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

## MINUTES

**DATE:** August 19, 2015
**TIME:** 9:30 a.m.

**LOCATION:**

| Meeting | Videoconference | |
|---|---|---|
| **Carson City** | **Las Vegas** | **Elko** |
| **4126 Technology Way** | **4220 S. Maryland Pkwy.** | **1010 Ruby Vista Drive** |
| **Second Floor Conference Room** | **Building D** | **Suite 101** |

**BOARD MEMBERS PRESENT**

| | |
|---|---|
| Steve Burt | Ridge House |
| Michelle Berry | CASAT |
| Lana Robards | New Frontier |
| Denise Everett | Quest Counseling |
| Annette Moran | Quest Counseling |
| Tammra Pearce | Bristlecone |
| Diaz Dixon | Step 2 |
| Mari Hutchinson | Step 2 |
| Michele Watkins | Central Lyon Youth Connections |
| Denna Atkinson | Foundation For Recovery |
| Stuart Gordon | Family Counseling Service |
| David Robeck | Bridge Counseling |
| Jamie Ross | PACT |
| Ron Lawrence | Community Counseling Center |
| Kevin Morse | Westcare |
| Debra Reed | Las Vegas Indian Center |
| Ester Quilici | Vitality Unlimited |
| Jennifer Snyder | Join Together Northern Nevada |
| Kate Coronado-Johnson | Bridge Counseling |

**BOARD MEMBERS ABSENT**

| | |
|---|---|
| Pauline Salla-Smith | Frontier Community Coalition |
| Frank Parenti | HELP of Southern Nevada |

**OTHERS PRESENT**

| | |
|---|---|
| Allyson Hoover | Amerigroup |
| Michelle Guerra | Health Plan of Nevada (HPN) |
| Woody Odom | SAMHSA |
| Altamit Lewis | Amerigroup |
| Barry Lovgren | Citizen |

**SAPTA/STATE STAFF PRESENT**

| | |
|---|---|
| Kevin Quint | SAPTA |
| Martie Washington | SAPTA |
| Kendra Furlong | SAPTA |
| Betsy Fedor | SAPTA |
| Sara Weaver | SAPTA |
| Cathy Wright | Division of Public & Behavioral Health |
| Brandi Johnson | Division of Public & Behavioral Health |
| Coleen Lawrence | Division of Health Care Financing & Policy |
| Betsy Aiello | Division of Health Care Financing & Policy |

1. Welcome and Introductions:

   Steve Burt called the meeting to order at 9:42 a.m. Mr. Burt noted there was a quorum present.

2. Public Comment:

   There were no public comments.

3. Introduction of Special Guest:

   Kevin Quint introduced Woody Odom who is a contractor to SAMHSA [Substance Abuse and Mental Health Services Administration]. Mr. Quint indicated that Mr. Odom was providing technical assistance to SAPTA with its MOE [maintenance of effort]. Mr. Quint stated that Mr. Odom would be onsite for the week of August 16. Mr. Quint stated that Mr. Odom would be reviewing all of SAPTA's policies and procedures related to the Block Grant.

   Mr. Odom stated that the Block Grant was implemented with the idea that funds be used to supplement existing services. To ensure that this happened, Mr. Odom explained, SAMHSA included the MOE requirement. The State must meet the average of the previous two years of State funds spent; this information must be included in the current year that the application for the Block Grant is submitted. Mr. Odom indicated that, if the State does not meet this benchmark, there would be a dollar-for-dollar reduction in the Block Grant award. Mr. Odom stated that he was reviewing the current definition of the MOE and stated that the definition may need to be modified. In addition, Mr. Odom indicated he was looking as the MOE definitions for women, HIV, TB, and Mental Health.

   Mr. Burt asked Mr. Odom if Nevada was meeting its MOE. Mr. Odom replied that Nevada would meet the MOE. Mr. Quint stated that SAPTA has had difficulty meeting the MOE in the past as State budgets have fluctuated. Mr. Odom stated that many states have faced what Nevada has in the past; however, in some instances, states have been allowed to include, for the MOE purpose only, the state match for Medicaid services provided for substance abuse treatment.

4. Discuss Medicaid Reimbursement for Substance Abuse Treatment:

   See Attachment A.

5. Standing Informational Items:

   Mr. Quint provided the SAPTA report. Mr. Quint announced that Cody Phinney had been named the Administrator of the Division of Public and Behavioral Health (DPBH). Mr. Quint also indicated that Marta Jensen, former Deputy Administrator of DPBH, was named the Acting Administrator of the Division of Health Care Financing and Policy (DHCFP). In addition, Kirsten Coulombe was named the Administrator of the Division of Child and Family Services.

   Mr. Quint indicated that Theresa Mitchell-Hampton, Project Officer of SAMHSA's Center for Substance Abuse Treatment (CSAT), would be visiting the week of August 24. She will visit with SAPTA staff and selected providers.

