Executive Committee (EC) Members Present:

- Jill Johnson, Chair, Island County Commissioner, Board of Island County Commissioners
- Ken Dahlstedt, Skagit County Commissioner
- Anne Deacon, Whatcom County Human Services Manager/County Coordinator; Designated Alternate for Ken Mann, Whatcom County Council
- Regina Delahunt, Whatcom County Health Department Director, Designated Alternate for County Executive Jack Louws
- David Kincheloe, Chair, North Sound Behavioral Health Organization Advisory Board
- Barbara LaBrash, San Juan County Coordinator, Designated Alternate for Jamie Stephens
- Mark Tompkins, San Juan County Commissioner, Designated Alternate for Jamie Stephens
- Cammy Hart – Anderson, Snohomish County Human Services; Designated Alternate for County Executive Dave Somers

Executive Committee (EC) Members Present by Phone:

- Robert Knoll, Snohomish County; Designated Alternate for Snohomish County Council Member Brian Sullivan (Phone)

North Sound Behavioral Health Organization (BHO) Staff Present:

- Joe Valentine, Executive Director, North Sound Behavioral Health Organization (BHO)
- Betsy Kruse, Deputy Director (Phone)
- Greg Arnold, Health Care Integration Analyst
- Joanie Williams, Administrative Manager North Sound Behavioral Health Organization (Recording)

Guests:

- Alice Lind, Manager-Grants and Program Development Health Care Authority (HCA)
- Melena Thompson, Department of Social and Health Services (DSHS)
- Brad Furlong, Legal Counsel
- Brad Banks, Banks Consulting Group, LLC (Phone)
- Skye Newkirk, Island County Human Services Behavioral Health Coordinator (Phone)
- Rebecca Clark, Human Services Manager Skagit County
- Julie DeLosada, Skagit County Public Health
- Linda Richards, Island County
- Helen Price Johnson, Island County Commissioner
- Jackie Mitchell, Whatcom County Behavioral Health Program Specialist

Call to Order and Introductions – Chair Johnson
Chair Johnson called the meeting to order and initiated introductions.

Revisions to the Agenda – Chair
Chair Johnson noted there may be public comment at the end of the meeting, should time allow.

Comments & Announcements from the Chair
There were no comments or announcements from the Chair.

Comments from the Public
Chair Johnson asked if there were any comments or announcements from the public, there were none.

Discussion Items

- **Review and Discuss Health Care Authority's (HCA) Responses to Questions from the County Authorities Executive Committee**

Chair Johnson referenced the handout provided in each of the packets (copied and pasted below).
Alice Lind from HCA noted Melena Thompson from DSHS worked in collaboration with HCA to address the questions. She added that each question would be discussed individually and there would be opportunity for additional discussion after each item was addressed.

Follow Up Questions for Health Care Authority
Regarding Mid-Adopter Integration
North Sound BHO County Authorities Executive Committee
DRAFT for discussion September 7, 2017

Assumptions regarding the BHO transition to a BH-ASO, with clarification	
1. Starting in 2019 [or 2020 if no mid-adopter], all Medicaid funds would be contracted to the MCOs	Correct

2. During the 2019 transition period for mid-adopters, the MCOs could choose to contract with and/or delegate certain Medicaid funded services or functions.	Yes, and this would be a focus of the Interlocal Leadership Group.
3. Starting in 2020, no behavioral health administrative essential functions can be delegated to the BH-ASO.	If there is a function that is widely agreed to be a value-add or most effective when delegated to the BH-ASO, this could be discussed.
4. The current BHOs must return all unspent Medicaid and non-Medicaid dollars to the state, except for an agreed upon portion to pay all remaining bills.	Yes, and the State will work with the BHO to develop an approved spend down plan to maximize spend down of reserve funds prior to the BHO closeout. BHOs should begin proactively planning for spend down now. For further details on reserves, please review the draft reserve Q&A.
5. There is no provision to provide "start-up" funds to the new BH-ASOs. This means that a BHO who wishes to transition to a BH-ASO would be required to determine how it will obtain the necessary operating funds to carry out its functions.	HCA is exploring possibilities and will keep Counties informed as we work through a resolution.

