SAPTA ADVISORY BOARD
FUNDING SUBCOMMITTEE
MINUTES

DATE: **March 29, 2019**
TIME: **12 p.m.**
TELECONFERENCE: **(888) 363-4734 / Access Code: 3865799#**

BOARD MEMBERS PRESENT

Ester Quilici, Vitality, Chair
Leo Magrdichian, WestCare
Rikki Hensley-Ricker, Bristlecone
Mari Hutchinson, Step 2
David Robeck, Bridge Counseling
Jolene Dalluhn, Quest
Jasmine Troop, Help of Southern Nevada
Patrick Bozarth, CCSN

BOARD MEMBERS ABSENT

Lana Robards, New Frontier
Life Change Center
(Jennifer DeLett-Snyder, JTNN *asked to be removed from group*

SAPTA STAFF PRESENT

Brook Adie
Kendra Furlong
Stephanie Woodard

1. Roll Call, Introductions, and Announcements

   Ms. Quilici asks attendees to announce themselves and their agencies. Done.

2. Public Comment

   None.

3. Approval of Minutes from Sept. 19, 2018 meeting

   Ms. Quilici – These minutes were amazing. They are verbatim. We have to acknowledge Rhonda for being so precise. I would like to correct spelling of my first name; it's E-S-T-E-R. If you would ask her to make that minor correction I would appreciate it. If there are no correction, I would motion to approve – publish.
   Ms. Hensley-Rikker - Motions to approve minutes and publish, please. Mr. Magrdician seconds. All in favor signify by saying 'Aye.' Several 'ayes' for approval; none opposed. Motion carries.
   Ms. Quilici – We're going by a modified version of "Robert's Rules," but we do have to have some way of indicating that we approve of what was stated. It was complicated. There was a lot going on in the conversations from all of us. I do appreciate how complete the minutes appear to be.

4. Discuss and Approves Goals, Priorities and Timelines of the Sub-Committee

   Ms. Quilici – asks if Brook or David would like to take the lead on this Question.

Mr. Robeck – I mentioned it the last meeting, and I have heard through the grapevine our block grant funding may be at risk, up to 40 percent, due to an issue with tobacco testing in the state. I don't know if that is true or accurate, and maybe somebody from SAPTA could share or respond to that. But I think that's where we started, is what dollars are available. There's been a lot of changes. Brook, could you respond to that?
Ms. Quilici – Goals, Priorities and Funding. So, you want to discuss block grant funding.
Mr. Robeck – No, I'm sorry, Ester, to talk over you. No, what block grant funding is available. I was just trying to understand what dollar amount it is we're working with. Otherwise, the goals and priorities are kind of hard to define, especially if there's a chance it could be reduced by 40 percent.
Ms. Adie – May I suggest we move to Item 6, then we can discuss that and go back to 4. Is that appropriate?
Ms. Quilici – Let's move on to 5 – Review and Discuss Reimbursement Rates. Do we want to discuss that, or do we want to go to 6?
Mr. Robeck – It sounds like Brook was ready to respond. If we could go to 6 first, then we can go back to 4 and 5.
Ms. Quilici – Okay, so if we have no one who doesn't want to do that. So, we'll go to discussion of Sub-Grant Funding Allocations; Residential vs Outpatient.
Ms. Adie – I wanted to touch on a couple of things there were questions about during our last meeting. If the IMD exclusion was approved, how was that going to impact our budget. And how are the funds going to be shifted for next year. One of the things I would like to make sure is understood, is the amount of funding we have available is going to be flat. We're not going to get additional funding. The way the IMD exclusion is written for the next year, from July to the end of December, funding will remain the same for inpatient services, as we have been funding right now. If the IMD exclusion is to be approved it would start Jan. 1st, (2020). That is when there would be a shift in payment, where Medicaid would be able to step in and reimburse for those services, but not the room and board. At this point in time, until the budget is approved, I don't have additional information on that, other than to say the first six months of the next fiscal year the funding is going to stay the same. Everyone will likely get the same amount of funding because we have the same amount of funding. Everything will shift at the start osf January. Do you have any questions?
Mr. Magrdician – Hypothetically, services only, not room and board. So, is SAPTA going to be able to cover the room and board for the residential programs?
Ms. Adie – Those are several things we are exploring in the budget, as far as being able to cover room and board. Once we determine what those numbers look like (room and board cost), we'll have our next discussion to say, here's how the funding will look from January on.
Mr. Magrdician – One more question, a funding thing, I might as well put it out there now. Are there still agencies that are not Medicaid-approved, and might not be in a residential setting, still getting SAPTA dollars from Level 1 and II treatment. And I'm curious what that's going to look like – if that's going to shift, so that everyone who can and should bill Medicaid, is.
Ms. Adie – Asks Ms. Woodard if she has additional information our would like to jump in on the conversation.
Ms. Woodard – When it comes to the IMD, it is important to recognize we are moving forward to get it approved with the 1115 Demonstration Waiver. It is currently not funded. The only part of the 1115 that is funded is the CBHC. We are continuing to move forward in our efforts to move the 1115 Demonstration Waiver in totality to approval. There's also a significant (undeciphered) that goes into that application that has to address budget neutrality, we are working on that. Brook already explained how that works, because if the IMD exclusion were to be funded, currently it is not, but if it were, and I want everybody to understand, it would allow, over the course of the biennium, more than $28 million dollars (that's including the federal match) could be going toward residential treatment services as well as inpatient hospitalization and IMDs. The IMD exclusion, if it were funded, is a complete and utter gamechanger when it comes to being a multiplier for funding. We are not, nor do we anticipate any additional funds coming through the block grant. If anybody has been following some of the federal appropriations through the president's budget, there's actually consolidation of many different funding streams or ending of funding for some of the ongoing initiatives. We also have not received an increase in any of our state general funds. In totality, we anticipate that we will continue to run into the same issues we have always had, which essentially, it's one pie. You can slice it as many times as you want but it's not getting any bigger. We have entertained

