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

MINUTES

DATE: **June 14, 2017**
TIME: **9:00 a.m.**

LOCATION:	**Carson City**	**Las Vegas**	**Elko**
	DPBH	**SNAMHS**	**DHCFP**
	4126 Technology Way	**6161 W. Charleston Blvd.**	**1010 Ruby Vista Dr.**
	Second Floor Conference Room	**Bldg. 1, West Hall Conference Room**	**Suite 103**

BOARD MEMBERS PRESENT

Steve Burt, Chair	Ridge House
Michelle Watkins	Central Lyon Youth Connections
Diaz Dixon	Step 2
Jennifer Snyder	Join Together Northern Nevada
Kim Moore	HELP of Southern Nevada
Tammra Pearce	Bristlecone
Misty Alegre	New Frontier
David Robeck	Bridge Counseling
Jolene Dalluhn	Quest Counseling
Jamie Ross	PACT Coalition
Michelle Berry	CASAT
Ester Quilici	Vitality Unlimited

BOARD MEMBERS ABSENT

Pauline Salla-Smith	Frontier Community Coalition
Debra Reed	Las Vegas Indian Center
Ron Lawrence	Community Counseling Center

OTHERS PRESENT

Dani Tillman	The Life Change Center
Helen See	The Life Change Center
Sara Hunt	UNLV
Richard Brown	The Empowerment Center
Christopher Croft	Tahoe Youth & Family Services
Cheryl Bricker	Partnership of Community Resources
Barry Lovgren	Private Citizen
Tenea Smith	Rural Nevada Counseling
Trey Delap	Group Six Partners
Angela Mangum	WestCare
Christian Lazarte	Serenity Mental Health
Michelle Guerra	HPN/BHO
Andrea Zeller	Churchill County Coalition
Melissa Denomme	Solutions

SAPTA/STATE STAFF PRESENT

Kyle Devine	Bureau Chief
Marco Erickson	Health Program Manager
Ruth Condray	Clinical Program Planner
Stephanie Woodard	Licensed Psychologist
Kendra Furlong	Health Program Specialist
Meg Matta	Health Program Specialist
Sheri Haggerty	Business Process Analyst
Bill Kirby	Management Analyst
Dennis Humphrey	Health Program Specialist
Julia Peek	Deputy Administrator
Sara Weaver	Administrative Assistant

1. Welcome and Introductions:

   Mr. Burt opened the meeting at 9:15 a.m. He noted there was a quorum present.

2. Public Comment:

   There was no public comment.

3. Approve Minutes of February 8, 2017, and April 12, 2017:

   Regarding the February 8, 2017, Mr. Robeck motioned to accept the minutes as written. Ms. Dalluhn seconded the motion. The motion passed.

   Regarding the April 12 minutes, Ms. Snyder motioned to approve. Mr. Robeck seconded the motion. The motion carried.

4. Standing Informational Items:

   Mr. Burt asked Ms. Berry to give the report on Assembly Bill (AB) 194 as part of her report.

   Ms. Woodard gave the CCBHCs [Certified Community Behavioral Health Clinics] report. Ms. Woodard stated was in the final week of certification of clinics. She stated she anticipate having four CCBHCs with five sites, launching on July 1. Ms. Woodard stated New Frontier and Bridge had been assured certification. Vitality and WestCare were having their final reviews this week.

   In regard to funding, Ms. Furlong stated she was looking at funding streams, where shortfalls existed, and to whom funds could be distributed. She added she was also looking at what funds were available to use through the State General Fund until the block grant period started. She reported she was in an analysis phase and hoped to be able to address everyone's needs in the next few weeks.

   Ms. Peek reported that the request for level funding was approved by the Legislature. The Legislature approved a mental health budget that was higher than what the Governor Sandoval's budget requested.

   Ms. Dalluhn requested information about medication assisted treatment (MAT) funding regarding the request for proposal (RFP) that was supposed to come out July 1. Mr. Erickson gave the SAPTA report.

   Mr. Erickson stated that as a result of receiving the State Targeted Response to the Opioid Crisis (Opioid STR) Grant, MAT funding would not be included in the announcement. He stated there would be a focus on enhancing services that were not currently funded by Medicaid. He stated receiving the grant shifted the priorities.

