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

MINUTES

DATE: September 16, 2015
TIME: 9:30 a.m.

LOCATION:

Meeting	Videoconference	
Carson City	**Las Vegas**	**Elko**
4126 Technology Way	**HCQC**	**DHCFP**
Second Floor Conference Room	**4220 S. Maryland Parkway**	**1010 Ruby Vista, Suite 103**

BOARD MEMBERS PRESENT

Michelle Berry	CASAT
Diaz Dixon	Step 2
Lana Robards	New Frontier
Michele Watkins	Central Lyon Youth Connections
Monica Elsbrock	Ridge House
Jennifer DeLett-Snyder	Join Together Northern Nevada
Tammara Pearce	Bristlecone
Ron Lawrence	Community Counseling Center
Jamie Ross	PACT Coalition
Denise Everett	Quest Counseling
Dallas Cunningham	Vitality
David Robeck	Bridge Counseling
Frank Parenti	HELP of Southern Nevada

BOARD MEMBERS ABSENT

Steve Burt	Ridge House
Richard Jimenez	WestCare
Debra Reed	Las Vegas Indian Center
Pauline Salla-Smith	Frontier Community Coalition

OTHERS PRESENT

Chris Croft	Tahoe Youth Family Services
Barry Lovgren	Citizen
Michelle Guerra	Health Plan of Nevada
Jamie Collins	Amerigroup
Michelle Agnew	Health Plan of Nevada
Mari Hutchinson	Step 2
Misty Alegre	New Frontier
Patrick Bozarth	Community Counseling Center

SAPTA/STATE STAFF PRESENT

Alexis Tucey	Division of Health Care Financing & Policy
Agata Gawronski	Board of Examiners for Alcohol, Drug, & Gambling Counselors
Kevin Quint	SAPTA
Martie Washington	SAPTA
Stephanie Robbins	SAPTA
Curtis Wiersma	SAPTA
Sara Weaver	SAPTA

DRAFT

1. Welcome and Introductions:

   Michelle Berry called the meeting to order at 9:42 a.m. Ms. Berry noted that there was a quorum present.

2. Public Comment:

   There were no public comments.

3. Approval of the Minutes from the June 17 Meeting:

   Diaz Dixon moved that the minutes be approved. Denise Everett seconded the motion. The minutes were approved.

4. Medicaid Reimbursement for Substance Abuse Treatment; Medicaid IMD Rules; and Utilization Management:

   See Attachment A.

5. Standing Informational Items:

   Mr. Quint provided the SAPTA report. Mr. Quint stated that Charlene Howard and Mary Wherry were retiring. In addition, he stated that three of the four Division Deputy Administrator positions were vacant. Mr. Quint stated that the SAPTA data team were moved to OPHIE [Office of Public Health Informatics and Epidemiology] recently.

   Stephanie Robbins gave the update on the SAPTA Avatar Support and Training Team. She indicated there are five facilities that would be using Avatar. Ms. Robbins indicated that requests for reimbursements (RFRs) are going well as they pertain to Avatar.

   Curtis Wiersma addressed some of the ongoing RFR issues. He indicated there were changes made in the last month to include use of SFTP [SSH File Transfer Protocol] server. SFTP will be used in the future once NHIPPS is discontinued; this will allow providers who are not on Avatar a means to transfer files. The front-end report has not been working; therefore, the back-end report has been being used. Mr. Wiersma indicated that providers would be seeing changes to the front-end report; however, in the event the front-end report was not working, providers would continue to see the back-end report. Mr. Wiersma indicated that several providers have requested additional reports and he will be generating reports based on those requests. Mr. Wiersma stated he had been receiving the signed cover sheet but not the Excel spreadsheet. He requested that providers submit both.
   Mr. Wiersma indicated that he analyzes each RFR as they are submitted to determine if services were paid previously. If they have been paid, he adjusts those RFRs. Mr. Wiersma was asked what day SAPTA pulls the NHIPPS data. He stated the data was pulled on the fourth business day of each month.

