

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

MINUTES

DATE: October 31, 2013

TIME: 1:00 pm

LOCATION: Division of Public & Behavioral Health
Substance Abuse Prevention & Treatment Agency
4126 Technology Way, 2nd Floor Conference Room
Carson City, NV 89706

Video-Conference

Desert Regional Center
1391 South Jones Blvd., Room 129
Las Vegas, NV 89146

Northern Nevada Adult Mental Health Services
480 Galletti Way, Bldg. 25
Sparks, NV 89431

Division of Public & Behavioral Health
1020 Ruby Vista Dr., Video Conference Room
Elko, NV 89801

BOARD MEMBERS PRESENT

Carson City Site

Kevin Quint
Michele Watkins
Steve Burt
Lana Robards (via teleconference from Fallon)

Join Together Northern Nevada
Central Lyon Youth Connections
The Ridge House
New Frontier

Reno Site

Diaz Dixon
Tammra Pearce
Michelle Berry

Step 2
Bristlecone Family Resources
CASAT

Las Vegas Site

Kay Velardo – Proxy for Ron Lawrence
Jamie Ross – Proxy for Brad Greenstein
Debra Reed
Kevin Morss – Proxy for Richard Jimenez

Community Counseling Center
PACT Coalition
Las Vegas Indian Center
WestCare

Elko

Ester Quilici – Proxy for Dorothy North

Vitality Unlimited

BOARD MEMBERS ABSENT

Ed Sampson
Representative

Frontier Community Coalition
Bridge Counseling

STATE OF NEVADA STAFF

Carson City Site

Lisa Tuttle (recorder)
Mary Wherry
Theresa Carsten
Alexis Ulrich
Coleen Lawrence
Brandi Johnson
Mike Willden
Richard Whitley
Dr. Tracey Green
Laurie Squartsoff
Betsy Aiello
Gary Steele

SAPTA/DPBH
DPBH
DHCFP
DHCFP
DHCFP
DPBH
DHHS
DPBH
DPBH
DHCFP
DHCFP
DPBH/IT

Las Vegas Site

Kim Davis
Steve McLaughlin
Tam Villar

SAPTA/DPBH
SAPTA/DPBH
SAPTA/DPBH

PUBLIC

Carson City Site

Kim West
Stuart Gordon
Denise Everett
Tray Abney

QuantumMark
Family Counseling Service of Northern Nevada
Quest Counseling
Bristlecone Family Resources

Las Vegas Site

Elaine Nelson
Anna Cedro
Judy Marshall
Greg Gibbs
Frank Parenti

Community Counseling Service
CARE Coalition
Las Vegas Indian Center
Amerigroup
HELP of Southern Nevada/NV AADAPTS

1. **Welcome and Introductions**

Chairperson Kevin Quint opened the meeting at 1:02 pm with introductions.

2. **Public Comment**

No public comment was made.

3. **Follow-up, Discussion, and Recommendations to the Division of Public and Behavioral Health Regarding Medicaid Issues for the FY14 State Budget and its Impact on SAPTA Funded Providers**

The purpose of this meeting is to discuss the position paper and the concerns of the SAPTA providers with the Division of Public and Behavioral Health (DPBH) and Department of Health and Human Services (DHHS) leaders. A letter was written by the SAPTA Advisory Board and signed by Kevin Quint back in June 2013, which was updated and converted into the position paper. The letter was generated and written based on comments and observations from the field. Kevin Quint recognizes there are some uncertainties and hopes these issues will be clarified in this meeting. The essential feature of the paper is that all the developments create great opportunities for the field and for their clients to be served. For those in the field, their concerns have been that the state does not see the issues as they do at the ground level. The goal of the meeting is to discuss these issues and to explore the options. Kevin will summarize each point and ask for conversation.

