

Division of Public and Behavioral Health
Substance Abuse Prevention and Treatment Agency (SAPTA)
Advisory Board (SAB)

MINUTES

DATE: November 13, 2013
TIME: 9:30am
LOCATION: Truckee Meadows Community College
Redfield Campus
1800 Wedge Parkway
HTC Room 103
Reno, NV 89511

Video-Conference
Nevada State College
311 South Water Street
Basic & Water 2 (BW2) Bldg., Room 119
Henderson, NV 89015

Great Basin College
1500 College Parkway
Berg Hall Conference Room
Elko, NV 89801

BOARD MEMBERS PRESENT

Reno Site

Kevin Quint (Chair)
Steve Burt (Vice Chair)
Michelle Berry – proxy for Nancy Roget
Diaz Dixon
Lana Robards (via teleconference)
Tammra Pearce
Ed Sampson

Join Together Northern Nevada
The Ridge House
CASAT
Step 2
New Frontier Treatment Center
Bristlecone Family Resources
Frontier Community Coalition

Las Vegas Site

Kay Velardo – proxy for Ron Lawrence
Natalie Grajedo – proxy for Brad Greenstein
Debra Reed
Kevin Morss – proxy for Richard Jimenez
Yolanda Correa

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

Elko

Ester Quilici – for Dorothy North

Vitality Unlimited

BOARD MEMBERS ABSENT

Michele Watkins

Central Lyon Youth Connections

STATE OF NEVADA STAFF

Reno Site

Mary Wherry
Charlene Herst
Lisa Tuttle (recorder)
Chuck Bailey
Becky Hepler
Betsy Fedor
Stephanie Woodard
Dave Caloiaro
Agata Gawronski

DPBH
SAPTA, DPBH
SAPTA, DPBH
SAPTA, DPBH
SAPTA, DPBH
SAPTA, DPBH
DPBH
Mental Health, DPBH
BOE for Alcohol, Drug, & Gambling Counselors

Las Vegas Site

Kim Davis
Steve McLaughlin

SAPTA, DPBH
SAPTA, DPBH

PUBLIC

Reno Site

Michelle Padden
Mark Disselkoen
Stuart Gordon
Denise Everett

CASAT
CASAT
Family Counseling Service
Quest Counseling

Becky Bailey
Barry Lovgren
Las Vegas Site
Judy Marshall
Elaine Nelson
Frank Parenti
Paul Del Vacchio

QuantumMark
Private Citizen

Las Vegas Indian Center
Community Counseling Center
NV AADAPTS
Las Vegas Recovery Center

1. **Welcome and Introductions**

Chairperson Kevin Quint opened the meeting at 9:35 am with introductions and acknowledged the meeting was properly posted.

2. **Public Comment**

As a group, Ester Quilici wants to facilitate their relationships with various boards they now have contact with. Vitality just received a report from their clinicians about communication being scant, and it would be desirable to have a more collegial relationship with these boards. She asked if this can be an official SAPTA Advisory Board (SAB) concern. Because this is public comment, Kevin will bring it up at the end of the meeting under future agenda items to discuss adding it to the next agenda.

Ester also commented on redundancies in the draft utilization manual. Kevin confirmed it will be discussed under Agenda Item 7.

3. **Approval of Minutes from the September 11, 2013, Meeting**

Ester Quilici made the motion to approve the meeting minutes as written and Steve Burt seconded. All were in favor and the motion was carried.

4. **Discussion, Recommendations, and Approval of Dates for 2014 SAPTA Advisory Board Meetings**

The group discussed and agreed upon the dates for next years' SAB meetings. Ester moved to accept the schedule with the meetings to occur on the second Wednesday of every other month beginning January 8, 2014. The motion was seconded by Steve Burt. All were in favor and the motion was carried.

5. **Presentation of Integrated Care Incentive**

Over the past six months, Stephanie Woodard with Rural Mental Health and Steve McLaughlin have been working together on bringing integrated care to Nevada. Last March they discussed what types of activities and what types of systems changes are needed to provide quality and effective care to individuals with co-occurring issues. Across the state substance abuse and mental health are not fully integrated, and they are pushing the ACA to integrate behavioral health into primary health. They came up with a three-phase plan to examine the system as a whole and bring the Minkof model to Nevada to see what they could do to build an integrated system of care and form alliances with primary care. This plan was presented to the Division of Public and Behavioral Health's (DPBH) administration last month to announce their intentions, what activities will be involved, and what they need in regards to support. They liked the plan, and it was then presented to Dave Caloiaro, the mental health leaders, and the Medicaid team. Funding sources are needed to obtain sustainability for this plan. They provided three presentations and are now ready to begin phase one of the plan. However, before doing so they will need to be trained to assess the system. Stephanie explained they have a standardized training plan to administer the dual diagnosis capability tool kits. They are standardized assessments that are the gold standard for SAMHSA. The trainer will train six or seven individuals in the "train the trainer" model to ensure long-term sustainability within the state. From there they will be contacting both SAPTA providers, as well as the state mental health clinics, to schedule teams to do site reviews. These are not considered compliance reviews, but they are to begin the technical assistance process. They will look at clinical records and policies and procedures, and talk with clinicians, provider leadership, and individuals who receive services. At that time they will gather information to give a written report for feedback and schedule feedback sessions with the site reviewers. The idea is to provide technical assistance and identify training needs to better help different providers become co-occurring capable and enhanced and ultimately integrate their services. Steve sees this as a benefit because providers that bill under provider type 17 have to be at least co-occurring capable, and they want to give them technical assistance to help accomplish this. This presentation has a lot of information and may require several hours to go through everything they have worked on

and what the plans are, but they hope to give them the whole presentation at the next meeting. By then they should be past initial phase one which assesses the system and identifies what the community providers and the state must do to bring the level of service for co-occurring capable services up to par.

Ester Quilici was told by rural clinics there are only 13 MFT supervisors in the entire state. The rural areas are struggling to attract qualified people. One way to execute the plan is collaboration with the Board of Examiners (BOE) and to facilitate this as a rural or statewide manageable issue. Otherwise they would be adding another layer of requirement. Steve specified this is not a requirement. They are looking at the state as a whole and not just at the urban areas, so when they assess the system there will be different action plans for different areas of the state. If workforce development issues are involved, they will work with other state and local entities to build that capacity. It is not a compliance piece but more of building an integrated system, and this will require speaking to the BOE for different licensing boards to see what they need to do to build capacity in the rural areas. It will be both a rural and urban issue. They will look at rural providers and rural mental health to build integrated care on both the state and community sides.