   Mr. Quint stated that SAPTA had received two visits from federal entities recently. Woody Odom visited SAPTA to assist with its maintenance of effort issues. Theresa Mitchell-Hampton visited SAPTA and met with a few providers in the State. Mr. Quint also stated that SAPTA had a prevention shortfall. He stated that SAPTA would dedicate 25 percent to prevention in the Block Grant so this shortfall does not occur in the future.

DRAFT

Martie Washington stated that SAPTA has two requests for applications (RFAs) that will be released. The prevention RFA will be released on October 14 for prevention and the applications will be due December 11. She stated there would be a mandatory bidders' conference on October 26. The treatment RFA would be released in early December and applications will be due in early February. Ms. Washington stated the prevention RFA is released earlier because part of the prevention activities include pass-through monies to their communities for direct prevention services. She stated that successful coalitions needed to hold their own competitive process to select direct service providers.

Mr. Quint stated that the Proposed Amendments to Nevada Administrative Code 458 were presented to the State Board of Health on September 11. The Board adopted the Proposed Amendments.

Ms. Berry stated there was no CASAT report.

6. Make Recommendations for the SAPTA/Mental Health Federal Block Grant:

Mr. Quint gave a synopsis of the Block Grant process. The Block Grant was submitted to WebBGAS, a federal database. He indicated that a few public comments were received. In addition, Mr. Quint indicated that, even though the official comment period had ended, the Block Grant is a living document, and comments or concerns are still being taken. The Block Grant is wrapped around the five Behavioral Health Planning and Advisory Council (BHPAC) priorities: increasing the number and quality of behavioral health professionals; improving screening and assessment of at-risk populations; support of early access to prevention and early intervention services; increase community-based services across the system of care; and provide community-based intervention support to address trauma issues. Also, there were five areas of technical assistance included in the Block Grant: use of a performance-based system; community living and implementation; medication-assisted treatment (MAT); ability to increase the number of providers qualified to provide MAT; and expanding treatment services for pregnant women and dependent children specific to MAT.

Mr. Quint stated that he is interested in the integration of the BHPAC and the SAPTA Advisory Board. He stated that this is a national movement. Mr. Quint also stated there is an interest in behavioral health and primary health care integration. Ms. Berry asked how funding for MAT in the Block Grant will be impacted by the substance abuse service expansion by HRSA [Health Resources and Services Administration]. Mr. Quint stated that would involve a broader conversation with FQHCs [Federally Qualified Health Centers].

Mr. Quint stated the Block Grant will continue to fund existing providers, but SAPTA needs to expand the number of treatment agencies especially those using MAT. He stated that SAPTA also wanted to look at including targeted case management, peer support services, and other recovery-oriented systems of care. In addition, there is a need to look at bed needs in Washoe County and Clark County. Mr. Quint advised that SAPTA is looking to fund other opportunities to fund gap services. Providers who cannot use all their funding may want to look at targeted case management. Mr. Quint stated that SAPTA is looking to build a robust recovery-oriented system of care.

Stephanie Woodard stated that this is only the second grant cycle in which integration of the SAPTA and Mental Health Block Grants had occurred. Ms. Woodard stated the process provided many opportunities to look at the array of the services provided as well as the gaps and opportunities to integrate services. She stated the Mental Health Block Grant is designed to provide treatment and recovery support for individuals who have severe mental illness or for children with serious emotional disturbance. Ms. Woodard stated the Mental Health Block Grant does not provide opportunities for prevention or early intervention. Ms. Woodard indicated that, of the many goals,

DRAFT

SAPTA would like to explore the expansion of telehealth and to look at the Intercept Model for the criminal justice system. Ms. Woodard asked that providers offer their input for new opportunities that will enhance provider communities.

Mr. Quint stated that the goal is to move the mental health funding to a more competitive process. He stated that within the next few years, he would like to see the mental health funding go through an RFA process. Christopher Croft asked if FASTT programs were included in the Block Grant. Mr. Quint stated, yes, money was set aside for those programs.

Mr. Quint concluded that SAPTA is working to improve the process for future Block Grants.

7. Make Recommendations for the State Plan:

This agenda item was tabled.

