Questions & Answers from meeting with Southwest Providers

Agencies represented: Skamania County; Community Services Northwest (CSNW) and Lifeline Connections—SUD; Clark County Crisis services; Children's Home Society, Family Solutions, Children's Center; Omsbuds and NAMI; Columbia River MH, Lutheran Community Services NW;

(A meeting also held with Beacon, however minimal content is included here because most of it was kind of a meet and greet about what we do.)

1. How are the MCOs different/ the same??
Molina has 80% of the business in Clark, CHPW has 20%; contracts are well-aligned. --Skamania "The MCOs talk like they are well-aligned, but they each have their own set of rules. I haven't really seen that they have unified ways of doing things. –Clark Co., Columbia MH
2. What has your experience been working with the health plans?
"This is the most exciting change work that has been done [with the MH system] in years…" "The MCOs and HCA made a commitment to make no changes that didn't need to be made." "No malevolence or money grabbing on the MCOs side. Far more promise in the SOC than there was with the RSN system. MCOs had 3 priorities: network continuity, decreasing the administrative burden, and no one goes out of business, and have achieved those priorities." Prior to changeover everything was geared to comply with administrative WACs. Administrative burden has increased in the respect that if the organization didn't have the billing capability before the change over it has been an additional level of administrative burden. For those who were already billing third parties it has been less onerous. There have been some glitches, though, specifically significant with SUD. The MCOs didn't know CD and there were some struggles. IOP was seen differently—had strenuous auth requirements (monthly), and all SUD services were paid as FFS (fee for service) MH contracts: Some paid through cost reimbursements, block grant, EBP, FFS **For cost reimbursement contracts , the 1/12 doesn't account for seasonal fluctuations.** Methodology for cost reimbursement used an inpatient bed model, maximum daily service rate, not in line with the full cost of service. Found some unexpected surprises: if 80% business is Molina, expected 80% paid, with 20% cost to CHPW. (split shared cost…)but it turned out that CHPW payment was 80% of the 20%, so there was a decrease in reimbursement that was unexpected. Whenever a consumer is enrolled with the ASO they are automatically enrolled in crisis services. Providers have many meeting regularly, including with each MCO & Beacon individually. Also have weekly provider HCA call—works out to 4 calls/ week. **Major issue mentioned:** FFS: Need one person to do the ins. billing. Need to register on-line for portal access in order to check benefits. Agencies submit their 837s and then get a bunch of checks back in the mail…then the agencies have to figure out where the payments go. Office Ally was the Clearinghouse used by one agency and Molina had not worked with them before so it was challenging.

3. How do the MCOs collaborate with providers ?
Initially were open to collaborating in negotiating payment structures…to some extent. Molina has been more flexible than CHPW and Beacon, although CHPW and Molina worked closely together to create similarity in practices so providers didn't have to juggle multiple different requirements. Beacon does capped contracts…refuses other methods of payment. (Meeting with Beacon revealed they are corporate with set rules and perspective as to how things will be done. The corporate office is in Boston, with the executive leadership based in California. They rent a small office in a congregate rental office space building in Vancouver, and appear to have only 2 staff based there. They don't know the local communities…and it appears they don't see that to be a concern.) There were a lot of system issues that had to be worked through. There was initially confusion around which bills were sent where; providers had some difficulty getting called back to resolve problems…they had to go to the HCA and magically the phone calls were returned. The HCA is invested in having this work.) Provider meetings are held with each MCO and Beacon individually, and there is a weekly provider meeting with the HCA—about 4 calls a week. HCA is responsive and applies pressure to MCOs when needed. The stakeholder group also meets 1 x/ month—minimal to no participation by health care providers.
4. What does the authorization process look like for services?
CD had a preauth process that was very onerous—every 30 days had to reauth; problem with them paying for UAs…allowed only 1 PACT has auth process with CHPW, Molina doesn't require and Beacon goes back and forth. "Access to care issues with MCOs within MCO system—lack of clarity around decision making—not well thought out. " *(not entirely sure what this means…)*
5. What Value based care options are currently in use?
Nothing established as of yet; no indications of where this is going.
6. What screening instruments are required to be used?
None required yet, but they see it coming.
7. How could the reserves be spent prior to the transition to the MCOs?
"Should bring this up with the BHO;" *(it seems that NCWBH is planning to use some of the reserve funds to assist providers with IT needs, although it is not clear as to what this means at present…?)*
8. Why did the RSN's reserves have to go back to the state? Can they be used before that point in time?
state legislature appropriated them and did not give anything back to the region; (does not appear that this was thought through before the transition so all money was returned to the state)