   Mr. Quint stated the SAPTA/Mental Health Block Grant would be finalized soon. He indicated that the Block Grant would be posted by Wednesday, August 26, on WebBGAS for viewing by interested parties. An email would be sent with instructions on how to access WebBGAS. Mr. Quint stated the Block Grant would be based on feedback received during public meetings that were held, needs assessment that had been prepared, the State Plan, and the meta-analysis developed by SEI [Social

Entrepreneurs Incorporated]. There were five priorities identified during the Behavioral Health Planning and Advisory Council (BHPAC) meeting of July 14. Mr. Quint stated the Block Grant must be submitted no later than September 1.

Mr. Quint updated the Board on Proposed Amendments to Nevada Administrative Code (NAC) 458. NAC 458 will be presented to the State Board of Health on September 11.

Martie Washington stated that, with the exception of one subgrant, all subgrants have been executed. Ms. Washington indicated that the numbers are being finalized for the October 1 Block Grant. Ms. Washington stated that Coalitions would be contacted to request Scopes of Work. Mr. Burt inquired if that meant there would be no competitive bidding process. Ms. Washington responded that a Request for Application (RFA) would be issued after October 1, for 2016. She stated the grants that begin July 1, 2015, and October 1, 2015, will be continuations, and they are not competitive. Mr. Burt asked Mr. Quint if there were funds for incorporating additional providers into the Provider Type (PT) 17 network. Mr. Quint responded that would be part of the RFA process. Mr. Quint indicated that the difficulty is that outpatient programs are not spending their funds because most clients are on Medicaid. Mr. Quint stated he would be contacting providers to determine if funds could be reallocated to other programs. Michelle Berry inquired if funds could be used by treatment providers to subgrant to other providers. Mr. Quint stated that would require another level of SAPTA staff to administer such a program. Mr. Quint indicated that there are people in jail in Clark and Washoe Counties simply because there is no space for them at treatment facilities.

Ms. Berry provided the CASAT [Center for the Application of Substance Abuse Technology] report. She stated that Peer Review Advisory Council held a meeting on August 12. The Advisory Council is now working on a Code of Ethics Subcommittee to determine how peers would operate within organizations.

Ms. Berry stated that, with the passage of Senate Bill 489, provider organizations would be created. These organizations could take advantage of certified behavioral health "A" codes currently accepted by Nevada Medicaid. These codes are already be used by PT 17s. Health Care Quality and Compliance needs to create the regulations, however, before providers who are not PT 17s can begin using the codes.

Mr. Burt provided the Chair report. He indicated that eight providers had signed a contract with Foothold Technologies to use the AWARDS System. Foothold Technologies is developing a transition strategy at this time. Mr. Burt will be in contact with SAPTA to determine what data is needed. Mr. Quint stated that TEDS [Treatment Episode Data Set] reporting is required by the federal government. Mr. Burt stated that the providers would provide any data that SAPTA needed. Kendra Furlong stated that SAPTA's data team is working to determine exactly what data is needed. Ms. Furlong indicated that there must be an expectation, in the event that providers are not using Avatar, that SAPTA will not have access to provider data. Ms. Berry stated that Foothold Technologies assured providers they could provide data as needed. Ms. Furlong advised the Board that Curtis Wiersma is the point of contact for questions related to required data.

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

   Mr. Burt and David Robeck stated they would like for representatives of DHCFP and MCOs to attend the September 16 SAPTA Advisory Board meeting.

   Mr. Quint indicated that he would like to discuss integration of the BHPAC and SAPTA Advisory Board.

7. Approval of Minutes from the June 17, 2015, Meeting:

   This item was tabled.

8. Public Comment:

   There were no public comments.

9. Adjournment:

   Mr. Burt adjourned the meeting at 12:08 p.m.

SAPTA Advisory Board Meeting
August 19, 2015
DISCUSSION OF MEDICAID REIMBURSEMENT FOR SUBSTANCE ABUSE TREATMENT
ATTACHMENT A

**Kevin Quint:**
Today, we have representatives from DHCFP and two MCOs in attendance to answer questions that providers may have. SAPTA requested questions from providers in advance and DHCFP has provided answers to those questions (see handout entitled, "SAPTA Advisory Board Questions and DHCFP Answers").

**Coleen Lawrence:**
We grouped the provider questions into three categories: eligibility, fee-for-service (FFS), and managed care. Some of the answers from the DHCFP on the handout seem redundant, but that is because many of the questions are similar and pertain to and are grouped in one of the three categories. In addition, some of the answers from the DHCFP include how issues will be handled in the future.

The first category is eligibility. Our partners at the Division of Welfare Supportive Services process much of the eligibility. The second category is FFS. Many of the questions relate to prior authorizations and what the DHCFP is doing with HP. The third category is related to the MCOs, so representatives from those entities will answer those questions.

