Meeting Minutes
Hybrid Meeting | Wednesday, April 8, 2026, 9:00 AM – 3:00 PM

ATTENDEES					
Council Members					
Name	**In-Person**	**Virtual**	**Name**	**In-Person**	**Virtual**
Michelle Laws (Chair)	P		Heather Johnson		V
Ashley Snyder-Miller (Vice-Chair)	P		Jeannie Irby	A	
Ada Elizabeth Gil-Jimenez	P		Jessica Aguilar		V
Amie Brendle		V	Johnnie Thomas	A	
Angela-Christine Rainear	A		Lilly Parker	P	
Annette Smith	P		Lorrine Washington	P	
Bob Crayton		V	Lynn Martin		V
Crystal Foster		V	Nathan Cartwright		V
Domenica “Mamie” Hutnik	A		Patty Schaeffer		V
Flo Stein	P				
Staff/Guests					
Name	**Staff**	**Guest**	**Name**	**Staff**	**Guest**
Stacey Harward	P		Erica Asbury	P	
Badia Hendersen	P		Lisa Jackson	V	
Jenniffer Meade	P				
Ann Marie Webb	P				
Crystal Dorsey	P				

Agenda Topic:	**Welcome/Roll Call/Approval of Agenda and Minutes**
Presenter:	**Dr. Michelle Laws, SCFAC Chair**

- Dr. Laws called the meeting to order at 9:14 AM.
- A roll call confirmed the absence of a quorum, so approval of the agenda and the March minutes was deferred.

Agenda Topic:	**Behavioral Health Urgent Care (BHUC) and Facility-Based Crisis (FBC) Services**
Presenters:	**Rob Robinson, CEO of Alliance Health & Sean Schreiber, Chief Innovation & Strategy Officer, Alliance Health**

Overview of Crisis Services History:

- Reviewed Alliance Health’s history in crisis service delivery.
- Noted that under Medicaid Transformation, Standard Plans (SPs) also became responsible for providing crisis services.

Facility-Based Crisis (FBC) Centers:

- 16-bed facilities operating 24/7 for behavioral health crises.
- Available in most counties; it may treat individuals under IVC.
- Funded by SPs and TPs; LME/MCOs cover uninsured individuals.
- Not covered by Medicare or commercial insurance.

Behavioral Health Urgent Care (BHUC) Centers:

- ED-alternative walk-in centers staffed by licensed clinicians.
- Stand-alone or co-located with FBCs; function similarly to physical urgent care.
- Provide triage, evaluation, and up to 23-hour observation.
- In-lieu-of Medicaid services; not covered by Medicare/commercial insurance.
- LME/MCOs pay for uninsured individuals.
- Can conduct first-level IVC evaluations.

Key Principles:

- No individual should be turned away due to inability to pay.
- Crisis system operates under a "firehouse model" requiring continuous funding regardless of utilization.
- Crisis providers bill fee-for-service; LME/MCOs subsidize shortfalls.
- Commercial plans often do not pay for services used by their members.

Crisis System Challenges:

- High start-up costs; single-stream funds cover shortfalls.
- SPs contribute, but Medicare and many commercial plans often do not.
- LME/MCOs and counties must fund system expansion.
- Providers face multiple audits from various health plans.
- Some payers refuse contracts, underpay, or do not pay at all.
- Resulting cost burden on LME/MCOs and counties totaled $24M in FY24.

Alliance Action Steps:

- Noted that the firehouse model is unsustainable.
- Alliance is working with counties, providers, LME/MCOs, and DHHS on long-term solutions.
- All eight health plans receive crisis-designated Medicaid funding.
- Best practice model: State owns core crisis components; counties supplement; LME/MCOs standardize administration.
- Exploring alternative funding, including requiring commercial plans to pay or using provider assessments.
- Discussed risk-reserve trust models with restricted fund considerations.
- Medicaid rates are considered reasonable; no funding source exists for non-Medicaid individuals.
- Shared comparisons of funding models in MA, AZ, and WA; the Arizona model most aligned with NC's needs.

Recommendations:

- Allow LME/MCOs to manage all crisis funding streams (Medicaid, Single Stream, County Crisis, Block Grants).
- DHHS should determine network adequacy and support start-up/infrastructure costs.
- The state should require commercial plans to contract with crisis providers statewide at Medicaid-equivalent rates or pay assessments.
- Local sustainability concerns highlighted using Mecklenburg County's higher-than-expected investment.