	Issue	Question	BHO Notes	HCA Response
1.	CONTINUUM OF CARE AND COUNTY SERVICES	What will the new integrated structure look like for counties? How will dollars the BHO uses to support the counties in their stabilization and continuum of care programs flow? How will the administrative costs of running stabilization/human service programs be paid?	The North Sound BHO currently delegates and funds certain allied coordination activities to the county human service departments.	If the county is also a service provider, the county provider agency would be eligible to contract with the MCOs and/or BH-ASO to continue providing treatment services, just as any other behavioral health provider agency in the region. This is the case in Skamania and Grant counties already. If the county provides allowable delegated functions or coordination functions on behalf of the BHO, and would like to continue providing those functions in the future, the MCO/BH-ASO

	Issue	Question	BHO Notes	HCA Response
				could choose to continue that arrangement. If these functions are paid for by county dollars, those dollars stay with the county and are used at the discretion of the county.
2.	CONTINUUM OF CARE AND COUNTY SERVICES	Where are current county staff (providing care coordination and mental health outreach services) going to work? What about public health staff who work on prevention programs? Is the role of health and human services at the county level being eliminated or simply changing? What (specifically) does it look like in an integrated model?	All North Sound counties use the 1/10 of 1% sales tax to help fund prevention and other related behavioral health service activities.	Any county staff or functions that are funded by local funds, such as 1/10th of 1%, will not be affected at all by this transition. Counties maintain full control over local funds and 1/10th 1% funds. The prevention programs funded through DBHR/Substance Abuse block grant will continue to be funded through counties unless the county chooses not to maintain this role. Care Coordination and outreach would become a responsibility of the MCOs. However, that does not prevent the counties from continuing some/all of those functions through contracting with the MCOs or ASO.
3.	CONTINUUM OF CARE AND COUNTY SERVICES	What assurances do local jurisdictions have that this is not a cost shift or unfunded mandate? What assurances do we have that service levels will not be negatively impacted?		HCA will be requiring the same services to be provided through contracted MCOs and ASOs. HCA will monitor utilization to ensure that services will not be negatively affected. The interlocal team has an opportunity to provide input on the monitoring activities, early warning system, and performance measures.
4.	RURAL HEALTH AND BEHAVIORAL HEALTH CARE	What is the significance of a **critical access hospital**, or in the case of San Juan County, having no significant healthcare system in place? How will the integrated model look in counties (or rural areas of counties) if there is an unwillingness, or inability, of the primary healthcare system to deliver service? What happens if they are prohibited from delivering certain services because of their		This transition will most significantly impact the BHO-contracted providers and behavioral health services paid for by the BHO. This transition should not result in any significant changes to the critical access hospitals or primary care providers that already operate in the medical system. The Managed Care Plans will continue to be held to network adequacy requirements that require them to maintain a network of medical providers