   Ms. Woodard stated that three new positions were added to the legislatively approved budget, two of which were CASAT, so there would be no fees associated with the administration of the grant. Since CASAT assisted in writing the grant, she stated they seemed to be the most reasonable partners for getting the program off the ground. Ms. Berry stated the cost built into the two positions paid the cost for administering the grant.

Ms. Woodard reported she was waiting on issuing the RFP because she was working with Medicaid to prepare a crosswalk for the services they want to build into the hubs. She stated the goal was to build the grant correctly. Ms. Woodard stated she hoped to start earlier than October 1.

Ms. Woodard explained that the Opioid STR Grant is a formula grant that was offered to all the states based on known treatment needs, burden of disease related to opioid use disorder, and rate of overdose deaths. Nevada applied for a two-year $5.6 million grant. Health and Human Services (HHS) Secretary Tom Price released the funds immediately for the first year. She added that year two of the funding was contingent on evidence that the funds were used effectively to address opioid use disorder. She explained that the grant had two primary requirements—that 20 percent of the grant would be targeted toward prevention and 80 percent would be targeted toward treatment.

Ms. Woodard added the Opioid STR Grant was not a typical grant. She stated that at the federal level there was recognition that these dollars were to be used to build systems that were sustainable when the grant ended. She mentioned that all federal partners, including Centers for Medicare and Medicaid Services (CMS) and National Institutes of Health (NIH), were at the table at HHS to assist states in developing sustainable systems for this funding. She added that NIH put out another grant that was due in two weeks that would evaluate some of the services and supports that were being provided by states for the Opioid STR Grant. She reported that the Region 9 coordinator, John Perez, had begun to convene all states in the region to discuss what they planned to do with their grants, where innovation were taking place, and was asking how SAMHSA [Substance Abuse and Mental Health Services Administration] and other federal partners could support efforts at the state level.

Ms. Woodard stated that Nevada is one of 25 states looking to adopt a version of the "hub and spoke" model. She added that other states have attempted this, with many of them adopting an 1115 Demonstration Waiver for substance use disorder treatment. She said they are working closely with Medicaid and MCOs [Managed Care Organizations] to help design what the hub and spoke model would look like with Nevada's vast areas of geography as well as areas of great population density. She stated that the majority of the treatment dollars would be going to build infrastructure for the hub and spoke model.

Ms. Woodard stated they were using much of the work that had been done by the Governor's Opioid Taskforce and the Governors' Summit, looking at the recommendations for prevention. She mentioned they were looking at provider education for non-pharmacological treatment of chronic pain. She added that, on the treatment side, they would like to provide education to prescribers on becoming office-based opioid treatment providers (OTPs), building competency in prescribing suboxone, for example. She indicated they would take a multi-pronged approach and that they saw their partnerships with Medicaid and managed care as critical for sustainability.

Ms. Woodard explained that they were planning to engage the OTPs and help them build out with these funds to meet the criteria to provide services that were currently covered under the state plan that would be required in a hub. She said they want to map on all the provider types and make sure they met all the qualifications so it could be known how far the reach is for each of them and what funding was needed to get them where the providers needed to be after the year of funding was completed. She stated that after the first year, those services should be sustainable because they could then be reimbursed by Medicaid and the providers would be credentialed to be allowed to provide those services.

Ms. Snyder asked how naloxone funding would be handled. Ms. Woodard replied that there would be funding in the grant for purchasing naloxone. She explained they were looking at this with a multi-pronged approach involving mobile recovery outreach teams going into communities in high-risk areas to do outreach for such things as needle exchanges. She mentioned there was a significant gap in services for those who had experienced an overdose or had ended up in the emergency room or inpatient unit due to some type of opioid use disorder as part of their presentation. The teams would reach out to those at risk for or those who have survived an opioid overdose, trying to connect them with overdose education and naloxone distribution, in addition to treatment and recovery supports.

Ms. Snyder pointed out that it did not appear that the funds would be distributed to the coalitions. She added there are many agencies in her community asking for the kits and asked what she should tell them. Ms. Woodard replied they were in the process of developing their strategic plans and that the information the coalitions had would be useful in that planning as they must complete a needs assessment by July 31. She stated that the strategic plan must be submitted by August 30. She reiterated that they are working with Medicaid and MCOs, and added that they are also working closely with the Office of the Attorney General. She indicated that the Attorney General's Office had reached out to law enforcement to determine which agencies would like to have naloxone. She mentioned the Nevada Rural Opioid Overdose Reversal (NROOR) program through UNR [University of Nevada, Reno] was going to expand to areas in Washoe and Clark Counties and the rural areas targeted by SAMHSA as areas of highest use, making those geographic areas the primary focus for at least year one of the grant. She added that they would work closely with emergency medical services (EMS) in the rural areas, using them as another conduit to get naloxone out into rural communities.

