Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Cody Phinney
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

Date: September 22, 2023

To: State of Nevada Behavioral Health Commission

From: Margaret Moe, Rates & Cost Containment Manager MMoe
Department of Health & Human Services
Division of Public and Behavioral Health, Revenue Management Unit

Re: Request for Additional Information (Reference Meeting May 15, 2020)

On May 15, 2020, the Behavioral Health Commission approved proposed rates presented by the Rates & Cost Containment Manager, Tiffany Lewis. The rates were approved upon the condition the Division of Public and Behavioral Health (DPBH) provide additional information and clarification to demonstrate the cost variations more effectively between the Northern Nevada Adult Mental Health Services (NNAMHS) vs. Southern Nevada Adult Mental Health Services (SNAMHS), including:

1. Differences, if any, in service demand/utilization per capita
2. Population statistics
3. Population rate per clinic
4. Total clients seen per clinic
5. Sample of different billing/services costs for stays for two typical clients using the most frequently used code (Attachment A, B & C).

The State's facility costs are determined using a proprietary software program called AlloCap which identifies and allocates costs. The Division used three distinct groupings to identify and allocate costs to the benefiting programs.

1. Administrative Costs including statewide and departmental indirect costs are identified and allocated to specific cost pools (activity code associated with a position) for behavioral health and public health programs. Full-Time Equivalent (FTE), these costs are considered administrative by DPBH and should not be confused with costs that may be allowable as Medicaid or CHIP administration.
2. Behavioral health programs are identified and allocated within the AlloCap software application for distribution to benefiting programs.
3. Public health costs are identified and included within the application to generate indirect cost rate for the public health program.

The AlloCap software tool identifies and allocates costs by a four-stepdown methodology and if necessary, a final/fifth stepdown for allocation. And, three types of accounts, initial, intermediate, and final.

1. Initial stepdown accounts are indirect costs pools located in the Chart of Accounts.
2. Intermediate accounts are used for time studies and other cost pools that require a cost to be split into multiple cost pools, each of which then has a separate allocation method.
3. Final accounts correspond to the benefitting objectives, which are usually funding sources.

Service cost disparities cannot be condensed into one reason, but differences are dependent upon area competition and the types and availability of physicians, types of physicians (i.e., Psychologist, Psychiatrist) and service providers in the region. Costs for services differentiate between facilities based on what providers are available and how they are utilized. In addition, costs to staff and maintain operations and programs are consistent regardless of the number or frequency of clients.

SFY21 NNAMHS & SNAMHS Clients Served by Provider (**Attachment C**) provides an overview of the different Provider types and the number of clients served by each Provider type. The inpatient and outpatient tables provide the different types of providers by programs and number of clients served.

The overview demonstrates why the rates are higher at SNAMHS, then at NNAMHS. The average Cost Per Unit at SNAMHS is $214.90 per unit compared to NNAMHS at $102.35 per unit. When calculating rates, DPBH takes into consideration revenues and expenditures as well as unit performed to provide the most affordable rates for our clients at each location.

The Relative Value Units (RVU) are used to support the calculation of reimbursement. They are an objective way to identify the cost components linked to procedures described in the Current Procedural Terminology (CPT) code set. The calculation enables health care professionals to combine the time, intensity and cost into a single relative ranking scale called the Resource-Based Value Scale (RBRVS). The RBRVS is based on the principle that payments for services should correlate directly with the resource costs for providing those services.

How To Understand Relative Value Units[1]

Determining relative value units by considering three factors and adding them up. These include:

- **The work the physician performed**: This factors in the amount of skill, time, and training that was required to complete the medical service or procedure. For example, physicians working on surgeries will pay more than a routine checkup. A major medical procedure requires more skill and more time, so it will generate a higher RVU.
- **The cost of maintaining or operating a medical practice**: These factors include rent costs in addition to the price of equipment and supplies. It also includes the costs associated with paying staff members.
- **The liability expenses**: Malpractice or liability expenses will range from provider to provider. In other words, doctors will have higher liability premiums due to the nature of their jobs. For example, primary care physicians will have less expense compared to brain surgeons or an obstetrician.

[1] Relative Value Unit Explantation Source : https://mbamedical.com/blog/rvu-medical-billing/

Each fiscal year, DPBH is required to review and update each CPT codes with the current RVU established by the Centers for Medicare & Medicaid Services (CMS), National Physician Fee Schedule as provided on the attached Quarterly Cost Report listed in the column labeled RVU.

Quarterly Cost Report (**Attachment A**) is a summary of the process for calculating unit cost for the services provided by NNAMHS and SNAMHS. In this example, I will use SNAMHS.

1. Number of Units Performed: A report from myAvatar is ran for each quarter providing the CPT code and the cost pool in which the service was performed.
2. Number of RBRVUs Performed: This section calculates the total units performed by CPT multiplied by the RVU. Using Med Clinic in this example.
    a. Med Clinic .77: CPT 90792; 390 units performed x $5.06 RVU = $1,973.40 Per Unit.
3. Cost Per Unit: This calculation provides the cost of each unit DPBH will charge for the services.
    a. Cost per RBRVU is calculated by taking the total for ***ALL*** CPT codes (RBRRVUs x Unit Performed) dividing that number into the cost it took to run the facility for the fiscal year ($1,533,485.25 Total Cost / $13,938.79 Total RBVU = $110.02 Cost Per RBVU).
    b. Cost per unit for Med Clinic .77: BRVU $110.02 x RVU $5.06, equals $556.68.
    c. CPT 90792 are costs listed under two cost pools: Med Clinic .77 $556.68 and PAS .81 $896.23. Moving to the far-right column, Average Agency Rate $563.50 is listed, which is the 1st Quarter cost per unit. The average agency rate is calculated for each quarter.
    d. If SNAMHS only had units under Med Clinic .77 and no other cost pool, the new rate would be $556.68.
    e. Once all the rates for the current year (all four quarters) have been calculated, they are entered into rate rollup spreadsheet comparing the last five years of rates for each facility and CPT code.

Rate Setting Rollup Report (**Attachment B**) uses the quarterly units performed and average agency rates from the Quarterly Cost Report for each facility. Rates from the previous five years are entered into the report for comparison when setting rates for the current year.

1. Units performed and Average Agency Rate are entered from each quarterly cost report.
2. The Rate Setting Rollup spreadsheet calculates the current fiscal years rate using the average rate.
3. Current and prior fiscal years are compared, adjustments are made if required. An example of an adjustment would be “FY23 Rate is higher than previous, using FY rate”.
4. All facilities (NNAMHS, SNAMHS and Rural Clinics) rates are analyzed to arrive at a comparable rate.

The information provided above is to demonstrate to the Board of Commissions the steps taken to complete the process to establish rates for DPBH. Once rates are approved and documentation is completed for the updates, DPBH Revenue Management Unit submits the new rates to Medicaid and the myAvatar system is updated.

Response to questions the Board of Commissions requested on May 20, 2020.

1. **Differences, if any, in service demand/utilization per capita**
   Service cost disparities cannot be condensed into one reason, but differences are dependent upon area competition and the types and availability of physicians and service providers in the region. Costs for services differentiate between facilities based on what providers are available and how they are utilized. In addition, costs to staff and maintain operations and programs are consistent, regardless of the number or frequency of clients.

2. **Population statistics**
   Statistics provided below, however, population may not play a role in number of units performed since each client may participate in a variety of services provided by DPBH facilities (Client J could be seen twice a week; include office visits each time and an injection each visit, which would equate to four units performed).

   https://www.leg.state.nv.us/Division/Research/Documents/PopulationofCountiesInNevada2020Projected.pdf

	Clark County	%	Washoe/Carson	%	Facilities Total	State Total
2016	2,139,000		504,135		2,643,135	2,918,000
2020	2,329,514	9% ↑	535,497	6% ↑	2,865,011	3,160,965

3. **Population rate per clinic (total clients/total population)**

(Total clients/total population)

	SNAMHS Clark County	NNAMHS Washoe/Carson
2016	0.004227676	0.00887064
2020	0.002695841	0.004478083

4. **Total distinct clients seen per clinic (myAvatar)**
   With the onset of the Affordable Care Act (ACA), DPBH has the ability to refer clients to other mental health providers, causing a decline in clients serviced per clinic and increase in rates.

	SNAMHS	NNAMHS	Total
2016	9,043	4,472	13,515
2020	6,280	2,398	8,678

36% reduction in clients over 4 years.

Summary

The State of Nevada's cost allocation system and reporting uses an established process that is standard for the industry. Our processes are conducted with fidelity. The process appears to generate a high level of accuracy, completeness, reliability, and relevance with the data as well as the calculated outcomes generated.

