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

SAPTA ADVISORY BOARD
FUNDING SUBCOMMITTEE
MINUTES

DATE: **September 19, 2018**
TIME: **1:30 p.m.**
TELECONFERENCE: **(888) 363-4734 / Access Code: 3865799#**

BOARD MEMBERS PRESENT

Ester Quilici, Vitality, Co-Chair
Jolene Dalluhn, Quest
Jasmine Troop, HELP of Southern Nevada
Mari Hutchinson, Step 2
David Robeck, Bridge Counseling, Co-Chair
Leo Magridician, WestCare
Lana Robards, New Frontier
John Firestone, The Life Change Center
Kendra Furlong, Substance Abuse Prevention and Treatment Agency (SAPTA)

BOARD MEMBERS ABSENT

Tammra Pearce, Bristlecone Family Resources
Jennifer DeLett-Snyder, Join Together Northern Nevada

OTHERS PRESENT

Amelia Castillo
Mike Waller
Sandra Kelly
Marie Cooke
Amanda Henderson, WestCare
Ms. Rush
Patrick Bozarth
Angela Mangum, WestCare

SAPTA/STATE STAFF PRESENT

Auralie Jensen, SAPTA
Jessica Hoff, SAPTA
Laurie Gleason, SAPTA
J'Amie Frederick, SAPTA
Judy Dumonte, SAPTA
Joan Waldock, SAPTA

1. Roll Call, Introductions, and Announcements
   Ms. Furlong determined a quorum was present.

2. Public Comment
   There was no public comment.

3. Discuss Current Eligibility Requirements for Clients Seeking Services and Identify Potential Eligibility Barriers
   Ms. Furlong asked providers to identify barriers to be addressed in upcoming years. She pointed out that one purpose of this meeting was to get recommendations or guidance on developing a funding formula so that SAPTA could distribute fee-for-service block grant dollars differently than in the past. She reminded them there would be flat-funding for federal fiscal year 2019. For state fiscal year 2020 and federal fiscal year 2020, there should be a formula to apply to the distribution of funds. She said SAPTA was aware of two current barriers—clients who could not afford their deductibles and Medicare clients. She also wanted to address funding outpatient, residential, detoxification (detox), and other uncompensated services.
   Ms. Quilici said a continuum of care, including American Society of Addiction Medicine (ASAM) Level 3 residential services, needed to be maintained. Ms. Furlong reminded them there would not be enough in the block grant to cover funding every currently certified residential bed for 365 days in the upcoming year. She reported the Advisory Board discussed the importance of outpatient

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services at lower levels of care, which are less costly and could prevent the need for inpatient care. She noted other payor sources existed for outpatient services. She added that outpatient services charged to SAPTA must include proof the client was evaluated for insurance eligibility and that the application was denied. The reason for denial must be evaluated by SAPTA to determine eligibility for SAPTA coverage.

Ms. Dalluhn asked Ms. Furlong to elaborate on "other payor sources" for outpatient services. She said Quest had other payor sources for adolescent services, but no other payor sources for adults. Ms. Furlong explained that Medicaid and other insurances could pay for services. She asked Ms. Dalluhn if Quest adult clients had insurance. Ms. Dalluhn said the adults did not—many of them worked at Tesla and were not eligible for Medicaid since they had United Health Care, a part of Health Plan of Nevada (HPN). She said Quest had about 30 adult clients working at Tesla who went from having Medicaid to having insurance with a $75 copay. These clients making $14-15 an hour are in the middle of treatment and cannot afford the copay. Ms. Furlong said the ability to afford copayments and deductibles was a real concern, but SAPTA did not have the ability to pay for everybody who could not afford treatment when their insurance covered most of the cost. Mr. Robeck asked what HPN would reimburse per individual. Ms. Dalluhn replied HPN would reimburse around $70, but that Quest was not credentialed with HPN. She said they completed the 35-page credentialing packet for each of their staff last week. It could be months before they were in the HPN network. Mr. Robeck pointed out that even if they waived or shrunk the copay, the reimbursement would not be enough to cover the service. Ms. Dalluhn said since most of these clients were in the medication-assisted treatment (MAT) program, Quest appealed to the court, but no one has given them money to make up for the loss in copays. She said these clients were doing well in the MAT program, so Quest would not refer them elsewhere, but would continue to see them. Mr. Robeck said the copay was not realistic for clients to pay and the reimbursement rate was not sufficient to cover the costs of the agency. Ms. Dalluhn said in addition, these clients had either a $1,000 or a $2,500 deductible and that clients just getting sober did not have $1,000 for a deductible right way. She said in the past, SAPTA funded one month of services for clients while the provider helped get them insured. Ms. Furlong asked Ms. Dalluhn what Quest was doing to get clients enrolled in insurance. Ms. Dalluhn replied someone from the Division of Welfare was onsite for eight hours, one day a week to determine if clients were eligible for Medicaid. If they were not, someone tried to help them find other options. Other clients have said they were not able to afford the insurance plan through work, which SAPTA viewed as having opted out of insurance.

