

Division of Mental Health and Developmental Services
Substance Abuse Prevention and Treatment Agency (SAPTA)
Advisory Board (SAB)

MINUTES

DATE: March 13, 2013

TIME: 9:30am

LOCATION: Truckee Meadows Community College
Redfield Campus
1800 Wedge Parkway
HTC Room 103
Reno, NV 89511

Video-Conference

College of So. Nevada Cheyenne Campus
3200 E. Cheyenne Ave., Room 2638
Las Vegas, NV 89146

Great Basin College
1500 College Parkway, Room 114
Elko, NV

BOARD MEMBERS PRESENT

Sparks Site

Kevin Quint (Chairperson)
Michelle Berry – Proxy for Nancy Roget, Vice Chair
Tammra Pierce
Steve Burt
Lana Robards
Amy Roukie – Proxy for Maurice Lee

Join Together Northern Nevada
CASAT – UNR
Bristlecone Family Resources
Ridge House
New Frontier
WestCare

Las Vegas Site

Brad Greenstein
Frank Parenti
Ronald Lawrence

PACT Coalition
Bridge Counseling Associates
Community Counseling Center

Elko

Ester Quilici – Proxy for Dorothy North

Vitality Unlimited

BOARD MEMBERS ABSENT

Diaz Dixon
Michele Watkins
Ed Sampson
Debra Reed

Step 2
Central Lyon Youth Connections
Frontier Community Coalition
Las Vegas Indian Center

STATE OF NEVADA STAFF

Reno Site

Betsy Fedor
Charlene Herst
Chuck Bailey
Deborah McBride
Gaylene Nevers
Lisa Tuttle (recorder)
Becky Vernon-Ritter
Dave Caloiaro
Agata Gawronski

Health Program Specialist, SAPTA
Health Program Manager II, SAPTA
Health Program Specialist II, SAPTA
Agency Director, SAPTA
Health Program Specialist I, SAPTA
Administrative Assistant IV, SAPTA
Grants and Projects Analyst II, SAPTA
Clinical Program Planner III, MHDS
Executive Director, Board of Examiners – ADGC

Las Vegas Site

Steve McLaughlin
Kim Davis

Health Program Specialist II, SAPTA
Administrative Assistant II, SAPTA

PUBLIC

Sparks Site

Denise Everett
Alissa Nourse
Barry Lovgren

Quest Counseling
Tahoe Youth and Family Services

1. **Welcome and Introductions**

Chairperson Kevin Quint opened the meeting in due form at 9:35 am.

2. **Public Comment**

Barry Lovgren, private citizen, noted a discrepancy between the meeting minutes of January 29, 2013, and the agenda for this current meeting. The minutes stated on page 2, Item 2, the sliding fee scale would be on the agenda for this meeting; however, it is not showing. He wanted to bring this to the Board's attention in case the minutes needed to be reviewed and corrected.

Kevin Quint responded that he made the decision not to add it to the agenda because it was dealt with two meetings ago and resolved that situation. Michelle Berry had said the sliding fee scale item would be on the next agenda but Ester believed it was never resolved and should have more discussion. She requested adding this item to a future agenda. Kevin stated for the record that this is the third time it has been added back to the agenda. He finds it to be a waste of time to continue the same discussion which they keep resolving. Kevin stated they will bring this up again at the conclusion of the meeting on Item 15 – Review Possible Agenda Items. Barry Lovgren's letter (attached) was presented, discussed, and decided unanimously by the Board at the November 14, 2012, meeting that this issue was addressed and resolved. Frank Parenti interpreted the letter to state that SAPTA was inventing its own sliding fee scale, but in actuality it was based on federal poverty guidelines. Frank agreed with Kevin, and he doesn't feel this should be pursued any further. Kevin will defer from his opinion if the group wanted to entertain adding this back to the agenda when they come to Item 15. If not, he suggested they move forward.

Kevin thanked Michelle Berry for a job well done for chairing the last meeting in Kevin's absence.

3. **Approval of Minutes from the January 29, 2013, Meeting**

Steve Burt made a motion to approve the January 29, 2013, meeting minutes as written, and Frank Parenti seconded the motion.

Ester Quilici wanted to follow up with the appeals added to the policy as discussed in the minutes. She did not receive the performance measures from the other states as discussed in the minutes. She wanted to discuss the liquor tax increase, performance measures, and the sliding fee scale. She also stated she was not able to attend the Treatment Standards Subcommittee meeting on March 11, 2013, due to traveling on Dorothy North's behalf. Ester asked how these issues can be discussed in relationship to these minutes. The first point was in relation to adding in the appeals policy directly before it was published instead of making reference to appeals. Deborah McBride confirmed that all the recommended changes by the Board were completed and posted to the SAPTA webpage. They can be viewed on the webpage on the left hand side under "SAPTA Procedures". Kevin asked Ester if she was requesting a change in the minutes or if she just wanted clarification. Ester wanted to clarify this had been done. Deborah's answer satisfies her question on appeals. Ester never received performance measures from other states from Steve McLaughlin and inquired if this will be agendaized for another time. She was referring to Item 10. Per Steve there may have been confusion at the last meeting, as he had not yet distributed performance measures from other states. He has, however, worked on treatment standards. They will be focusing on performance standards at a later date. Deborah stated this is Item 9 on the agenda for this meeting.