Ms. Ross questioned how information was being gathered, as they had many community partners wishing to participate in this. She stated there is a lot of momentum on this in southern Nevada. Ms. Woodard replied that the grant was awarded in mid-May but authority through IFC [Interim Finance Committee] had not been given to use the funding. She stated they had been quick to try to identify the order in which they planned to get these pieces moving. She added they had been working at engaging communities to the degree possible. She stated they had met with the opioid task force in southern Nevada, Tom Robinson of Reno Police Department, all of the OTPs, and almost every Federally Qualified Health Center (FQHC) to get the message out to communities that they had the funding and what their plans were. She stated that CASAT would be gathering the information and requested relevant data for their assessment. She mentioned they must guarantee, through their strategic plan, they were accounting for every activity that was funded through a different funding source to ensure there was no duplication of services through the Opioid STR Grant. She mentioned that during the Opioid STR Grant development process, information was gathered relating to activities from the coalitions through the Partners for Success (PFS) Grant. That information helped guide many of their strategies.

Ms. Woodard stated they were looking at different strategies they could use to build their hub and spoke model, as nothing was prescribed. She added that the hub and spoke model worked with an OTP at its center, but they were looking at Ken Stoller's stepped approach to treatment as well. His model is to have office-based opioid treatment providers for suboxone, who determine the level of severity of an individual they manage. She shared that many prescribers would be interested in expanding their services to include MAT and that many who were waivered and not currently prescribing feel isolated. She added that the core of the hub and spoke model is that the care is coordinated care. She mentioned that when it came to managing and mitigating high-risk patients and providing all the necessary care—such as urine drug screens and random pill

counts—many were prevented from doing that because of staffing and lack of reimbursement for those services.

Mr. Burt stated that the entire wheel of the hub and spoke is a recovery-oriented system of care. As a result, it includes employment, education, housing, transportation, and vocational education.

Ms. Woodard agreed, stating that they recognized they needed to start with the hub; however, in some communities, hubs are not established. She referred to Elko, which was identified by SAMHSA as key area they need to focus on, which does not have an OTP and is not expected to build one soon. She stated that as a result, they would start building from the spokes inward.

Ms. Dalluhn asked if the OTPs in Washoe County are the methadone clinics and if they would be the hub. Ms. Woodard replied that, ideally, they would be the hub. She added that was the model other states had gone to because they could provide the entire array of services, including methadone, which was still the key medication that needed to be used and available to those struggling in recovery from opioid use disorder. She stated they saw the OTPs as the hub and building them out so they could provide the full range of MAT services, as well as all of the treatment services and recovery supports.

Ms. Snyder asked if OTP referred only to those not using suboxone and methadone, but to methadone clinics. Ms. Woodard replied that, historically, OTPs were methadone clinics. Ms. Snyder added that she was thinking of it in broader terms. Ms. Woodard stated the OTPs would need to provide the array of MAT options, recognizing that one size does not fit all, so for some suboxone or methadone was the preferred choice.

Ms. Woodard concluded that she would be happy to come back to report on their progress as the hub and spoke model is designed, as engagement with community providers, coalitions, and community stakeholders takes place and as the strategic plan is developed. She added she was looking for meaningful input along the way.

Mr. Erickson stated SAPTA was pushing for sustainability plans. He said SAMHSA removed several million dollars from various grantees across the nation where funds were not spent down. He added that instead of carrying them forward as they have in the past, they had to pay back dollars and had to offset states not spending down the dollars. As a result of that, he said his teams would be monitoring spend downs and request spend down plans from SAPTA-funded providers. He reported SAPTA had been advised it would be unlikely to get no-cost extensions on current funding.

Ms. Woodard gave the report on the proposed amendment to Nevada Administrative Code (NAC) 458.336.

She reported it contained provisions for tribal entities to operate evaluation center programs and treatment for substance-related disorders in the same geographic area, regardless of population. Mr. Erickson added that the proposed amendment was approved at a recent Board of Health meeting. Ms. Woodard also stated there was a public workshop on the topic held on May 16. Ms. Weaver added that the regulations had been amended and that next the amendment would be presented to the Legislative Commission.