Crisis Continuum:

- Includes 988 and health plan crisis lines; Mobile Crisis Management (MCM); co-responder models:
  - MORES; BHUCs; FBC/Non-hospital detox; and NC START.
  - ED utilization remains high due to a lack of awareness of alternatives.
  - MCM is under-utilized; the goal to reduce response time from two hours to one hour.

Crisis System Performance Measures:

- Utilization
- Accessibility
- Service quality
- Response times
- ED wait times
- Complaints, grievances, incidents
- Recidivism (viewed as part of engagement, not failure)

Operational Notes:

- All LME/MCOs contract for out-of-catchment beds.
- Step-down facilities operate under defined scopes with peer and transitional supports.
- Alliance does not discharge individuals without a safe plan.
- BHUC stays are limited to 23 hours; longer stays require FBC licensure.
- Fewer than 25% of Steve Smith BHUC clients require higher-level care.
- FBC and BHUC services are distinct; no financial incentive to self-refer.
- Private insurance does not cover FBC operational costs, leaving LME/MCOs to subsidize.

MORES Program:

- Provides 24/7 mobile crisis and stabilization for youth/families.
- 45-minute response goal, needs assessment, immediate stabilization, linkage.
- Up to eight weeks of engagement; covered by TPs.
- In the first year, no MORES participants returned to the ED within 90 days.

New Child Crisis Facility:

- Fuquay-Varina facility heavily used by commercial Blue Cross members.
- Recently licensed for IVC to divert youth from EDs.
- Also available for youth in DSS custody.
- Alliance conducting outreach to law enforcement.

Additional Notes:

- Recommended reviewing ILO crisis services (e.g., BHUCs) and establishing sustainable rates.
- CEO Robinson emphasized NC's crisis system is viewed nationally as a model but remains underutilized.
- Ensuring all payers contribute is essential for system stability.
- SCFAC will review its annual report for potential crisis-system recommendations.
    - Alliance will provide a White Paper from all four LME/MCOs.

Agenda Topic:	**Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) Update**
Presenters	**Renee Rader, Deputy Director & COO, DMH/DD/SUS**

DMHDDSUS Updates

Deputy Director & COO Rader filled in for Assistant Secretary Kelly Crosbie.

April Awareness Observances:

- Alcohol Awareness Month
- Alliance NC provides FASD education/resources (proofalliancenc.org).
- NC Peer Warmline: 1 855 PEERS NC.
- Autism Acceptance Month
    - Inclusion Connects initiative.
    - Autism Society (national) and Autism Society of NC resources.
- Second Chance Month
    - Supports individuals returning from incarceration.
- Raj Mehta Day of Good – April 15
    - Annual celebration of kindness.
- National Minority Health Month
    - Highlights health disparities and aims to strengthen access to care.
    - DMHDDSUS efforts:
        - Partnering with organizations serving immigrant, rural, and underserved communities.
        - Expanding access via 988, community services, and recovery supports.
        - Using data and community engagement to address care gaps.
- Stress & Counseling Awareness Month
    - Promotes mental well-being; highlights 988 and Peer Warmline resources.
    - Recognizes impacts of stress on health and functioning.
- SCFAC Chair requested a budget update; was told it would occur after other DMHDDSUS reports.

NC Black Youth Suicide Prevention Report: Hanna Harms:

- Cross-sector partnership with state agencies
    - UNC and Village of Care to address rising suicide rates among Black youth.
- Five-year Action Plan (released July 2025) guided by dual board model:
    - COPE Community of Practice, Adult Advocates Council, and Youth Advisory Board.
    - Key Initiatives
    - Training in Mental Health First Aid and CALM.

- Expansion of youth-led efforts (Stronger Together NC, Black YAB).
- Peer leadership and crisis gatekeeper training for youth/young adults.
- Creation of wellness-centered youth spaces and mentoring; supports addressing social determinants.

Updates & Events:

- 2025 End-of-Year Report available on request.
- Recent events: spoken word contest; Gwen K. Newsome Foundation launch; Expression Tunnel exhibit.
- Upcoming events:
  - Partnership with NC Council of Churches (transportation needs noted).
  - Youth Paint Party at Imperial Center.
  - 988 and State event in May.