Ms. Quilici commented that no one was asking SAPTA to fund every residential bed. She reiterated that residential services were part of the continuum of care and should not be eradicated. Ms. Furlong agreed. She said SAPTA was doing an estimate on the cost of funding the open beds for a full year, knowing that not all of those beds were slotted for SAPTA clients. She asked what else created barriers to eligibility for SAPTA dollars. Mr. Magridician said WestCare has had significant obstacles moving to billing Medicaid and dealing with MCOs for Levels 1 and 2 treatment. He pointed out he saw the barriers Levels 1 and 2 were facing and was trying to find ways to obtain the needed funding without using SAPTA dollars. For residential treatment, this is the only option. Many clients come from being incarcerated. Even before they are admitted at WestCare, they get enrolled in coverage, but residential services are not covered. He said SAPTA has been their lifeline. He wished they could use SAPTA as a last resort, but the majority of his clients have no way of paying for the residential treatment they need according to ASAM criteria. Ms. Hutchinson agreed with Mr. Magridician. She said Step 2's barriers for residential treatment were enormous. They could not find a single other payor source for residential treatment. She said they did not bill SAPTA for outpatient dollars, relying on Medicaid or private pay or eating the costs. Without SAPTA paying for residential treatment, women would not be able to have residential services with Step 2 because Medicaid refuses to even discuss residential services.

Ms. Quilici commented that insurance companies did not like to pay for detox and methamphetamine withdrawal, but noted people needed help when withdrawing from

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methamphetamines. She said SAPTA needed to support detoxification units working with such clients. Ms. Furlong said they had heard reports of denials for detox for individuals using meth.

4. Discuss Current State Capacity and Funding for Clients Seeking Services

   Ms. Furlong said over the last four years SAPTA has noticed provider sites running out of money—from mid-year through the end of the year—to support the services needed in their communities. She said she asked for a breakdown of how many Medicaid clients they were served, how many of them were pregnant women, and how many were SAPTA-eligible. Within the SAPTA-eligible group, they broke down each population to see what was billed. She was surprised to see individuals being billed to SAPTA who did not qualify based on the current eligibility flowchart. She said SAPTA was working on a written policy. They have seen an increase in need not supported by the waitlist. Finding funds to fill the gaps has been a challenge. As the need has increased, services have increased but funding has not. SAPTA hoped to increase residential and transitional rates in October 2018, but already could not afford to treat the capacity at the current rate. If the rates were increased without an increase in dollars, services would be cut in the community. She would prefer not to increase rates and figure out how to fund things without increased dollars. One area they recently cut was outpatient services—SAPTA no longer funds pending-eligible clients. She said for a client who qualified for insurance, there were ways to get immediate eligibility—especially with Medicaid. The provider could be listed as an authorized representative to get the eligibility determination and to start billing services, but that would not cover residential or transitional living. She said Stephanie Woodard was working on the 11-15 waiver that would allow Medicaid/MCOs to cover 15 days of service at a time. She did not know how it would turn out or what its impact would be. That could be another payor source, but it would make billing to SAPTA more complex. She said SAPTA struggled to make sure every provider had what was needed to continue providing services, indicating there has been an increase in services. The capacity and waitlist has not shown all levels of care at capacity; there has not been a large number of waitlisted clients. She said they needed to ensure reporting on waitlist and capacity was being done correctly, and that all providers needed to use the system so SAPTA could better determine the needs in Nevada. She asked providers what SAPTA should take into consideration in distributing current funding.