Mr. Burt gave the report on the SAPTA strategic plan. He noted that a few members of SAB were on the SAPTA strategic planning committee that was managed by SEI [Social Entrepreneurs Inc.]. He stated there were a few modifications made. Mr. Erickson stated the main changes they

made regarded dates. He commented there were items they felt might take a little longer, including some of the reports from the coalitions. He stated they wanted to bring all the information together and do a meta-analysis. He explained that data would drive their future, with staff aligning their efforts with the strategic plan. He added he would ask them where what they were working on and how that work would align with the strategic plan. Mr. Burt stated the strategic planning committee had been asked not to release the report in draft form. He stated the plan still had to go through a final internal review process before it could be released.

Mr. Erickson gave the report on the SAMHSA site visit.

Mr. Erickson stated that last year there was a treatment and prevention visit. He said this year's visit would focus on treatment, and next year's would focus on prevention. He added SAPTA was putting a package together so that when SAMHSA arrives, SAMHSA representatives would have information about the full array of activities taking place at treatment sites in the last year.

Ms. Berry gave the CASAT report.

She reported on bills that were passed by the Legislature this year.

- AB 425 pertains to the Board of Examiners for Alcohol, Drug, and Gambling Counselors. The bill authorizes a certified drug and alcohol abuse counselor who has been certified for at least three years, meeting all other requirements prescribed by the Board, to supervise interns. Part of the bill removes the requirement that an applicant must have completed not less than 30 hours of instruction specific to alcohol and drug abuse, adding the requirement that the applicant must have received at least 6 hours of instruction relating to confidentiality and 6 hours relating to ethics.
- AB 65 passed, which revises provisions relating to medical care for indigent persons, setting up a supplemental payment to hospitals.
- AB 429 pertains to the interstate practice of psychology.
- AB 457 regards professional licensing boards reporting to the Legislative Committee on Health Care.
- Senate Bill (SB) 27 adds that the definition of "mental health" excludes mental health disorders that result in diminished capacity.
- SB 50 regards psychiatric advance directives, allowing for psychiatric care for individuals in crisis or with diminished capacity.
- SB 91 regards drug donations programs for all medications, expanding them beyond those for HIV/AIDS.
- SB 192 extends hours for mobile crisis units in urban areas to 16 hours per day, 7 days a week.
- SB 227 revises provisions related to the practice of nursing, allowing for e-signatures in specific instances and expands the role of advanced practice registered nurses (APRNs) based on scope of practice.
- SB 121 directs the Legislative Commission to appoint a committee to perform an interim study regarding behavioral health and cognitive care needs for older adults.

She reported that AB 194 would have made certification of peer support mandatory, but the bill died.

Ms. Berry noted there would be 4 regional behavioral health policy boards, each made up of 13 members. She stated the boards would provide advisement to DHHS, the Division, and many

of the behavioral health commissions. She asked that anyone interested in representing SAB submit their names for a potential seat on one of the boards. Ms. Bricker requested information regarding Mobile Outreach Safety Team (MOST). Ms. Berry replied that the hours of operation for MOST have been increased from operating for 8 hours to operating for 16 hours per day, 7 days a week in urban areas. She added they were looking to increase their staff by three people, based on the additional funding they received.

Ms. Bricker stated that Carson, Douglas, Lyon, and Churchill communities had funding for MOST FAST [Forensic Assessment Service Triage] through the coalition in Carson City and understood that funding would be stable. She stated they did not know whom the funding would go through after July 1, so the communities could continue to provide this service during a 10 hour day a week. Mr. Erickson stated it was his understanding that funding would continue to be through Partnership Carson City. Ms. Berry explained that her report on MOST was for Washoe County only.

Mr. Burt gave the chair's report.

Mr. Burt thanked the Division's team for getting some bills passed and the Behavioral Health Association for meeting and strategizing, under the leadership of CASAT. He pointed out that Mr. Delap did a great job of attempting to kill AB 194. He stated he was excited for the rural providers that AB 425 passed, which increases the supervision responsibilities to an intern and created an inactive license that many providers had complained did not exist. He added it increased the Board of Examiner's ability to go after those not providing services correctly. In the past, he said, the only recourse was to go to District Court to file a complaint to have someone's license put on hold. He mentioned that if the person did not have a license, they were out of the Board's jurisdiction and could not be held accountable.

