

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

MINUTES

DATE: July 10, 2013
TIME: 9:30am
LOCATION: Truckee Meadows Community College
Redfield Campus
1800 Wedge Parkway
HTC Room 103
Reno, NV 89511

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

Great Basin College
1500 College Parkway, Room 121
Elko, NV

BOARD MEMBERS PRESENT

Reno Site

Kevin Quint (Chairperson)
Michelle Berry – for Nancy Roget (Vice Chair)
Diaz Dixon
Steve Burt
Lana Robards
Amy Roukie – for Maurice Lee
Michele Watkins
Christy Navarro – for Ron Lawrence
Tammra Pearce

Las Vegas Site

Brad Greenstein
Frank Parenti
Debra Reed

Elko

Ester Quilici – for Dorothy North

BOARD MEMBERS ABSENT

Ed Sampson

STATE OF NEVADA STAFF

Reno Site

Charlene Herst
Lisa Tuttle (recorder)
Chuck Bailey
Tonya Wolf
Betsy Fedor
Sheri Haggerty
Dave Caloiaro
Mary Wherry

Las Vegas Site

Kim Davis

Via Teleconference

Brandi Johnson

Join Together Northern Nevada
CASAT
Step 2
The Ridge House
New Frontier
WestCare
Central Lyon Youth Connections
Community Counseling Center
Bristlecone Family Resources

PACT Coalition
Bridge Counseling Associates
Las Vegas Indian Center

Vitality Unlimited

Frontier Community Coalition

Prevention, SAPTA, DPBH
Admin, SAPTA, DPBH
Data, SAPTA, DPBH
Data, SAPTA, DPBH
Treatment, SAPTA, DPBH
Data, SAPTA, DPBH
Mental Health, DPBH
Deputy Administrator, Community Services, DPBH

Admin, SAPTA, DPBH

Central Billing, DPBH

PUBLIC

Reno Site

Ian Curley
Denise Everett
Kelly Bown
Becky Bailey

Rural Nevada Counseling
Quest Counseling
QuantumMark
QuantumMark

PUBLIC

Las Vegas Site

Jamie Ross
Anna Adams
Judy Marshall
Pat Nelson

PACT Coalition
CARE Coalition
Las Vegas Indian Center
Foundation Recovery

1. **Welcome and Introductions**

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

2. **Public Comment**

No public comment was made.

3. **Approval of Minutes from the May 15, 2013, and June 12, 2013, Meetings**

Two sets of minutes were presented for approval. Ester Quilici made a motion to approve the May 15, 2013, meeting minutes and Steve Burt seconded the motion. Ester Quilici made a motion to approve the June 12, 2013, meeting minutes and Tammra Pearce seconded the motion. All were in favor and the motion was carried.

(Kevin Quint began discussion with Item #6, Discussion and Recommendations Regarding the DSM V. He wants to discuss Items 4 and 5 when Dr. Green arrives at the meeting. However, if she is not able to come, they will revisit the items afterward.)

4. **Discussion, Recommendations, and Approval of Advisory Board's Letter Regarding the State Budget for FY14-15 and its Impact on SAPTA Funded Providers** (discussed 7th in order)

Kevin wanted further direction on the letter which was approved by the group at the SAPTA Advisory Board Meeting held June 12, 2013, and sent to Deborah McBride, Richard Whitley, and Dr. Tracey Green. Many subjects in the letter had been addressed during the SAPTA Providers Medicaid Training held on June 25, 2013. He had intended to rewrite another version of the letter which still addressed a few gray areas, but wasn't able to do so prior to this meeting. He will send it out when updated.

Kevin agreed with Tammra Pearce's suggestion that it would be beneficial to add data about the cuts. The programs received information about their cuts from the Division after the letter was written, so the information was not known yet. He suggested not only to look at numbers but the potential impact, because this is much of what the letter addressed. What prompted the creation of the letter was the question of the gap between July and January. There are still unknowns, but he realizes precise answers cannot be given on every question. On the last paragraph of page 3 of the letter, it discusses SAPTA-funded programs may fail to exist or decrease capacity and people will not be served by the for-profit sector. This has been the history of their field over the last 40 years. He encouraged everyone to use this approach when advocating this letter.

Raising an issue without a solution will not help the system respond timely. Mary Wherry's recommendation for each agency is to quantify the impact and risk in the first six months based on what they deem reasonable to bill and collect beginning January 1. Kevin agreed. The letter engages DPBH and attempts to give some thoughts and solutions about what will be helpful regarding their concerns. He appreciated Dr. Green saying that no one will go out of business, but he also wants to make sure they have the ability as a group of providers and agencies to help that become a reality.

5. **Discussion, Recommendations, and Follow Up of the June 25, 2013, Medicaid Training** (discussed 6th in order)

Brandi Johnson of DPBH Central Billing said it was brought to her attention there was a bit of confusion about the new field available in NHIPPS containing the procedure code drop down. That field was intended for providers to begin coding by procedure code of the service actually provided to the client. In the event someone is identified as having Medicaid there can be a correlation made as to where there may be other appropriate funding sources

available. Everyone must immediately begin utilizing that field in order to identify their client base. When someone is found eligible after running a report, it is important to move thought processes in a direction toward the standard coding mechanism used by insurance companies. This information was put forth for further reference in order to focus efforts on individual assistance to the providers or identify global training needs.