8. SAPTA Budget and Plans for Unspent Funds:

Mr. Quint stated SAPTA thought its Block Grant was $12 to $13 million; however, but SAPTA never received official notice of its NOGA [Notice of Grant Award]. When the NOGA was received by SAPTA, it was in excess of $16 million. Mr. Quint stated he contacted providers to discuss back billing to July 1. Ms. Washington inquired as to what would happen with the 1/12 cap. Mr. Quint stated that if a provider were underspent, that would not be a problem. He stated if a provider were overspent, SAPTA would prepare a grant amendment.

Mr. Quint indicated that, in the new Block Grant, 25 percent would be allocated toward prevention, 5 percent for administrative costs, and the remainder would be allocated toward treatment and administrative programs (e.g., CASAT).

9. Review Possible Agenda Items for the Next SAPTA Advisory Board Meeting:

Ms. Berry stated that the following items should be included on the next agenda:
- Update on Medicaid Reimbursement
- State Plan
- Update on Peer Support
- Coalition Prevention Specialist Credentialing
- Rate Analysis

10. Public Comment:

Jennifer DeLett-Snyder stated that Join Together Northern Nevada would be partnering with the University of Nevada, Reno School of Medicine to bring a program to Reno on October 22. Ms. DeLett-Snyder stated there would be several physicians in attendance who currently use MAT in various medical settings.

11. Adjournment:

Ms. Berry adjourned the meeting at 11:35 a.m.

DRAFT

SAPTA Advisory Board Meeting
September 16, 2015
DISCUSSION OF MEDICAID REIMBURSEMENT FOR SUBSTANCE ABUSE TREATMENT
ATTACHMENT A

Michelle Berry:
Alexis Tucey has joined us from the Division of Health Care Financing and Policy (DHCFP) today. We also have representatives from Health Plan of Nevada (HPN) and from Amerigroup.

Alexis Tucey:
I will be filling in for Coleen Lawrence today.

Lana Robards:
There were several questions posed during our last meeting on which DHCFP was going to follow up. One of the issues pertained to prior authorizations for assessments.

Ms. Tucey:
Ms. Lawrence did not mention that to me; however, she mentioned there was a concern regarding therapy sessions as they pertain to utilization management.

Ms. Robards:
We all had concerns over preauthorizations and numbers of sessions. We were told that everything under Provider Type (PT) 14 was rolled up into PT 17, but technically that is not true. Under PT 14, 26 sessions do not require prior authorization. This gave us the ability to get individuals enrolled, etc.

Ms. Tucey:
Regarding therapy sessions and how they relate to PT 14 and PT 17, 26 sessions are specific to psychologists. Therapy sessions are particular to the level of care. In addition, there is different utilization management criteria for psychologists. In the service level-of-care grid, services are dependent on the actual level of need, and dependent on the number of sessions authorized. The number of sessions prior authorized is dependent on a number of variables and is not necessarily 26. For the PT 17 model, the reason it is preauthorized up front is that it is intended to be a fluid combination of services. We are relying on providers to tell us what combination of services are needed and we prior authorize those services based on need. We are not placing a limit on sessions.

Ms. Robards:
I believe the prior authorization process is difficult and time consuming. We use the sessions for all of our providers under PT 14.

It does not make sense that we need to prior authorize assessments. An assessment is needed to prior authorize additional services and to determine the level of care for individual needs.

Misty Alegre:
One of the problems that we run into is that we are required to prior authorize the assessment but the prior authorization is not received without having performed the assessment so that a diagnosis can be made. Frequently, we have to perform the assessment without having received the prior authorization. In addition, we are constrained by the 15-day rule to submit the prior authorization, but sometimes assessments take more than one session. Most of the time we end up providing assessments without reimbursement because we cannot get them prior authorized.

Ms. Tucey:
Is this on the fee-for-service (FFS) or the managed care organization (MCO) side?

DRAFT

Ms. Alegre:
This happens on the FFS side.

Ms. Tucey:
I will need to follow up with you on this.

ACTION ITEM: DHCFP to provide clarification on prior authorizations for assessments.

Ms. Robards:
Ms. Lawrence indicated during our last meeting that she was going to try to get this matter changed without the need for public hearings.