Facility costs are assigned to initial cost pools, each of which has a method of allocation assigned to it. Each allocation method consists of statistics such as direct allocation, full time equivalent count, time study results, etc. that determine how the cost will be allocated to the benefiting objective or final receiver. After the allocation process is completed, reports are generated to show the amount of cost allocated to all benefiting objectives.

The reports are reviewed and amended as necessary. DPBH is confident that the data and information currently provided and extracted is reliable and truly reflects an accurate accounting of costs associated with delivering behavioral health services to State of Nevada consumers.

Attachments

Attachment A, Quarterly Cost Report
Attachment B, Rate Rollup
Attachment C, NN SN Provider Clients Served
Attachment D, COBH May 15, 2020, Approved Minutes

Quarterly Cost Report

Attachment A

!!INAMHS QTR 1 (CPT Information is from Avatar)

Number of Units Performed

CPTIHCPCS Code	Descnpt1on	Relative Value Unit (RVU)	AOT .43	Med Clime .56	Mental Health Court .48	Outpatient .49	PACT .50	PAS .51	PSR .53	Total Units
90785	Interactive Complexity	0.38								-
90791	Diagnostic Evaluation - No Medical	4.48				1				1
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48				1				1
907911	Diagnostic Evaluation - Virtual	4.48				35				35
90792	Diagnostic Evaluation - wnAedical	5.06		8						8

Number of RBRVUs Performed (RVU x Units Performed)

CPTIHCPCS Code	Descnpt1on	Relative Value Unit (RVU)	AOT .43	Med Clime .56	Mental Health Court .48	Outpatient .49	PACT .50	PAS .51	PSR .53	Total RVBSs
90785	Interactive Complexity	0.38	-	-	-	-	-	-	-	-
90791	Diagnostic Evaluation - No Medical	4.48	-	-	-	4.48	-	-	-	4.48
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48	-	-	-	4.48	-	-	-	4.48
907911	Diagnostic Evaluation - Virtual	4.48	-	-	-	156.80	-	-	-	156.80
90792	Diagnostic Evaluation - wnAedical	5.06	-	40.48	-	-	-	-	-	40.48
	Line includes all RBRVU for all CPT in Cost	Total RBVU's	528.40	4,265.52	72.19	1,434.65	-	45.76	-	6,346.52
	Pools AlloCap Actual FY Expenditures for Facility	Total Cost	19,920.36	279,857.68	1,795.62	139,479.92	167,251.44	15,592.93	23,636.38	
	Total Cost Per RBVU/Total RBVU	Cost per RBVU	37.70	65.61	24.87	97.22	N/A	340.75	N/A	

Cost Per Unit (RBRVU Performed x Cost Per RBRVU / Units Performed= Average Cost Per Unit)

CPTIHCPCS Code	Descnpt1on	Relative Value Unit (RVU)	AOT .43	Med Clime .56	Mental Health Court .48	Outpatient .49	PACT .50	PAS .51	PSR .53	Average Agency Rate
90785	Interactive Complexity	0.38	-	-	-	-	-	-	-	N/A
90791	Diagnostic Evaluation - No Medical	4.48	-	-	-	435.56	-	-	-	435.56
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48	-	-	-	435.56	-	-	-	435.56
907911	Diagnostic Evaluation - Virtual	4.48	-	-	-	435.56	-	-	-	435.56
90792	Diagnostic Evaluation - wnAedical	5.06	-	331.98	-	-	-	-	-	331.98

SNAMH S QTR 1 (CPT Information is from Avatar)

Number of Units Performed

CPTIHCPCS Code	Descnption	Relative Value Umt (RVU)	Med Chmc .77	Mental Health Court .78	Mobile Cns1s .79	OUtpatient .80	PACT.71	PAS .81	AOT.115	Total Umts
90785	Interactive Complexity	0.38	-	-	-	-	-	-	-	-
90791	Diagnostic Evaluation - No Medical	4.48	3	-	-	114	-	-	-	117
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48	-	-	-	-	-	-	-	-
907911	Diagnostic Evaluation - Virtual	4.48	-	-	-	22	-	-	-	22
90792	Diagnostic Evaluation - w/Medical	5.06	2A 390	2A -	-	-	-	8	-	398

Number of RBRVUs Performed (RVU x Units Performed)

CPT/HCPCS Code	Descnption	Relative Value Umt(RVU)	Med Chmc .77	Mental Health Court .78	Mobile Cns1s .79	OUtpatient .80	PACT.71	PAS .81	AOT.115	Total RVBSs
90785	Interactive Complexity	0.38	-	-	-	-	-	-	-	-
90791	Diagnostic Evaluation - No Medical	4.48	13.44	-	-	510.72	-	-	-	524.16
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48	-	-	-	-	-	-	-	-
907911	Diagnostic Evaluation - Virtual	4.48	-	-	-	98.56	-	-	-	98.56
90792	Diagnostic Evaluation - w/Medical	5.06	1,973.40	2A -	-	-	-	40.48	-	2,013.88
	Line includes all RBRVU for all CPT in Cost Pools	Total RBVU's	13,938.79	3A 102.93	-	5,617.47	807.17	243.91	1,211.74	21,922.01
	AlloCap Actual FY Expenditures for Facility by Cost Pool	Total Cost	1,533,485.25	3A 357.15	76,130.66	309,423.11	8,548.86	43,201.37	82,559.38	
	Total Cost Per RBVU/Total RBVU	Cost per RBVU	110.02	3A 3.47	N/A	55.08	10.59	177.12	68.13	

Cost Per Unit (RBRVU Performed x Cost Per RBRVU / Units Performed = Average Cost Per Unit)

CPT/HCPCS Code	Descnption	Relative Value Umt(RVU)	Med Chmc .77	Mental Health Court .78	Mobile Cns1s .79	OUtpatient .80	PACT.71	PAS .81	AOT.115	Average Agency Rate
90785	Interactive Complexity	0.38	-	-	-	-	-	-	-	N/A
90791	Diagnostic Evaluation - No Medical	4.48	492.87	-	-	246.77	-	-	-	253.08
90791GT	Diagnostic Evaluation - No Medical - Tele	4.48	-	-	-	-	-	-	-	N/A
907911	Diagnostic Evaluation - Virtual	4.48	-	-	-	246.77	-	-	-	246.77
90792	Diagnostic Evaluation - w/Medical	5.06	556.68	3B & 3C -	-	-	-	896.23 3C	-	563.50 3C

Rate Setting Rollup Report

Attachment B

NNAMHS		FY 21 Qtr. 1 Units	FY 21 Qtr. 1 Rate	FY 21 Qtr. 2 Units	FY 21 Qtr. 2 Rate	FY 21 Qtr. 3 Units	FY 21 Qtr. 3 Rate	FY 21 Qtr. 4 Units	FY 21 Qtr. 4 Rate	FY23 Average Rate (via FY21 Data)	5 Yr Rate History FY22 Rate	FY21 Rate	FY20 Rate	FY19 Rate	FY18 Rate	FY23 Calculated Rates	FY22 Rates	FY23 Final
90785	Interactive Complexity	-	$ -	-	$ -	1	$ 42.96	-	$ -	$ 42.96	$ 37.15	$ 11.69	$ 11.69	$ 20.30	$ 29.94	$ 42.96	$ 37.15	**$ 25.62**
90791	Diagnostic Evaluation - No Medical	1	$ 435.56	9	$ 867.44	8	$ 506.43	10	$ 1,033.27	$ 808.10	$301.81	$ 501.41	$ 501.89	$ 688.89	$ 847.79	$ 808.10	$ 301.81	**$ 301.81**
90791GT	Diagnostic Evaluation - No Medical - Te	1	$ 435.56	-	$ -	8	$ 506.43	-	$ -	$ 498.56	$301.81	$ 501.41	$ 501.89	$ 688.89	$ 847.79	$ 498.56	$ 301.81	**$ 301.81**
90791T	Diagnostic Evaluation - Virtual	35	$ 435.56	11	$ 1,070.28	-	$ -	-	$ -	$ 587.34	$301.81	No Rate	No Rate	No Rate	No Rate	$ 587.34	$ 301.81	**$ 301.81**
90792	Diagnostic Evaluation - w/Medical	8	$ 331.98	5	$ 450.44	35	$ 513.01	44	$ 1,212.51	$ 828.41	$288.43	$ 185.12	$ 185.12	$ 227.17	$ 412.65	$ 828.41	$ 288.43	**$ 354.48**