before doing rate increases for residential treatment services. The problem with that is, if you get flat funding, and we anticipate everyone will get flat funding, you will essentially be serving less people for more money. The dollar amount does not change. We feel the IMD exclusion is the way we have a clear path forward to be able to expand access to residential treatment services statewide. What we did when we built the budget for the IMD exclusion, we built in the actual enhanced rate (after having a study completed by Myers and Stauffer in 2016), they looked at the current residential treatment services rates and they built a rate based on the actual cost of doing business. We used those rates in the IMD. So, that is the fiscal projection that we view. The federal government CMS is prohibited from paying room and board for residential treatment services so that is where the SAPTA funding would come in and continue to be in play. That day rate for residential treatment services room and board was also calculated as part of that rate study back in 2016. In totality, those rates will equal to what the enhanced rate was, established by Myers and Stauffer. Our fiscal projection has to take many things into consideration when we talk about the potential of the IMD moving forward. We are looking at starting January 1st, 2020. That means we have to look at doing business as usual and budgeting as usual from July 1 to January 1 of 2020. We also recognize that not everyone is on Medicaid and have to reserve a certain amount of funding to be able to continue to pay for residential treatment services for individuals who otherwise would not be covered by Medicaid. We have to otherwise continue to project out what room and board would be for those individuals who would be covered under Medicaid, not only those individuals who are currently receiving services in our funded providers, but the expansion of services to other residential treatment providers, so we can ensure to continue to cover that $25.55 for residential treatment. What I will tell you, the impact to our budget is pretty minimal. Especially if you project out what the fiscal analysis will look like in 2021. We would then have 18 months in this biennium of having the IMD exclusion funded primarily through Medicaid. It will alleviate a great deal of our budget of having to continue to absorb, in totality, the costs for residential treatment.
Ms. Quilici – You literally mean, 3.5 or what. When you say residential, what do you actually mean?
Ms. Woodard – We built in 3.1, 3.5 as well as 3.7 withdraw management.
Ms. Quilici – You also built in 3.2 WM?
Ms. Woodard – No. Not 3.2. We built in 3.1, 3.5 and 3.7.
Ms. Quilici – So, those of us who run detox will not have payment again?
Ms. Woodward – I did not say that. Social model detox is not supported, so we have to look at ASAM. Everything we built into the 1115 demonstration waiver must be predicated on ASAM. There's been a significant shift to medically managed or medically monitored withdraw management and move away from social model.
Ms. Quilici – And we do have medically managed, except we are still classed as social models. Those of us, and Lana's not on this call, those of us who run detox are medically supported, but not 24-hour nurse guided, but we're medically supported. So, we've been left out. We're orphaned.
Ms. Woodard – No. You'll still be receiving SAPTA funding. We haven't withdrawn any of that funding for those services.
Ms. Dalluhn – Dr. Woodard, I'm not sure I understand, and want to ask, for our group homes, which are really transitional housing/transitional living. Does this mean that in six months, funding for room and board may go away, in January?
Ms. Woodard – No. There is a difference in what we can cover in the 1115 demonstration waiver and what we can't. What we can cover in the 1115 demonstration waiver under Medicaid reimbursement is very prescribed by the federal government. We had to look and map out of what we could provide is if it's already covered by Medicaid or some other type of payer system, then tried to true-up what those gaps were. The primary gap continued to remain residential treatment services. That's between 3.1 and 3.5. Which is why they were added into the 1115. Transitional housing cannot go into the 1115 because it's residential treatment. It's not treatment services, it's basically room and board. That remains in our budget, it doesn't get touched. The other levels of care that remain in our budget continue to remain in our budget. The biggest issue is that the 1115 demonstration waiver with the IMD exclusion funded, would allow us to make our dollars go farther because we wouldn't be self-limited to the amount of residential treatment services we can provide simply because we don't have enough money to expand.
Mr. Magrdician – Dr. Woodard, in this study, what about the Medicaid length of stay with the 1115 waiver and residential treatment. Can you explain a little about what that might look like?