Frank Parenti asked about being reimbursed by SAPTA if they mark the drop down as a Medicaid service for someone who is Medicaid eligible even though the agency is not yet certified or qualified to provide Medicaid services. Brandi said at this time there will be no funding declined due to the fact that someone is shown to be Medicaid eligible. The intent is to focus on those who are Medicaid eligible and identify the services to build into their infrastructure for what they are able to bill to Medicaid and to understand how to get reimbursed from that other funding source. Currently there will be no penalty imposed or denial of payment for that service. It is a concern for Frank when marking a progress note as COD (or whatever it might be) that they are marking it as a SAPTA service, which is how the billing is generated with the reimbursement requests. They've encountered issues with billings not identified which they thought they had entered correctly but didn't show up. Steve Burt said it is simple to mark an individual or group outpatient visit as a Medicaid service but there is no Medicaid code for daily service which requires them to unbundle residential.

A discussion was made regarding the residential component and if it will be made available and require a medical model. For those who currently have residential services, they have been advised they will be billing piece meal and cannot currently use those Medicaid codes. Steve is unsure if they are being requested to unbundle internally. Lana said residential is an unfunded Medicaid service, so regardless of what happens in the next year SAPTA dollars will always cover a day in residential. Steve's understanding was to unbundle residential and include pieces of residential as billable units of service for opportunities to bill back up residential services as Medicaid reimbursable through Qualified Behavioral Aides (QBAs) and peer recovery services. Lana believes SAPTA will always continue to fund those services because they are non-Medicaid eligible for reimbursement. There is only three to four days Medicaid reimbursement coverage for residential. Steve wanted clarification on unbundling internally and doing chart notes to get a sense of what it would be in the long run and asked if there is a reporting mechanism.

Chuck talked about the one report discussed at the June 25 SAPTA Providers Medicaid Meeting, and since then they've had internal discussions about the need for an additional report. That report requires system changes and has gone to the developer which should be done within the next week. This is a work in progress, and they are hoping for completion in July or through early August. Problems currently for the data team staff are trying to finish everything from SFY13, requests for reconciliation, and handling helpdesk calls. The priority is to ensure providers are paid out fully for any work in the system. They have been meeting with Brandi and the fiscal team on various issues. Once downloads are complete, there may be an issue with exporting into an access database from excel unless agencies have staff who are knowledgeable to do so. The reports will be run on a timeframe. The goal is to use the reports as a learning tool which are aimed to look at what services are provided and to understand how it will work in the new world. Until January 1 comes they are not looking to use that to drive SAPTA reimbursements, per Brandi.

Mary Wherry said she is working on a letter to the Director to explain their current standing and what the concerns are specifically for July to January. Everyone should understand that they are not going back to the same funding as in the past with SAPTA because no money was added into the budget from the Legislature. She doesn't know how many agencies are currently billing Medicaid and if they've looked at their reasonable projections starting January 1. Mary is offering to tell the story for each SAPTA agency. She requested by tomorrow they send her how much they reasonably estimate they must earn beginning January 1 through June 30 to make themselves whole and deep their doors open. They cannot request the exact same amount they were getting because it would suggest to her that they are not billing Medicaid. She asked them to email their information to mwherry@health.nv.gov. Ester wanted clarification of what Mary is asking for regarding the projections. Mary already knows the amount of money they were decreased. When she receives their information she will aggregate the amount and provide the information to the Director.

Mary gave some hypothetical situations:

- If not currently billing Medicaid then current billable is zero.
- If currently billing Medicaid and collecting \$2,000 per month then that is \$2,000 currently received.
- If reasonably able to bill Medicaid \$5,000 per month then that is what the new revenue stream will be. If billing zero and now will be at \$5,000 that is \$5,000 of new revenue for six months so that would be \$30,000
- If currently generating \$2,000 per month and come January 1 it is estimated to bill \$7,000 per month then they will generate \$5,000 of new revenue per month.

They must start billing Medicaid by January 1 and to anticipate what they can reasonably earn beginning January 1. Hopefully the agencies are looking at their business models and have a sense of what codes they will be able to bill. Mary must understand if they are judiciously billing Medicaid no later than January 1 and how much revenue will they be able to generate from those billings. They will be monitored to ensure what needs to be done. It is unsure how the ACA will roll out, how many people will be added due to Medicaid expansion and Silver State Exchange, or what the essential health benefits will look like for those other payers. This is the challenge of working into a reimbursement methodology that nobody can specifically define.

