>Brief description of Topic</strong></td>
<td></td>
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<tr>
<td><strong>Suggestions/Comments</strong></td>
<td></td>
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<tr>
<td><strong>Next steps:</strong></td>
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</tbody>
</table>

Next meeting will be August 15, 2013 at 4:00 pm to 6:00 pm in room 237.
Committee name: Board Policy Committee
Meeting date: 8/15/13
Report submitted by: Lascel Webley Jr., Board Chair
Members: Lascel Webley Jr. (Chairperson Area Board; Member, Board Policy Committee)
Members Present: Lascel Webley Jr.,
Members Absent: N/A
Staff: Monica Portugal (Corporate Compliance Officer, Staff Support, Board Policy Committee)
Minutes from (Date) 7/11/2013 minutes reviewed and approved by Lascel Webley, Jr.
Follow up Items N/A
Announcements None
Documents Provided Agenda, Board Policy Index, Governance (14) and General Administrative (6) Policies

Non-Report Topic Annual Review: Governance, General Administrative
Brief description of Topic The Committee reviewed 13 Governance policies and 6 General Administrative policies.

Suggestions/Comments
A. The following Governance Policies were reviewed without revisions:
   1. Area Board member Meeting Attendance Compensation
   2. Area Director Compensation
   3. Evaluation of Area Director
   4. Area Board Member Code of Ethics
   5. Consumer, Family Advisory Committee
   6. Delegation of Authority to the Area Director
   7. Guidelines for Public Comment at Area Board meetings
B. The following General Administrative Policies were reviewed without revisions:
1. Reporting of Abuse, Neglect, Dependency and Exploitation
2. Health and Safety
3. Emergency Management Plan
4. Internal Control

C. The following Governance Policies were reviewed and suggested revisions were made:
   1. Area Board Conflict of Interest
   2. Area Board Processes
   3. Development of Policies and Procedures
   4. Area Board Media Policy
   5. Appeals of Area Authority Decision (suggest to repeal based on changes in the law effective 8/23/2013 this policy)
   6. Dispute Resolution (replaces Appeals of Area Authority Decision)
   7. Area Authority Relations with Catchment Area County Boards of Commissioners

D. The following General Administrative Policies were reviewed and suggested revisions were made:
   1. Management of Service Delivery
   2. Strategic Planning

Next steps:
Reviewed policies will go as a consent agenda item for approval at the next Board meeting. Revised policies will either go to the next Board meeting as a consent agenda item (if changes do not substantially change the content of the policy) or as an agenda item for the Board to review and discuss.

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<tr>
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<tbody>
<tr>
<td>Brief description of Topic</td>
<td>The Committee reviewed policies submitted by staff including revisions for review and consideration by the Committee.</td>
</tr>
<tr>
<td>Suggestions/Comments</td>
<td></td>
</tr>
<tr>
<td>A. Business Operations Policies with suggested revisions:</td>
<td></td>
</tr>
<tr>
<td>1. Accounting by Funding Source</td>
<td></td>
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<tr>
<td>2. Accounting Manual</td>
<td></td>
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<tr>
<td>4. Purchasing (new)</td>
<td></td>
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<tr>
<td>B. Information Technology Policies with suggested revisions:</td>
<td></td>
</tr>
<tr>
<td>1. Information Technology Business Continuity Plan</td>
<td></td>
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<tr>
<td>2. Service Codes</td>
<td></td>
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<tr>
<td>C. Utilization Management Policies with suggested revisions:</td>
<td></td>
</tr>
<tr>
<td>1. Financial Eligibility (new)</td>
<td></td>
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</tbody>
</table>
Next steps:
Revised policies will either go to the next Board meeting as a consent agenda item (if changes do not substantially change the content of the policy) or as an agenda item for the Board to review and discuss.

Non-Report Topic
Meeting adjourned

Brief description of Topic

Suggestions/Comments

Next steps:

Next meeting will be November 14, 2013 at 4:00 pm to 6:00 pm in room 237.
ITEM:  Consent Agenda

DATE OF BOARD MEETING:  September 5, 2013

REQUEST FOR AREA BOARD ACTION:
   A.  Approve the draft minutes from the June 6, 2013 Board meeting.
   B.  Approve the draft minutes from the August 1, 2013 Board meeting.
   C.  Annual Review of Board Policies.

CEO RECOMMENDATION:
Approve the Consent Agenda as presented.

RESOURCE PERSON(S):
Ellen Holliman
Ann Burns
DRAFT MINUTES

PLACE: Alliance Behavioral Healthcare, 4600 Emperor Blvd. Room 208, Durham, NC 27703.

MEMBERS PRESENT: Ann Akland, Cynthia Binanay, Dr. George Corvin, George Quick, Barbara Gardner (via phone), Phillip Golden, Dr. Nancy Henley, Ellen Holliman, William Stanford, Scott Taylor, John Griffin (via phone), Amelia Thorpe and Lascel Webley, Jr., Chairman.

MEMBERS ABSENT: Michael Page, Jim Edgerton, and John Barry.

GUESTS PRESENT: Dr. Peggy Terhune and Kara Froberg from Monarch, Janis Nutt and Vicki Shore from Johnston County, and Denise Foreman from Wake County.

STAFF PRESENT: Doug Fuller, Kelly Goodfellow, Amanda Graham, Tracy Hayes, Carlyle Johnson, Pamela Norton, Ann Oshel, Sara Pacholke, Monica Valiria Willis, Doug Wright, and Rob Robinson.

1. CALL TO ORDER:
   Chairman Lascel Webley, Jr. called the meeting to order at 4:05 pm.

2. ANNOUNCEMENTS:
   Chairman Webley made the following announcements:
   
   A. According to the bylaws there will not be a meeting in July; therefore the group will reconvene on Thursday, August 1, 2013.
   
   B. Johnston County has a vacant Board seat. The two applicants we have are Vicki Shore and Timothy Moore. Mr. Moore will be interviewed at the June Executive Committee meeting and Ms. Shore will be interviewed at the July meeting.

3. AGENDA ADJUSTMENTS:
   Chairman Webley added an update that Item 12, the Results of the Workplace Survey, will be suspended until the August Board meeting.

4. OATH OF OFFICE FOR CYNTHERIA BINANAY:
   Chairman Webley administered the oath of office to new MCO Board Member Ms. Cynthia Binanay.
5. **PUBLIC COMMENT:**
None

6. **DR. PEGGY TERHUNE, MONARCH CEO:**
Monarch CEO Dr. Peggy Terhune and Monarch Clinical Operations Director Kara Froberg presented the Board with an overview of Monarch’s past, present and future. Monarch has recently submitted an RFP which was selected to provide adult outpatient services to consumers in the catchment area and those previously served by Wake Behavioral Health.

   No Motion needed.

7. **FINANCE COMMITTEE REPORT:**
The Finance Committee met at 3:00 p.m. prior to the regular Area Board meeting. George Quick gave an overview of the finance position of the organization. Draft minutes from the May 2, 2013 meeting are attached. Kelly Goodfellow, Chief Financial Officer, presented the Board with the budget amendment for Fiscal Year 2013.

   A motion was made by George Quick to approve the FY13 Budget Amendment as presented; seconded by Dr. Nancy Henley. Motion passed.

8. **APPROVE FY-14 BUDGET:**
Kelly Goodfellow, Chief Financial Officer, presented the Board with the recommended budget for Fiscal Year 2014 for approval. Ms. Goodfellow identified changes between recommended budget and the approved budget.

   A motion was made by George Quick to approve the FY14 Budget as presented; seconded by Phillip Golden. Motion passed.

9. **COMMITTEE REPORTS:**
   A. Quality Management Report
   B. Executive Committee Draft minutes

   No motion required.

10. **CONSENT AGENDA:**
   A. Draft Board minutes from the April 24, 2013 Board Meeting
   B. Draft Board minutes from the May 2, 2013 Board Meeting
   C. Revised HR Policies

   A motion was made by John Griffin to approve the Board minutes from April 24, 2013 and May 2, 2013 along with the revised HR policies; seconded by Bill Stanford. Motion passed.
11. **UPDATES:**
Tracy Hayes, General Counsel, provided an update on Senate Bill 208; it will be on the floor to be voted upon in the coming days.

Ellen Holliman, Chief Executive Officer, updated the Board on Daymark as they will not be able to fulfill their obligation to provide crisis services. Carlyle Johnson provided a quick update on the Wake Divestiture Plan and transitions.

*No motion required.*

12. **PRESENTATION ON STAFF SURVEY:**
Postponed until August Board meeting.

13. **STRATEGIC PLANNING:**
Amanda Graham, Medicaid Program Director, shared details from Senior Management staff’s two-day strategic planning session held on May 16-17. Staff focused their efforts on clearly identifying the various structural and functional components which comprise Alliance. An overview of the process was shared along with a list of positive outcomes.

*No Motion required.*

14. **ANNUAL APPROVAL OF CORPORATE COMPLIANCE PLAN FOR FY14:**
Monica Portugal, Corporate Compliance Officer, presented revisions to the Compliance Plan to the Board revisions of the Compliance Plan and consider approval by the Executive Committee in June.

A motion was made by George Quick to approve revisions to the Compliance Plan; seconded by Scott Taylor. Motion passed.

15. **CUMBERLAND COUNTY MERGER:**
The Cumberland Board of County Commissioners passed a motion to pursue a merger between the Cumberland County LME and Alliance Behavioral Healthcare. The merger agreement and supporting attachments was presented to the Board for approval. The merger is expected to be effective July 1, 2013.

A motion was made by Scott Taylor to approve corrections to the merger agreement; seconded by Bill Stanford. Motion passed.

16. **CLOSED SESSION:**
Chairman Webley called for a closed session in accordance with N.C.G.S. § 143-318.11(a)(3) at 6:18pm.
A Motion was made by George Quick to return to open session; seconded by George Corvin. Motion Passed and the Board Meeting returned to open session at 7:05pm.

The Board evaluated the performance and salary of Ellen Holliman, Chief Executive Officer.

A Motion was made by Barbara Gardner to approve an increase in pay to $165,000 for Ellen Holliman retro-active to April 1, 2013; seconded by Dr. Nancy Henley. Motion Passed.

17. ADJOURNMENT:

With all business being completed the meeting was adjourned at 7:10pm.

Respectfully submitted:

[Signature]

Ellen S. Holliman, Chief Executive Officer          Date Approved
WHEREAS, the annual budget ordinance for FY 2012 - 2013 was approved by the Alliance Behavioral Healthcare Area Board on June 26, 2012;

WHEREAS, on November 1, 2012, the Alliance Behavioral Healthcare Area Board adopted a budget ordinance making appropriations in such sums that the Board considers sufficient and proper in accordance with G.S. 159-13;

WHEREAS, on June 6, 2013, the Alliance Behavioral Healthcare Area Board adopted a budget ordinance making appropriations in such sums that the Board considers sufficient and proper in accordance with G.S. 159-13;

BE IT ORDAINED by the Alliance Behavioral Healthcare Area Board that for the purpose of operations for the Durham and Wake LME/MCO, for the fiscal year beginning July 1, 2012 and ending June 30, 2013, the appropriated funds are hereby being amended per G.S. 159-15 by the following function:

Section 1: General Fund Appropriations
LME/MCO Administration $ 24,346,563
Medicaid Services $ 142,241,650
State Services $ 39,565,775
Local Services $ 21,199,987
Grant funded Services $ 276,800
Implementation Expenses $ 8,690,214
TOTAL $ 236,320,989

Section 2: General Fund Revenue
LME/MCO Administration $ 24,346,563
Medicaid Services $ 142,241,650
State Services $ 39,565,775
Local Services $ 21,199,987
Grant funded Services $ 276,800
Implementation Funds $ 8,690,214
TOTAL $ 236,320,989
INTERLOCAL AGREEMENT BETWEEN ALLIANCE BEHAVIORAL HEALTHCARE, CUMBERLAND COUNTY AREA AUTHORITY AND THE CUMBERLAND COUNTY BOARD OF COUNTY COMMISSIONERS TO CONSOLIDATE ALLIANCE AND THE CUMBERLAND AREA AUTHORITY INTO A MULTI-COUNTY AREA AUTHORITY FOR THE MANAGEMENT OF MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITY AND SUBSTANCE ABUSE SERVICES IN CUMBERLAND, DURHAM AND WAKE COUNTIES

AGREEMENT

This INTERLOCAL MERGER/CONSOLIDATION AGREEMENT (“Agreement”) is made and entered into by and between Alliance Behavioral Healthcare, Cumberland County Area Authority for Mental Health, Developmental Disabilities and Substance Abuse Services (“Cumberland Area Authority”) and Cumberland County (“Cumberland”) (collectively, the “Parties”).

WITNESSETH:

WHEREAS, Cumberland Area Authority is a single-county Area Authority/Local Management Entity (“LME”) organized and operating in accordance with N.C. Gen. Stat. §122C-115.1; and

WHEREAS, Cumberland County is one of the 100 North Carolina Counties as set forth in N.C. Gen. Stat. §153A-10, with all the rights and powers attendant thereto; and

WHEREAS, Alliance Behavioral Healthcare (“Alliance”) is a multi-county Area Authority/LME operated by a Board of Directors appointed by the Wake and Durham County Boards of County Commissioners in accordance with N.C. Gen. Stat. §122C-115.1; and

WHEREAS, Alliance was formed by the July 1, 2012 merger and consolidation of Wake County Area Authority for Mental Health, Developmental Disabilities and Substance Abuse Services (“Wake LME”) and Durham County Area Authority for Mental Health, Developmental Disabilities and Substance Abuse Services (“The Durham Center”) and is responsible for managing publicly-funded mental health, intellectual/developmental disability and substance abuse (“MH/I-DD/SA”) services in Durham and Wake Counties; and

WHEREAS, The Durham Center, Cumberland Area Authority and the Johnston County Area Authority for Mental Health, Developmental Disabilities and Substance Abuse Services entered into an Interlocal Agreement in September 2011 whereby The Durham Center was designated as the Lead LME for purposes of operating as a risk-based Medicaid Managed Care Organization (“MCO”) and administering MH/I-DD/SA services in Cumberland, Durham and Johnston Counties; and

WHEREAS, Alliance is the successor in interest to The Durham Center, and entered into Contracts with the Division of Medical Assistance (“DMA”) and the Division of MH/DD/SA of the North Carolina Department of Health and Human Services (“NCDHHS”) to operate a Prepaid Inpatient Health Plan (“PIHP”) in accordance with the 1915 b/c Medicaid Waiver and
42 CFR Part 438, and to manage and administer publicly-funded MH/I-DD/SA services in Cumberland, Durham, Johnston and Wake Counties; and

WHEREAS, Alliance and the Cumberland Area Authority entered into a Subcontract for Cumberland Area Authority to perform certain of the delegated functions of the 1915 b/c Medicaid Waiver Contract, including but not limited to local Care Coordination and Community Relations, and reimburses Cumberland Area Authority for certain staff costs associated with performance of those functions; and

WHEREAS, considering geographic proximity, similar urban composition and issues, working relationships, organizational values, advantages to providers and consumers, and cost efficiencies, the Alliance Board of Directors and the Cumberland County Board of County Commissioners believe that it is in the Parties’ best interests to combine the Alliance and Cumberland catchment areas and consolidate Cumberland Area Authority into the Alliance multi-county Area Authority operating as a political subdivision of the State of North Carolina and organized under N.C. Gen. Stat. §122C-115.1, to manage publicly-funded MH/I-DD/SA services for Cumberland, Durham and Wake Counties; and

WHEREAS, the terms of this Agreement are intended to establish the process whereby the Parties will consolidate the single-county Cumberland Area Authority into the multi-county Alliance Area Authority; and

WHEREAS, the Boards of County Commissioners of Cumberland, Durham and Wake Counties intend to consolidate Cumberland Area Authority into the Alliance multi-county Area Authority consistent with the governance outlined in N.C. Gen. Stat. § 122C-115.1, contingent upon satisfaction of terms outlined in this Agreement and upon each county’s respective execution of a resolution approving this Agreement; and

WHEREAS, the Parties have the authority to enter into this Agreement pursuant to N.C. Gen. Stat. §122C-115.1 and N.C. Gen. Stat. §160A-461.

NOW THEREFORE, in consideration of the mutual promises and considerations set forth herein, the Parties do covenant and agree as follows:

1. **Purpose:** The parties enter into this Agreement for the purpose of consolidating the single-county Cumberland Area Authority into the multi-county Alliance Area Authority, which shall continue to manage the provision of high-quality, cost-effective MH/I-DD/SA services to individuals in the Cumberland, Durham and Wake County catchment areas and any other catchment areas provided for by agreement.

2. **Adherence to Law and Contract:** Alliance shall adhere to the requirements of Chapter 122C of the North Carolina General Statutes, the 1915 b/c Medicaid Waiver, the NC State Plan for Medical Assistance, APSM 30-I, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SA) State Plan as updated, Contracts with DMA and DMH/DD/SA, the terms and conditions of this Agreement, and applicable local, state or federal law, including but not limited to all federal and state confidentiality laws and regulations, i.e. the
Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 CFR Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290ddd-2 and 42 CFR Part 2, the Health Information Technology for Economics and Clinical Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5). Alliance shall effect such by-laws, resolutions, policies and actions as are reasonably required to carry out the terms and conditions of this Agreement.

3. **Name:** The consolidated Multi-County Area Authority is a local political subdivision of the State of North Carolina in accordance with N.C. Gen. Stat. §122C-116 and will continue to be known as “Alliance Behavioral Healthcare.”

4. **Office Location:** The corporate headquarters for the consolidated area authority shall be 4600 Emperor Boulevard, Suite 200, Durham, NC or as approved by the Alliance Board of Directors. Subject to reduction in funding appropriated to Alliance, statutory changes or administrative actions by the General Assembly, the Governor or the Secretary of NCDHHS, Alliance shall (1) maintain a local office in Cumberland County within close proximity to other human services agencies and (2) shall maintain the following MCO functions and related staff in Cumberland County: I/DD and MH/SA Care Coordination, Community Relations, and System of Care Coordination, provided however that no reduction in funding shall disproportionately affect Cumberland County. The local office for Cumberland County shall initially be located at 711 Executive Place Fayetteville, NC, which such property is owned by Cumberland County. The Parties acknowledge and agree that Alliance shall utilize this site location rent-free from July 1, 2013 through June 30, 2014, pursuant to the terms and conditions of a separate Lease Agreement between the Parties, which shall include the following provisions:
   a. All utilities will continue to be paid by Cumberland County during the time frame listed above.
   b. Alliance agrees to provide written notice at least 90 days prior to June 30, 2014 of intent to vacate or to commence paying rent at a rate to be negotiated by the parties, but not more than the rate of twelve (12) dollars per square foot. Only that portion of the building which is actually used by Alliance shall be leased. If the entire building is leased to Alliance, Alliance shall be solely responsible for the utilities. If a portion of the building is leased to Alliance, the utilities shall be prorated by the floor space leased.

5. **Operational Date and Effective Date:** The Operational Date of this Agreement shall be July 8, 2013, which is the date of the first Alliance pay period in July, unless otherwise agreed to in writing by the Parties. This Agreement shall be effective upon execution by all signatories (“Effective Date”) and approval by the Secretary of DHHS and shall remain in effect until the Operational Date, provided that all representations, warranties and indemnifications made by any Party to this Agreement shall survive the establishment of the consolidated Area Authority, as more specifically set forth in Section 33 of this Agreement. As of the Effective Date or as soon thereafter as practicable, Cumberland Area Authority and/or Cumberland County shall no longer enter any new contracts or otherwise bind or obligate the Cumberland Area Authority.

6. **Board of Directors:** Alliance shall be governed by a Board of Directors comprised of
nineteen (19) members consistent with the provisions of N.C. Gen. Stat. §122C-118.1(a). The Board composition shall be in conformity with the formula set forth in paragraph 7, below. The counties shall begin the Board appointment process immediately upon the Effective Date and will use best efforts to have all Board members appointed and approved by September 1, 2013.