Ms. Woodard – When we did our projections, we looked at typical utilization and (do not have numbers off the top of my head), but it's all based on medical necessity. If an individual needs a greater amount of services, they've already reached 30 days of residential treatment services but need more, as long as they meet medical necessity they would be able to remain in that level of care.
Ms. Hensley-Rikker – I want to make sure I understand … when you say medical, do you mean clinically? As in ASAM treatment?
Ms. Woodard – Yes. Exactly.
Ms. Hensley-Rikker – Thank you.
Ms. Woodard – For several years now, especially since the new ASAM criteria came out, is using the criteria as the primary driver to ensure that medical necessity and clinical appropriateness is met for individuals to be placed in levels of care. Makes complete and total sense. We want to make sure we reserve the most costly services for individuals who truly need them, and if they can be treated in a lower level then we need to be sure that level is available to them. For medical necessity, it really is using the ASAM criteria and coming in alongside our certification. I will tell you when it comes to other states, we are further down the road than many other states are because we are already certified by level of care. We already know, at least for the service providers who are certified, what the capacity is of the totality of the system at each level of care.
Ms. Robards – When you're talking about the 1115 waiver as it deals with the IMD exclusion, that covers residential services for up to 30 days under Nevada Medicaid. Should a client need medical/clinical necessity, for a longer length of stay, would those additional days then be billed under the block grant?
Ms. Woodard – No, they would still be billed under Medicaid. As long as they meet medical necessity.
Ms. Robards – Thank you.
Ms. Quilici – Does it allow us to increase our bed counts?
Ms. Woodard – Yes, it does. You'll no longer be restricted under what we call the IMD exclusion. The 1115 allows us to waive that. Even free-standing psychiatric facilities that provide 3.7 withdraw management currently are prohibited from being able to bill Medicaid for those services because they would be considered an IMD, they would now be allowed to bill Medicaid for those services.
Ms. Quilici – Do we have to apply for this additional funding by request or is it as we do for Medicaid – we bill fee for service?
Ms. Woodard – I'm not sure, for extra money, you would bill Medicaid for residential treatment and we would reimburse for the room and board portion.
Ms. Quilici – But you would not allocate a certain amount of money to us, we would just bill you.
Ms. Woodard – Correct. For residential treatment services? Some would be allocated because we do have individuals who are not covered by Medicaid. And for those individuals who would still be reimbursable by SAPTA. It's not all or nothing, it's a combination.
Ms. Quilici – It isn't a pot of money for which we have to apply, it would be an open amount.
Ms. Woodard – Correct.
Ms. Quilici – Okay. Do we have others out there who would like to ask Dr. Woodard questions regarding Number 6?
Dr. Woodard – There's been a concept paper as well as a budget put together from Medicaid I'm happy to send to you. As I said before, we're moving forward with writing it into the 1115 demonstration waiver. We have verified with CMF we can have portions of the waiver that if not funded we would have moved into inactive. So, if it's not funded, we can move it into inactive and when it does get funded we can be able to implement. We're still in that holding pattern.
Ms. Quilici – The public hearing was canceled. What does that mean, Stephanie?
Ms. Woodard – It means we are constantly in discussion with CMF. Remember there are eight states with the demonstration program. All eight states are in discussion around the 1115 demonstration waiver or state plan amendments. This is very complicated, so I will try to streamline it if possible. The recommendations we have since received since engaging CMF in these discussions is that it's likely going to be a combination of a state plan amendment and the 1115 demonstration waiver. Every week we are working with them to figure out what we need to put in the 1115 demonstration waiver. The waiver essentially gives us authority to waiver certain requirements through Medicaid. Currently there are federal prohibitions from putting any service in the state plan, if it's not available to anyone and everyone who qualifies to bill for that service. We're currently working with Medicaid to determine what portion we had thought we would just put in the 1115 demonstration waiver, in fact, are better served by putting in the state plan. Then, what