The first point involved the cuts to the SAPTA-funded programs for the current fiscal year that began July 1, 2013, which was understood to be 20 to 30 percent total equating to about \$6.4M for the Biennium. The Medicaid piece starts January 1, 2014. There are concerns on many levels that there will be some gaps. Richard Whitley agreed with Kevin's reduction numbers; however, some are not publically related. Sequestration relates to the Block Grant reduction and general fund was reduced in anticipation of clients being served, being Medicaid eligible, and being able to bill for those services. When the reduction was applied to the SAPTA state general fund the same logic was used for behavioral health in terms of percentage, knowing at the time the percent was low in the probability that there would be more eligible people. Since July 1, they have reconciled per provider how many people are currently Medicaid eligible by doing a match with Welfare, which is approximately 20 percent total. The handout from DPBH breaks it out by provider. The program has been giving feedback to individual providers when they seek reimbursement to how many people they serve were in fact Medicaid eligible. Richard believes what is important to Kevin's point is in reviewing and using criteria for expanded Medicaid, 89 percent of the clients in this last quarter will be eligible for Medicaid. They are confident that the dollars on the state general fund side of the budget will be more heavily used in the first half of the year. When clients are able to be made Medicaid eligible, in the global sense of budgeting, he believes they are covered with the margin of more than what was originally anticipated when the budgets were built and are revealed to be eligible for expanded MCD.

The question was asked about the determined Medicaid eligibility period. As a result of the exchange and how the new application process will work for Medicaid eligibles, Laurie Squartsoff from Medicaid explained that with the "no wrong door" application process the beneficiary will go to the district office or apply on line for Medicaid. The application is then submitted into the system and the goal for turnaround time will be between three to five days. 45 days is the maximum duration it takes for DWSS to make the determination for eligibility, but it is encouraging that there has already been a reduction in the turnaround time for eligibility determination because of the continued streamlined process and applications being submitted on line. The goal is to shorten the process to three to five

days to eliminate or reduce the necessity for having a presumptive eligibility. Lana Robards' team at New Frontier was given paper applications from the local Fallon office and was told to mail them in instead of delivering them, which she feels will extend the response time. Laurie said they can either be mailed in or taken directly to the district office.

The question was asked which percentage of clients would be eligible for health maintenance organizations (HMO) versus fee-for-service Medicaid in Washoe and Clark counties. Laurie expects 85 percent of Medicaid eligibles after the Biennium to January 2015 will be covered by managed care organizations (MCO) because the preponderance of clients are in Washoe and Clark counties, which is where services are provided through MCOs. In addition, they will have MCOs for persons with chronic illnesses that will be overseeing fee-for-service patients with care coordination for their services. The model is not the same as managed care, but it is a comparable type of service for the Medicaid client population (not for newly eligible clients) that will ensure access to appointments and coordination with transportation, labs, and follow up visits.

It was discussed that the newly eligibles by design, like childless adults or adults without dependent children, will be enrolled in managed care in urban Clark and urban Washoe counties. A question was raised about the expansion population being allowed to disenroll if they have an SED or SMI determination. Mike Willden does not know the details, but the plan is evolving and the goal is to keep those clients in managed care if possible. Per Laurie there will not be a separation between behavior and medical health; it's the care of the particular patient. A struggle currently with providers that Mary hears during their bi-weekly calls is their current enrollment as a provider type 14. Chapter 400 has a set of associated rules, and some providers already work with MCOs and are enrolled on their panels, but part of their anxiety is the unknown about how this will directly affect their business practices. The SED/SMI determination process is a part of the existing structure. They will have to begin designing their staffing models and financing around determining today versus January going from provider type 14 to 17 and Chapter 400 being expanded to include the substance abuse population. It is those questions that emerge with what other rules will change. Stu is aware that one of the HMOs is planning to provide services on their own; therefore, there will be overflows on mental health which will have a huge impact on their agencies. He expressed they are a board of trustees that represent the citizens of Nevada. Many providers may be in jeopardy of going out of business if they don't recognize the provider type 17. They should be concerned for the citizens that these traditional organizations that provide will be lost in this move. Kevin reiterated this is not about individual agencies surviving. The letter states if the current system doesn't survive then who will treat the most chronic people, and he doesn't feel the for-profits will provide this service. This is the heart of the whole issue. What will happen with the capacity of the field to continue to do what it has been doing for 40 years in Nevada? Richard expressed they are facing the same situation with managed care with mental health on the behavioral health side. A discussion point they are currently having with them is do they have an adequate network for this population which they haven't before served. This conversation is happening with both substance abuse and the severely mentally ill. He suggested they revisit this to determine where to go from here, the role, and how it relates to SAPTA providers. Steve Burt believes the managed care issue had developed as a primary issue. It has the potential to water down the field and also presents the opportunity to create additional barriers to treatment for clients. He is worried about running a client through 13 steps before they are seen. The federal Block Grant requires access to treatment to be minimized, and he questioned whether the MCOs need to assess them. Steve agrees with Stu's concern about clients coming to the agencies which will not be able to serve them. They will have to refer their clients to the MCOs to be served by people that are not skilled in this area. He is wondering how this will work and will it create additional barriers to treatment.