Next, Ester mentioned work done in relation to NHIPPS, the cubes, and information that will be added. Her basic concern was that NHIPPS is gathering information not useful to them such as treatment plans, for instance. She said her agency was told to just discard the information and redo it in a format that is accessible during the certification. She spoke to Steve about this but wanted to also discuss this as a Board. Kevin said this item must be agendaized to discuss at the next meeting. Kevin stressed they need to abide by open meeting law and this should be discussed under Item 15 in order to add to the next agenda. Steve Burt said this may come up naturally in this meeting's agenda Item 9.

Charlene mentioned there was a typo in the minutes which were already mentioned to Lisa Tuttle for correction. There was no more discussion of the minutes. Kevin reiterated the motion and the second to approve the meeting minutes. All were in favor. Motion carried.

4. **Update, Discussion, and Recommendations for SAPTA Treatment Standards and Subcommittee Report**
Frank Parenti talked about the Treatment Standards Subcommittee meeting which was held to discuss composing a manual of potential procedures to define some of the monitoring certification instruments which are somewhat ambiguous. Steve McLaughlin and Mark Disselkoe both had great ideas for moving forward on this. Another meeting will be held in approximately three weeks to compile the examples and potential changes and to clear up any questions or confusion that people may have. The goal is to make sure definitions are not up for interpretation. He believes that will help address a lot of questions. The examples Steve provided were very helpful, and the progress being made by the subcommittee has been exceptional.

There were no questions or comments. Kevin thanked Frank and the subcommittee for their work on this project.

6. **Discussion, Recommendations, and Approval Regarding Sequestration Impact**
Kevin Quint skipped to Item 6. Deborah McBride updated the group on sequestration which took effect on March 1, 2013, and what it means for Nevada. According to the letter she received from the Substance Abuse and Mental Health Services Administration (SAMHSA), seven percent of funding will be cut from the payments to be received for the remainder of the year which would be approximately \$658,000. SAPTA will have to examine where to make funding cuts between now and the end of the federal fiscal year in September. Deborah is waiting to receive a table from SAMHSA which will specify the cuts for Nevada. It works out to five percent overall for the entire year. They've already received first and second quarter funding, so the remaining funds will be cut seven percent. On the national level, there is talk of possible changes to the sequestration. There is no formal information, so they must move forward with the current plan until instructed otherwise. There has been much thought put into how these reductions will lessen the impact on the programs. Deborah doesn't believe they should cut any funding for the remainder of this state fiscal year, since there are only a few months left. It would be difficult to reduce any amounts currently. They need to begin looking at formulas for distribution of funding percentages to treatment, prevention, and administrative programs, as well as SAPTA itself. When examining just the treatment side, the estimated number would be approximately \$20,000 per program. Deborah stated they will make the distribution as fair as possible. She sent emails out to agencies asking them to think about where to implement cuts within their programs. Prevention receives a smaller percentage of funding, so the dollar amount will be less. Once she gets SAMHSA's confirmation of the final numbers, work can begin to formulate reductions and how to apply them. She hopes to expect exact numbers and get a better understanding of what will need to be done by the next May meeting. Deborah asked the Board if this was a reasonable approach, or if anyone had different ideas. It sounded to Ron Lawrence that SAPTA has been very conscientious about their thought process and he believed it to be very good so far. Steve Burt inquired whether it had become evident enough if underperforming programs created a situation for themselves to receive less funding in the current fiscal cycle which might make up for cuts in the next fiscal cycle. Deborah has not seen this yet from the latest figures. The programs are within the time frame of spending down their funding, but that is something to be revisited and closely examine.

Ester brought up a few questions on the liquor tax increase discussed at the last meeting: (1) how much of a mitigation will this be, (2) will it be only for the detox programs, and (3) how will cuts be determined by SAPTA and how will they affect the programs. Deborah explained the sequestration reductions will be known when firm numbers are received from SAMHSA for the federal funding. The state liquor tax fund shows a minor increase and is not subject to sequestration. Reserves are carried over from year to year because of having to wait for first quarter tax revenues to be received from the tax department after the end of the state fiscal year, which can take up to three or four months.

Public comment was made by Denise Everett asking if the \$20,000 reduction was entirely for the next state fiscal year or was it for the last three months left in the federal fiscal year. Deborah confirmed it would be for the last three months left in the federal fiscal year (July, August, and September). She stated this figure may be estimated a bit high and expects it to be somewhat lower than the \$20,000.

Kevin temporarily adjourned the meeting at 10:00 am for the public forum on the Block Grant Application. There will be opportunity to comment or discuss Item 6 again when the meeting is re-adjourned. Ester Quilici stated she had to leave the meeting due to an emergency situation.

5. **Adjournment at 10:00 am of SAPTA Advisory Board for Public Forum Regarding the Block Grant Application (meeting to resume at its conclusion and public comment limited to 3 minutes per person)**