authorities do we need to request in the 1115 demonstration waiver. That's all that that means. We were ready to go, quite frankly, which is why we were scheduling those meetings, thinking everything could go into the 1115. Because CMF, who has been working with all these eight states, has since decided they would rather see the state be consistent in putting certain portions in the state plan, then asking for certain authorities in the waiver. Because of the ongoing discussions with CMF, we are not ready to hold those workshops.
Ms. Quilici – Will we be on time, to meet all the deadlines?
Ms. Woodard – We are trying. We are doing a ton of work behind the scenes. We are doing our best.
Ms. Quilici – Thank you for your efforts, and those on your team. Those of us who are concerned about the timelines because that means, we may have a gap. So, let's hope for the best outcome.
Ms. Robards – Stephanie, is there anything that we can provide as support or backup, as providers most directly affected?
Ms. Woodard – Even with CCBHC, if you're talking about the IMD exclusion, certainly information and advocacy can go a long way.
Ms. Quilici – What department of CMF is actually working on this, Stephanie?
Ms. Woodard – About 12. At any time on a phone call, we have about 17 representatives from CMF, all with different sections and specializations.
Mr. Magrdician – Question, when we first created this sub-committee, it was before any of us had heard of this waiver. So, the conversation was going to be directed toward determining how the block grant money would be given out in relation to the who/how/what percentage, through Medicaid would be able to get it. Should we still make that plan just in case this 1115 waiver does not go through?
Ms. Woodard – Certainly we are interested in this committee putting forth recommendations around funding. If that's something this committee continues to endeavor for, there's no reason not to.
Ms. Dalluhn – Was the state's block grant funding reduced? Is that why this has come about? Or has the block grant funding remained the same?
Ms. Woodard – It has remained the same. We know that needs for residential treatment services far exceed what we have the capacity for when we're solely and complete depending on block grant and general fund dollars to pay for it. We know the need exceeds what it is we can pay for. And we continually hear about this. Part of the problem, I will tell you is, I don't have data to back that up, because people haven't been actively keeping 90 percent capacity and wait-lists for us. Without the data it's hard for me to make that argument. Hearing about the need state-wide, we have a number of individuals who need residential treatment services and aren't able to obtain them. This is about meeting the need and expanding access to a level of care and a service we know is needed, we just don't have capacity for. And we don't anticipate getting any more funding through block grants. Remember, Medicaid funding allows us to take general fund dollars or other dollars the state has that pulls down into a federal match. For an individual who's newly eligible, we, the State pays 10 percent of the cost of care; the Federal government matches 90 percent. That means, for every dollar we currently spend in SAPTA to provide residential treatment services for that individual, one dollar equals one dollar. But, if we do it in this way, one dollar equals 10 cents from us and 90 cents from the federal government.
Ms. Dalluhn – I appreciate the explanation. That makes a lot more sense to me, thank you.
Mr. Robeck – Is any of the money that came through extra funding and restrictions of SOP program, following the FTR, I was wondering if any of that goes toward residential. After listening to the challenges in the room, so to speak, and I'm wondering if any of that opioid money is available for that as well.
Ms. Woodard – It is. Vitality has had residential treatment funding through the FTR grant. My biggest concern, and everyone has heard me say this and I'll continue to say it, we don't want to fund something that isn't sustainable over the long term. I'm much happier sending those funds now to expand beds, if we know we have the IMD exclusion being funded. Without it, it doesn't help for us to use those dollars to expand beds if only in 18 months from now to have to reduce funding again if we don't have grants to sustain that. We've had history where we've been able to provide funding to help providers expand beds, we didn't come in alongside to have secure extra funding to pay for those beds to be occupied. I don't want to run into a situation where we build the system only for in 18 months from now for us to turn that system back.
Mr. Robeck – I appreciate that. So, what are we investing those funds in? What is sustainable now?
Ms. Woodard – It's a good question. The RFA for SORs should be going out, we anticipate, the first week of April. Certainly, increasing access to medication assisted treatment specifically in our rural areas where

