

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

MINUTES

DATE: May 15, 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 2647B
Las Vegas, NV 89146

Great Basin College
1500 College Parkway, Room 118
Elko, NV

BOARD MEMBERS PRESENT

Sparks Site

Kevin Quint (Chairperson)
Michelle Berry – for Nancy Roget, Vice Chair
Diaz Dixon
Steve Burt
Lana Robards
Amy Roukie – for Maurice Lee
Michele Watkins

Join Together Northern Nevada
CASAT
Step 2
Ridge House
New Frontier
WestCare
Central Lyon Youth Connections

Las Vegas Site

Jamie Ross – for Brad Greenstein
Frank Parenti
Ronald Lawrence
Debra Reed

PACT Coalition
Bridge Counseling Associates
Community Counseling Center
Las Vegas Indian Center

Elko

Ester Quilici – for Dorothy North

Vitality Unlimited

BOARD MEMBERS ABSENT

Ed Sampson
Tammra Pearce

Frontier Community Coalition
Bristlecone Family Resources

STATE OF NEVADA STAFF

Reno Site

Charlene Herst
Lisa Tuttle (recorder)
Steve McLaughlin
Chuck Bailey
Dave Caloiaro
Agata Gawronski
Betsy Aiello

Prevention Team, SAPTA
Admin, SAPTA
Treatment Team, SAPTA
Data Team, SAPTA
MHDS
Executive Director, BOE – ADGC
Medicaid

Las Vegas Site

Kim Davis

Admin, SAPTA

PUBLIC

Las Vegas Site

Christy Navarro
Sherry Thomas

Community Counseling Center
CASAT

1. **Welcome and Introductions**

Chairperson Kevin Quint opened the meeting at 9:50am with introductions and acknowledged the meeting was properly posted.

2. **Public Comment**

No public comment was made.

3. **Approval of Minutes from the March 13, 2013, Meeting**

Steve Burt made a motion to approve the March 13, 2013, meeting minutes and Amy Roukie seconded the motion. All were in favor and the motion was carried.

4. **Presentation, Discussion, and Recommendations by Medicaid Representative**

Kevin reminded the group that it was decided at the last meeting to have a representative from Medicaid come and discuss issues about Medicaid, issues surrounding the agencies, and the undergoing transition with health care reform. He introduced Betsy Aiello from Medicaid.

Betsy spoke on health care reform and how the State is onboard and moving forward with a start date of January 1, 2014. The Governor's expansion with Medicaid includes Welfare and the Health Insurance Exchange. States are given the choice to join the federal health insurance exchange or develop their own, and Nevada chose to operate its own which is called the Silver State Health Insurance Exchange. Medicaid, Welfare (which does eligibility for all programs including Medicaid and Nevada Check Up) and the Health Insurance Exchange have been working closely together with a few different contractors to develop a "no wrong door" entry system. People can either (1) go in through the health insurance exchange to enter their information, (2) go to Welfare as usual, or (3) go onto the Medicaid or Check Up website. Whichever way information is entered, it will stream into one engine to search eligibility through a federal hub to obtain information on citizenship, legal status, and income. The process for eligibility will change except for the aged, blind, and disabled population. The same modified adjusted gross income process will be used throughout the country. When people enter their information into the single-entry system, and if everything matches such as name, date of birth, and social security number, it will search to verify eligibility for Medicaid, the Exchange, or Check Up.