SNAMHS		FY 21 Qtr. 1 Units	FY 21 Qtr. 1 Rate	FY 21 Qtr. 2 Units	FY 21 Qtr. 2 Rate	FY 21 Qtr. 3 Units	FY 21 Qtr. 3 Rate	FY 21 Qtr. 4 Units	FY 21 Qtr. 4 Rate	FY23 Average Rate (via FY21 Data)	FY22 Rate	FY21 Rate	FY20 Rate	FY19 Rate	FY18 Rate	FY23 Calculated Rates	FY22 Rates	FY23 Final
90785	Interactive Complexity	-	$ -	1	$ 29.28	3	$ 21.81	-	$ -	$ 23.68	$ 30.70	$ 43.80	$ 40.66	$ 40.06	$ 70.10	$ 23.68	$ 30.70	**$ 30.70**
90791	Diagnostic Evaluation - No Medical	117	$ 253.08	104	$ 345.16	117	$ 274.46	101	$ 385.97	$ 311.17	$ 295.13	$ 162.15	$ 132.02	$ 156.40	$ 194.89	$ 311.17	$ 295.13	**$ 311.17**
90791GT	Diagnostic Evaluation - No Medical - Te	-	$ -	-	$ -	-	$ -	1	$ 385.97	$ 385.97	$ 295.13	$ 162.15	$ 132.02	$ 156.40	$ 194.89	$ 385.97	$ 295.13	**$ 311.17**
90791T	Diagnostic Evaluation - Virtual	22	$ 246.77	17	$ 345.16	33	$ 262.44	6	$ 385.97	$ 285.55	$ 295.13	No Rate	$ 132.02	$ 156.40	$ 194.89	$ 285.55	$ 295.13	**$ 311.17**
90792	Diagnostic Evaluation - w/Medical	398	$ 563.50	352	$ 763.86	340	$ 706.29	323	$ 931.67	$ 731.93	$ 509.93	$ 689.41	$ 568.71	$ 529.36	$ 736.08	$ 731.93	$ 509.93	**$ 509.93**

Attachment C

SFY 21 NNAMHS & SNAMHS Clients Served by Provider
Includes (Earned Revenue and Actual Expenditures)

NNAMHS Outpatient Hospital Adult (Program Decscription)	Provider Types: APN	Inter	LADC	LCSW	MD	PHD	Resident	RN	Serv Coord	RX	Total Served	Revenue	% of Clients Svc'd
NNAMHS (AOT)Assisted Outpatient Treatmnt						61			2,045		2,106	$ 104,197.01	**11.62%**
NNAMHS Ambulatory Service Adult		1			1				97		99	$ 8,478.90	**0.55%**
NNAMHS CBLA Adult									5		5	$ 192.85	**0.03%**
NNAMHS Co-Occurring Disorder Adult									1		1	$ 38.57	**0.01%**
NNAMHS Forensic MH Team Adult									982		982	$ 47,238.89	**5.42%**
NNAMHS ICBLA Adult									6		6	$ 231.42	**0.03%**
NNAMHS Int Svc Coord Adult						1			464		465	$ 23,403.14	**2.56%**
NNAMHS Med Clinic Adult	30	528			832		14	390	861		2,655	$ 143,285.12	**14.65%**
NNAMHS Mental Health Court Adult									4,613		4,613	$ 284,758.13	**25.45%**
NNAMHS OP Counseling Adult		9		29		105			1		144	$ 16,600.76	**0.79%**
NNAMHS Pharmacy Adult										72	72	$ 1,208.08	**0.40%**
NNAMHS Svc Coord Adult			12						6,969		6,981	$ 349,225.29	**38.51%**
Grand Total	**30**	**538**	**12**	**29**	**833**	**167**	**14**	**390**	**16,044**	**72**	**18,129**	**$ 978,858.16**	**100.00%**

NNAMHS IP By Provider Type - # of Patients Served

Provider Type	Patients Serviced	Revenue By Provider	% of Clients Svc's
APN	15	$ 865.89	1.26%
Intern	356	$ 204,516.37	29.92%
MD	781	$ 272,069.24	65.63%
Resident	38	$ 21,073.47	3.19%
Grand Total	**1190**	**$ 498,524.97**	**100.00%**

SNAMHS Outpatient Hospital Adult (Program Decscription)	Provider Types: APN	CSA	DO	Inter	LCSW	MD	MHT	MS	PA	PHD	Resident	RN	Serv Coord	Total Served	Revenue	% of Clients Svc'd
Laughlin Med Clinic						528						15		**543**	**$ 66,791.95**	**1.91%**
Laughlin OP Counseling					96								6	**102**	**$ 7,633.50**	**0.36%**
Mesquite Med Clinic						394					43	79	1	**517**	**$ 44,866.35**	**1.82%**
Mesquite OP Counseling					1,178					4				**1,182**	**$ 67,403.22**	**4.16%**
Mesquite OP Screening					42								2	**44**	**$ 2,335.05**	**0.15%**
Mesquite Svc Coord													138	**138**	**$ 19,057.55**	**0.49%**
SNAMHS Ambulatory Svc Adult	1				119	1						34	29	**184**	**$ 8,791.48**	**0.65%**
SNAMHS AOT Adult			749									486	2,177	**3,412**	**$ 462,900.62**	**12.01%**
SNAMHS Community Services Adult					5									**5**	**$ 269.99**	**0.02%**
SNAMHS Detention Center Adult													74	**74**	**$ 9,411.43**	**0.26%**
SNAMHS Int Svc Coord Adult		1						110					1,768	**1,879**	**$ 246,078.10**	**6.62%**
SNAMHS Med Clinic Adult	2,620		1	3	1	2,745			964		162	2,399	17	**8,912**	**$ 668,499.89**	**31.37%**
SNAMHS Med Clinic Wait List	1					4			2		1	2		**10**	**$ 2,622.47**	**0.04%**
SNAMHS Mental Health Court Adult		1,352											2,306	**3,658**	**$ 299,066.05**	**12.88%**
SNAMHS OP Counseling Adult					717								309	**1,026**	**$ 82,770.80**	**3.61%**
SNAMHS OP Counseling Wait List					2									**2**	**$ 227.44**	**0.01%**
SNAMHS Outpatient Restoration						1								**1**	**$ 145.08**	**0.00%**
SNAMHS PACT Adult					190			1			5	616	1,442	**2,254**	**$ 192,341.10**	**7.94%**
SNAMHS Svc Coord Adult					541		302	256					3,363	**4,462**	**$ 412,375.39**	**15.71%**
Grand Total	**2,622**	**1,353**	**750**	**3**	**2,891**	**3,673**	**302**	**367**	**966**	**4**	**211**	**3,631**	**11,632**	**28,405**	**$ 2,593,587.46**	**100.00%**

SNAMHS IP By Provider Type - # of Patients Served

Provider Type	Patients Serviced	Revenue By Provider	% of Clients Svc's
APN	60	$ 33,958.85	1.74%
Intern	38	$ 24,802.33	1.10%
LADC	9	$ 8,036.88	0.26%
MD	1694	$ 1,075,146.63	49.13%
PHD	11	$ 463.90	0.32%
RN	18	$ 12,734.88	0.52%
Resident	1618	$ 961,437.63	46.93%
Grand Total	**3448**	**$ 2,116,581.10**	**100.00%**

NNAMHS - FY21 Cost Per Unit (E-R/C)		**102.35**
SNAMHS - FY21 Cost Per Unit (E-R)/C)		**214.90**

As Demonstrated it cost more to operate SNAMHS, than it does NNAMHS causing the rates to be higher in the South then North.

NNAMHS - FY21 Revenue Earned	**$ 1,477,383.13**	**23.88%**
SNAMHS - FY21 Revenue Earned	**4,710,168.56**	**76.12%**
	$ 6,187,551.69	**100.00%**

NNAMHS - FY21 Actual Expenditures	**$ 3,454,656.00**	**23.02%**
SNAMHS - FY21 Actual Expenditures	**11,555,246.00**	**76.98%**
	$ 15,009,902.00	**100.00%**

NNAMHS - FY21 Clients Served	**19,319**	**37.75%**
SNAMHS - FY21 Clients Served	**31,853**	**62.25%**
	51,172	**100.00%**

Steve Sisolak
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public and Behavioral Health
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Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

DPBH COMMISSION ON BEHAVIORAL HEALTH
Meeting
MINUTES
May 15th, 2020
8:30 AM

MEETING LOCATIONS:

In accordance with Governor Sisolak's Declaration of Emergency Directive 006; Subsection 1; The requirement contained in NRS 241.023 (1)(b) that there be a physical location designated for meetings of public bodies where members of the public are permitted to attend and participate is suspended.