**Betsy Aiello:**
I will read the first question.

***Provider Question***: "Regarding FFS, why do we not enroll the new clients immediately in an MCO since the authorization on the FA11D is often denied as they then move to Medicaid?"

***DHCFP Response***: Everyone who is on Medicaid is under one of two different delivery models—FFS or managed care. Historically, people would be first enrolled in FFS. This allows the person time to research and choose the MCO they want. In addition, under federal regulations, once someone makes their initial choice, they have 90 days change to the other MCO if they wish. If someone loses eligibility, that person is no longer cover by Medicaid. This is referred to as "churn." It makes it difficult to manage through churn. Please keep in mind that the MCOs, by contract, need to have a transition plan and maintain the FFS care; however, the MCOs do not necessarily know if a person is undergoing treatment during this period. The MCO must be notified so that a Case Manager can handle the process for each of these individuals. MCOs must manage a care incident once they are aware that the individual is in a transitional period.

The DHCFP will be holding a Public Workshop on September 9. During the Public Workshop, we will explore the possibility of allowing individuals to enroll directly in managed care upon eligibility determination. This is a result of the difficulties of managing the continuity of care. The federal regulation stating that individuals have 90 days to change MCOs will remain. At the federal level, there are proposed new managed care regulations. This would include a mandatory FFS period at the beginning of coverage. Most states have expressed that this is not a good way to manage continuity of care. It is unknown if this provision will be included in the new regulations. Also, during the Public Workshop, we will look at the variety of impacts of proposed new regulations.

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "Technical denial from Medicaid stating that recipient will become member of the MCO during the requested PAR dates. Follow up call to Medicaid could not verify the technical denial information – refer to PAR #20000573260."

***DHCFP Response***: Some providers have contacted us and requested a technical denial. There may be a lapse of eligibility during the 15-day period. Direct enrollment may help with difficulties providers have in these situations. There are sometimes new members waiting to get into managed care. We have had continuity-of-care nuances from the beginning; however, with the expansion of Medicaid, there are many more members in the system and the number of nuances has grown.

**Ms. Aiello:**
Some people choose, on their application, the MCO they want. Because Medicaid eligibility is month-to-month, and there is a day on which capitation payments are downloaded to the MCO (usually the last three to four days of the month), if the person has chosen their MCO, their eligibility is worked. If you are treating the person, for instance, on the 18th day of the month and you ask for a 90-day authorization, we look at the prior authorization and advise you the member is going into managed care in 13 days. In this scenario, we would not approve a prior authorization for 90 days because the member is going into managed care. The member may be in managed care for 4 weeks. Eligibility can be viewed on EVS [Electronic Verification System], but that is why we are considering direct enrollment into managed care. This is where many of your prior authorizations have issues.

If you have a managed care prior authorization, the continuity of care needs to be maintained. The MCOs can address these issues.

There are many questions about eligibility in general. Medicaid eligibility runs month-to-month. If someone loses eligibility, we cannot pay for Medicaid services. Individuals must be re-determined every year. Individuals are notified that they need to do their re-determination; however, many people change addresses but do notify the State of their new address. After multiple notifications, members who have not re-determined will lose eligibility. The DHCFP cannot guarantee that, because someone has a prior authorization request (PAR), the member will be eligible for the entire 90-day span.

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "Not being able to determine when a recipient's eligibility ends causes the following problems: denial and/or delay in approving PAR because eligibility ends during requested 90 days; service(s) billed denied payment because eligibility ends invalidating PAR; and disruption of services for recipient or lost revenue for provider for at least two weeks on average. Medicaid has 5 days to deny, provider has 5 days to respond. Usually longer because denial of payment is generally how we find out that the eligibility has ended abruptly."

***DHCFP Response***: The DHCFP cannot provide a prospective end in eligibility. The key factor to remember is that prior authorization and eligibility are separate issues. When checking eligibility on EVS, eligibility is the factor that needs to be considered. Eligibility runs on a month-to-month basis, and eligibility must be checked each month regardless of the service. This may be one of the most difficult operations in your system.

During each Legislative Session, the DHCFP has submitted a concept paper to the Legislature requesting that we be able to have yearly eligibility. Each year, the Legislature has turned down that request. It is imperative that providers develop an operational procedure to check eligibility on a month-to-month basis. This is separate matter from prior authorizations.

Prior authorizations must be reviewed for their medical appropriateness. Typically, for Medicaid, prior authorizations are valid for 30 to 90 days. Medical prior authorizations are not connected to eligibility authorizations. Medical authorizations are prospective for 90 days.

**Ms. Aiello:**
Also, there is a disclaimer stating that the service is authorized as long as the individual remains eligible. You must ensure that the individual is eligible.