Partnerships:

- NAMI chapters and UNC-led suicide prevention training, including for HBCUs.
- AFSP's "Let's Save Lives" culturally adapted training.
- Active involvement from churches/ministries; initiative co-led by Dr. Sonya Richardson (UNC).

TBI State Action Plan - Ginger Yarbrough:

- Draft plan (July 2026–2029) developed by a time-limited work group; out for public comment through 4/27/26.
- Feedback sought from multiple councils and stakeholders.
- Four focus areas: access, provider support, caregiver/individual support, and prevention.
- SCFAC members encouraged to comment.

Youth Justice Mental Health Pilot - Deputy Director Rader:

- Partnership with DHHS, DPS, Alliance Health, and New Hope Treatment Centers.
- $3.5M initiative at Dillon Juvenile Detention Center serving up to 10 youth with significant MH/SU needs.
- Includes family outreach and community reintegration.
- Questions about expansion to other facilities will be addressed by staff.

Mental Health Bed Registry Update - Lisa DeCiantis:

- Major upgrades to BH SCAN for improved crisis care access.
- New real-time integration with facility EHRs; replaces manual updates.
- Usable by larger hospitals, SU facilities, and FBCs; some small facilities lack technical capacity.
- NC is first in the nation with this capability; compatible with multiple EHR systems.
- System is separate from HIE.

Additional Discussion:

- Concerns about hospital staffing and the use of incarcerated workers.
- Facility autonomy to decline admissions may lead to out-of-state placements.
- Chair Laws asked about child placement trends; responses included trauma-informed PRTF practices (Ukeru), pilot programs, and case-specific decision-making.

Continued Updates - Deputy Director Rader:

- VA Suicide Prevention Grants
- $112M Staff Sgt. Parker Gordon Fox program for community-based suicide prevention.
- Eligible applicants include nonprofits and local partners serving Veterans/families.

LEAD Program (Law Enforcement Assisted Diversion):

- Divert individuals with MH/SUD issues from the justice system for low-level, non-violent offenses.
- Expansion in Fayetteville, Gaston, Greensboro, New Hanover, and Robeson; $1.5M investment.
- Participants are 40% less likely to be re-arrested.
- Discussion noted limited providers in eastern NC and the importance of local law enforcement support.

Budget Issues:

- Cuts to Single Stream, 3-way beds, and Task Force funds are creating strain.
- Block grant planning must stretch funds further; potential merger with SOR grant adds uncertainty.

Sustainability Concerns:

- Crisis system sustainability requires high investment and recurring needs.

- Justice-related programs face community resistance and depend on hopes of local funding transitions.

Additional Comments:

- Flo Stein emphasized collaboration with sheriffs on jail-based treatment and careful use of opioid settlement funds.
- Chair Laws requested a future update on settlement dollars.

Agenda Topic:	Division of Health Benefit (DHB) Update
Presenters	Angela Smith, CMO, DHB and other DHB staff

Medicaid Expansion & Budget Updates:

- No new updates from the General Assembly on the Medicaid Expansion trigger law.
- Medicaid is still awaiting the current year budget.
    - Without approval within 38 days from 4/8, Medicaid will run out of funds around 5/16.
    - $319M shortfall remains; spending patterns align with projections.
    - DHB CFO anticipates a full rebase of funding from the GA.
    - Next year's budget is under review; recurring funds preferred over one-time funds.

General Medicaid Program Updates:

- Carolina Complete Health and WellCare successfully merged on 4/1; the new entity is Carolina Complete Health.
- Spring Cell & Gene Therapy Education Campaign launching to expand Sickle Cell Disease treatment awareness and explain Medicaid coverage options.

Federal H.R.1 Eligibility & Enrollment Changes:

- Review of Redeterminations and new requirements.
- Sec. 71119 mandates eligibility reevaluation every 6 months for Expansion Adults starting Jan 1, 2027.
- Discussion on possibly recommending exemptions, though federal rules may prevent this, awaiting CMS guidance.
- Up to 20% of Medicaid members may lose coverage due to re-enrollment barriers.
- DHB/NC Medicaid may present on H.R.1 at the May meeting.