An abridged version of the presentation was suggested to be integrated into the next January meeting, but Kevin wants to ensure the board receives as much information as possible for a better understanding of the plan and to provide feedback. He would be willing to have a longer meeting if necessary in order to obtain the right information. Steve Burt asked why they are spending resources building a strategic plan to integrate co-occurring when it is already somewhat expected. Individually as agencies they have moved toward integrated primary care at some level. Steve McLaughlin said it goes further down to also look at the system. When looking at integrated co-occurring care there is more involved than just the program level. It is also on the system level in regard to finance and policy and linking the community providers to build that integrated system. They want to help the system become more integrated to increase capacity and access for these clients, but also to provide more effective treatment on the system as a whole and not just individual providers. There is more the state must do to get to those levels when looking at co-occurring capable and co-occurring enhanced definitions. The goal for the future is see how the state will come by funding opportunities and how it looks at policies of open access to providers to increase their services and to get paid. There is a lot more involved, but they wanted to give a brief presentation as to why they did this integrated care incentive.

Richard wants the assessment done prior to building budgets. Mary said the Governor has invested in the mental health delivery system and wants to capture the unmet needs for funding mental health services, which includes co-occurring. The assessments are important to identify not only how effective they may be to providing services, but to identify the gaps in order to build budgets based on solid ground. Secondly, next year the Block Grant is integrated between mental health and substance abuse. Mary thinks this information will be very useful going forward in partnering with the feds toward a better integrated system. Currently, there is much anxiety because everyone is struggling financially. A positive Mary hopes will come from this is it does compel where funding is needed. She is unsure if the Legislature will be empathetic of them asking for more straight SAPTA dollars, but it comes down to how the story is told. Kevin asked for this to be brought up again under future agenda items to possibly add it to the next agenda.

6. **Report, Discussion, and Recommendations Regarding the SAPTA Sliding Fee Scale**

Mary Wherry informed the group of the three handouts: sliding fee scale, sliding fee scale worksheet agreement, and sliding fee scale draft policy. Dr. Green has been supervising the Community Health Nursing Program for about 17 years of which Mary has been the program manager for the last 3 ½ years. Because of their sliding fee scale, there was a federal finding with their Family Planning Title X dollars. Much time was spent on the regulatory process with NAC439 and 442. Dr. Green wanted to have a standardized sliding fee scale across all direct service delivery programs under DPBH once she began to understand and experience SAPTA and mental health. Mary explained comparisons between the handouts for the sliding fee scale and the worksheet agreement with the box showing Tiers 1 to 5. A significant change to the programs is consumers will not be responsible for payment if they fall into Tier 1, which is a zero pay category. They will, however, become responsible at the Tier 2 level. Tiers are set up are in 50 percent federal poverty level increments. People within 101 to 150 percent of federal poverty level are Tier 2, 151 to 200 percent are Tier 3, 201 to 250 are Tier 4, and 251 and above are Tier 5. Tier 5 is theoretically considered to be their cost, but for most programs that provide services to safety net consumers, it is not affordable to reimburse them so that is why they are subsidized with general fund. A negative

cost of living adjustment (COLA) is done so cost is lowered and made more affordable for people within these poverty levels. Deborah McBride was working on this before she retired. The sliding fee scale must still be updated. It will not be in effect until July 1, 2014, unless the agencies want it into effect sooner. Mary explained how to compare the tier worksheet box and the sliding fee scale with the CPT/HCPCS codes that are billed for services. According to the worksheet, if people are less than 100 percent of federal poverty level they would be zero pay; otherwise, these are in 25 percent increments based on those 50 percent federal poverty level increments. She hopes this is easier to read and understand. Mental health will be implementing the sliding fee scale within the next month or two, which is the same structure. Mary is unsure if it will be taken to the December Mental Health Commission, so it may not occur until the one after. More procedural information should be in the policy to instruct staff on how to use the specific forms. There is more work to be done on the sliding fee scale policy. The rates must also be adjusted because what is in there currently is what SAPTA has historically reimbursed based on one-hour increments. Ester requested these documents be resent to her. Steve went on to explain the draft mark ups to the document. He will present the changes and adjustments at the next SAB meeting. They can discuss the changes and gather feedback to implement this in July 2014.

Mary said the programs are currently not charging for returned checks, but this would allow them to charge the consumer which is standard in their other two programs. If clients are not able to pay their fees, the programs may choose to add an administrative billing surcharge. Theoretically if agencies are enrolled on the MCO panels, they should make referrals to the agencies. At some point it is possible they will have more than safety net clients in their service delivery system. Agencies serving clients needing continuity of care that are not Medicaid eligible for that particular month can revert them over into the sliding fee scale so they can capture their costs. Agencies should retrain staff to adjust their business models to not write off their services or expect coverage from SAPTA. Because there are so many unknowns for the upcoming year, it is best for SAPTA to get their feedback on when they want this implemented and whether they need more instruction or clarification in policy.

Kevin asked the board for any comments or questions about their concerns. Steve Burt said they should only maintain one set of full fee rates for their contracts within their client files because they should ultimately align with Medicaid rates. He is comfortable with the proposed sliding fee scale; it is clearer and more comprehensive than the current standard sliding fee scale. If the Medicaid reimbursement fees are less, then the discussion gets into unit cost and what it costs them to do business. Aligning the numbers is the best way to keep them to a minimum. Diaz believes it needs to be as clear and simple as possible, as it keeps everyone honest to treat clients and their needs. It will be a challenge to keep the integrity of their individual programs and how they work. Substance abuse and co-occurring treatment is going to change. Unit costs are not the same, and because Medicaid will not reimburse for the room and board component, Mary asked how SAPTA will proceed in developing a unit cost representative of the whole. Transitional housing and residential housing costs are different. Steve's unit costs for the houses change every month based on utilities. It was asked if it would be beneficial to form a subcommittee to discuss rates for non-Medicaid covered services, which are unknown. The Medicaid state plan reimbursement rates will be different than the managed care reimbursement rates, and it is a concern of how they will be able to maintain a level playing field. Mary wants to keep business as simple as possible, but not to where they are undercut and struggling more than what they are currently. Because of frequent state audits, there must be some methodology to defend how they figure their rates. Because of aligning with Medicaid fee for service and not managed care, residential will be sticky because there may be different rates. This is meant to be a tool to help agencies subsidize their business for people who fall into pay categories.