Ms. Tucey:
I will follow up with Ms. Lawrence on this for clarification. Is it the consensus that the prior authorization process is considered challenging?

Ms. Alegre:
It is challenging because it does not operate the way it is stated in Medicaid policy. The policy states that assessments must be prior authorized but that is not reality. The service must be performed to obtain information before it can be prior authorized. Technically, we are receiving retro prior authorizations for assessments.

Ms. Robards:
We are also concerned about the actual date we can start billing. On the website, there are different dates provided for eligibility.

We receive advance notice that an individual's Medicaid is going to expire or lapse on a specific date. How can we determine why an individual's coverage is lapsing?

Ms. Tucey:
There are many variables affecting eligibility. Eligibility is determined through the Division of Welfare and Supportive Services (DWSS), not by Medicaid. The information is then transferred to Medicaid. Providers see a snapshot of eligibility in the Eligibility Verification System (EVS). Eligibility is determined by whether the individual is FFS and they roll over to an MCO. That has been ongoing process for some time. SAPTA providers are not the only providers that experience this issue. We are working to enroll recipients immediately in MCOs, but we need to allow individuals the freedom of choice of MCOs. This creates a barrier once recipients are eligible for an MCO. HP does their best and, if they see that they are rolling into an MCO, it will be indicated on the prior authorization. Also, we have been trying to streamline the process of enrollment. We want to reduce the lag between the coordination of FFS and MCO as well as for provider groups.

Ms. Robards:
The MCOs do not want New Frontier. We were told that we should not even apply. We have 28 beds, but there would not be referrals for residential and outpatient services would all go under FFS anyway. We are beginning to see a few individuals under MCOs that are being converted to FFS, but there is a lapse in eligibility.

DRAFT

Ms. Tucey:
Are you in a rural area? MCOs will primarily be in urban areas. It may be that MCOs advised you not to apply because of your location. The likelihood that you would see an individual on an MCO is slim if you were located is in a rural area.

Ms. Robards:
There are a few referrals in rural areas. If you are going to enroll individuals automatically in MCOs, some of the rural providers are going to see some of the MCO enrollees for treatment services in an FFS area. We end up writing off more services than we can collect because we do not have a safety net of funding. Medicaid always has a gap between when we can legitimately start billing and when we actually began services.

Ms. Tucey:
Regarding retroactive enrollment, applications go to DWSS and the eligibility could be in a pending status. At that point, it is at the provider's discretion as to whether to take the chance to provide services. Recipients can go to DWSS for a "pending" slip and present it to the provider. Again, there are many variables affecting eligibility.

If an individual is determined eligible, their eligibility will go back to the initial application date. Another component is retroactive eligibility. If an individual turns in an application this month and has had medical services for the last three months, DWSS would determine if they were eligible for the prior three months. Timeframes for which you can bill are based on the date of service and eligibility. If an individual becomes eligible after the fact, there is a "date of decision." The date of decision is when eligibility is determined. Providers can go back and bill from that date. That information is listed on the billing guide. The date of decision is there so that the provider can bill for services provided previously and not be penalized. Providers will have to rely on the recipient to inform you that they have been determined eligible after the fact.

Michelle Agnew:
I contacted New Frontier in early 2014. It is true that, because of the rural area, the number of HPN members would be limited. A member can jump from HPN to Amerigroup to FFS and they could inadvertently end up in a rural area. We identified New Frontier as being a good group; however, at the time we did not see that any of our members would be going there. We are willing to do a letter of agreement with rural providers, but it is probably better to look into getting providers credentialed and contracted because we do not require prior authorization for assessments and triage. It might be time for HPN to look into some of the rural areas and contract with some providers. I suggest that the rural facilities contact me again and we will research this issue.

Ms. Tucey:
This a growing process. Communication is beneficial to all involved.

Ms. Robards:
I understand it is a growing process but providers are left holding the bag on the fiscal side. We have clients who present, but we eventually write off more than is necessary.

Denise Everett:
I agree. I believe that SAPTA should step in and provide funding in these instances. The services have been provided and they are documented. When someone has a substance abuse disorder and/or is in crisis with a mental health condition, it is not as if they have a headache.