7. **Board Composition:** The consolidated Alliance Area Board will consist of nineteen (19) members. Seven (7) members shall be appointed by Durham County, seven (7) members shall be appointed by Wake County, four (4) members shall be appointed by Cumberland County, and one seat shall be at large. The process for appointment shall be according to the following general terms and conditions:

   a. Seven (7) Area Board members shall be appointed by the Durham County Board of Commissioners. All but one currently-seated members representing Durham County now serving on the Alliance Board of Directors shall remain on the Alliance Board of Directors through the expiration of their current terms. In order to reduce the Durham Board seats from eight (8) to seven (7), the Durham County Board of County Commissioners shall select a member whose appointment expires in March 2014 for early cancellation.

   b. Seven (7) Area Board members shall be appointed by the Wake County Board of Commissioners. All currently-seated members representing Wake County now serving on the Alliance Board of Directors shall remain on the Alliance Board of Directors through the expiration of their current terms.

   c. Four (4) Area Board members shall be appointed by the Cumberland County Board of Commissioners. The currently-seated member representing Cumberland County now serving on the Alliance Board of Directors shall remain on the Alliance Board of Directors through the expiration of his current term.

   d. The eighteen (18) Board members appointed by Cumberland, Durham and Wake counties as set forth herein shall then establish the term of and appoint one (1) at-large seat. The at-large seat shall initially be filled by one (1) representative from Johnston County and shall continue to be occupied by a representative from Johnston County for so long as Johnston County is party to an Interlocal Agreement with Alliance. Upon termination of the Interlocal Agreement between Alliance and Johnston County, or the admission of additional counties by agreement to the consolidated Area Authority or any agreement by consent with any other county via Interlocal agreement, the at-large seats shall be filled in accordance with needs and wishes of the consolidated Area Authority.

   e. Other Area Board requirements will be jointly developed consistent with the requirements of N.C. Gen. Stat. §122C-118.1(a). Alliance will advertise, accept applications, interview and recommend appointments to the respective Boards of County Commissioners based on categories established in the by-laws of the Alliance Board, to include individuals with business expertise, financial expertise, clinical expertise, child/adolescent expertise, and/or who represent the interest of
consumers’ family members.

f. Terms and term limits for the appointed board members shall be established consistent with the requirements set forth in N.C. Gen. Stat. §122C-118.1(d).

g. Cumberland, Durham and Wake counties may have equal representation on the Alliance Area Board Finance Committee. The Finance Officer or designee of each participating county may serve as an *ex officio* non-voting member of the Finance Committee.

h. Significant actions by the Alliance Area Board will require fifteen (15) votes, or a corresponding 75% majority in the event the number of Board members changes. Significant actions shall include: 1) Area Board policy decisions which affect consumer benefit plans or provider rates; 2) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (N.C.G.S. Chapter 159); 3) personnel policies; 4) employee benefit plans; 5) the selection and dismissal of the Chief Executive Officer; 6) changes to the Area Board structure; 7) execution of contracts or leases for real or personal property including accepting any assignment thereof; 8) acceptance of grants; 9) settlement of liability claims against the new Area Authority or its officers or employees; 10) approval or amendment of Area Authority by-laws, and; 11) any other matter so designated by the new Area Authority Board.

8. **Area Director/Chief Executive Officer:** The Area Director/Chief Executive Officer (“Area Director/CEO”) of the consolidated Alliance Area Authority shall be Ellen S. Holliman. The Area Authority by-laws shall set forth the procedure for hiring any subsequent Area Director/CEO consistent with the mandates set forth in N.C. Gen. Stat. §122C-121, and shall enter into an employment contract with any Area Director/CEO so hired specifying the terms of employment.

9. **Consumer and Family Advisory Committee:** Consistent with N.C. Gen. Stat. §122C-170 *et seq.*, Alliance shall establish a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC) and which shall consist of eight (8) members from each participating County for a total of no more than twenty-four (24) members. The CFAC shall be a self-governing and self-directed organization that advises the Area Authority on the planning and management of the local public MH/ID/DD/SA service system. The CFAC and the Board of the consolidated Area Authority shall execute an agreement that identifies the roles and responsibilities of the CFAC. The consolidated Area Authority will provide financial, technical and administrative support to the Alliance CFAC and to the local Cumberland, Durham and Wake CFACs as needed.

10. **Transfer of Property and/or Assets:** A true and accurate list of property and/or assets owned by Cumberland Area Authority, other than inventory, any assets leased by Cumberland Area Authority, and any assets specifically excluded from this Agreement, is attached hereto as Schedule 1 and incorporated herein by reference. All property and/or assets currently owned by Cumberland Area Authority and set forth in Schedule 1, as well as all inventory currently owned
by Cumberland Area Authority and described in Schedule 2, shall be transferred to Alliance on or before the Operational Date. Notwithstanding N.C. Gen. Stat. §122C-147(c), the Parties agree and acknowledge that Cumberland Area Authority does not own or hold title to any real property. If any of the property identified in Schedule 1 requires a title or other document establishing ownership, said title or other document shall be transferred to Alliance on or before the Operational Date, or as soon as reasonably practicable thereafter. The Parties understand and agree that if Alliance is dissolved or there are any statutory changes or administrative actions by the Governor or the Secretary of NCDHHS that limits or terminates the Alliance contract to operate the 1915 b/c Medicaid Managed Care Waiver, then in such case, title to any property transferred to Alliance shall revert to Cumberland County upon the demand of Cumberland County.

11. **General Liability Insurance:** Alliance shall procure and maintain appropriate insurance policies for general liability, professional liability, property damage and injury to individuals, automobile insurance, and Workers Compensation consistent with the requirements established by NCDHHS for operation as an LME-MCO, and shall provide the County Commissioners of all participating counties with evidence of insurance.

12. **Directors’ and Officers’ Insurance:** The Area Authority shall purchase an insurance policy for the purposes of protecting its Directors and Officers from liability in the performance of their official duties.

13. **Employment of Cumberland County Employees:** No later than June 15, 2013, Alliance will post for hiring on its website the positions listed in Schedule 5, attached hereto and incorporated herein. Positions will be filled by the determination of the CEO or her designee(s) following a cursory application and interview process. Preference will be given to Cumberland County employees currently filling the positions listed in Schedule 5. All current full-time employees (but not independent contractors) filling the positions listed in Schedule 5 will be hired into the same classification and position at their current FY13 salary unless they opt to retire from Cumberland County employment, choose not to apply with Alliance, are subject to any current or pending disciplinary action, or do not meet hiring criteria due to criminal history or failure to hold necessary licensure. All hires who wish to maintain continuity of service and leave accrual rates must begin employment with Alliance no later than the Effective Date or the date of the first Alliance pay period beginning after the Effective Date, and will be subject to a probationary period in accordance with the State Personnel Act and Alliance Human Resources policies and procedures. Those employees who wish to retire from Cumberland County in order to maintain their county retiree health insurance benefit will be allowed to delay their employment with Alliance for the 30 day period necessary to qualify for retirement in the NC Local Government Employees’ Retirement System (LGERS), contingent upon acceptance of a full time employment position as a new employee with Alliance and if allowed by LGERS. Alliance shall participate in the NC Local Government Employees’ Retirement System. Alliance shall accept all accrued sick leave and up to 80 hours of accrued vacation leave for each employee hired, contingent upon reimbursement from the County for such vacation leave hours. Employee rights shall be subject to the State Personnel Act under the auspices of the State Personnel Commission. Alliance shall maintain Substantially Equivalent designation from the State Personnel Commission for the administration of its personnel system. Alliance will
establish personnel policies and procedures in compliance with applicable local, state and federal laws and regulations. The Alliance Human Resources Director will be responsible for monitoring and recommending policy and procedure changes to the CEO as needed. Alliance agrees that it will comply with all applicable law before instituting any Reduction in Force for any of its employees.

14. **Financial Disclosure:** The Parties hereby covenant and agree that they will share with each other all requested financial information, and represent that such financial information is complete and accurate, does not contain any material misrepresentations, and does not omit any material information concerning each Party’s financial status.

15. **Funds Administration:** The Area Authority shall directly receive all local, state and federal funds consistent with Chapter 122C of the North Carolina General Statutes and administer them to carry out the purpose of this Agreement.

16. **Cumberland Funding Obligation:** Funding obligations will be shared proportionally between Cumberland, Durham and Wake Counties not to exceed a total of Eight Million and No/100 Dollars ($8,000,000.00), as set forth below:

a. Both Durham and Wake Counties have each contributed Four Million and No/100 Dollars ($4,000,000.00) to Alliance in the form of a loan. Cumberland agrees to remit a total of One Million, Five Hundred Eighty-Four Thousand and No/100 ($1,584,000.00) to Alliance towards this obligation in two equal payments. The first payment shall be remitted on or before July 1, 2013 and the second payment shall be remitted on or before July 1, 2014 in accordance with the Payment Schedule attached hereto and incorporated herein as Schedule 4, and the further terms of this Agreement. Repayment of these funds shall be in accordance with the Payment Schedule attached hereto and incorporated herein as Schedule 4. Interest shall accrue on the amount transferred at an annual rate of 1% beginning July 1, 2013 until paid in full.

b. The value of any previous contribution, assets, inventory or equipment conveyed or transferred from Cumberland to Alliance shall not be counted towards or included as part of the funding obligation unless specifically agreed to by the Parties in writing.

c. Alliance shall be responsible for obtaining an annual independent certified audit inclusive of the operations and shall provide copies of the annual audit to the Cumberland, Durham and Wake County Boards of County Commissioners.

d. In the event that Cumberland takes any action pursuant to N.C. Gen. Stat. §122C-115.3, then and in that event, the county shall forfeit the repayment authorized by this Section if such repayment schedule continues over into a fiscal year in which the county is not participating in the Alliance Area Authority.

e. In the event that Alliance is put on notice prior to July 1, 2014, by any statutory
changes or administrative actions by the Governor or the Secretary of NCDHHS that Alliance’s Contract with NCDHHS to operate the 1915 b/c Medicaid Managed Care Waiver will be terminated on or before July 1, 2015, or Alliance will be consolidated into another LME-MCO and will no longer be the lead LME-MCO for purposes of managed care operations on or before July 1, 2015, then and in that event, Cumberland shall be under no obligation to remit the second payment referenced in paragraph 16.b., above.

f. In the event Alliance is dissolved for any reason, Cumberland County’s liability for any liabilities of Alliance shall be established in accordance with N.C. Gen. Stat. Chapter 122C.

17. County MH/I-DD/SA Services Funding: In accordance with N.C. Gen. Stat. 122C-115(a), the Parties acknowledge and agree that county funding allocated for local services annually shall be conveyed through an annual funding agreement between each County and Alliance. The terms of the annual funding agreement will be mutually developed and in compliance with applicable county and state requirements. Alliance shall adhere to all requirements set forth in the Local Government Budget and Fiscal Control Act. The Parties acknowledge and agree that Cumberland County, Alliance and Cape Fear Valley Health System (CFVHS) will enter into a three-way funding agreement on or before July 1, 2013, and that Alliance will enter into a Contract with CFVHS on or before July 1, 2013 for the provision of a county-funded facility-based crisis, detoxification and drop-off center in addition to the outpatient therapy services previously provided by the Cumberland County Health Department, in accordance with the terms and conditions of the annual funding agreement. Alliance shall ensure that CFVHS does not receive preferential treatment, including, but not limited to referrals for services, favorable rates, and compliance or performance reviews, that could create actual or perceived conflicts of interest that would unfairly benefit CFVHS.

18. Cumberland County Fund Balance: Notwithstanding the requirements of N.C. Gen. Stat. §122C-116(a) and Senate Bill 208, the Parties acknowledge and agree that the Cumberland Area Authority was considered a department of Cumberland County government for purposes of Chapter 159 of the General Statutes prior to the amendment of N.C. Gen. Stat. §122C-116(a) on July 12, 2012; and that any portion of the fund balance of Cumberland County which has been assigned for mental health is and shall remain the fund balance of Cumberland County subject to its exclusive control.

19. Leases and Other Liabilities Incurred in Ordinary Course of Business: Schedule 3 separately itemizes all Accounts Receivable, service contracts, office and equipment leases, and standard operating agreements to which Cumberland Area Authority is a party, and current payables and other liabilities of Cumberland Area Authority incurred in the ordinary course of business. The term “Accounts Receivable” shall refer to any outstanding and unpaid bills, invoices or claims owed to third party payers or other responsible parties for goods or services rendered prior to the Operational Date in the normal and ordinary course of Cumberland Area Authority business. Alliance shall, prior to the Operational Date, evaluate Schedule 3 obligations and assess its ability and desire to assume responsibility for such service contracts, office and equipment leases, and standard operating agreements and obtain all necessary
consents to assignment. Cumberland Area Authority shall cooperate in a reasonable manner with Alliance to accomplish such assignments. It is expressly understood and agreed that, except for any obligations of Cumberland Area Authority listed in Schedule 2 which are assumed in writing by Alliance, that Alliance shall not be responsible for any liability or obligation of Cumberland Area Authority which is fixed or contingent, disclosed or undisclosed, as of the Operational Date or otherwise.

20. Inventory: Schedule 2 contains a complete and accurate summary of the inventory purchased with non-County funds and owned by Cumberland Area Authority as of the Operational Date.

21. Liabilities: The following provisions shall apply to the terms and conditions of this Agreement:
   a. Alliance Liabilities: Alliance shall be solely responsible for any acts or omissions after the Operational Date that are not covered by applicable insurance coverage.

   b. Liabilities: Any liabilities of Cumberland Area Authority arising prior to the Operational Date, existing at such time, or coming into existence after such date for acts or omissions of Cumberland Area Authority prior to the Operational Date that are not covered by applicable insurance coverage shall remain the sole responsibility of Cumberland County. These potential liabilities specifically include, but are not limited to, all claims, liabilities, damages or judgments imposed upon or incurred by Alliance, including reasonable attorneys’ fees, that are primarily caused by (i) the acts or omission of Cumberland Area Authority or Cumberland County and/or Cumberland Area Authority directors, officers, employees or contractors, or (ii) any breach of Cumberland County’s representations, warranties, covenants or obligations under this Agreement.

22. Pending Litigation and Claims: Cumberland affirms and warrants that there are no pending litigation matters or claims, or potential claims or suits against Cumberland Area Authority or its directors, officers, employees, agents or contractors, including but not limited to actual or alleged medical malpractice or professional negligence, with the exception of those expressly listed in Schedule 3 attached hereto and incorporated herein.

23. Conditions Precedent to Consummate Merger and Consolidation: The obligations of each Party to consummate the transaction described in this Agreement are subject to the following conditions precedent. Upon the non-performance or breach of said conditions, either Party may, at its option and in its sole discretion, cancel and nullify this Agreement prior to or as of the Operational Date.

   a. All necessary approvals have been obtained from the Alliance Board of Directors, the Boards of County Commissioners of the counties that will be members of the Area Authority and from the Secretary of the N.C. Department of Health and Human Services in accordance with state statutes and administrative rules relating to the consolidation of area authorities. This includes formal
dissolution of Cumberland Area Authority’s current responsibilities and activities by the Cumberland County Board of County Commissioners.

b. The representations and warranties of Cumberland Area Authority contained in this Agreement shall be true, complete and correct in all material respects as of the Effective Date.

c. Each of the covenants, agreements, conditions and obligations to be performed or complied with by each Party on or before the Operational Date pursuant to the terms hereof shall have been duly performed or compiled with on or before such date, unless otherwise agreed to in writing by the Parties.

24. **Cumberland Provider Enrollment:** Alliance shall consider, on a case by case basis, provider enrollment applications submitted within forty-five (45) days from the Effective Date by applicants interested in providing MH/I-DD/SA services in Cumberland County, and shall enroll applicants who meet Alliance credentialing, selection and retention criteria. The Parties agree and acknowledge that there is no right for any provider to participate in the Alliance closed provider network.

25. **Conflict of Interest:** Alliance will adhere to all provisions regarding conflicts of interest as set forth in state or federal law and Contracts with NCDHHS, including the prohibition on any County which appoints individuals to an Area Authority Board operating a 1915 b/c Medicaid Waiver from directly providing behavioral health services.

26. **Waiver:** The failure of a Party to insist upon strict adherence to any term of this Agreement on any occasion shall not be considered a future waiver of the term or deprive that Party of its right thereafter to insist upon strict adherence to that term or any other term of this Agreement. Any waiver must be in writing, and no waiver of any breach of any provision of this Agreement shall constitute a waiver of any other breach of such provision or of any other provision thereof.

27. **Entire Agreement:** This Agreement constitutes the entire agreement among the Parties as of the date hereof with respect to the subject matter hereof and cannot be amended or terminated orally. All prior agreements, understandings, representations and statements, whether oral or written, are merged in to this Agreement. This Agreement specifically supersedes and replaces the previous Interlocal Agreement between The Durham Center and Cumberland Area Authority. All of the Schedules referred to in this Agreement and attached hereto shall be deemed and construed to be a part of this Agreement and shall be incorporated herein by reference.

28. **No Third Party Beneficiaries:** This Agreement is not intended for the benefit of any third party. The rights and obligations contained herein belong exclusively to the Parties hereto, and shall not confer any rights or remedies upon any person or entity other than the Parties hereto.

29. **Severability:** The Parties agree that if any provision of this Agreement, or portion
thereof, is deemed invalid, unlawful or unenforceable for any reason by any court of competent jurisdiction, such determination shall be confined to the operation of the provision at issue and shall not affect or invalidate any other provision of this Agreement, and such court shall be empowered to substitute, to the extent enforceable, a provision similar thereto or other provisions so as to provide to the fullest extent permitted by applicable law the benefits intended by such provisions.

30. **Paragraph Headings:** Paragraph headings contained in this Agreement are included for convenience only and do not define, limit or describe the scope of intent of this Agreement or in any way affect this Agreement.

31. **Choice of Law/ Forum:** This Agreement shall be interpreted, construed, governed by and enforced in accordance with the laws of the State of North Carolina. The venue for all legal actions concerning this Agreement shall be in the State Courts of Cumberland, Durham, or Wake County.

32. **Execution:** The Parties agree to execute all documents, instruments or further assurances as may be necessary or required to effectuate and complete all transactions contemplated by this Agreement.

33. **Multiple Originals:** This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original and it shall not be necessary to make any proof of this Agreement to produce or account for more than one such counterpart.

34. **Survival:** Survival of the representations, warranties and indemnifications made by any party to this Agreement shall survive the establishment of the consolidated Area Authority. The representations, warranties and indemnifications hereunder shall not be affected or diminished by any investigation at any time by or on behalf of the party for whose benefit the warranties and representations were made. For purposes of this paragraph, the Agreement shall be construed as a continuing contract so as to bind future boards to the extent permitted by law.

35. **Assignment:** This Agreement shall not be assigned, in whole or in part, without the prior written consent of the Parties.

36. **Notification to NCDHHS Secretary:** In accordance with N.C. Gen. Stat. §122C-115.1(a)(5), the Parties agree to provide written notification to the Secretary of the North Carolina Department of Health and Human Services prior to the withdrawal of any County from the Alliance multi-county Area Authority.

37. **Notice:** All notices, reports, records, or other communications which are required or permitted under the terms of this Agreement shall be sufficient in all respects if given in writing and delivered in person, by confirmed facsimile transmission, by overnight courier, or by registered or certified mail, postage prepaid, return receipt requested, to the receiving Party at the following address, unless any Party has notified the other of a different address by means of the notification formalities described in this paragraph, or has been dissolved upon this Agreement becoming effective.
If to Alliance:  
Alliance Behavioral HealthCare  
Attention: Ellen Holliman, Area Director/ CEO  
4600 Emperor Boulevard  
Durham, North Carolina 27703  

With a copy to: Ms. Tracy Hayes, Alliance General Counsel, 4600 Emperor Boulevard, Durham, North Carolina 27703  

If to Cumberland Area Authority:  
Cumberland County Area Authority for Mental Health,  
Developmental Disabilities and Substance Abuse Services  
Attention: Hank Debnam, Area Director  
711 Executive Place  
Fayetteville, NC 28301  

With a copy to: The Charleston Group, Post Office Box 1762, Fayetteville, North Carolina 28302, Attn: R. Jonathan Charleston  

If to Cumberland County:  
Mr. James E. Martin, County Manager  
Cumberland County Courthouse  
117 Dick Street, Room 512  
Fayetteville, NC 28301  

With a copy to: Mr. Rick Moorefield, Cumberland County Attorney, Cumberland County Courthouse, 117 Dick Street, Room 551, Fayetteville, NC 28301  

If to Durham County:  
Mr. Mike Ruffin, County Manager  
200 East Main Street  
2nd floor, Old Courthouse  
Durham, N.C. 27701  

With a copy to: Mr. Lowell Siler, Durham County Attorney, 200 E. Main Street, Durham, N.C. 27701  

If to Wake County:  
Mr. David Cooke, County Manager  
P.O. Box 550, Suite 1100  
Raleigh, N.C. 27602  

With a copy to: Mr. Scott W. Warren, Wake County Attorney, P.O. Box 550, Raleigh, N.C. 27602
38. **List of Attached Schedules:**

- Schedule 1 – Cumberland Area Authority Assets
- Schedule 2 – Cumberland Area Authority Inventory
- Schedule 3 – Cumberland Area Authority Leases and other Liabilities
- Schedule 4 – Loan Repayment Schedule
- Schedule 5 – Employment Position Listing

[THIS SPACE INTENTIONALLY LEFT BLANK]
AUTHORITY TO EXECUTE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Cumberland County

[Signature]
James E. Martin
County Manager

[Signature]
Jimmy Keefe
Chairman, Board of County Commissioners

6/26/13
Date

6/25/2013
Date

Pre-audit Statement:
This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

[Signature]
Amy Cannon
Finance Director
Deputy County Manager
Chief Finance Officer, Cumberland County

6/26/13
Date

APPROVED FOR LEGAL SUFFICIENCY
BY: ____________________________
County Attorney's Office
AUTHORITY TO EXECUTE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Alliance Behavioral Healthcare

[Signature]
Robert G. Robinson
Chief Operating Officer

[Signature]
Lascel S. Webley, Jr.
Board Chair

[Signature]
[Signature]
6-24-13
Date
6-24-13
Date

Pre-audit Statement:
This instrument has been pre audited in the manner required by the Local Government Budget and Fiscal Control Act.

Sara Pacholke
Director of Finance

[Signature]
Date

AUTHORITY TO EXECUTE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Cumberland County Area Mental Health, Developmental Disabilities and Substance Abuse Authority

[Hank Debnam, MPH]
Hank Debnam, MPH
Area Director

[Ladies Gloston]
Ladies Gloston
Board Chair

[Signature]
[Signature]
6/25/13
Date
6/25/13
Date
SCHEDULE 1

Property and Assets Owned by the Cumberland Area Authority

The Cumberland Area Authority does not own any property or assets. All property and assets used by the Cumberland Area Authority are owned by Cumberland County.