Ian Curley is fascinated by the opportunities for enhancement. With co-occurring disorder clients automatically there is medication, medical screenings, and health and wellness involved. He gave a scenario of clients on depression medication, which obesity can result as an adverse affect. Therefore, weight control and monitoring can be billable for those clients. If a client has regular blood pressure checks because of medication that can be a billable event. APNs have autonomous practice, and they can contract with a memorandum of understanding to do physicals or health and wellness. He doesn't think the billable codes have been explored and recommends a coding expert or someone that runs a health and wellness clinic to give ideas of what is billable for those enhancements they may have the opportunity to provide. Administering medication automatically fits into a medical model which clients have to be monitored for adverse affects. Currently, doctors are limited to reviewing files. He believes they can do physicals and medications, etc. Until they know the potential of billing codes, it is hard to project numbers. Mary referred to Chapter 600 of the Medicaid Services Manual which outlines physicians, APNs, and PAs. Medicaid has now added a listing at the end of the chapter of all prevention services they cover sorted by male, female, and adolescence. She is also facing the same thing this week for her community health nursing clinics which are primary care. It is only reimbursable for prevention which hasn't always been highly valued as a medical reimbursement methodology. Medicaid will allow for a 15 minute code, but doesn't reimburse for 30 min, 45 min, or 60 minutes. The code for a 15 minute session for obesity education, for example, reimburses at approximately \$24. There is also tobacco cessation which is a medical model and falls under Chapter 600. Amy interjected that WestCare has a medical model and employs clinicians. However, they provide residential treatment which is not a medical model. Even if medication is self administered, it's not as easy without completely increasing their costs to employ an APN to fit under a medical model.

Mary will send the spreadsheet to those interested who use a medical model to examine prevention services they may be providing but not billing. The spreadsheet has the Medicaid reimbursement codes with the increments and dollar amounts. The ACA is coming as of January 1, and their business models have to change. Every state is going through the exact same phenomenon. New Frontier has already finished their projections. Budget cuts sustained were for treatment services for drug and alcohol. As of January 1, 70 to 90 percent of clients they currently serve will have Medicaid. When Lana ran her projections, it was based on how much she will be able to recover from Medicaid for the services that were actually cut and not on other additional revenue streams by the RNs or medical doctors providing additional services because she must still pay them. She said there is no guarantee that Masters-level counselors can bill after January 1, and the general consensus at the last meeting was there may be as much as a 40 percent chance that the SAPTA-certified category may not exist. Her focus is ensuring the 40 percent chance drops to zero, and that they have an excellent chance of giving those providers the ability to bill Medicaid.

Mary explained that Mike Willden oversees the Department of Health and Human Services which includes Medicaid, and has compelled Medicaid to expand their provider qualifications for those LADCs and to expand reimbursements for substance abuse treatment beyond just the detox of the co-occurring model. Timelines must be met with the federal government to do a state plan change, but they are not getting much back yet. She needs

realistic projections from the agencies which are not based on past reality. Beneficial information for Mary to have is how much revenue will they lose if they cannot bill for those Masters-level providers if they are not recognized by Medicaid. Lana also agrees with Ian that they are missing out on reimbursement opportunities if not billing for those types of services. New Frontier bills for them; there are other services to balance expenses with some of the Medicaid codes. Lana also has a provision spreadsheet showing the codes and billable providers and will share it with anyone who needs it.

6. **Discussion and Recommendations Regarding the DSM V** (discussed 4th in order)

The idea of the group was to revisit this discussion from the May 15, 2013, meeting regarding timeframes, training, and preparation for DSM V. Steve Burt attended the Reno training which included every mental health provider from the north. The general consensus was that the insurance industry will pick up the combination of DSM V and IDC 10 on January 1, 2014. It made sense to everyone that SAPTA should do this as well. CASAT has an upcoming series of webinars and a face-to-face meeting for DSM V training. Kevin cannot find leadership in any sector of the field whether it be providers, SAPTA, or CASAT, and isn't sure that will they do between now and January 1, 2014. Steve Burt is advising the new orals go into effect after January 1, because they are dependent on the SM justification. MyAvatar must have the DSM V codes when going live January 1. It makes sense to him that DSM V and myAvatar roll out simultaneously. Some agencies are already training internally to be ready for DSM V. Mary Wherry spoke about her IT staff working hard to roll out myAvatar by October or possibly the first part of November. They are trying to get DSM V fully loaded for mental health purposes, as well. She will update Kevin with the status. Steve Burt said the codes are essentially the same. If myAvatar has DSM V by November that will still leave a few months of decent transition time.

Ester was informed that myAvatar was only desktop-based. Deborah McBride had a meeting with the internal mental health staff regarding the ability to access myAvatar through the web. Mary expressed they are still working with the vendor, Net Smart, to explore the feasibility. There are many drivers, including rural mental health services, to find a solution. It did not make sense to the group if myAvatar is not web based. Frank said there must be a password to access a web-based server, and he is guessing it's based on certificates to identify specific computers because of firewalls. The group discussed requirements of firewalls to specifically meet the needs of accessing information for myAvatar which will need to be clarified. Mary said this is on their discussion list for Net Smart. The questions are do they have the authority, will a work program need to be done, or will they write a sole source waiver. If a work program has to be done it will be presented at the next IFC in October, since the August deadline was missed. Once a timeline is established, it will be published for the agencies. SAPTA will talk to their IT contact, Greg Dykes, on Monday regarding their concerns. As a group they must recommend implementing DSM V no later than January 1. A timeline is good but Kevin hasn't heard anything regarding an implementation plan except what individual agencies are doing to prepare. He gave an example if an agency implements DSM V by the January 1 deadline, how will they know it will comport with funding sources and insurance companies, among other things. He suggested presenting an implementation plan goal to fit into the timeline. Steve Burt does not see this as complicated or a huge issue. He discussed the diagnosis codes for alcohol disorders in DSM IV and DSM V are realistically the same. Some language in the justification will change and the criteria are 11 instead of 7 and 4. CASAT is rolling out webinar trainings and most of the agencies have already ordered the DSM V. The assurances for the new subgrant awards do not require DSM V. Frank suggested making it a requirement by SAPTA to participate in the trainings. Ester asked if this could wait because they may know more at the next meeting in September. Kevin said he could keep it on the agenda, but Frank disagreed about tabling this. They need to take action because the ACA is coming and those involved in eligibility enrollment training with SAMHSA and NIATx understands the DSM V requirement. Diaz also stressed they cannot wait and will make necessary changes in September if the direction shifts. They discussed taking a course of action. They must look at how agencies will implement this and at the components they are tackling. They must depend on the State to do their part with myAvatar and follow the State's timeline. Organizations have to choose their priorities, investigate the impacts as of January 1, 2014, and tackle them piece by piece. Amy proposed to send emails as to what they need, where they get information, and how to disseminate the information. Because there is some confusion, it was suggested beginning a checklist of things to come and sharing it amongst themselves and their service providers. It is uncertain how they will proceed if the essential benefits are unknown. Kevin suggested that NVAADAPTS sent out an email to the group to being the process.