The group agreed to set up a Rates Subcommittee. The subcommittee volunteers are Mark Disselkoe (Chair), Steve Burt, Diaz Dixon, Kevin Morss, and Ester Quilici, and Vitality's Chief Financial Officer. Mary made an informational statement about the super bill enclosed their packets, which has the known procedure codes from the sliding fee scale and diagnosis codes. Betsy Fedor crosswalked the DSM V to the IDC 9 and IDC10. This is a Medicaid billing tool for clinicians and billing staff. Steve Burt suggested an additional blank column be added next to each category to indicate the amount of time spent because some are broken down by varied units. Mary agreed to add the columns and to redistribute the super bill. They agreed to have the subcommittee meet before the January meeting.

7. **Report, Discussion, and Recommendations Regarding the SAPTA Manual and the Treatment Services Grid**
Steve McLaughlin stated they are looking to implement this for the next RFA process. It enables them to build an efficient and effective manual for use in July 2015. This is an opportunity to construct the utilization management manual and the treatment services grid. There was an informational provider workshop on October 18 where the manual and the grid were presented and feedback requested from providers. There was 100 percent feedback, and many ideas and concerns were incorporated into the working draft of the manual and grid.

Manual Discussion

Client Eligibility. They are looking at what makes a client eligible to receive SAPTA dollars. This has also been a crosswalk with the sliding fee scale. He made a few changes to the Nevada resident document by removing the undocumented and transient individuals not able to access identification from the draft because he did not want to limit access. If it can be removed by federal mandate then it should be done because there are many state boundaries within their scopes. People are coming out of prison with no ID, and they are technically not residents when released.

The medical necessity definition is very broad regarding services. The ASAM medical necessity definition somewhat mirrors this. It does not mean it is a medical condition, but is bio-psychosocial as well. This speaks to what ASAM identifies in their criteria as being medical necessity, but it is not pulled from ASAM. They tried to include some language from the medical necessity criteria from one managed care plan and Medicaid to have more standardization across the delivery system. This is standard in the behavioral health industry, and the definition is flexible to fit bio-psychosocial conditions within medical necessity.

Ester described her concerns about how to obtain proof of denial from other payer sources and how long it will take to get answers. Mary said it is important to maintain current information in client files and to rule out that clients have no other pay source by investigating EVS eligibility. From a federal level, SAPTA will be coming down hard to assure they are truly the payer of last resort. Because Medicaid has always been considered the payer of last resort, the feds are struggling to answer questions. State funds are linked to the Block Grant because they are the Maintenance of Effort. The state must be able to satisfy any federal audit. It would be satisfactory for providers to maintain documentation proving client ineligibility. Mental health created four different forms which were condensed into one double-sided page for their income eligibility verification. If a copy of this form was completed and kept in clients' files, it should satisfy program monitors. Mary will provide the agencies a copy if they are interested. Kevin asked how much of a barrier to access will this present for a client who needs immediate treatment. There may be a time gap that is not clinically acceptable. Mary discussed that SAPTA funds are capped. Providers have not had health care norms applied to SAPTA, so there may be a shock to the system. Courts will continue to order people for as long as needed without regard to the reimbursement mechanisms. SAPTA will be responsible for reimbursing for residential treatment. Many providers are quickly spending down and may not have the funding to sustain themselves through the end of this fiscal year, and SAPTA may not have the additional funds to pick up any non-Medicaid piece. Kevin stated the importance of having these conversations because the system is shrinking. Going forward over the next year, they must identify how to accommodate serving clients. Budget building will begin in May 2014 and will finish by August. Mary said it is important they have close conversations between now and May and suggested they contact the Governor, Legislature, and Director to discuss what is in the budget. It is unknown if Medicaid will pay for funds that were cut. There are only a few months before this goes into effect and they begin to realize the behaviors of the managed care plans and the Medicaid expansion population in order to get a sense of what they need to ask for in the budget to keep them whole. Also, the feds are watching the block grants. It is important the providers collect good data, have close conversations, and monitor their fiscal reality. Mary is confident that everyone is working diligently to capture every piece of third party reimbursement.

If provider type 17 is perfected, Steve hopes this will be looked at as a recovery-oriented system of care. They have an opportunity to see what Medicaid is reimbursing, what the SAPTA dollars are, and what type of recovery support services SAPTA can build into their auxiliary services. An opportunity for the state is to possibly utilize Block Grant and general fund dollars for services geared toward treatment that third party payers do not pay, such as transportation. This is a perfect opportunity as a community to build long term care into the system. Becky

Bailey said that Chapter 400 will allow providers 26 unauthorized Medicaid fee for service visits, as well as HMOs. Mary clarified this being for provider type 14, and it is still unknown what will be done for those people who are type 14 and 17. It was said that Coleen Lawrence is developing a system using 17 with 82. Quantity limitation rules are different for the rehab option and for provider type 17. Mary cautioned they don't yet know if a type 14 can be billed in this new environment, and Mike Willden will need to understand the unintended consequences. Steve McLaughlin suggested forming a utilization management subcommittee to help build recovery support services into the treatment services grid and to look at what type of services to build around specific populations. It is a good opportunity to keep the conversation going then just at the advisory board level. They need to better define court ordered clients and what type of services can be provided for them.

Covered Services. This discusses what is in the treatment services grid and what needs to be revised. They must identify what levels of services are offered and what different non-traditional ASAM levels are offered. There are semantic language issues in the division criteria. Medicaid covered services is building on what Medicaid covers and how SAPTA will offer either auxiliary services or pick up those services Medicaid does not cover. Discussions with MCOs about getting on their panels may continue until type 17 is fully unveiled. This section needs to be examined more as a group and revised. There is a typo in the Certified Intern's Roles and Responsibilities section that states a clinical supervisor needs to be in there with the intern, but it should mean consult with the clinical supervisor. This section needs revised, as well. They must identify the interns' roles, verify the use of HCPCS and CPT codes, and determine individuals qualified under those codes to deliver services. It is not to limit interns' roles, but to identify their capabilities. Ester has many questions and will visit with Steve at a later date.

Required Documentation. This covers consent to treatment, client rights, confidentiality releases, substance abuse assessment of comprehensive evaluation, and treatment planning. They examined other states' standards and came to a consensus of what should be in a file when doing their reviews and utilizing the services. Ester asked the question if they have to turn a client away that is covered by an MCO which the program is not paneled. Mary reminded Ester that Chapter 100 of the Medicaid Services Manual lists both provider and recipient responsibilities, and each are responsible for assuring compliance with Medicaid rules and regulations. Recipients have to receive services from a Medicaid allowable provider, which for managed care would be a paneled provider. The expectation of Medicaid is for programs to refer those clients back to the managed care plans so they are able to access services. From a federal level, this is an area where SAPTA will audit and expect to see that programs are not using federal/state dollars to pay for clients that have another pay source. SAPTA is the payer of last resort.