Mr. Burt stated that AB 457 was passed. In its bill draft request form, it was a board consolidation bill. He explained that the Division was able to work with the four boards so they could in manage themselves better to eliminate barriers to those entering the field. He reiterated that much progress was made 2017 Legislative Session for his field.

5. Review and Make Recommendations on the SAPTA Advisory Board Bylaws

Mr. Burt suggested adding an OTP to the array of providers on the SAPTA Advisory Board. He stated that would require a change to the bylaws to increase the number of members from 16 to 17. He explained that now there was not adequate OTP representation on the Board, so he recommended the addition of another member. The current contact list includes:

- Ridge House
- Step 2
- Join Together Northern Nevada
- Bristlecone
- CASAT
- New Frontier
- Frontier Community Coalition
- Central Lyon Youth Connection
- WestCare
- Las Vegas Indian Center
- Bridge Counseling

- Community Counseling Center
- HELP of Southern Nevada
- PACT Coalition
- Vitality Unlimited
- Quest Counseling

He stated that the distribution of agencies north, south, and rural were equally represented. He also stated they had distribution of treatment and prevention providers and/or coalitions. He said there was adolescent representation through Vitality and Quest; criminal justice representation was across the board; and there was an administrative program through CASAT.

He reported he was given a list of agencies that had not attended SAB meetings from 2015 through 2016. He said the bylaws required the Chair to ask agencies that had two or three absences if they wanted to continue their involvement with the SAB, giving them the option to start attending meetings or be off the Board. He pointed out there had been no representation from Frontier Community Coalition in the entire year of 2016. He stated he had not corresponded with Frontier Community Coalition to find out if they wanted to continue to be on the board, but thought a change in the bylaws might not be needed to increase representation if Frontier Community Coalition were held accountable to attendance policies in the bylaws.

Ms. Snyder mentioned that she was unaware of a Vice Chair for the Advisory Board. Mr. Burt replied that CASAT holds the Vice Chair position. Ms. Snyder noted the bylaws state elections are to be held in even-numbered years, so should have been done in 2016. She stated that Frontier Community Coalition was a board member, and said she had a conversation with its director who wanted to know if his board member attended meetings. She agreed that Ms. Salla-Smith should not be representative. She added that those in prevention do not get the information that people involved in treatment get, and that as result many do not know when the meetings take place. She suggested asking if the director of Frontier Community Coalition would like to be on the board, instead of removing the position. She further suggested that the chair contact those who have not been attending, see if they want to be removed, then offer a slate of those who could fill vacancies at the next meeting.

Mr. Croft asked if membership on the Board was limited to agencies on the list, or if it was open to those who attend the meetings. Mr. Burt replied that organization representation is limited by Article 4.22 of the bylaws to organizations receiving state funding. He added that has changed somewhat since they had been contract based, so he is not opposed. Mr. Croft asked if a private citizen could be a member. Mr. Burt replied that a private citizen could not, according to current bylaws. Ms. Snyder asked if the agencies listed were receiving SAPTA funding. Ms. Furlong stated they were. Mr. Croft asked if there were objections to having a private citizen as a board member if the bylaws were amended to allow for it. He stated he could see advantages to allowing for that, as a private citizen's input would not be predicated on how decisions would affect funding or reflect a clinical viewpoint rather than what was good for patients. Mr. Burt added he thought having a non-funded provider who is not in competition with the rest of the board for resources could provide more objectivity. Mr. Croft clarified an unfunded agency or private citizen could point out what was better for the community rather than the Board alone. Ms. Snyder asked who had the authority to change the bylaws; Mr. Burt answered that the Advisory Board does. She stated she would be in favor of term limits.

Mr. Burt stated that the discussion over the usefulness and the role of the SAPTA Advisory Board was tabled over the past six months during the 2017 Legislative Session. He mentioned that the

Behavioral Health Planning and Advisory Council (BHPAC) had been tasked with taking on additional roles, including oversight of the boards, which would allow for discussion about the future of the SAPTA Advisory Board. He added that SAB would need to meet with the BHPAC to find out what their new makeup would look like, and if it would include substance abuse counselors and treatment providers. He suggested this topic become a standing item on the agenda.

Ms. Berry volunteered to contact board members who have been absent and would provide an update at the next meeting. She noted the bylaws allow members to miss three consecutive meetings without permission of the Chair. Ms. Berry stated that she would give an update at the next meeting.