9. What kinds of payment structures are being used by the MCOs?

"Each provider will be treated differently as far as the $ goes. Pre go-live there was more flexibility, but once went live there was a different set of rules."

SUD—fee for service; MH is cost reimbursement and some FFS, depending on the provider. County (crisis team) uses a variety of funds to pay for services, but is paid mostly through cost reimbursement. Beacon holds the state dollars; 1/10 used to support SUD, and county keeps the agency whole if referrals are insufficient to maintain position. Flat reimbursement rate regardless of level of education. PACT program is cost reimbursement. Cost reimbursement for the PACT program has been problematic…as the costs are allocated across multiple providers, and the payments 60-90 days later after they sort out what is paid by MC and the other MCO. Noted that AR (accounts receivable) is being carried much further out as the roster of clients and MCO assignments are fluid.

SUD: Medication Assisted Tx is being done by a few agencies—but MCOs have not pushed it or really focused on it at all.

Pre-auth process for PACT differs between MCOs. Molina doesn't require but CHPW has done auth and reauth procedures. (PACT appears to be closely monitored for consumer assignment, and LOS)

10. How does the ASO function? Do they provide services or contract with provider network? Are there contracts with multiple providers for different components—i.e., block grant funds, jail, crisis, etc. or does one provider have to do it all? If they were providing direct service vs. contracting how would things look? How does the ASO work with the MCOs?

Lots of meetings between Clark and Skamania; theory was that the services would be delivered the same; many differences between Clark and Skamania due to rural nature of Skamania, plus they have a 1/10 of 1% which provides additional $ support;
In Skamania, if the individual is in outpatient crisis care is billed to the MCO; if not in care and they show up in crisis they are billed to the ASO.

Answers from Clark county (the County provides crisis services in Clark):

Beacon holds the Omsbuds contract, as well as NAMI and CDBG funds.

Crisis contracts are paid by cost reimbursement. Initially there was a 90 day payment lag due to system set-up problems on Beacon's end. Their system is not flexible and even though all invoicing was submitted timely and was done correctly the County (Crisis svcs in Clark Co.) was required to resubmit all the billings.

Beacon has taken on Omsbuds & advocacy groups. FYSPRT & NAMI; NAMI was originally funded slightly…then funding with RSN increased from $60K to $260K when Beacon took over they changed the contract and decreased funding considerably ($100, 000).

NAMI is not a fan of the new system…thinks it has made things more difficult for consumers to get their needs met. NAMI is an important resource for families and clients—provides advocacy and helps to resolve problems. NAMI in SW has merged four counties, and they provide BH services—educational and group services, as the wait time for services was 90 days to get into the CMH system and they

wanted to provide access to individuals. The MCOs & Beacon cover different things (MH, physical health, crisis) so consumers are having to deal with 3 systems, and the systems aren't coordinating care for the most difficult consumers, which involve health, disabilities & MH issues.

It appears that different Beacon contracts with multiple providers for specific services.

11. How does the crisis team function? Are there differences from before the transition and after that we should know about/expect (positive or negative)?

Separate contracts/crisis systems in Clark and Skamania. After hours response done by the Clark and Skamania teams. Clark Co. picks up clients who go from Skamania to Clark for hospitalization as there is no hospital in Skamania. There are 3 hospitals in Clark Co.