Phone: 1-669-900-6833 (Access Code: 775-684-5906)

COMMISSIONERS PRESENT:
Lisa Durette, M.D., (Phone), Tabitha Johnson, (Phone), Debra Scott, (Phone), Natasha Mosby, Melanie Crawford, Ph.D. (Phone), Jasmine Troop, LCPC (Phone), Barbara Jackson (Phone), Lisa Ruiz-Lee (Phone)

COMMISSIONERS EXCUSED:
Asma Tahir

Phone:
Joseph Filippi, DPBH; Rex Gifford, DPBH, Suzanne Sliwa, DAG; Stacy Barns, SRBH coordinator; Teresa Kimberly-Clark, RBH Coordinator; Tiffany Lewis, DHCFP; Kristen Rivas, DCFS; Dr. Leon Ravin, DPBH; Cody Phinney, DHCFP; Gujuan Caver, ADSD; Marina Valerio, ADSD; Russell Fallon, ADSD;; Ellen Richardson-Adams, SNAMHS; Joanne Malay, DPBH; Susan Lynch, SNAMHS; Megan Wickman, ADSD; Stan Cornell, SNAMHS; Tina Gerber-Winn, DPBH; Aaron Schoch, DPBH Billing; Brook Adie, DPBH; Julian Montoya, ADSD; Jasmine Cook, Clark Regional BH Policy Board; Julie Slabaugh, DAG; Christina Brooks, NNAMHS, Jennifer Richards, ADSD

Chair Durette called the committee meeting to order at 8:33 a.m. Roll call is reflected above. It was determined that a quorum was present.

Public Comment

Public Comment: Nevada Psychiatric Association represented by Leah Cartwright.

The Nevada Psychiatric Association has been working with legislators regarding two topics in different divisions. IMD Exclusion and Mental Health Pairing. IMD Exclusion is the Institutions for Mental Disease Exclusion at the federal level. Ms. Cartwright highlighted the inability at the federal level for financial participation in funding Medicaid for individuals ages 21 to 64 who need that intuitional level of care if the authority has more than 16 beds. They have been advocating at the state level to have Medicaid submit a waiver to the federal government to allow Nevada to have an IMD Exclusion. This would allow Medicaid funding for our Medicaid population. Vermont has an IMD Exclusion and the Nevada Psychiatric Association has developed a hand-out with a comparison between Nevada's hospitalization data for mental illness and Vermont's hospitalization data for mental illness. The handouts show how Vermont uses the IMD Exclusion and there is a lot better follow-up care for patients that are hospitalized with care between 7 and 30 days discharged. A hand-out was received and is on the DPBH website for reference.

The Nevada Psychiatric Association is also working on Mental Health Parity. They are discussing this with the Division of Insurance, Public Employee Benefits, and making sure Medicare and Medicaid are all on the same page. What was observed with Mental Health Parity is that not all insurance companies are succinct, even though there is a federal requirement for insurance companies to provide mental health at the same level as other health care that they cover. Some insurance companies are not playing by those rules. What the Nevada Psychiatric Association is asking for is either in regulation, or in law, to have a form or requirement that an insurance company demonstrate that they are complying with the Mental Health Parity Act here in Nevada. Some examples of Mental Health Parity issues seen in Nevada are patients not being able to stay in in-patient care if they need it. Patients being denied medication or being charged more for their mental health medication. The major issue in Nevada is that a patient has to know and complain their treatment to the Division of Insurance or Medicaid in order to have any of these issues addressed. What the Nevada Psychiatric Association would like to see is a pro-active approach on insurers so that patients do not have to complain to get better parity in mental health treatment. A hand-out was received and is on the DPBH website.

Ms. Cartwright offered to answer any questions at this time.

No questions were asked.

Previous Meeting Minutes

Chair Durette asked Commission Members if they had a chance to review the previous minutes, if there were any edits needed, or if the Commission wanted to move forward.
Dr. Crawford had an edit suggestion for the March 20th, 2020 Commission on Behavioral Health minutes. Dr. Crawford stated that there was a mistake and she did not attend that meeting. Commissioner Troop stated that she was at the March 20th, 2020 meeting but not listed as having attended.

Dr. Crawford highlighted that there were some inconstancies across the meeting minutes as to whether the Commissioner's credentials were listed or not. Dr. Crawford requested more consistency. Chair Durette requested what was specifically inconsistent? Dr. Crawford complained that Chair Durette's credentials are consistent saying M.D.; however, all the other Commissioner's credentials are not consistently listed. Dr. Crawford stated that she did not know what the other Commissioner's credentials are, but she has a Ph.D.

Chair Durette suggested a motion that all the Commissioners send their preferred credentials listing to Joseph Filippi and edit that going forward.

Dr. Crawford made the motion that Commissioners send their preferred credentials/listing in for the purposes of editing the minutes. Commissioner Mosby seconded the motion.

All Commissioners approved the motion.

Chair Durette asked the Commissioners for a motion to approve the previous meetings minutes as long as the suggested edits are made.

Commissioner Scott moved to have the minutes approved as edited. Commissioner Johnson seconded the motion.

All Commissioners approved the motion.

Consent Agenda: Consideration and Possible Approval of Agency Director Reports

Chair Durette stated that the Agency Director Reports were sent by mail and email and expressed her appreciation for sending Agency Director Reports by both means. Chair Durette asked the Commission if they had questions or items that they would like to have additional discussions, or would the Commission like to move the reports forward?

Commissioner Scott asked if there was a tally of positive COVID-19 patients, patients who were diagnosed, and any deaths that may have occurred?

Chair Durette asked for clarification as to where Commissioner Scott was referring to?

Commissioner Scott clarified for any of the agencies submitted their report.

Joanne Malay, Deputy Administrator, DPBH, responded that she can speak for the hospitals that are under DPBH (Division of Public and Behavioral Health). Ms. Malay stated that for statistical reasons the numbers are so low that the Division can't actually report these incidents because they would be identifiable, but the Commission is assured that all incidents of COVID-19 are reported weather they are staff or patients to the Local Health District and are followed up by the Local Health District. There are also numerous precautions to screen in all of our facilities for any kind of signs and symptoms related to respiratory illness and fever. Of course, patients that test positive would be transferred out, if they were stable and had to be transferred back then isolation precautions would be taken as well as transmission-based precautions.

Chair Durette asked if there were any further questions for the agency, or would the Commission like to move forward?

Commissioner Scott moved that the Commission move the Consent Agenda forward and approve the reports as written. Commissioner Johnson seconded the motion.

All Commissioners approved the motion.

Consideration and approval of Updated Fee Schedule

Consideration and approval of an updated fee schedule of Discounts for Inpatient and Outpatient Behavioral Health Services and Related Supplies for Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) per NRS 433.404 presented by Tiffany Lewis, Rates and Cost Containment Manager for DPBH (Division of Public and Behavioral Health) Fiscal Services. Presented as Exhibit "A."

Tiffany Lewis, former, Rates and Cost Containment Manager for DPBH was asked to come to the Commission on Behavioral Health to speak on the topic. Ms. Lewis mentioned she had a conversation in December with Chair Durette to set cost-based rates for their behavioral health services. At that time Ms. Lewis was asked to come back for the next meeting, which was rescheduled in March, and we needed to postpone to speak to specific, in depth questions to answer how the Division arrived at the cost-based rate for the Division of Public and Behavioral Health (DPBH). Ms. Lewis provided information on the client mix at Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinics on page 2 of Item Number 5. Ms. Lewis highlighted that the client mix is different than private practices because NNAMHS, SNAMHS, and Rural Clinics are the safety net providers in Nevada communities. Therefore, there is a higher volume of those using Medicaid, and Medicare and there are less patients utilizing private insurance. Ms. Lewis asked the Commission Members to look at page 3 of Item Number 5, the patient breakdown is by client pair type. Ms. Lewis did highlight a variation with Rural Clinics, pointing out that there is a higher percentage of those using private insurance. This is attributed to the fact that in rural areas, many times, the clinic is the only clinic in the area, so they are taking more of the commercial pairs because of the lack of private practices in rural areas.

Ms. Lewis directed the Commission Members to look at page 5 which shares information usually provided to the legislature and some of the budget officers during the legislative session to give a high-level overview of how reimbursement rates are set. The cost base rates are developed with the Division of Health Care Financing and Policy (DHCFP) to set those rates which gives the division the ability to capture about 65% of the cost of the matched federal participation through DHCFP. This highlights the plan, what is classified in the plan, and what is considered allowable costs to Medicaid.