Denise Everett wants clarification on a discussion had with HPN telling her the agencies will get the overflow of their clients if HPN cannot serve them. She was also told that clinicians who see clients would have to be credentialed with Blue Cross Blue Shield and Humana. She doesn't understand how they can be both guarding and spending the dollars. Stu's other fear is the traditional workforce that sees clients will be cut off from the provider type 14 program, and will there a workforce in the community to take care of these clients. The numbers will jump as more people are eligible for Medicaid. He doesn't believe the MCOs understand the amount of treatment some individuals require, including the severely mentally ill. Per Laurie, it is helpful to know that Medicaid and DPBH had many meetings with the managed care plans to articulate on behalf of the beneficiaries with the issues everyone will face with the expansion on January 1, 2014. These are not typical patients that MCOs have historically cared

for. The state oversees those contract dollars, and they have a business lines unit that carefully manages the contract and its oversight with their two managed care plans. She understands and believes it is helpful to be gathered together and share concerns to understand the entire process in order for agencies to interface with managed care plans and to know what their criteria are for becoming certified as a provider within their network. Those are decisions made by the managed care plans. Sharing agencies concerns with the MCOs will better prepare them and set up their systems so they are able to accommodate and assure agencies there is adequacy of providers within the network for people coming into the program.

The message the field is getting from the MCOs is they will not use any provider below an LADC (which is 90 percent of the programs' workforce) and not being able to get on panels, or if so, not be used. The programs have no control of what happens. When Stu spoke to Medicaid someone told him that it is not their problem. The MCOs do not appear to be willing to participate. This meeting gives Administration the opportunity to hear from the SAPTA providers and get additional information to understand their issues. There were similar concerns with the behavioral health side with managed care. They discussed having a meeting with managed care on this topic with substance abuse to explain the client population and to quantify with numbers. Laurie is not sure there is a distinction. John Whaley with DHCFP will have a special meeting for SAPTA with managed care plans. Mary touched on the public Medicaid workshop yesterday and Hillary Jones made it clear that the MCOs are intending to now enroll the SAPTA providers. The MCOs were provided with NHIPPS data to give them an idea of how many clients are served and what services are provided. Mary stated how many services SAPTA may have paid for in the past will certainly not be the same amount of services they pay in the future when it's managed. QuantumMark has agreed to perform the same liaison function between both MCOs to help with the enrollment process, and they will be discussing this process during their provider call tomorrow. Per Hillary Jones the enrollment would be under provider type 17. Steve Burt wondered if it is a requirement by Medicaid that the units requiring the MCOs accept them as provider type 17 or is it still optional. Questions were asked if MCOs will recognize provider types 14 and 17 or only 17. Coleen Lawrence said they are still working through how provider types 14 and 17 will work together in collaboration. They are working with the managed care plans for provider adequacy and provider network issues. A concern for Steve Burt is that alcohol and drug abuse technically falls under a LCSWs or MFTs scope of work, but not necessarily under their scope of competence, and they need to be careful of their workforce in terms of trained individuals with substance use disorders. Those who are eligible to serve alcohol and drug clients can do great harm if they are not properly trained. Coleen said they currently have that issue in Chapter 400 because they rely on the licensing boards to monitor what happens with people for proper oversight of the clinicians and that is why they have been a supporter of this model for substance abuse. Policy says the individual professional must be within their scope of licensure. If there are two MCOs of which the majority of Medicaid clients are under and neither one of them recognize provider type 17, then this will not work. This doesn't make sense to Denise because provider type 17 is only viable in the rurals. It was discussed there may differences between the provider type 17s and those people who provide services for co-occurring disorders versus substance abuse. The focus is to create a delivery model for all the agencies here today. HPN told Denise that they do not recognize LADCs, nor will they ever. Betsy Aiello urged the providers to readdress everything with managed care. It is a moving target and they are looking at accepting those qualifications; however, it doesn't mean everyone with those qualifications will enroll. To be certified as MCOs they have to do added provider certification. The MCOs said they are looking at accepting that model, and Betsy reiterated for the providers to approach them. Mary Wherry said they are using QuantumMark as the liaison to make the connection on behalf of the providers with MCOs and they are collecting information in terms of the barriers they experience. Betsy said clinicians have to credential to be managed care licensed and to get the quality assurance for managed care. Their credential would be under their provider qualification but they have to do it in addition to Medicaid for all providers. Coleen stated they have to go through a process for the managed care panel whether it is HPN or Amerigroup. They go through the network providers for their own insurance. As far as them accepting or not accepting LADCs or CADCs she encouraged them to reengage the conversation about what is out there because some of the thought processes have definitely changed.