Ms. Woodard added it was the intention of the Division to evaluate the utility of all of the boards and, where there are duplications, determining which ones were required for grants or through statute. She stated the goal was to minimize as much duplication as possible. She noted this was part of the reason for the discussion about blending the SAB and the BHPAC. She stated there were specific obligations required as part of the Mental Health Block Grant, but since the Division had moved to providing an integrated block grant application, and in looking at the roles of the SAB, it seemed they matched well. She mentioned that one of the requirements for the BHPAC was at least 51 percent representation of individuals served and family members to provide input. She said SAMHSA was moving in this direction, noting that one of the certification requirements for a CCBHC was that the boards meet that 51 percent. If they could not meet that percentage, they have to have a specific accountability plan approved by the State.

Mr. Robeck stated he wanted clarification of whether they are a Board and what that Board looks like before they make any changes in membership. He also noted that private citizens have freedom to make public comment and that Mr. Lovgren had served on a subcommittee as a private citizen. He suggested that private citizens would need to go through a process similar to the one agencies go through for certification that includes documentation and interviews in order to determine their agenda.

Mr. Burt stated that the agenda item for the next meeting should be about who is on the membership list. He asked if the future of SAB should be an agenda item. Mr. Burt asked that agenda item 5 be included on the next agenda and that a separate agenda item be added that would be the future of SAB.

6. Review and Make Recommendations on the Capacity Policy

Ms. Furlong stated the latest update included changes resulting from Mr. Lovgren's comments, and that they are available for review, recommendations, and comments from the Board.
Mr. Lovgren verified the documents that were sent out electronically and the documents at the meeting with the June 1 revision date were the ones to which she referred. Mr. Robeck noted the documents did not appear to be drafts, but were policies. Ms. Furlong replied they were drafts, not finalized policies. Mr. Burt asked what it was that Ms. Furlong needed regarding these recommendations. She replied she was looking for input from the group so policy could be established.
Mr. Robeck asked whether the entire document was the new policy, or whether there were marked specific changes. Ms. Furlong replied there were minimal changes made, but they were not marked. She stated that when she received feedback from the Board, there were no specific changes needed, so she sent out the same policy. She further stated the comments that came in from Mr. Lovgren were addressed, and that Ms. Haggerty was prepared to review them.

Ms. Haggerty reported that changes were minimal. She stated they addressed all the concerns and made adjustments where they felt appropriate. She added that many of the issues brought up were addressed in the policy. She recommended that people read the entirety of the policy so they would know what was coming, in what order, and so that they could see everything that was addressed before making comments on individual items. She drew attention to a specific change to SAPTA "certified and funded," for accuracy. She pointed out that the capacity management policy dealt with the capacity issues they have seen—bed counts, reporting to HAvBED when 90 percent of capacity had been reached—so that clients could be referred as needed. She stated she would like to see more frequent updates in HAvBED so that clients could be referred to providers that had open beds. She continued that the policy addressed priority populations, as reflected in the addition of 4.0 d, "Substance using females with dependent children and their families, including females who are attempting to regain custody of their children." She stated that would help meet the goal for the carve-out for women's services. She noted that, if the board did not want to see this as a priority population, the issue could be discussed. She added that 4.0 a, b, c, and e was guidance received from SAMHSA. She pointed out that SAPTA was the "payer of last resort" per SAMSHA guidance.

Mr. Burt requested a motion for agenda item 6. Ms. Dalluhn moved to approve the Capacity Policy. Mr. Robeck seconded the motion. The motion carried.

7. Review and Make Recommendations on the Waitlist Policy

Ms. Haggerty stated that once capacity was reached, the next step was wait listing. She reported the waitlist policy pertained to who should be waitlisted and how it should be done. She stated the goal of this policy was to not waitlist pregnant women wherever possible, although it was allowable under special circumstances. She noted pregnant women was one of the top priority populations, and that it was the goal to get them into treatment as soon as possible without gaps because there are two lives at stake. Ms. Tillman stated she was looking for coverage in the gaps of treatment for pregnant, IV [intravenous] drug using women who are on MAT. Ms. Haggerty replied this issue might need to be sidelined, as some view those on MAT as still using a substance and not being accepted into a program as a result. Ms. Woodard noted there were federal regulations that prohibit courts from disrupting an individual's course of treatment because they are on MAT. She stated this issue would be addressed with the project officer for the relevant guidelines.