The expansion population is increasing, and everyone up to 138 percent of federal poverty level will be Medicaid eligible. Currently, mothers and children and the aged, blind, and disabled are only eligible. There are also different eligibility levels, such as children above age six up to 100 percent of federal poverty level, and beyond that up to 200 percent they are eligible for the Children's Health Insurance Program (CHIP) which appears very similar to the Medicaid program. There is a huge increase in the legislative budget due to the addition of welfare eligibility workers with this new online enrollment. Betsy isn't sure if the budget has closed. The workers will no longer be required to gather income statements, etc., except in cases of clients with mismatched information. Those cases will still require eligibility workers to be hands on, and there is uncertainty of how many will fall into that category. There are big increases in the budget for this expectation. It is expected people will receive eligibility within a few days after entering information into the system. Unless they are of the aged, blind, and disabled population they will still need disability determination through SSI. If a person is on the Silver State Health Exchange and receives a subsidy, they will have to determine which plan level to choose, whether it is the silver, bronze, or platinum product. Navigators through the Exchange will help people determine the best product for them. Based on diagnoses or health care utilization, one product or one level may be better than another for a person's needs. She believes this can become more familiar to advocacy groups and agencies. She offered to email more of this information to the group. Family eligibility level under TANF Medicaid was around 30 percent of federal poverty level and is anticipated to rise to 133 percent because more families are expected to join the Medicaid population. The level for pregnant women and children under six will basically remain the same. The federal government is cross walking some of the disregards that will no longer exist. Because it will be a certain level and an automatic 5 percent disregard, it will be simpler to figure. The largest population will be childless adults under 133 percent that were never covered. Many people in this population have issues with mental illness and are low income, so they would most likely move into the Medicaid product and become eligible. This population will be 138 percent of federal poverty level, due to the automatic 5 percent disregard on top of the 133

percent. These are Nevada's rules and every state is different. Again, the plan is to quickly have information determined electronically. Ester questioned if each person is considered as an individual what are the benefits coverage for alcohol and drug treatment and co-occurring disorders and what relates to their industry. Betsy said she will come to that, but how households are assessed is very complex and that answer may need to be requested of Welfare. The Center for Medicaid Services (CMS) is still rolling out rules. The systems for eligibility will begin October 1, 2013, but actual eligibility will begin January 1, 2014. The system is being called an open enrollment process. Ester asked how the 138% translates in dollars. Betsy does not have that answer but will send it to Lisa Tuttle at SAPTA to distribute to the group. She does know the federal poverty level changes every year, and around February they post it on their website for the different household sizes to give a general idea. It is very complex – some streams of money don't count and some do. If information is correct and matches up, people should have answers within a few days which will still give them the right to a hearing if they believe they are incorrectly denied. Matching percentages have not been done. Amy stated years ago in the Check Up program, the bigger issue with getting people eligible was the need for them to provide a large amount of paperwork. For this population, it was a participation process which not everyone had the strength to follow through. Betsy said this is the entire point, and it was developed to make it easier and user friendly. According to Jon Hager from the Silver State Health Exchange they are on track with computer programming and testing; however, there is still a lot to do because of having to test with federal government linkages. The goal is to have a smoother eligibility process, quicker determinations, and coverage.

CMS has not released the final rule on the benefit plan, but it will cover the 10 essential health benefits which includes mental health that covers substance abuse. Medicaid is working with the Health Division and Steve McLaughlin to examine the benefit policy coverage for substance abuse and to develop a benefit that matches the evidence-based, SAMHSA-recommended ASAM criteria. Kevin asked if it is anticipated that people will now be covered under substance abuse without the co-occurring mental health disorder. Betsy replied it is not a simple yes or no answer because they do not know the final benefit policy plan, but Colleen is working with Steve to put together some suggestions based on ASAM criteria. It was discussed this may be a burden for the larger agencies; however, the smaller agencies will go out of business if they cannot bill for drug and alcohol alone. It is Betsy's belief it is moving that way, but she is unsure. There will be a benefit policy plan process under ASAM that will be submitted to a public workshop and public hearing. The goal is to have the new policy up and running by January 1, 2014, and to provide substance abuse in a way that is evidence based which SAMHSA supports. They are at the very beginning and have no final answers, but will meet with the Health Division administrators next week. Steve discussed the direction is to have a substance abuse plan that is separate from co-occurring. The current plan is for LADCs to be recognized, but he doesn't know what it will read when finalized. Colleen is writing a policy for a substance abuse-only plan. Kevin understands this is not a statement of what will happen, but that it is currently being discussed. As an advisory board to SAPTA, at some point they must use this conversation to develop a position to present and articulate at those hearings. Secondly, what is the place of the LADCs, CADCs, interns, and the different levels? Betsy stated they are beginning to research what is evidenced based and who is covered at the level. The plan Colleen is assembling will identify the LADCs and their roles. Steve Burt requested that Agata Gawronski also be invited to those meetings. Betsy said there will be a straw man workshop, which is a roll out to a public workshop, where input is gathered and changes are made. Amy commented how qualified providers are currently credentialed to provide services in the State based on SAPTA guidance with Medicaid federal rules regarding who are considered qualified mental health providers or assistants and therefore can bill under Medicaid rule. They must crosswalk the language currently used to the language of what the federal government deems appropriate. There is also the issue of required NPI numbers for providers. Betsy discussed the two different benefit plans. The Medicaid benefit plan is now the current plan, and there may be some changes to it. Under Health Care Reform, the new essential health benefits plan will help the expansion population. This population has the 10 required essential health benefits. Title 19 rules haven't changed by the federal government. There may be some instances to crosswalk the new benefit plan to the existing one to provide services. Based on input from advocacy groups a year ago, the State chose a Medicaid "look-a-like" plan which wraps the essential health benefits. The exchange plan for those with a higher income levels will be a commercial product plan with the 10 essential health benefits. People are concerned, especially in children's mental health groups, because they feel many children will fall into a commercial product. The Medicaid plan does not have to be given between commercial and federal rules. The Medicaid mental health plans are fairly extensive because they're more social