Kevin Quint called the Block Grant Application meeting to order and stated that comments will be taken from the Board and from the public after the presentation from Deborah McBride. Each year a public forum is presented to take public comment on the Block Grant. The link to the Block Grant was emailed to everyone for review prior to the meeting. Deborah stated the organization is going through many changes and that things are not the same as they were in the past, which is reflected in the Block Grant. Everyone will have to be open to changes, especially with the upcoming health care reform. This is the first year our Block Grant has been combined as mental health and substance abuse, and it was challenging to integrate activities. It is currently a work in progress. Deborah discussed the various sections within the Block Grant, which is divided into planning and reports. The planning steps are shown on page 15 which assess the strengths and needs of the organization to address specific populations. They've combined Mental Health and the Division of Child and Family Services. There is much data that refers to service needs, gaps, and unmet service needs. Priorities (page 45) jointly set up between Mental Health and SAPTA include: strategic partnerships, prevention, Native American women, alcohol and other drugs, suicide, military, treatment, health care reform, workforce development, priority populations, peer support program services, evidence-based practices, justice, trauma, co-occurring disorders, mobile crisis, community behavioral health promotion, and prevention awareness and education. Deborah and Dave Caloiaro have worked closely together on integration and spoke to some prevention and treatment providers about working closely with mental health and mental health promotion, which is an area of focus. The programs will see a lot more of this and will be contacted by them. Deborah expressed her appreciation to Lana Robards and other agencies for their participation. The tables (page 46) go into detail on priority areas, population, goals, annual performance indicators, strategies, data sources, etc. She spoke about the application guidance (page 70), also recognized as the 17 goals for SAPTA, which is still required in the Block Grant Application. It goes through each of the goals and the intended use and the plan for 2014 and 2015, which is currently the focus. Next, the total for planned expenditures (page 109) is \$13,745,028. This is based on flat funding. Deborah is waiting to hear from SAMHSA about the application of sequestration into 2014 and 2015 and what the impacts will be. Currently they are moving forward with continuation subgrants based on current funds; however, those will be modified due to sequestration. The narrative plan section (page 118) discusses coverage and various methodologies on what Mental Health and SAPTA are doing, ACA, and Health Care Reform. There is a lot of information being requested to include in the Block Grant Application.

The Block Grant Application also includes letters of support for Mental Health and SAPTA, new technology information, and quality improvement. The Block Grant Application was originally due by SAMHSA on April 1, 2013, but it was delayed to wait on the completion of the application guide. The new date for Mental Health falls at the end of the statutory fiscal year which is September 1, 2013, and for SAPTA October 1, 2013. Spring is the targeted time period, since it is close to being completed. There were no questions or comments from the Board.

Barry Lovgren made public comment on the Block Grant Application. He commented on publicizing treatment and admission priority for pregnant women and about technical assistance needs. He touched on the following goals in the application: Goal 9 (pages 85-86) which addressed services for pregnant women at all funded treatment programs and described how the State intended to meet the requirement to publicize availability of treatment and admission priority, and Goal 3 (page 78) which addressed services provided by the two programs receiving funding

set aside for specialty treatment of pregnant women and women with dependent children. He also spoke on prevention services for women describing the statement as false (page 51) and about technical assistance needs of the State and program staff which do not include development of an appropriate State Medicaid Plan and development of billing mechanisms by programs. Mr. Lovgren's complete testimony is attached.

There were no other public comments. Anyone with further questions can email Deborah McBride.

Kevin stated that a hardcopy of the Block Grant used to be given out by BADA. Kevin read part of it online, but he needed to read into it more carefully. He was impressed by the structure of the application describing the divisions and the integration of the divisions and how health care reform is coming along. Kevin encouraged everyone to read this document in its entirety and provide feedback to SAPTA.

The Block Grant draft had been posted for a few weeks, but Steve Burt was wondering if there was a mechanism to do this again without shutting down the SAPTA Advisory Board Meeting in May to give them another opportunity to read through it more carefully. Kevin is fine with that if everyone else agrees. There may be ways to read through it to get a good flavor of the document. Becky Vernon-Ritter said they have an idea of the submission date as July 1, 2013. This is new to SAPTA, as well, and it would be helpful and appreciated for everyone to review it and provide feedback by the end of March or April. The hope is to get a second draft posted at least before the next meeting. A question arose about what type of grant this was, and Becky verified a formula-based grant.

Dave Caloiaro emphasized the joint planning bi-weekly meetings held between MHDS, SAPTA, and DCFS, for the last four to five months, and the effort that had been done on this first ever joint Block Grant. Mental Health efforts are more toward the substance abuse side, such as promotion, awareness, and activities. The Mental Health Block Grant is focused on funding a number of positions for statewide agencies. They are not only looking in treatment but for more collaboration with prevention awareness promotion activities for mental health. Kevin wanted to know if the full mental health piece had been integrated into the Block Grant at this point. Dave said the joint Block Grant appears to be leaning toward the substance abuse or the historic SAMHSA block grant model more so than he had been used to on the Mental Health side. It is more mental health integrating into the substance abuse side and making it work that way. Deborah stated rather than working on direct services for Mental Health, they are looking to change that model to move more toward community service. Dave informed everyone that the joint Block Grant was presented at the Mental Health Planning Advisory Council (MHPAC) meeting last week.

There were no other questions or comments. Kevin Quint adjourned the SAPTA Advisory Board for public forum regarding the Block Grant Application at 10:23 am.

The SAPTA Advisory Board meeting reconvened at 10:23 am and Kevin revisited Item 6 regarding the sequestration impact. There were no further questions or comments on the item.

7. **Discussion, Recommendations, and Approval of Actions Regarding Legislative Issues and BDRs/Bills and Subcommittee Report**

The Legislative Subcommittee which met recently consists of Kevin Quint, Frank Parenti, Diaz Dixon, and Maurice Lee. During the meeting, they generally discussed a list of Bill Draft Requests (BDRs) and bills and also discussed the BDR for medical use of marijuana in more detail. Kevin stated there are several bills for marijuana and dispensaries in particular.