	Issue	Question	BHO Notes	HCA Response
		hospital designation? How will that gap be filled? How will those patients be diverted to another system and who will pay for that diversion?		(including primary care, hospital, specialty, etc.) that meet time and distance standards, etc. If providers are unwilling or unable to contract with managed care plans, or choose not to serve Medicaid patients, the managed care plans must find new providers to contract with, otherwise they will be out of compliance with network adequacy which will result in an enrollment stoppage, or additional corrective actions.
5.	RURAL HEALTH AND BEHAVIORAL HEALTH CARE	What tools does the integrated model have to improve access (notably in rural areas) that the current system does not have? What happens if providers refuse to improve access (for whatever reason? What are the MCOs commitment to the local communities, especially small rural ones, in funding for full integration?		As noted in prior questions, if behavioral health services are delivered in new settings then this will lead to increase penetration rates and access. While not the same as BHO standards, the MCOs are required to adhere to access standards in rural areas, and also have care coordination requirements specific to rural and frontier regions. Through network adequacy standards, time and distance standards will also be required for BH services. We would be happy to discuss better aligning standards through the Inter-local leadership. Rural and frontier providers will play a critical role for MCOs in their ability to meet these network standards. Commitment to supporting these communities will be critical to these efforts. This is also why HCA does not plan to have less than 3 plans in any region.
6.	BLENDED FUNDING SERVICES	How will the funds for Crisis Services be "braided" after integration? Will MCOs be contractually required to provide Medicaid funds to partially support Crisis Services moving forward? What requirements will	This includes the full "continuum" of crisis services: ITA, mobile outreach, Triage	The MCOs are required in Contract with HCA, to establish a contract with the BH-ASO to pay for Medicaid-covered crisis services for their members. This includes mobile crisis outreach and the crisis hotline and any short term crisis

	Issue	Question	BHO Notes	HCA Response
		there be for MCOs to help maintain other services that require blended funding.	Centers, Crisis Line, etc.	stabilization activity that might occur during a mobile outreach visit, etc. If as a result of their encounter with the crisis system, a Medicaid client is committed to treatment, such as being committed to an E&T by a DMHP, the MCO's are contractually required to pay for that treatment service (the MCO pays the E&T directly). They are not able to do prior authorization or deny a service that has been court ordered. The BH-ASO *also* has a contract with HCA funded by non-Medicaid funding sources. This covers the non-Medicaid crisis related costs, such as crisis services delivered to non-Medicaid individuals or court reimbursements for any individual who is involuntarily committed or the cost of a DMHP ITA investigation. The braiding of funding really happens at the BH-ASO level, just as it does right now at the BHO level. The actual crisis providers should expect to be paid by the BH-ASO similar to the way they are today by a BHO. Providers will directly negotiate with the MCOs and ASO a payment method that works best for them.
7.	MAINTAINING AND EXPANDING TREATMENT CAPACITY	How will residential treatment be paid for, and what assurances are there that systems the counties are investing in will be utilized		Residential treatment beds are paid for by the MCO, or for non-Medicaid clients, by the BH-ASO. The MCOs will have a portion of state-only funds that will allow them to pay the non-Medicaid room/board cost, just as the BHO's do today. Residential treatment services are Medicaid

	Issue	Question	BHO Notes	HCA Response
				covered and therefore are paid for by the MCO's using Medicaid funds. As the BHOs currently do, the MCOs will be required to provide medically necessary services, including treatment in IMDs that extends beyond 15 days. If an individual is involuntarily committed to residential treatment or is otherwise authorized for residential treatment by the BH-ASO, the BH-ASO would pay for that out of non-Medicaid funds (state funds, block grant, proviso, CJTA - - as allowable/available). In terms of assurances to the county regarding whether the beds will be contracted; there is a shortage of beds in the State of Washington. As Essential Behavioral Health Providers, the MCOs will need as many providers as are available. MCOs are responsible for the full spectrum of services, it behooves them to serve clients in the least restrictive manner possible, where clients are likely to succeed. This would include maintaining relationships with the communities in which the person resides.
8.	MAINTAINING AND EXPANDING TREATMENT CAPACITY	If the North Sound is successful with its request for new capital dollars to build new crisis centers and residential treatment facilities, it's not likely all of these will be completed by 2019. What requirements will there be for MCOs to partner with the counties in maintaining and expanding the capacity of treatment facilities?	The BHO contracted for population modeling that shows there is currently a gap of over 100 treatment beds and this will grow over the coming years.	Depending on how this is currently operates or is funded, HCA will work with the region during the lead-up to integration to ensure capacity building continues.

