Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD
MEETING MINUTES
November 8, 2021
3:00 p.m. to Adjournment

The meeting was held using remote technology in compliance with *Nevada Revised Statutes* (NRS) 241.023.

1. Roll Call, Introductions, Announcements
The meeting was called to order at 3:03 p.m. A quorum was present.
Members: Julia Ratti (Chair), Char Buehrle, Sandy Stamates, Steve Shell (Vice Chair), Wade Clark, Frankie Lemus, Henry Sotelo
Members Absent: Assemblywoman Sarah Peters, Dr. Kristen Davis-Coelho, Cindy Green, Dani Tillman
Staff and Guest Present: Falisa Hilliard, Abigail Bailey, Anne-Elizabeth Northan, Dr. Antonia Capurro, Dorothy Edwards, Ben Russell, Brandon, Brianna Oki, Ben Trevino, Ginny Thompson, Jeanette Belz, Kelly, Lauren Cottrell, Lea Case, Lena Hatzidopavlakis, Linda Anderson, Maurice Cloutier, Megan Sullivan, Peter Ott, Theresa Carsten, Sarah Dearborn, Valerie Balen, Stephen Wood, Sarah Hunt, Tray Abney, Trey Delap, Wendy Whitsett, Steve Messinger, Teresa Etcheberry, Stephanie Brown, Lea Tauchen, Jimmy, Edward Shelley, Barbara Scaturro, Andy Herod, Jessica Flood Abrass, Joan Waldock

2. Public comment
There was no public comment.

3. Approval of Minutes for October 2021 Policy Board Meeting
Ms. Stamates made a motion to approve the minutes; Lt. Clark seconded the motion. The motion passed without abstention or opposition.

4. Nevada Division of Health Care Financing and Policy (DHCFP) Presentation
Dr. Capurro, Deputy Administrator; Ms. Carsten, Social Services Chief III, Managed Care Quality and Compliance; and Ms. Dearborn, Social Services Chief II, Behavioral Health, shared their PowerPoint presentation. Ms. Carsten stated the managed care organizations (MCOs) for the new contract cycle are Anthem Blue Cross/Blue Shield, Health Plan of Nevada (HPN), Silver Summit, and Molina Health Care. Weekly transition of care calls will be held to determine how each will honor prior authorizations and pharmacy scrips January through March 2022. During that transition period, members assigned a new health plan will have 90 days to select an alternate MCO if they choose. In this contract, children needing residential treatment center (RTC) services or certified community behavioral health center (CCBHC) services will be covered under MCO contracts rather than under fee for service. MCOs will be responsible for case management and discharge planning with those facilities. State and county mobile crisis providers will be in network with the MCO health plans to prevent disruption across providers.

No adult category will be able to disenroll due to a severely emotionally disturbed (SED) determination.

Ms. Dearborn reported on the current state plan amendments (SPAs) for behavioral health under review with Centers for Medicare and Medicaid Services (CMS). The first one updates Nevada Check Up and State Children's Health Insurance Plan (SCHIP) with no new services, but follows a requirement of CMS to outline all the behavioral health services that are being billed. The amendment is on pause with CMS while minor details are being worked out. Once approved, it will outline behavioral health services available for children. The next state plan amendment proposes eliminating biofeedback and neurotherapy services in the treatment of a mental health diagnosis. This SPA is on pause with a request for additional information as CMS has determined elimination of these services would violate the maintenance of effort requirements of Section 9817 of the American Rescue Plan Act (ARPA) of 2021, jeopardizing the enhanced funding for home- and community-based services available under ARPA.

Updates to Medicaid Services Manual (MSM) Chapter 3700's Applied Behavioral Analysis policy were approved at a public hearing in September. The changes incorporate the findings from Senate Bill 174 from 2019 and Senate Bill 96 from 2021 to include specifics about which provider types can provide Applied Behavioral Analysis and documentation requirements for treatment notes. Updates to MSM Chapter 4000 were approved at an October public hearing. This policy relates to the 1915i program used in specialized foster care and in the home- and community-based state plan option for intensive in-home services and crisis stabilization. Revisions clarify language to ensure eligible youth are not excluded from these services. Different care coordination models approved in the state plan are used by child welfare agencies; this policy chapter will take all of them into account to determine who is eligible for services.