The uncertainty lies with the Qualified Health Plans (QHP). There is another 120,000 people purchasing insurance through managed care plans, and it is unknown how they will engage with those organizations. Quest has contracts with many insurance companies. Denise has highly-qualified staff to perform services for co-occurring disorders, which is not necessarily true of other programs. It is concerning that traditionally BCBS and Humana won't

credential LADCs and CADCs. Talking about how panels work with managed care, once a provider is in network for Medicaid they are also in network for substance abuse or co-occurring services. The Human Behavior Institute (HBI) may be subcontracting with those MCOs, which Mary believes may be the phenomena. Stu Gordon brought up that if a client comes into to apply for services in their program that has private insurance or the other form of Medicaid, they could not bill SAPTA. The client would be turned away to search for a provider who takes their insurance. Mary discussed a two-fold concern: (1) will the existing provider network for the SAPTA-funded providers be recognized by the managed care plans, and (2) if not, it starts to break down the long-term infrastructure of having qualified people to provide services to this population over time. It will no longer be an incentive for people to go to the Board of Examiners to get certified and move up the hierarchy because they will not be able to get jobs. If they cannot get hired many SAPTA-funded providers will have to close their businesses because they are their primary workforce. Diaz agrees with Mary and stated this is killing the field. It was made clear by HBI they will not pay for interns, which is the composition of most of their programs. Looking at these different credentials, he is guessing between 90 to 95 percent of people who are qualified to do everything in this big picture do not have a full understanding of substance abuse as a concept or disease. He described an example of someone he just hired having longevity of community involvement; however, they have had several conversations about how much she does not know about the field and how much catch up will have to be done. Because someone has particular letters behind their name on paper, it does not reflect the competence needed to deal with these clients. The clients will suffer and the bottlenecks will be huge. It is paramount that substance abuse and mental health clients get the most appropriate treatment as soon as possible. Programs must have great integrity because he is afraid clients will be viewed as targets for money instead of genuinely providing for their needs. It is about what programs can provide for clients and not what clients can provide for programs. Mary discussed this is one reason why SAPTA has been looking at creating some utilization management criteria. If SAPTA continues to have an open field that has no controls over the amount of services provided to an individual, it starts to create a two-tiered system whereas people are not insured by any product and could be covered by SAPTA and receive more services than if they had a product. This may create public outcry from those who are working, carrying their own insurance, or have taken responsibility to get Medicaid, etc., who will get less than those having no financial accountability and obtain as many services as they want. Balance is necessary so as not to have significant unintended consequences that become very political over time. The SAPTA-funded providers cannot be for-profit. Federal regulations and the Block Grant are very specific to being 501C3s. SAPTA-certified for-profit providers will continue to provide services, but probably not to the safety net population which the not-for-profits are providing. In the public health realm, counties and health authorities often are the safety net providers for many prevention and treatment services, which Medicaid and the MCOs would benefit from this understanding. The group discussed the maximum number of services allowed to be provided within a calendar year. For example, if clients using all their sessions at HBI clinics then come over to SAPTA-funded programs to receive services, those programs would not be able to get reimbursed. If cash flow is diminished and Medicaid or other insurance is not brought into the programs as anticipated, there will not be as much capacity. Kevin recognized the discussion about why payment is important to individualized care issues and how it creates a disparate system with one population that is capped and the other population that receives as much as they need.