Ms. Lewis directed the Commission Members to page 6 to look at the cost settlement process. The cost-based rates are set every year and at the end of each reporting period of the year once there is four quarters in the system based on cost. This is then reconciled with DHCFP based on all the claims data. It is then determined if the hospitals owe money back to DHCFP based upon the rates set. The rate is based on the set prior year rate. The hospitals sometimes receive money from DHCFP, based on prior years cost data, that the cost set at that time was low. There is an example on page 6 that helps explain how the hospitals are arriving at the cost base. The scenario for a hospital clinic in which the cost would be $1,000.00 if psychiatric services were provided the cost for each service would be $200.00. The calculation is made by dividing the total cost of the clinic by the number of visits that were provided by that clinic.

Ms. Lewis directed the Commission Members to page 7, which explains in more detail the rate setting with the cost rate applied for each service provided to Medicaid clients the clinic multiplies by the appropriate federal matching amount and then subtract the amount that PNP/Medicaid services already paid for. That is how the settlement amount is reached every year with the division's other agencies.

Ms. Lewis directed the Commission Members to page 8. Ms. Lewis highlighted the clinic costs, not for all facilities, just NNAMHS and SNAMHS for fiscal year 2016, 2017 and 2018. The annual cost for one clinic at the facility is shown on Item 5. Ms. Lewis directed the Commission to look at the cost of the medical clinic alone on NNAMHS campus was $2.1 Million dollars. $9.2 Million dollars for SNAMHS.

Ms. Lewis directed the Commission Members to page 9. Some of the top costs were outlined for both facilities. This is specific to the medical facilities, there are other programs on both campuses that there are additional costs for, but this cost was highlighted as an example for the previous discussion of "why are costs so high for our individual rates?" This example explains the reason why. When you look at the total for fiscal year 2018 regarding NNAMHS, the personnel cost alone was $1.7 Million dollars. The personnel costs for SNAMHS is over $6.0 Million dollars. This is one example of the costs that must go into setting the cost-based rate. Operating costs were also highlighted as well as information services and utilities to give a cost overview of just one of the facilities.

Ms. Lewis directed the Commission Members to page 11. One of the Commission Members had a question about codes 90791 and sent an inquiry to Joseph Filippi asking why this was the only code that was highlighted. Ms. Lewis explained that if all codes that NNAMHS, SNAMHS and Rural Clinics utilizes that would have been a very large data set, that might have been overwhelming for the meeting. Ms. Lewis did state that if the Commission Members had any questions on any of the other codes not referenced DHCFP, DPBH and the billing unit will work to get additional data on those codes. The purpose was to highlight one specific code as an example to show the what the division's utilization costs look like for that specific code over the period of time. On page 11 for NNAMHS and SNAMHS PPP code 90791 was used as an example of what the services utilization would look like for fiscal 2014 through fiscal 2019, knowing that not all the data may be entirely complete for fiscal 2019 as some of the services shifted over time as we are recalculating information based on billing information that was received in the system. There was an increase in service use in fiscal 2017 for SNAMHS, which started to show a decrease in 2018 and 2019 in service. NNAMHS shows a significant decrease in service from fiscal 2014 through fiscal 2019. Graphs were provided in the hand-out for Item Number 5 showing the clinic costs versus the utilization and service utilization year over year. If the cost for the clinic, even though the cost year over year is dropping. If, it is not dropping as fast as the utilization you are not going to see drastic changes in those rates. This is significant in showing how clinic costs are calculated.

Ms. Lewis directed the Commission Members to page 12. This is the overall synopsis of NNAMHS and SNAMHS utilization for 2017, 2018 and 2019. This also shows how the rate has changed through fiscal year 2015 to fiscal year 2020. For NNAMHS the rate went from $530.99 to $688.89. This is attributed to the fact that even though there is a decrease in services the cost for that service is not decreasing as rapidly, so that inadvertently caused the rate to increase. However, at SNAMHS there has been enough of a change between the utilization and the costs on a downward trend for the service to decrease the rate for SNAMHS for fiscal 2015 from $176.31 to $132.02 for fiscal 2020.

Ms. Lewis asked the Commission Members if they had any questions?

Chair Durette asked about page 8. NNAMHS and SNAMHS utilization by date of service from 2014 to 2019. What is the cost data from 2014 and 2015? Only the cost data from 2016, 2017, and 2018 is provided. Has the equation for the cost-based setting been changed since 2014?

Ms. Lewis answered, setting the cost base rates started around 2014 and a few years of data was needed to set those costs. Right now, there is a 2-year lag in the reporting of the costs. For example, the 2016 clinic costs are based on the data from fiscal year 2014 because of the 2-year lag. Prior to that the division was not setting cost-based rates, so there would not be any cost base data to show what the cost rate base would have been.

Chair Durette said her concern was that we know the Medicaid expansion happened and you can see that in the growth chart of your payer distribution for clinics. What is seen, in the data, is that in 2014 and 2015 there was a spike in the 90791 utilization, which I think is fair reflection of patients coming into the system, for this intake code. Then what you see is the precipitous drop off from the north where it is relatively stable for the south. Yet it appears to me that perhaps the equation was not recent such that the total cost of clinics in the north still reflects the surge in intakes. Whereas the data from 2016 shows there have been very few patients coming in. That does not necessarily support this cost structure from the way I am reading it. Help me reconcile this.

Ms. Lewis replied, keep in mind that the data is always for the next clinic. That utilization is for that clinic, and the percentages of individuals that is for the entire facility. That is not just for the clinic itself. The costs are going to be different based on the type of individuals we are seeing in each facility. They may be seeing more individuals that are higher need, in the next clinic they may see more individuals that are falling under the uninsured population, or the Medicaid population. The client mix varies by the type of service they are receiving, so you may see, for example there are individuals with a higher level of Medicaid, Medicare or private insurance being seen for in-patient services in the medical clinic. Some clinics may see a higher population of individuals that are uninsured, which increases the cost of the clinic because the clinic is not getting that additional fee from the insurance companies.

Chair Durette stated that she is still struggling with such a differential between the north and the south, knowing that there is a huge population difference. Chair Durette asked for Dr. Leon Ravin's opinion because he is "on the ground" there. Chair Durette said because of her position working with medical school trainees she knows what is happening at SNAMHS, it is constant and busy. In both in-patient and out-patient. Chair Durette did not understand how there could be such a different cost operational differential between north and south. When the data is looked at the first thought is that the rate increase was set back when the first Medicaid expansion was set when there was a surge in intake. Chair Durette questioned; why we are seeing such a relative lack of cost in the south and such a relatively high cost in the north when they have the same services, with much higher service demand in the south. Chair Durette asked that if anyone could do better articulating her question, to please rephrase the question, if it does not make sense.

Ms. Lewis replied, there are somethings that need to be kept in mind. Even at the fiscal 2018 cost/2018 fiscal data it is reflective of what was captured since fiscal 2016, remember there is a 2 year lag, so what you are seeing as cost for fiscal 2018 is based on the information what occurred in the clinic or at the facilities during fiscal year 2016, which was still at the peak of when all of the additional Medicaid expansion in population. We are seeing downward trends in the utilization and we are starting to see some of that in the cost of some of our other services. That is expected to continue downward as the populations change. The population itself, over all does not come into the equation. What we look at is the cost to provide those services versus all of the overhead associated with that and the things that are considered allowable to build those cost-based rates. Therefore, it could be a variation in the type of personnel that are staffed at the facilities, the individuals providing the services, it could be based on the lease agreements as to what those different lease rates are facilities. There are a lot of other factors that come into that rate based on the size of the campus, they have more overhead and they are able to spread things out versus a smaller campus with a smaller amount of personnel. There are a lot of other things that need to be factored into this.

Chair Durette stated that when looking at the data on page 5 where the NNAMHS and SNAMHS med-clinic cost are shown and go quarter by quarter through the different elements of cost, personnel operations etc. Chair Durette said she divided it out per 90791, because in the previous graph the total number of 90791 was listed, so in the north the cost per unit was $13,658.00 whereas in the south the cost per unit was $7902.00. Going operationally the way you described, there is still a huge difference in the cost per unit. Now, let's fast-forward to the 2020, and the data being adjusted by 2 years, but our State is in critical budget shortage and so it is hard to understand, that if I am taking the data that was provided and dividing price per unit, how can there be such an operational difference? How as a Commission, can support this knowing that; a) we are in a huge budget crisis, and b) we are also in a huge mental health crisis. There should be more even price per funding, north versus south.

Ms. Lewis responded that there is more than one service being provided by that clinic. The example provided was one service code. There are multiple service codes and multiple variations in utilization and costs associated with each individual service provided in the clinic. Taking the operating costs and personnel provided and equating that to a rate for the specific code listed is not the most effective approach because there are many other codes that are provided there and the level of personnel providing the service depending on the code varies in addition to the client mix and their specific needs. Each client can be specifically different depending on the clients needs and the amount of time taken with the client as well.