All furnishings, furniture, appliances, office equipment, office supplies, inventory, computers, printers, and telephones used by the Cumberland County Authority at its offices located at 711 Executive Place, Fayetteville, NC, shall remain in the offices located at 711 Executive Place, Fayetteville, NC, for the use of Alliance to conduct its business operations in Cumberland County, or may be moved to any other office location within Cumberland County which is leased or used by Alliance for the same purpose. No fixtures, conduit, wiring, power supplies or control devices which are affixed to any surfaces of the building shall be moved without the written consent of Cumberland County. In the event Alliance ceases to maintain an office to conduct business operations in Cumberland County, then Cumberland County may elect to take possession of any of the described property. An actual inventory of the described property is attached to this Schedule 1 on the spreadsheet entitled “Transfer to Alliance.”

Cumberland County shall transfer ownership of the following two (2) motor vehicles to Alliance:

2008 Ford Crown Vic with VIN 2FAFP73V18X172126
2008 Ford Crown Vic with VIN SFAFP73VX8X172125
<table>
<thead>
<tr>
<th>Object Description</th>
<th>Quantity</th>
</tr>
</thead>
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<td>122</td>
</tr>
<tr>
<td>BOOKCASES</td>
<td>72</td>
</tr>
<tr>
<td>DESKS</td>
<td>60</td>
</tr>
<tr>
<td>5 DRAWER FILE CABINETS</td>
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<td>43</td>
</tr>
<tr>
<td>DESK CHAIRS</td>
<td>57</td>
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<tr>
<td>CREDENZA</td>
<td>10</td>
</tr>
<tr>
<td>COMPUTER DESKS</td>
<td>15</td>
</tr>
<tr>
<td>SOFA</td>
<td>2</td>
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<tr>
<td>TABLES</td>
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</tr>
<tr>
<td>TV</td>
<td>4</td>
</tr>
<tr>
<td>COFFEE TABLE</td>
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</tr>
<tr>
<td>CHAIRS - LOBBY 2ND</td>
<td>21</td>
</tr>
<tr>
<td>LEATHER SOFA</td>
<td>3</td>
</tr>
<tr>
<td>LEATHER CHAIRS</td>
<td>6</td>
</tr>
<tr>
<td>UPHOLSTERED CHAIRS</td>
<td>2</td>
</tr>
<tr>
<td>3 MATCHING SIDE TABLES</td>
<td>3</td>
</tr>
<tr>
<td>TYPEWRITER</td>
<td>3</td>
</tr>
<tr>
<td>STORAGE CABINETS</td>
<td>4</td>
</tr>
<tr>
<td>WAITING ROOM CHAIRS - 3rd floor</td>
<td>6</td>
</tr>
<tr>
<td>WAITING ROOM TABLES</td>
<td>2</td>
</tr>
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SCHEDULE 2

Inventory Owned by the Cumberland Area Authority

The Cumberland Area Authority owns no inventory. Any item considered which may be regarded as inventory is included in Schedule 1.

SCHEDULE 3

Liabilities of the Cumberland Area Authority Incurred in the Ordinary Course of Business

The following is a complete itemized list of all current payables and liabilities of the Cumberland Area Authority which have been incurred in the ordinary course of business:

Accounts Receivable (defined as outstanding and unpaid bills, invoices or claims owed to third parties for goods or services rendered prior to the Operational Date in the normal and ordinary course of business): None

Service Contracts: None

Office and Equipment Leases: None

Standard Operating Agreements: None

Pending Litigation and Claims (against the Cumberland Area Authority or its directors, officers, employees, agents or contractors, including but not limited to actual or alleged medical malpractice or professional negligence): None

Potential Litigation and Claims (against the Cumberland Area Authority or its directors, officers, employees, agents or contractors, including but not limited to actual or alleged medical malpractice or professional negligence): None
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<th>Loan Amount</th>
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**DEBT PAYBACK SCHEDULE - Wake - Revised**

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<th>Principal</th>
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<th>Ending Balance</th>
<th>Cumulative Interest</th>
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<td>$396,000.00</td>
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<tr>
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*Payment will be made within ten (10) business days of receipt of payment from Cumberland County

**DEBT PAYBACK SCHEDULE - Durham - Revised**

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<th>Cumulative Interest</th>
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*Payment will be made within ten (10) business days of receipt of payment from Cumberland County

**DEBT PAYBACK SCHEDULE - Cumberland**

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<th>Payment Date</th>
<th>Beginning Balance</th>
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<th>Cumulative Interest</th>
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<td>1</td>
<td>$42,674</td>
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**Total:** $2,054,305
1. CALL TO ORDER:
   Chairman Lascel Webley, Jr. called the meeting to order at 4:35 pm.

2. ANNOUNCEMENTS:
   A. Chairman Webley announced that for the second year in a row our BECOMING initiative has garnered national recognition in the form of two prestigious awards. Out of 79 entries across the country, BECOMING has received a silver award in the professional outreach category for a mini-documentary showcasing the diverse range of people involved in the program (including staff, partners, youth and family members) and they also won a bronze award in the partnership development category for a short video highlighting its unique and innovative relationship with the Durham Police Department. Chairman Webley introduced Dr. David Currey, Director of the BECOMING project and Mr. Brandon Alexander, BECOMING project Social Marketing Coordinator. The BECOMING project is supported by a six-year federal grant, and is nearing the end of year three. It is about supporting 16 to 21 year olds in Durham County that have mental health challenges along with other challenges, so it is a difficult but important population to work with. The BECOMING project staff thanked Alliance Behavioral Healthcare staff and Board members for their ongoing support with this project.

   Ellen Holliman, Chief Executive Officer, stated we will send Board members a link to view the videos. Ann Oshel, Director of Community Relations, pointed out that
these awards are highly-coveted SAMSA awards and that it is a very prestigious honor to be recognized.

B. Ellen Holliman, Chief Executive Officer, announced we will have an All-staff Training on September 27, 2013. We will be essentially closing our sites that day, except for phone access, and will go off-site for training and team building activities. More information will be provided at our next meeting.

No motion required.

3. **AGENDA ADJUSTMENTS:**

Chairman Webley added that since the Finance committee update is not listed on the agenda, we will add that after public comments. George Quick will give a Finance Committee update between Public Comments and Committee Reports.

No motion required.

4. **RECOMMENDATION OF NEW BOARD MEMBER:**

Chairman Webley on behalf of the Executive Committee recognized Ms. Vicki Shore. Ms. Shore met with the Executive Committee in July which gave the Board members the opportunity to get to know her. She recently retired from Johnston County Industries, Inc., with over 30 years of service.

The Executive Committee, along with the other Board members present, recommended Ms. Vicki Shore to be appointed to the Alliance Behavioral Healthcare Area Board for a three-year term representing Johnston County.

A Motion was made to appoint Ms. Vicki Shore to serve as an individual representing Johnston County for a period of 3 years ending on August 30, 2016. The motion was seconded and passed.

**OATH OF OFFICE FOR MS. VICKI SHORE**

Chairman Webley administered the oath of office to new MCO Board Member Ms. Vicki Shore.

5. **PUBLIC COMMENT:**

None

**FINANCE COMMITTEE REPORT:**

The Finance Committee meets monthly at 3:00 p.m. prior to the regular Area Board meeting. Draft minutes from the June 6, 2013 meeting are attached.

George Quick reviewed the finance position of the organization through May, 2013. An audited statement through June 2013 will be provided at the end of this calendar year. Another item brought before the Finance Committee was a request from management to review an audio visual configuration plan that consists of equipment for the Board Room.
and a video signage board for the lobby at Headquarters. The Finance Committee has recommended it be approved.

A Motion was made to approve the equipment in Board Room 208 and the video signage boards for the lobbies at the corporate site. The motion was seconded and passed.

6. COMMITTEE REPORTS:

A. Quality Management Report
B. Human Rights Committee Report
C. Consumer and Family Advisory Committee (CFAC) Report
D. Executive Committee Report
E. Finance Committee Report

A Motion was made to accept the committee reports. The motion was seconded and passed.

7. CONSENT AGENDA:

A. Selection and Retention
B. UNC Certificate of Need Request

A Motion was made to approve the consent agenda. The motion was seconded and passed.

8. PRESENTATION ON STAFF SURVEY:

Valiria Willis, former Director of Human Resources, provided the Board with information on the results of the workplace survey. She presented a summary of the results, emphasizing that there was an 84% participation rate. The organization received high marks in team work and morale. Employees are proud of the work they do. Areas that need improvement include: communication, pay and opportunities for advancement, and supervisor training. The Classification and Pay Study was ongoing at the same time as the survey and recommendations were implemented in July 2013.

Chairman Webley, on behalf of the Board, expressed appreciation for Valiria’s past contributions.

Ellen Holliman, Chief Executive Officer, discussed the hiring process for Valiria’s position. Kim Newsom is serving as Interim HR Director. There were seven applicants for the HR Director position and we have narrowed the list down to two. We hope to announce the new HR Director next week.

No motion required.
9. **STRATEGIC BEHAVIORAL MEMORANDUM OF AGREEMENT:**
Rob Robinson, Chief Operating Officer, presented the Strategic Behavioral Memorandum of Agreement to the Board for approval. This MOA requests that Alliance, Department of Health and Human Services, and Strategic Behavioral Center transfer twelve child and adolescent psychiatric inpatient hospital beds from Broughton Hospital to Strategic Behavioral Center.

A Motion was made to accept the Memorandum of Agreement. The motion was seconded and passed.

10. **UPDATES:**
A. Carlyle Johnson, Clinical Program Development and Design Administrator, presented an update on the status of the Wake Divestiture Plan. We completed the process for 10 RFP’s and have one update which is the Work First RFP, which has been awarded to Southlight. Also, within Wake there was a Substance Abuse Prevention program that 4-H was operating that was awarded to NC State; however, they withdrew and it is now being awarded to the Alice Aycock Poe Center.

Ellen Holliman, Chief Executive Officer, recognized Carlyle Johnson for his outstanding performance and leadership on this huge project.

B. Tracy Hayes, General Counsel, gave an overview of recent legislative updates.

11. **AMENDMENT TO CUMBERLAND COUNTY MERGER AGREEMENT:**
Tracy Hayes, General Counsel, presented the amendment to the Cumberland County merger agreement to the Board for approval. This amendment is to revise the paragraph in regards to the Cumberland County fund balance.

A Motion was made to approve the Amendment as presented. The motion was seconded and passed.

12. **PROVIDER NETWORK REVIEW:**
Rob Robinson, Chief Operations Officer, discussed performance indicators for the State. Information is provided in the enclosed handout and we are contractually bound to meet these standards. The indicators are based on HEDIS, or Healthcare Effectiveness Data and Information Set. Beth Melcher, Chief of Network Development and Evaluation, discussed where we are as a system and looked at next steps. Staff will be gathering data and will come back to the Board to get ideas and feedback.

No motion required.
13. **AREA BOARD ORIENTATION/ANNUAL TRAINING:**
Ellen Holliman, Chief Executive Officer, presented information regarding Area Board orientation and annual training. Senate Bill 191 requires not only orientation training but also annual training. We are proposing the following schedule for our new board orientation training and annual training for existing staff: September 5, October 3 and November 7, 2013 with each session beginning at 3:00 p.m.

Ms. Holliman also informed the board that 14 citizens of Cumberland County have expressed interest in the open Board seats. She will be meeting with each of them in the coming weeks to answer any questions they may have about the process of our Board and to discuss potential conflicts of interest. Related to conflict of interest, she disclosed for the record that four current Board members have a potential conflict of interest. George Quick and John Griffin have relatives that work in non-management positions in providers agencies contracted with Alliance. Cynthia Binanay and Lascel Webley are employees with companies that contract with Alliance. At this point we want to make sure this information is in our minutes as a potential conflict; however, we do not see a major conflict that would prevent these individuals from serving on the Board.

No action taken at this time.

14. **CHAIRMAN’S REPORT:**
Chairman Webley distributed information regarding Alliance Board committees. Each year we ask Board members to join committees, so this document includes an outline of committees and on the first page you will see the person who has been asked to Chair each committee.

With that, Board members, our next Executive Committee meeting will not be held next week, but will be held August 13, 2013 at 8:30 am.

15. **ADJOURNMENT:**
With all business being completed the meeting was adjourned at 6:03pm.

Respectfully submitted:

Ellen S. Holliman, Chief Executive Officer  Date Approved
First Amendment to the Interlocal Agreement between
Alliance Behavioral Healthcare, Cumberland County Area Authority and the
Cumberland County Board of County Commissioners

This First Amendment to the Interlocal Agreement between Alliance Behavioral Healthcare, Cumberland County Area Authority and the Cumberland County Board of County Commissioners is made and entered into this _____ day of July, 2013, by and between Alliance Behavioral Healthcare, the Cumberland County Area Authority and the Cumberland County Board of County Commissioners;

WITNESSETH:

Whereas, the parties hereto previously entered into an Interlocal Agreement to consolidate Alliance and the Cumberland Area Authority into a multi-county area authority for the management of mental health, intellectual/developmental disability and substance abuse services in Cumberland, Durham and Wake Counties, to be effective upon approval by the Secretary of the North Carolina Department of Health and Human Services (the “Agreement”); and

Whereas, the Secretary of the North Carolina Department of Health and Human Services (the “Secretary”) has approved the Agreement save and except the provisions contained in Paragraph 18 of the agreement; and

Whereas, the Cumberland County Board of Commissioners has requested the parties to amend the Agreement to clarify their intent for the purpose of obtaining full approval of all the terms of the agreement by the Secretary; and

Whereas, the parties have determined to amend the Agreement for this purpose.

Now therefore, in consideration of the mutual covenants and provisions contained herein, the parties do hereby agree as follows:

1. Paragraph 18 of the Agreement shall be deleted in its entirety and replaced with the following language:

   18. Fund Balance: The parties acknowledge and agree there is no fund balance available to the Cumberland Area Authority and, therefore, none shall be transferred.

2. In all other respects, the Agreement shall remain unchanged.

3. The Agreement shall be effective upon approval of this First Amendment by the Secretary.

   [SIGNATURE PAGES FOLLOW]
AUTHORITY TO EXECUTE FIRST AMENDMENT TO THE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into
this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Alliance Behavioral Healthcare

______________________________  ________________________
Ellen S. Holliman              Date
Area Director

______________________________  ________________________
Lascel S. Webley, Jr.          Date
Board Chair

Pre-audit Statement:
This instrument has been pre-audited in the manner required by the Local Government Budget
and Fiscal Control Act.

______________________________  ________________________
Sara Pacholke                  Date
Director of Finance

AUTHORITY TO EXECUTE FIRST AMENDMENT TO THE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into
this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Cumberland County Area Mental Health, Developmental Disabilities and Substance
Abuse Authority

______________________________  ________________________
Hank Debnam, MPH               Date
Area Director

______________________________  ________________________
Ladies Gloston                 Date
Board Chair
AUTHORITY TO EXECUTE FIRST AMENDMENT TO THE AGREEMENT
The undersigned parties represent and warrant that they have the authority to enter into this agreement on behalf of their principal and bind them according to its term.

SIGNATURES
For Cumberland County

James E. Martin  
County Manager  
2-15-13  
Date

Jimmy Keeffe  
Chairman, Board of County Commissioners  
8/13/2013  
Date

Pre-audit Statement:
This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Howard L. Baker  
Date  
7/15/13

Amy Cannon  
Deputy County Manager  
Chief Finance Officer, Cumberland County

APPROVED FOR LEGAL SUFFICIENCY
BY:  
County Attorney's Office
ITEM:  Annual Review of Board Policies: Governance, General Administrative

DATE OF BOARD MEETING:  September 5, 2013

BACKGROUND:  Per Alliance Behavioral Healthcare Area 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. Below is a list of policies reviewed, divided into two categories – policies reviewed which require no revisions and policies reviewed which require minor revisions but without changing the content of the policies.

Policies reviewed and ready for Board approval without revisions:
(Governance)
Area Board member Meeting Attendance Compensation
Area Director Compensation
Evaluation of Area Director
Area Board Member Code of Ethics
Consumer, Family Advisory Committee
Delegation of Authority to the Area Director
Guidelines for Public Comment at Area Board meetings
(General Administrative)
Reporting of Abuse, Neglect, Dependency and Exploitation
Health and Safety
Emergency Management Plan
Internal Control

Policies reviewed with minor revisions:
(Governance)
Area Board Processes
Area Board Media Policy
Area Authority Relations with Catchment Area County Boards of Commissioners
Development of Policies and Procedures
(General Administrative)
Strategic Planning
Management of Service Delivery

REQUEST FOR AREA BOARD ACTION:
As part of the Annual Review process, approve the above policies for continued use.

AREA DIRECTOR RECOMMENDATION:
Approve the reviewed policies for continued use.

RESOURCE PERSON(S):
Lascel Webley Jr., Policy Committee member
Monica Portugal, Corporate Compliance Officer
I. PURPOSE

To provide formal guidelines for compensation that Area Board Members are entitled to receive under G.S. 122C-120.

II. POLICY STATEMENT

All members of the Area Board are entitled to receive a payment of $50.00 per meeting for attendance at the following meeting:

Regular Monthly Area Board Meetings

Each member has the right to decline this compensation by giving written notice to the Area Director.

III. PROCEDURES

Compensation shall be made consistent with the fiscal procedures of the Area Authority
I. PURPOSE

The purpose of this policy is to establish a process for determining compensation for the area director.

II. DEFINITIONS

**Area Director:** Chief Executive Officer who is hired and evaluated by the Area Board and is responsible for leading and conducting the Area Authority’s business and affairs.

III. 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 Area Board 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 area director’s performance. The Board’s compensation plan shall comply with all relevant Federal, State and local requirements.

IV. 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 Area Board 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.
C. Documented Process

The Area Board shall document the process used to determine the area director’s compensation. Documentation may include:

1. Terms of compensation arrangements – description of amount and stipulations of compensation.
2. Approval date – date compensation recommendations were completed and approved by the full Area Board.
3. Data used in the compensation decision – documentation of all materials, surveys, reports, research, etc. used in completing the final recommendations.
4. Disclosures of conflict of interest, if any – identification of any conflicting elements.
5. Annual performance review of area director.
6. Authority of Area Board to set area director compensation – reference to Area Board By-laws or policies, etc.

D. Compensation Review Process

The board chair may appoint an ad hoc evaluation/compensation committee to conduct the area director’s annual performance evaluation and compensation review. The ad hoc committee must submit its recommendation to the full Area Board for final action.
AREA BOARD
POLICIES AND PROCEDURES

I. PURPOSE

The purpose of this policy is to set forth the requirement that the Area Board conduct an annual performance evaluation of the Area Director.

II. POLICY STATEMENT

The Area Board shall complete a formal review (at least annually or more often if necessary) of the Area Director using a method that encompasses areas of operation that are important to the Area Board 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 Area Director and additional priorities as mutually agreed to by the Area Board and the Area Director. Among other things, the board shall use the performance evaluation to (1) assure that the Area Director 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 Area Director’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.
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 area board.

**Immediate Family:** The area board 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.

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.

Area board 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 they represent. Board members serve in an important advocacy capacity in meeting the needs of their citizens 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 adjudicatory or administrative capacity and must, when doing so, act in a fair and impartial manner. Area board 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. An Area Board 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. An Area Board Member Shall Uphold the Integrity of His or Her Office. Board members shall demonstrate the highest standards of personal integrity, truthfulness honest 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. An Area Board Member Shall Avoid Impropriety and the Appearance of Impropriety in All His or Her Activities.

1. It is essential that Alliance Behavioral Healthcare attract those citizens best qualified and willing to serve. Area Board 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. Area board members must exercise their best judgment to determine when this is the case.

2. Area Board 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. An Area Board 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 may actively pursue policy goals they believe to be in the best interests of their constituents within the parameters of orderly decision-making, rules of the board and open government.

2. 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.
3. 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.

4. Board members shall demand and contribute to the maintenance of order and decorum in proceedings before the board.

5. 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.

6. 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.

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 Area Director all honorariums and gifts and favors from friends and relatives if made by a covered contractor, subcontractor, 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. **Area Director to Secure Advice.** In any case where the value of a gift is in question, or when the circumstances make it unclear as to whether a thing constitutes a “gift” within the meaning of this provision, any board member may consult with the Area Director who will secure an advisory opinion.

V. **VIOLATIONS OF THE CODE OF ETHICS; SCHEDULING OF HEARING BEFORE THE AREA BOARD; RIGHTS OF ACCUSED AT HEARINGS; SANCTIONS**

A. The Area Board Chairperson, after receiving an allegation of a violation of the Code of Ethics, shall refer the matter to the Board’s Executive Committee for further investigation and inform the Area Director of the alleged violation.

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 Area Board 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 Area Board 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 Area Director who shall obtain an advisory opinion. 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.

________________________
Chairperson, Area Board

ATTESTED:

________________________
Clerk to the Board
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 Area Board.

_________________________    ___________
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 Area Board 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. The initial Consumer and Family Advisory Committee shall be approved by the Area Board and serve in an advisory capacity to the board.

B. The committee, upon creation, shall develop bylaws for the purpose of self-governance.

C. The membership of the committee will be 100 percent consumers and family members.

D. The Area Director, in consultation with the Board Chairperson, shall develop procedures for providing support and assistance to the CFAC to ensure compliance with NCGS 122C - 170.
I. PURPOSE

The purpose of this policy is to define the relationship between the Alliance Behavioral Healthcare Board of Directors (Area Board) and the Area Director.