Nevada received the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Planning Grant in 2019. A comprehensive medication-assisted treatment (MAT) policy in MSM Chapter 3800 implemented screening, brief intervention, and referral to treatment (SBIRT) codes, which were expanded to multiple provider types to support identification of individuals struggling with a substance use disorder. Prior authorization will no longer be required; individuals struggling with SUD will be allowed to access treatment early. Throughout the SUPPORT Act Planning Grant, a five-year Strategic Plan ensures the development and long-term sustainability of provider capacity to meet the needs of Nevada Medicaid beneficiaries. The goals of the strategic plan are to expand provider capacity, enhance access to care, and facilitate data-driven decision-making. In September 2021, Nevada was awarded the CMS SUPPORT Act Post-Planning Demonstration Grant Award. Nevada will focus on Section 1115 Demonstration Waiver application and develop the Patient-Centered Opioid Addiction Treatment (P-COAT) Model.

Nevada received the one-year Mobile Crisis Planning Grant. It will help the state implement the American Rescue Plan State Option to Provide Qualifying

Community-Based Mobile Crisis Intervention Services and coincide with the national 988 behavioral health crisis line requirement in July 2022.

Senate Bill 154 directed the Department to apply for a Medicaid Section 1115 demonstration waiver to provide coverage and reimbursement for inpatient substance use disorder treatment. It will be submitted to CMS in November 2021. The proposed effective date of the waiver is January 1, 2023. Senate Bill 156 requires the Department to ensure that crisis stabilization services provided at hospitals with a crisis stabilization center endorsement are covered and reimbursable under Medicaid.

Senator Ratti asked what progress is being made in the MCO contract. Dr. Capurro replied that greater case management, utilization of services, and service expansion will occur as RTCs and CCBHCs will be covered. Mr. Shell asked if rural areas would have access to MCOs. Ms. Carsten explained that would have to be in the DHCFP budget at the next legislature; it is not a division decision. Mr. Shell asked if the MCOs would be required to receive advanced approval for day-to-day management of services they are contracted to provide. The three current MCOs use two companies in Nevada to manage prior authorizations and case management. Ms. Carsten replied that if an MCO delegates any part of their function, the subcontract is reviewed and approved; that has been done. Ms. Stamates asked who would provide behavioral health services for MCOs. Ms. Carsten said part of HPN's ownership is Behavioral Health Options; they will continue to exercise their panel through Behavioral Health Options. She does not know about the others. Ms. Stamates asked if Well Care is a provider. Ms. Buehrle, from Well Care, said they are. Senator Ratti asked if all MCOs are contracting with the crisis triage center. Ms. Carsten said the MCO contract requires them to contract with CCBHCs, but there is not a mandate to contract with every CCBHC—they are required to show they have enough CCBHCs enrolled to cover their members. Senator Ratti asked if MCOs are required to impanel crisis stabilization units and mobile crisis teams as they come online. While that provider type is not recognized, it is Ms. Carsten's understanding that they would bill services covered by Nevada Medicaid. MCO contracts would require provider capacity to cover those services. Ms. Dearborn added crisis stabilization centers will go forward as a specialty. Ms. Carsten noted administration included county mobile crisis teams in the request for proposals (RFP). Senator Ratti asked if MCOs will be required to impanel crisis stabilization units once rates are set. Ms. Carsten did not think it was part of their rate-setting process for managed care in calendar year 2022. She added that if policy expands that and administration expects it to be covered by managed care, it can be amended. Senator Ratti pointed out that SB156 required Medicaid to cover crisis stabilization units. She asked if that extends to the MCOs to impanel them. Ms. Carsten said there may have been a delay between when the bill was executed and the RFP, so it could be updated. Senator Ratti said Washoe County received a grant to start working on mobile crisis teams. The slides show the 85 percent enhanced Federal Medical Assistance Percentage (FMAP) is available in April 2022 for 988, but the state will not have the Medicaid rate in place and mobile crisis teams impaneled by July 1. Ms. Carsten said they did not