Frank wants to survey each agency to gather specifics for their training needs and have the results returned no later than the second week in August. He asked Lisa Tuttle to help distribute them to all funded agencies. Diaz believes CASAT should take the lead in understanding the agencies' gaps so it can be integrated in upcoming trainings. It would make sense if each agency doing in-base trainings notified Michelle Berry of their trainers to communicate with them for what is covered and where the gaps are. Diaz suggested creating the baseline survey to determine the most important components for what is consistently missing and set up training based on that information. Mary Wherry suggested using Survey Monkey with questions formulated by the agencies. Steve Burt said the entire day training of DSM V covered the entire book, and that's what they should follow. The substance abuse section was about seven minutes. He asked a few of questions, they received answers, and then moved on. This does not need to be complicated, and it is not different enough to create a process. In his opinion, they need a drop dead date they can all implement. The section will take approximately 20 minutes to read. It is literally a switch from DSM IV to DSM V. He or Betsy could help if anyone needs it. The LCSWs and MFTs will have more of a process of conversion because nearly every diagnosis changes in some way, but none are complicated. They are evolutionary and not too different. Lana agrees, and her agency chose a target rollout date of January 1, 2014. This is the least complicated change then anything they are dealing with. Denise Everett's staff did the DSM V training; however, many of their funding sources are not yet using DSM V. There are many changes if doing mental health program disorders. The complication is who will use DSM V versus DSM IV and when.

Kevin reiterated both ideas of going by the book by January 1 or using Survey Monkey, and the consensus was to go by the book. Steve Burt made a motion to advise SAPTA to require SAPTA-funded and certified providers to implement DSM V by January 1, 2014. Amy Roukie seconded the motion. Ester opposed and the majority was in favor. The motion was carried.

7. **Update, Discussion, and Recommendations for SAPTA Treatment Standards and Subcommittee Report**
(discussed in 5th order)

Frank Parenti gave an overview that the Treatment Standards Subcommittee meetings have been held in large part due to the work by Mark Disselkoen and CASAT to offer constructive suggestions about necessary changes to the NAC458 requirements. A few copies have already been disbursed. Much concern surrounds ambiguity of what the requirements are. It will help alleviate the subjective nature of the actual review by taking the regulation and moving it to the monitoring tool so it can be followed more clearly and what content will need to be included for programmatic issues. He asked for suggestions so they can more clearly formalize this and take action instead of waiting for the next meeting. Frank is not asking for an approval of the document without everyone's input first. He is asking for everyone's review prior to meeting again as a subcommittee, and requested Lisa Tuttle email it to all providers for their input, changes, or suggestions by a specific date.

Ester commented that Mark Disselkoen has worked very hard on this and it has been interesting to be part of the process.

Steve Burt asked Lisa to send emails with "delivery" and "read" receipts. Because they are moving forward with changes, he wants to ensure people are accountable for receiving and reading emails and documentation in order to provide feedback. He wants to minimize the possibility of people saying they did not receive the information, so he asked Lisa to include this feature when emailing the group. Frank stated they want basic knowledge it was received.

Kevin Quint called the meeting for a break at 10:46am.

Kevin Quint called the meeting back to order at 11:00am.

Ester Quilici explained to Mary Wherry she just wanted clarification about the cuts previously discussed prior to the break. Ester specified that Dorothy North is currently working on the spreadsheet and Mary should receive it tomorrow. Mary thanked Ester, and she told the group email is the best way to communicate with her.

8. **Report, Discussion, and Recommendations on Performance Measurements from Other States**
Steve McLaughlin was not in attendance, so this topic was tabled for the next meeting.

9. **Discussion, Recommendations, and Approval of Nomination Subcommittee for Election of Chair and Vice Chair**

The Nomination Subcommittee met and put forth names for Chair and Vice Chair. The candidates nominated during the subcommittee meeting were Ester Quilici and Kevin Quint for Chair and Ester Quilici and Frank Parenti for Vice Chair. Other nominations included Ron Lawrence and Steve Burt. Michelle Berry asked if anyone else had other nominations. Steve Burt expressed he is willing to be nominated for Vice Chair only.

Ester commented on putting her name in for nomination because she believes it is an exciting future and wants to be a part of the vision and take a more proactive approach. The officers have served with distinction but she thinks change would be good for the organization and feels she can offer more participation by being involved as an officer. She spoke about her experience in the field and that she would appreciate their votes.