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "Recipients with rural addresses enrolled into MCOs by Medicaid – prevents recipient from receiving services."

***DHCFP Response***: Sometimes there are exceptions. We realize there are exceptional issues pertaining to zip codes. Please send those to me so I can review. Nevada is growing and new zip codes are created as a result. Submissions under this circumstance should be sent to Ms. Lawrence for further research.

**Ms. Aiello:**
A simple explanation could be that the individual moved from an urban to a rural area without notifying the State. In this scenario, the individual will be in the system as being enrolled in an MCO until they are disenrolled from the MCO.

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "What is Medicaid's official definition(s) for 'Date of Decision' and 'Date of Eligibility' and how do they apply to PARs [Preauthorization Requests]? We have received many different answers from Medicaid."

***DHCFP Response***: The answer to this question is in the Medicaid Billing Manual as follows:

> "Retrospective request: Submit no later than 90 days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively."
>
> Access the Medicaid Billing Manual at https://www.medicaid.nv.gov/providers/BillingInfo.aspx

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "Why can't assessments (H0001) be pre-authorized based on the screening before being done? Currently the "cart" goes before the "horse" – the assessment is provided and the provider has 15 calendar days to submit PAR. Policy states that PAR can be submitted 5 to 15 calendar days prior to start of services – however, we tried but have never had an assessment get approval prior to being done. Doesn't it make sense that a recipient seeking treatment is screened (H0049) and from that screening it is determined that an assessment (H0001) to determine the appropriate LOC is needed? The assessment is then pre-authorized and provided."

***DHCFP Response***: Screenings do not require prior authorization. We do not want to delay screenings by requiring that they are preauthorized.

**Lana Robards:**
We are attempting to obtain prior authorization of assessments prior to the actual assessment.

**Ms. Lawrence:**
We do not require prior authorizations for assessment because we do not want to delay the that being performed. A PAR can be submitted 15 days prior to services being provided. Are assessments being performed within the 15-day period?

**Ms. Robards:**
No, we are trying to obtain a prior authorization before the assessment is done.

**Ms. Aiello:**
Without an assessment, how do you know there is medical necessity for the services?

**Ms. Robards:**
I do not dispute that issue; however, there are two PARs at issue. There is a PAR 4 for whatever the services are determined by the assessment and there is a PAR for the assessment itself. One should be allowed to preauthorize for the assessment prior to services being provided, but that is not being approved. It will only be approved during the 5 to 15 days after the assessment has been performed. So, if the service is denied, we have already provided the service.

**Ms. Lawrence:**
Are your assessments being denied?

**Ms. Robards:**
Yes; however, the manual states that services can be approved regardless of the 5 to 15 day period. An assessment is a treatment service. When we attempt to have assessments approved before the patient's appointment for the assessment, the service is denied.

**Ms. Aiello:**
We need to research this because an assessment does not require a prior authorization.

**Ms. Robards:**
Level of care cannot be determined without an assessment, so screening does not require a prior authorization. Screening does not require a prior authorization; however, individuals are screened to determine if they need to go to the next level of care, which is assessment. Medicaid regulations state that assessments can be preauthorized before the service is actually performed. One cannot preauthorize an assessment on a standalone PAR. The only time FFS Medicaid accepts the PAR, is after the services have been completed.

**Ms. Lawrence:**
Do you submit a standalone assessment?

**Ms. Robards:**
Correct.

**Ms. Lawrence:**
Are you able to have an assessment processed?

**Ms. Robards:**
We are unable to preauthorize an assessment.

**Ms. Aiello:**
You do not need to have an assessment preauthorized.

**Ms. Robards:**
Yes, we do need to preauthorize assessments.

**Ms. Lawrence:**
Are you able to submit and receive reimbursement for assessments?

**Ms. Robards:**
Yes, but only after the assessment has been completed.

**Ms. Lawrence:**
So, you are reimbursed for assessments.

**Ms. Robards:**
Yes, but only after the assessment has been completed.

**Ms. Lawrence:**
So, you have submitted and been reimbursed for assessments alone.

**Ms. Robards:**
Yes, because an assessment is completely different. The assessment is the determination for the need for treatment services.

**Steve Burt:**
Reimbursement is made only if it is diagnosis authorization. We can get assessments paid retroactively.

**Ms. Robards:**
Medicaid was not reimbursing for assessments, so we submitted assessments by themselves. Assessments were not being approved as part of the treatment services, so we chose to submit them alone.

**Ms. Lawrence:**
So, you can be reimbursed for assessments; however, you cannot be reimbursed if it is included with treatment services?

**Ms. Robards:**
Why can we not get a preauthorization for assessments as we can for treatment services? We cannot submit and be reimbursed for an assessment before any treatment services are rendered. One should be able to preauthorize for assessments as one can for treatment services. Assessments cannot be preauthorized as treatment services are.