   Ms. Robards said she understood the intent of the 11-15 waiver was to open up Nevada Medicaid funding for Level 3 services and to support the three existing Certified Community Behavioral Health Clinics (CCBHCs) and the five new facilities that have agreed to become CCBHCs. Even if the waiver were approved, there would still be the issue of how much financial burden Nevada's Medicaid system could withstand without additional outside funding. Without increases in funding, agencies manipulate or massage existing dollars. Ms. Furlong agreed. Ms. Quilici asked if they could divvy up the enhanced opioid money and give agencies opioid money rather than putting out another Request for Applications (RFA). Agencies could apply for some of the money to increase per person reimbursements. Ms. Furlong said she would take that suggestion to the team. She said they were able to fund some residential and outpatient services for MAT and for opioid-addicted individuals. She said it was important they did not supplant dollars. She has not discussed with Dr. Woodard a formula to determine the number of dollars to go to providers to fund fee-for-service. Mr. Robeck added the money was reserved for opioids and he did not know how many on the call served opioid clients, although every agency was prepared to provide opioid services. He said the problem was opioid money restricted things. If there were agencies with beds available, they would need to have the bed available for a person with an opioid addiction who needed treatment. He pointed out that Ms. Quilici would take those patients, but she would have to make sure she would be paid. He agreed the opioid pot needed to be expanded, but said providers needed to be qualified to handle the clients. He asked why the State was where it was

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with the federal block grant—wondering if it was because there were more years to go, if the State did not get its audits until the funding was determined, or if it was for some other reason. Ms. Furlong explained that the SAPTA block grant was a formula grant. There has been an increased need from providers, but no additional dollars coming in. SAPTA has talked about increasing rates, but that would cut services in the community. SAPTA does not have a formula to distribute these dollars to everyone. They know that outpatient services can be covered by other insurance sources and that it difficult for the working poor and those who cannot afford their copayments and deductibles. Mr. Robeck asked why there were no additional dollars coming in to a state that continued to grow the need. He asked if they could do a better job of documenting bed waits. Ms. Furlong agreed that SAPTA has not been able to show the need to increase capacity and funding. She added they have applied for grants in other areas—the CCBHCs, the STR, SSI/SSDI Outreach, Access, and Recovery (SOAR), and ACT. Those dollars do not fund direct treatment services. It would better if Nevada could improve in telling the story of where we are and what we need. Mr. Robeck thought everyone on the call would agree to do something more to support that. He mentioned that in most meetings Ms. Furlong asked for improved counts for the bed waits and the extra needed for services and the emergency issues and he wondered if agencies were providing the information. Ms. Furlong said not much reporting on waitlist and capacity has been coming in. Ms. Jensen has worked with agencies to go over how to report, why reporting is important, and what kind of things should be tracked for waitlist and capacity versus what kind of things should be tracked internally but are not capacity issues—such as a person waiting for a release date from jail. She said in order to ask for additional dollars, the State had to show the need existed. She noted certain aspects of data were no longer available to SAPTA, as provider agencies have moved to their own electronic health records systems. With the data repository, data for reports will be available again. She said she wanted to be show a three- to five-year trend of how much was awarded to each agency and what SAPTA's spendouts have been, but she did not have access to the information. She has had staff pull the RFRs and backup documentation for the last three years and manually collect the data by Current Procedural Terminology (CPT) code, agency, and level of care. Analysts have been trying to mine the data so SAPTA can evaluate the history. If she could show a five-year trend of unique client count by level of care and service code and dollar amounts charged, that would give her a base. If the unique client counts had not gone up but the services had, they would have to ask why more services were being provided and what was being done differently. Perhaps a larger problem was identified that took more resources and capacity to serve, or providers were able to do things that were not done in the past. She noted it was difficult to have these conversations without the data. She wondered if agencies would be willing to answer a query. It could be easier for them to pull trends for the last three years than it would be for her to data mine. Mr. Robeck said his agency would do that. Ms. Furlong said she would put together the information SAPTA needed, have the agencies send it in, then assemble it for evaluation. Ms. Robards asked if their quarterly reports on the number of clients they were serving in each level of care would contain the data. She asked how the data from the quarterly reports was used by SAPTA. Ms. Furlong said she would have to research that. Ms. Robards said she would let SAPTA know where they send their information. Ms. Furlong said there are several quarterly reports: the ones used for the budget in fiscal; quarterly reports pertaining to prevention; and quarterly reports that measure outcomes. Ms. Robards said the quarterly report originated with SAPTA and that all providers were required to submit them. She said the report provided information regarding how many clients served in what level of care and some demographic information. She explained it was different than Treatment Episode Data Set (TEDS). Ms. Henderson said providers used to submit quarterly reports that addressed capacity, total number of clients in treatment at 90 days, and waitlist information. Ms. Furlong said those were the quarterly performance measures and were still required. She explained that, in the past, Sheri Haggerty compiled the information.