II. DEFINITIONS

**Area Director:** The Area Director is the Area Authority’s chief executive officer. The Area Director is hired and evaluated by the Area Board and is responsible for leading and managing the Area Authority’s business and affairs.

III. POLICY STATEMENT

The Area Board shall maintain an ongoing relationship with the Area Director 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 Area Director

The Area Director shall be employed by the Alliance Behavioral Healthcare Board of Directors (Area Board) to administer the affairs of the Area Authority within the policies and procedures adopted by the Area Board and applicable Federal, State and local laws and regulations. The duties of the Area Director shall include but are not limited to:

1. Hire, suspend and dismiss employees as necessary.
2. Provide the Area Board with required reports, data and information regarding programs, services, finances and any other business areas as identified by the Area Board.
3. Assume overall responsibility for implementing programs and services.
4. Develop procedures to implement the policies of the Area Board.
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 Area Board and the N C Department of Health and Human Services.
9. Assist the Area Board in understanding their legal responsibilities in performance of their assigned duties.
10. Meet with the Area Board or specific Area Board members, during regularly established, or impromptu, meetings as required.
B. Area Board Access to Area Authority Management and Employees

From time to time Area Board members may need to interact with staff of the Area Authority in order for the Board to fulfill its mission. The Area Director 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 Area Board to receive public comment at Board meetings.

II. POLICY STATEMENT

The Area Board 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 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. The public comment period shall be slotted into the early part of the Board’s agenda.

D. Area Board members may ask clarifying questions at any time during the public comment period.

E. The discussion of all items is to occur only among Board members.

F. If an organization or group wishes to be heard, one person shall serve as their spokesperson.

G. Two (2) minutes per speaker is the established time limit (apart from any comment that is made in response to an Area Board member’s request for clarifying information). (Note: Any individuals/groups seeking formal inclusion on an Area Board agenda will be considered by the Executive Committee when it sets the agenda at its monthly meeting).

H. Yielding time to others is not permitted.

I. The Chairperson shall have the discretion to conduct the public comment session in a manner that maintains good order and decorum.
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, insofar as they 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.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
# AREA BOARD
## POLICIES AND PROCEDURES

<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>Health and Safety</th>
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<td>LINES OF BUSINESS:</td>
<td>All</td>
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<tr>
<td>NUMBER:</td>
<td>GA-4</td>
</tr>
<tr>
<td>URAC:</td>
<td>CORE, v. 3.0, Standards 4 &amp; 27</td>
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<td>REFERENCE:</td>
<td>G.S. 122C-115.4</td>
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<td>Area Board, Area Director</td>
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<tr>
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<td>05/03/2012</td>
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<td>LATEST REVISION DATE:</td>
<td>5/28/2013</td>
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<tr>
<td>APPROVAL AUTHORITY:</td>
<td>Chairperson, Area Board</td>
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## I. PURPOSE

The Area Board 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 Area Board 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 Area Board 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 Area Director shall develop a comprehensive emergency management plan and shall conduct periodic emergency 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 Area Director 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.
AREA BOARD POLICIES AND PROCEDURES

I. PURPOSE
To identify activities necessary for the orderly planning and implementation of Area Board processes.

II. DEFINITIONS
Processes: activities associated with Area Board meetings including agenda planning, developing and distributing meeting materials, overseeing committee work, compiling meeting minutes, etc.

III. POLICY STATEMENT
The Area Board 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 Area Board meeting shall utilize an agenda developed by the Area Board Executive Committee with assistance from the Area Director. 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 Area Board members at least five (5) working days prior to each meeting.

B. Developing and Distributing Meeting Materials
The Area Director is responsible for the following:
1. Sending notices to Area Board members regarding meetings
2. Mailing "Board Packets" to be available to Board members five (5) working days prior to each regularly scheduled board meeting. The packets shall include:
   a. The meeting agenda
   b. Agenda Action Form
   c. Minutes from the previous Area Board meeting
   d. Minutes from committee meetings, as applicable, to include:
i. Area Board Executive Committee meeting
ii. Area Board Finance Committee meeting
iii. Quality Management Committee
iv. Human Rights Committee
v. Policy Committee
vi. Consumer and Family Advisory Committee

3. The Board Packets shall be sent to the following at least five working days before each Board meeting:
   a. County Managers
   b. Mailing Area Board meeting agendas only to:
      a. County Boards of Commissioners
      b. Area Authority Management Team
      c. The News and Observer: News Desk (at least 48 hours prior to the meeting)
      d. The Herald Sun: News Desk (at least 48 hours prior to the meeting)
      e. Place on the Area Authority “Shared Drive”
   4. Post agenda on website

C. Role of Committees

The Area Board may utilize committees chaired by an Area Board member and supported by Area Authority employees to accomplish its work. These committees may include standing as well as ad hoc committees. These committees shall function in accordance with the Area Board’s by-laws.
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 Area Board is accountable to the citizens of Durham, Wake, Cumberland and Johnston counties 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 area board.

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 Area Board 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.

10. Board members are encouraged to cooperate at all times with media outlets subject to the guidelines provided in this policy.
I. PURPOSE

Durham County and Wake County, in accordance with North Carolina Department of Health and Human Services (DHHS) regulations and NC GS 122C, have agreed to establish a new multi-county Area Authority. The Alliance Behavioral Healthcare multi-county Area Authority LME/MCO is a political subdivision of the State of North Carolina and organized under North Carolina General Statute §Chapter 122C-115, to administer all publicly-funded mental health, intellectual/developmental disability, and substance abuse (“MH/I-DD/SA”) services for the residents ofDurham, Wake, and Cumberland Counties. Alliance is also responsible for managing federal and state-funded MH/I-DD/SA services in as well as Johnston and Cumberland Counties through Inter-local Agreements. 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 Durham, Wake, Johnston, and Cumberland counties—the multi-county area per contracts with the Department of Health and Human Services (DHHS) approved application. 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 written 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 beginning no later than Jan 1, 2013 including those counties covered by Inter-local Agreements.

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, Chapter 122C of the...
North Carolina General Statutes, APSM 30-I, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services’ (DMH/DD/SAS) State Plan as updated, and DMHDDSAS Performance Agreement as updated, and any other applicable local, state, or federal laws, 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 Area Director/CEO shall negotiate and sign a Performance 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 Performance Agreement between the funding County and the Area Authority. The terms of the Performance Agreement shall be mutually developed and in compliance with applicable County, and State and Federal requirements.

D. The Area Director/CEO or designee may attend Durham and Wake 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 semi-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

To provide a process for the Alliance Behavioral Healthcare Board of Directors (Area Board) 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 Area Board and Area Authority policies and procedures. The Area Board approves Area Board policies and procedures and the Area Director 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 accompanied by the signature of the approval authority.

Policy: Documents developed and approved by the Area Board that provide direction to guide the Area Authority’s decision making including the development of operating procedures.

Procedures: Documents developed and approved by the Area Director that provides steps for employees to follow when performing a particular function.

Review date: the date the policy or procedures were reviewed and approved for continued use. Policies and procedures shall be reviewed at least annually 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 Area Board 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.

Policies for inclusion in the policy manual require Area Board action. Annually, the Area Board shall review its governance policies. These reviews may occur more often if required by rules, statutes, or outside accrediting bodies.

The Area Director (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 enunciate the critical role the strategic planning process plays in guiding the Area Board as it carries out its mission of providing mental health, intellectual/developmental disabilities and substance abuse services to the residents of Durham, Wake, Johnston and Cumberland counties 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, Area Board 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 Area Director shall develop procedures to implement the provisions of 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 Durham and Wake counties.

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 Durham and Wake counties 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.
ITEM: Review of Revised and Proposed Board Policies

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND: Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board is to review all policies annually. Alliance employees and the Board Policy Committee have recognized needed revisions to the below Area Board policies.

Area Board Conflict of Interest: Suggested changes would remove the requirement to resign from the board if certain prohibited conflicts exist to instead take certain steps to remove the conflict. Examples of such prohibited conflict are Board members with family members as providers or with financial interest in a vendor.

Dispute Resolution: This policy would replace the Appeals of Area Authority based on changes in the law effective August 2013. The new policy complies with North Carolina Statutes and Administrative rules and is designed to comply with URAC accreditation standards.

Business Operations Policies (Accounting by Funding Source, Accounting Manual, Management of Financial Risk, Purchasing): These policies were reviewed in preparation for upcoming audits and proposed changes are minor, however proposed in order to clarify the intent of the policies. The Chief Financial Officer has requested to add a Purchasing Policy in order to tie corresponding procedures to applicable policy.

Information Technology Business Continuity Plan: The intent of these revisions is to broaden the scope of the Business Continuity Plan (BCP) to include all of Alliance business. Information Technology is one part of the BCP. Alliance is required to have a BCP which covers all pertinent business functions.

Service Codes: Change title to reflect the purpose of the policy, broaden the applicable lines of business and correction to one word.

Financial Eligibility: This proposed policy would authorize the LME/MCO to establish financial eligibility criteria for individuals not eligible for Medicaid and who are seeking treatment in the Alliance area. Financial eligibility would be met 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.

Appealing Clinical Utilization Management Decisions: Changes have been suggested in order to meet federal and state due process rights regarding service reductions, suspensions, termination and denials.

Selection and Retention of Providers: Suggested changes have been made to more clearly identify the intent of the policy and federal requirements of a Prepaid Inpatient Health Plan and to provide guidance to the development and implementation of operational procedures.

Employee Grievance: Revisions to this policy are suggested in order to comply with new changes in the State Personnel Act.

Disciplinary Action: Changes include clarification of definitions and intent as well as to comply with changes in the State Personnel Act.

REQUEST FOR AREA BOARD ACTION:
Approve policies with minor changes: Accounting by Funding Source, Accounting Manual, Management of Financial Risk, Service Codes.
Review all other above listed policies for consideration.
AREA DIRECTOR RECOMMENDATION:  
Approve policies with minor changes.

RESOURCE PERSON(S):  
Lascel Webley Jr., Policy Committee member  
Monica Portugal, Corporate Compliance Officer
I. PURPOSE

The purpose of this policy is to establish standards and guidelines to prevent conflict of interest on the part of Area Board members. The policy is intended to supplement, but not replace any applicable state laws governing conflict of interest. This policy is also intended to meet the requirements of the Division of Medical Assistance regarding conflict of interest under the NC Medicaid 1915(b)/(c) waivers.

II. POLICY STATEMENT

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

Each Area Board member shall fulfill his or her responsibilities consistent with all Federal and State laws, rules and regulations, Area Board and Area Authority policies, and Area Board 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 Area Board to maintain public confidence and trust in the Area Authority.

III. DEFINITIONS

**Provider agency**: Agency, organization or individual contracted with Alliance to provide or receive referrals for treatment, habilitation, rehabilitation and/or recovery related publicly-funded MH/I-DD/SA services to consumers, regardless of whether reimbursed on a UCR or non-UCR basis.

**Vendor**: Company or other entity that has a contract with Alliance or provides goods and services needed to develop, maintain or operate the corporation Alliance.

**Family Member**:
- a. The board member’s spouse;
- b. The board member’s parents, children, and siblings;
- c. The board member’s stepparents, stepchildren, stepbrothers, and stepsisters;
- d. The board member’s father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- e. The board member’s grandparents and grandchildren;
- f. A spouse of any of the board member’s grandparents or grandchildren.
IV. RESTRICTIONS

Certain activities are prohibited as conflicts of interest; specifically Area Board members are prohibited from the following:

A. Receiving reimbursement as consultant or employee or being employed by Alliance Behavioral Healthcare during the time they serve as board member.

B. No member of the Area Board may be a family member, as defined in Section III-E of this policy, of any employee of Alliance Behavioral Healthcare.

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

D. Having a financial investment, an ownership interest (whether by stock ownership, partnership, or otherwise), board membership, or employment with any provider agencies with which Alliance the Area Board has a current contractual or referral relationship.

   1. A list of the provider agencies with which Alliance has contractual or referral relationships shall be available upon request and shall be provided to board members annually when Board members complete updated disclosure statements.

E. Having a family member (who has a financial investment, an ownership interest whether by stock ownership, partnership, or otherwise), board membership, or employment with any provider agencies with which Alliance Behavioral Healthcare has a contractual or referral relationship.

F. Personally having, or having a family member who has, any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit from any provider agencies with which Alliance Behavioral Healthcare has a current contractual or referral relationship.

G. Having a family member who has any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit from any provider agencies with which Alliance Behavioral Healthcare has a current contractual or referral relationship.

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

1. The board member’s spouse;
2. The board member’s parents, children, and siblings;
3. The board member’s stepparents, stepchildren, stepbrothers, and stepsisters;
4. The board member’s father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
5. The board member’s grandparents and grandchildren;
6. A spouse of any of the board member’s grandparents or grandchildren.

G. Serving on the Consumer and Family Advisory Committee, unless as a designated liaison and reflected in the bylaws.

H. Having any interest in an Alliance Behavioral Healthcare 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.

   2. 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.
I. 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.

II. 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.

V. REQUIREMENTS

Certain actions are required on the part of Board members for effective implementation of this policy:

A. Board members must observe the highest moral and ethical standards in any dealings in which they represent the Area Board.

B. Board members must disclose a 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.

C. All board members are required to update the information on the disclosure form when (1) a board member or family member invests in or becomes employed by a provider agency with whom Alliance Behavioral Healthcare has a contractual or referral relationship or (2) the Area Board begins a contractual or referral relationship with new provider(s) with whom the board member may have a conflict of interest.

D. Board members who are aware of any violations by any board members of this policy are required to report them to the Area Board Chair. The Board Chair shall notify the Area Director of the reported violation.

VI. CONFLICT OF INTEREST DISCLOSURE

The following actions may be required as a result of a disclosure:

A. If a board member has an interest that violates Part IV D, F, H 1, and/or I of this policy, the board member may be required to resign from the board.

B. If a board member (or board member’s Family Member) has an interest that is reportable under Part IV E, G, H 2, and/or J of this policy, the board will review the situation and determine what steps, if any, need to be taken to avoid conflict of interest. Such steps may include, for example, prohibiting the board member from participating in any decisions regarding the use of, or negotiations with, the relevant vendor.

C. Board members who do not fully comply with the provisions in this policy may be subject to removal from the board.

D. 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.

E. The Area Board shall make the final decision regarding the disposition of all conflict of interest issues.
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 Area Board 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 a Dispute Resolution procedure for Network Providers that offers the opportunity for reconsideration before a panel that includes a peer provider representative. The process shall be informal and provide an opportunity for those who dispute the decision to present their position. 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 Area Director 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 Behavioral Healthcare 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 Area Director shall develop procedures to implement 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 Behavioral Healthcare 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 processes procedures consistent with generally accepted accounting principles, in accordance with contractual requirements and that 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 Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that procedures are in place to identify, reduce, and eliminate risk and to safeguard the financial integrity of the organization.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to ensure that service and administrative costs do 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 for the month and year-to-date basis indicate a savings or loss of revenues versus over expenditures. Alliance Behavioral Healthcare shall emphasize capturing, analyzing and reporting accurate data as the foundation of financial risk management.

III. PROCEDURES

The Area Director shall develop procedures to implement the provisions of 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 Behavioral Healthcare 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 and local ordinances.

III. PROCEDURES

The Area Director will develop procedures to implement this policy.


## I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare’s information technology functions 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 area.

## II. POLICY STATEMENT

Alliance Behavioral Healthcare shall develop an Information Technology Business Continuity Plan (BCP), 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 (DR), 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 Area Director shall develop procedures to implement this policy.
I. PURPOSE

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

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare that all procedure 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 Area Director shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to establish financial eligibility criteria for individuals not eligible for Medicaid and who are seeking treatment in the Alliance Provider Network. Eligibility for non-Medicaid funded services is not an entitlement and is contingent upon availability of funding.

II. POLICY STATEMENT

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

1. there must be funding available to pay for such treatment;
2. the individual must be a resident of a county in the Alliance 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.

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

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

III. PROCEDURES

The Area Director will develop procedures to implement 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 Behavioral Healthcare 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 state-funded 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 and expedited appeals, i.e. cases involving urgent care. The process and 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 made available upon request 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 Area Director/CEO shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare (“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 shall follow must also meet the credentialing and re-credentialing requirements as 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 Alliance Behavioral Healthcare shall 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. Alliance shall not discriminate solely on the basis of the Provider’s license or certification for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law.

III. PROCEDURES

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

The purpose of this policy is to provide a grievance process for permanent certain employees of Alliance Behavioral Healthcare contesting a disciplinary action, Reduction in Force, alleged illegal discrimination or harassment based on race, religion, color, national origin, sex (including pregnancy, childbirth, and related medical conditions), age, disability (physical or mental including AIDS/HIV status), genetic information (i.e. Sickle cell or hemoglobin C trait), citizenship status, military status or service, or political affiliation, or other issue grievable under state law. This policy applies to Alliance career status and permanent employees. Career status employees are eligible for appeal rights through the internal Alliance grievance process and the State Personnel Commission/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.

Permanent, temporary and contractual employees are encouraged to use Alliance Behavioral Healthcare’s complaint process for issues that do not involve disciplinary, reduction in force, or discriminatory actions.

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 24 months. This includes employees who came to Alliance directly from The Durham Center, Wake County Local Management Entity (but not Wake County Human Services), Cumberland Area Authority, or State government.

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

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

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

Alliance Behavioral Healthcare is committed to a consistent, equitable, and legally defensible process for the resolution of employee grievances regarding hiring, separation, disciplinary, reduction-in-force, or alleged discriminatory actions that are grievable under state law. Employees shall follow the grievance process as outlined in this policy and procedures developed by the CEO/Area Director.

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

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

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

IV. PROCEDURES

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

The purpose of this policy is to establish a policy and procedures for disciplinary actions.

II. DEFINITIONS

**Disciplinary Action** – A written warning, disciplinary suspension without pay, demotion, or dismissal, per 25 NCAC 01I .2301(a), except that a dismissal which is not imposed for disciplinary reasons (i.e. Reduction in Force, unavailability of employee) shall not be considered a disciplinary action.

**Grossly Inefficient Job Performance** – Failure to satisfactorily perform job requirements as set out in the job description, work plan, or as directed by the supervisor or Alliance management; and the unsatisfactory job performance causes or results in: (a) death or serious injury to an employee(s), or to members of the public, or to a person(s) over whom the employee has responsibility; or (b) the loss or damage to Alliance property, contracts or funds that results in a serious adverse impact on Alliance; or (c) failure to obtain or maintain legally required certification, licensure or other credentials.

**Unacceptable Personal Conduct** – Means as defined in 25 NCAC 01I .2304(b), including (1) conduct for which no reasonable person should expect to receive prior warning; or (2) job related conduct which constitutes violation of state or federal law; or (3) conviction of a felony or an offense involving moral turpitude that is detrimental to Alliance or impacts the employee’s service to Alliance; or (4) the willful violation of known or written work rules, policies or procedures; or (5) conduct unbecoming an employee that is detrimental to Alliance; or (6) the abuse of client(s), patient(s), student(s) or a person(s) or animal over whom the employee has charge or to whom the employee has a responsibility; or (7) falsification of an employment application or other employment documentation; or (8) insubordination which is the willful failure or refusal to carry out a reasonable order from an authorized supervisor; or (9) absence from work after all authorized leave credits and benefits have been exhausted.

**Unsatisfactory Job Performance** – Failure to satisfactorily perform job requirements as set out in the job description, work plan, or as directed by the supervisor or Alliance management.

**Disciplinary Action**: process for dealing with job related behavior that does not meet expected and communicated performance standards.

**Grossly Inefficient Job Performance**: Work related performance so egregious that it creates the potential for death or serious harm to clients, employees, or the public, or causes or results in a serious loss of, or damage to the employer’s property or funds adversely impacting the Area Program or the work unit.

**Unacceptable Personal Conduct**: Employee behavior for which a reasonable person should not expect to receive a prior warning, (e.g., conduct deemed unbecoming of an employee and detrimental to the organization).
Unsatisfactory Job Performance: Work related performance that fails to satisfactorily meet job requirements as outlined in the relevant job description, work plan, or as directed by the management of the department or agency.

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to provide an opportunity for a regular status permanent employee to correct identified performance problems or unacceptable personal conduct. Approval for all disciplinary actions except a written warning shall be obtained from the Area Director/CEO or designee before action is taken.

There are two grounds for disciplinary action: Unsatisfactory Job Performance, including Grossly Inefficient Job Performance, and Unacceptable Personal Conduct.

If an employee’s behavior creates grounds for disciplinary action then the employee may be warned, demoted, suspended or dismissed by the supervisor. The degree and type of disciplinary action taken is based on the judgment of the supervisor in consultation with Human Resources and the Area Director/CEO or designee. Depending on the disciplinary action taken, the employee may have the right to grieve or appeal the action.

At no time shall an employee be demoted, dismissed, or suspended as discipline without the final approval of the Area Director/CEO or designee. As requested by the Area Director/CEO, consultation with the Human Resources Director, and/or the Attorney for the Agency may occur before a dismissal. An employee shall be provided written documentation and explanation of the disciplinary action taken. A copy of Alliance Behavioral Healthcare’s Grievance policy shall be disseminated to all employees and a Grievance form and instructions will be included for disciplinary action taken against employees with the right to appeal.

The Area Director/CEO shall establish procedures to implement this policy in accordance with guidance issued by the State Personnel Commission and applicable state laws, rules and policies governing area authority personnel actions.