programs which last longer than many of the commercial plans. Everyone will have to examine the exchange closely to determine which plan meets their needs. The expansion population will have the Medicaid benefit plan. Also, the Feds will require the State to examine the commercial markets essential health benefits, federal employees, state employees, and the largest state HMO which to wrap the Medicaid plan to adjust and make it fit. They are trying to match it to the Medicaid plan for developing the ASAM model for substance abuse because it is one of the essential health benefits coverage areas. The final rule will be out in a few weeks, so adjustments are happening quickly. Programming into their claims payment system and the utilization management process must be through public hearing by January 1, 2014. She will keep everyone posted and send information to the group when it becomes available. Colleen is working closely with Steve to compile the appropriate benefit plan.

Medical care in the rural areas is different than the urban areas, and Ester asked if there will be accommodation for access to HMOs. Betsy is not bringing up HMOs; they look at their benefit plan. The federal rule in health care reform says the exchange and the expansion population must benchmark their benefit plan, so they are researching what the plan offers and at what level and how much. Initially cost sharing was studied closely by the Governor which is allowable in expansion. At this point cost sharing is not impending this year but may in another year. Some states are suggesting it because the expansion population is considered a different population, and they are trying to cover them. The goal under Health Care Reform was not necessarily to give the Medicaid product to everybody in the country. It is known that the Medicaid product would benefit adults which may have social needs at that income level. Ester asked about eligibility determination, waiting periods, and premiums. Betsy specified there is no co-pay or premium for Medicaid; however, there is a premium for Nevada Check Up and eligibility begins the next active month. If a person has a medical claim while obtaining eligibility determination, they may go back to the date of application if they ask for prior coverage on regular Medicaid. She is not sure it applies to the expansion population. Subsidies help to pay premiums for those with higher incomes on the health insurance exchange. Premiums will be different based on the product and level they choose. The health insurance exchange is a marketing exchange of insurance products by different insurance companies. Providers will have to be paneled in order to treat the expansion population. For those who don't qualify for Medicaid or Nevada Check Up and receive subsidies to buy insurance on the exchange, service providers will have to examine the different insurance products and become a provider in those insurance plans. The NPI number plays into that level of activity. It was implied there are a few insurance companies signed up for the exchange program, but that would be a question for Shawna DeRousse or Jon Hager with the Silver State Health Insurance Exchange. It is believed they may have changed the name to Healthlink. The provider enrollment for Medicaid is not changing, but Betsy isn't familiar how commercial enrollment is done. Ron Lawrence's agency is Medicaid certified, and it's his understanding that after so many Medicaid sessions it moves over to an HMO for management of health care benefits for treatment. He has already been refused by Amerigroup. Betsy expects new people joining Medicaid in urban areas of Clark and Washoe counties will go into an HMO, such as Amerigroup and HPN, except for the aged, blind, and disabled. Unless providers are paneled there will be a huge barrier, and they will not be able to continue treatment on that basis. Managed care organizations (MCO) must maintain network adequacy with certain provider-to-recipient ratios and ensure recipients receive the care they require. Ron is concerned that providers are at the mercy of the HMOs which basically are making decisions on who to include on the panel and who not to include. They will never be able to do business on that basis. He expressed each provider must become part of those HMO networks to avoid barriers from putting them all out of business. Currently Medicaid has approximately 320,000 enrollees, and they are expecting 500,000 by the end of the biennium. People enrolled in MCOs must have provider adequacy to serve them. Medicaid is contracted with Amerigroup and Health Plan of Nevada; however, they are included in the rural areas. At this point the rural areas will stay fee for service, but different models are constantly being examined. Insurance providers can change every four years. A request for proposal re-procurement for their contracts begins July 1, 2014. Ester asked if out of town business will be allowed entry into the HMO. It was explained that the State has contracted with the HMOs to run their Medicaid benefit plan and they have contract requirements which relate with network adequacy. They must have a certain amount of providers per recipient. Medicaid does not direct who to contact or which payment model to choose.