**Ms. Lawrence:**
If you are asking me to approve a “bucket” of services, but there has been no evaluation, how do you know what additional services are needed?

**Ms. Robards:**
I am not asking that a “bucket” of services be approved. I am requesting that assessments be preauthorized.

**Ms. Lawrence:**
That is why I asked if assessments were being approved.

**Ms. Robards:**
Yes, assessments are being reimbursed, but we are not receiving a preauthorization to do so. Medicaid will approve the services after the services have been rendered within the 5 to 15 day period.

**Ms. Aiello:**
We will check on that and get back to you.

**Mr. Quint:**
Did another attendee indicated that if there is no diagnosis, there is no reimbursement?

**Mr. Burt:**
We have all experienced that.

**Ms. Lawrence:**
A diagnosis is required to adjudicate a claim.

**Mr. Quint:**
But an assessment is performed to determine a diagnosis.

**Ms. Lawrence:**
There is a "V" code for a diagnosis. The code is required for claim adjudication.

**Mr. Burt:**
What is the V code?

**Stuart Gordon:**
The V code is "V7.109."

**Ms. Lawrence:**
All claims adjudications require a diagnosis code. If there is no diagnosis, for instance if you are doing an assessment and there is no diagnosis, there are V codes in the back of the ICD-9 book.

**Mr. Quint:**
Are any providers in attendance using V codes for assessments?

**Ms. Robards:**
Yes, we have used them.

**Mr. Gordon:**
Only as secondary codes because most insurance companies do not pay for V codes.

**Ms. Lawrence:**
Medicaid allows the use of V codes.

**Ms. Robards:**
We have only had two claims that did not have a diagnosis.

**Mr. Burt:**
It is rare that there is no diagnosis.

**Kate Coronado-Johnson:**
I just performed an Internet search on V codes. There is V71.09, "no diagnosis or condition on access 1 or access 2." So, if an assessment were performed and there was no diagnosis, would that be the correct code to use when billing for an assessment?

**Ms. Lawrence:**
The clinician would need to determine if that was the correct code. Medicaid does accept V codes.

**Mr. Burt:**
Yes, that V code has worked in the past.

**Ms. Lawrence:**
I will map out the process for assessments and get back to you.

**ACTION ITEM: DHCFP to research why standalone assessments cannot be preauthorized and relay that information to providers.**

**Mr. Gordon:**
Will Medicaid and HP accept that code?

**Ms. Lawrence:**
Yes, we accept a whole range of V codes. To clarify, HP is the vendor who was hired to administer FFS claims adjudication. HP acts on behalf of Medicaid.

I will read the next question.

***Provider Question***: "Regarding FFS, why is a for-profit corporation making authorization decisions on clients? It appears that, on denials, little to no information is sent to Medicaid, since Medicaid in Carson City could not bring up the information and referred me to HP."

***DHCFP Response***: Hewlett Packard Enterprise is the authorized vendor to represent Nevada Medicaid FFS Medicaid Management Information System, which includes claims adjudication and utilization management functions (prior authorization). The procurement of the vendor follows State of Nevada's competitive Purchasing regulations and procedures (http://purchasing.state.nv.us/). DHCFP is the policy writer for Medicaid, for MCOs, and for the HP FFS. The MCOs and HP FFS have to follow the policies that DHCFP writes.

**Ms. Aiello:**
HP is simply adjudicating claims, not paying claims. Service payments come from the State of Nevada and the federal government. Service payments are not being paid from HP's profits.

**Annette Moran:**
HP's motivation is that they are paid premiums, correct?

**Ms. Aiello:**
No. HP is not paid premiums. HP is paid according to adjudication claim line, preauthorization decision, etc.

**Ms. Moran:**
Is HP paid according to the number of claims they deny and/or pay?

**Ms. Aiello:**
No.

**Mr. Gordon:**
I am frustrated by denials. I cannot get answers to legitimate questions. Then, there is a computer company making eligibility decisions on medical issues. I would like a little more feedback rather than a denial.

**Ms. Aiello:**
The utilization management decisions are made by a medical team of experts such as nurses, psychologists, etc.

**Ms. Lawrence:**
You may speak to them on a peer-to-peer basis.

Also, HP is not paid based on whether a preauthorization or claim is approved or denied. They are paid based on the number of claims processed.

**Mr. Gordon:**
There are situations in which I have to tell addicts, mentally ill, and alcoholics services are interrupted because I receive a denial. I have to tell them I cannot serve them. SAPTA will not pay for denials. People are dying.

**Ms. Aiello:**
We should get you some training on how to handle denials.

**ACTION ITEM: DHCFP to ensure providers receive training on handling of denials.**

**Ms. Lawrence:**
When a claim is denied, the appeal rights are sent to the patient. During the appeal process, the patient has the right to continue to receive services.