we have large geographic areas where we do not have even one BPNRB prescribing MAT. Treatment and recovery support services for individuals who have an opioid use disorder. We're continuing to provide training and education to providers to assist in the prevention of the development of opioid use disorder, and opioid overdose prevention. Those are the primary targets of that funding.
Mr. Robeck – Thank you.
Ms. Quilici – Thank you, Dr. Woodard. I can say on Vitality's behalf, the money has been expended as anticipated. It did help a lot of people over a period of time who would not have been helped otherwise. We are fortunate to have Stephanie with us today. Do we want to end the meeting on this topic, and future the rest of the topics?
Mr. Magrdician – The time is passing again, there's not guarantee the 1115 waiver is going to be successful. I think it will be, but again, it's always good to have a plan b. We were supposed to be talking about percentages, and how, if we're just going to use the same amount of the block grant funding for the next time it's awarded, and everybody's going to have the same amount as they did last time, or, figure out how we're going to disperse it, maybe a little differently. With Dr. Woodard's concern, which is also everyone's concern that there are individuals who can't utilize or can't get treatment in a residential setting because there's not enough funding to do so. I'm going to be premature in saying this; WestCare, our two residential programs that get the funding we get, we have a great team that is making sure we utilize the funding properly and we don't run out at the end of the year as it happened before. In that, it's got both our residential programs, at level 3.5 and 3.1, have open beds. We're going to vote on it at our management team meeting on Monday, I don't see any reason why the management team isn't going to approve it, we're going to make a decision to offer another five beds in each location for a total of 10 beds, at no cost, in order to work on this SAPTA wait list. We've got open beds we might as well fill them. I hate to call it free beds, but we're going to try to do our part, because we're grateful for the SAPTA funding with out a doubt, how its carried us this long. Even though the amount of funding is the same, we're going to add another five beds at Harris Spring Ranch and the Women and Children locations in order to hopefully make some kind of an impact on this wait list for residential beds.
Ms. Quilici – How do you do that with the IMD?
Mr. Magrdician – We're already above that. We're part of the IMD exclusion. We're not getting any funding through Medicaid for residential beds anyway. What I mean by that is we used to be able to. SAPTA … Block grant money, and they've usually found more money and we've been able to stay full and serve as many SAPTA people that we could in relation to capacity. We can't do that now. We're utilizing funds, so we don't run out; but that means there's empty beds in our residential programs. We still have some individuals coming from specialty courts and some other funding sources. A specific example: Harris Spring Ranch is licensed for 56 beds. Right now, there's probably 40 clients receiving treatment from all of the different funding streams, which is specialty court and SAPTA. That leaves 16 open beds. Those beds, although we don't have a funding source for them, we can't put in an additional 16 men. But what we can do, at least to help with this wait list, is put in five people for nothing. We've got the staff, and we're going to try to work on the long SAPTA wait list. Down here, Ms. Ester, there's people waiting for a SAPTA bed, probably four months before we're able to place them in a residential program. It's a little shorter for the women's program. We're going to try to make an impact and at least do our due diligence and provide services for people who can't get them any other way and treat an additional five with no funding source.
Ms. Quilici – Well good for the people you treat. That's great news. How else can we address the topics we have left? Nobody wants to stay on 6, let's go back to 4 – Goals, Priorities and Timelines of the Sub-Committee. Leo just brought something up about a goal. How can we define our suggestions for our block grant funding?
Ms. Adie – Ester, do you mind if I make a comment?
Ms. Quilici – No Brook, please do.
Ms. Adie – I wanted to talk about some of the priorities we're doing here. We are working toward implementing the participant satisfaction surveys. We're going to be pushing that out to July 1, requiring all SAPTA providers are completing the surveys. This is important data we need in order to help make decisions regarding funding and budget and other things. There are some things we'll be implementing that in the long term will help us make decision regarding funding and in helping us advocate for funding. One would be the surveys, which is an important piece for us to hear from the people who are getting the services and identifying gaps. The other is the TEDS data, having everyone submit their data. Stephanie