Michelle stated that Steve Burt accepted the nomination for Vice Chair and asked if anyone had other recommendations for nominations. Michelle was also nominated for Vice Chair but respectfully declined. She reiterated the standing nominations for Chair are Ester Quilici and Kevin Quint and for Vice Chair Ester Quilici, Frank Parenti, Steve Burt, and Ron Lawrence. Ron is not present to formally accept his nomination; however, Michelle was informed by board members that he is not interested in the position.

10. **Election of Chair and Vice Chair**

Nominations were taken by ballot in Reno and Las Vegas. The results from Las Vegas were called in. Ester expressed her vote via teleconference.

Michelle Berry read the results aloud. The new Chair is Kevin Quint and the new Vice Chair is Steve Burt.

Kevin thanked everyone for their vote of confidence. He expressed their job as a group is to implement good ideas and support the field's needs. Also, he congratulated Steve Burt.

11. **Legislative Session Update Discussion**

This is the first SAPTA Advisory Board meeting since the Legislative Session ended, and Kevin wanted one more opportunity to discuss legislative issues. However, Charlene Herst mentioned they may want to think about the direction they want SAPTA to go legislatively over the next year.

Prevention was flat funded by the State; however, it previously incurred large cuts and also federal sequestration. Kevin thinks prevention may eventually move toward Medicaid reimbursement; however, Mary Wherry will be highly surprised if Medicaid ever reimbursed for those services. A national dialog is occurring due to the ACA being about integration of primary care with public health and behavioral health. She attended a national conference in Chicago in April which was heavily attended by the AMA. Primary care doctors are very interested in what public health could bring to the table. Doctors are now providing information to public health departments for an epidemiological study about the type of clients they are seeing, and they may be looking to public health to help with that prevention point. Primary care gets reimbursed for all things, but public health will lose due to subsidizing themselves by providing family planning services. Clients will no longer come to public health, and there is no reimbursement mechanism from any pay source, let alone Medicaid, for those prevention services. Although the ACA values prevention, there is no mandate Mary is aware of other than the 10 essential services covered under the ACA. A payer may say they recognize substance abuse as an essential health benefit, but only five visits are covered for treatment. Other than the prevention spreadsheet that covered tobacco cessation counseling, it is under the medical model of care under Chapter 600 for APNs, physicians, PAs, and possibly some RNs if they are in a specific governmental entity.

She is not exactly sure how the gap will be addressed over time. Kevin wants to discuss this in more detail in a future meeting. Mary's suggestion is to examine the spreadsheet that shows the prevention codes for Chapter 600 providers. There may be other CPT or HCPCS codes that should be recognized. Her point is how much money is needed to stay in business. The conversation with Medicaid or Silver State Exchange needs to be code specific

for reimbursement, how much, and how many. Detailed questions are necessary if the plan requires a prior authorization and they are allowing it for a medical professional. Kevin will contact Mary at a later time to discuss these issues.

Ian Curley is interested in expanding codes; for example, a medical person providing a primary health assessment should be a billable service. It is for the medical professionals, and Mary understands that access is a huge issue in Nevada. There are not enough providers, let alone everyone having a pay source theoretically, and they will be challenged to do educational interventions. Looking at the ACA, it is an insurance reform model and is all about incremental policy making. The next phase is helping people truly recover from addiction which takes sustained intervention. There are not enough doctors trained, prepared, or having the time for educational intervention. Mary believes the sessions it takes to implement a best practice for recovery from specific types of addictions must be clear and specific.

There was no other discussion regarding budget or bills. Kevin reiterated Charlene's point to continue conversations looking forward to 2015. He suggested keeping this item on the next agenda. In preparation, he will also speak to the Legislative Subcommittee about future topics.

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

No discussion was made.

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

Charlene Herst discussed between mental health and substance abuse there have been four or five grants applied for in less than a two month period, which were all submitted on time (PATH, a new homeless grant, Partnerships for Success prevention grant, and the behavioral health Safe Schools Grant). Guidance documents were sent out, but returned with an appendix regarding confidentiality. This is usually signed off; however, this time every one of them came back to redo. There was no guidance for any changes to these documents. They are looking for these specifics to the grants being applying for, and it is no longer a template. Currently, they are all signed off and in waiting. SAPTA is always looking for other grants, as well. They are trying to get the Block Grant in by August 1, 2013.

Mary Wherry asked if it would be beneficial for Betsy Fedor and Steve McLaughlin to do some focused education and on-going re-education in the next few months regarding assessing whether agencies have clients not considered, but who really are, co-occurring. In regard to the DSM V discussion, if a client declares anxiety or depression problems, Mary suggested they may or may not have been diagnosed. If agencies are treating clients for substance abuse in an addiction model, most likely they are missing out on billing opportunities by using a diagnosis code for depression or anxiety to be reimbursed for COD. She is unsure if this may be something to help providers determine other ways to generate revenue. Amy Roukie believes identifying co-occurring clients is not a problem most agencies encounter, but rather identifying which services to integrate to raise the level of billing. Most of them already work with co-occurring even if they say they are doing strictly substance abuse. The focus is getting paid for their services. They are working with co-occurring on many levels, but it may not be with a licensed practitioner recognized by Medicaid. DPBH is having the same issue with mental health. Mary Wherry said they have to change their business practice to truly be billable. They are in a process on how to use mental health technicians more specific to services they could be billing, such as being trained on how to document or be enrolled on the list which is given to Medicaid. These conversations can be helpful to re-evaluate their business models in this world of third party payment.