	Issue	Question	BHO Notes	HCA Response
9.	MAINTAINING AND EXPANDING TREATMENT CAPACITY	What is the logistical process for bringing on more providers and increasing consumer access to services? What happens if the limitation for increased access is workforce? How will capacity be developed in order to keep people stable and out of crisis?		As noted in prior questions, the MCOs are held to network adequacy requirements that require them to have an adequate network of providers to meet the access needs of the population. If the limitation is workforce, the MCOs have flexibility and discretion to increase provider rates for certain types of hard-to-access services. Additionally, in SWWA HCA is working on a capacity building process with the MCOs, BH-ASO, ACH and counties to collectively work towards increasing provider capacity in the region. One of the benefits of this model is that the access to care standards and silos are removed, which allows new providers such as medical systems to obtain licensure for BH services (if desired) and offer additional services or clinically integrated models that they have not previously delivered. If this occurs over time, it will improve access to services.
10.	COORDINATION WITH PUBLIC SAFETY SYSTEMS	Who is responsible for coordination with jails to ensure diversion services are working? What will counties do if they are not, who is responsible for coordination with courts to ensure timely access to assessments and funding support and treatment access for Drug Court. How will the CJTA money be distributed?		The MCOs and BH-ASO all must coordinate with the criminal justice system and treatment providers to assure their members are engaged in treatment and diverted from jail whenever possible. The region should expect that the MCOs and ASO hire jail liaisons and are actively engaged in jail diversion activities. In SWWA and NC, the BH-ASO receives the "jail transition" proviso funds and contracts those funds to the providers who have been providing jail transition services in the region.

	Issue	Question	BHO Notes	HCA Response
				The BH-ASO also receives the CJTA funds and contracts those to providers, primarily to support the non-Medicaid justice-involved population that is eligible for CJTA funded treatment. Many of the treatment services funded via CJTA are also Medicaid-covered and thus covered by the MCOs for their clients. The use of CJTA funds is directed locally, by each region's CJTA panel. This does not change - - the BH-ASO simply contracts the funds out in accordance with the priorities and parameters that are determined by the local CJTA panel. Depending on how the Drug Court currently operates or is funded, HCA will work with the region during the lead-up to integration to ensure Drug Court continues.
11.	WORKFORCE	Who will do advocacy for workforce needs and training? Who will identify future local needs and how will those needs be addressed?	North Sound BHO currently provides significant funding support for on-line and classroom training.	This should be a topic for the interlocal group as implementation progresses.
12.	COORDINATION OF REGIONAL PLANNING	Who is responsible for regional planning on programs and services that need to be coordinated	If this function is assigned to the BH-ASO then there needs to be an adequate level of administrative funding carry it out. The BHO currently depends heavily on	HCA would further discuss with the regional stakeholders and selected MCOs/BH-ASO how they would like this to look in their region, and how they think it can be most effective. This should be a topic for the interlocal group as implementation progresses.

	Issue	Question	BHO Notes	HCA Response
			its Medicaid administrative funds to plan and coordinate a network of services across the five county region.	
13.	COORDINATION OF REGIONAL PLANNING	**With county involvement** (BHO/ASO) how will the above coordinating services be funded? What is the protection for counties that the system we are involved with will be adequately compensated and not require backfill with local county funds?		HCA would need more specific information on the type of coordinating services this question refers to. HCA has no ability to require the counties to "backfill" the cost of services in the Medicaid program. Strategies for ensuring the system of care within the region remains intact, could be a task for the inter-local group.
14.	COORDINATION OF REGIONAL PLANNING	The transition period will require additional demands on our local staff as well as additional staffing to do reporting and maintain Level of Services [LOS], how can this be funded?		SIM-funded TA dollars to assist mid-adopter counties in the transition to 2019 are available, up to $200K per region. These funds should be used to support planning and implementation that will need to occur at the local level. Also, the ACH has the ability to provide integration incentive funding to the counties to support implementation costs.
15.	CLIENT RIGHTS	What does a County do if a MCO or the local health care provider "fires" a client for things like "no-show," "behavioral issues," or simply not following medical advice? What happens if the client has a barrier to accessing care? Who is their advocate?	BHO contacted providers are not allowed to refuse services to someone except in exceptional circumstances and only with BHO approval.	HCA MCO contracts include requirements regarding "involuntary disenrollment", including, e.g. 4.12.6.3 "HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or behavioral