Brad Greenstein was present at the Judicial Senate hearing for SB75 which Dr. Mel Pohl, Medical Director of Las Vegas Recovery Center, testified on behalf of the sponsoring senator of the Bill. He said it was a pretty contentious atmosphere. There was only one entity there in support of the bill which was a drug laboratory testing company; otherwise, the room was filled more with physicians and other staff who opposed it. Brad's thought was that everyone on this committee believed this a bad bill. Addressed in Dr. Pohl's testimony, we are being faced with a prescription drug epidemic, such as prescribing practices. Rather than opening it up to lawyers, his suggestion was to explore how to expand and enhance the existing laws to include the Pharmacy Management Program (PMP)

which does not require mandatory participation on behalf of the physicians, and training toward responsible prescribing practices, as well as consumer training on storage of medications. At the hearing, the data presented included information that 70 percent of individuals which show up are prone to prescription drug overdoses, and those drugs are received through diversions. Since these drugs were not personally prescribed to individuals, they are being abused as a result from receiving them from a third party. There are benefits to educating seniors and adults on managing medication, so hopefully some of the messages this body wants to pass along in terms of PMP and education was done.

Kevin updated the Board that the Legislative Subcommittee met a few weeks ago. At that time, most of the BDRs were not yet bills, so the discussion was very vague. The other discussion was the Governor's proposed budget.

8. **Discussion, Recommendations, and Approval of Actions Regarding the Governor's Budget**

Kevin discussed the Governor's proposed \$3,000,000 shortfall in State funding for treatment which will be substituted by Medicaid. This may appear as a potential expansion; however, there are some problems that come with it. Kevin spoke to Jon Sasser, a lobbyist and attorney in Reno, to gain a different perspective on the budget outside of the state and the providers. Kevin asked him if there would be a gap due to the supplanting of Medicaid funds if health care reform begins January 1, 2014, and the state fiscal years begins July 1, 2013. The second issue is that SAPTA makes timely, monthly payments to the agencies, and Medicaid is not always known for making timely payments which will present another gap. Third, the majority of treatment programs are not yet capable of billing Medicaid, and he is unsure if this will happen by July 1, even when health care reform is in place. Kevin is not questioning the logic of the new funding mechanism, but he is arguing there must be an interim period between now and when health care reform begins because agencies that will be getting Medicaid reimbursement will not be able to wait two to six months for payment. Jon Sasser's opinion was that Kevin's concerns were valid, and he understood there could be some issues regarding a gap. Kevin wanted to bring this before the Board for discussion.

Ron Lawrence believed there to be another gap issue which is the burden on agencies of establishing Medicaid entitlements to clients. It will not be the simple process of consumers providing their Medicaid cards. The agencies will need some form of training on how to establish Medicaid entitlement. The process will begin with establishing entitlement for the client, then back bill from the day the entitlement was established, and lastly wait for the Medicaid payment. This is much more complex than what was thought in the beginning.

Amy Roukie believes the state sees all of them as providers to figure out the way to navigate the system and to begin billing Medicaid immediately. They should be up to speed now in getting the most amount of reimbursement so there are no hiccups between now and 2014. Many of the services that are provided based on the current provider levels are not Medicaid reimbursable services. A good example is using CADACs. A CADAC, CADAC interns, or LCADCs, who supervise can be used. However, in Medicaid translation, an agency will not get paid unless they have an LCSW or MFT. At a CADAC level, unless an LCADC is qualified as a mental health professional, the biggest gap will be whether or not services are defined as essential services in the package that is offered in Nevada. It is unknown whether treatment, depending on the level, may or may not be reimbursable. One area of Medicaid reimbursement that may be realistic is inpatient detox which is medically monitored with licensed medical providers. The bigger issues, however, are social model detox services which may or may not be reimbursable. The other piece is the assumption that 100 percent of Medicaid eligible persons as of 2014 will actually be eligible because some will not have the fortitude to completely follow the process to obtain their Medicaid card. There is some expectation at the state level there will be a higher number of Medicaid-eligible people, but because of their mental health issues, co-occurring issues, and disorganization, they may not be Medicaid reimbursable. The agencies are supposed to be able to provide reimbursable services under the essential health services to bill out, but they are unsure that is true yet. The third piece is that most agencies have no eligible practitioners that can bill. Eligible clients may not immediately be enrolled because of the laborious process of actively obtaining Medicaid cards.

Kevin expressed this is even more of a gap, and he hadn't thought about the eligibility portion, plus back billing and waiting for payment. Frank said prior authorizations will be need to be obtained. SAMHSA's goal is to keep people involved in treatment for as long a period as possible. If LCSWs, MFTs, CPCs, and psychologists, are to scope credentials, consumers will not improve with 90 or 180 days worth of care. He believes keeping people in treatment for a long time period won't happen. Also, CADCs will be reimbursable but at a dramatically lower rate, which will cut into the bottom line for everyone. The recovery area and systems of care model being pushed and the changes to the DSM are moving toward consumers being seen for 5 to 10 sessions with a credentialed person and then the rest of the time doing recovery support.

Brad added that everyone in treatment that works for a non-profit is accustomed to using block grant funds, and one of his concerns is being confined to just billing Medicaid. He suggested commercial insurance as another means. The big part of the ACA is the creation of the Silver State Health Exchange. They may work with the Silver State Health Exchange or with consumers that purchase their health care coverage through the exchange. He expressed the transparency in commercial insurance which is not currently being looked at, for example, with HPN, Cigna, Aetna, and Anthem Blue Cross Blue Shield. Everyone is SAPTA certified, has good clinicians that meet standards, and has the credentials to be in-network today. It has been discussed how it is difficult to meet the QMHP standard for Medicaid; however, agencies can get in-network with an LACD today.