Chair Durette asked if anyone on the call can support the testimony that the client make up is significantly different in the north versus the south

Cody Phinney, Deputy Administrator from the Division of Health Care Financing and Policy (DHCFP) asked Ms. Lewis to verify, since she did not have a copy of the report, if the report suggested that there is a significant difference in the client make up?

Ms. Lewis said yes.

Ms. Phinney said that the cost being divided by the agency with limited codes, that are provided, is skewing the concept and the division would be happy to get some additional information to you if that would be helpful. This is incredibly complicated and, in some ways, an artifact of the way that Nevada's mental health system has been designed. This is how it has evolved over time, in that the northern structure developed very different in a very hospital focused manner. Whereas the southern structure developed later in a very community services manner. Having worked with these budgets for many years, I know that there are still some artifacts on both sides of DPBH and Medicaid with their cost allocation plans that impacts some of the budgeting. Overall, there is benefit to the state budget by being able to match much of those costs with federal dollars. Ms. Phinney reiterated that her and Ms. Lewis would be happy to answer any questions Chair Durette has. Ms. Phinney then asked for clarification from Chair Durette to verify if her concern is that a lack of parity between the money in the north and the money in the south?

Chair Durette thanked Ms. Phinney for her explanation and said yes that is accurate and added that with layoffs of psychiatrists, why is the north, per population, getting more services than the south. That is a very concerning inequity that negatively impacts our communities.

Commissioner Crawford mentioned an additional concern, from a consumer prospective, is that individuals utilizing these fee schedules will be paying a lot more for services in the north than in the south, based on the data provided. Is that true?

Ms. Phinney responded. Yes, the sliding fee schedule is based on fees for that specific clinic at that specific location.

Commissioner Crawford clarified. For example, in the south code 90751 would be paying $66.00 for that specific CPT code, whereas they would be paying $344.00 in the north. That seems like a disparity from the consumer perspective.

Ms. Phinney stated that would be up to DPBH Administration to decide how they would like to align those from the setting of the cost-based rate. We are required to set the rates per NRS (Nevada Revised Statutes) based on the cost of the individual facility.

Chair Durette addressed the Commission asking for more feedback. Chair Durette noted the concern of Nevadans having access to care north versus south in the state system and, as Commissioner Crawford pointed out the cost disparity between the two regions. Chair Durette expressed concern that the cost was not even.

Ms. Phinney asked if Ms. Malay or Dr. Ravin have any information on the use of the sliding fee scales, are people paying more?

Ms. Malay did want to clarify, understanding the questions of cost based and fee-based services, the makeup of the population is slightly different based on their insurance and payer source. That is in the report as well, and that may reflect some of the differences in our reimbursement. One other point is that we have not lost doctors and psychologist positions due to budget cuts. The loss of doctors and psychologists is due to their caseloads. As caseloads decrease the demand for physicians decreases as well.

Chair Durette asked the Commissioners if they have any other questions and highlighted that she didn't feel alone with these concerns.

Commissioner Jackson, representing consumers, stated her concern with the rates described. Commissioner Jackson asked if the person responsible for setting the rates could come and explain the rates to the Commissioners and see what changes can be made.

Commissioner Troop agreed with Commissioner Jackson and highlighted that if this is a DPBH issue the Commission needs to talk to DPBH. Commissioner Troop stated the fact that it is more expensive, for most things, to live in southern Nevada. Commissioner Troop added that, looking at the sliding fee scale and the cost for care is $300.00. To pay those fees as a consumer making an average wage is "ludicrous" in her opinion when the consumer can go to Las Vegas and pay $60.00. That does not make a lot of sense. Having worked at SNAMHS and NNAMHS, the disparity between northern Nevada and southern Nevada is not understandable considering there is a difference of $500.00 for service. Commissioner Troop thinks that is something to be discussed with DPBH.

Ms. Phinney responded that she, and Ms. Lewis are representing the DPBH rate setters. Ms. Phinney asked Ms. Lewis what additional information do you think could be provided that would help with the Commission's concern?

Ms. Lewis responded that she was the former Cost Containment Manager and that she now is in the Division of Health Care Financing and Policy (DHCFP). She would have to talk to DPBH Administration to see what information could be provided, and to work with their billing unit to pull any additional information. Ms. Lewis responded that the confusion might be because only one service code was used as an example for all the costs. Because the cost for NNAMHS is different in total than the cost for SNAMHS which is different as stated because of client mix and the variables with reporting. Ms. Lewis said she believes that it might be beneficial to bring back some of that information to show what the cost might be for some of the other services using the full-service fee, not the sliding fee schedule to show what the costs are for each individual service. If the Commission would like additional information, they could provide a list of cost information to the billing unit and they could see what information can could be pulled.

Commissioner Crawford commented, what would be helpful, from my prospective, is if you could prepare a sample of two different typical billing costs for stays for two typical clients using the most frequent codes, so we can compare cross settings. That might give the Commission a more realistic idea of what the differences are between the two regions.

Chair Durette added that total clients served per clinic would be good information as well. It would be helpful to see the population rate, how many people are being served in each clinic. Chair Durette questioned a patient shift in the Henderson clinic since the medical school no longer exists. Chair Durette expressed her concerns such as access to care, and as mental health consumer's advocates, the Commission constantly hears there is a lack of access to mental health care in Nevada. Chair Durette expressed that she did not understand why the psychiatric staff that used to be in Henderson no longer are there.

Ms. Malay responded that she believed that what Chair Durette was asking for would be helpful and that Dr. Ravin was working on standardizing the coding between north and south educationally and division wide.

Chair Durette asked about the Henderson clinic?

Ms. Richardson-Adams replied that the caseloads for the Henderson clinic had reduced by 50%, there were less than 100 individuals that are served out of that area, so looking at outpatient care in southern Nevada, caseloads continue to reduce and the doctor patient ratio was effected, therefore adjustments had to be done. Specifically, for the School of Medicine there was no longer a need to continue the contract to cover that area. Other internal resources, state positions were able to take over and take the caseload.

Chair Durette confirmed that answered her question and reiterated that the report was good. She also wanted to express that the Commission is making sure they are representing the best interests for Nevadans regarding mental health, especially with the eminent budget cuts that are going to happen.

Commissioner Crawford pointed out that the codes used on the fee schedule provided were old codes and that the psychiatric and neurological testing codes changed in 2019. Commissioner Crawford offered to send the updated codes to the Commission and asked if anything that was billed under the old codes would they be paid.

Ms. Lewis thanked Commissioner Crawford and stated that they already had the new codes and assured the Commission that they check for new codes annually and makes sure to adjust the codes to the most current, accurate codes. Ms. Lewis also highlighted that having the cross based rates agreement with DHCFP, if the division does not have their rates set and costs the division is no longer eligible for federal matching. And they would go from receiving about 65% reimbursement for the facility for Medicaid to about 20% to 30% which would affect the DPBH budget significantly. Losing federal matching funds would mean that the difference would have to come out of Nevada's general fund.

Chair Durette asked what the deadline was for getting this approved?

Ms. Lewis expressed that since the latter part of last year the Division has been trying to implement these rates. The longer the Division is delayed the longer the Division is considered out of date with the cost-based scenario, so there was urgency to update the rates last October since it was the most recent cost settlement.

Chair Durette asked, knowing the Commissions concerns, does anyone have a motion of approving with the expectation that more data is brought before the Commission, knowing that October is when the fiscal year switches, so there is an expectation to have more data and decision making prior to next year's units being set. Since this is an action item I would like to move forward.

Commissioner Crawford clarified with Chair Durette to verify if Chair Durette was asking if these rates be approved pending further review.

Commissioner Troop asked if we do a temporary approval would that satisfy the requirements needed?

Ms. Lewis said that she would have to ask DPBH, because she no longer works for DPBH. The temporary approval can be looked at. The larger issue is having the rates approved to the point that the Division can continue to get these rates

billed and the federal funds are matched. Especially since the State is facing a budget shortage. This could cause a significant fiscal burden on DPBH if we do not have approved set rates to continue to receive the federal matching.

Commissioner Troop made a motion to temporarily approve these rates as listed. Pending further information forthcoming to make decisions clearer the following year. Commissioner Scott seconded the motion.

The motion passed unanimously.

Chair Durette expressed interest in having this issue continue in other Commission meetings so the Commission and the Division would be prepared for a decision in October.