eluded to it when she spoke about the wait list information. If we don't have accurate information on the wait list it's very difficult for us to go forward and say, 'Look at all these people waiting,' here's where the need is in order for us to advocate for funding. Or to make decisions regarding funding throughout the state. As far as priorities and guidelines, those are things we're looking at doing long term, but there are things you, as providers, can be giving us regarding wait lists, TEDS data. It's not going to help us for July 1st, but if we get this implemented and we have a good year of data it's going to help us with the next year. These are important pieces that we're working on.
Ms. Quilici – Thank you. It addresses number 4 from your standpoint. How about number 4 from our standpoint? SAPTA provider land. Okay, so the timeline is July 1, or from July 1 to the end of the year.
Mr. Magrdician – I think one of the things we discussed last time, and Brook you were open to it. It had to do with so many people on Obamacare who have such high deductibles and co-pays, it's more realistic to say they're paying for their full service. Has there been more discussion within SAPTA of maybe expanding SAPTA coverage for some of those folks who are basically the working poor?
Ms. Adie – During the last meeting we did have this discussion. It is something we're willing to look at. We don't have a lot of data for us to be able to move forward. The request is for you guys to be able to give us some data about the volume of people that is, what is their deductible in order for us to look at all this information to decide if this is something we might be able to do. We're not looking to make a lot of changes this next year in the structure, simply because we're at a standstill until this 1115 gets approved and we determine how we're going to move forward. That decision's going to come at the first of June and that's giving us a lot of time for any long-range planning. Those pieces of information are important to have and for you guys to be tracking in the event we do get funding for and the 1115 does get approved, so we can look at our dollars and see how we can utilize them.
Ms. Furlong – I want to add one thing. If the group was to identify a specific population they wanted to have covered, you're also going to have to identify where those dollars are going to be pulled from, because there are no additional dollars. So, if we're going to cover whatever that population is, and you want to take 20 percent of the entire treatment block grant and allocate it to that, that's one type of recommendation. But if you just come forward and say we want the working poor population covered and this is the special population, but we don't want to lose dollars anywhere else, that's not going to help us identify how to move forward with it.
Mr. Robeck – When we discussed this last time, it's because many of the outpatient providers have been reduced substantially and we didn't know where those dollars went. So, if those dollars were not going to the outpatient treatment facilities now to the extent they were, could any of them come back to cover the people we basically have to help. Or, is that being referred to residential treatment which is does not appear to be done, based on this conversation, if it's not going to residential treatment and yes, outpatient treatment has been reduced substantially, where did those dollars go?
Ms. Furlong – Right now what were doing, is an evaluation on our block grant. I've got a second meeting scheduled with the management team in two weeks. We're going to go over spending plans with all the providers, if and what dollars may be unallocated, and we'll be putting together a request for application based on those needs that are identified. Everybody will have an opportunity to seek additional dollars.
Ms. Quilici – Is Stephanie still on?
Ms. Adie – No, she had to go. She's at the legislature, they're going to start hearings. If you have something specific you want me to ask her, I can bring it back to the next meeting, or email the group.
Ms. Quilici – I guess we always talk about 1115 waivers, are all Medicaid waivers under 1115?
Ms. Adie – No. This is the first 1115 waiver this state has done. There are other states who have an 1115 waiver and they're amending them to include IMD or CCBHC, but we don't have one in the state, so, we're submitting one now.
Ms. Quilici – So, CCBHC is not an 1115 demonstration waiver?
Ms. Adie – Yes, we've put it in our 1115 SUD demonstration waiver. That's where it's sitting right now. There are pieces of it that are going to be in the state plan amendment, then pieces of it that will be in the 1115 demonstration waiver. Once the entire application is complete it will go to public hearing and you'll get to see how it all lays out. It's still in draft form right now.
Ms. Robards- On that public hearing is the hearing that was scheduled and almost immediately canceled?
Ms. Adie – Yes.
Ms. Robards – Okay. That's what I thought. Madam Chair, with permission, I've got a couple target populations I'd like to have put on the table. The first one being Medicare clients. SAPTA no longer will