Clark County: MOT, ITA/DMHPS, Protocall, Youth svcs, CCS--Wise
"Beacon has been creating an incredible crisis system but billing has been difficult;"
"You need to think about getting the IT issues handled as soon as possible-- can't dedicate enough time to preparing IT for the transition; Great Rivers has a deal with Avatar—*which they seem to feel is working out for them(?)*

"Provider Alliance could have come together and got more representation with Netsmart or looked at purchasing", *but the consortium version of Avatar seemingly did not work for SW providers any better than it has for Chelan-Douglas.*

Have to create 837 to bill insurances in billing system; they are 10 mos in and not yet on solid ground with billing for Beacon;

Editorial comment from a SW provider: "contracts with MCOs need to be incentivized & they aren't...provides no motivation to address problems effectively/efficiently."

Big issue: Crisis system was reliant on MSO system to see info re: previous episodes of care, but this was removed when Avatar went away with the consortium-- now there is no way of checking on the client's history in the system or provider assignment, etc. in the MSO. Portals are available for purchase, but every portal access costs $1500 and every person on the crisis team needs to have access, so is cost prohibitive.

SW Provider* Advice: *"Need to think about how we are currently getting data and what data we need to have…to prepare for when it won't be available…"

12. What would your line staff and supervisors say about how things are running in the new system?

Now authorization process is much less onerous for clinical staff because RSN was so micromanaging. The entities struggling with billing have more challenges in this regard, but overall considered to be less onerous than when the RSN ran things there.

Note: (*Comment from a friend of mine who is a provider with CCS crisis team: Things are a mess…")*

13. How is Protocall working as the crisis line provider? Does the ASO hold the Protocall contract?

Didn't discuss…

14. How is coding working? Are there a full range of codes available for use? Any difference from the RSN in that regard? Are peer services billable/countable in the new system?

"Some coding issues…working them out."

"Setting up billing systems for the MCOs is no small task…" This is the biggest challenge for agencies who had not been billing FFS to insurers.

Dual eligible clients…10% MA/MC dual eligible have been challenging. RSN used to pay the agency first, and the provider would reimburse the RSN when payment came; now can't bill MA until the rejection from MC comes…took 6 months to get paid for services.

Hard to know the rules…very different from the RSN. RSN was a hub and did a lot of training…rules were clear for those who didn't have a lot of business processes are in place…RSN required everyone to do things their way. RSN was good at not letting people get too rich. Molina provided Columbia River MH $750K in advance, and they are paying it back monthly;

Issues with Telepsych and counseling over the phone…Molina and CHPW had different codes for phone counseling which were complicated and confusing. They didn't have a system set up for paying for calls…were carrying a large AR because the MCOs didn't have a system to bill for these services.

15. How do the MCOs work with Qualis? How has the transition to integrated care been going? What about for providers like Catholic Family who don't have medical facilities/physical health care?

Qualis will be providing some technical assistance. Integrated care is something of a struggle with physical health providers in SW – they are reticent to make time and allocate resources –will be tough until a higher rate for medical providers create an incentive for medical providers to come on site to BH clinics. Some won't even coordinate care. Not really a clear pathway or plan for the medical / BH integration…waiting for someone to step up and provide leadership there.

16. How is "medical necessity" impacting your operations?

Axis to Care criteria went away–but visits still need to be clinically indicated.
If seeing only MA don't need to report demographic data; if you receive state funding need to report state demographics;
Need to register all clinicians with NPI #s…student interns posed a problem as everyone was required to use NPI number and they don't have them. (This agency uses a lot of students…)

17. Is there a payment lag with the MCOs?

**Recommended to focus on before going live. Providers have had to work out many denials, which has caused
Skamania—Issues with lack of clarity who was supposed to get the submission (which MCO for what); the budget submitted for cost reimbursement was the RSN budget, which caused some confusion around where a bill was supposed to be sent…for providers *(and maybe MCOs, too?)*