Kevin questioned in the second bullet that if Provider Type 17 is not accepted can the state plan be amended. Mike Willden is uncertain of what the positions are, and he will assure they get a group of SAPTA providers to sit down with the two MCOs, Medicaid, and DPBH before January 1 to make this determination. It was discussed that SAPTA funds cannot make up the loss for agencies to be made whole from the 20 percent revenue reduction going to Medicaid because of the restrictions for billing Medicaid eligibles from the Block Grant due to payer of last resort. Non profits are not like typical corporations and are paid fairly small margins, so a 20 percent cut is close to being catastrophic. Mike does not make any guarantees, but he understands they will be somewhere different in two years than today if the Affordable Care Act (ACA) works as it is designed. They are trying carefully to have a good transition window to protect DPBH's and SAPTA's ability to be a provider. From conversations Mike has had with the MCOs he believes they understand this; however, there needs to be a clear understanding of what they say they will do and will not do. Mary made the point of there is a real anxiety for the more solvent providers because of the broader range in population base. If smaller providers go under there is no capacity to quickly absorb the volume of new treatment clients spread out throughout the State. Stu had discussions with Greg Gibbs at Amerigroup who indicated they are leaning toward approval of provider type 17. The group said they are seeing differences in approaches from the two MCOs. After speaking with HPN, Denise feels their intent is to serve

everyone they can and to give the providers whoever is leftover. Amerigroup has not been providing their own services and has been more collegial in working together with the providers. There are still glitches with reimbursement; however, her conversations with Amerigroup have had a different flavor than with HPN.

Kevin spoke on the next bullet which touched on eligibility and lag time. Some of the dysfunctional population who come to treatment will not sign up. Mike will share enrollment numbers in the next two weeks as soon as they close out October statistics. The October enrollment numbers are fairly robust. Also, August and September numbers were big because of the 5,200 new Medicaid recipients enrolling within the last 60 days. People are enrolling, not so much for the QHPs, and everyone coming through the system is being transferred over to Medicaid. As soon as it's analyzed, Mike will publically share the data and will be able to inform everyone of the speed of enrollment. Currently, there are two or three different models. One example is "one and done" meaning the client is only touched once and enrollment is taking about seven days. Other offices have different enrollment times and different models. It should through the end of December to roll out the best model in each office. Enrollment numbers are up and speed is improving. The goal is to enroll in three to five days. Dr. Green said they are facing the same issue with behavior health and the clients they serve. It is important to know that many of the substance abuse clients are behavioral health clients, so there is the great potential for them to touch the system in many places where there is an active enrollment process. 45 days before January 1 will be a direct focus for all Division of Public and Behavioral Health staff that interact with clients to begin actively enrolling as many as they touch. There is the likelihood of needing many sites where clients could be enrolled. She believes the focus on active enrollment is critical as we come to the end of November and early December. Mary discussed that SAPTA providers have engaged in the CAC training which QuantumMark has been tracking the numbers registered, the numbers completed, and the numbers of exams taken. They are committed to getting people involved. A key point will be the SED/SMI determination and whether it applies to the entire Medicaid population or just the core. Mike gave some statistics on the "no wrong door" which was spoken about earlier. There were 3,500 referrals from the Health Link to make a QHP/Medicaid application. Since closing and reopening Access Nevada they have taken over 5,000 new applications. This doesn't include any volume that came through the district offices nor does it yet include the new Medicaid eligibles.

Kevin discussed the next bullet on page 3 regarding the safety net. The recommendation is to construct the safety net plan to help articulate some of the steps when funding isn't yet received or how to help the perspective client navigate the system and still receive services if their payment source is not yet settled. He realizes some of the intricacies with the Block Grant and Medicaid. This is a complicated but necessary request, and it forces them to think about the cash flows and allocations of SAPTA-funded programs. Mary is interested in recommendations. All SAPTA treatment money within a state fiscal year from July 1 to June 30 is represented in their scopes of work. Once the money is spent by the providers on consumers, there is nothing left to distribute. Kevin said this is intended to construct a system for how the money should flow. He gave some historical facts on changes happening within the last year. It will impact how programs apply for money, what they ask for, and how they consider their own budgets. There are many unknowns.