pay for services for Medicare primary coverage, even though Medicare doesn't cover our facility and we've tried on several locations to get approved. If anybody's got any magic answers out there on how that's supposed to work, we have a huge Medicare disabled population that has no funding sources. Under Nevada Medicaid, if they have Medicare, the new plan apparently is, that even for disabled, they will get their premiums paid, but they won't get any of the other benefits of Medicaid services like eye glasses, and behavioral health, those things. I'd like you to reconsider SAPTA dollars being able to cover the Medicare population. The other population I would like to throw on the table is; I have an email, previously, that said since incarcerated individuals in local jails have their Medicaid suspended, SAPTA would pay for services that were being provided while the individuals were incarcerated. Short term, long term, whatever. Then it became and unfunded SAPTA, then I couldn't provide those services and bill those services to SAPTA and I'm wondering, could I get additional clarification on that as well.
Ms. Adie – Ester, do you mind if I just in here and give some updates and add to the discussion.
Ms. Quilici – No. I guess we need to figure out, does this go Number 5? Reimbursement rates?
Ms. Robards – Actually, I was just going in line with David's comments about additional consideration on how some of the SABG funds could be spent.
Ms. Adie – I think this fits under Number 4.
Ms. Quilici – Okay, go ahead.
Ms. Adie – Let's talk about the Medicare population. I did sit in on a discussion about Medicare, so I have been in contact with someone who works with states regarding Medicare issues and helps providers overcome barriers and fears with enrolling with Medicare. I have a follow-up meeting set with him next week because we do recognize this is a population we haven't been able to fund. Talking with him about how we can make it work in our state, I want him to come and have CASAT set up trainings for providers in the north and south so you can get some information from him directly. We've also reached out to our federal, to NASDAD to get additional information about how other states are doing this and how we can work on that. Those are meetings I have set up for next week. We know this is a group of individuals who hasn't been to get funding and we are working on it. Any information you can provide on the numbers of people who come to your door who you haven't been able to serve, who are Medicare/Medicaid, or who have straight Medicare, any information you can provide us would be helpful. It's difficult for us to make any shifts in funding decisions if we don't understand what the volume is. If you can get that to us it would be helpful. The more information I have regarding Medicare, I'll be sure to provide to you.
Ms. Robards – Thank you. Keep me in the loop on anything you find. Point of record, though, SAPTA used to pay for the Medicare population then did an abrupt face and now no longer cover those individuals. I have never turned anyone away, I can say that specifically. But I've not billed anyone for these services, even though they desperately need them. The majority of them are elderly or disabled. Talking about a population that is a true, unmet need, that is the one you need to focus on. Any comments on the detention center population?
Ms. Furlong – One of the things I would like to say about the detention center is we got guidance from our state federal project officer, Dr. Mitchell, who said, with our block grant dollars it is absolutely not allowable to pay for any services inside the jails. With that guidance we had to pull back and we are no longer covering any services within the jail. We had a couple entities who were providing services as part of the FAST and MOST programs that had to be re-routed. We're trying to get everybody in contact with who they need to be in contact with involved with FAST and MOST so they're the dollars from the correct venues. But, as a concrete rule from this point forward, or from the point we notice from Dr. Mitchell, services inside the jail, with block grant dollars are not allowable.
Ms. Adie – To add to that, I did hear at NAPCON, and I can follow up with our Medicaid office so I can see where this is, there was language put out there while people are incarcerated to would actually suspend their Medicaid, so when they are discharged they can actually pick it up right away rather than reapply. I think Nevada actually terminates their Medicaid and they have to reapply. I know it doesn't solve problems or payment inside the jail, but it will make it quicker once they are discharged.
Ms. Robards - To make a comment, if the criminal justice population is a state priority, then not having a vehicle to provide these services to determine what these individuals may need, up to and including the evaluation for either mental health or substance abuse and kind of blocking that, I was under the impression of SABG rules, you couldn't do it in a penal institution or prison, but you could do it in local jails or detention centers. I understand you're taking the guidance from the powers that be for you that regulate the money, but I would question that.