14. **Standing Informational Items:**

Chairperson's Report

No report was made.

SAPTA Report

Charlene Herst introduced Kelly Bown of QuantumMark to discuss where they are currently and what the next steps are with providers. At this point 13 applications have been turned in to Medicaid, and they are working on some follow-up information. Three applications are 100 percent complete, and they are waiting for evaluation from HP in order to move forward with them. Two providers have completed, but outstanding applications, due to waiting for medical supervision to be completed which they believe will happen this week. At this point they anticipate being 100 percent in their provider applications to Medicaid. Communication was sent to Hewlett Packard (HP) yesterday to request the start of the applications review. Kelly is hearing they are four to six weeks behind, but they are coming up on the four week mark on the first set of applications. At this point the tentative date for approval is September 15. Becky Bailey is meeting with HP individually on a weekly basis regarding additional information needed. QuantumMark is helping agencies to look for additional training opportunities, help them through business model revision, and work with their teams. This is their focus once all agencies become Medicaid billable. Kelly understands their questions about eligibility, as well as HPN and Amerigroup. These concerns are on the agenda for both Mary Wherry and Dr. Green. They are already discussing the billing process issues internally. QuantumMark is looking specifically for the next steps to make those viable for their business model. Currently, they are waiting on application evaluation and approval from HP.

HP is able to provide many types of training opportunities once providers are approved. The way to ensure HP answering questions is to have all the entities provide their questions to Becky. She has some from Bristlecone and Tahoe Youth and Family Services. Because New Frontier and Quest Counseling already billing Medicaid, it is important Lana and Denise submit their questions in order to help providers see the path they are heading down. It is imperative the agencies review the trainings that Kelly sent and submit their questions no matter how remedial they may seem. A webinar type format will be set up to answer questions. HP wants all questions ahead of time to ensure they put their knowledgeable staff on the call. Also, as QuantumMark continues through the process they will continue with provider visits to examine the business model and how billing Medicaid will be viable for each of the entities. The next step is they will learn from each resource and provide the information for everyone to be on the same page. Lana asked when developing the questions for HP to format them in such a way to receive a direct answer of yes or no. Although she attends all the meetings, she still is confused when she leaves. Kelly explained they are being asked a lot of Medicaid questions which are very different from HP questions regarding the billing process side. They are trying, but will not be able to provide some of those answers to the Medicaid questions through this process approaching January 1. At the meeting, Coleen spoke a lot about changes that will happen in the next six months, and QuantumMark is trying to provide answers regarding the HP billing side. If agencies have not yet done so, Kelly encouraged them to share the attachments they sent with their staff to trigger some possible questions. She also encouraged them to review the Medicaid training schedule on a monthly basis and to get organizations' resources trained based on what is available now. Amy asked whether or not HPN and Amerigroup are opening their paneled provider list, especially in Las Vegas. WestCare has approached them in the past and they were refused because they had enough. Kelly said they have no answer for this yet, but the topic was discussed a few weeks ago with Dr. Green. QuantumMark wants to keep the managing process in order of first getting everyone approved and billing capable. Dr. Green has committed to having those discussions after this process has been completed. This has been communicated to Dr. Green from the agencies' perspectives. Dr. Green clearly understands for this to work, the providers must be able to bill Medicaid. Amy commented this process may be backward. The providers will go through the process of becoming Medicaid eligible but will not be able to bill if Amerigroup doesn't open up their provider list. They will have done all this work for nothing. Dr. Green can advocate for them, but Amy believes this should be taken to the insurance commission. Fee for service Medicaid is okay in the rural areas, but if the larger groups cannot get paneled it will be a big problem. QuantumMark and Dr. Green are aware of this and understand there is a 30 day initial eligibility time period. Amy has no doubt about Dr. Green's efforts in this area, but she doesn't believe she has any control over this. Kelly said she may not; however, she does have the ability to bring the issue to the surface. SAPTA providers, as a group, will be stronger in partnership with Dr. Green and Richard Whitley to at least be speaking as a singularity.

Charlene Herst thanked QuantumMark, specifically Kelly and Becky, for the incredible work they have done and acknowledged that they are ahead of schedule. They update SAPTA with weekly status reports, and SAPTA is aware of the hard work of the providers and the successful relationship they have with QuantumMark. Steve Burt said it would not be happening without them and thanked SAPTA for choosing QuantumMark.

Treatment Update

Betsy Fedor reported that subgrants are in process of going through for signature, and agencies should be receiving their copies shortly.

Data Team Update

Chuck introduced Sheri Haggerty, the new MA II, who replaced Margaret Dillon. She will become familiar to them through the help desk.