DRAFT

Kevin Quint:
Are you stating that SAPTA should fill the gap in eligibility or the gap in being on a plan?

Ms. Everett:
All of it. If a client presents and, for various reasons, they do not have coverage, SAPTA should fill that gap.

Ms. Tucey:
If they are not eligible for a month, I believe that is different in terms of funding if an individual is not eligible for a month. There has been much dialogue surrounding what is covered and what is not, what is Medicaid billable and where SAPTA could come in as a wrap-around piece, etc.

Mr. Quint:
If an individual is not eligible, SAPTA does cover services. We would need to discuss those instances where the eligibility is pending or where they are not yet on Medicaid.

David Robeck:
If HBI is not going to certify any agencies, will SAPTA take care of those services? We do not want to transition a client midway through therapy. I am holding over $80,000 of bills from last year that should have gone to HBI, but they have refused to take them. We are not going to hand over a client that needs the care.

Mr. Quint:
According to the assurances as they are now, a client that has Medicaid, regardless of the carrier, must be referred to an in-network provider. If the client receives services for which Medicaid does not pay, SAPTA covers those services.

Mr. Robeck:
I understand; however, HBI is the one Medicaid payer that is not paying for those services because they have their own clinic in Las Vegas.

Ms. Agnew:
HBI is the capitated provider for Smart Choice for the HPN population, but not the expansion population. HBI has their own SAPTA-like services and they provide those services. My job is to ensure that individuals have access and availability, and they do. Until there is a problem for someone in scheduling an appointment and someone cannot be seen, I determine if there needs to be additional providers. The only thing I can dictate to HBI is that they offer access and availability. I cannot dictate to HBI with whom they contract.

Mr. Robeck:
What do other providers think about the continuity of care midway through therapy?

Ms. Agnew:
They should be given a 90-day transition period.

Ms. Everett:
That has not been my experience.

DRAFT

Mr. Quint:
I have asked providers if they have applied with HPN. Their response is that they applied with HBI, but they were turned down. I have heard this often. If a provider is not on HBI, can they apply with HPN?

Ms. Agnew:
Yes. The majority of the services for SAPTA providers should be coming from the over-21 population, which is under the expansion piece. The Smart Choice population is comprised of mothers and children. We are contracted with ten SAPTA providers now, and they are receiving prior authorizations and they are being paid. During the last SAPTA meeting, three providers indicated that their contracts had been terminated. That was done without my approval, so those provider contracts have been reinstated. Since that time, HBI has been given guidelines to follow. They must receive my approval prior to terminating any providers.

Mr. Robeck:
We have not received that documentation.

Tammara Pearce:
We have not received that information either.

Ms. Agnew:
I am relaying this information. If you have any problems with HBI, please contact me directly.

Ms. Everett:
What is Smart Choice?

Ms. Agnew:
Smart Choice is HPN's product for women and children. In January 2014, newly eligible or "expansion" clients were allowed to come on. HBI does not cover the expansion population. We have close to 90,000 members in that group. There are two different plans under HPN—one that is capitated (Smart Choice) and one that is made up of the expansion population.

Ms. Everett:
We work with adolescents. Did you state that Smart Choice is under HBI?

Ms. Agnew:
Yes. If there is a problem with HBI, contact me directly, so I can address the issues.

Ms. Everett:
We have many concerns about what HBI is doing; however, I believe they are contractually allowed to do some of the things of which we are concerned.

Ms. Agnew:
Yes, I understand.

Ms. Everett:
We do not contract with them because they are incredibly difficult with which to work.

DRAFT

Ms. Agnew:
It is my job to ensure that members have access to care. Until there is a member that cannot be seen, I cannot tell them how to run their risk business.

Ms. Everett:
They receive payments and they keep the money in house because they have their own therapist. It makes no sense to me.

Ms. Agnew:
I understand, but until they have an access issue, I cannot step in. They receive a per member, per month fee and hold them in house.

Mr. Quint:
Is HBI for the non-expansion population?

Ms. Agnew:
Yes.