Ms. Furlong – That is exactly what we questioned. The response back was – no jails, no prisons, nothing. What we have been able to do is, we pay for some of the MOST and FAST services through State general fund dollars, and we are trying to make sure everybody is routed through I believe it's the coalitions, who are receiving the money to run FAST and MOST. We're trying to get everybody routed through there, as everything's staying the same. That's were your evaluations and other services can be paid through. We want everybody doing it the same. Not some people doing it on their own over here and some doing it through the coalitions and other people doing it other ways. We're also trying to put that responsibility back on the counties, because these individuals who are incarcerated are covered under the county's medical. So, there needs to be some ownness there. The counties are also participating in this type of coverage.
Ms. Robards – I know the FAST team does the enrahs? Which is that screening, they call it an assessment tool, but to me it's a screening. Up to that point it doesn't include any therapy or the actual comp evals or anything else that is required. I think there's a definite disconnect in what the interpretation is of what FAST is and what MOST is.
Ms. Adie – You are correct. I think you might have been involved, but we've put forth a grant application to secure some FAST funding so we can create a program that is statewide, evaluate it, and create a good system that we can then hand to the counties and say, 'this is evidence based practices, this is how it's done. We've evaluated it, we have a good outcome,' so that we can help in that transition of the counties taking over and paying for it. As of now we're going to continue for fund those programs but we're working with the FAST programs, the regional coordinators on creating a system then working with them to transition to the counties. I hear a lot of the things you're saying about them doing an assessment or an evaluation but they're really not doing services. That's one of the things we're looking at, is making sure they're all, all the FAST teams are doing the same.
Ms. Robards – I wrote the application for New Frontier, to do the same thing the five counties got together to do. I didn't submit mine, just because I thought it'd be political suicide if I got funded and they didn't. Well, I kinda hope they get funded. But you're taking non-clinical professionals and putting them in charge of clinical treatment services. That's always been a big question for me. Anyway, thank you.
Ms. Adie – We can talk more about that if you want. I appreciate the information in your comments.
Ms. Quilici – We can continue this wonderful conversation, but I thought Kendra said we had to cut it off at 1 o'clock, and it's 1:09 p.m.
Ms. Adie – We do. We were able to stall our next meeting a little bit because this conversation is important, and it has a lot of value in it. If we're in a good stopping place, then I think that would be great.
Ms. Quilici – Thank you all for joining us today. We would like to continue this conversation. There were a lot of questions Lana posed in our joint question, that was proposed last time. What are the wishes of this group? Do you want to continue these basic questions or expand it?
Ms. Robards – At this point I would ask Brook, whether there's anything else she could utilize our input and guidance on. We act in an advisory capacity and if she needed one of these expanded on or if the state wants to continue with this. Personally, I would like to continue with these meetings.
Ms. Adie – I would appreciate the information on the populations we discussed. The Medicare, the high-deductible individuals, the incarcerated. Talking about making sure we have your wait list information. I think all of those are helpful. I think this is a beneficial call so, I'm in agreement to continue this. The frequency of when you want to meet, I'll leave that up to you. Do you want to meet in a month, and we can give updates on where we are at that point? Do you want to meet more frequently, or until the end of session? I'm open and available to whatever you guys decide.
Ms. Quilici – Let's meet in the month of April. If you would ask Rhonda to send out a Doodle Poll.
Ms. Adie – How about whatever date is decided in April, we'll try for later in April, we'll set that as a goal to provide us with whatever data you can, so that we can have a meaningful discussion about where the gaps are and what the volume is of the individuals who are being impacted.
Mr. Magrdician – I agree with sometime in April, to talk a little bit more about priorities. Just so you know, we are tracking some of the Medicare, Medi-Medis and even Medical, that we get here if anybody needs that information. As far as our OP, IOP and Level I and Level II, we're not billing SAPTA for any of that, it's all Medicaid for us. I'd like to make sure we remember residential as being a priority as well.
Ms. Adie – Leo, we have a meeting on Tuesday. If you could give us something on Tuesday that would help with our conversation.

Mr. Magrdician – Please let me know, or email me, and Angela Mancum, if there's anything else we, WestCare, is missing, because I'm pretty sure, I mean we're right on top of all the things you're asking for and if you want to give us a survey and have us start to implement a survey, a discharge survey or something else, I'd be more than happy to share that with you. We're also doing the Point in Time survey that are a cost requirement for us. So, all you have to do is let us know what you need and send me an email and we will provide it to you.
Ms. Adie – We're working on that state-wide. We're identifying, getting all the Scantrons set up, the process, the timelines and all of that. You should be hearing something sometime in April about the next steps and the anticipation of go-live, July 1st. Those of you who are CCBHCs, are already doing this, so the process is going to look very similar for all other entities. Everybody you serve, regardless of funding, for all our funding providers, the next step would be to do it for all certified providers, but that's far down the road.
Ms. Hensley-Ricker – Who's paying for services, how they got into our facility, whether they get SAPTA or not, this survey will be completed by them.
Ms. Adie – Yes. The idea is so we can capture state-wide data on everybody not just the people we are serving.
Ms. Quilici – It's 1:14 p.m. and hearing no objections we'll adjourn. Thank you.

5. Adjourn