IV. APPEAL RIGHTS

Adverse actions (disciplinary demotions, suspensions, dismissals, reduction in pay, and reduction-in-force) can be appealed by a regular permanent employee. Non-regular (probationary) employees do not have appeal rights and cannot appeal adverse actions, except on the basis of illegal discrimination.
ITEM: Utilization Management Trends and Activities

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND: Alliance has completed six months of operations as a MCO. During this time the Utilization Management Department has received and processed upwards of 36,000 requests for Medicaid funded services. Alliance has been able to develop informative statistics based on these requests and has identified early trends, which has helped shape the actions and direction of the Utilization Management Department as well as other departments within Alliance. The presentation will provide a brief review of general statistics, with a focus on noted trends and interventions initiated over the past several months.

REQUEST FOR AREA BOARD ACTION: No formal action by the Board is being requested other than feedback and comments.

CEO RECOMMENDATION:
Accept the report as presented.

RESOURCE PERSON(S): Sean Schreiber, Chief Clinical Officer
ITEM:
Wake County Transportation Plan

DATE OF BOARD MEETING:
September 5, 2013

BACKGROUND:
Wake County Government has developed a plan to transport persons subject to involuntary mental commitments (IVC) in conformity with the requirements set forth in N.C.G.S. 122C-251. In alignment with the legislative requirements, Wake County’s transportation plan is to contract out the responsibility for transporting individuals who meet IVC criteria as opposed to assigning the responsibility to the Sheriff’s department. This decision was reviewed and has been supported by Alliance. Wake County’s transportation plan has been included for your review.

REQUEST FOR AREA BOARD ACTION:
Hear the presentation on Wake County’s transportation plan

CEO RECOMMENDATION:

RESOURCE PERSON(S):
Rob Robinson
A. **SCOPE OF PLAN**

It is the policy of Wake County to transport persons subject to involuntary mental commitments (Respondents) in conformity with the requirements set forth in N.C.G.S. 122C-251. This plan regarding transportation of Respondents applies to Wake County Deputies as law enforcement officers, Wake County Detention Officers and any contract transportation provider designated by the Wake County Commissioners pursuant to N.C.G.S. 122C-251(g).

B. **SERVICE OF INVOLUNTARY COMMITMENT ORDERS ON RESPONDENTS AND INITIAL CUSTODY MUST BE PERFORMED BY A LAW ENFORCEMENT OFFICER**

The initial service of the Involuntary Commitment Order upon a Respondent and the initial custody of the Respondent shall be accomplished by a law enforcement officer pursuant to N.C.G.S. 122C-261(e). Once the Respondent has been committed to a 24-hour facility, transportation to and from that facility can be accomplished by a law enforcement officer or anyone authorized to provide transportation to involuntary commitment Respondents pursuant to N.C.G.S. 122C-251(g).

C. **TRANSPORTATION OF RESPONDENTS WITHIN WAKE COUNTY**

Transportation of a Respondent within Wake County pursuant to involuntary commitment proceedings, including initial custody, medical and psychiatric evaluation, admission and discharge, shall be provided by deputies of the Wake County Sheriff’s Office for (1) a Respondent who resides in Wake County but outside city limits or (2) a Respondent who is taken into custody in Wake County but outside of city limits. However, transportation after initial custody by deputies can be performed by Wake County Detention Officers or a contract transportation provider designated by Wake County pursuant to N.C.G.S. 122C-251(g).

D. **TRANSPORTATION OF RESPONDENTS BETWEEN COUNTIES**

Transportation between Wake County and other counties under involuntary commitment proceedings for admission of a Respondent taken into custody in Wake County to a 24-hour facility shall be provided by members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g).

Transportation between counties under involuntary commitment proceedings for Respondents held in 24-hour facilities who have requested a change of venue for their District Court hearing shall be provided by members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g) if the petition for involuntary commitment for the Respondent was initiated in Wake County.

Transportation between counties under involuntary commitment proceedings for discharge of a Respondent from a 24-hour facility shall be provided by members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g) if the discharged Respondent is a resident of Wake County. Nothing in this policy prevents a Respondent being discharged from a facility to use their own transportation at their own expense.
E. PROCEDURES FOR TRANSPORT OF RESPONDENTS

Members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g), to the extent possible, shall advise Respondents, when either taking them into custody or performing transport, that the Respondent is not under arrest, has not committed a crime, but is being transported to receive treatment for their own safety and that of others. It should also be explained to the Respondent that it will be necessary for the Respondent’s safety and the safety of others that the Respondent be handcuffed or otherwise restrained.

In providing transportation pursuant to this policy, members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g), may use reasonable force to restrain the Respondent if it appears necessary to protect themselves, the Respondent, or others. Members of the Wake County Sheriff’s Office or contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g) should carefully read the Involuntary Commitment Order and Petition or seek information from the committing facility to determine if the Respondent presents any danger of assault or escape during the transport. All Respondents being transported shall either be secured in a car or van cage, if available, or handcuffs and waist chains shall be used if there is no car or van cage. The transportation of Respondents may require the use of restraints other than, or in addition to, handcuffs and waist chains. Restraints used in these situations should restrain the Respondent securely, without causing injury. If special restraints are required to transport a Respondent, the person performing the transport should coordinate with the Wake County Crisis Assessment Center or other facility to obtain use of available appropriate restraints.

In providing transportation of a Respondent there shall be a driver or attendant who is the same sex as the Respondent unless a family member of the respondent is allowed to accompany the Respondent in lieu of an attendant of the same sex as the Respondent. Trained NAMI Volunteers may also be used to comply with this section of the policy. The Wake County Sheriff’s Office maintains a list of trained NAMI Volunteers.

F. COUNTY TRANSPORTATION PLAN PURSUANT TO N.C.G.S. 122C-251(g)

Wake County Law Enforcement Officers, Wake County Detention Officers or any person or firm contracted to provide transportation of involuntary commitment Respondents shall be subject to the terms of this plan and shall be trained using appropriate lesson plans provided by the North Carolina Justice Academy for interacting with the mentally ill, emotionally disturbed and other special populations. Crisis Intervention Training will also be provided. In this manner, this plan and approved training plan shall assure adequate safety and protections for both the public and the Respondent.

Wake County Detention Officers or a contract transportation provider designated by Wake County pursuant to N.C.G.S. 122C-251(g) to provide transportation to Respondents shall provide the transportation and follow the procedures in this policy and appropriate statues in Article 5, Chapter 122C of the North Carolina General Statutes. References in Article 5 to a law enforcement officer apply to Wake County Detention Officers or to a contract transportation provider retained and approved by Wake County pursuant to N.C.G.S. 122C-251(g) when providing transportation to involuntary commitment Respondents.

Contract transportation providers designated by Wake County pursuant to N.C.G.S. 122C-251(g) shall agree to indemnify and hold harmless the County of Wake and the Wake County Sheriff and his employees or agents and provide necessary insurance as required by the Wake County Risk Manager before performing transportation duties pursuant to said contract.
ITEM: Provider Network Development

DATE OF BOARD MEETING: 9/5/13

BACKGROUND: We are implementing initiatives to begin shaping our provider network toward increased quality, filling service gaps, meeting state initiatives and performance standards, and in support of evidence based and best practices. Our Selection and Retention procedure provides guidance on identifying providers with performance and compliance issues for whom we may decide not to extend a contract. It also offers ways in which we may extend the network. We have developed a mechanism to review and respond to specific service gaps that are identified by UM, Care Coordination, Access, or Provider Networks. We also will expand the network to comply with the Local Business Plan requirements. In addition, we have identified several services that either have frequent quality concerns, evidence high cost with limited outcomes, or have concerns related to models of practice. These services are Intensive In-Home, Substance Abuse Intensive Outpatient, and Community Support Team. It is our intention to develop RFPs for these services to identify providers that will offer these services to the standards identified in the RFP in order to improve quality, outcomes, and the fiscal stability of the provider network.

REQUEST FOR AREA BOARD ACTION: Receive Report

CEO RECOMMENDATION: Accept Report

RESOURCE PERSON(S): Beth Melcher
ITEM:  Local Business Plan Presentation

DATE OF BOARD MEETING:  September 5, 2013

BACKGROUND:
As part of NC General Statute 122C-115.2, LME’s/MCO’s are to submit a Local Business Plan (LBP) to DHHS that identify gaps, needs, and barriers, as well as goals and strategies to address issues over the period of July 2013 to June of 2016. Alliance Behavioral Healthcare must submit this LBP by December 31, 2013.

Several Statewide Initiatives are required of all LME’s to address, and each LME is to identify a minimum of 3 Local Initiatives to address in the LBP. The Statewide Initiatives are:

- Transition to Community Living
- ACTT/Supported Employment
- Crisis Service Enhancement
- Closer to Home (PRTF)
- I/DD Waitlist

The Local Initiatives identified by the Continues Quality Improvement Committee are:

- Complex Physical and Behavioral Health (PROACT)
- Open Access (Access to Care)
- Jail Initiatives (Diversions and Post Linkages)

Requirements for approval of the LBP are that the LME/MCO CFAC’s have input and review of the draft LBP, that the LME/MCO Board approves, and the LME/MCO county Boards of County Commissioners approve. In order to meet the deadline of December 31, 2013, following are timelines that need to be met for approval:

- CFAC review and input (August/September)
- Alliance Provider Advisory Council Review (August)
- Alliance Behavioral Healthcare Board approval (September)
- All 4 County BOCC’s approval (October/November)
- Submission to DHHS (December)

AREA DIRECTOR RECOMMENDATIONS:
Approve the Local Business Plan

RESOURCE PERSON(S):
Lena Klumper, Ph.D
Local Business Plan
Overview

8/27/13
Purpose

- DHHS Requirement
- Originally in NC Statute G.S. 122C-115.2
- To guide the MCOs over the next 3 years
- 5 State Initiatives
- 3 Local Initiatives
- Short and Long Term Measurable Goals
- Regular reporting to DHHS
- Need Provider and Consumer/Family Input
State Initiatives

- Transition to Community Living
  - Per the DOJ Settlement regarding people with severe mental illness having access to community-based supported housing
  - Alliance Goals:
    - Perform in-reach to a minimum of 150 people already in Adult Care homes or transitioning from hospital settings
    - 50% of those identified will transition within 90 days
    - At least 50% of identified individuals will have an advocate assigned
    - At least 30% of individuals will be diverted from entry into Adult Care Homes by December 31, 2014

- ACTT/Supported Employment
- Crisis Services/ED Wait Times
- Closer to Home (PRFT)
- I/DD Waitlist
State Initiatives

- Transition to Community Living
- **ACTT/Supported Employment**
- Crisis Services/ED Wait Times
- Closer to Home (PRFT)
- I/DD Waitlist

- **ACTT/Supported Employment**
  - A primary Alliance Objective is to develop a robust provider network and consistent approach to Assertive Community Treatment services and Supported Employment throughout the coverage area.
  - **Alliance Goals:**
    - Increase the number of consumers engaged in competitive employment by 20%
    - At least 50% of providers will be following fidelity to the models of care
    - Alliance will contract with at least 2 additional providers of Supported Employment
    - Consumers utilizing ACTT services for at least 12 months will have at least a 50% decrease in crisis events
• **Crisis Services/ED Wait Times**
  - The lack of adequate crisis resources in the Alliance 4 county area has led to over-utilization of EDs, created extended ED wait times, and at times increased admission rates to hospitals.
  - **Alliance Goals:**
    - Decrease ED admissions in Cumberland County by 30%
    - Decrease the number of times the WakeBrook crisis facility is on diversion by 40%
    - Decrease the number of Durham consumers admitted to CRH by 30%
    - Improve % of F/U appointments occurring within 7 days post inpatient
    - Improve the % of F/U appointments occurring within 5 days post crisis stays
State Initiatives

- Transition to Community Living
- ACTT/Supported Employment
- Crisis Services/ED Wait Times
- Closer to Home (PRFT)
- I/DD Waitlist

**Closer to Home – PRTF**
- Alliance strives to reduce out of state PRTF placements of youth
- **Alliance Goals:**
  - Reduce the # of children referred out of state by 75%
  - By January 1, 2015, no more than 2% of authorizations for PRTFs will be out of state
State Initiatives

- Transition to Community Living
- ACTT/Supported Employment
- Crisis Services/ED Wait Times
- Closer to Home (PRFT)
- **I/DD Waitlist**

- **I/DD Waitlist**
  - Waiver slot allocations have not kept pace with demand, and eligible individuals wait long lengths of time to be placed.

- **Alliance Goals:**
  - Remove 227 individuals from the Registry of Unmet needs by enrolling them in available new and vacated slots.
  - Update information of those on the lists.
  - By 2015, reduce the wait time for waiver slot allocation to less than 5 years.
Local Initiatives

- **PROACT (Preventable Readmission Options and Care Transitions)**
- Open Access (Access to Care)
- Jail Initiatives (Diversions and Post Linkages)

**PROACT**

- Individuals with behavioral health disorders often have comorbid health issues that can be life threatening, thus tend to utilize EDs more frequently

**Alliance Goals:**

- Reduce ED admissions of those with Co-Morbid conditions by 50% by 2015
- Reduce readmissions to EDs by 50% by 2015
- Ensure all consumers receive a medication review within 5 days post inpatient or ED discharge
Local Initiatives

- PROACT (Preventable Readmission Options and Care Transitions)
- Open Access (Access to Care)
- Jail Initiatives (Diversions and Post Linkages)

- **Open Access (Access to Care)**
  - Due to Wake and Cumberland county late divestiture of the service continuum, many services were not billed or billed properly. In addition, waitlists have occurred due to MCO merger transition and divestiture
  - **Alliance Goals:**
    - At least 75% of outpatient services providers will offer open access/same day appointments
    - 95% of consumers will have an appointment within 5 business days
    - The no-show rate for first appointments will be less than 30%
    - By 2015, the no-show rate for first appointments will be less than 15%
Local Initiatives

- PROACT (Preventable Readmission Options and Care Transitions)
- Open Access (Access to Care)
- Jail Initiatives (Diversions and Post Linkages)

**Jail Initiatives**

- Consumers are taken to jails rather than crisis facilities as a first responder location, and follow up post incarceration is to be improved.

**Alliance Goals:**

- A minimum of 4 CIT classes will be provided across the catchment area each year
- A minimum of 4 different first responder types to attend, i.e., EMS, fire departments, university/community college law enforcement.
- A central repository for data sharing will be developed
Need your Input/Feedback

Please provide your input and feedback to:

Lena Klumper by phone: 919-651-8442 or email: Lklumper@Alliancebhc.org

Next Steps:
CFAC to Review in September
Alliance Board to Approve in September
County BOCC’s to Approve in October/November
To DHHS by December 31st
LME Name: Alliance Behavioral Healthcare

Local Initiative: Preventable Readmission Options and Care Transitions (PROACT)

GS 122C-115.2 Administrative Function Addressed with Initiative (select all that apply):
- Planning
- Provider Network Development
- Service Management
- Financial Management
- Service Monitoring
- Evaluation
- Collaboration
- Access

Behavioral health issues can have a significant impact on physical health issues and physical health issues can negatively impact an individual's behavioral health issues. Behavioral and emotional disorders can diminish an individual's attention to their overall health, impact important preventative health strategies such as making and keeping routine health care appointments adversely affect follow-up and aftercare for an illness and can lead to poor compliance related to the care of more chronic health conditions. Often these individuals seek primary health services through local emergency departments when symptoms worsen or become exacerbated. Additionally, oftentimes individuals seeking services in an emergency department may present with a physical health complaint, yet the true reason for the visit can be attributed to a behavioral health issue. As a result, the appropriate treatment and follow up is often missed. These individuals tend to have high overall healthcare costs based on the usage of emergency departments and because more expensive healthcare interventions are required as a result of non-compliance. These issues require an integrated approach to the overall care management for these individuals. This issue impacts the State Performance Indicator of "Medical Care Coordination." The average percent of consumers served by Alliance who have received a preventive health visit in the past 12 months is 86%. The statewide average is 90%, which is the Alliance goal. Data source: NC-TOPPS; claims data; CCNC data.

Issue:

Reasons for Action

There are several reasons to integrate behavioral and physical health care management for this population. Studies have revealed that in general individuals with serious and persistent mental illness have an average life expectancy of up to 25 years less than individuals without a persistent mental illness. Individuals with co-occurring physical health and behavioral health issues are high utilizers of emergency room services and tend to have higher inpatient readmission rates on medical floors and psychiatric units or hospitals. Individuals with primary behavioral health related issues tend to use emergency departments to address physical health care needs at higher rates than those without an identified mental illness. In general, based on national data, this population has an average of eight (8) or more emergency department visits per year, primarily for physical health complaints oftentimes across multiple hospitals. This population also is at risk for adverse medication events if there is no coordination between their physical health and behavioral healthcare prescribers. Currently, MCOs only receive ED claims for consumers whose primary reason for an ED visit was coded a behavioral health disorder. Oftentimes, individuals with depression, anxiety, trauma, and substance abuse present complaining of physical symptoms that can be attributed to these conditions, however based on coding and billing practices, the ED claims for these visits are sent to general Medicaid and not Alliance for payment, therefore we miss these individuals as high users through typical MCO data mining activities and in turn miss the opportunity to better manage care.

Measurable Goal(s) please specify if these are short term (< 1yr.) or long term (> 1yr.) - Listed as ST for Short term and LT for Long term
Alliance will implement an integrated care management model with the local CCNC networks that focuses on the PROACT population, which is described above. The integrated care model will include specific interventions, timeframes for interventions and benchmarks for all consumers identified as being in the PROACT population. This planning and model development is currently underway. Alliance and CCNC will develop a management and oversight structure for the initiative. Distinct PROACT teams comprised of Alliance staff and local CCNC staff will be formed to manage this population in each Alliance/CCNC region. Alliance will enter into formalized agreements with both the state CCNC and local CCNCs that will detail all responsibilities, expected practices, case assignment, discharge processes and expected outcomes for the initiative. Alliance will identify staff within our existing Care Coordination units to assign to PROACT Teams. Roles for all PROACT members will be developed and will outline role specific tasks. Alliance will work with CCNC to develop and implement formal data sharing arrangements that will inform target populations and improve outcome monitoring, including developing efficient ways to exchange data. Alliance and local CCNCs will educate stakeholders in the initiative and develop needed agreements to work with stakeholders to meet the needs of the target population and initiative goals. In conjunction with local CCNCs, Alliance will complete a review of all consumers that have been identified as falling within the priority population based on CCNC analytics. This will include a review of all consumer history in Alpha and the CCNC CHMIS system. Alliance and CCNC will develop standard operating procedures for the team in relationship to interactions with other CCNC and Alliance staff and activities. The roles of Alliance and CCNC psychiatrists, CCNC pharmacists, Alliance ED and Inpatient Liaisons, CCNC practice embedded care managers, Alliance UM and Access to Care Center staff will be delineated as well. In addition to cost reduction data, Alliance, in collaboration with CCNC, will develop a mechanism to evaluate the effectiveness of the program.

LME Name: Alliance Behavioral Healthcare

1. (ST) Reduce ED admissions of consumers with both behavioral health and physical health conditions by 25% by June 30, 2014.
2. (LT) Reduce ED admissions of consumers with behavioral health and physical health conditions by 50% by June 30, 2015.
3. (ST) Reduce readmissions to EDs within 90 days by 30% by June 30, 2014.
4. (LT) Reduce readmissions to EDs within 90 days by 50% by June 30, 2015.
5. (ST) Ensure all consumers identified as part of this population receive a medication review within 5 days of inpatient or ED discharge, by June 30, 2014.

If necessary, reference hyperlink for additional information on LME-MCO Website

If necessary, please list document name if attachments are submitted with printed copy of LBP

N/A
Prior to the merger of the Wake LME and the Durham Center, which initially formed Alliance Behavioral Healthcare, the majority of state funded outpatient behavioral health services were provided by Wake Health and Human services in Wake County. Additionally, prior to the inter-local agreement between Cumberland and Alliance, the majority of outpatient behavioral health services were provided by the Cumberland County Area Authority. These entities could no longer provide direct services based on the county relationships with Alliance. As a result, all services provided by these entities needed to be divested. A second divestiture of services needed to occur as a result of the merger of Cumberland Area Authority with Alliance. The divestitures created access to care issues during the time that providers were ramping up to accept a greater volume of consumers. In both Cumberland and Wake counties, the divesting agencies stopped accepting new referrals sooner than anticipated and before adequate capacity was available in these communities. Longer wait times for initial assessments were creating delays in regard to consumers' ability to access medication evaluations, necessary follow-up, and increases in the no-show rate for first appointments. Beyond issues related to divestiture, timely access to psychiatry care had been an issue in Wake and Cumberland counties. As a result of these issues, Alliance's access percentages have slipped below the state's average timely access to care performance criteria. Data utilized: Access to Care (STR) data - Alpha.
LME Name: Alliance Behavioral Healthcare

Alliance believes that services need to be available to consumers when they need them. It is difficult at times for individuals to ask for help and the longer the wait for services after seeking them the more likely it is that an individual will end up not accessing services. No show rates for services begin to spike when appointments are not available in a timely manner. In fact, no show rates may go as high as 50% when a consumer cannot be seen within several days of a request for service. Alliance network providers were reporting these high no-show rates, which was supported by internal data. Often, these providers did not have first appointments available for 7 to 10 days of the times consumers called seeking services. High no-show rates waste the clinical capacity of providers and can lead to fiscal instability. Beyond access issues for consumers who called seeking services, a greater impact was being experienced by the local crisis facilities and EDs and consumers leaving inpatient units. While consumers leaving an inpatient facility or those referred by a crisis facility receive priority status for an initial assessment, access to prescribers was limited. Consumers were leaving facilities on medications and their prescriptions would run out prior to seeing a prescriber. Additionally, EDs and crisis facility physicians were less likely to divert consumers back to the community or take a consumer off of involuntary commitment if they could not be seen by a prescriber within a few days. For these reasons, Alliance began exploring other models that would allow more immediate access to an assessment and psychiatric services. In Durham, Alliance has shared a strong historic relationship with an outpatient psychiatric clinic where consumers are seen by a prescriber for their initial appointment. Based on the network make-up in the other communities this model was not an option. The service divestitures in Cumberland and Wake County provided the opportunity to begin implementing best practices related to service access such as open access and same day prescriber appointments, both with existing providers as a way to capitalize on their current capacity and with the providers who would assume the roles of the divesting programs.