Steve McLaughlin and QuantumMark visited WestCare which was very helpful and beneficial to Amy and the agency to prepare them for the upcoming changes. She recommended and encouraged everyone to participate in those visits. The reality of the health care environment is changing. It doesn't mean people or agencies won't

survive, but they will have to adapt to a different model. They are examining their benefit plan to better serve the new set of individuals joining Medicaid. The MCOs provide the same benefit plans Medicaid provides but the provider qualifications may be slightly different.

During the last meeting it was discussed to organize some outside meetings regarding Medicaid issues to understand how to make those changes as an Advisory Board and as providers. Betsy advised them to look at provider qualifications and what people must do to become a provider, obtaining NPI numbers, and adjusting business plans when the new policy comes forward. They are working on adjusting the benefit plans and different provider qualifications. Billing rules are standardized across the country by using the CMS 1500 form and electronic billing. Some of the paper billing may be reduced or omitted. It was discussed at the March meeting that having a Medicaid navigator would provide a way to complete this process and get the best competitive edge in order to survive. Steve McLaughlin is partnering with QuantumMark, a consulting firm in Reno, to help each funded provider become Medicaid eligible to bill. They are currently in the process of mapping a plan for each provider. Provider trainings include many different areas, such as applications, electronic billing, and claims. Medicaid can help with the actual logistics of how to input a claim into the system, what a provider must sign up for, what sections to complete, what codes are providers authorized to bill, how do providers ask for prior authorizations for services, etc. The Annual Medicaid Conference will be held in October where they review procedures and billing. Also, Hewlett Packard (HP) provides training information on their web portal. They have an entire catalog of training events that anyone can view. Some of these trainings are requested and some are scheduled for the entire year. Steve McLaughlin explained that QuantumMark will coordinate with HP to establish trainings for all the providers, but the training may be a little different for those who are already billing Medicaid. Lana reinforced that even though they are a current Medicaid provider, they will need someone to walk them through the process because of all the changes. Betsy suggested they also attend the benefit policy workshop and attend public hearings, as well as to the website for continual updates on provider trainings. The workshop will be scheduled for mid summer and the public hearing is toward the end of summer or early fall. She suggested the providers approach the MCOs to check what type of business model or expansion they're looking for; however, they will not be able to give full answers until benefit policy is known. If agencies are already providing for Medicaid they may want to learn more of what they are looking for; it would be hard to believe they would not need some expansion of their provider network. Historically, Amy said the response has been that there are enough paneled providers in that specialty area; however, with the expansion they would hope a new approach would lead to more successful panels. It is about volume, not qualifications. Betsy said they must meet network adequacy for their caseloads, but caseloads are expected to go up. Per Amy, if the services are expanded there is both a new expanded service delivery system and new enrollees. Betsy will send links for federal poverty levels and for existing provider trainings to Lisa Tuttle to email to the group. If anyone has anymore questions, her information is in the employee directory on the State's website under Elizabeth Aiello.