Frank asked if this will affect the initiative Ron discussed earlier with amount of time it would take to get authorization, reimbursement, and paperwork completed by staff. The supplanting of \$3,000,000 did not appear to be a budget cut, but that is what he believes it to be. It will create a huge disadvantage for the smaller agencies that cannot easily equip themselves, such as in the rural areas that also deal with special populations. Although they will utilize Medicaid, Brad's point was that the agencies would be remiss to ignore the commercial sector. Kevin agrees, but historically it has been difficult for SAPTA-funded programs to get on certain panels because they are very exclusionary.

Also, in the Governor's budget it looks like a direct trade between Medicaid and State funds. He wants to discuss if there is any logic. He is meeting this afternoon with the Chief of Staff of the Mental Health Commission to discuss if there is any logic in this, and to present any questions or concerns from the Board. Denise Everett commented that Quest Counseling now takes fee for service Medicaid which is a cumbersome and time consuming enterprise for their staff, taking up 50 to 85 percent of some staff members' time. Even after hiring a Medicaid consultant it still took them several months to only become eligible for Medicaid fee for service. Currently, they are not yet on Amerigroup or HPN panels because they simply haven't responded back to Quest. They have more MFTs on staff than CADCs; however, it is still very difficult and not an easy proposition. She thinks programs that predominately have CADCs on staff will have incredible difficulties. They do get reimbursed for psychosocial rehab and behavior skills training, PSR, and PST, but there are several levels of service that are not Medicaid reimbursable, such as transitional housing. She understood the value of streamlining processes to serve people more efficiently, but it's these pieces which need to be examined and addressed prior to January 1, 2014.

Dave Caloiaro also appreciated the discussion and understood this will be a challenge as Denise discussed. He suggested that the key players, Medicaid and Hewlett Packard (HP) Enterprise Services (the Medicaid-contracted utilization management company), may be of help to the agencies during this transition. As Medicaid develops Chapter 400 State Plan and Policies, he suggested the agencies engage with Medicaid at their public hearings. People are speaking with HP in terms of prior authorization requirements for continuing length of stay. They host several training per year and an annual Medicaid conference in October. It would be beneficial to talk to Medicaid and HP about including substance abuse, which they have not had breakout sessions for substance abuse and alcohol and other drugs. He believes these two main factors will be when Medicaid ultimately establishes policies and procedures on coverage and the day to day operations handled by their contractor HP. HP handles authorizations for about 25 different provider types, such as doctors' offices, pharmacy, home health, nursing homes, etc. They want to make sure to include these as part of the training and at forums to discuss these issues. Ron Lawrence also examined this issue closely in areas they need help. Most importantly, his major goal is to

preserve all of the agencies. Having worked off grant funds through the years, the idea of fee for service is good. However, he believes they need assistance with transition planning with the separate agency cultures and how to make these changes to preserve the agencies. His agency is Medicaid certified and has some insurance, but they must examine each employee, what they do, and how they're certified in order to take a grant funded MFT, for example, to transition the caseload to fee for service insurance. Transition planning must be done with every employee and every piece of agency culture. In his opinion, help is needed or some of the agencies will not survive.

Deborah added that Richard Whitley and Tracey Green are working closely with state Medicaid to make changes to the Medicaid State Plan and to discuss coverage for substance abuse. Also, SAPTA hired QuantumMark as a consultant for project management, transition planning, and business processes of providers. They met yesterday to start the paperwork and scope of work. The agencies will be hearing more from SAPTA on this piece. Kevin appreciated the emails he had seen that SAPTA is moving in this direction.

Per Frank Parenti, AADAPTS was approved as the convener for SAMHSA, NIATx, and SASS, training which will begin in May for eligibility enrollment specific to what has been discussed. He thinks this will help; however, he agreed with Ron that in order to take the necessary steps to provide services in this new fashion they still have to look at this differently. They need more help with getting people on board. In terms of disparity, larger and well-established agencies with co-credentialed people is good, but the rural and smaller agencies are being missed which he doesn't think is fair. It was extremely helpful when SAPTA held the conference call with HP because they went through the steps and gave tips. This is still coming very fast, and moving \$3,000,000 doesn't seem like much, but it is far more involved than anyone realized.

Kevin stated these are all good points and asked the group what direction they want to take. He appreciated Dave's solutions and his willingness to help as a convener with Medicaid and HP. Also, he appreciated the direction of SAPTA to address transition planning. He reiterated what Frank said about this coming faster than anticipated and what Denise addressed about the terrific overhead. They are used to running the agencies with low overhead.

Amy requested they acquire a specific "go to" navigator at Medicaid for treatment providers. She discussed her previous experience while working at Medicaid. As a provider now, it is difficult to speak to a Medicaid associate that can help answer your specific questions without getting passed around. There was a hotline specifically for the substance abuse programs and it was easier to navigate through the Medicaid system. Amy asked if Richard could request a contact name from a Medicaid for the group. Deborah recommended Laurie Squartsoff, the new Medicaid administrator, as the person to direct their questions or concerns, as she seems open to discussion. Lana said before HP took over there was a specific person designated as their contact. She doesn't know who that person is now, but she recognizes it is currently more difficult for new providers making an application than it was for her in 2005. The other trend throughout the years is Medicaid pays for less services that the agencies provide. In 2005 through 2007 they paid for residential treatment and social model detox, which now they do not pay. Agencies must now take the time to break services down into individual components, such as the number of process groups, number of individual sessions, and type of individual sessions. The cost of billing for services by each component is very expensive. Lana is an advocate of having more funding sources available, including commercial insurance. She believes there is a better chance of getting approval from commercial insurance than from Medicaid; however, payment from insurance is now months out opposed to receiving immediate payment as it used to be.