Connecting Communities and Medicaid (CCM):

- Monthly forum on 2nd Wednesdays; SCFAC may adjust its meeting date due to overlapping.
- With H.R.1 changes, as many as 29,000 people may lose Medicaid.

CAP-C Guidance:

- Program serves medically fragile children.
- Recent guidance caused confusion and created unintended barriers; Medicaid is restoring clarity and aligning guidance with the waiver.
- Input from the Medicaid Beneficiary Advisory Council and CAP-C Workgroup; concerns directed to the NC Medicaid Ombudsman.

General Resources:

- NC Medicaid Website: medicaid.ncdhhs.gov
- Medicaid Bulletins: medicaid.ncdhhs.gov/providers/Medicaid-bulletin

Medicaid Waivers Overview - Dr. Clapp, LaCosta Parker, Renee Stapleton:

- Managed Care Authorities
    - Medicaid managed care supported by the 1115 Waiver and 1915(b) Waiver, which work together.
    - 1115 Waiver authorizes Medicaid Transformation, SPs, TPs, CFSP, Healthy Opportunities Pilots, SUD improvements, and reentry demonstrations.

1915(c) Waivers:

- **TBI Waiver**
    - HCBS waiver for adults with TBI meeting institutional level of care, up to 300% FPL.
    - Pilot in Alliance Health region; 107 slots, 93 filled with ongoing onboarding.

- DHB is developing a standard process to identify potentially eligible members; updates expected by Q3.

- **CAP-C Waiver**
  - For children and adults under 21 who are medically fragile, statewide, with no waitlist.
  - Operates under Medicaid Direct (FFS).
  - Covers care, technology, home/vehicle mods, case management, equipment, and supportive services.
- **CAP-DA Waiver**
  - For adults 65+ or adults 18–64 with physical disabilities who meet nursing facility level of care.
  - Alternative to institutionalization; 11,648 slots with a 4,000-person waitlist.
  - Delivered through Medicaid Direct; no duplication of services; no PMPM.
  - Tailored Care Management available through PIHPs.
- **Innovations Waiver**
  - Supports individuals of any age with IDD (including Autism, CP, Down syndrome, and TBI before 22).
  - Covers HCBS support, employment services, communication devices, crisis services, and caregiver support.
  - Implemented through PIHPs/TPs.
  - 14,736 slots; nearly 19,000 on waitlist.
  - Questions raised about IQ testing, criteria updates, and assessments for nonverbal individuals.

Feedback & Follow-up:

- SCFAC members found the comparison table helpful; Dr. Clapp was invited back in May to complete the presentation.
- Presentation considered educational and useful for members and legislators.
- Clarified that individuals cannot be enrolled in both CAP and Innovations; reserve slots exist for CAP-C to Innovations transitions.
- DHB will follow up with DMHDDSUS on cross-program engagement among CAPC, CAPDA, and waitlists.

Agenda Topic:	**Approval of Agenda and March Meeting Minutes**
Presenter:	**Dr. Michelle Laws, SCFAC Chair**

- With a quorum confirmed, a motion was made by Lilly Parker and seconded by Lorrine Washington to approve the agenda. The motion carried.
- With the addition of Ashley Snyder-Miller as the second for the March agenda approval, a motion was made by Flo Stein and seconded by Ashley Snyder-Miller to approve the March Meeting Minutes.

Agenda Topic: Public Comment

Public Comments:

- Two public comments were submitted online.
  - **Matt Brandon**
    - SCFAC Chair Laws summarized Mr. Brandon's comment.
    - He shared that substance use services in Durham have positively impacted him and addressed both medical and mental health needs.
    - Education will be part of his two-year recovery plan, and he expressed appreciation for the support and opportunities to give back.
  - **Wes Rider**
    - Attended virtually and summarized his concerns:
    - Transparency: Requested the Mental Health Block Grant budget; submitted a Public Records Request, but has not received a response.
    - Non-clinical, secular MH recovery supports: Few resources available in Eastern NC; emphasized that 12-step models are not suitable for everyone and may discourage mental health discussions.
    - DMHDDSUS Community Engagement Team changes: Asked whether SCFAC or other groups were notified of restructuring.
    - Vacant state/LME/MCO properties: Suggested evaluating properties that appear unused or seldom used.