Kevin asked as an advisory board to develop thoughts about their representation at the workshop and/or hearing in mid to late summer and early fall. The importance of attending and going on record to provide input as an advisory board was discussed. It is not known what they can change as to what will be determined. They will know about 80 percent more information after the legislation closes in June, which may determine some of the direction. Medicaid may not act until CMS acts on their final rule. The Board decided to wait until they have more information, but will keep it on the agenda for July. As informative as Betsy was, Amy said a piece of the discussion was a bit too deep into eligibility, and it was more than they needed to know. They need to understand how to direct their people to specific locations to participate in the eligibility process, and more importantly how to get their services paid. Most importantly, how do providers get paid once qualified.

They will keep this on the next agenda for discussion due to not yet having enough information to have an opinion.

5. **Update, Discussion, and Recommendations for SAPTA Treatment Standards and Subcommittee Report**
Currently, Mark Disselkoe from CASAT is refining details in the actual document regarding duplication between monitors and certifications. The next Treatment Standards Subcommittee meeting will be May 28, 2013. The subcommittee hopes to present more information about the document at that meeting.

6. **Discussion and Recommendations Regarding the Block Grant**

Charlene Herst reported that SAPTA still has not received management and budget approval on the guidance for the Block Grant from SAMHSA, and cannot yet submit. She recommended they review it again, and for questions about the mental health side contact Dave Caloiaro and the substance abuse side contact Deborah McBride or Charlene Herst. Part of the issue was sequestration which was important when looking at the guidance, especially formula funding for the State. It can be uploaded but cannot yet be submitted. The Block Grant was originally due April 1, 2013; however, SAMHSA moved it because they need OMB approval on the original guidance document. The new federal year, although it was going to change, will probably remain October 1. They will have the extended funding between the July 1 date and the October date, if that will be the date of submittal.

7. **Discussion and Recommendations Regarding the DSM V**

Kevin Quint asked for this item to be added to the agenda to discuss DSM V as a group knowing it should be unveiled at the APA Conference in San Francisco this month. There has been public criticism by NIMH of DSM V as being a total paradigm. Kevin made inquiries, but did not receive any answers on the roll out. He suggested the Advisory Board express opinions and make recommendations to SAPTA on how this should roll out. Kathryn Baughman at Rural Services had contacted Steve McLaughlin to roll out a DSM V training to which the SAPTA providers will be invited, but he is not sure when this will take place. When ASAM was implemented in Nevada around 1997 or 1998, it involved all providers and the number of trainings began at the executive director level, which really engaged individuals. Kevin believed it got the agencies involved. He is asking for more of a comprehensive approach. Dave Caloiaro noted they are currently working with one of their master service agreement contractors to do this training the last three or four weeks of June. They have some block grant money left to spend but the challenge will be if the DSM V manual is not rolled out until October, but that is unofficial. If they feel the training is too soon, they may do it budget forward in the next fiscal year. The training would focus on changes.

Kevin also wants to think about a timeline and a strategic roll out of DSM V, realizing once it is approved it may be several months before it is implemented. Steve Burt believes it will take more time because there is DSM IV and DSM IV TR peppered throughout NRS and NAC. Medicaid will require it as of July 1 and as of January 1, so Frank feels regardless of what the State is doing the Block Grant is a mute point. This will impact how business is done, and it goes back to the idea of not being based on research or evidence in any way. Unless certain excessive criteria are met, the legal issues would not be considered for someone using alcohol, for instance.