Kevin inquired as to what action to take at this point and for thoughts toward a plan. Dave mentioned Coleen Lawrence is the formal Medicaid representative for MHPAC. They are in the process of hiring (or have hired) their new behavior health program manager who will be a help to the MHDS side. Dave suggested inviting Coleen to the next SAB meeting to understand the concerns and get a different perspective. Deborah recommended inviting Laura, as well.

There was a consensus by the group to make a request to obtain a Medicaid navigator contact, to invite Medicaid to the next meeting, and to have Dave organize outside talks with Medicaid.

The meeting was called for a break at 10:57 am.

The meeting was called back to order at 11:16 am.

9. **Report, Discussion, and Recommendations on Performance Measurements from Other States**
Steve McLaughlin does not have anything on this yet due to other priorities, but requested to keep it on the agenda.
10. **Report, Discussion, and Possible Action on SAPTA Health Care Reform Readiness Survey**
At the last Advisory Board meeting Steve McLaughlin requested everyone complete the Health Care Reform Readiness Survey. It helped to identify and offer technical assistance to providers regarding the Affordable Care Act, and more specifically, Medicaid. Twenty providers participated in the survey. Some specific programs which cannot bill Medicaid did not participate due to their populations, such as China Springs and the Washoe County Sheriff's office. Steve shared the following data as a result of the survey.

Steve stated some of these numbers may have changed since it was done last October. The survey showed that 11 of 20 providers still do not have NPI numbers. Eight of 20 providers are not prepared and do not meet the basic requirements to bill Medicaid based on the providers' self reports. Ten of 20 providers are not billing Medicaid. One of these providers is ready to bill Medicaid but is not currently doing so. Five of 10 providers currently billing Medicaid are identified as a provider type 14, one as provider type 82, and one as provider type 17 (methadone). Five of 20 providers reported billing private insurance companies. In order to move forward, it is important to discuss this at a future Advisory Board meeting to obtain knowledge from those having success billing private insurance companies and what type of model they use, with whom they are contracting, and who their providers are in order to begin linkages. Five of 20 providers reported they did not have an action plan in regard to the Affordable Care Act. There was a question in the survey which identified if agencies have a written plan, a quality assurance plan, and an action plan to deal with the changes that will result from ACA. Only five of the providers mentioned they do. Many providers have a comprehensive assessment that includes a physical evaluation or can provide a reference to a provider for physical evaluation. The linkage with primary health care has been missed in this discussion for the Affordable Care Act which is an important piece. Most of the providers reported not having sophisticated electronic record systems, which includes a billing system. Currently NHIPPS is used, which has pros and cons, with one con being that it doesn't have a comprehensive efficient billing system which is needed to move forward. The main result of the survey will enable SAPTA to help providers, and it has already resulted in some training activities over the past few months. There were no questions.

Kevin was enlightened by the results, as it relates to the last conversation about transitioning.

11. **Possible Action for Approval of SAPTA Policies and Procedures: Policy #10 Fiscal Monitoring – Risk Analysis**
Changes were made by the Board's recommendation for this policy at the last meeting. Comments were made to add items back that would be positive to the score. Deborah pointed out on they've taken points off Item 5 if an agency is never late or if there are no errors and Item 6 if there are no findings, which would also lower the score. These are positive actions occurring at the Agency. The "three years" were left in the monitor; however, it is written that an agency can request a fiscal monitor prior to that time. Some felt three years was too long to wait for a fiscal monitor.

Lana's concern for agencies receiving large grant awards is the 30 points added to their scores without a chance to receive the entire credit back. There are potentially 20 points total to be credited back for no findings, no errors, and never late, but 10 points would be lost no matter what an agency did or how hard they worked. Deborah specified the larger the grant the higher the chance for risk. She asked the LCB auditors their opinion if adjustments needed to be made, but they felt the points system was appropriate. Steve Burt added there was a "catch all" category in Item 8 (between 10 and 60 points), which isn't specific enough. They had a data loss that took a month to fix, and their A-133 audit considered it a risk factor. They are generally low risk but when

factoring in the margin between 10 to 60 points it becomes subjective again, and at the last meeting he discussed removing subjectivity. Deborah pointed out this was based from the Director's Office, Grants Management Unit, so if different items came up for review there would be a particular category to add them in. Although everyone scores differently, there essentially is no guidance written for the person giving the score. She has been receiving follow up questions from the Legislature as to why SAPTA hasn't approved, completed, or posted this policy, because they feel this is proper and adequate.

