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

MINUTES

DATE:	December 12, 2013	Teleconference Number
TIME:	10:00am	1-888-363-4735
LOCATION:	Substance Abuse Prevention and Treatment Agency 4126 Technology Way, 2nd Floor 2nd Floor Conference Room Carson City, NV 89706	Access Code: 1602938

BOARD MEMBERS PRESENT

Via Teleconference

Mark Disselkoen (Chairperson)	CASAT
Ester Quilici	Vitality, Unlimited
Diaz Dixon	Step 2

BOARD MEMBERS ABSENT

Steve Burt	The Ridge House
Kevin Morss	WestCare

STATE OF NEVADA STAFF

Via Teleconference

Steve McLaughlin	Treatment, SAPTA
Becky Hepler	Data, SAPTA
Lisa Tuttle (recorder) – Carson City Site	Admin, SAPTA

PUBLIC

Via Teleconference

Judye Marshall	Las Vegas Indian Center
Stuart Gordon	Family Counseling Service of Northern Nevada
Kris Darnall	Foundation for Recovery
George Gatski	Las Vegas Recovery Center
Dottye Dexter	Vitality, Unlimited
Frank Parenti	HELP of Southern Nevada / NVAADAPTS
Richard Jimenez	WestCare

1. **Welcome and Introductions**
   Chairperson Mark Disselkoen opened the meeting at 10:07 am and introductions were made.

2. **Public Comment**
   No public comment was made. However, there was discussion regarding proxies for the SAPTA Advisory Board (SAB) under the By-Laws, which Ester was not aware of. She requested a copy of the By-Laws.

3. **Discussion and Recommendation Related to Residential Rate Study and the Sliding Fee Scale**
   As of the November 13 SAB meeting, Mark Disselkoen did preparatory work related to this subject and examined the intent of the subcommittee. He gave a brief summary as to how the subcommittee was formed.

Mary Wherry and Steve McLaughlin brought forth and discussed the draft sliding fee scale originally slated for July 1, 2014. However, it would be beneficial to have it completed earlier. The goal is to have one sliding fee scale for treatment providers and behavioral health for consistency across the systems. During the November SAB meeting everyone seemed comfortable with the basic policies to the sliding fee scale. Steve Burt recommended there be one set of fees consistent with Medicaid rates. Mark gave a brief summary of what was discussed during that meeting:

- A concern is transitional and residential housing costs are different.
- Often unit costs change monthly.
- Rates for non-Medicaid covered services are unknown and it would be beneficial to form a subcommittee to discuss.
- Medicaid state reimbursement rates will be different than managed care reimbursement rates.
- A methodology must be made to defend how rates are figured. Due to aligning with Medicaid fee-for-service and not managed care, residential will be sticky because the rates are different.
- This is a tool to help agencies subsidize their business for people falling into different pay categories.
- Concerns around rates must be addressed as they relate to co-pays under Tiers 1 – 6. Client co-pays fall under Tiers 2 – 4. The biggest concern is residential rates because they are different based on the payer.
- The task of this subcommittee is to make recommendations to develop a unit cost represented of the whole for consistency purposes.

(Richard Jimenez of WestCare joined the call.)

- In the draft sliding fee scale, the CPT codes and the different tiers and rates within the CPT codes are based on a particular fee. The ultimate the goal is to have consistency.
- Discuss rates and make recommendations at the January SAB meeting.

Mark asked the members if there was any information he misrepresented in his stated summary. Diaz said it is correct. The next question is to define what the sliding fee scale is for. It is based on rates essentially set by SAPTA. When looking at Tiers 2 – 5 on the sliding fee scale, the residential rate is currently $100 per day, detox is $130 per day, IOP is $75 per hour, and outpatient is $60 per hour. The draft sliding fee scale is based on co-pays by the client. The unit costs are low and below the regional average for those types of services. The sliding fee scale is for individuals not on Medicaid or third-party insurance and need to determine what co-pays will be based on financial income levels. This will allow the agencies to recommend a higher unit cost rate to obtain more co-pay money from clients. The unit cost rate will not necessarily translate to what they will be paid by SAPTA because of lack of funding. Mark asked if it is okay to recommend a higher rate than what the sliding fee scale is or what SAPTA recognizes, even though that is not what will be paid through grants. Steve agreed it is a beginning point to negotiation and is perfectly okay. Richard Jimenez suggested they go higher rather than lower. Ester asked if they need a 2-tier payment system for residential. She understands room and board is not covered and questions if it will be paid by SAPTA. Whether or not the client has Medicaid, she feels this should be a SAPTA standard and will they match Medicaid reimbursement rates. There is a need to maximize the potential for reimbursement while delivering service. Mark confirmed SAPTA will continue to pay for residential. Medicaid reimbursable clients will have a category of service for room and board. This becomes a two part discussion: (1) how does it relate to the sliding fee scale, and (2) what will be the unit cost rates. Currently the discussion is how it relates to the sliding fee scale. Ester could have contributed regional facts about their costs, but Mark had no handouts to present for this meeting because he did not have much time to prepare. They can determine to meet again prior to January because of the importance of addressing the sliding fee scale. Mark did this on his own because he believed it would be helpful and useful for the discussion. Diaz and Richard appreciate Mark doing the preliminary ground work in gathering the information.