Measurable Goal(s) please specify if these are short term (< 1yr.) or long term (> 1yr.) -Listed as ST for Short term and LT for Long term

1. (ST) By June 30, 2014, at least 75% of outpatient service providers will offer open access/same day appointments within all Alliance regions. 2. (ST) By June 30, 2014, 95% of consumers contacting Alliance for routine services will have an appointment within 5 business days from their request for services. 3. (ST) By June 30, 2014, the no-show rate for first appointments will be less than 30%. 4. (LT) By June 30, 2015, the no-show rate for first appointments will be less than 15%.

LME plan for addressing issue and achieving goals
A complete evaluation of average time from referral to first appointment in all Alliance covered counties will be conducted. Alliance staff will meet with key service providers that offer assessments in order to review capacity to accept new consumers, review barriers and review resource needs. Alliance will arrange for training and ongoing consultation on the Open Access model to providers in the Alliance catchment area. Alliance will prioritize Open Access with same day physician appointments within the catchment area, and recruit providers to the network who have demonstrated successful implementation of open access, or those who outline how they will implement this model if awarded a contract to serve Alliance consumers. For providers that use Open Access, Alliance will set-up Open Access times and days in the Alpha scheduler for providers to ensure appointments are used, and report utilization of these appointments. In addition, Alliance will prioritize Open Access with same day physician services to consumers seen in an ED, leaving an inpatient unit or post crisis and assessment center visit. Staff will ensure Open Access providers have sufficient service codes in contract to address multiple assessment appointments within the same day. Education will be provided for local emergency departments and crisis facilities about Open Access on how to refer directly to Open Access providers or how to access these appointments through the Alliance Access and Information Center. An FRI will be released for additional outpatient services in Cumberland county with Open Access being a requirement for a successful response. A routine meeting schedule will be developed with Open Access providers to ensure Alliance is utilizing Open Access appointments and address barriers or issues as they arise.

If necessary, reference hyperlink for additional information on LME-MCO Website
If necessary, please list document name if attachments are submitted with printed copy of LBP

N/A
Access Data
LME Name: Alliance Behavioral Healthcare

<table>
<thead>
<tr>
<th>Local Initiative: Jail Initiatives (Diversions and Post Linkages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS 122C-115.2 Administrative Function Addressed with initiative (select all that apply):</td>
</tr>
<tr>
<td>✔️</td>
</tr>
</tbody>
</table>

Consumers are sometimes taken to jails as a first responder destination rather than to a crisis facility or by having mobile crisis units contacted. This is due in part to many law enforcement personnel still not being trained in Crisis Intervention techniques (CIT), although it has been offered for several years in each of the Alliance Behavioral Healthcare counties. Another issue regards a need for improved follow up post incarceration to ensure consumers are connected to services and to reduce recidivism (crisis events and incarceration).

Issue:

Reasons for Action

Alliance Behavioral Healthcare wants to ensure that the maximum number of individuals in each community receive CIT training because training has proven to be effective in jail diversion, increasing referrals to community-based services and crisis centers, and promotes decreased utilization of jails for misdemeanor and non-violent offense arrests. In addition, the Alliance Community Relations team wants to include all types of Law Enforcement Officers (LEOs) and First Responders that may have contact with individuals with MH/IDD/SA in various settings, such as community, detention, schools, and facilities because there is an increase in the number of effective and respectful interactions between individuals with MH/IDD/SA and CIT trained LEOs; consumers improve their access to treatment resources via CIT LEO, and safety for CIT LEO and individuals with MH/IDD/SA increases due to a use of CIT skills, verbal de-escalation, and decreased use of physical interventions. Data utilized to track goals: CIT training logs; incarceration data system developed.

Measurable Goal(s) please specify if these are short term (< 1yr.) or long term (> 1yr.) - Listed as ST for Short term and LT for Long term

1. (ST) Alliance Behavioral Healthcare will provide a minimum of four CIT classes during FY14 for Durham, Wake, and Cumberland Counties. A minimum of two classes will be held in Johnston County. A minimum of twenty individuals will attend each CIT class. 2. (ST) There will be a minimum of four different first responder types attending CIT classes during FY14. Examples would be police officers from the universities/community colleges, city police officers, County Sheriff’s Departments, and general first responders such as EMS and fire department personnel. 3. (ST) By June 30, 2014, Alliance will develop a central repository for data collection from the four counties regarding incarcerations, recidivism, and diagnostic information that can be standardized for reporting data. During FY14, base line data will be collected as part of this process.

LME plan for addressing issue and achieving goals
Alliance will maintain, develop, and collaborate with the CIT Leadership Committee in each community using the SAMHSA’s GAINS model (located at this web site) -- gainscenter.samhsa.gov. Data will be reviewed from every CIT class to engage the CIT Leadership Committee in a continuous quality improvement process. To improve consumers’ access to treatment resources via CIT LEO, training will enhance safety for CIT LEO and individuals with MH/IDD/SA increases due to a use of CIT skills, verbal de-escalation, and decreased use of physical interventions. The CIT Leadership Committee will ensure all LEO types are invited to participate and engage in CIT training and the CIT culture of community policing. Data will be reviewed to obtain information from every CIT class to show engagement in the CIT Leadership Committee. The Alliance Provider Network needs to know when consumers are incarcerated so that consumers can re-engage in treatment upon release. Alliance will use the data reports to identify system trends and patterns, interpret and integrate the facts, and stimulate change. This will be done by working closely with IT and QM to use technology to develop auto-generated reports decrease staff time manually collecting data. Data will be maximized to gather information from the various internal and external group meetings to interpret and integrated the facts, and stimulate change.

CIT data
ITEM: Legislative Update

DATE OF BOARD MEETING: September 5, 2013

BACKGROUND: Overview of recent legislation affecting Medicaid, mental health, Alliance and the consumers we serve, with particular focus on SB208 and SB553 at request of Board Members.

REQUEST FOR AREA BOARD ACTION: None

CEO RECOMMENDATION: N/A

RESOURCE PERSON(S): Tracy Hayes

ATTACHMENTS: NC Council Legislative Overview, S208, S553
<table>
<thead>
<tr>
<th>House</th>
<th>Bill Title</th>
<th>Primary Sponsor</th>
<th>Brief explanation of the bill</th>
<th>Status of bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 5</td>
<td>Temporary Funding/Group Homes &amp; SCUs</td>
<td>Dollar and Burr</td>
<td>Requires DHHS to provide temporary, short-term financial assistance to group homes serving residents who are now not eligible for Personal Care Services under Medicaid and Special Care Units with residents who qualify for PCS on or after 1/1/13.</td>
<td>SL 2013-4</td>
</tr>
<tr>
<td>H 70</td>
<td>NC Health Plan</td>
<td>Brandon</td>
<td>To cover all NC residents with comprehensive health benefit coverage, including MH services, as an alternative to a Health Benefit Exchange.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>H 130</td>
<td>MH Workers’ Bill of Rights</td>
<td>Bell</td>
<td>Specifies rights of Mental Health Workers by amending 122C</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>H 173</td>
<td>Revise Controlled Substance Reporting</td>
<td>Horn, Brisson, Fulghum, Hollo</td>
<td>Makes revisions to the State requirements on controlled substance reporting</td>
<td>Passed House as amended 4/30/13, referred to Senate Health Care, then Finance</td>
</tr>
<tr>
<td>H 308</td>
<td>Funds/MHDDSA Services/Non-Medicaid Eligibles</td>
<td>Insko</td>
<td>Appropriates $78 million for each year for community MH/DD/SA State-funded services.</td>
<td>Committee on Appropriations</td>
</tr>
<tr>
<td>H 320</td>
<td>Medicaid Managed Care/Behavioral Health Services</td>
<td>Dollar, Burr</td>
<td>Establishes federal Medicaid managed care requirements for appeals under the Medicaid 1915 (b)(c) waiver.</td>
<td>Passed House as amended 5/15/13, referred to Senate Health Care, then Appropriations S. 553 (Ratified) was passed into law. It is not a companion but does include the federal managed care requirements for recipient appeals.</td>
</tr>
<tr>
<td>H 344</td>
<td>Uniform MH Reporting Requirements for NICS</td>
<td>Insko</td>
<td>Establishes uniform reporting requirements for reporting MH and SA judicial determinations or findings to the National Instant Criminal Background Check System.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>H 398</td>
<td>Systematically Reform</td>
<td>Burr, Hollo,</td>
<td>A placeholder bill with no language yet waiting on the</td>
<td>Referred to Cmte. on</td>
</tr>
<tr>
<td>Bill</td>
<td>Sponsor(s)</td>
<td>Description</td>
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<tr>
<td>H 399</td>
<td>Burr, Hollo, Avila</td>
<td>Amended Laws Pertaining to DHHS. DHHS requested changes to law related to child abuse, neglect and dependency, Medicaid and public health. Medicaid changes include provisions on estates and deceased as well as additions to limited and moderate categorical risk provider types. Includes a provision giving LME-MCOs responsibility for screening.</td>
<td></td>
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</tr>
<tr>
<td>H 543</td>
<td>Jones, Avila, Glazier, Turner</td>
<td>Medicaid Providers as Uncompensated Guardians. Allows providers of MH/DD/SA services to serve as uncompensated, court-appointed guardians to unrelated clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H 580</td>
<td>Martin, Burr, Avila, Lambeth</td>
<td>Establish statewide Telepsychiatry Program. Appropriates $2 million for each of two years to establish a statewide telepsychiatry program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H 635</td>
<td>Lambeth, Conrad, Terry, Hanes</td>
<td>Involuntary Commitment Custody Orders. Allows for magistrate, clerk of superior court to send a fax of the involuntary commitment orders to petitioning physician, eligible psychologist or designee.</td>
<td></td>
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</tr>
<tr>
<td>H 638</td>
<td>Steinburg, Tine</td>
<td>Increase Membership of Area Boards. Increases to allow multicounty authorities with 10 or more counties can have up to 30 area board members.</td>
<td></td>
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</tr>
<tr>
<td>H 674</td>
<td>Stevens</td>
<td>Study Medicaid Provider Hearings. Study contested care process for Medicaid provider appeals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H 693</td>
<td>Whitmire, Fulghum, Brisson, Schaeffer</td>
<td>Eliminate Exceptions/Med Tx/ Minors. Eliminates exceptions for parental consent for abortion in areas including diagnosed substance abuse and mental illness.</td>
<td></td>
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</tr>
<tr>
<td>H 867</td>
<td>Avila, Burr</td>
<td>Medicaid County of. Makes individuals under the Medicaid 1915(b)(c) waiver.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legislative Actions:**
- **H 580 (See Section 12A.2B(a) of S 402)**: Passed House 5/14/13, referred to Senate Rules.
- **H 638**: DID NOT MAKE CROSSOVER.
- **H 674**: Passed House 5/14/13, referred to Senate Rules.
- **H 693**: DID NOT MAKE CROSSOVER.
<table>
<thead>
<tr>
<th>Senate</th>
<th>Bill Title</th>
<th>Primary Sponsor</th>
<th>Brief explanation of the bill</th>
<th>Status of bill</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Residence</td>
<td>Hollo, Brisson</td>
<td>exempt from the home county requirements. Further makes (c) innovations waiver slots portable.</td>
<td>referred to Senate Health Care</td>
</tr>
<tr>
<td>H 881</td>
<td>Greater Financial Oversight of LME-MCO</td>
<td>Farmer-Butterfield</td>
<td>Requires reporting of LME-MCO prior to purchase of real estate costing over $100,000 and requires DHHS to consider LME-MCO financial reserves and administrative costs when negotiating PMPM.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>H 973</td>
<td>Funds/Two-tiered pay for 3-way Contracts</td>
<td>Martin, Burr, Avila, Hollo</td>
<td>Proposal from LOC on HHS to provide for a two-tiered payment on 3-way hospital contracts to ensure payments for higher risk consumers are sufficient.</td>
<td>Provision in S.L. 2013-360</td>
</tr>
<tr>
<td>H 974</td>
<td>Governor’s Proposed Budget</td>
<td>Dollar, Johnson, Holloway, Burr</td>
<td>Includes provisions the Governor proposed for the SFY13-15 budget.</td>
<td>Referred to Cmte. on Appropriations</td>
</tr>
<tr>
<td>H 980</td>
<td>Medicaid/2012-2013 Additional Appropriations</td>
<td>Burr</td>
<td>Provides funding for Medicaid shortfall. (Was previously a bill for the House budget)</td>
<td>S.L. 2013-56</td>
</tr>
<tr>
<td>H 981</td>
<td>New MHDDSA Region and Psychiatric Hospital</td>
<td>Burr, Howard, McNeill, Carney</td>
<td>Proposal from LOC on HHS to study the need for a new MHDDSA region and psychiatric hospital.</td>
<td>Referred to Cmte. on Appropriations</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Brief explanation of the bill</th>
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</tr>
</thead>
<tbody>
<tr>
<td>S4</td>
<td>No NC Exchange/No Medicaid Expansion</td>
<td>Apodaca, Brown, Rucho</td>
<td>Clarifies State’s intent not to operate a state-run or “partnership” health benefit exchange and to provide that future Medicaid eligibility determinations will be made by the State and to reject the Affordable Care Act’s optional Medicaid expansion.</td>
<td>S.L 2013-5</td>
</tr>
<tr>
<td>S137</td>
<td>Prohibit Co-Pay Waiver/Medicaid Providers</td>
<td>Tillman</td>
<td>Provides that the regular practice of waiving the Medicaid recipient co-payments by a Medicaid provider constitutes fraud.</td>
<td>S.L. 2013-145</td>
</tr>
<tr>
<td>S 208</td>
<td>Effective Operations under the Medicaid 1915(b)(c) Waiver</td>
<td>Tucker</td>
<td>Sets parameters for the Secretary to monitor and measure solvency of the LME-MCOs and addresses timeliness of payments to providers.</td>
<td>S.L. 2013-85</td>
</tr>
<tr>
<td>S 222</td>
<td>Revise Controlled Substance Reporting</td>
<td>Allran, Bingham</td>
<td>Makes revisions to the State requirements on controlled substance reporting</td>
<td>S.L. 2013-152</td>
</tr>
<tr>
<td>Bill No.</td>
<td>Title</td>
<td>Sponsor(s)</td>
<td>Description</td>
<td>Status</td>
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<td>------------</td>
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<tr>
<td>S 223</td>
<td>Severance and Relocation for Area Directors</td>
<td>Hise</td>
<td>Allows area boards to offer several and relocation packages to area directors.</td>
<td>S.L. 2013-339</td>
</tr>
<tr>
<td>S 335</td>
<td>Payment of 2012-2013 Medicaid costs</td>
<td>Brunstetter, Brown,</td>
<td>Gives direction on adjustments to the State budget to increase the authorized budget for Medicaid.</td>
<td>Referred to Appropriations</td>
</tr>
<tr>
<td></td>
<td>(See H 980)</td>
<td>Hunt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S 347</td>
<td>Study Unified Public Health System</td>
<td>Hartsell</td>
<td>Requires a study be done and reported to the HHS LOC on a unified public health system, including a review of public health and mental health governance structures.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 367</td>
<td>Systematically Reform Medicaid</td>
<td>Hise, Pate</td>
<td>A placeholder bill with no language yet waiting on the RFI draft on Medicaid reform from DHHS.</td>
<td>Referred to Committee on Health Care</td>
</tr>
<tr>
<td>S 417</td>
<td>Establish State Public Health Authority</td>
<td>Hartsell</td>
<td>Creates a State Public Health Authority and four public health authorities by amending G.S. 130A that have the authority to create health care networks and conduct managed care activities. Also folds DEHNR into DPH under DHHS.</td>
<td>Referred to Cmte. on Health Care, then Appropriations</td>
</tr>
<tr>
<td>S 447</td>
<td>Eligibility Requirements/Public Assistance</td>
<td>Brock</td>
<td>Requires applicants to undergo substance abuse testing before being eligible for public assistance. Also requires Social Services Commission to adopt rules regarding substance abuse screening and treatment and public assistance eligibility.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 473</td>
<td>Health Care Cost Reduction and Transparency</td>
<td>Rucho, Brown</td>
<td>Amends hospital collection and billing practices requirements and allows General Assembly to intervene in judicial proceedings related to NC statute or NC constitution.</td>
<td>Ratified</td>
</tr>
<tr>
<td>S 551</td>
<td>Amend Laws Pertaining to Medicaid</td>
<td>Hise</td>
<td>DHHS requested changes to law related to child abuse, neglect and dependency, Medicaid and public health. Medicaid changes include provisions on estates and deceased as well as additions to limited and moderate categorical risk provider types.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 552</td>
<td>Public Paid Claims Data/Health Info Exchange</td>
<td>Hise</td>
<td>Requires LME-MCOs to provide monthly (two business days after month ends) all client-specific paid claims, encounter data and shadow claims</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 553</td>
<td>LME/MCO Enrollee Grievances and Appeals</td>
<td>Hise</td>
<td>Establishes grievances and appeals under the Medicaid 1915 (b)(c) Waiver.</td>
<td>Ratified</td>
</tr>
<tr>
<td>S 562</td>
<td>Establish Statewide</td>
<td>Hise</td>
<td>Appropriates $2 million for each of two years to</td>
<td>Provisions in S.L.</td>
</tr>
<tr>
<td>Bill</td>
<td>Description</td>
<td>Sponsor(s)</td>
<td>Summary</td>
<td>Status</td>
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<tr>
<td>S 573</td>
<td>MH/DD/SA Providers/Guardianship Issues</td>
<td>Randleman, Barringer, Robinson</td>
<td>Further clarifies what entities may provide guardianship to individuals with MH/DD/SA issues.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 604</td>
<td>Amend Laws Pertaining to Medicaid</td>
<td>Hise, Pate</td>
<td>DHHS requested changes to law related to child abuse, neglect and dependency, Medicaid and public health. Medicaid changes include provisions on estates and deceased as well as additions to limited and moderate categorical risk provider types.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 618</td>
<td>Modernize State Personnel Act</td>
<td>Tucker, David, Curtis</td>
<td>Renames this act the &quot;NC Human Resources Act&quot; and renames State Personnel as NC Office of State HR. Modifies references under statutes including 122C.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 663</td>
<td>Blue Ribbon Cmte Recs/Supportive MH Housing</td>
<td>Hise</td>
<td>Requires DHHS to establish a Supportive Housing Program, includes funding for the Program and creates a Transitions to Community Living Housing Budget. Note: Provisions added to S. 553)</td>
<td>Passed Senate 6/17/13, referred to House Health and Human Services Provisions in S. 553, Ratified</td>
</tr>
<tr>
<td>S 675</td>
<td>Eliminate Exceptions/Med Tx/Minors</td>
<td>Daniel, Randelman, Newton</td>
<td>Eliminates exceptions for parental consent for abortion in areas including diagnosed substance abuse and mental illness.</td>
<td>DID NOT MAKE CROSSOVER</td>
</tr>
<tr>
<td>S 687</td>
<td>Involuntary Commitment Custody Orders</td>
<td>Parmon, Brunstetter</td>
<td>Allows for magistrate, clerk of superior court to send a fax of the involuntary commitment orders to petitioning physician, eligible psychologist or designee.</td>
<td>DID NOT MAKE CROSSOVER</td>
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Senate Budget Bills Introduced:

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<tr>
<th>Bill</th>
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<td>S 398</td>
<td>Governor’s Budget Act</td>
<td>Brunstetter, Brown, Hunt</td>
<td>Includes provisions the Governor proposed for the SFY13-15 budget.</td>
<td>Referred to Cmte. on Appropriations</td>
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<td>S 418</td>
<td>Appropriations Act of 2013</td>
<td>Brunstetter, Brown, Hunt</td>
<td>Placeholder for Senate Budget.</td>
<td>Referred to Cmte. on Appropriations</td>
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<td>S 419</td>
<td>Governor’s Budget Act</td>
<td>Brunstetter,</td>
<td>Includes provisions the Governor proposed for the</td>
<td>Referred to Cmte. on</td>
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AN ACT TO ENSURE EFFECTIVE STATEWIDE OPERATION OF THE 1915 (B)/(C) MEDICAID WAIVER.