Kevin asked for any comments or concerns. Per Deborah it would become active immediately if approved today. Michelle Berry believes there is a sufficient cushion in the scoring because 0 to 45 points is low risk. If there are any changes on the Board, however, it would be good to understand what the amounts between 10 and 60 are and what the different factors would actually be worth because of the huge variable. Deborah said it is not detailed down to that level. If an issue arises, they need that "catch all" area. The Board discussed what might be in the "catch all" area, such as a board member leaving or a term ending. If a member didn't leave and just changed positions there would be a place for written explanation, which no points would be given. Steve Burt felt this is still subjective. He asked if they would have opportunity to come back to SAPTA to explain why something should not increase their risk and to please consider said score, and Deborah agreed. The only impact is the frequency of the monitors. SAPTA needs to set up something. Steve Burt was concerned about not wanting SAPTA's assessment of high risk to roll into their auditor's assessment of high risk. If this is approved and implemented, Michelle asked if this could be piloted for six months for the programs who have fiscal monitors. If changes are needed, they can then address them at that time. The motion was made by Michelle to pilot test for six months to monitor its success and to address any issues that may arise.

Michelle moved to approve this document with a review in six months and Steve Burt seconded. No more discussion was made. All were in favor. Motion approved.

12. **Standing Item – Discussion and Recommendations Regarding Health Care Reform**

There was no further discussion on this item.

13. **Standing Item – Discussion and Recommendations Regarding New Funding Streams:**

There are some SAMHSA RFAs that MHDS, in conjunction with SAPTA, are reviewing and putting together as applications for submission. Once the applications are completed and meet the specific requirements, Steve McLaughlin will inform everyone which RFAs are identified and will be pursued.

Brad Greenstein revealed there is an application through the Silver State Health Exchange for navigators and enrollment specialists. One of his affiliates, Foundation for Recovery, had just won a SAMHSA Brass Tac Award to work with the Silver State Health Exchange to promote how people can purchase insurance. They are also working with Kevin Quint on doing some peer support training through that grant as well. There is also a Cure to Cure Grant out currently by SAMHSA for \$250,000 a year for three years, which is due Friday, March 15. Also, there is a re-entry grant and the ASPR Grant worth \$10,000,000, among other things.

Kevin stressed the importance of applying for grants because there is money available.

14. **Standing Informational Items:**

Administrator's Report

No report was given.

Chairperson's Report

No report was given.

SAPTA Report

Deborah reported on the previous Medicaid training, which had a good attendance. She also mentioned hiring a consultant and delivering more Medicaid training to providers. Currently, Brandi Johnson, who oversees the central billing system, is working directly with providers to give training. SAPTA has been asked to move toward using the myAvatar system which is an upgrade of Avatar which Mental Health is currently using. There is a substance abuse treatment module that fits into myAvatar, and they are examining it to ensure it has everything needed to replace NHIPPS for the treatment side. It does not currently have a prevention module, but it is possible something may develop. They will need to figure how to transition the data; if it will be migrated over or just start anew. Funding is still an issue. Mental Health is beginning to work toward upgrading to myAvatar. Deborah will inform the Board when there is new information. Amy asked if the myAvatar system would have data matching between Mental Health and Substance Abuse. Deborah expects this to happen, but because it is still early she cannot answer for sure. They are still waiting on information from Netsmart who oversees the myAvatar system.

Deborah gave an update that Administration wants changes to standardize the sliding fee scale so that everyone within Mental Health, SAPTA, and the Health Division, uses the same scale based on federal poverty level and the CPT codes. They are working on it currently, and SAPTA is not involved in that piece. She will inform the Board when she gets more information.

Evidence-based practices were mentioned at the last meeting to review the old minutes to recap what was discussed on this topic. Deborah and Lisa reviewed minutes back to 2007 and found information about evidence-based practices on prevention but did not locate anything for the treatment side. Frank suggested looking at the RFAs. .

It is time again for the election of the Advisory Board Chair, and action will be taken at the next Board meeting.

Prevention Updates

Charlene Herst stated the prevention coalition continuation applications are now out and due back to SAPTA by May 6. The administrative programs will be sent the first week in April, and since they don't have sub-recipients SAPTA can wait a little longer to receive them.

SAPTA is currently reviewing information, revising narrative, and adding new items on their website.

Upcoming meetings:

- April 16 – Evidence-based Workgroup
- April 17 – SEW/MPAC Meetings
- April 24 – Quarterly Coalitions and Admin Programs Meeting

Also, on the prevention side the fiscal and programmatic monitors are currently being scheduled, but the big push will be April and May. This year, the goal is to try and have fiscal and their analyst do monitors at the same time to make it easier on the coalitions.

Treatment Updates

Steve McLaughlin reported that the continuation applications have been sent out with a due date of April 1 at 4:00 pm. He announced that interviews were held for the HPS I position for the SAPTA Las Vegas office. Also, they are in the process of developing another survey based on Medicaid checklists to further evaluate where the programs are and what is needed to help providers bill Medicaid.

The treatment team (Betsy, Inna, and Steve) offered their time to the providers to help them with technical assistance or anything else they may need. Amy gave praise to Inna and Betsy for their help with technical assistance and suggestions on how to do things differently when they came out for their audit last week. She found a very helpful relationship with the auditors, and their support and guidance was highly appreciated.

Data Team

Chuck Bailey reported the coalition event record should be deployed soon. They are also in the process of enhancing the web portal to allow for the public access of the OLAP cubes.

He reported that Margaret's position has received justification to fill. The data team currently is overloaded with responding to helpdesk requests, and they are trying to keep work flow going. He was hoping to hold back the position until reclassification went through and until they had a better idea of the myAvatar conversion because of the possible technical support needed to support a new system. They are tracking and documenting the helpdesk tickets to better understand the work load and whatever may occur in the near future. Once they know what the changes will be, they will have a better idea of what it will take to staff the position to meet the needs.