**Mr. Gordon:**
Will the provider be reimbursed if the denial is upheld?

**Ms. Aiello:**
On initial denials, there is no continuation of services.

**Ms. Lawrence:**
Another thing to look at is why the service is being denied. There are a number of reasons for denials. These claims come to my office and we can work through these.

**Mr. Gordon:**
It terrifies me that I cannot provide services to someone who needs them.

**Mr. Burt:**
Is this an opportunity for us to discuss the utilization of SAPTA funds as a safety net? If we were reimbursed by Medicaid after receiving funds from SAPTA, this would show as a credit. We are not going to stop seeing someone because we have not received reimbursement.

**Ms. Lawrence:**
I have spoken to Brandi Johnson many times about this issue. When this program was developed, we knew there were services that Medicaid would not cover. Medicaid will not cover vocational rehabilitation, respite, care coordination, social detoxification, room and board, etc.

I sent an email last evening regarding PTs 17 and 82. Providers can be enrolled in the dual delivery model of PT 17 and, if there is a need, in PT 82 if you want deliver BST [Basic Skills Training] and PSR [Psychosocial Rehabilitation] services. There is no reason to be enrolled as a PT 14 because that would be a duplication of services. If you would like to enroll, please contact DHCFP directly.

**Denise Everett:**
Did you state that PTs 14 and 17 is a duplication of services?

**Ms. Lawrence:**
Yes.

**Ms. Everett:**
If we were a PT 14, we could bill for our licensed personnel such as psychologists and psychiatrist. Our licensed drug and alcohol counselors could be billed under PT 17. It was my understanding was that all the benefits of being a PT 14 would transfer over to being a PT 17; however, that has not occurred. Under PT 14, many services do not need to be preauthorized.

**Ms. Lawrence:**
All services float under PT 17.

**Ms. Moran:**
They will not let us do that. HP will not allow us to be a PT 20.

**Ms. Lawrence:**
We will work on that. No one has called this to our attention.

**Ms. Moran:**
May we contact you anytime we hit a dead end with HP?

**Ms. Lawrence:**
Yes.

**Ms. Aiello:**
HP is our contractor. It may be that we have not communicated things to them adequately. They are operating in a fashion in which they think we have instructed them.

**Ms. Lawrence:**
PT 17 is an evidence-based model. I have said from the first day, we would miss some services that were missed. Codes were remapped. Claims were recycled and reprocessed. The idea is that PT 17 is a fully integrated model.

**Mr. Quint:**
We have said consistently that there is a disparity between PT 14 and PT 17. It is my understanding that if one is a PT 17, one cannot be a PT 14. Please clarify why.

**Ms. Lawrence:**
The reasoning is that partly because of how the claims adjudication system works. The goal is to have outpatient mental health services and rehabilitation services.

**Ms. Moran:**
PTs 14 and 17 have different fee schedules.

**Ms. Lawrence:**
No, they have the same fee schedules. If there are services that have not been covered under a provider type, we can map those over once the matter is brought to our attention.

**Ron Lawrence:**
On the issue of psychiatry, I represent one of the agencies that had to work through this. First, it depends upon how the provider is credentialed. It must be determined if they are a PT 17 or a PT 20. If a psychiatrist has credentialed himself or herself as a PT 17, that psychiatrist will never be able to bill under PT 20. I worked through that by petitioning the system and, personally, by becoming a PT 20. There have been no problems since doing this.

**Ms. Everett:**
Our psychologist is a PT 20, but our agency is not. Is that the problem?

**Mr. Lawrence:**
Yes, that is correct. You need to explain that to Medicaid.

**Ms. Lawrence:**
We will help you with that.

**Ms. Everett:**
What about other clinicians? Should they be PT 14 or 17?

**Ms. Lawrence:**
They fall under the ASAM model.

**Ms. Everett:**
So, that is different from PT 14.

**Ms. Lawrence:**
Yes.

**Ms. Moran:**
That is disrespecting substance abuse clients.

**Ms. Lawrence:**
But it is built on the ASAM model. If you want to do something different, we can work with you. The ASAM model builds your utilization.

**Mr. Burt:**
We were all at the table when this was developed; however, many things have changed since we met. We need to meet more often so we can discuss issues such as this.

**Ms. Aiello:**
I will read the next question.

***Provider Question***: "As referral fees and fee splitting is not permitted in Nevada, why do MCOs hold a percentage?"

***DHCFP Response***: The MCOs do not bill or get paid on a fee for service basis, nor do they hold a percentage of the payment that goes to the provider they pay for a service. The MCOs have risk-based contracts where they are paid a per-member, per-month fee. This payment is based on historical claims paid (set as an actuarial sound rate) and does have a percentage increase that covers their administrative processes (utilization management, claims payment, case management, provider services, quality management, etc., and some profit).