Trainings are available on line and in person, which should be done as soon as possible. There was a training in Las Vegas through AADAPTS to prepare them for the upcoming changes. Frank does not believe this is the direction they should go. Michelle Berry added that CASAT rolled out DSM V; it is speculation about what to anticipate. They are waiting until the manual is produced before setting up training. She is hoping it will be available this month to add into their next catalog and have time to digest and interpret it. They also have to anticipate the changes with ASAM, and once those occur there will be a self-paced online course, along with face-to-face training. There are some specific changes to the adolescent portion. It is supposed to coincide with the DSM V, but she does not know the exact date. This is almost the first change to the DSM V in 20 years. CASAT will have a series of webinars along with face-to face classes. It then poses issues of what Medicaid, SAPTA, and the programs will require to prepare for the 2015 Legislature. Kevin does not understand the regulatory and NRS pieces. Steve McLaughlin agreed they must begin strategic planning now. Steve Burt said their experiences in the field are driving the decisions of SAPTA because SAPTA is short staffed. It was discussed if this should be included in NHIPPS training, but it will be myAvatar that will anticipate the changes. Netsmart is working on an easier transition from an electronic standpoint. QuantumMark is involved with trainings and the rollout of myAvatar, which is different from Avatar, to help providers become acclimated. Steve McLaughlin was able to view a demo which he described as amazing. From a clinical standard, he went through the treatment planning and the dimensions and feels it is seamless. It is also a billing system and can run reports.

It was decided to leave the DSM V topic on the agenda until it is resolved. Kevin did research last year prior to the website change and he found, for example, a 10-page paper on why DSM is considering cannabis withdrawals legitimate and part of the criteria for dependence. Currently DSM doesn't show this.

8. **Discussion, Recommendations, and Approval Regarding Sequestration**

Charlene mentioned SAPTA still does not have a definitive answer on sequestration. An email was sent stating it could possibly be six percent beginning July 1, but they are still waiting on an official letter from SAMHSA regarding cuts. She is hopeful they will receive it before then, but they may amend subgrants after the fact. She encouraged the agencies to have a plan if cuts occur within their organizations and how it will affect services and staffing.

9. **Discussion, Recommendations, and Approval of Actions Regarding Legislative Issues and Bills and Subcommittee Report**

Before they began Amy Roukie thanked Frank Parenti and is appreciative for him sending all the informative articles.

Frank was concerned about the direction of legalizing marijuana for recreational use. That was defeated; however, he believes it will come up again and to watch for it.

SB501 interested Kevin regarding SAPTA's place within the Division and also the language about eliminating evaluation centers which he received information from Barry Lovgren. His information wasn't completely correct but it was alarming. Kevin spoke to Marla McDade Williams regarding the evaluation centers in some length. Kevin understands that section was removed from the bill. Charlene Herst also understood this to be true but she hasn't seen the next draft. Evaluation centers don't affect the rural areas but they affect Clark and Washoe. Marla told him they were not intending to omit the evaluation centers but just the language in the NRS.

There was discussion on a bill to have a legal limit for THC. Frank will keep everyone posted as soon as he has more information. There is no evidence showing any level of THC is safe.. It says it is not a harmful substance and a person is not impaired.

Charlene spoke on AB488. The budgets have been closed and approved for Mental Health and SAPTA to move under the new Division of Public and Behavioral Health. Early intervention services and developmental services will move to Aging.

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

Kevin discussed the \$6.4M that will be reduced from state funding of treatment over the biennium – \$3M over the first year and \$3.4M over the second year. He has had many conversations and testified at a budget hearing and believes this doesn't necessarily match up to what was previously discussed. He has been assured at the state level this will be okay, but he is weary of what might happen. In his personal opinion the State is viewing this as a savings opposed to a seamless way to fund treatment. He is concerned about eligibility and the gap between July 1, 2013, and January 1, 2014. Charlene reminded everyone about sequestration on top of the state cuts. Kevin feels there is more awareness with Richard Whitley and the legislators. The issue is not necessarily state money versus Medicaid, but the rigidity of the budget. There is a move for providers to become Medicaid eligible and talk about how money can and cannot be spent. It is a matter of being aware and informing individuals about their concerns.