	Issue	Question	BHO Notes	HCA Response
				health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b) (2)).” MCOs are required to provide access to care for clients, and provide assistance to them when providers terminate services. MCOs are required to provide information on grievances and appeals to clients. Additionally, the Ombuds function will continue within the region and can assist the client, should they feel they have been wrongly terminated or denied services.
16.	PREPARING PROVIDERS	Which partners need to be ready if the region decides to be a mid-adopter? Who is responsible for knowing if they can be ready in time? Who is responsible for ensuring that our healthcare systems are ready to take on behavioral health patients; and or that they have enough capacity to provide preventative care to the expanded population?		The initial change means that BH providers currently contracted with the BHO will need to contract with the MCOs/ ASO and be paid using more standard insurance payment/billing methods. Additionally, allied systems that coordinate closely with the BHO will need to transition to working with and partnering with the MCOs/ASO. The MCOs/ASO are required to develop an allied system coordination plan that clearly outlines these partnership agreements, including with MOUs where appropriate. Best approaches for ensuring ongoing relationships with allied system partners could be discussed and developed further through the inter-local leadership. We think it could be a creative approach for this work to be delegated to the BH-ASO, as a single coordinating entity. HCA has learned lessons from SWWA, and has been working to develop tools that will assist with assessing provider readiness. This includes a survey tool to assess providers billing and IT

	Issue	Question	BHO Notes	HCA Response
				capacity, that the Department of Health contracted practice coaches will be trained to use. Additionally, DOH, through its Transformation Hub, is responsible for developing a full toolkit and "roadmap" that will complement the survey tool, to clearly define the MCO billing expectations for providers and provide guidance and clear timelines on what they need to do to be ready for implementation. These tools should ideally be paired with hands-on technical assistance. For example, in North Central and SW, HCA has devoted SIM grant dollars to bringing on consultants to provide hands-on TA to providers to configure their billing systems, implement new EHRs, and test billing/claims submission with MCOs. HCA is invested in finding solutions to assist providers with readiness. In mid-adopter regions we believe this type of work should be a priority use of Medicaid Transformation Demonstration incentive funds via the ACH. Assessing "readiness" of providers is something that will require a very high degree of collaboration between HCA, the BHO, the selected MCOs and the ACH. It is not something one entity will be solely responsible for. We should discuss what you mean by "expanded population", since from our view the only new population for MCOs is the BH Services Only group.
17.	PREPARING PROVIDERS	Who will pay the providers to upgrade their computer software/systems to meet the new	The BHO has provided significant	HCA would expect that ACH Demonstration incentive funds would be used to support provider