A discussion was had about who pays for detox. It was said at the last workshop that Medicaid will not be covering social detox, which will be a service SAPTA will pay. However, Medicaid will provide reimbursement for medical detox. Steve Burt inquired what will be paid for an intoxicated individual. If only SAPTA paid, everyone coming through the detox unit would be a SAPTA client and they can just be admitted. However, now they must be run through the Medicaid eligibility check list which complicates matters. If a client does not have Medicaid, Ester asked should programs insist they go through the qualification process to become eligible, or do they accept them without Medicaid or insurance due to not everyone having CACs. Mary explained it is the same situation as an emergency room. There is staff to help people become eligible. Hospitals will do everything possible to enroll clients in a pay source; otherwise, there will be uncompensated care. Having the same rates as SAPTA keeps people from manipulating the system. It is in the providers' interest to capitalize the best payer source possible. A person may not be Medicaid eligible when they first walk in, but according to Mike Willden eligibility will be faster using the electronic process. People still need to be treated, and ultimately the client is the most important piece. This is what must be worked out until they do become eligible for some other third party payer. From an audit perspective, it is important to keep documentation. Mary spoke of the data that is needed for reporting in terms of what general fund to ask for back. She gave the example of non-eligible clients receiving services and agencies having to spend several weeks getting them eligible for a pay source. During that time, SAPTA will have to reimburse until they are eligible. They need that data in order to tell that story to the Legislature.

Utilization Management. This will not be implemented until FY15 due to certain things that must be done before SAPTA can perform these functions. As a subcommittee this could be better accomplished. They view the entire billing process and determine the NHIPPS or myAvatar systems. Kevin suggested discussing this in more detail within a subcommittee. Steve Burt discussed where it states on page 6 that SAPTA will act as an insurance

company, and presuming through myAvatar there will be more capacity to do checks on required documents, missing notes, assessments, and treatment plans which seems it would require additional staffing. Mary is unsure if this is what is needed for next year's budget concepts, or do they already have sufficient staff and resources. Currently there is a ratio of 1:7 for treatment analysts to programs. Part of the issue is not knowing where the feds will go, and the assumption is this is how many state programs are managing their business models. They need to start migrating in this way in order not to fall behind, and they are trying to align with what they understand the national practices to be. This will not be implemented immediately, but the conversation must be started so they end up in a collective place and is not a shock.

Grid Discussion

The grid identifies what is to be included in each level of service and the programs and what can be offered under those services. Some Level 1 changes are under the utilization management side regarding increased time of sessions and intensive outpatient. The treatment services descriptions came from comparing how other states operate and how they utilize ASAM and services that could be provided under each of the levels. It was a consensus taken across the country of what was offered, and this is what they were able to do for Nevada. Denise does not understand the utilization management regarding Level 1 session periods for adolescent and adult. Is this utilization management a suggestion or a regulation, and can they ask for extensions. This is something that needs to be revised in the manual, and as a group they can make these decisions. The hope is a Level 2 client can also act as a Level 1 so their length of stay would increase. Also, an IOP client could receive individual therapy on top of the IOP or after the IOP. Level 1 could be utilized for resistant clients for a few sessions a week and then reinstate them back into Level 2, which gives options for clinical services. Treatment allowances for a child are different than for an adult, so the group needs to work on what they are going to have for people up to the age of 18 or 21 and also over that age. The idea of moving an adolescent back and forth from different levels is cumbersome. Concerns are not only about utilization management but the consistency with various evidence-based practices. A comment that came from a state leader was that the new system would be more clinically driven than dollar driven, which frustrates Denise because her experience is exactly the opposite. Steve wants to look at this as a group in order to alter these utilization management practices to better serve clients. Severity of the client will have to be integrated within the criteria per the ASAM six dimensions, and how will it impact length of stay. Discussions were made regarding concerns of mechanisms, which are now being built and in the infancy stages. Mary called this intensity of need. Kevin said they are looking at flexibility and need not to think about the method but how they get it done.

A discussion was had about identifying the different levels of care and what will be included. Level 3 will be pulled apart and called level 3.1, level 3.3, and level 3.5. It doesn't mean facilities cannot be certified as a 3.3 and 3.5, but they should all have access to those different levels of care. Breaking it out also provides options for the client. They can work under each level 3 which is where SAPTA will be reimbursing for residential services. Level 3.3 is for individuals who have a functional cognitive impairment for which staff must be present to treat an individual that may have an MR or developmental disability. They want to ensure the client will be placed in the level of care for the services that they need. Opioid Maintenance Therapy (OMT) was changed and more counseling sessions built in. Steve spoke to Shirley Adelson, which they were able to identify her concerns and incorporate them. Ester asked if transitional requirements will be outpatient or stand alone. He discussed when transitional housing is implemented clients may need different levels of service, but not necessarily clinical intervention. This gives the provider flexibility to bill under a different payment source for a level of care. Social detox will stay as is. By the time this is implemented they hope to see a 3.7 and also the higher level of detoxification. The requirement of having clinical intervention for transitional housing will be examined, but it also involves building skills to transition back into the community. Civil protective custody will remain the same. The COD services have been revised. For comprehensive evaluation the amounts can be adjusted. Steve and Dr. Woodard will work on the assessment of the system which is going to change these services and make them more robust to meet the needs of the co-occurring client. Women's services have been filled in with more detail. As a group they need to identify the different components for women's services to better serve these individuals. There are caveats to the care of pregnant women, such as should there be a higher level of authorization or more services included under these service levels. Recovery support services offer a great opportunity as a community to start identifying what should be covered. Diaz commented this is exciting and positive.

The group agreed upon Steve's suggestion of forming a subcommittee to discuss these issues. Volunteers are Diaz Dixon (Chair), Steve Burt, Mark Disselkoen, Denise Everett (Quest), and unnamed individuals from Vitality, Bristlecone, Community Counseling Center, and WestCare. They will have a meeting sometime in January.

Kevin called for a break at 11:25 am.

Kevin called the meeting back to order at 11:37am.