Big problems with providers in Clark—90 day lag (FFS); Beacon system is not flexible and had some issues with their system that prevented claims from being paid. Recommended to have provider network discussion regarding the HER and how data is collected, shared; need an IT operational person to understand the implications of the switch to independent records; lack of uniformity in approach of provider network made it difficult to address the system change;
Molina offered the 1/12 contracted rate to resolve potential billing challenges, but didn't happen with other payors; 837 billings have been very difficult with Beacon in particular. 835s come back without clarity as to payments made…
Have to open up the guarantor report to reconcile payment with bills. Some of billings were coming back as an intentional write off…and weren't showing anywhere. Laborious to reconcile payments with what was billed.

18. Are there things you weren't getting paid for before that you are now being paid for doing?

Started a new program at the jail with both SUD and MH providers…that is new. Beacon pays for this because it is non-MA; uses block grant funds. (Seems like they are open to doing things new ways but it is hard enough just to get things up and running well to be doing much new stuff…?)

19. How has the transition impacted the agency financially? Better/worse/same?

Sounds like the FFS billing has been challenging for folks, especially those who didn't have a system already in place. Denials have been a problem, as have the lags in payment that have occurred as a result of billing struggles, and challenges coordinating billing/payment by 2 MCOs.

SOC funding shortfalls? No.. service shortfalls… (?)

20. What do care management functions done by the MCOs look like?

"Not well coordinated…need a coordinator to coordinate the coordinators. Coordinated care with medical is spotty, especially with individuals with high needs who cross systems. " Molina? aCHPW? (one of them—I can't remember which) doesn't cover physical health and BH, so consumers may receive services from other systems. Consumers also seem to be moving from one system to the other as they seek care from specific providers. (No one seems to have stopped that process as expected…)

21. Were the MCOs already in the area prior to the changeover in contract?

Molina had a couple of tiny contracts…grew to be the largest provider when they took over the Kupp stuff during the RFP, and then they got the contract and overnight became the largest provider. Molina has health home contracts but so do Seamar and Catholic Community Services.

22. What are the MCO deliverables? Do all providers have the same deliverables? What is your experience achieving the deliverables?

No deliverables ID—MCOs are waiting for 18 mos when they have data. MCOs have maintained status quo. Skamania doesn't have any ideas about what they may be in the future. There are things they would like to see changed, but no discussions have been held around that as yet.

23. What value based payment systems are in place or being developed? They incentives or punitive?

Something going on but not in place…possibly will be developed but nothing ID as yet

Beacon is looking at incentive payment (1% of risk) need more data to say if that is a workable idea or

not. Beacon has requested an increase in MOT outreach by 5%, but there is no baseline established so not clear what that means at this point.

24. What surprised them both before and after April 1? What do they know now that they wish they'd known then?

State was going through Data consolidation process. And MCOs and Beacon didn't get information from the state until October/November; uniqueness of Skamania co. was surprising—MA auths became more complicated. Adminstratively more burdensome but that is getting resolved. MCOs have provided a lot of TA. Skamania had been billing ins. Companies so that was not new, but it was new experience to Clark Co.

25. How would they have contracted differently if they knew then what they know now?

**** "Need to have a financial "glide path" for this transition. " --reserves and line of credit needed. Providers recommended getting a 1/12 assignment of contract that is not contingent on billing claims on time…since it has taken so long to figure that part out. One issue with that though is there is no flexibility on the expenditure of $ with the seasonal ebb and flow that occurs in delivering BH services.**

CCS is paid on 1/12 /mo. One of the agencies referenced an issue that CCS had (no specifics) but there was some problem with CHPW; CCS did not want to sign a contract with them initially.

26. What changes are you expecting in the 2nd year? Have the MCOs been talking with the agencies about their plans?

No, not really. Don't have any ideas…not discussing.