Whereas, S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, required the Department of Health and Human Services (Department) to restructure the statewide management of the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the statewide expansion of the 1915(b)/(c) Medicaid Waiver; and

Whereas, a local management entity/managed care organization (LME/MCO) that is awarded a contract to operate the 1915(b)/(c) Medicaid Waiver was required to maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model; and

Whereas, LME/MCOs are acting as Medicaid vendors and the Department must ensure that they are compliant with the provisions of S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, as well as all applicable federal, State, and contractual requirements; Now, therefore,

The General Assembly of North Carolina enacts:

**SECTION 1.** G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act."

**SECTION 2.** Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver."

(a) For all local management entity/managed care organizations, the Secretary shall certify whether the LME/MCO is in compliance or is not in compliance with all requirements of subdivisions (1) through (3) of subsection (b) of this section. The Secretary's certification shall be made every six months beginning August 1, 2013. In order to ensure accurate evaluation of administrative, operational, actuarial and financial components, and overall performance of the LME/MCO, the Secretary's certification shall be based upon an internal and external assessment made by an independent external review agency in accordance with applicable federal and State laws and regulations. Beginning on February 1, 2014, and for all subsequent assessments for certification, the independent review will be made by an External Quality Review Organization approved by the Centers for Medicare and Medicaid Services and in accordance with applicable federal and State laws and regulations.

(b) The Secretary's certification under subsection (a) of this section shall be in writing and signed by the Secretary and shall contain a clear and unequivocal statement that the Secretary has determined the local management entity/managed care organization to be in compliance with all of the following requirements:

(1) The LME/MCO has made adequate provision against the risk of insolvency with respect to capitation payments for Medicaid enrollees. "Adequate provision" includes all of the following:

a. The LME/MCO has submitted to the Department all the financial records and reports required to be submitted to the Department under the Contract, including monthly balance sheets.
b. There are no consecutive three-month periods during which the LME/MCO’s ratio of current assets to current liabilities is less than 1.0, based on a monthly review of the LME/MCO’s balance sheets for each month of the three-month period, as determined by the Secretary.

c. An intradepartmental monitoring team, as designated by the Secretary and consisting of the Secretary or a designee, representatives of the Division of Medical Assistance, and representatives of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, utilizing the monitoring team’s solvency measures, determines that the LME/MCO has made adequate provisions against the risk of insolvency based on a quarterly review of the financial reports submitted to the Department by the LME/MCO.

(2) The LME/MCO is making timely provider payments. The Secretary shall certify that an LME/MCO is making timely provider payments if there are no consecutive three-month periods during which the LME/MCO paid less than ninety percent (90%) of clean claims for covered services within the 30-day period following the LME/MCO’s receipt of these claims during that three-month period. As used in this subdivision, a "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse or a claim under review for medical necessity.

(3) The LME/MCO is exchanging billing, payment, and transaction information with the Department and providers in a manner that complies with all applicable federal standards, including all of the following:
   b. Standards for health care claims or equivalent encounter information transactions specified in HIPAA regulations in 45 C.F.R. § 162.1102, as from time to time amended.
   c. Implementation specifications for Electronic Data Interchange standards published and maintained by the Accredited Standards Committee (ASC X12) and referenced in HIPAA regulations in 45 C.F.R. § 162.920, as from time to time amended.

(c) If the Secretary does not provide a local management entity/managed care organization with the certification of compliance required by this section based upon the LME/MCO's failure to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (b) of this section, the Secretary shall do the following:

(1) Prepare a written notice informing the LME/MCO of the provisions of subdivision (1), (2), or (3) of subsection (c) of this section with which the LME/MCO is deemed not to be in compliance and the reasons for the determination of noncompliance.

(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.

(3) Not later than 10 days after the Secretary's notice of noncompliance is provided to the LME/MCO, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.

(4) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (e) of this section.

(d) If, at any time, in the Secretary's determination, a local management entity/managed care organization is not in compliance with a requirement of the Contract other than those specified in subdivisions (1) through (3) of subsection (b) of this section, then the Secretary shall do all of the following:
(1) Prepare a written notice informing the LME/MCO of the provisions of the Contract with which the LME/MCO is deemed not to be in compliance and the reasons therefor.

(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.

(3) Allow the noncompliant LME/MCO 30 calendar days from the date of receipt of the notice to respond to the notice of noncompliance and to demonstrate compliance to the satisfaction of the Secretary.

(4) Upon the expiration of the period allowed under subdivision (3) of this subsection, make a final determination on the issue of compliance and promptly notify the LME/MCO of the determination.

(5) Upon a final determination that an LME/MCO is noncompliant, allow no more than 30 days following the date of notification of the final determination of noncompliance for the noncompliant LME/MCO to complete negotiations for a merger or realignment with a compliant LME/MCO that is satisfactory to the Secretary.

(6) If the noncompliant LME/MCO does not successfully complete negotiations with a compliant LME/MCO as described in subdivision (5) of this subsection, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.

(7) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (c) of this section.

(e) If the Secretary assigns the Contract of a noncompliant local management entity/managed care organization to a compliant LME/MCO under subdivision (3) of subsection (c) of this section, or under subdivision (6) of subsection (d) of this section, the Secretary shall oversee the orderly transfer of all management responsibilities, operations, and contracts of the noncompliant LME/MCO to the compliant LME/MCO. The noncompliant LME/MCO shall cooperate with the Secretary in order to ensure the uninterrupted provision of services to Medicaid recipients. In making this transfer, the Secretary shall do all of the following:

(1) Arrange for the providers of services to be reimbursed from the remaining fund balance or risk reserve of the noncompliant LME/MCO, or from other funds of the Department if necessary, for proper, authorized, and valid claims for services rendered that were not previously paid by the noncompliant LME/MCO.

(2) Effectuate an orderly transfer of management responsibilities from the noncompliant LME/MCO to the compliant LME/MCO, including the responsibility of paying providers for covered services that are subsequently rendered.

(3) Oversee the dissolution of the noncompliant LME/MCO, including transferring to the compliant LME/MCO all assets of the noncompliant LME/MCO, including any balance remaining in its risk reserve after payments have been made under subdivision (1) of this subsection. Risk reserve funds of the noncompliant LME/MCO may be used only to pay authorized and approved provider claims. Any funds remaining in the risk reserve transferred under this subdivision shall become part of the compliant LME/MCO’s risk reserve and subject to the same restrictions on the use of the risk reserve applicable to the compliant LME/MCO. If the risk reserves transferred from the noncompliant LME/MCO are insufficient, the Secretary shall guarantee any needed risk reserves for the compliant LME/MCO arising from the additional risks being assumed by the compliant LME/MCO until the compliant LME/MCO has established fifteen percent (15%) risk reserves. All other assets shall be used to satisfy the liabilities of the noncompliant LME/MCO. In the event there are insufficient assets to satisfy the liabilities of the noncompliant LME/MCO, it shall be the responsibility of the Secretary to satisfy the liabilities of the noncompliant LME/MCO.

(4) Following completion of the actions specified in subdivisions (1) through (3) of this subsection, direct the dissolution of the noncompliant LME/MCO and deliver a notice of dissolution to the board of county commissioners of each
of the counties in the dissolved LME/MCO. An LME/MCO that is dissolved by the Secretary in accordance with the provisions of this section may be dissolved at any time during the fiscal year.

(f) The Secretary shall provide a copy of each written, signed certification of compliance or noncompliance completed in accordance with this section to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

(g) As used in this section, the following terms mean:

(1) Contract. — The contract between the Department of Health and Human Services and a local management entity for the operation of the 1915(b)/(c) Medicaid Waiver.

(2) Compliant local management entity/managed care organization. — An LME/MCO that has undergone an independent external assessment and been determined by the Secretary to be operating successfully and to have the capability of expanding.

SECTION 3. G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"(39) Develop and use a standard contract for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver that requires compliance by each LME/MCO with all provisions of the contract to operate the 1915(b)/(c) Medicaid Waiver and with all applicable provisions of State and federal law."

SECTION 4.(a) G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area authority or through a county program established pursuant to G.S. 122C-115.1. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a) or G.S. 122C-115.1, the provisions of G.S. 153A-77(a) this section control."

SECTION 4.(b) G.S. 122C-115(a3) reads as rewritten:

"(a3) A county that wishes to disengage from a local management entity/managed care organization and realign with another multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver may do so with the approval of the Secretary. The Secretary shall adopt rules to establish a process for county disengagement that shall ensure, at a minimum, the following:

1. Provision of services is not disrupted by the disengagement.
2. The disengaging county either is in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-115(a) of this section.
3. The timing of the disengagement is accounted for and does not conflict with setting capitation rates.
4. Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.
5. Provision for distribution of any real property no longer within the catchment area of the area authority."

SECTION 4.(c) G.S. 122C-115(c1) reads as rewritten:

"(c1) Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties upon the adoption of a resolution to that effect by a majority of the members of the area board and the approval of the Secretary."

SECTION 5.(a) G.S. 122C-115.3(a), (c), (d), (f), and (g) are repealed.

SECTION 5.(b) G.S. 122C-115.3(b) reads as rewritten:

"(b) Notwithstanding the provisions of subsection (a) of this section, no county shall withdraw from an area authority nor shall an area authority be dissolved without first
demonstrating that continuity of services will be assured and without prior approval of the Secretary."

SECTION 5.(c) G.S. 122C-115.3(e) reads as rewritten:

"(e) Any fund balance available to an area authority at the time of its dissolution shall be distributed to those counties comprising the area authority on the same pro rata basis that the counties appropriated and contributed funds to the area authority’s budget during the current fiscal year. Distribution to the counties shall be determined on the basis of an audit of the financial record of the area authority. The area authority board shall select a certified public accountant or an accountant who is subsequently certified by the Local Government Commission to conduct the audit. The audit shall be performed in accordance with G.S. 159-34. The same method of distribution of funds described in this subsection shall apply when one or more counties of an area authority withdraw from the area authority that is not utilized to pay liabilities shall be transferred to the area authority contracted to operate the 1915(b)/(c) Medicaid Waiver in the catchment area of the dissolved area authority. If the fund balance transferred from the dissolved area authority is insufficient to constitute fifteen percent (15%) of the anticipated operational expenses arising from assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%) operational reserves."

SECTION 6. G.S. 122C-118.1(a) reads as rewritten:

"(a) An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. The boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 shall have the option to appoint members of the area board in a manner or with a composition other than as required by this section by each county unanimously adopting a resolution to that effect and receiving written approval from the Secretary by January 1, 2013. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term."

SECTION 7. G.S. 122C-118.1 is amended by adding the following new subsection to read:

"(f) An area authority that adds one or more counties to its existing catchment area under G.S. 122C-115(c1) shall ensure that the expanded catchment area is represented through membership on the area board, with or without adding area board members under this section, as provided in G.S. 122C-118.1(a)."

SECTION 8. Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

§ 122C-118.2. Establishment of county commissioner advisory board.

(a) There is established a county commissioner advisory board for each catchment area, consisting of one county commissioner from each county in the catchment area, designated by the board of commissioners of each county. The county commissioner advisory board shall meet on a regular basis, and its duties shall include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders in the catchment area. The county commissioner advisory board serves in an advisory capacity only to the area authority, and its duties do not include authority over budgeting, personnel matters, governance, or policymaking of the area authority.

(b) Each board of commissioners within the catchment area shall designate from its members the commissioner to serve on the county commissioner advisory board. Each board of commissioners may determine the manner of designation, the term of service, and the conditions under which its designee will serve on the county commissioner advisory board."
SECTION 9. G.S. 122C-142(a) is rewritten to read:

"(a) When the area authority contracts with persons for the provision of services, it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority or county program may amend the contract to comply with any court-imposed duty or responsibility. An area authority or county program that is operating under a Medicaid waiver may amend the contract subject to the approval of the Secretary. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met."

SECTION 10. G.S. 150B-1(e) is amended by adding a new subdivision to read:

"(21) The Department of Health and Human Services for actions taken under G.S. 122C-124.2."

SECTION 11. By no later than August 1, 2013, the Secretary of the Department of Health and Human Services shall complete an initial certification of compliance, in accordance with G.S. 122C-124.2(a), for each local management entity/managed care organization that has been approved by the Department to operate the 1915(b)/(c) Medicaid Waiver and provide a copy of the certification to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 12. Section 4(a) of this act becomes effective January 1, 2014. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 6th day of June, 2013.

s/ Daniel J. Forest  
President of the Senate

s/ Thom Tillis  
Speaker of the House of Representatives

s/ Pat McCrory  
Governor

Approved 4:27 p.m. this 12th day of June, 2013
AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME/MCO) MEDICAID ENROLLEES; TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A SUPPORTIVE HOUSING PROGRAM FOR INDIVIDUALS TRANSITIONING FROM INSTITUTIONAL SETTINGS TO INTEGRATED COMMUNITY-BASED SETTINGS, TO CLARIFY HOW FUNDS APPROPRIATED TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE ESTABLISHMENT AND OPERATION OF THIS PROGRAM SHALL BE USED, AND TO CREATE A COMMUNITY LIVING HOUSING FUND WITHIN THE HOUSING FINANCE AGENCY TO INTEGRATE INDIVIDUALS WITH DISABILITIES INTO COMMUNITY-BASED SUPPORTED HOUSING; AND TO MODIFY ALLOCATION OF STATE'S SHARE IN HOSPITAL PROVIDER ASSESSMENT TAX.

The General Assembly of North Carolina enacts:

PART I. ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION MEDICAID ENROLLEES.

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108D.
"Medicaid Managed Care for Behavioral Health Services.
"Article 1.
"General Provisions.

"§ 108D-1. Definitions.
The following definitions apply in this Chapter, unless the context clearly requires otherwise:

(1) Applicant. – A provider of mental health, intellectual or developmental disabilities, and substance abuse services who is seeking to participate in the closed network of one or more local management entity/managed care organizations.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-8 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(6) Emergency services. – As defined in 42 C.F.R. § 438.114.

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local management entity/managed care organization.

(8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3(20c).
(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).
(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
(12) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).
(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.
(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).
(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.
(18) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

"§ 108D-2. Scope; applicability of this Chapter.
This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

"§ 108D-3. Conflicts; severability.
(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails.
(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.
(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 2.
"Enrollee Grievances and Appeals.

"§ 108D-4. LME/MCO grievance and appeal procedures, generally.
(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.
(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. However, unless the enrollee or network provider requests an expedited appeal, the oral filing must be followed by a written, signed grievance or appeal.
(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from doing any of the following:

(1) Offering an enrollee alternative services.
(2) Engaging in clinical or educational discussions with enrollees or providers.
(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.
(d) An LME/MCO shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.
(2) Requesting an LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level appeal.

(3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or supporting an enrollee’s request for an LME/MCO level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

§ 108D-5. LME/MCO grievances.

(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than a managed care action. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment of receipt of the grievance to be sent by United States mail.

(b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance and cause a notice of grievance disposition to be sent by United States mail to the enrollee and all other affected parties as expeditiously as the enrollee’s health condition requires, but no later than 90 days after receipt of the grievance.

(c) Right to LME/MCO Level Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.


(a) Notice of Managed Care Action. – An LME/MCO shall provide an enrollee with written notice of a managed care action by United States mail as required under 42 C.F.R. § 438.404. The notice of action will employ a standardized form included as a provision in the contracts between the LME/MCOs and the Department of Health and Human Services.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a notice of managed care action no later than 30 days after the mailing date of the grievance disposition or notice of managed care action. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

(c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than 45 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this 45-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-8 as long as the enrollee or network provider has exhausted the appeal procedures described in this section or G.S. 108D-7.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-8(f).


(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care action no later than 30 days after the mailing date of the notice of managed care action. For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with written notice of denial by United States mail by no later than two calendar days after receiving the request for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time limits established for standard LME/MCO level appeals in G.S. 108D-6.
(c) Continuation of Benefits. – An LME/MCO shall continue the enrollee’s benefits during the pendency of an expedited LME/MCO level appeal to the extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee’s health condition requires, and no later than three working days after receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this three-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-8 as long as the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-6 or this section.

(f) Reasonable Assistance. – An LME/MCO shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-8(f).


(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning a managed care action, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting a managed care action.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution issued by an LME/MCO is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for appeal to contest a notice of resolution as long as the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7.

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no later than 30 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The LME/MCO shall be the respondent for purposes of this appeal. The LME/MCO or enrollee may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

1. A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, by no later than 30 days after the mailing date of the notice of resolution.

2. The enrollee's name, address, telephone number, and Medicaid identification number.
(3) A preprinted statement that indicates that the enrollee would like to appeal a specific managed care action identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. — An LME/MCO shall continue the enrollee’s benefits during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order an LME/MCO to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. — Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

(1) OAH shall schedule and hear cases by no later than 55 days after receipt of a request for a contested case hearing.

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the LME/MCO unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

(3) The administrative law judge assigned to hear the case shall consider and rule on all prehearing motions prior to the scheduled date for a hearing on the merits.

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by United States mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee’s right to examine at a reasonable time before and during the hearing the contents of the enrollee’s case file and any documents to be used by the LME/MCO in the hearing before the administrative law judge.

b. The enrollee’s right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the LME/MCO's expense and made part of the record, including all of the following:

1. A hearing involving medical issues, such as a diagnosis, an examining physician's report, or a decision by a medical review team.

2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the
medical assessment performed by an individual involved in any previous level of review or decision making.

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-8(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of a managed care action until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. Nothing in this subsection shall restrict the right to a contested case hearing.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the LME/MCO's managed care action and regardless of whether the LME/MCO had an opportunity to consider the evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the request of the LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(l) Issue for Hearing. – For each managed care action, the administrative law judge shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the conflict. All rules, rights, and procedures for contested case hearings concerning managed care actions shall be construed so as to be consistent with federal law and shall provide the enrollee with no lesser and no greater rights than those provided under federal law.


The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the LME/MCO to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes."
SECTION 4. G.S. 150B-23 is amended by adding a new subsection to read:

"(a3) A Medicaid enrollee, or network provider authorized in writing to act on behalf of the enrollee, who appeals a notice of resolution issued by an LME/MCO under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article. Solely and only for the purposes of contested cases commenced as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose."

SECTION 5. By September 30, 2013, the Department of Health and Human Services shall take any action necessary to implement this act, including submitting to the Centers for Medicare and Medicaid Services a Medicaid State Plan Amendment with a retroactive effective date of July 1, 2013. On or before September 30, 2013, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the implementation of this act.

PART II. BLUE RIBBON COMMISSION RECOMMENDATIONS/SUPPORTIVE MENTAL HEALTH HOUSING.

SECTION 6.(a) Chapter 122C of the General Statutes is amended by adding a new Article to read:

"Article 1B. Transitions to Community Living.


§ 122C-20.5. Definitions.

The following definitions apply in this Article:

(1) Individual with serious mental illness or SMI. – An individual who is 18 years of age or older with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services, supports, or all three. The term does not include a primary diagnosis of Alzheimer's disease or dementia.

(2) Individual with serious and persistent mental illness or SPMI. – A person who is 18 years of age or older who meets one of the following criteria:
   a. Has a mental illness or disorder that is so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self-care, decision making, interpersonal relationships, social transactions, learning, and recreational activities.
   b. Is receiving Supplemental Security Income or Social Security Disability Income due to mental illness.

§ 122C-20.6. Department to establish statewide supportive housing program for individuals transitioning into community living; purpose.

The Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency, shall establish and administer a tenant-based rental assistance program known as the North Carolina Supportive Housing Program. The purpose of the program is to transition individuals diagnosed with serious mental illness or serious and persistent mental illness from institutional settings to more integrated community-based settings appropriate to meet their needs. Under the program, the Department, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, shall arrange for program participants to be transitioned to housing slots available through the program with all the rights and obligations created by a landlord-tenant relationship.

§ 122C-20.7. Administration of housing subsidies for supportive housing.

The Department may enter into a contract with a private vendor to serve as the housing subsidy administrator for the North Carolina Supportive Housing Program with responsibility for distributing rental vouchers and community living vouchers to program participants based on a formula developed by the Department.
§ 122C-20.8. Eligibility requirements for NC Supportive Housing Program.

The Division of Aging and Adult Services shall adopt rules to establish eligibility requirements for the program. The eligibility requirements shall, at a minimum, include income eligibility requirements and requirements to give priority for program participation and transition services to individuals diagnosed with serious mental illness or serious and persistent mental illness who are currently residing in institutional settings. The Division may adopt temporary rules necessary to implement this Article.

§ 122C-20.9. In-reach activities for supportive housing.

The Department shall have ongoing responsibility for developing and distributing a list of potentially eligible program participants for each LME/MCO by catchment area. Upon receipt of this information, each LME/MCO shall have ongoing responsibility for prioritizing the list of individuals to whom it will provide in-reach activities in order to (i) arrange an in-person meeting with potentially eligible participants to determine their eligibility and level of interest and (ii) report back to the Department on the LME/MCO's recommended list of program participants on a daily basis. Upon receipt of an LME/MCO's recommended list of program participants, the Department shall make a final determination of eligibility.

§ 122C-20.10. Allocation of supportive housing slots to LME/MCOs.

The Department shall annually determine the number of housing slots to be allocated to each LME/MCO as follows:

1. Each year, the Department shall distribute at least fifty percent (50%) of the housing slots available through this program equally among all LME/MCOs.
2. The Department shall award additional housing slots to LME/MCOs based on local need, as determined by the information provided by LME/MCOs to the Department in accordance with G.S. 122C-20.9.

§ 122C-20.11. Transition of program participants into housing slots.