8. **Discussion and Recommendations for the Division Criteria for Treatment Services**

Steve McLaughlin mentioned some items in the draft division criteria need to be removed, and he will reissue a clean copy at the next board meeting. The utilization management manual and the treatment services grid change the division criteria. Historically, it was believed using the word ASAM in the division criteria created a copyright issue; however, now it is gone. They are moving forward as a division to fully adopt ASAM and change the policy to read to that. In the existing criteria there are some contentions that it doesn't match ASAM, but actually looking at the different levels of service it does match. There are wording issues that need to be cleaned up to say that it does adhere to ASAM services. One of the wording issues was identifying transitional housing and CPC. These are a few things to fix in policy and to speak more to what the treatment services grid says. The treatment services grid is more detailed than the division criteria and identifies services. He questions whether this is something they can do to say the division criteria is actually the treatment services grid, which is actually the case because it takes the levels of service and identifies the grid and is more detailed than what the current criteria states. He is uncertain if this can be done or if the existing policy must remain and reference the treatment services grid. They can add something to the utilization management side for just the funded programs. He reiterated that the old division criteria are altered and some things must be removed. The existing division criteria approximate the ASAM level of care it is under. ASAM states in that programs and state programs have the ability to meet the needs of the state. There is an opportunity to identify specific Nevada program issues within the criteria. One issue could be said the placement is based on ASAM criteria. For example, Nebraska is going above and beyond ASAM. Again he questioned if the treatment services grid could also be the division criteria. Steve will take this to the subcommittee. The current policy must be reworded to ensure it is clear they have ASAM, to possibly go above and beyond at different levels of service, and to also offer non-ASAM levels of service such as transitional housing, CPC, and evaluation centers. They can build upon it or decide if the grid will replace it.

9. **Discussion and Recommendations Regarding the Uncertainty of the SAPTA Reimbursement Process**

This was originally brought up in public comment by Ester at the September meeting. Even though some issues delay reimbursements, at least it is a determined path. She believes it is better than what it was.

10. **Follow-up on Letter from the SAPTA Advisory Board to the Division of Public and Behavioral Health Regarding Medicaid Issues**

Kevin thanked the group and the state's administration for attending the special SAB meeting held on October 31. He appreciates that they had a good conversation and are on the road to getting issues worked out. One of the big issues of the meeting was getting providers paneled and getting the panels to refer clients to them. There will be a meeting regarding safety net issues between Kevin, Frank Parenti (NVADAAPTS), Mary Wherry, and Steve McLaughlin. The meeting is intended to discuss developing strategic plans if there is an emergency. If programs spend down too quickly in a time where there is less funding, there will likely be a crisis because the state has no extra money to fund them. Kevin's personal goal is to form an RFA process. Mary's biggest concern is how other providers will absorb consumers if some of these providers have to lay off staff, limit capacity, or close their doors. Not knowing the stability of the providers and how fragile or strong the network is a concern. She expressed it was wise for Kevin to ask for the meeting. Any input to be taken into consideration is encouraged.

Mike Willden from the Director's Office will be calling a meeting with the two MCOs and some of the providers. Kevin said unfortunately there may not be enough room for everyone to attend, so people from around the state from various programs and regions will be represented to ensure proper coverage. The meeting will talk about provider types 14 and 17 and Mike's follow up on other issues stemming from the October 31 SAB meeting. Mary's perception is that one MCO will be represented in the morning and the other MCO in the afternoon, and she is not exactly sure how the provider type discussions will be structured into the meeting.

Elaine Nelson from Community Counseling Center commented that the demand for services at their agency during the months of September and October have been in the 130 range each month, so their ability to provide services based on current funding is extremely tapped. They are only handling about two-thirds to one-half of the numbers being requested for services. She said they always refer clients to other providers, because their numbers are increasing and their services are limited.

11. **Update, Discussion, and Recommendations for SAPTA Treatment Standards and Subcommittee Report**
Mark Disselkoe discussed the draft manual. It was recommended the Treatment Standards Subcommittee be formed to develop some basic standards of practice, although it is not required. Other states have done this, but some of those manuals are too comprehensive. The subcommittee decided to do this in a more simplistic manner. It is a two step process. The first step is not necessarily related to standards of practice, but to understand NAC458. They looked at the current standards to make sure everyone was in agreement regarding the intent of the standards, so when doing a site visit they are not getting varying views of what this particular compliance standard is requiring. The second part is best practices, which go beyond the minimum standards compliance. They should always aspire to provide better services than even the minimum compliance. The draft is currently in bullet form, but will be submitted as a narrative after any other feedback is received.

Organizational Practices: For organizations to get prepared for managed care means having a good risk management plan. Sometimes programs don't understand what this means. Usually everyone is doing risk management to some degree but there is usually no policy or plan driving it, and there is no needs assessment to review what the liabilities and risks are financially for organizations. In fiscal management there are obviously minimum standards and Generally Accepted Accounting Principles (GAAP); however, he added some things regarding the differences between grants, the differences between contracts and third party payers, and the differences between Medicaid and Medicare. Diversification of funding is important to look at. Mark briefly discussed his different funding experiences while at Bridge Counseling. For organization ethical framework and practices, Mark focused on the governing board. He is thinking about their capacity, competency, and training. Many agencies get into trouble because their governing boards are either not active enough, do not have an ethical code, or are under qualified for what they are managing.

Human Resource Practices: This focuses on staff, professional development, supervision, competency, chain of command, and cultural resiliency and competency. These are critical in terms of do programs have actual staff professional development plans and are staff getting training and technical assistance as related to the specific services they provide. Clinical supervision is critical, and TAPS 21 and 21-A are utilizing that. Even if clinicians have been licensed for a long time there should be some level of supervision and building of competency.

Clinical Practices: Mark asked what organizations are doing to be driven by needs assessment. Many times organizations treat the same populations for many years because that is what they do or maybe they don't treat adolescents because they are difficult. What is provided by a treatment standpoint should be driven by their local needs assessment which is helpful when asking for state funding. Needs assessment does not have to be expensive because there is much archival data or data collected as an agency daily that is not used to making treatment or program decisions. If treating a special population, free tips and taps from the feds are used as part of program development and training.

The new ASAM manual is out. There are some new enhancements within the manual, but the dimensions are essentially the same. It is easier to go through the manual and for making decisions. CASAT will be doing trainings starting in January. Evidence-based practices discuss the NIDA Thirteen Principles. Principle Six gives them what is deemed evidence based by the feds. Mark will give guidance to programs for understanding evidence-based practices, if they are utilized, and if they are implemented with fidelity. There are simple ways to measure fidelity with flexibility. He gets into clinical practices, admission and assessment, utilization management, and individual treatment planning which goes beyond what the standards say. ASAM is a utilization management tool which provides criteria to help make decisions about levels of service from the beginning throughout the continuum of treatment and ultimately at discharge. Many professional fields that do not have an ASAM would benefit from having it. ASAM is very powerful and useful that provides boundaries to make clinical decisions and help build program systems. ASAM was not written with the intent to be "black and white," otherwise it becomes

too problematic. It gives a good standard foundation to build programs. Case management and coordination will be an important part of Medicaid and managed care. A very thorough case management assessment will be needed which often the ASI does not do. Programs must think about coordinating and building formally documented elements to better assess case management needs which need to be followed through. Mark will put into narrative form prior to the January meeting.