Ms. Haggerty referred to the flow chart of what an individual would go through to be placed on a wait list for SAPTA providers. She mentioned that Medicaid clients might not go through all of the same steps and referral processes, such as if they are members of an MCO, they must be referred back to that organization if there are no beds available. She stated that Medicaid clients must follow Medicaid's rules. Ms. Furlong added she had requested feedback in order to make the necessary adjustments. She stated she had received feedback from only two providers.

Mr. Burt stated the Division needed to move forward on these policies and would like recommendations on each of them. He stated the policies were not written in a way that requires SAB approval for possible action. Ms. Dalluhn stated she had questions about the utilization management process. Ms. Pearce concurred with Ms. Dalluhn that she had no problems with the policies regarding the waitlist and capacity, but had concerns about utilization management. Mr. Robeck suggested that Mr. Lovgren's comments be taken out of order. Mr. Burt agreed.

Mr. Lovgren expressed he was pleased that a capacity management policy was being addressed as the need to conduct outreach to injection drug users in a way that meets specific federal

requirements had been a problem. He stated the mandated programs' funding structure had not changed, but noted the policy addressed that. He reported problems with other block grant requirements. He shared the problems he found in the drafts, stating that the policy did not meet block grant requirements for capacity and waitlist management while it imposed burdensome requirements with no foundation in the block grants. For an example, he cited that members of MCOs are not placed on wait lists because of problems with the third-party funding sources. He stated that was dangerously close to denial of services due to inability to pay. He added that unnecessary and burdensome requirements include requiring every program to provide services currently only required of programs that receive set-aside funding for specialized treatment of pregnant women and dependent children to any woman with a child of any age such as making arrangements for transportation. He mentioned that requirement adds to the Bureau's enforcement burden, which it already had trouble meeting.

Ms. Haggerty noted that those services were to be provided if applicable, so if something does not apply to the program it is not a requirement. She explained that if a program only serves males, the requirement to provide transportation for a mother would not apply. She also pointed out that she reached out to Medicaid and Department of Welfare Supportive Services to confirm that what they had in the policy was accurate and that referring clients back to the MCO was the requirement.

Mr. Lovgren stated that none of the programs could bill Medicare, so that it is irrelevant to refer patients back to Medicare because there is blatant discrimination against the elderly. Ms. Furlong interjected that she could see his point, and that they discussed how to better serve the Medicare population. She stated that current policy was if someone has the ability to receive treatment through their insurance, they must be referred to their insurance program unless they chose to receive care out-of-network. She added that, if they did that, they were not eligible for reimbursement from SAPTA because they had opted out of using their own insurance coverage. She mentioned she was aware of the problem with the Medicare population insurance issue, as our providers are not covered under the Medicare place of service, which is the hospital. She added they might not be able to receive the appropriate care in a hospital that they could receive in one of the SAPTA-funded facilities. She stated it involved the eligibility policy that Mr. Lovgren had asked for, which she said is 90 percent complete. Mr. Lovgren stated that their policy, in effect, denied service based on an inability to pay. Ms. Furlong disagreed, stating a patient could become a self-pay client and go on to a payment plan or sliding fee scale. She stated that SAPTA ensured that systems were in place so that a client could receive care, but were prohibited from paying when there was another payment source available. Mr. Lovgren stated that under federal law the payer of last resort applies only to ancillary care, not to treatment. He asserted SAMHSA is very clear on that.

Mr. Burt commented that both sides made very good points. He said that trying to find the right funding source so that someone could receive the care needed was of great importance.

Mr. Burt requested a motion to approve agenda item 7. Ms. Dalluhn moved to approve the Waitlist Policy. Mr. Robeck seconded the motion. The motion carried.

8. Review and Make Recommendations on the Utilization Management Process

Ms. Quilici made a motion to create a subcommittee to discuss the Utilization Management Process. Ms. Dalluhn seconded the motion. The motion passed.

Members who volunteered for the subcommittee included: Ms. Quilici, Mr. Robeck, Ms. Mangum, Ms. Moore, Mr. Lovgren, Mr. Disselkoen, and Ms. Furlong.

9. Public Comment
   Andrea Zeller commented on Board attendance. She stated her coalition sent a letter to members not attending meetings, reminding them of the commitment they had made—giving them the option of either resigning from the board so they could be replaced or reinstate themselves and that they could not miss any more meetings.

10. Adjourn
    Mr. Burt adjourned the meeting at 11:21 a.m.