Due to the SFY13 closeout, they are under timelines to reconcile and produce lists for providers for review of services not billed, not paid, or from problems resulting from the system. They will try to produce lists in instances where there is money left in the grant. If anyone is aware of having certain service levels not yet burned to notify Chuck so he can communicate with fiscal as soon as possible. He requested an update of their final billing in order for him to do the final reconciliation to create his report. Amy asked if there will be redistribution of unspent units; however, Chuck is unaware. He wants to make sure there are no process problems within the NHIPPS system and the payment mechanisms. His goal is to ensure their work is eligible to be paid and is paid. Locations where they may have overproduced still need to be sorted out. Currently, the scopes must be enforced as they were written. This is an implementation on unit cost and why there were so many process problems with reimbursements that went ahead of scope change and information not collected in NHIPPS when doing short pays. He would provide a list of work reported, but not billed, for a one-time manual billing. He is uncertain about reimbursement if they overproduce at certain locations. There must be some backup data and reason to pay for the Block Grant. The focus is on auto billing. He does not have the process automated well enough to provide the list of work that wasn't factored into that billing, but will be working on it through the end of the week.

The other issue is rollover into the new fiscal year. Most scopes are in; however, there are a number of help desk problems. There is new internal staff and new provider staff working on the scopes, not to mention all the changes being dealt. A number of scopes came in which did not have service levels opened, but he can add a zero service level if necessary, as far as he understands. He reiterated that locations and service levels must be attached to scopes. As scopes change throughout the year they can solve problems as they did last year. There should be no problem currently with the change made in March. Now they cannot be SAPTA billable until after the scope changes. Providers will be able to see the progress note changes, as well as the CPT codes, on the download list which is separate. At one time Steve McLaughlin requested having another field for actual reimbursement requests, but that never went through. Location becomes a problem with some reimbursements. Frank Parenti expressed many providers were concerned they had to come up with a projected scope of work through the end of the year, and wanted to know if there is there a way to capture those units that were not covered under the scope of work for which they had to submit three months in advance. This would involve Steve McLaughlin and the fiscal staff. In the next 20 days these issues should be sorted out. First, they want to ensure work was eligible as it was entered into the system so providers will be paid. Internal communications changed when the fiscal team moved. They would have preferred the March fix to have been implemented back in November or December prior to capping out on service levels and different locations in order to have a smoother process for the scope of work changes. Fiscal requested providers submit final scope of work changes for the entire year, which Frank stated is difficult to project. Many agencies left units on the table because they weren't moved in advance. He believes it is categorically unfair if providers cannot get paid for services provided because of a fiscal requirement. In the past this hasn't been an issue. Overall Chuck has examined the utilization as an agency, and the money has been flowing. He is hoping at least 50 percent of providers have burned their grants so he doesn't have to be concerned with having those reconciled and answering questions in those cases. The providers having issues will have to look at the magnitude of the problem, which there will ultimately be a decision made by Deborah, Steve, or potentially fiscal. SAPTA's existing fiscal staff was aware of this; however, the new fiscal staff that came on board was not aware and moved money until they had a problem, which they have been working to sort out.

Lana discussed co-occurring not used due to state general funds and no restrictions in any documentation signed by providers agreeing it would be specifically for that purpose. This has been clarified moving forward into the new fiscal cycle; however, technically the stance taken from last year may have been incorrect. New Frontier is over utilized in almost every category and office. For example, they preauthorized and submitted to insurance and were

denied, so then they submitted to SAPTA and were paid. During this time period, they went into appeal with the insurance company which they paid. New Frontier reversed the dollar entries with SAPTA; however, fiscal never received notification that New Frontier reversed the entries and reimbursed the detox dollars which still showed they were 100 percent utilized. Even though their utilization had money, SAPTA cut down their reimbursement every month. Her issue is with the reversing of those entries. Chuck stated when they reconcile, the number actually needed and what will be paid is substantially below their \$51,000 figure. Throughout the year, problems were discovered prior to the reimbursement requests. Manually this would be easy, but he does not know the magnitude. Lana's point was that fiscal was not notified funds were reversed, and on her next reimbursement those funds were actually deducted from what was to be billed that month. Chuck is not convinced the flagging process has been entirely accurate. The phasing out of NHIPPS is not a big issue because all the data and the full list of work are in the system. Fiscal's timeline is this has to be done by July 30th. Chuck has Tammra's initial reconciliation finished and will give her the initial early cut, but the problem is working on the mechanism to supply the list of other work. It is a tedious process, but he is close.

Mary made the point that if providers do not have their reimbursement requests submitted, they cannot reconcile and analyze how much they will be able to cover and what dollars are left. The close out of SFY13 is next month, and they are under a timeline for completion. A cover letter, along with a modified form, will be submitted with new subgrants. People have been asking for money in categories of expenditure for which there was no authority. Charlene informed Mary she is talking about prevention, and they need to discuss fee for service for treatment. The discussion was that agencies bill based on clients that are receiving allowable services. They are entering treatment information in NNHIPPS and being billed based on the service category, but never say it is operating cost for something else. Mary explained if agencies are granted general fund money with a certain amount of block grant money and what was invoiced was more in general fund than what they had been awarded and is not in the block grant, then Debi Reynolds will not be able to reconcile. Betsy Fedor said the new scopes of work will separate different funding pots. It is the groups understanding they don't provide SAPTA with line item details of what they are reimbursed. Mary said they will be receiving new spreadsheets that will direct them specifically to their funding categories and the population and location they are serving. If they don't comply with using that tool, they may have reimbursement problems. The agencies will be provided the funding streams for their fee for service billing, which they will need justifications to support. If there is money left over, they will have to modify their subgrants. Language will be added to the subgrant so they can move money around and fully expend, but the detail will need to be read. This will be another change in accountability. When new subgrants are officially signed, agencies must review all attachments and language to see the changes that will demarcate how it was done and how it has to be done now. From a provider's standpoint, Lana commented it would be helpful to recognize the urgency of signing documents. From a personal experience, she submitted a change request which took six weeks to receive back. During that period, her scope of work changed in all locations and her problems were compounded by doing the change request in the first place.