Mary commented that Medicaid only reimburses for six different categories of targeted case management, but she believes provider qualifications are restricted to governmental entities or quasi governmental, meaning Mojave. She said it is something to keep in mind in terms of Chapter 400, but will it be a path to pursue with the targeted case management Chapter 2500. As time goes on it will be interesting to monitor how many non managed care clients will be seen. The management of the clients will fall on the programs which are not necessarily getting reimbursed for those activities. For co-occurring and SMI clients that managed care has opted out, it is then reasonable for agencies to think about how to be recognized as a qualified provider. It opens a door for the programs because they are not governmental, but they are SAPTA funded and SAPTA certified.

Ester served with Mark on the Treatment Standards Subcommittee and thanked him for the work he has done.

12. **Discussion, Recommendations, and Approval of New Chair for Treatment Standards Subcommittee**
Since Frank Parenti is no longer with Bridge Counseling serving on the SAB, Kevin asked for a volunteer to replace him as Chair for the Treatment Standards Subcommittee. Steve Burt volunteered to chair the subcommittee and Bristlecone will add a representative to the subcommittee.

Tammra Pearce made the motion to approve Steve Burt as the new Chair for the Treatment Standards Subcommittee and Michelle Berry seconded. All were in favor and the motion was carried.

13. **Standing Item – Legislative Update Discussion**
The agency bill drafts are due by the end of May to the Director's Office. The Interim Health Committee will only be meeting for about six months, and Mary is unsure if they have started them. During the budget process the Legislature does not like to be faced with items regarding money if they are about public policy. If there are items the Board believes should be considered that are non-agency bill drafts or agency bill drafts that are public policy, then the Interim Health Committee is probably the forum to present those. It will then be about talking to a legislator to put them on the agenda for that topic. There is a short period of time for those interim policy discussions to occur. When public policy is presented to them for the first time in a budget, they are usually unhappy about it and funding becomes precarious; it is unknown whether they will support it or not. Kevin asked Steve Burt or someone from NVADAAPTS to develop a legislative agenda sometime during the week. At the last public workshop, Coleen Lawrence mentioned that Medicaid usually begins their budget concepts by February or March. If there are items the group wants Medicaid to reimburse for that are not in the current chapter, such as peer support services, they must be added into their budget concept. Medicaid does zero base budgeting, meaning if something is in their existing 2014 budget that is what their new budget will be based on. They must have a budget concept for anything above and beyond and have to price it out to be included in their budget. Steve Burt mentioned one of those items was to include the extension of provider type 17 to SAPTA certified and funded providers. Mary suggested they be done no later than March and notify Coleen.

Kevin will ask for an agenda item for January requesting NVADAAPTS to present some of these thoughts. Kevin, Frank, and Mary will be meeting via teleconference on November 21 regarding safety net concerns. Steve Burt said it is Mary's opportunity to walk into the new Legislative session with a clean slate. It would be best coming from the field, rather than Mary, to advocate for the changes needed for SAPTA. Mary said Avatar may also be part of that.

14. **Standing Informational Items:**

Chairperson's Report

No report was made.

SAPTA Report

Mary Wherry acknowledged and appreciated their patience during this time of transition and her learning curve to understand SAPTA. She apologized for not being as up to speed as she would like to be, if she has misspoken in any way, and for not giving the attention to the prevention side during this time. The Bureau Chief position will be opened this week as “open competitive” and encouraged all interested applicants to apply. Anyone in the private sector interested in applying must not minimize their application information. The recruitment screening process consists of lower-level staff that reviews the class concepts and language on the applications. If the applications are not worded correctly, the recruiters can say they are not qualified. Mary encouraged them to call her with any questions and to help walk them through the process. The payout of Deborah McBride’s position goes through February, but there is enough salary savings to hope fill it at the end of December. She introduced Becky Hepler who just filled Gaylene Nevers’ position. Mary believes her background as a front office manager for a southern California orthopedic physician practice where she was part of the design team for an electronic health records system will bring a lot of knowledge about third party payment and how the agencies’ businesses operate. She will be working with Becky Bailey from QuantumMark for the next month. Mary also reported that Tonya Wolf is leaving SAPTA to pursue a career with the WIC program, and Chuck will be working to replace her.

The SAPTA staff has been working aggressively to get the most current information about the agencies’ year-to-date fiscal expenditures. She asked the fiscal staff to establish a brief summary of each provider and how much is spent down per expenditure category to give a month to month snapshot to Mike via Richard. Category 10 should be spent first before the Category 28 Block Grant money. The treatment analysts will be in touch with the providers. There is no extra room in this budget, so there is no fail safe money for over expenditure. For some providers, spending is in accordance with the fiscal year. For example, if it is 42 percent of the fiscal year through they are spending about 40 percent of their dollars. The worst case scenarios for those providers who have been able to siphon off money in accordance to their fiscal year progress would still have some money. For those that over expend, the result would be taking money from other providers. They have to be conscience about monitoring dollars so that over expenditure of categories does not occur. The conversations with treatment analysts over the next three to five months will be very important.

They had to resubmit an MOE waiver request that was supposed to be done last year for SFY12. The maintenance of effort requirements were not met, so they are hoping the feds will grant the waiver. If not, the worst case will be a cut to the Block Grant. Seven other states have also requested waivers for this same time period. Economic indicators such as unemployment rate and tax base are examined. They compare it to 2010 – 2012 trends which for Nevada the unemployment has gone down and the tax base up. This is the opposite of why they would grant a waiver. Mary compelled them to look at other economic indicators and compare Nevada to other states because it still lags behind in terms of recovery. She is not sure when she will get word.

Due to the ambiguous nature of the federal budget, SAMHSA’s site visit to Nevada next week was cancelled. The CSAP group will be coming out February 25 to 27 and their focus will be on prevention and SYNAR. It is formally called a systems review which they are supposed to come out every four or five years, but it has now been eight years. They are asking for SAPTA to send them information electronically for their three-day meeting. One day will be all about SYNAR, but there will be time for them to meet with community coalitions. Even though it is a systems review, it is a technical assistance. They have acknowledged SAPTA has done very well on the prevention side, and they hold up the coalitions as a model. They are looking at where SAPTA is and how they can help us.