For Possible Action: Approval of DPBH Policies:

Therapeutic Plasma-Serum Level Guide for Antipsychotics and Mood Stabilizers

Dr. Ravin presented guidelines for the DPBH medical staff. This is not mandatory to impose on the independent practitioners as a specific way to prescribe in their practice. These suggestions are made from evidence-based literature reviews and recommendations with suggestions that could utilized in day to day patient care. The first policy is on the Therapeutic Plasma Level of Anti-Psychotics and Mood Stabilizers policy. It provides a general description of benefits, and the process of determining the level of medications in a patient's blood. Further down it lists specific recommendations for minimum and maximum levels to assure accurate therapeutic responses. As listed as general reference, you want to compare a patient's clinical response to the increased adverse reactions to their levels of medication in their blood. Towards the end of the policy it describes preferences and lack of preferences for specific mood stabilizers and explains why it is the less favorable to use mood stabilizers compared to other medications. There are 10 references at the end if you would like more information. Dr. Ravin asked if the Commission would like more detail or had questions.

Chair Durette asked the Commission if they had any questions on this policy. Without any feedback from the Commission Chair Durette asked Dr. Ravin to continue with the next policy.

Dr. Ravin continued by apologizing for the different formats the policy page was in, his team was trying to make the document ADA (Americans with Disabilities Act) compliant. This policy is a guideline. The Division recognizes that a significant number of our patients are treated with psychotropic medications and may experience weight gain. Once again, the Division used a scientifically based literature to determine what the current recommendations should be, and it provides an overview of the metabolic syndrome specific ways to assess the presents of metabolic syndrome in the population we serve. As well as a guide of what medical staff should do to manage symptoms of metabolic syndrome starting with education and moving to more direct intervention. Including treatment with medications that are designed to mitigate the consequences of metabolic side effects and ongoing guidelines that needs to be performed for anyone with developing metabolic syndrome. Although the guidelines are lengthy, a lot of research went into them. They are handy for staff to have.

Chair Durette asked the Commission if they had any questions

Commissioner Scott asked specifically about recommendations mentioned in the policy stating, "Medical staff should" or "Individuals should". She would prefer it read the medical staff "will."

Dr. Ravin answered that these are treatment guidelines. We recognize that all our medical staff are independent practitioners. The guidelines provide evidence-based reviews they are not considered to be enforceable policies, as you know even with FDA recommendations there is room for options and standards of care derived from scientific literature. Specifically, from the Psychiatric Association recommendations and from tech books. We recognize that there could be some limitations of scientific literature published and new publications are coming out all the time. We are trying to

make information available to our staff about best practices, however narrowing it down to “must” and “shall” may limit the individual medical staff’s abilities to provide patient care tailored to the needs of the patient. Since all of them are independent licensed providers we are not in the position to dictate specific interventions they must do as part of their practice. We do perform routine practice evaluations therefore if a practice is observed not operating at our expected, or understood, standards of care they are invited to explain their position. Except for PA’s, everyone else is a licensed provider and entitled to make their own medical choices in the best interest of the patient.

Commissioner Scott stated that she is a Psychiatric Nurse Practitioner and she understands what Dr. Ravin is saying and agrees, but if the guidelines are put under recommendations there are two diluting words in the policy it says “recommendations” and then it says “medical staff should” so if it is a recommendation then you should say “medical staff will” so it is a recommendation that the medical staff will, or medical staff educate individual.

Dr. Ravin replied and thanked Commissioner Scott stating that he could revise it.

Commissioner Scott was concerned that the policy would be so diluted that it is not followed because she feels that this is very important. Commissioner Scott thanked Dr. Ravin for listening to her concerns.

Chair Durette asked for any other concerns or discussions.

Commissioner Scott made a motion that the policies be approved as written with some consideration for strengthening section for recommendations.

Commissioner Jackson expressed she would like a motion to be made that “will” will be inserted instead of “should”.

Chair Durette asked Commissioner Jackson if she was making a new motion.
Commissioner Jackson confirmed that she would like to make a new motion to make the policy say “will” instead of “should.” Chair Durette asked for a second on the motion, in which Commissioner Scott seconded Commissioner Jackson’s motion. Then asked if there were anymore questions.

Commissioner Crawford stated she had some reservations changing the wording to “will” from the discussion earlier siting that the language of the policy is important. She suggested to take some of the language and make it more concise. Regardless, Commissioner Crawford liked the first motion better by Commissioner Scott that there be some consideration for strengthening the language.

Chair Durette asked if anyone else would like to comment.

Commissioner Jackson stated she was looking at the policies from a consumer standpoint, and that if the policy says “should” the clinical staff may interpret the policy as “I don’t have to.” But, if we say the medical staff “will” provide care, the medical staff will. If you say the medical staff “should” that is a maybe, or when I get around to it, or if I have time. Commissioner Jackson said that she thinks that so long the consumers have been put at a disadvantage because they are not educated about their health risks and about becoming obese or about paying attention to their nutrition. These things have never been brought to play and they are very important for recovery. So I hate to see “should” when it is very important for recovery.

Dr. Ravin replied this is not an attempt to establish practice guidelines it is a recommendation to medical staff based on literature available to the Division at this point. The Department is trying to provide medical education and advice to independent practitioners who are employed in various contract agreements with the Division of Public and Behavioral Health (DPBH) and it is recognized that there could be a difference in perspective in set standards of care derived from many sources. In this particular policy, we would add about a dozen of the most recent publications and there could be more in development, so the purpose of this document is to educate our staff and hopefully improve care for our

patients. If anything, it is more designed to improve quality of care to patients through a peer reviewed process, not through policies.

Ms. Malay responded that if the intent of the wording is unclear, it is suggested that maybe the DAG can help language to meet the Commission's intent.

Ms. Slabaugh, Deputy Attorney General expressed her hesitation, as a lawyer and not a clinician, to dictate policy to medical staff and Dr. Ravin. To Ms. Slabaugh' s understanding this policy is simply a documentation of accepted literature with standards that medical staff are expected to follow, how they follow those would be within the view of their medical judgement. Dr. Ravin is that a correct statement?

Dr. Ravin acknowledged that the statement by Ms. Slabaugh was correct. Dr. Ravin added that all the documentation is designed to provide up to date education and recommendations to our doctors not to take judgement away from them and replace it with a document.

Ms. Malay clarified that her question to Ms. Slabaugh was more about the language of "shall" "will."

Ms. Slabaugh suggested that the heading change from "Recommendations" to "Current Professional Literature Indicates" or "Current Research Indicates That Medical Staff Should" clarifying with Dr. Ravin that he is trying to document current national standards, is that what this is or should be?

Dr. Ravin replied that the current national standards do not exist. The standards of care derive from multiple sources. What we know from the literature is good practices that have been found to be beneficial for patient outcomes.

Ms. Slabaugh suggested to change "Recommendations" to "Current Accepted Literature on Best Practices Indicates a Medical Statute" or something like that. I believe this will address the concerns expressed by the Commission.

Dr. Ravin asked if the Commissioners would be comfortable if section 4 read "Evidence Based Recommendations For Improved Treatment Outcomes" or leave "shall" and leave it to individuals who are counseling to work in what is beneficial for the patients.

Commissioner Scott added that she is not questioning that these are good things to do, she is suggesting the word "should" be eliminated. Commissioner Scott explained that if "Should" is eliminated then people can make a choice about what they want to do by what is recommended.

Commissioner Jackson agreed because, in her opinion, a recommendation is a change. You are asking for this to be changed. If you want to keep it like this "Should" should not be in the policy. That would be better.

Chair Durette asked the Commission for a new motion.

Commissioner Scott made a motion to approve the policies with the change under section 4 of the second policy to remove the word "should" and edit the policy to make sure that the wording is appropriate. Commissioner Mosby seconded the motion. The motion passed unanimously.

Informational Item: Update on Seclusion and Restraint/Denial of Rights:

Ms. Malay, Deputy Administrator, Department of Public and Behavioral Health presented the Seclusion and Restraint/Denial of Rights for DPBH. Ms. Malay stated that both NNAMHS (Northern Nevada Adult Mental Health Services) and SNAMHS (Southern Nevada Adult Mental Health Services) are below the national rate of Seclusion and Restraints. There were 40% less restraints in December, based on a few individuals. Overall, when you look at the

average stay for SNAMHS it is about 30 days. Forensics overall continues to meet the consent decree and they have increased numbers in long term commitment. Long term commitments are expected to increase in the future. Chair Durette asked if there were any questions. No questions were asked.

Ms. Valerio, Agency Manager, Desert Regional Center, Aging and Disability Services Division (ADSD) presented the Seclusion and Restraint/Denial of Rights for ADSD. Ms. Valerio stated that for March and April the individuals at the ICF are not attending their JDP program, so no occurrences happed there. There was a total of 5 restraints used in March and 2 in April. One individual in March was in 5 different holds. It is believed to be related to a change in their routines. They are struggling with not going out of the homes. The total time in restraints for March was 540 seconds, not minutes. April time in restraints for the 2 individuals was 900 seconds.