**Mr. Burt:**
If there is a certain group rate and we bill for that amount, we will receive 70 percent of that amount, correct? They are keeping 30 percent.

**Ms. Aiello:**
No, we do not pay MCOs based on the amount for a service. They are paid on a per-member, per-month basis. Sometimes we make adjustments and agreements with MCOs based on utilization.

**Mr. Quint:**
I understand MCOs are not fee splitting; however, they are not paying providers enough to cover the provider costs. It has been stated before that providers need to negotiate rates with MCOs.

**Mr. Burt:**
We were not given any sort of leverage to negotiate.

**Ms. Aiello:**
We try to stay at arms' length from our managed care and provider networks. MCOs have to have providers for enrollees. They are allowed to manage their networks. DHCFP do not dictate to MCOs what they pay.

**Mr. Burt:**
We would like your involvement.

**Ms. Aiello:**
We cannot get involved with negotiations between providers and MCOs.

**Ms. Moran:**
Who negotiates contracts with MCOs?

**Ms. Aiello:**
Each year there are requests for proposals and contracts are negotiated. Once we have given the MCOs the capitation rate, it is then the MCOs money to administer. Delivery models are managed under federal regulations. Each state decides what model is the best. This is managed through a political process.

I will read the next question.

***Provider Question***: "Why is HBI/HPN taking clients from agencies to provide direct services when the client sought out service with that agency and does not want to go to HBI/HPN?"

***HPN Response (Michelle Guerra)***: Frequently, patients present with co-occurring issues. It is our preference that providers treat both concerns.

**David Robeck:**
We do that, but we are losing clients to you.

**Mr. Lawrence:**
I can verify that Mr. Robeck is correct. There are various positions that HMOs take. Some refuse to accept the fact that PT 17 can treat substance abuse and mental health. We treat co-occurring issues.

**Tammara Pearce:**
We just received correspondence from HBI stating that we will be dropped from the network. I contacted SAPTA and was told they would not be able to pay for Medicaid-eligible clients. We have a contract with Washoe County and we will not be able to provide services any longer.

**Ms. Guerra:**
I will need to refer your concerns to my supervisor, Michelle Agnew.

**Ms. Aiello:**
It is my understanding that HBI is a subcontractor to HPN and has "historical" Medicaid enrollees. The expansion population are enrolled under BHO.

**Ms. Guerra:**
The expansion membership is under BHO. HBI is the capitated provider with its own provider network. I will follow up with Michelle Agnew regarding the HBI correspondence that some providers have received.

**Mr. Lawrence:**
I received the same correspondence from HBI. The reason I was given for being removed from the network was that they do not have clients with substance abuse problems. They no better than to challenge me on the co-occurring issue because, as a PT 17, we provide for substance abuse and mental health treatment services. We were told that clients needed to be sent first to HBI for an assessment and clients will then be referred back to us, but that is not happening.

**Mr. Gordon:**
HBI has a different set of requirements for credentialing and they do so because they want to keep the clients. They hired one of our licensed alcohol and drug counselors (LADCs); however, HBI will not accept us as LADCs. HBI is treating clients with only substance abuse issues. They are just expanding their client base.

**Ms. Guerra:**
HPN and HBI have the same level of credentialing. An LADC with a master's degree in an appropriate field can be credentialed.

**Mr. Gordon:**
I disagree with that statement. The person who HBI hired from our agency had a master's degree in an unrelated area.

**Ms. Moran:**
HBI will not credential any intern.

**Ms. Guerra:**
Did they have a master's degree in an appropriate field?

**Ms. Moran:**
Yes.

**Ms. Guerra:**
What I would suggest is that you submit that list to me and I will consult with Michelle Agnew. We will take appropriate action.

**Mr. Burt:**
Ms. Aiello, based on your contract with HPN, are you troubled by what you are hearing?

**Ms. Aiello:**
HPN can use the providers they wish. The State has asked that they use SAPTA providers. We have asked that they be good players within the system. Are you getting work from BHO?

**Mr. Gordon:**
No, we are not having problems with BHO.

**Ms. Pearce:**
If we are denied participation, may we turn to SAPTA as the safety net to pick up the charges?

**Ms. Aiello:**
With other types of providers, they are told to refer clients to those on the network.

**Mr. Burt:**
When we are called, it is a live or die situation. We cannot refer clients to another provider. They may die.

**Ms. Aiello:**
So, you are operating in an emergency mode.

**Mr. Lawrence:**
This is wrong. Not only may they die, if we turn someone away, he or she may get drunk, drive a car, and run someone over. We cannot allow them to perpetrate anything in the public domain. It is an ethical and moral issue. The federal government under Medicare. Medicare says they will honor anyone, even an authorized intern, as long as they have been authorized under State rules.