Mary spoke about NHIPPS and myAvatar. Becky Bailey now has 100 percent feedback on the Avatar survey. Mary will gather the information which she may be asked to share at the IFC in December. She gave them a one-paragraph written informational update last week. She is hoping they don’t call her to the table because there are still a lot of unknowns. NHIPPS will remain until it is migrated toward myAvatar. She is working with the project manager to determine what the data warehouse functionality could be. She questioned if they capture a large percent of federal reporting requirements and use NHIPPS for the remainder, could the data warehouse get 100 percent of data by downloading from the award system and from NHIPPS to match the client level. Theoretically the answer is yes but the pricing is unknown. If providers could afford the alternative of having some staff on myAvatar in different time increments, the data warehouse could be a repository for a business that has, for

example, 20 percent users on myAvatar and 80 percent users on NHIPPS. This may be a solution for programs that cannot afford to buy licenses for all their named users at this point in time. Although Mary presented this as a game changer, the IFC has not reversed their decision. Steve Burt suggested Mary forward the December IFC meeting agenda to the programs in order to prepare to filibuster that agenda item until they consent. Amongst them all having significant historical knowledge of how this has played out since CDS, they know what needs to happen. The recommendation or decision to switch to myAvatar was not fully researched, and the political challenge is not having money to buy licenses for every named user. Mary has been asking questions since stepping into the SAPTA role. The survey results are in and the math shows 376 named users needed, but it is assumed it will be around 500. Steve Burt commented that much volume cannot possibly be charged, but Mary said it doesn't go down much. She can't give an exact number until NetSmart gives an exact quote. 83 licenses were purchased after the August IFC – approximately 17 for SAPTA and the remainder for providers, and it is unknown how many more licenses can be purchased. Another dilemma will be created for agencies' business models if their entire practices cannot be added onto myAvatar. There are too many variables which Mary is trying to problem solve. The initial request was to use Block Grant dollars already set aside, but that was conceptually purchasing myAvatar for SAPTA without understanding the nuances of pricing for all named licenses. Mary believes myAvatar is a great product and would be very useful for the programs to manage their businesses; however, it is how to figure the mechanics of getting from here to there. A big part of the solution would be to use NHIPPS hand in hand with myAvatar until it is affordable for all users. The Avatar workgroup consisting of the Net Smart team and DPBH IT staff will be assigned to develop the project plan. Mary wants to know when they will begin engaging the community and the representatives from the last Friday provider call in developing the Avatar system. Mary will continue to give updates as they come in.

The SAPTA and Mental Health staffs have done a great job applying for grants this last year. Dave Caloiaro has two new grants: the Safe Schools Grant (Nye, Lyon, and Washoe counties) which is \$2M for year one and \$2.2M for the next three years and the CABHI Grant which is about \$700,000 for three years. Coalitions are heading the discussions for Washoe County, along with Kathleen Sandoval. The Safe Schools Grant is focused on having healthier schools by ending situations of shootings which happened at Sparks Middle School, ending bullying, and ending substance abuse. Rob Jones is the lead for the CABHI grant which is to house the mentally ill/co-occurring population. A data link is hoped to be created between Avatar and housing to ensure there is congruent information. These grants are from SAMHSA and are cooperative agreements which are involved in teaching lessons from other states with these types of funds to have successful implementation. SAPTA also received the Preventive Framework Grant which is \$2.2M for five years which focuses on prescription drug abuse, veterans, and suicide. There is no new state staff, so all the money is going out to the community. When the co-occurring assessment is complete, it will help them compete for additional funds.

A newsletter was started last week to raise questions and give people an overview of health care reform. Mary encouraged everyone to submit ideas for anything they wanted written. In the newsletter there is a link connecting to Kathleen Sebelius' news conference on substance abuse and mental health parity. Also, Mary printed information from the Parity Implementation Coalition website and an FAQ on the Department of Labor website regarding mental health and substance abuse parity. Mary will leave those documents to review for anyone interested. The final rules have been issued which to into effect July 1, 2014. Final comments are being taken until January 8, 2014. People who have a mental illness or substance abuse addiction should be entitled to the same amount of services with similar utilization management rules as anybody with a medical surgical issue. Mary believes disparity came from psych mental health in the 80s and early 90s from those who kept patients until private insurance was exhausted, which helped to create the nightmare of insurance companies not be willing to have parity with mental health. They have to be careful not to reinvent history.

Mary acknowledged the programs' great work in keeping their missions true. Chuck ran a report showing unduplicated treatment clients admitted and served which have continued to climb every year without the programs having new money. She gave some statistics of number of services and average units per treatment client served in 2010 to 2012.

QuantumMark's contract with SAPTA will end in December. Becky Bailey will no longer be available to provide assistance, so Becky Hepler and the treatment analyst will be a resource to the programs to help them in any way possible. QuantumMark has done a great job in helping with the Medicaid enrollment process and with improving communication via the Friday calls. Lisa Tuttle will be setting up those calls via teleconference in the future. Mary wants to make sure everyone is taking advantage of maximizing opportunities in obtaining Becky's help with the managed care plans while she is still here.

During the safety net discussions, Mary's big concern was wait list. Chuck gave her capacity management for substance abuse treatment systems documents from the feds, but she has not yet had the chance to read through them. A new definition of wait list will be established as they go into this conversion with managed care. The priority population is pregnant women first, then adolescents. The treatment staff will be reaching out to the agencies so they understand the importance of documenting wait list and how to report it. The current NHIPPS data around wait list is messy. Mary needs that data in order to tell the story to administrative staff and the Legislature so it is no surprise to them if clients cannot get placed.

Mary received the Medicaid ACA caseload projections document which was completed in September 2013. She gave some statistics of what is anticipated for new enrollment based on the Medicaid expansion for people with no children ages 19 to 64 and parents ages 19 to 64 starting January 2014 to June 2015. By the end of the biennium 149,299 people are expected to be covered by Medicaid.

Mary found an article on therapists who are exploring dropping their solo practices to join groups. At the October SAB meeting, Richard mentioned this presented an opportunity for people to think about how they do business. It seems the private sector is also moving toward integrated care because it is hard to exist as a single practice due to challenges with reimbursement.