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Now Ms. Furlong has had to pull the information. She has not found the new place it is going. She said she and Laurie Gleason were working on a special project to address reporting. It will include what agencies need to report on a regular basis and when the reports are due. Ms. Robards said there could be data at SAPTA that could help determine trends in treatment in Nevada. Ms. Furlong said if all agencies were not sending in the same information and if the information was not compiled and used appropriately, it would not be beneficial. She said SAPTA needed to ensure that everybody was reporting so there was meaningful data to evaluate. Ms. Robards said her staff sends the quarterly reports to Sheri Haggerty. Ms. Furlong asked if New Frontier could send those reports to the analyst or upload them to the Secure File Transfer Protocol (SFTP) site.

Ms. Robards said if they were looking for places to divert SAPTA funds, Tammra Pearce asked that they consider helping facilities with the annual audit requirements.

5. Public Comment

Mr. Firestone said Life Change Center has had a problem with Medicare. As a provider type 17, specialty 215 offering MAT services and outpatient treatment, they have noticeably more Medicare clients coming for treatment because of new regulations about prescribing. He asked whether SAPTA would reimburse for patients who have Medicare and Medicaid. Medicare has told them under partial hospitalization or certain services, they will do service-to-service-basis coverage if treatment was provided by a Licensed Clinical Social Worker (LCSW). The service-to-service basis has meant Medicare denies in every case and then allows Life Change Center to appeal. It has been difficult to continue providing service to this growing need. Ms. Furlong replied this could be a future topic of discussion on barriers. Mr. Robeck said CCBHCs must have an LCSW in order to accept Medicare. Mr. Firestone pointed out that his agency is an Integrated Opioid Treatment and Recovery Center, so was in the same boat as any other PT 17, 215. Ms. Robards said being a CCBHC did not give them preferential standing with Medicare. New Frontier has not gotten through the gatekeepers for any of their services, including those done by a Qualified Mental Health Professional (QMHP). It has been an ongoing struggle. She commented that up until not long ago, SAPTA paid for those clients if an agency could prove Medicare was the primary insurance. Ms. Furlong said Medicare/Medicaid clients were still covered by SAPTA, but the provider must submit proof of denial from both insurances before SAPTA will pay. Mr. Firestone said his agency has done that, but has been told they will get less funding from client service fee patients in the coming year because Medicare would cover these services, which was not the case. Ms. Furlong agreed they needed to discuss this.

Mr. Firestone asked how others could become part of the subcommittee. Ms. Jensen said Christopher West from Seven Hills would like to become a member. Mr. Robeck asked if the bylaws of the SAPTA Advisory Board prohibit nonmembers from being members of the subcommittee. Ms. Furlong said they would look into that.

Ms. Furlong recapped the following as barriers:

- Copayments and deductibles that could impact eligibility
- No other coverage for residential and detox services
- A consideration for Medicare clients
- A consideration to cover the audit requirements that are put on the providers
- The possibility of moving opioid dollars to fee-for-service for those kinds of clients, which could increase the funds for fee-for-service

She reviewed that the Subcommittee was open to providing additional data as requested by SAPTA to help develop a three- to five-year trend and that SAPTA would explore the current reports to see if data was onsite that could be used.

Ms. Robards asked if the rates increases SAPTA was considering were the same ones as approximately two years ago. Ms. Furlong said they were.

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Ms. Furlong said she would pull together some of the data and set up a future meeting where data can be evaluated so they could start making some decisions. She asked if there were any other agenda items members of the subcommittee would like to add. There were none.

6. Adjourn
   Ms. Robards moved to adjourn the meeting. Mr. Robeck seconded the motion. The motion passed. The meeting adjourned at 2:30 p.m.

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