Chair Durette asked if anyone had questions. Nobody had questions, so Chair Durette continued the meeting.

Informational Item: Local Governing Board Reports

Ms. Malay reported the Southern Nevada LGB (Local Governing Board) meetings were primarily special session related to credentialing for physicians. Next quarter will be the next LGB meeting.

Ms. Brooks, of NNAMHS stated that the northern Nevada LGB meeting was cancelled due to the COVID-19 outbreak. The next meeting is scheduled for August 5th.

Nobody represented Lakes Crossing.

Informational Item: Update on the Bureau of Behavioral Health, Wellness and Prevention.

Presented by Brook Adie, Bureau of Behavioral Health and Wellness, for DPBH.

Ms. Adie, Bureau Chief, Bureau of Behavioral Health and Wellness, DPBH gave presentation and provided information about what is going on with the Bureau. Within the week the Bureau has received 2 Notice of Funding opportunities. One is for the Bureau's Mental Health Block Grant and the other is for the Substance Abuse Block Grant. All the Bureaus treatment providers must apply for the Substance Abuse Block Grant, so there is a funding announcement to receive future funding including the women's off-site services. All applications are due June 29th, 2020. The Mental Health Block Grant funding award applications are due June 11th, 2020. They also received an Emergency Health COVID Grant for 16 months for Crisis Services. Ms. Adie added that The Emergency Health COVID Grant is helping many divisions in the Bureau, all the many different agencies and programs are listed on the DPBH website. The Bureau also received an Early Diversion Grant through SAMSHA that will help expand our Assertive Community Treatment Team at Carson-Tahoe Hospital. The SAMSHA grant will serve Churchill, Lyon, Carson City, Douglas, and Storey Counties. The Bureau is applying for 2 other grant opportunities, one is a Crisis Counseling Grant through FEMA and another grant through SAMSHA, which is a COVID-19 Suicide Prevention Grant.

Informational Item: Department of Health and Human Services-Public and Behavioral Health- Behavioral Health Prevention and Treatment-FY 2020 – Addition of $328,827 SAPTA Block Grant funds to provide substance abuse and mental health prevention and treatment activates.

Presented by Brook Adie, Bureau of Behavioral Health and Wellness, for DPBH.

Ms. Adie provided information about the SAPTA Block Grant to provide substance abuse and mental health prevention and treatment activities. Ms. Adie explained to the Commission that usually this Block Grant would be before the Interim Finance Committee (IFC) but for expedience the Commission on Behavioral Health meeting was chosen to serve as the public hearing to ensure the Block Grant was presented before the public.

Update on Aging and Disability Services Division (ADSD)

Presented by Jessica Adams, Deputy Administrator for ADSD.

Ms. Adams, Deputy Administrator, ADSD focused on the changes due to COVID-19. All ADSD Offices have been closed to the public as of March 16th, 2020. However, all services have not stopped. Most of the staff are telecommuting or working in the offices with a rotating schedule reducing the staffing to adhere to social distancing guidelines. Flexibility and changes in services were done to help those that ADSD serves. Approval was granted for Appendix-K from CMS. The Appendix-K will help with compliance issues during changes with CMS and waver funds. Most of the face-to-face visits that were done by service coordinators and other staff has temporarily stopped, but ADSD is keeping in contact with everyone in service via telephone, or other electronic means. All the meetings with families and individuals and contracted providers are being held through conference calls. 24-hour home environments continue to be monitored through Facetime or other video calls. All job training sites have been closed since March 16th, 2020. Very few job training (JDP) sites continue to be open, and those sites are operating with very few personnel that are practicing social distancing and taking clients temperatures. Those that can or wish to have JDP services in their home was authorized, all the data on how many clients requested in home JDP services has not been collected yet. This has allowed those clients who live with their family to keep working as well as help with residential staff shortages for 24-hour homes. Retainer payments have been approved for JDP providers for up to 30 consecutive service days for anybody who has not receiving JDP services during this time. 24-hour homes have followed the Governor's recommended guidelines for staying home. ADSD has worked with providers to adjust service authorizations to accommodate the increased need for in-home services. The time for needed fingerprints and background training has been adjusted to insure providers can continue to hire staff in a timely manner. Guardians were approved for those people who did not want staff in their homes to help with provider/staff shortages. Electronic signatures were approved to be used. All these adjustments are approved until January 26, 2021.

Item Number 12, Update on the Division of Health Care, Financing and Policy (Medicaid)

Presented by Cody Phinney, Deputy Administrator, ADSD.

Ms. Phinney, Deputy Administrator for ADSD. DHCFP is in the process of re-procuring contracts for managed care. There are 3 vendors that handle 70% of managed care vendors. Public comment on the next 5-year contract is quickly ending. Public comment and feedback can be sent to the email address: dhcfp@dhcfp.nv.gov . A contract was signed with Mercer, who is a vendor that has experience. The RFP will be issued in January of 2021 and the contract will be active in January of 2022, this is a long-term project. Because billions are spent DHCFP is making sure the contracts are designed to better help develop Nevada's health care delivery system.

Chair Durette expressed that in future contracts she would like to see parity and outcome measures related to behavioral health, not just outcomes related to fiscal health.

Ms. Phinney offered to have staff prepare brief reports for future meetings about current outcome measures. Chair Durette asked to add network access for the community, she stated that the Medicare network is inadequate as well as not up to expectations regarding behavioral health. Additionally, provider restrictions for mental health professionals is causing difficulty for Nevada consumers to get help. Ms. Phinney answered by highlighting the importance that the next iteration of contracts have new adequacy measures, and she welcomed Commission members feedback how they would like to, specifically, have those measures adjusted. Ms. Phinney highlighted the fact that the staff working on the contracts are also looking at how similar contracts are written in 14 other states and again, she welcomed feedback from the Commission.

Commissioner Troop asked if DHCFP was looking for more than the 3 NCOs currently in the ASD process, and if the email address dhcfp@dhcfp.nv.gov was specifically for consumers or if providers can give feedback there.

Ms. Phinney acknowledge that there could be more than 3 participants. And that the email address dhcfp@dhcfp.nv.gov is for everyone to use. Ms. Phinney stated that not all ideas and feedback will be used, but all feedback and ideas will be listened to.

Ms. Phinney continued with disaster operations related to COVID-19. The DHCFP has gone almost exclusively to telecommuting with some staff on rotating shifts into the office. The office is closed to the public with public service being performed through telephone and email communication. CMS has approved a disaster waiver allowing the division flexibility in the field. Reimbursements have been expanded to include telehealth. Provider enrollment has been expanded because of COVID-19 effecting fingerprinting and backgrounds. The work on the Disaster Plan Amendment continues, possibly even after the COVID-19 pandemic is over because of Medicaid's flexibility. The Division is working on making COVID-19 testing as available to as many individuals as possible, and the Division is seeking Medicaid's help to cover uninsured individuals for COVID-19 testing. The Division is expecting Medicaid's approval for that.

Chair Durette asked about how the Medicaid Disaster Waiver for telehealth and telephonic services would help.

Ms. Phinney stated that they are ready when funding becomes available, but what the waiver would allow is for Medicaid to pay for substance abuse disorder residential services, because the Social Security Act prohibits the Division from paying for those services that are in an institute of mental disease. There is some flexibility in the managed care program because of a clause to pay for residential treatment services. The Division is preparing to issue a formal definition that is broader about residential services, being more specific about how it would be paid for in the managed care program.

Ms. Phinney updated the Commission on policy updates related to behavioral health. The Division has been successful updating the codes that were needed for medical providers to bill for screening intervention and referral to treatment. The codes were opened in March for a broader array of providers so that they can help identify, get reimbursed for, and are incentivized to help identify mothers who are using substances that could benefit from treatment. Often this intervention helps their unborn children to fight opioid use disorder and/or their substance abuse disorder. The second major policy that the Division is advocating is more specific and clarified medication assisted treatment policy. Nevada Medicaid does not have a policy in place. Ms. Phinney encouraged the Commission to look at the public workshop and hearings, where the policies get finalized. The hearings and public workshops are on the Division website under public notices.

Item Number 13, Approval of the 2019 Annual Governor's Letter per NRS 433.314

Chair Durette asked the Commission if they would like to edit the 2019 Annual Governor's Letter or approve the letter.

Commissioner Scott made a motion to approve and accept the 2019 Annual Governor's Letter as written. Commissioner Crawford seconded the motion. The motion passed unanimously.

Public Comment

No public comments made.

The DPBH Commission on Behavioral Health Public Meeting was adjourned at 10:37 a.m.