**Mr. Gordon:**
HPN takes an extended period to credential providers. This makes it difficult to hire personnel. It can take as long as six months to credential someone through HPN.

**Mr. Lawrence:**
I have to wait two months to get someone credentialed. This results in providing services for no reimbursement.

**Ms. Guerra:**
I will have to get back with you on some of these issues.

**Mr. Robeck:**
Medicaid representatives are indicating they are hearing these issues for the first time. That concerns me. Mr. Quint has asked questions regarding this issue for months and members of the SAPTA Advisory Board has given Mr. Quint feedback. The Board has discussed these issues for months. Perhaps Medicaid should meet with the Board at least on a quarterly basis.

**Ms. Aiello:**
We are not hearing these issues for the first time. Ms. Guerra is indicating they believe they have an adequate network.

**Ms. Lawrence:**
It sounds like we need to come together in a collaborative manner. Our MCOs are showing us that there is no need to add providers to networks; however, it sounds like providers are saying there is a lot of demand.

**Mr. Lawrence:**
There is a difference between referral sources. Our referral basis is vastly different in our field.

**Ms. Lawrence:**
MCOs may not be seeing the pent up demand.

**Debra Reed:**
We have no issues with Amerigroup. Our issues are with HPN, HBI, and BHO.

**Mr. Burt:**
Generally, they are the same group.

**Mr. Gordon:**
When we went to the PT 17, there was an attempt to preserve the SAPTA-type organizations and other agencies that had done this for years. Now we are competing for our existence with for-profit agencies and with HBI. The promises we saw with PT 17, now we are being told MCOs can do it just as well. PT 17 is not working correctly. No portion of Amerigroup is competing with us.

**Ms. Everett:**
It is the fox guarding the henhouse. I have complained about this for years. I do not understand this, and I do not understand why it is legal.

**Mr. Gordon:**
It is probably legal, but is it ethical? I feel betrayed as a funded agency by going to FFS. We are on the verge of bankruptcy.

**Ester Quilici:**
We receive five to ten calls a week. We say to HPN subscribers that we are not part of the HPN network. They will not accept Vitality; therefore, we cannot accept you as a client. That speaks to the fact that HPN does not have an adequate network. It is a pleasure to work with Amerigroup. Amerigroup has embraced our system. HPN says they do not have provider openings, but that is not borne out by the number of potential clients that contact our agency.

**Ms. Lawrence:**
I will read the next question.

***Provider Question***: "Why don't MCOs have the same process for authorization and paperwork? This would make it easier to change with client changes in their choice of Medicaid."

***DHCFP Response***: There has been a concerted effort to streamline prior authorization policies. From the start, we have been aware of differences across the board. When we can come together [DHCFP and MCOs] to streamline processes, we do.

**Mr. Burt:**
Does the HPN Representative have a timeline that you will have answers to our questions?

**Ms. Guerra:**
No, I cannot give you a specific timeline.

**Ms. Aiello:**
We would like to have the answers back within two weeks.

**Mr. Quint:**
Would you like to discuss this during a provider meeting rather than a SAPTA Advisory Board meeting?

**Mr. Burt:**
This relates to the preservation of our field. This is a pressing matter. I believe the discussion should continue during our monthly SAPTA Advisory Board meeting.

**Ms. Aiello:**
If the HPN Representative can distribute answers to attendees within two weeks, that will give providers adequate time to review the answers.

**Ms. Guerra:**
I will do that.

**ACTION ITEM: Michelle Guerra to distribute answers to questions following her meeting with Michelle Agnew.**

**Mr. Quint:**
I acknowledge that we have a broken system right now. SAPTA's policy is that we do not reimburse for Medicaid-eligible clients. These discussions will help us to determine what our options are.

**Ms. Lawrence:**
SAPTA does not pay for Medicaid-eligible services, correct?

**Mr. Quint:**
I misspoke. You are correct. SAPTA is trying to fill the gaps that Medicaid does not pay for. Medicaid does not pay for certain services and SAPTA fills that gap. Bristlecone is a perfect example of how problems occur.

**Ms. Pearce:**
Everything was working fine until we received the letter from HBI indicating that they did not want Bristlecone on their network.

**Mr. Quint:**
I want us to lay issues out on the table and discuss all the difficulties and obstacles providers are facing.

**Ms. Aiello:**
Another question for the HPN Representative is what a provider should do when they see a client on an emergency basis. Providers need to know how to handle HPN individuals.

**Ms. Lawrence:**
I have heard issues regarding certifications. I need more information on that from providers.

**Mr. Quint:**
Some providers are concerned because providers feel they are not receiving consistent information from DHCFP and MCOs.

**Mr. Burt:**
We would like representatives from DHCFP and the MCOs attend future meetings.

**Ms. Aiello:**
We would be happy to attend.