The LME/MCO shall develop a written transition plan for each individual determined to be eligible and interested in participating in the North Carolina Supportive Housing Program. The transition plan for the approved housing slot shall identify at least all of the following:

1. Available housing units that meet the individual's needs.
2. Any transition services that will be necessary for the individual, including, but not limited to, a one-time transition stability payment, not to exceed two thousand dollars ($2,000) per individual, for up-front move-in costs approved by the Department or the housing subsidy administrator.
3. Solutions to potential barriers to the individual's successful transition to community-based supported housing.
4. Any other information the Department deems necessary for the individual program participant's successful transition into community-based supported housing.

§ 122C-20.12. Transition services.

LME/MCOs shall provide individualized transition services to program participants within their respective catchment areas for the 90-day period following the individual's transition into a housing slot provided through the program.

§ 122C-20.13. Tenancy support services.

The Department or the housing subsidy administrator shall provide ongoing tenancy support services to program participants.

§ 122C-20.14. Approval of landlords and housing units.

The Department shall develop an application process for owners of housing units seeking to participate in the program as landlords. The application process shall, at a minimum, include an inspection of the owners' selected housing units and a requirement that owners receive educational information from the Department about the North Carolina Supportive Housing Program prior to being approved as landlords.

§ 122C-20.15. Annual reporting on NC Supportive Housing Program.

Annually on October 1, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services of the General Assembly on the number of individuals within each LME/MCO catchment area who transitioned into housing slots available through the North Carolina Supportive Housing Program during the preceding calendar year. The report shall include a breakdown of all funds expended by each LME/MCO for transitioning these individuals into the housing slots.

§ 122C-20.16. NC Supportive Housing Program not an entitlement.
The Department shall not be required to provide housing slots to individuals beyond the number that can be supported by funds appropriated by the General Assembly for this purpose. The supportive housing program established under this Part, whether administered by the Department or a private entity, is not an entitlement, and nothing in this Part shall create any property right.

SECTION 6.(b) By no later than October 1, 2013, each LME/MCO shall transition at least 15 eligible individuals to community-based supported housing slots available through the North Carolina Supportive Housing Program established under G.S. 122C-20.5.

SECTION 7. Funds appropriated to the Department of Health and Human Services for the 2013-2015 fiscal biennium to develop and implement housing, support, and other services for people with mental illness pursuant to the Department of Justice settlement agreement shall be used as follows:

1. The sum of one million seven hundred forty-five thousand two hundred eighty dollars ($1,745,280) for fiscal year 2013-2014 and the sum of three million one hundred twenty thousand thirty-seven dollars ($3,120,037) for fiscal year 2014-2015 shall be used to establish and operate the North Carolina Supportive Housing Program authorized in Article 1B of Chapter 122C of the General Statutes.

2. The sum of one million four hundred forty thousand dollars ($1,440,000) for fiscal year 2013-2014 and the sum of one million five hundred forty thousand dollars ($1,540,000) for fiscal year 2014-2015 shall be used for program administration for the North Carolina Supportive Housing Program authorized in Article 1B of Chapter 122C of the General Statutes.

3. The sum of six hundred fifty thousand dollars ($650,000) for fiscal year 2013-2014 and the sum of one million two hundred sixteen thousand dollars ($1,216,000) for fiscal year 2014-2015 shall be used to provide one-time transition stability funds, not to exceed two thousand dollars ($2,000) per individual, to cover the cost of up-front move-in costs for individuals placed in housing slots available through the North Carolina Supportive Housing Program authorized in Article 1B of Chapter 122C of the General Statutes.

4. Any funds appropriated for the 2014-2015 fiscal year that are not used for the purposes set forth in subdivisions (1) through (3) of this section shall be used to provide a comprehensive array of services that individuals need to transition to and be maintained in the community.

SECTION 8. Chapter 122E of the General Statutes is amended by adding a new section to read:

§ 122E-3A. Community Living Housing Fund.

(a) Definitions. – The following definitions apply in this section:

(1) Catchment area. – As defined in G.S. 122C-3.

(2) Targeted units. – Units within Low Income Housing Tax Credit developments that are specifically designed to facilitate the inclusion of individuals with disabilities.

(b) Creation and Source of Funds. – The Community Living Housing Fund is established within the Housing Finance Agency to pay for the transition of individuals diagnosed with severe mental illness or severe and persistent mental illness as defined in G.S. 122C-20.5 from institutional settings to integrated, community-based supported housing and to increase the percentage of targeted housing units available to individuals with disabilities for use in the North Carolina Supportive Housing Program under Article 1B of Chapter 122C of the General Statutes. Beginning with fiscal year 2013-2014, any unexpended, unencumbered balance of the amount appropriated to the Transitions to Community Living Fund established pursuant to Section 10.23A(d) of S.L. 2012-142 at the end of each fiscal year shall not revert but shall be transferred and made available to the Community Living Housing Fund.

(c) Use of Funds. – The North Carolina Housing Finance Agency, in consultation with the Department of Health and Human Services, shall be responsible for administering the Community Living Housing Fund. The monies in the Fund shall be available for expenditure only upon an act of appropriation by the General Assembly and only for the following purposes:
(1) To provide permanent community-based housing in integrated settings appropriate for individuals with severe mental illness and severe and persistent mental illness.

(2) To support an increase in the number of targeted units for individuals with disabilities located in housing projects funded by the Housing Finance Agency from ten percent (10%) to fifteen percent (15%). The additional targeted units funded shall be made available to the Department of Health and Human Services for use in the North Carolina Supportive Housing Program under Article 1B of Chapter 122C of the General Statutes. Priority for funding of the additional targeted units shall be given to units to be located in catchment areas identified by the Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, as having the greatest need for targeted units."

SECTION 9. The Transitions to Community Living Fund established pursuant to Section 10.23A(d) of S.L. 2012-142 terminates on June 30, 2020, and any balance remaining on that date shall revert to the General Fund.

PART III. MODIFY ALLOCATION OF STATE’S SHARE IN HOSPITAL PROVIDER ASSESSMENT TAX.

SECTION 10. If Senate Bill 402, 2013 Regular Session, becomes law, then G.S. 108A-123(d) reads as rewritten:

"(d) State's Annual Medicaid Payment. – The first forty-three million dollars ($43,000,000) of the State's annual Medicaid payment must be allocated between the equity assessment and the UPL assessment based on the amount of gross payments received by hospitals under G.S. 108A-124. The remaining portion of the State's annual Medicaid payment must be allocated to the UPL assessment."

SECTION 11. Sections 1 through 5 of this act are effective when this act becomes law and apply to grievances and managed care actions filed on or after that date. Section 7 of this act becomes effective October 1, 2013. Section 10 of this act becomes effective July 1, 2013. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 26th day of July, 2013.

s/ Philip E. Berger
President Pro Tempore of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 10:47 a.m. this 23rd day of August, 2013
Budget

The House released their budget on Friday. A comparison to the Senate budget is below. The House HHS Appropriations has already met and full House Appropriations will meet tomorrow. The plan is to have it passed by the House by this week. That will leave them a full two weeks of conference committee deliberations between the House and Senate before their self-imposed deadline of June 30th. Key legislators are remaining committed to a June 30th adjournment date but it’s difficult to tell if they will meet that goal. As you probably know, the House tax plan deliberations threw things into some chaos last week. The items below marked “in contention” are those items that they will need to negotiate on. If a budget item was the same in both the House and Senate budget it is not in contention and will most likely not be considered in the conference committee.

Other Legislation

S. 208, the Effective Operations of LME-MCOs, has now been sent to the Governor to be signed into law. The House added significant language to the bill through amendments on the floor and the Senate concurred with those changes without questions.

Meetings this Week

Tuesday, June 11, 8:30 a.m. House Appropriations Committee, 643 LOB (audio available). The House budget bill was considered and passed.

Wednesday, June 12, 8:30 a.m., Senate Appropriations Committee, 643 LOB (audio available). S. 663, Blue Ribbon Cmte Recommendations/MH Housing

Wednesday, June 12, 9:00 a.m., House Judiciary Subcommittee C, 415 LOB (audio not available). S. 594 Work First Initiative for discussion only

CANCELLED Wednesday, June 12, 11:00 a.m., Senate Health Care Committee, 544 LOB (audio available). H. 867, Medicaid County of Residence
<table>
<thead>
<tr>
<th>Citation (either S. 402 or committee report or both)</th>
<th>Title/ Synopsis of Senate Provision</th>
<th>Title/ Synopsis House Provision</th>
</tr>
</thead>
</table>
| S. 402, Sec. 12A.2(c) **IN CONTENTION** | **Competitive Grants Process for Non-Profit Funding** allocates $9.5 million SFY13-14 and $5.2 million SFY14-15 to non-profits including:  
- system of residential support for substance abuse;  
- advocacy and supports for I-DD, SPMI, substance abuse or the elderly;  
- supports and services for I-DD, MH | **Competitive Grants Process for Non-Profit Funding** allocates $9.5 million SFY13-14 and $3 million SFY14-15 to non-profits including:  
- system of residential support for substance abuse;  
- advocacy and supports for I-DD, SPMI, substance abuse or the elderly;  
- supports and services for I-DD, MH  
Further, it lists the certain non-profits and the amount they will receive and gives a longer period of time for full implementation (April 2014). |
| S. 402, Sec. 12A.4(c) **NOT IN CONTENTION** | The Replacement **MMIS** will have full capacity to implement the administration of all “relevant” Medicaid waivers. | The Replacement **MMIS** will have full capacity to implement the administration of all “relevant” Medicaid waivers. |
| S. 402, Sec. 12A.4(j) **IN CONTENTION** | Requires all Medicaid claims to be adjudicated through **MMIS**, including claims done by contracted vendors. | Provision not included in the House budget. |
| S. 402, Sec. 12C.6(a)(e) **IN CONTENTION** | Designates area mental health authorities as the entities that will conduct the **required drug testing of Work First applicants**. | Provision not included in the House budget. |
| Committee Report, Item 34 (Senate) and Item 38 (House) **NOT IN CONTENTION** | **LME-MCO Administration** from expected savings with full implementation of the waiver, cuts:  
($15.2 million) SFY13-14 and  
($15.2 million) SFY14-15. | **LME-MCO Administration** from expected savings with full implementation of the waiver, cuts:  
($15.2 million) SFY13-14 and  
($15.2 million) SFY14-15. |
| S. 402, Sec. 12F.2(a) **IN CONTENTION** | **Local Inpatient Bed or Bed Days** allocation $38.1 million SFY13-14 and $38.1 million SFY14-15. DHHS Secretary has the authority to designate existing funds allocated to the LME-MCO for community services to be used for the purchase of additional beds. | **Local Inpatient Bed or Bed Days** allocation $38.1 million SFY13-14 and $38.1 million SFY14-15. DHHS Secretary has the authority to designate existing funds allocated to the LME-MCO for community services to be used for the purchase of additional beds.  
Further, the bill directs the Secretary to develop a two-tiered payment system to reimburse for higher acuity consumers. |
<table>
<thead>
<tr>
<th>Committee Report, Item 41 (Senate) and Item 42 (House)</th>
<th>Transfers $9 million recurring from crisis services to fund <strong>Three-Way Contracts</strong>.</th>
<th>Transfers $9 million recurring from crisis services to fund <strong>Three-Way Contracts</strong>. Further, the DHHS is required to implement a two-tiered payment system.</th>
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</thead>
<tbody>
<tr>
<td>S. 402, Sec. 12F.2(d) NOT IN CONTENTION</td>
<td>Allows DHHS to pay hospitals directly if a LME-MCO is deemed to have ineffective management of the <strong>Three-Way Contract Funds</strong>.</td>
<td>Allows DHHS to pay hospitals directly if a LME-MCO is deemed to have ineffective management of the <strong>Three-Way Contract Funds</strong>.</td>
</tr>
<tr>
<td>S. 402, Sec. 12F.2(f) NOT IN CONTENTION</td>
<td>DHHS must report to the LOC on Health and Human Services by 3/1/14 on a uniform system for operating the <strong>Three-Way Contract Funds</strong>.</td>
<td>DHHS must report to the LOC on Health and Human Services by 3/1/14 on a uniform system for operating the <strong>Three-Way Contract Funds</strong>.</td>
</tr>
<tr>
<td>S. 402, Sec. 12F.4(a-e) IN CONTENTION</td>
<td>Provision not included in the Senate budget.</td>
<td>Requires DHHS to implement <strong>clinical integration of CCNC and LME-MCOs</strong> through TotalCare.</td>
</tr>
<tr>
<td>S. 402, Sec. 12F.5 IN CONTENTION</td>
<td>Prohibits any more expenditures on <strong>information technology in State-operated facilities</strong> until a report is submitted by 3/1/14 to the LOC on Health and Human Services and others on the purpose, etc.</td>
<td>Provision not included in the House budget.</td>
</tr>
<tr>
<td>S. 402, Sec. 12F.7(a) IN CONTENTION</td>
<td>Close all three <strong>Alcohol and Drug Abuse Treatment Centers (ADATCs)</strong>. No new admissions will be allowed after 7/1/13 and all operations will cease after 9/30/13. Expected savings from closures are ($37.9 million) recurring SFY13-14 and ($50.6 million) recurring SFY14-15.</td>
<td>Provision not included in the House budget.</td>
</tr>
<tr>
<td>S. 402, Sec. 12F.7(a) IN CONTENTION</td>
<td>Allocates to LME-MCO for <strong>community-based and residential alcohol and substance abuse treatment</strong>: $10 million recurring SFY13-14 $20 million recurring SFY14-15</td>
<td>Provision not included in the House budget.</td>
</tr>
<tr>
<td>Committee Report, Item 39 (Senate) IN CONTENTION</td>
<td><strong>Close Wright School</strong> effective 7/1/13 ($2.7 million) recurring SFY13-14 ($2.7 million) recurring SFY14-15</td>
<td>Provision not included in the House budget.</td>
</tr>
<tr>
<td>Committee Report, Item 40 (Senate) and Item 41 (House) NOT IN CONTENTION</td>
<td>Realigns DMH budget to give <strong>Broughton</strong> $3.5 million recurring in SFY13-14 for <strong>19 new adult psychiatric beds</strong>.</td>
<td>Realigns DMH budget to give <strong>Broughton</strong> $3.5 million recurring in SFY13-14 for <strong>19 new adult psychiatric beds</strong>.</td>
</tr>
<tr>
<td>Committee Report, <strong>New Broughton Hospital</strong> allocation:</td>
<td><strong>New Broughton Hospital</strong> allocation:</td>
<td></td>
</tr>
</tbody>
</table>
| Item 43 (Senate) and Item 43 (House) NOT IN CONTENTION | $11.5 million non-recurring SFY13-14  
$16.5 million non-recurring SFY14-15 | $11.5 million non-recurring SFY13-14  
$16.5 million non-recurring SFY14-15 |
| S. 402, Sec. 12F.1(a), Committee Report Item 42 (Senate) and Item 10 (House) IN CONTENTION | Create a **Statewide Telepsychiatry Program** for referrals from hospitals:  
$2 million recurring SFY13-14  
$2 million recurring SFY14-15 | Create a **Statewide Telepsychiatry Program** for referrals from hospitals:  
$2 million recurring SFY13-14  
$2 million recurring SFY14-15 |
| S. 402, Sec. 12F.3, Committee Report Item 43 (Senate) and Item 44 (House) NOT IN CONTENTION | Create **NC Child Treatment Program** to provide clinical training to Medicaid-certified physicians and child trauma services:  
$1.8 million recurring and $250,000 non-recurring SFY13-14  
$1.8 million recurring and $250,000 non-recurring SFY14-15 | Create **NC Child Treatment Program** to provide clinical training to Medicaid-certified physicians and child trauma services:  
$1.8 million recurring and $250,000 non-recurring SFY13-14  
$1.8 million recurring and $250,000 non-recurring SFY14-15 |
| S. 402, Sec. 12F.8 IN CONTENTION | Allows area boards to provide **severance and relocation for Area Directors** | Provision not included in the House budget. |
| S. 402, Sec. 12H.1(a-d) IN CONTENTION | Medicaid Reform process requirements which require DHHS secretary to submit a plan to the General Assembly by 3/17/14. | Medicaid Reform process requirements which require DHHS secretary to submit a plan to the General Assembly by 2014 or earlier. Establishes an advisory group that includes a LME-MCO CEO that is appointed by the Governor. |
| S. 402, Sec. 12H.2(a) NOT IN CONTENTION | Codifies that **Medicaid is a secondary payor** with the exception of Medicare, Medicare Advantage and Medicaid. | Prohibits the submission of Medicaid State Plan Amendments except under noted circumstances (changed in statute, etc.) and requires DHHS to post amendment on their website within 10 days of submission and notify the LOC on Health and Human Services. |
| Committee Report Item 68 (Senate) and Item 65 (House) NOT IN CONTENTION | Allocates funds in anticipation of increased Medicaid recipients from "woodworking" and Affordable Care Act:  
$49.6 million recurring for SFY13-14  
$114.1 million recurring for SFY14-15 | Allocates funds in anticipation of increased Medicaid recipients from "woodworking" and Affordable Care Act:  
$49.6 million recurring for SFY13-14  
$114.1 million recurring for SFY14-15 |
| S. 402, Sec. 12H.2, Committee Report Item 69 (Senate) NOT IN CONTENTION | Moves children at or below 133% of the Federal Poverty Level from **Health Choice to Medicaid** and allocates for this transfer:  
$22 million for SFY13-14  
$46 million for SFY14-15 | Moves children at or below 133% of the Federal Poverty Level from **Health Choice to Medicaid** and allocates for this transfer:  
$22 million for SFY13-14  
$46 million for SFY14-15 |
<p>| S. 402, Sec. 12H.4 NOT IN CONTENTION | Codifies that <strong>Medicaid is a secondary payor</strong> with the exception of Medicare, Medicare Advantage and Medicaid. | Prohibits the submission of Medicaid State Plan Amendments except under noted circumstances (changed in statute, etc.) and requires DHHS to post amendment on their website within 10 days of submission and notify the LOC on Health and Human Services. |
| S. 402, Sec. 12H.14 | Changes requirements in <strong>Personal Care Services</strong> | Provision not included in the House budget. |</p>
<table>
<thead>
<tr>
<th>IN CONTENTION</th>
<th>S. 402, Sec. 12H.16</th>
<th>Adds language to provisions on Medicaid Administrative Hearings Funding and Procedure Modification</th>
<th>Adds language to provisions on Medicaid Administrative Hearings Funding and Procedure Modification Further, repeals 108C12-d.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. 402, Sec. 12H.16(c)</td>
<td>NOT IN CONTENTION</td>
<td>Adds Rules 90, 91, 92 in OAH proceedings</td>
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</tr>
<tr>
<td>S. 402, Sec. H.18, Committee Report Item 76 (Senate)</td>
<td>IN CONTENTION</td>
<td>Establishes a Shared Savings Plan to incentivize certain providers including Adult Care Homes and Personal Care Services by withholding 4% of their rates and giving back to those deemed most effective: ($1.1 million) recurring SFY13-14 ($2.4 million) recurring SFY14-15</td>
<td>Establishes a Shared Savings Plan to incentivize certain providers including Adult Care Homes and Personal Care Services by withholding 2% of their rates and giving back to those deemed most effective.</td>
</tr>
<tr>
<td>Committee Report Item 47 (Senate) and Item 56 (House)</td>
<td>NOT IN CONTENTION</td>
<td>MH Drug Management requires prior authorization for MH drugs. ($4.9 million) recurring SFY13-14 ($11.2 million) recurring SFY14-15</td>
<td>Prescribed Drugs Payment based on invoice costs. ($18.4 million) recurring SFY13-14 ($36.9 million) recurring SFY14-15</td>
</tr>
<tr>
<td>S. 402, Sec. H.21</td>
<td>NOT IN CONTENTION</td>
<td>Study the CCNC model to determine if it saves money and improves outcomes. $100,000 non-recurring SFY13-14</td>
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</tr>
<tr>
<td>S. 402, Sec. 12H.22, Committee Report Items 49, 79, 80 (Senate) and Item 50, 75, 76 (House)</td>
<td>NOT IN CONTENTION</td>
<td>Separates payments to CCNC care management and to CCNC providers and establishes a per member per month, performance-based payment. $59.3 million recurring SFY13-14 $44 million in State Funds for care management $15.3 million in State Funds for Providers $62 million recurring SFY14-15 $46.1 million in State Funds for care management $16 million in State Funds for Providers</td>
<td>Separates payments to CCNC care management and to CCNC providers and establishes a per member per month, performance-based payment. $59.3 million recurring SFY13-14 $44 million in State Funds for care management $15.3 million in State Funds for Providers $62 million recurring SFY14-15 $46.1 million in State Funds for care management $16 million in State Funds for Providers</td>
</tr>
<tr>
<td>S. 402, Sec. 12H.23</td>
<td>IN CONTENTION</td>
<td>Governance of Entities to Manage Care and Control Costs. Requires a board for an entity providing statewide care coordination, cost containment or management of care. Specifies governing board members.</td>
<td>Provision not included in the House budget.</td>
</tr>
<tr>
<td>Committee Report Item 51 (Senate) and Item 51(House)</td>
<td>NOT IN CONTENTION</td>
<td>Sets hospital base rates on a regional basis.</td>
<td>Sets hospital base rates on a regional basis.</td>
</tr>
<tr>
<td>Committee Report Item 46 (House)</td>
<td>IN CONTENTION</td>
<td>Provision not included in Senate budget.</td>
<td>Provides $250,000 to LME-MCOs to serve individuals on the waiting list for the Adult Developmental Vocational Programs (ADVPs)</td>
</tr>
</tbody>
</table>