Center for the Application of Substance Abuse Technologies (CASAT) Report

Frank and Michelle have been working on bringing CBT training to Nevada. The next CPT training is scheduled May 7 through May 9, 2013, in Las Vegas. It is recommended for people attending to have a Masters degree to obtain their certification. People who receive a certification can then provide CPT trainings. Frank is screening all participants and Michelle will be sending out the registration shortly. The criteria for people attending that are in a graduate program will receive the certificate of completion, and if they are not at a Masters level they will receive a certificate of completion but will not be eligible to train. The next webinar in the clinical supervision series is March 28, 2013, from 10:00 am to 12:00 pm.

The FASD Conference will be held in Reno on May 19 through May 21, 2013. Everything is going well with the clinical supervision series. There were 18 people who attended the first class, and there are 25 people registered for the training in Las Vegas which will be held in two weeks.

Michelle introduced Agata Gawronski from the Board of Examiners, Alcohol, Drug, and Gambling Counselors, and stated she can help answer any questions regarding clinical supervision. Amy asked when someone becomes a new LADC do they have to wait the two years before they can supervise, and is it different if they are an LCADC. Agata specified the way the law is written now, people can interpret it to say that they have to practice in the field for two years and, obviously when you're an intern you're practicing. They are trying to clarify the statutes that a person has to be licensed for two years in order to become a supervisor. Currently the way the law is written a person can become a supervisor after obtaining their LADC. There were no further questions.

15. **Review Possible Agenda Items**

Sliding Fee Scale: Steve Burt didn't believe it needed further discussion. Deborah discussed standardizing the sliding fee scale across all the agencies. She is not sure exactly when this will occur, but Administration is currently working on it. The Board agreed to leave it in the report and once Deborah receives new information she will share it with the Board.

NHIPPS: Kevin mentioned Ester had an NHIPPS item to discuss. Because she had to leave, Lisa will verify with her the item when building the next agenda. Steve Burt believed it is their intention to address this in the Treatment Standards Subcommittee which Frank is leading that met earlier in the week in terms of defining a treatment manual that would need to include concepts from NHIPPS or myAvatar to make sure they blend.

Block Grant: This will be an agenda item at the next Advisory Board meeting. SAPTA wanted their recommendations to have another draft available before the next Advisory Board Meeting. They must send in writing any comments they have to Becky and Deborah.

Medicaid: It was suggested that a Medicaid representative come speak at the next meeting, whether it be the new Administrator, Laurie Squartsoff, or whoever may be available.

Item 9 - Report, Discussion, and Recommendations on Performance Measurements from Other States:

Steve Burt asked to keep this on the next agenda.

Elections: During the next meeting, a nominating committee will need to be formed and the elections will occur at the following meeting. They will next discuss it before the nominating committee for Chair and Vice Chair.

A few weeks prior to the next Advisory Board meeting on May 15, Kevin and Deborah will discuss agenda items. If anyone has something to add, please address it to Kevin or Deborah.

16. **Public Comment**

No public comment was made.

17. **Adjourn**

Meeting was adjourned by Kevin Quint at 11:55pm.

Attachment

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Public Comment on the SAPT/MH Block Grant Application
March 13, 2013

With three minutes to testify on a 241-page document, I'm only going to talk about publicizing treatment and admission priority for pregnant women and about technical assistance needs.

Goal #9 of the application on pages 85 and 86 addresses services for pregnant women at all funded treatment programs. It describes how the State intends to meet the requirement that it publicize the availability of treatment and admission priority for pregnant women: SAPTA and MCH are going to partner in a public education campaign through the Nevada Broadcasters' Association. This portion of the State Plan is very, very good news and hopefully will do much to remedy the decline in substance abuse treatment of pregnant women. That decline began in 2005, and now has leveled off with less than half as many pregnant women getting treatment as had in 2004. This public education campaign closes the gap created by the unenforced condition of subgrant award that treatment programs publicize the availability of treatment and admission priority for pregnant women through public service announcements or street outreach projects. The 2012 year-end report of the Nevada Statewide MCH Coalition indicates that it had surveyed the funded treatment programs and couldn't find a single one that had such a PSA.

There are a couple of places in the application where services for women aren't described accurately.

Goal #3 on page 78 addresses services provided by the two programs receiving funding set aside for specialty treatment of pregnant women and women with dependent children. It includes statements that belong in Goal #9 because they refer to all funded treatment programs, not just the pregnant/perinatal set-aside programs. But the larger problem is misleading information about outreach, for example, stating that "All funded programs are required to provide outreach services to pregnant woman. Some of these activities include... Public service announcements". This leads one to believe that the funded treatment programs provide outreach to pregnant women through PSA's, but the Statewide MCH Coalition found that they don't.

On page 51, describing prevention services for women, a statement is made that's patently false. It's stated that "...two SAPTA staff are members of the PSAP subcommittee of the Maternal and Child Health Advisory Board." This can't possibly be true. That subcommittee doesn't even exist, having been dissolved back in 2011.

Finally, on pages 229 and 230 the technical assistance needs of State and program staff doesn't include development of an appropriate State Medicaid Plan and development of billing mechanisms by the programs. These continue to be problematic, indicating the need for technical assistance. For example, on page 119 the application describes a State Medicaid Plan that provides reimbursement only for treatment of mental disorders and co-occurring disorders. Such a plan won't support substance abuse treatment.

I'd like to reiterate how pleased I am with Goal #9. A public education campaign on the availability of treatment and admission priority for pregnant women can reduce the number of babies born in Nevada with substance-related birth defects.