27. What have the MCOs done to augment the service continuum—like E&Ts, crisis respite, etc.?

MCOs have not provided any beds, although providers have put together a legislative proposal to increase beds. No hospital in Skamania—all people in Skamania must go to Clark Co. for hospitalization. Clark County changed their system—was driven by mutual agreement. There was a work group that identified gaps for adults and children, and a planning group trying to figure out how to address the gaps. Has been in process since before the early adopter. The meetings are extremely important. Transportation is provided by EMT, a transportation contract and it is paid for by MA. Skamania doesn't have a multi-faceted crisis team. Beacon prefers to have services like EMT direct bill to them. DMHPs do evals in the office—Sheriff's office brings them to Skamania office, or if the person isn't safe they will take them to the Sheriff's dept where DMHPs will interview them there.

28. Are SIRI codes still used?

?? Referred to coding so …yes?

29. Are the measurable outcomes in the contracts the same between the BHOs?

Not so far…MCOs are waiting for data to determine what that will look like.

30. What are the audit procedures and how do they differ from what was done by the RSN?

"RSN used to audit all the time…never were finished but another audit started;

Clark—pleased with changes in auditing by practices of MCOs. Coding issues, integration issues –still working through; generally collaborative approach, however; very different from RSN.

31. What is happening for coordinated services with physical health? How many providers are there and what is the service network? How does it work for non-co-located programs?

"Primary care involved with BH providers at all?"…Not really, not participating in meetings with MH providers. Only work with the MA population because they have to as their "charity care" and only have to have 5000 lives. Some medical providers just won't work with MH, and won't even let a MH provider in their clinics. "No motivation or incentive to work together. " No incentive for focusing on integration of BH & primary care…for anyone. BH will be seen as "specialty care" but no one is really talking about that at this point. A couple of providers are working on co-location but PCPs don't appear interested in taking this on, and no one is pushing it. Providers are disappointed in the lack of leadership.
"Integration has been tough…One provider has attempted to add a medical provider on site, but the plan fell apart. Tried to work with Kaiser, but that has been difficult…primary care not open to working with BH unless have providers on site—unless there is a higher payment as an incentive to work in BH clinics PCPs not interested."

Funding is coming to support integration over the next 5 years.

"No one is providing leadership and vision/unified theory-not the MCOs or the HCA;" The bottom line is there has been no larger vision or plan put forth by the state to facilitate integrated care.
No strong ACH presence in SW—maybe part of the problem?

32. Beacon—What do they do? How are crisis services defined—ITA vs full range of crisis services? Are there multiple crisis service providers?

In Skamania, no—sole source contract; only have DMHPS. DMHPS see people at the office or at the Sheriff's dept. No home calls made due to the prevalence of guns in the county. Sheriff dept would not allow.
In Clark the County provides the ITA services.
Beacon does not provide direct services.

33. Have administrative costs increased? Have they taken money out of the system? How has the transition impacted care? Positively or negatively? What do consumers say about that? What do staff say about that?

Skamania: Not more money but can spend more flexibly; more available on SUD side than the block grant $ allowed. This is due to relationship between MCOS & HCA.

Clark Co.: Consumer experience (per NAMI report) is not improved. There are more problems and the experience hasn't been good for clients so far. Division of health care for clients is split between 3 entities CHPW, Molina, Beacon), with no one entity being willing to take responsibility or do good care management for difficult to serve individuals. Care management was better because there was one entity to go to. Coordination isn't working well. Case management provided by MCOs is directed to highest medical needs. Multiple care managers now as they exist—one for each entity (Molina, CHPW, Beacon). No one entity to coordinate the care managers.

Beacon was given the block grant $ as an afterthought, and they weren't sure how much the crisis system was going to cost so they cut some of the funding for support services. Beacon cut NAMI from

$260K to $150K. NAMI takes crisis calls from the community. No one is thinking about how to sustain NAMI , with a board, an office and staff…never have, since NAMI was started by families of individuals with mental illness.