QuantumMark's plan is to prepare the agencies to bill Medicaid as of July 1, 2013, rather than holding off until January 1, 2014. If agencies cannot get paneled they cannot bill under Amerigroup. It will be a problem if they are closing their provider enrollment. Agencies in the rural areas can bill fee for service, but agencies not in those areas need to be paneled. Lana is not comfortable with the issue of credentialing and where it is heading. As long as it's in the Medicaid budget, which precludes LADAX and those alcohol and drug professionals from billing for therapeutic services, it is not replacing the services currently being provided into Medicaid. It is there for agencies with QMHPs to capitalize, which many smaller organizations do not have. How big a caseload can agencies handle with the anticipated number of people to be billed? Frank wants to ensure Agata Gawronski is on top of this. He discussed CPCs are covered as QMHPs under Medicaid and the criteria for an LADC versus the people grandfathered in. It's the same behavioral health field qualification for a Masters Degree and qualifications would not be different when just taking the national exam in the CPC state. It is as simple as taking one more test, if in

fact the plan includes LADCs. Basically, it is how it works for SAS members throughout the country. Too much time is spent on this topic when there is a simple resolution. Kevin had not heard the paneling piece for the HMO before today. It used to be that health insurance panels were open and most BADA-funded programs could not have access because they wouldn't accept non-hospital providers. It's now a different situation, but it will be the same problem for SAPTA-funded providers to not become paneled. This is why other meetings and discussions are being held regarding having a conglomerate of providers speaking out under one heading instead of each individual agency. Ron believes there are several choices: (1) people must obtain a license to manage insurance which involves the insurance commission, and the agencies may have to challenge their licenses because of not being allowed on their panels, (2) form their own HMO if they cannot get on the panels, and (3) HPN, now United Health Care, is doing their own substance abuse treatment and keeping those monies in house. The agencies are at the whim of these insurance panels and they must find a way to work through this.

11. Report, Discussion, and Recommendations on Performance Measurements from Other States

No discussion was made. This topic will be tabled for the next meeting.

12. Discussion, Recommendations, and Approval of Nominating Subcommittee for Election of Chair

Kevin Quint asked for a Nominating Subcommittee to be formed to meet and return with a slate of officers at the next meeting. Michelle Berry, Frank Parenti, Diaz Dixon, and Ester Quilici, have volunteered to be on the Nominating Subcommittee, and Michelle Berry will be the Chair.

Amy Roukie will be representing WestCare in future meetings in lieu of Maurice Lee once he submits his resignation from the position in writing. It is, however, about agencies and not individuals.

13. Standing Item – Discussion and Recommendations Regarding Health Care Reform

No discussion was made.

14. Standing Item – Discussion and Recommendations Regarding New Funding Streams

Steve McLaughlin discussed two grants. One is a reentry grant coming out of Southern Nevada Adult Mental Health (SNAMHS). It was completed and sent yesterday to Deborah McBride and it will be submitted on time, but Charlene is unsure if it has yet gone over for signature. Dave Caloiaro spoke about the two or three year grant for \$700,000 which targets women released from prison with SMI. Richard Whitely asked SAPTA to be the grant management entity for any and all grants, regardless if submitted by MHDS agencies or Central Office. An RFP would be done if subgrantees were awarded at the federal level. According to the Department of Corrections, there are currently 80 women that qualify for this grant, which is one of the reasons they targeted this population. This would be the pilot program for the entire State, which was written by Myra Schultz of SNAMHS. When the women are released, they go straight into the program. The second grant due May 28 is a statewide grant for homeless people with co-occurring disorders, which SAPTA and Joann Flanagan (MHDS) are involved.

It would be helpful to have a formal grants management unit with a grant writer within the Health Division, but currently SAPTA is the agency handling it. The various bureaus within the Health Division are responsible for writing grants. It is more of a quality team approach with Health. The subject matter experts are gathered together on one particular grant on the subject of the grant, people at the state and community levels work together on the grant (which is what has been done on these two grants), and a team lead is assigned to ensure the process. This is the approach for all grants. If the homelessness and co-occurring disorders grant comes through they would hire a program manager for the grant with the grant money.