Responsible for epidemiology, Mary wanted everyone to be aware of the news article about the Las Vegas Caucasian woman diagnosed with tuberculosis (TB) that delivered twins. All three died and were flown to California. Her family and many people at the hospital where this occurred were exposed. Currently, there is a TB case at one of the Las Vegas middle/high schools, and there is another case that is atypical. This is being mentioned because not all staff or clients follow through with getting routine TB testing. From a public health perspective many are concerned with the events occurring from this disease. It is not following the normal trend which is seen historically from migrant workers or people from other nations coming into the communities. There are multi-drug resistant problems in treating people with TB. She encouraged their staff and clients to get tested annually. The risks will be monitored more closely. Steve Burt said testing has become more complicated. The excuse is a serum supply and demand problem. Whether that be true or not, it has become more complicated because they now have to do the Mantoux test for people coming out which delays the process another week.

Mary said SAPTA has been set as the priority to receive TB testing. If an employer sends people for OSHA purposes that are not SAPTA related, they will not get PPD test right away. She stressed everyone to re-educate their staff on the signs and symptoms.

Nevada, along with four other states, become qualified for a governor's association learning collaborative for improving birth outcomes. She gave thanks to Barry Lovgren for being proactive in making sure SAPTA and the maternal child health program is doing everything possible to get women into prenatal care and into substance abuse treatment for healthier birth outcomes. The client can be considered the core; however, these babies are being born without informed consent to a disease process they inherited because of choices by the mother. They will be working to develop a state plan for this learning collaborative. The expectations of SAPTA and the maternal child health program for both prevention and treatment are to adhere to the state plan and do everything possible to prevent negative outcomes. The prevention side has realized the opportunity to step back from what has always been done, examine root cause, and determine bigger strategies. SAPTA received a great article from Christy McGill regarding a few organizations committed to ensuring that kids have access to food for school and playgrounds for activity. Those companies realized they did not set their visions high and were not aggressive or focused enough on public policy changes and prevention opportunities. The Block Grant will have to be modified once the state plan is solidified as a result of the birth outcome study.

Kevin was thankful for Mary's insight regarding the coalitions. During a two-hour teleconference meeting yesterday about the role of the coalitions, there was an agreed consensus that they are not just about drug and alcohol but many things, and this how it is currently trending in public health. From a public health perspective the goal is to have healthier citizens, which is probably why BETA was originally with public health. Many systems can be broken down, but it is all part of an integrated process. Those in prevention activities serve a critical role, and DPBH is interested in partnering with them because the local health authorities tend to have a fairly narrow scope. The goal is to grow the prevention coalitions to be a local lead agency for the public health entity.

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

Michelle Berry reported the CASAT training site is getting a makeover. Within the next few weeks there will be noticeable user friendly updates. Registration for classes will be the same, but it will provide more across-the-board training in order to know what is happening regionally with projects at the ATTC level and at state levels. Michelle had questions about CBT training which were coordinated with NVADAAPTS and Aldo Pucci. It was intended to be a TOT, but there was miscommunication with the trainer which resulted in only a level-one certification, of which five levels of training are needed before moving on to TOT. They are currently working with the trainer to circumvent the cost because they want to provide a TOT to people who have initially gone through that level-one certification. Michelle is hopeful the next series of trainings will begin in January and move through March. The new catalog will be ready for distribution the second week of December. They will offer some new classes along with update classes, such as the ASAM and DSM V. Also, the clinical supervision series will continue. They worked with the Board of Examiners to provide the first year free, but starting January they will no longer be free. The last in-person training will be November 21 – 22, 2013. Call Michelle with any questions.

15. Review Possible Agenda Items

- Co-occurring presentation by Steve McLaughlin and Stephanie Woodard
- The board should investigate how to reach out to other occupational boards in the wake of all the changes to improve communication and cooperation.

Kevin commented there are biases and stigma issues within the field. He finds it difficult that an MFT with no drug and alcohol experience can be paid by Medicaid to perform those services; however, he cannot get paid with having 40 years experience. Mary said that discussion should occur with the Interim Health Committee. The mental health system is having the same challenges because staff cannot afford to pay for clinical supervision and their time, so there are many barriers for people to engage in a workforce development process. This is a conundrum the Legislature is faced with, and she doesn't believe it is done in a very well organized manner. Kevin feels the big issue is workforce development, which the strategies may be working with the occupational boards and finding ways to reach out to IFC. Thoughts need to be developed about that within the field.

- Sliding fee scale items that Steve McLaughlin mentioned were not being funded by SAPTA, such as recovery support services. They should have a conversation as a board to determine how this will work.
- ADAAPTS to give a report of the legislative agenda and discuss ideas.
- Verify the Bridge Counseling board representative; Yolanda Correa is in attendance at this meeting.

- What will be the most efficient COD strategic plan and how do they obtain the right information. Steve Burt suggested sending the presentation and they will have a Q&A on the agenda. Kevin wants to talk with Steve McLaughlin about how they wish to present this.
- Dave Caloiaro to speak on the Nevada Peer Support Plan and Activities.

16. **Public Comment**

Barry Lovgren found in August 2009 the number of pregnant women in Nevada receiving substance abuse treatment had fallen by half since 2004. He believes the reason there was no decrease in the number of pregnancies and no evidence that the rate of prenatal substance abuse had fallen is largely due to the lack of publicity of available treatment and admission priorities for pregnant women, and that the sliding fee scale did not make treatment affordable. He addressed these problems to many public bodies, but the number of pregnant women receiving substance abuse treatment continued to fall and bottomed out at a third of what it had been. Other than co-occurring disorders, he found substance abuse was outside the purview of both the Mental Health Planning and Advisory Council and the Mental Health and Developmental Services Commission. He found more problems such as certification criteria for co-occurring disorder treatment never having been lawfully established. He is pleased that progress has been made toward a resolution. The SAPT Block Grant Application finally meets the federal requirement describing how treatment and admission priorities for pregnant women will be publicized. SAPTA and MCH are working on a statewide, multi-media public education campaign on services for pregnant women. The draft sliding fee scale is based on the federal poverty level. The Mental Health Planning and Advisory Council has become the Behavioral Health Planning and Advisory Council and the Mental Health and Developmental Services Commission has become the Behavioral Health Commission, with substance abuse services now within the purview of both public bodies. He reported the number of pregnant women receiving substance abuse treatment has rebounded from its all time low; however, it's only back to where it was in 2009. He wanted to acknowledge that progress is being made.

Denise Everett personally and publically thanked Mary Wherry for reaching out as much as she has to the providers. From Denise's perspective, Mary has learned a significant amount of knowledge in the short time she has taken over. She thanked her for putting time, energy, and effort into being a wonderful advocate for their field.

17. **Adjourn**

The meeting was adjourned by Kevin Quint at 1:05 pm.