What about the advisory groups that have been in existence—how have they fared with the transition? Beacon now runs FYSPRT and CLIP (now CLIP is called something else)—meetings held 1 x month. CLIP—children's long term inpatient program—number of CLIP kids has increased … ? *(called something else now in SW…?)*

34. What is used to determine level of care?

No more LOC requirements; need to meet medical necessity to justify services. Not terribly firm at present so some docs are referring more for warm care than SMI individuals. Visits must still be clinically indicated.

35. Are payments capitated rates of fee for service? Do providers have different rates and/or contracts with each MCO?

Skamania has fee for service and a cost reimbursement contract; providers do have different rates/ contracts. Clark has been against capitated rates so all providers are doing FFS; FFS was not new to Clark providers though. Some MCOs were talking about case rates, but providers requested not to do that for 2-3 years as didn't want to change the financial model with the all the transition.

36. We have heard that some providers received a loan from Molina to stay financially stable and are now paying back 1/12 each month. Have the issues that led to that problem been identified and resolved?

1/12 of contract paid out by Molina to keep providers financially stable. CHPW and Beacon did not do this. The issues have to do with IT challenges on both sides, and processing of claims.
Access to State PRISM system was granted after much lobbying, but only to 1 person at Crisis organization to obtain data.

37. We know that providers in SW had been using Avatar and that some of them chose not to continue with Avatar. What other EHRs have been chosen and how has that implementation gone? Who funded the hardware & software if providers were unable to afford it? Any information you think would be helpful to us if we are contemplating staying with Avatar or switching to another EHR?

****Cost of Avatar has increased dramatically since move to early adopter. Now there is an extra $50K in expenses as the company who took over has jacked up the price. No assistance provided by the MCOs, although the RSN gave each provider $15,000 out of reserves.** Most are continuing with Avatar until they get through the financial transition, although aren't happy about that. (Training is labor intensive for new staff.) Looked at Netsmart products, pricewise couldn't match what was found on the open market. No connection anywhere that allows the ER to see who a patient is connected with. Looking at collaborative pricing with Qualifacts as one possibility. **Recommended to have very capable billing person. Get as big of reserves as you can. Didn't get paid for 90 days and person who set up system was recruited away from the agency so made it difficult to reconcile payments with billing. Need a dashboard to have visibility; Need 6 month lead time to address IT needs…**

Note: NCWBH--IT meeting with Netsmart at 9:00 -11 on Friday at BHO. ***(to be rescheduled due to***

weather…) some discussion on setting up an interoperable system planned. **Very advisable to have operations and IT people in attendance as many issues of importance are related to IT and data infrastructure.** Qualis going to do an IT assessment with the agencies although it may be contracted out to another entity more IT centric than they are; HCA wants requests for technical assistance. Skamania purchased a new EHR system they are very pleased with—(Qualifacts?); they are very willing to share info and have people come to see it; their hours of operation are M-TH 7:30 am to 5:30 pm if we are interested in contacting them. Some SW providers looked at Valant, and participated in the system development with hopes that could be an IT answer, but nothing substantial has materialized with Valant.

The issue of data requirements is significant. The BH data dictionary is used and reported to the MCOs for their clients. There are conversations at the state level as to what is required…HCA claims not to need data but DBHR historically has wanted it..

Need to discuss at every meeting with everyone about system changes that are occurring, collaborate. Not sure what this was about…but in general, yes, of course…

Tight provider group is pulling info together and sharing with HCA—regarding problems that have emerged. There is an informal stakeholder network with a Board and Chair; meet 1/x month. Minimal participation by primary care /health.