Richard asked if the providers will be changing the design of their service delivery model to diversify in any way or expand capacity to create that safety net internally. Steve Burt said he will be adding the mental health components to diversify but not as a part of the co-occurring model; he will still keep the substance abuse model separate. He has a niche market in terms of working with criminal justice so it would be smart to do that. The providers are anxious because they are uncertain if they can be both a provider type 14 and 17. If they are SAPTA funded and can only be provider type 17, it will be a disincentive to become a provider type 14 because they will not be reimbursed. The provider of last resort applies to not just to Medicaid but also to private insurance. In theory, if the ACA works Nevada will only have 8 to 10 percent of uninsured population in two years so the providers' models will need to change. Behavioral health is looking to be moved to a community model. Kevin believes this will be an opportunity for the field to have greater chances of accessing funding for a greater number of clients. If SAPTA-funded providers cannot access a good portion of those funds that will create a gap. The way it looks now there will be some challenges and possible barriers for providers to get funding. Where is the safety net if there is less state funding and Medicaid cannot be accessed? Mike is uncertain what will happen with the ACA and has questions whether people will enroll in QHPs as heavily as projected; however, he has no doubt Medicaid enrollment will be extreme. Conversations are that counties are working with welfare and they will mass enroll

thousands of people within the next 90 days. There was a discussion made about the large quantities of people currently enrolling in Medicaid. Stu encourages HMOs to look at provider type 14 and 17 at both behavior health and substance abuse at intern levels above MFTs and LCSWs to have the ability to move people into the system to take third party payment. There must be a vehicle for people to get their internships and become fully licensed in order to serve Medicaid clients in the future. He also encouraged them to have dialog with the universities, otherwise they will not be able to find people due to the cutbacks in the intern programs. Coleen said with the next Legislative session professional associations need to help the licensing boards advocate for more resources for oversight of those interns. Currently, the largest issue is for the supervision and oversight of those interns in the state. A large concern is that internship rules are being abused within the licensing boards, which currently do not have the manpower. She understands the clinical need for it, but in fairness, also understands the licensing board's need for assistance. On the safety net piece, Kevin still wants to have a conversation on figuring this out. He shared his experience with the Nevada Health Link Website and the enormous cost to insure his family with the cheapest plan. He feels there will be more uninsured people due to the cost. Mike explained that people will make choices to be either insured or to be uninsured and pay tax penalties. For people under 400 percent poverty for a family of four the facts of how this works is an advanced premium tax credit (APTC) would be available to significantly lower premiums. They would have to evaluate all the tier choices of the plan and then apply for APTC to find what their net cost will be.

Mary said they will be working on the RFA in November and December and won't release it until after the January SAPTA Advisory Board meeting. It is her understanding they would have to meet quickly to determine how to design the RFA. Per Kevin, it may not be necessary to plan, but to just discuss the issues. Nothing may come from it, but it would be worth having a conversation about how they should structure themselves. Steve Burt commented that to release the RFA the first month into this entire new model does not seem reasonable because they need a few months to evaluate where their scope of work will be; otherwise, their numbers will be wrong. The challenge for Mary is that everything must be completed and signed through the system to ensure provider payment by July 1. They will schedule a meeting between now and January and make this the priority with the transition. It was questioned why they are doing grant applications if they are going with a fee-for-service model. Mary explained the state has to know how to contain their budget to not exceed their authority. The process is managed by the dollar amounts in the budget linked to the number of clients seen by the providers and the dollar amount cap associated by funding categories in their sub awards. If not contained, the providers would not know how much money they have. It was suggested to brainstorm ideas and to think outside the box to create a new environment for SAPTA funding.

The next bullet is regarding the current SAPTA predictable payment versus the capacity for Medicaid to pay timely. Laurie said the turnaround time for Medicaid checks to be cut for providers are consistent, and they are likely to receive reimbursement the following week after claims are submitted. As long as there is a timely billing and it is a "clean" claim, then there is an ongoing weekly reimbursement of services. There are Hewlett Packard (HP) trainers who can be scheduled to come out to individual businesses that have the capacity within their fiscal intermediary to address those concerns. A collective group or an individual can contact HP to schedule trainings. Today at 4:30 pm, Mary will contact Jennifer Schaefer, supervisor over the HP provider training. She will recommend them partnering with QuantumMark to be the liaison to the providers to set up a training schedule. Coleen said the SAPTA providers are already in line for training.