	Issue	Question	BHO Notes	HCA Response
		data demands? Who will do the training on how to use the systems? Who will do compliance monitoring? Who will advocate for the providers so that they have the resources they need to succeed in providing care?	financial and technical support to both MH and SUD provides to upgrade their systems to meet managed care requirements.	IT infrastructure building. Additionally it would be an allowable use of BHO funds to support providers' transition to the MCO delivery system. As noted in prior sections, HCA would strongly encourage the provision of TA on IT/billing changes, which could be a good use of ACH integration incentive funds. The MCOs will also be very involved in the provider readiness. Providers can also advocate for themselves and should. A best practice from SWWA is the formation of a BH Provider Alliance, which the providers use to advocate for their needs.
18.	INTEGRATION INCENTIVE DOLLARS	Could the mid-adopter incentive dollars be used to help providers make the necessary changes to their electronic record systems so that they can meet the new MCO requirements for data reporting and billing?		Absolutely and we would strongly support this as a priority.
19.	INTEGRATION INCENTIVE DOLLARS	Assuming we become mid-adopters, for small counties, what assurances do we have that the ACH will utilize the incentive dollars to make the investments needed in rural areas to ensure adequate capacity in our healthcare system?		The ACHS are expected to use those incentive dollars for providers for be better prepared for integration, for example, developing infrastructure that supports clinical integration, etc. In order to maintain adequate networks within rural areas, the MCOs have a vested interest in ensuring that providers have the resources they need to continue providing services.
20.	INTEGRATION INCENTIVE DOLLARS	Does agreement to use 2019 as a transition year with some Medicaid services still contracted back to the BHO-ASO still qualify the region to receive incentive dollars?		Yes.
21.	REINVESTMENT OF BHO RESERVES	When specifically will we know what spend-down is eligible for our reserves? Will we know early enough to spend the money		The BHO can spend the PIHP and BH State Contract inpatient reserves to the minimum, and this amount is defined in contract.

	Issue	Question	BHO Notes	HCA Response
		down in the region? How much flexibility will we be given as a region to plug identified holes or prepare the system for full-integration?		The BHO can spend the PIHP and State Contract operating reserves to 0. The State is limited in the "flexibility" we can allow because Medicaid (PIHP) reserves must be spent in accordance with the BHO Medicaid contract, and BH State reserves must be spent in accordance with the BH State Contract (which is already fairly flexible). In the process of approving the BHO spend-down plan the State can work with you further on this. Please see reserves Q&A for additional details.
22.	REINVESTMENT OF BHO RESERVES	Can any unspent dollars remaining at the end of 2018 be "redirected" with legislative approval to continue capacity building efforts that were begun before 2019, e.g., development of crisis and residential treatment facilities?		This would require legislative action and is something that will require additional discussion
23.	BH-ASO	Does the BH-ASO contract with HCA or is it a sub-contract with the MCOs?	It is our understanding that the "ASO" contract is with HCA, but that the MCOs can also contract with the ASO for delegated Medicaid functions. However, for blended funding services, such as the various types of crisis services, will there	Both. The BH-ASO has a contract with HCA that is funded by multiple non-Medicaid funding sources (State General Fund, SAMHSA Block Grant, proviso, CJTA, etc.). Additionally, the MCOs are REQUIRED to contract with the BH-ASO to reimburse for Medicaid covered crisis services. HCA has encouraged the MCOs to contract on a capitated basis with the BH-ASO. They are essentially passing through the portion of the PMPM that is for crisis services, and delegating the administration to the BH-ASO.

	Issue	Question	BHO Notes	HCA Response
			be multiple contracts with HCA and the MCOs?	
24.	BH-ASO	What is the role of the BH-ASO? Can you provide examples of activities/programs?	Will the contracted ASO functions be the same as it is for SW Washington and North Central?	Please see ASO contract for further details. The primary role is: • Manage the crisis system regionally including mobile outreach, ITA investigations, DMHPs, crisis hotline, etc. BH-ASO contracts with existing crisis providers to do this, and then will work overtime to expand services if desired by the community. • Pay for BH services for non-Medicaid clients, including services if a client is involuntarily committed, or other BH services as funding allows. • Manage the FYSPRT, BHAB, block grant project plan writing process, and any other regional committee or convening structures focused on planning or coordination efforts. • Administer CJTA funds and other non-Medicaid funding sources in accordance with CJTA Panel Plan and locally developed block grant project plan • Employ the regional BH ombuds • Manage discharge planning for non-Medicaid clients out of the state hospital • Other centralized functions as agreed upon by BH-ASO/MCOs, etc.