38. Other issues & conversation topics of note…

- Ricky's Law changes coming in April…related to secured detox for integration of SUD detention; not enough resources, and barely getting things working with Beacon. Historical challenges with court system in Clark county…these changes will be challenging.
- **Interpreters are contracted through the ASO . It is difficult to get them when needed, especially 24/7; Crisis provider worked with HCA to get exemption due to imminence of need. System of obtaining interpreters has been difficult and slow. All Providers were required to change interpreting co.; Interpretation service are now a sole source contract with CTS, and an agency can't get paid for any interpretation unless it is done by CTS. Interpreters who had established relationships with consumers are cut out of the system…and can't get reimbursed for their services. Sometimes CTS interpreters don't show up for services.. Interpreters are only paid if the client shows, and they get a lower rate with MA so if they get a call with a better payment source they may not show up as scheduled.**
- Advice: Identify HCA contacts you will use when you need assistance…they will really push MCOs & ASO to address issues that they aren't responsive to. Don't need to wait for a long time to go by—contact HCA if not getting response.
- If provider was an MHP agency wasn't getting paid for claims submitted, but weren't getting denials, either. Medicare payments very difficult to manage.
- MCOs are incentivized to clean out WSH; now each MCO is responsible for over use.
- **More people coming out on LRAs, creating revolving door for crisis system & high recidivism rate**—resulting in revoking people more often, but can't get people back into the hospital so they create a backlog in the ENT. Care coordination provided by MCOs is focused on getting people out of WSH but resources aren't adequate locally to handle people who are returned prematurely.
- Regional data—contact Isabel at HCA to find out more about early adopter reports and data that they are gathering. Initially Beacon did not report the NO BED reports—didn't know they had to. There are possibly some dashboards Early Adopter/ Early Warning Steering Committee.

- IT systems: All providers are still technically with the consortium but all plan to eventually leave them. Claim info is submitted by one person due to Avatar—literally paper and pencil. Takes forever to get forms updated/built through the consortium.

- Institute for Family Development—Small Homebuilders MH contract (2 clients at a time—come in on a crisis basis which isn't what WISe does) used for MH on CA contract; Learning curve for billing services—had no idea about medical billing; has learned how to use clearinghouse (hasn't had to purchase as is using it through other resources;) Went in with cost reimbursement contract and had to work with MCOs to figure out how to cover cost of "no client days".

- **Other parties we should talk to who helped you get through the past year?** Not really…

- Sheriff's office…anything we need to know?
  Providers have regular meetings with the sheriff's office and police.

- [Tim: NCWBH is in process of developing a regional ENT—anything we need to know about that?] Need coordination of system pieces ahead of time so people don't call 911, but call appropriate provider instead. Additional cost added by some contract in SW for services delivered over 2 hours away. Average number of people in jail has increased by 100 from where it was before. Some of that is likely because no history is available for use by crisis system without the interoperational data system/access.

- Care coordination is a big topic for discussion; not going as well as expected—the care coordinators need a care coordinator as they aren't very coordinated, a problem for complex patients who cross multiple systems for care.

- Funding eligibility is an issue at times as in SW clients cross over into different RSAs when they seek services; they are not eligible for services now—this is new since the changeover.

- Used to have conversations with RSN about complicated cases to justifying continuing care and they weren't receptive. MCOs are much more positive and thankful for efforts

Columbia River MH: CEO came in 3 years ago without a background in MH; Oldest and largest provider of BH in Clark Co. – Columbia River MH -- adult opt, med svcs, crisis services (non-ITA), SUD, IDDT, OTP services, COD services, crisis stabilization; supported employment (BEST) & PATH now are funded through DBHR; ; separate contracts through state and county funding sources include third party insurances in addition to CMH & SUD funding;

Surprises? What do we need to know? Lessons learned?

- **CRMH has worked on care integration, but reportedly it is challenging due to reticence of medical providers to participate.**

- **Funding: One of the issues was the state legislature took all of the reserves and froze the rates at last year's level. In addition, now they are providing some high intensity contracts that are now are being paid for at an outpatient rate in new system—this is a current struggle.**

- Molina refused to pay for Telepsych—required to use specific providers they identify.