The last bullet presents the idea that the ACA is a for-profit business model. In the history of Nevada and the country, the non-profits seemed to be the last in line to receive payment. The heart of the concern of the letter and this position paper is to make sure this doesn't happen, if at all possible. In the opinion of the providers, if the system diminishes then the capacity to treat chronic people will also diminish greatly. Dr. Green will clarify through Medicaid if there is an opting out from managed care into fee-for-service for those seriously mentally ill and/or high end users of substance abuse systems. It will be critical that DPBH and the providers work together to serve this population. As she understands, interns are covered under the provider type 17 fee-for-service. There will be a large population of people that will now have a fee-for-service Medicaid card that will either be opted out of managed care and/or be inappropriate by their determination as an SMI or high utilizer. They will be moving forward as a team in the future to continue to serve these individuals. She believes the system will allow for serving them and giving them the benefit of a Medicaid card for pharmacy, primary care, etc. Perhaps it won't be

available, but they constantly understand that managed care will continue to own these difficult individuals. However, as they see this roll out occur there will be more Medicaid fee-for-service for them to assure they continue to get the services that are being provided. It is the goal of DPBH to work with the providers to create their own behavioral health home for those individuals on fee-for-service Medicaid. A system must be created for clients, not just a card. Moving forward DPBH will approach the providers to examine that population because there will not be wrap around services available through the MCOs. DPBH will partner with the providers to assure people will continue to receive their substance abuse and co-occurring services. Kevin appreciates there is access to a system of services.

The summary section of letter describes the system to survive, safety net, access, and workforce. They want to ensure that clients get choices. Current literature talks about the needs for clients to be involved in their own care, and one way to do so is to choose providers. If they choose a non SAPTA funded provider, it would be their choice. The state has recognized the system with SAPTA as viable and having high standards with a skilled workforce. Kevin stressed he is not fighting for one individual agency to survive or an individual person to serve but that the field needs and depends on the capacity of this particular skilled workforce to work with this population.

Denise asked about clarification on the handout from DPBH regarding client Medicaid eligibility. Richard explained that it was not based on current eligibility but on expanded Medicaid beginning in January 2014. She expressed over the last few months a missing piece for the providers is being left out of most conversations with subjects that touch them on multiple levels and hopes they can be involved in more of the process. She heard Richard say in the past to create a committee for discussions to include providers, but it has never happened. There is a lot of expertise in this field, and perhaps the providers could have been of use and help in conversations. She recognizes things are changing and wants to what is best for her agency, funding sources, and regulatory sources. Steve Burt agreed. He commented that the public workshops have been very helpful. However, he feels they have been talked at and not with during the Friday calls, but still is getting good information. He appreciates the transparency from the Medicaid office and always has a better understanding of more when he leaves the meetings opposed to other meetings. Kevin also agreed with Denise. He appreciates everyone that came together for meeting. The state culture is different than the non-profit culture on how business is done, and it is a matter of keeping conversations open. Laurie asked everyone to contact them to keep the conversations going. Ester spoke about non-profits and how they are a people business. In some cases, they have to manage well with a lot less. When everyone is at the same table they hear the whole conversation, and not a filtered one. Vitality is a statewide provider and needs access to the HMOs because of their clients coming in from Washoe and Clark counties with co-occurring disorders that are hard to manage, which other providers will not take. Vitality is considered a rural program which has its advantages; however, it also means they don't have access to the professionals in the urban areas. Before today, the complaint was receiving piece meal information. It is important to understand they need to have access to payer sources that the private sector has. They provide far more services and each time they bill it means less money because it is not a true fee-for-service business. If they could receive more money from SAPTA, they would be billing more services than today. They may be the only non-profit in the entire system that bills for a large portion of insurance. If it can be set up to call insurance companies to obtain prior approval, it will be a boom to the system and it will take more clerical support than ever intended. Ester thanked everyone for listening and thanked Kevin for organizing this meeting.

Kevin thanked Ester, and he mentioned that his concluding comments were what Ester had just summarized.

15. **Public Comment**

No public comment was made.

16. **Adjourn**

The meeting was adjourned by Kevin Quint at 2:45 pm.