Amy commented service providers shoulder the burden of continuing to provide services even though it is likely they will not be reimbursed. It is imperative the State provides clarification. It was suggested the point person for the state be available to provide the local community providers with technical assistance for this new categorical spending. Amy understands the State's complex budgeting process. There is a need for communication so the agencies understand what the state defines as operating versus personnel. Mary will talk with Debi Reynolds about this to see if this is something she can do before the next meeting.

Prevention Update

Charlene Herst reported SAPTA is completing their continuation applications for SFY14. There is a new front page template and new addition to their assurances. They are currently in process, and some moved over to administration today for review of the budgets.

She discussed the recent integration and the complexities when merging agencies. They have developed six separate domains under the Division of Public and Behavior Health. Mary Wherry is the new Deputy under Community Services. It will be seen how all the programs will look together in partnership, integration, etc., under her purview. Charlene is leading a program on primary prevention and is bringing in all the pertinent people from the former health division and others. Their first meeting will be held today at 3:00 pm to brainstorm and develop a

strategic plan similar to what the other domains will be doing. After this first meeting, she would like to invite those SAPTA-funded providers affected by this merger and integration to participate in primary prevention, but that does not limit the treatment side to be there as well. They are developing goals, strategies, objectives, and possible activities as they move forward. She will add to her list of attendees anyone who wishes to join the meetings, especially the SAPTA-funded providers doing the direct services.

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

No report was made.

15. Review Possible Agenda Items

The next SAPTA Advisory Board Meeting will be held September 11, 2013. If there is anything to be added on the agenda notify Kevin Quint or Deborah McBride a week or two prior to the meeting. Steve Burt requested that Dave Caloiaro's upcoming discussion should be added as a recurring item to the agenda.

Finding billable staff has been an issue in the rural areas and also the avenue on how to get there. They will be billable once they establish internship. Ian Curley asked who to contact about obtaining the practicum, how much is charged, and what is the discipline. He is hoping to find a generated qualified list of people under the Board of Examiners for Marriage and Family Therapists to provide supervision. Steve Burt recommended he go the boards themselves because they maintain those lists. Ian would ask whether the Board could be more helpful to navigate the rural areas. Steve Burt believes there is distance supervision happening for social work, the MFT, and the Board of Examiners for Alcohol, Drug, and Gambling Counselors. There are certain requirements telephonically and, in some cases, through recording sessions and Skype video, but he cannot speak for the MFT or the social worker. For workforce development and survival, they must think more about people with bachelor's degrees that live in rural areas and want to stay in rural areas. It is restrictive in the rural areas because of requiring clinical settings. Michele Watkins' supervision is in Carson City, and it took some time to open an office in Dayton because there was no full time staff in case of an emergency. The BOE for Marriage and Family Therapists requires onsite supervision but the BOE for Alcohol, Drug, and Gamblers does not.

16. Public Comment

Dave Caloiaro from the Division of Public and Behavioral Health updated the group on peer support program building. It is projected to take up to a year. Many of the deliverables with the strategic plan will be developing within the next six months. They are using an organization called Peer Link which will help devise a statewide network of peers.

They had a town hall meeting in Reno in May and will be conducting another town hall meeting in Las Vegas on September 10. Dave sent emails to a number of people within his organization to garner interest with peers on how to empower them in the new world. The long term plan will allow them to work alongside psychiatrists, psychologists, social workers, and alcohol and drug abuse counselors, and will be respected and accepted as such.

They were fortunate to apply and receive a six-month technical assistance award for \$50,000, and will see it come through shortly. As part of this award, a peer support academy team was developed consisting of 12 people, which includes Brad Greenstein, Steve McLaughlin, and Betsy Fedor. They are focusing on a strategic plan and logic model within the year and most of the deliverables in the next six months to see peers certified and credentialed as peer supporters. They want to establish an inner-strategic plan and logic model called a Peer Leadership Council. They also want peers to become Medicaid certified as providers because Nevada is one of a handful of states that will reimburse for peer support and services, which has not been taken advantage of. Dave speaks of peer support across the board as state public

agencies, state employees, private organizations, and also meaning mental health and substance abuse co-occurring disorders. The goal is to make this truly a widespread effort and to use the help of peers with aspects of the ACA. This includes the health care exchange. They will not necessarily be navigators of the system, but for those interested for a price and going through certain training could become Certified Application Counselors (CACs). They would be a bridge to help eligible people go through the exchange or the navigator.

Two statewide workgroup meetings were held with facilitators from the feds that contracted with certain organizations. They helped to facilitate a strategic plan and logic model. The last meeting held a few weeks ago in Las Vegas, so this will be a work in progress. Dave will report to everyone on how the process is going. Also, enlisting their support and expertise which would be greatly appreciated.

There was no public comment in Las Vegas or in Elko.

17. **Adjourn**

Meeting was adjourned by Kevin Quint at 12:20pm.