	Issue	Question	BHO Notes	HCA Response
25.	BH-ASO	Can certain delegated functions continue beyond 2019 if the MCOs and BHO develop a plan for limited delegation of functions? See attached diagram of possible functions for a BH-ASO. Delegation to ASO?		Potentially – yes. If you choose to use the 2019 transition year, delegation would be allowed. This role identified in the attached document is similar to the existing BH-ASO role, with some additional services such a PACT being fully managed by the BH-ASO. HCA is open to working on this model further with the region. Beyond 2020, delegation is limited by contract language
26.	BH-ASO	If the Medicaid money is going to the MCOs, what is the funding mechanism for the BH-ASO? How will it work for a smooth transition? What is the best way to guarantee adequate funding for a BH-ASO?		See attached funding grid. MCOs are required to sub-contract a portion of Medicaid funds to the BH-ASO for crisis services to Medicaid Clients. Additionally, a large portion of GFS dollars also go to the BH-ASO and other grant and proviso funds.
27.	BH-ASO	What is the nature of the "risk" that will be assumed by the ASO? Will there be a financial risk to counties if they assume the ASO role using their BHO structure?		See risk document.
28.	TRANSPORTATION AND OTHER NON-MEDICAID SUPPORT SERVICES	Some of the support services to persons receiving Medicaid funded treatment are paid for entirely with non-Medicaid funds, e.g., transportation from SUD residential treatment facilities and "flex" funds for outpatient providers. How will transportation issues and costs in general be addressed if services are regionalized and who will be responsible for connecting patients with the network of providers?	Because persons in SUD residential treatment may be returning from facilities out of the region, the BHO uses non-Medicaid funds to reimburse the cost of their transportation back to their community from out of county facilities. The BHO also provides an allocation of state	For transportation, if the client is being transported to a Medicaid-covered treatment service, the providers can access HCA's transportation broker service to obtain Medicaid-covered transportation. This applies regardless of whether the treatment provider is in the region or out of the region. If there is concern with access or timeliness of access to the broker services, please notify Health Care Authority and we will work with you to resolve this issue. The flex funds proposal is a very interesting idea for transportation costs not covered by Medicaid. We would expect the MCO's/Beacon to replicate at least initially in their provider contracts, and assuming it is something that continues to be

	Issue	Question	BHO Notes	HCA Response
			general funds to outpatient providers for flex funds to pay for incidental services that support the treatment plan.	viewed as a value-add, it's likely that type of contracting arrangement could continue, as agreed upon by providers & payers. The MCOs are provided some GF-S dollars to support this type of wraparound supports.
29.	MCO PROCUREMENT	How many MCOs will there be for a given region? The HCA presentation suggested only one but this is confusing.		Clients will have a choice of at least two health plans. Most regions will have three to five health plans.

The BHO Reserves and the Transition to FIMC document was added to the packet, in addition to the integrated Managed Care Funding Distribution document. Additional documents added and referenced included the PowerPoint from MaryAnne Lindeblad on Integrated Managed Care and the Lessons Learned document.

Discussion took place regarding the questions and answers listed above. Additional conversation followed as clarification and/or additional explanation was requested from CAEC Members.

The Chair asked if there were any questions from individuals in the audience or those on the phone.

Questions and comments included:

- Mid-adopter, non-mid-adopter status and confirmation in knowing the HCA and MCOs are hearing the county concerns until full integration
- Usage of mid-adopter incentive dollars and reserve dollars
- Transportation issues in the five-county region, particularly in the non-Medicaid and rural areas
- Contracts and funding regarding the counties 1/10th of 1% and continued services with diminished capacity for counties
- Upon integration, January 2020, County Behavioral Health and Human Services will not have staff available to address issues with MCOs

The Chair said the next meeting will be September 14th. Joe pointed out there may be a need to recess the meeting until the following week, as the extension request was granted by HCA. He also said there may be willingness on the part of the Governor's Office to grant an additional extension into October.

The meeting adjourned at 3:47 p.m.

Respectfully Submitted;
Joanie Williams
Administrative Manager

Next meeting: September 14th, 2017