Charlene touched on the Partnerships for Success prevention grant that is due Friday, which is currently being compiled for signature today and for submittal tomorrow. The grant is \$2.255M per year for five years, so this would go a long way to offset other discretionary grants that have ended and will help with sequestration. She thanked Linda Lang for helping to establish the goals and strategies of that grant because it is specific to prescription drugs. It would be prescription drugs or underage drinking or both. They tried both the last time but it didn't work. This is the third attempt with this grant application, so they are focusing on prescription drugs from

ages 12 to 25 by the grant guidance. It was decided to take it through the age span 12 and up due to what the data says. The issues are skewed older and is seen in emergency rooms and overdose deaths. They are also targeting suicides related to prescription drugs in the military and other specific populations. SAPTA is hoping for this grant.

Steve discussed two other treatment grants which would bring Minkoff's integrated co-occurring model to Nevada and start building that infrastructure. The HELMUS grant will focus on co-occurring disorders. Both grants will start building Recovery Oriented Systems with Care (ROSC) in Nevada which is being pushed as a pilot to discover if it will be successful and begin delivering it throughout the State. He hopes the ROSC system is built so they can begin wrapping services around the Medicaid plan, which is a goal everyone should have.

15. **Standing Informational Items:**

Chairperson's Report

No report was made.

SAPTA Report

Charlene reported on the current merger between SAPTA and the Health Division and programs within the Health Division. There will be four separate agencies within the Division. SAPTA is within Community Services. Discussions have begun on the merger and transition process and what the result will be. Some MHDS and Health staff are occupying SAPTA cubicles.

Prevention Updates

Charlene reported the coalitions continuation applications for State Fiscal Year 2014 were submitted and are being reviewed. They will be working on subgrants and negotiations and then their subgrants with their coalitions.

The continuation applications for the administrative programs, Crisis Call Center and Nevada Prevention Resource Center (except for CASAT), were submitted and are due at the end of the month. The target date for everyone to be started in the system is July 1. She is hoping the coalitions are working with their current subgrantees, at least the ones to be funded next time. She is working on those negotiations knowing it is level funding this year.

Treatment Updates

Steve reported a new SAPTA staff member will be starting in the Las Vegas office.

Last week they conducted visits with QuantumMark in southern Nevada which went very well. QuantumMark will be extremely helpful in this process. The northern Nevada appointments will be scheduled today by Betsy Fedor and Meg Matta for the next week. A billing specialist and/or IT person should also attend those meetings.

Continuations have been reviewed, and he is waiting on the fiscal numbers before he can start negotiations. There will be a new template with an added Section D, because the Health Division has specific subgrants and wording.

The meeting between WestCare and QuantumMark went very well. Amy said they were helpful with explanations and it wasn't so ominous by the time the meeting was finished. Steve expressed the treatment team willingness to help them with anything they may need, including visiting in person.

Data Team

Chuck reported on the release of the coalition events report now available for review and also to provide feedback and the session activity report. Tonya has sent out information on the use variables from the pre-post test, and any feedback would be helpful.

On the treatment side, a huge period of change in NHIPPS will occur in the very near future. QuantumMark will be the lead in that project. They are still working with the NHIPPS vendor as necessary but are not investing new dollars. The new system deployment will be expensive, and higher management is exploring where dollars will come from to make that successful. The goal is July 1, but it isn't certain that myAvatar will be completely

accessible. SAPTA will do their best to keep the agencies informed. QuantumMark will be working with the agencies one on one and will be assessing their individual needs. They also have a relationship with Netsmart. Chuck reassured them to be patient because it is a change for everyone.

Amy thanked everyone for all the helpful information.

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

No report was made.

16. Review Possible Agenda Items

- DSM V
- Medicaid
- Treatment Standards
- Performance Measurements from Other States
- Legislative Updates
- Nominating Committee

If anyone wants to add anything to the next agenda to email Kevin Quint or Deborah McBride.

The next SAPTA Advisory Board Meeting will be face-to-face on July 10, 2013, in Reno, Nevada.

16. Public Comment

No public comment was made.

17. Adjourn

Meeting was adjourned by Kevin Quint at 11:45am.