Mr. Quint:
Ms. Everett's facility treats adolescents and their families. Many of their clients are in the expansion population. Would they fall under HBI or HPN?

Ms. Agnew:
It sounds like they would fall under HBI Smart Choice. HBI has the capacity to bring them in house.

Mr. Quint:
Even if they are considered part of the expansion population?

Ms. Agnew:
If they are part of the expansion population, I oversee them in my department. We are contracted with ten SAPTA providers. SAPTA providers have access to "At Your Service" where eligibility can be checked to see if the member falls under expansion or Smart Choice.

Ms. Everett:
My billing manager sent an email to Ms. Lawrence on September 1. Ms. Lawrence indicated in the last SAPTA Advisory Board meeting that there were areas under PT 17 that did not transfer to PT 14. My billing manager asked if these could be included in PT 14. Do you know if this was resolved?

Ms. Tucey:
I have not heard anything about this, but I will follow up with Ms. Lawrence on that issue. In addition, I will follow up on assessments and therapy sessions. I also saw that IMD [Institutions for Mental Disease] was on the agenda. Are there questions?

ACTION ITEM: Ms. Tucey to follow up with Ms. Lawrence and provide clarification to SAPTA providers.

Mr. Quint:
Two providers contacted me with issues. One provider indicated they had reduced their bed count to 16 beds, but SAPTA was paying a provider who had more than 16 beds. I advised the provider that

DRAFT

neither SAPTA nor Medicaid ever said that there needed to be a reduction in bed count. Another provider contacted me and said essentially the same thing. I was concerned that there was a miscommunication, so I met with Ms. Lawrence and Betsy Aiello to clarify this issue. Within reason, SAPTA does pay for beds. If it is a facility with 25 beds, SAPTA can help fund that.

Ms. Tucey:
There are different pieces to IMD. IMD is a federal regulation that goes back to the days when we had psychiatric asylums. The federal government said they were no longer going to fund asylums. For ages 22 to 64, if the facility were designated as an IMD, Medicaid would not be federally reimbursed. CMS [Centers for Medicare and Medicaid Services] designed criteria that essentially states a facility with 16 beds or more, or a 50 percent or more of a facility that is dealing with diagnosis and treatment, would be considered an IMD. This specifically refers to mental health, although that has been further clarified to include mental health and substance abuse. That becomes a concern for us because if the facility is designated as an IMD, which in turn the recipient is inpatient, not a single service, whether provided in or out of that facility, is reimbursable. This becomes a sticky wicket when we are looking at facilities.

Mr. Quint:
In meeting with Ms. Lawrence and Ms. Aiello, Ms. Lawrence indicated she is working on a paper to define this issue further. This will then become a business decision for the facility. If a facility has 30 beds as opposed to 16, you will not be able to unbundle services because Medicaid will not reimburse for those services, although they will reimburse for outpatient services. We need to have these things articulated so everyone involved understands.

Ms. Tucey:
This is a federally based decision. CMS determines if a facility is considered an IMD. When we brought SAPTA on, suddenly CMS asked states to make the determination. We did not want to determine this because it could have resulted in a loss of federal funds in the event we misinterpreted the regulations. Our policy is outlined in Chapter 400. This becomes challenging for SAPTA providers that have a residential component. Medicaid does not pay for room and board. Also, if it becomes a residential inpatient situation, providers will need to determine what the best business decision is that is beneficial to the facility.

Ms. Robards:
We are a Medicaid provider. In the past, Medicaid paid for room and board under the 99 code, but I think it was because of a misunderstanding on the part of the State. Because of that, I believe I have a better understanding of what the IMD rule is. Amerigroup is spearheading an initiative to ask congress to look at this issue at the federal level.

We made a conscious choice not to reduce our bed count for two reasons. First, we felt that there was an unmet need in Nevada and we thought that reducing the number of beds would compromise that issue. Second, at the time, I did not have faith in Medicaid. There were so many problems under PT 17. I understand that this is a work in progress, but I feel we made the right decision.

Ms. Tucey:
I believe Ms. Lawrence will attend the next SAPTA Advisory Board meeting. I will follow up with her on the outstanding issues we discussed today.

DRAFT