Mark discussed Idaho's current unit cost rates which has been a managed care fee-for-systems service for about 10 years and is ahead on services for addiction. These rates are relative and helpful because they are current. He shared some key information regarding Idaho's residential rates: adolescent transitional housing $143 per day all inclusive, adult transitional housing $154 per day (this is high and above the regional average), adolescent residential housing $198 per day, and adult residential $176 per day. The NIDA unit cost study based on several states for residential services showed within $130 per day range, but was not distinguished between adolescent and adult. Another state cost analysis between seven to eight regional states showed an average of $155 per day. The previous Wyoming study shows numbers fairly consistent in comparison to other places. Wyoming's unit cost is approximately $150 per day. Between the three different data sets, residential rates are within $150 to $180 per day. Nevada unit costs are within $130 to $160 per day. Typically residential services, whether for-profit or non-profit, have a one day, all-inclusive rate which includes room, board, and clinical services. Private hospitals are more expensive for managed care, which are usually about $400 per day all inclusive. Residential services are usually $150 to $200. Detox rates were not broken out, and Mark feels further research should be done. Currently the SAPTA rate is $130 per day. This discussion is focused on the concern of residential as noted in the SAB meeting; outpatient will be a different discussion. Wyoming wanted to finish residential first before focusing on intensive outpatient. Medicaid has outpatient rates which are comparable, whereas residential is more difficult to determine. Ester does not think they can discuss residential without discussing detox because it is expensive and is becoming more specialized. Per Mark, ASAM breaks detox into three categories: social, medically monitored (medium), and medically managed (intensive). Based on the category, it will ultimately impact the rate. Medicaid recognized monitored detox 3.7. According to the new ASAM it is now called withdrawal management instead of detox. They changed the names but essentially the descriptions are the same. The highest level 4D (now called 4WM) is typically within a medical facility or psych hospital where there is 24 hour nursing, medication for the withdrawal process, and doctor accessibility for am and pm hours. He described the differences between the higher and lower levels of withdrawal management. Mark will be doing upcoming webinar and in-person ASAM trainings in Nevada. More research needs to be done on detox. There are many different levels of residential which will impact rates. Mark asked the members if what he discussed regarding the all-inclusive residential rates were correct and consistent with unit costs. Ester said theirs is more expensive and Diaz and Richard said it is fairly consistent for them.

The goal of the sliding fee scale is for the agencies to determine the co-pay of the client who does not have Medicaid or third party insurance. A determination must be made on how much to charge per unit of service (one day) for residential. Ester asked how to approach and determine their unit costs. Mark specified unit cost as (1) relating to the sliding fee scale and (2) determining how much SAPTA may pay an agency in an RFA. He recommends a more thorough unit cost analysis to determine what would be a contract unit cost. If raised, a unit cost set within the sliding fee scale will allow agencies to obtain more co-pay from the client, but it is not necessarily the unit cost that would be utilized in determining their funding amount through SAPTA. It was recommended to have a more consistent unit rate when using the sliding fee scale. If they present a unit rate at the SAB meeting as it relates to the sliding fee scale, SAPTA would not be committed to pay that contractually. It is a complicated process because 5 to 10 percent is collected from client co-pays once determined what was initially agreed upon. Mark is unsure financially how much it will help agencies long term to be paid more or make the client more accountable based on the percentage of what they currently collect. It is better to have a consistent rate as part of their sliding fee scale. At the January meeting he suggests they recommend a unit cost for the sliding fee scale, but also that the subcommittee continue to meet to determine a more universal unit cost rate that may be used contractually. They should provide a range to recommend building a consensus. If they cannot determine this at the meeting then recommendations will be postponed. There should be a systematic way to justify particular rates by looking at what others pay regionally, as well as their own unit costs. Ester discussed her concerns about uninsured or non-Medicaid eligible people receiving services and if SAPTA will pay for them. She wants to see fees increase because they don't receive enough money. Mark clarified the goal and scope of the subcommittee is to approve a consistent sliding fee scale based on a unit cost. Potentially, the recommended rates can be impacted if they change; however, the basic sliding fee scale is sound. The next step is to examine unit cost analysis by taking a cross section of the system and do a unit cost analysis based on a simple formula and

compare it to the rates shared in this meeting. This consensus building approach was done in Wyoming. Ester said they have not agreed with the sliding fee scale for a very long time. She discussed it is the responsibility of the client to give back and be accountable for services. At the last meeting, Mary Wherry presented the draft sliding fee scale and draft policies, which Mark stated she had the task of ensuring its consistency within all areas of the Health Department. It has been updated with the latest federal poverty amounts, which is simplistic and straight forward. Frank Parenti agreed that Mark is on point and trusts his taking the lead to determine the outcome of the final discussion. He requested Ester's information specific to both residential and detox to include, as well. Mark requested people send him information on a range to present at the SAB meeting for consensus and recommendations on unit cost to determine how it relates to the sliding fee scale. Ester discussed her various levels of detox costs and how to support them. Mark believes they must bring a range to the SAB to determine a justifiable method. A discussion was made about where Vitality falls into the ASAM for medically monitored detox and what they are gearing their costs to demonstrate.

A motion was made to present a range of unit cost for residential and detoxification services for discussion and possible action at the SAB meeting on January 8, 2014. Ester moved to approve the motion and Diaz seconded the motion. All were in favor and the motion was carried.

This will be fulfilled by Mark working together with the subcommittee members to determine a range to agree upon a unit cost for those services.

4. **Review Possible Agenda Items and Future Meeting Dates**
The subcommittee will present information at the January 8 SAB meeting and wait to set a date for a future meeting until determined necessary.

5. **Public Comment**
No public comment was made.

6. **Adjourn**
Mark Disselkoen adjourned the meeting at 11:00 am.