Agenda Topic:	Rural Health Transformation Program - Rural Organizations Orchestrating Transformation for Sustainability (RHTP-ROOT)
Presenters:	Rachel Couper, A DHB Project Manager, Hanaleah Hoberman, Behavioral Health under RHTP, DHB, and Kimberly Waterman, support and coordinates RHTP initiatives, DHB

NC ROOTS Hubs & Rural Health Transformation Program Overview:

- Ms. Couper leads Initiative 1, focused on establishing NC ROOTS Hubs.
- Application process for a major NC ROOTS Hub component is complete, evaluations underway.
- Rural Health Transformation Program (RHTP) includes $213M in Year 1 funding to improve rural health statewide.

Rural Health Context:

- 28.4% of NC residents live in rural areas.
- 90 counties are designated mental health shortage areas.
- Diabetes rates are 17% higher in rural communities.
- 24 counties lack primary care: significant shortages in BH, oral health, and EMS.
- 12 rural hospitals have closed or converted since 2006.
- RHTP is a CMS one-time funded initiative under H.R.1, aligned with 11 required federal categories.
- Funding supports Year 1 of a 5-year program.

Guiding Principles:

- Maximize resources for rural health.
- Build detail around high-level strategic approaches.
- Achieve quick wins while planning for sustainability.
- Prioritize measurable, community-level impact.
- Implement flexible, agile strategies.
- Maintain transparency and integrity.
- Apply an equity lens across all initiatives.

Six RHTP Initiatives (Developed with 400+ Stakeholders):

1. Build rural community care network “Hubs.”
2. Expand primary care, prevention, and chronic disease management.
3. Expand and integrate BH/SUD services.
4. Build a resilient workforce with innovative team models.
5. Ensure fiscal sustainability through new financial models.
6. Modernize rural care delivery through digital health solutions.

- ROOTS Hubs will implement Initiatives 1, 2, 4, and 5.
- Year 1 investments target quick-start projects and long-term impact (e.g., Mobile Outreach, CCBHCs, Mobile OTPs, First Episode Psychosis programs).
- Priority in Year 1 is given to providers able to implement rapidly, regardless of organization size.

Member Requests:

- SCFAC member requested a 1–2-page fact sheet on ROOTS.
- Issues noted: counties without OB-GYNs and interest in the successful First Health model.

Initiative Details:

- Initiative 1: Regional hubs linking medical, BH, and social supports; foundation for Initiatives 4 & 5.
- Initiative 2: Add-on package expanding areas like perinatal and chronic disease care.
- Initiative 3: Previously covered by Asst. Secretary Crosbie.
- Initiative 4: Expands rural residencies and training pipelines.
- Initiative 5: Develops value-based payment models.
- Initiative 6: Improves data exchange, HIE connectivity, and telehealth adoption.

ROOTS Hubs Overview:

- NC ROOTS = Rural Organizations Orchestrating Transformation for Sustainability.
- Hubs are regionally based, locally governed networks implementing RHTP priorities.
- Governance will include hospitals, FQHCs, BH agencies, academic partners, CBOs, and community members.

ROOTS Hub Lead Responsibilities:

- Coordinate regional partners to improve health outcomes.
- Establish standards for connecting residents to health and social support.
- Ensure culturally responsive care, including for tribal communities.
- Collect and analyze data to track outcomes and drive performance.

Award & Implementation Timeline:

- Up to six Hub Leads will be selected, regions aligned with Medicaid SP areas for CMS consistency.
- Awards targeted for mid-summer.
- Year 1 focuses on infrastructure and immediate needs, future funding contingent on CMS evaluation.
- Member question about SCFAC-population providers: eligibility is outlined in the RFA.
- • Additional information available at: https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program

Agenda Topic:	**SCFAC Work**
Presenter:	**Dr. Michelle Laws, SCFAC Chair**

Annual Report Review:

- Chair Laws outlined the review process: focus on whether to keep each recommendation, not on wording edits.
- **Recommendation 1:**
  - Limit and contextualize the term "behavioral health" to improve accessibility.
  - One concern raised by Annette Smith; others approved by consent.
  - Costs acknowledged; recommendation will be included.
- **Recommendation 2:**
  - Increase DSP wages through annual state cost-of-living adjustments (removed specific $20/hour figure).
  - Motion made by Ashley Snyder-Miller and seconded by Flo Stein.
  - Final approval is deferred until all recommendations are reviewed.
- **Recommendation 3 – Innovations Waiver Waitlist:**
  - Break into three parts:
    - Prioritize placement of active, eligible individuals.
    - Publicize the formula for waitlist management.
    - Require annual DHHS audits and updates.
- **Recommendation 4:**
  - Increase TBI funds from $3.4M to $10M; justification to be added.
- **Recommendation 5:**
  - Establish a statewide TBI ECHO program using RHTP funds and an academic medical institution.
  - Remove reference to Duke University; ACL funding may also support.
- **Recommendation 6:**
  - Institutionalize AskMeNC across state/local government.
  - Add sub-recommendation for enhanced support for Veterans not receiving VA care.
- **Recommendation 7:**
  - Standardize Medicaid Waiver terminology; no changes needed.
- **Recommendation 8 – CAP-C:**
  - Placeholders will follow the previous Annual Report format.
  - Crystal Foster is adding the remaining material.
- **Recommendation 9:**
  - Expand Medicaid coverage to include Transcranial Magnetic Stimulation, no changes.
- **Recommendation 10 – Housing:**
  - Placeholders focus on housing support for people with disabilities.

- Chair Laws and Johnnie Thomas continuing work.

- **Recommendation 11 – TBI Expansion:**
  - Proposed consolidation into three parts:
  - Funding
  - ECHO
  - Waiver components
- **Recommendation 12 – Child Welfare / BH Stabilization:**
  - Remove reference to gender discrimination.
  - Focus on support for children of parents who are justice-involved or have MH/SU needs, and unbiased DSS staff training.
  - Patty Schaeffer recommended statewide START training and Peer Support; will send draft language.

Additional Actions:

- Add crisis system recommendations reflecting issues discussed by Renee Rader and Rob Robinson.
- Annette Smith raised concerns about aging parents and limited ICF availability (only three statewide).
  - Recommend a one-year study of small community ICF-IDDs (quality, staffing, stability, oversight).
  - Note: Not all families desire ICFs; DSP benefits gaps hinder sustainable in-home models.
  - Chair Laws requested a draft proposal.
- Aging-parent topic will be included in the May Community Collaboration, State to Local Call.
- Recommendation revision from LaCosta Parker and Greg Daniels remains pending.
- Suggestion to add a Substance Use recommendation regarding housing for pregnant women, women with children, and fathers in recovery.

Approval:

- Motion to accept all recommendations (including additions) made by Lorrine Washington, seconded by Annette Smith.
- Motion passed unanimously.
- Nomination Committee – May Meeting
- Members: Patty Schaeffer, Lilly Parker, Lorrine Washington, Nathan Cartwright, Jessica Aguilar.
  - Motion to approve made by Ashley Snyder Miller and seconded by Flo Stein.

Legislative Day – May 12:

- Sponsors: Senators Burgin & Hawkins; Representatives Potts & Crawford.
- Members wishing to speak must email Chair Laws immediately.
- Talking points will reflect the recommendations for the Annual Report.
- Jessica Aguilar is collecting family/consumer stories.
- Additional planning steps discussed.

Scheduling:

- June meeting remains set for June 10 (despite previous conflict concerns with i2i Conference).

Adjournment

- Lorrine Washington made the first motion, and Lilly Parker made the second.
- The motion was carried, and the meeting adjourned at 3:00 PM.

Action Items	Responsible	Deadline
• Have DMHDDSUS staff present an update on opioid settlement dollars	DeDe Severino for presenter suggestions	Future meeting
• Have DHB staff present on H.R.1 work requirement changes impacting the Medicaid Expansion population	Sarah Gregosky or delegate, DHB	May Meeting
• Complete Waiver Presentation	Dr. David Clapp, DHB	May Meeting

• Question re: information about people being on CAP-C or CAP-DA and also being on the Innovations Waitlist	DHB staff would have to follow up with DMHDDSUS staff re: this, so ultimately DMHDDSUS staff should respond	Unspecified
• Recommendation revision for Annual Report remains outstanding	LaCosta Parker and/or Greg Daniels, DHB	As soon as possible