have the information required to include that in the calendar year 2022 rate, so it will be revisited for MCO coverage in 2023. At the time 988 was being discussed, they were not aware additional mobile crisis teams were being enrolled. Senator Ratti asked if only government-led mobile crisis teams would be reimbursed. Ms. Carsten replied the current MCO contract only covers state- or county-entity mobile crisis. Senator Ratti asked if they could pay a nonprofit or private provider that wants to do a mobile crisis team. Ms. Carsten said they could not as it is currently written right now. Senator Ratti mentioned trying to figure out how that meshes with the notice of funding opportunity (NOFO) for mobile crisis teams. Ms. Dearborn said there is not a provider type for mobile crisis; they are currently billing for crisis intervention services under the behavioral health outpatient program, Provider Type (PT) 14. Ms. Carsten added an independent mobile crisis team could enroll as a PT-14 and provide and bill for crisis intervention services under managed care, but MCOs are not required to enroll them. If their network is full and they have enough PT-14s to cover crisis intervention services, the state cannot mandate they enroll more. Senator Ratti said there is no mobile crisis team provider type in Washoe County. She assumes “crisis intervention response” is not defined as a mobile crisis team. Ms. Carsten added that adequacy is related to any provider type that can cover crisis intervention services, anyone who meets the requirements to bill crisis intervention service in an MCO’s network can be counted. If the network adequacy standard of one provider to 1,500 members enrolled is met, it is considered adequate. Senator Ratti said the state and county have been working on a crisis stabilization model that includes a crisis hub that is the call center, a mobile crisis team that can meet you where you are, and a crisis stabilization unit. She noted the 988 number goes live in July. A NOFO will give some providers start-up money for new mobile crisis teams and crisis stabilization units in Washoe County. She asked if those businesses could be sustained by being able to bill Medicaid after the ARPA money goes away. Ms. Dearborn replied there is one reimbursable service—crisis intervention service. With the planning grant, they will identify services in the state plan. If necessary, they can identify what mobile crisis looks like versus what crisis intervention and stabilization are. She added that the planning grant is only a year long, so they will need to do a lot of work to identify what kind of state plan services to create or update and move forward. The one year will start September 30. There might be a time lag in making this required coverage. There could be a period of time where the business model is not sustainable because there is no billing mechanism. Senator Ratti said DPBH has been working on this type of crisis response for three years; the federal 988 requirement accelerates the concern for this to be functional sooner. This has taken a long time, and there is still not a rate published for crisis stabilization units. At the local level, people are being asked to apply for the NOFO now for start-up money for something that is not sustainable. She asked if there is there anything that can be done to accelerate the process to meet the rollout timeline. A provider cannot put together a pro forma on how they will run a crisis stabilization unit when they do not have a Medicaid rate. Private insurers set their rates based on what Medicaid does. Ms. Dearborn said crisis stabilization centers will move forward differently than mobile

crisis services. She shared they hope for a January 1, 2022, effective date for crisis stabilization centers. The approval process for CMS may take months, but the state plan amendment will be retroactive to the first date of the quarter it was submitted. Senator Ratti reminded her the grant application deadline is December 23. She asked if they could publish a likely rate so applicants could have a ballpark figure. Ms. Dearborn said she has a proposed rate that must be approved by CMS. Dr. Capurro stated that number should be available by the time they hold their public workshop, which is tentatively set for December 13. Senator Ratti noted trying to reform behavioral health crisis response is not easy. She asked if the Board could do anything to add clarity on reimbursement levels so potential providers could make decisions about getting into this line of business. Details about rates would be helpful their calculations. From what has been learned in best practices from other communities, if not all the MCOs impanel the providers, the system does not work. Law enforcement needs to be able to drop off at a facility regardless of who they are bringing in and who their provider is. Anything that can be done to encourage, incentivize, or mandate MCOs to cover these essential crisis response services is important. Ms. Edwards noted community-based mobile crisis intervention services could receive an 85% FMAP for expenditures for the first 12 quarters of the five-year period. She asked about the last two years of the five-year period. Senator Ratti thought there was a five-year deadline for spending the ARPA funding, so they have three years within the five years of ARPA as the enhanced rate was within the ARPA funding. Dr. Capurro said they would provide a handout providing details about crisis stabilization rates. As they move forward with the mobile crisis grant, they will be adding the MCO amendment components to their planning activity.

5. Washoe County Crisis Response System Implementation Plan Update
Ms. Edwards stated they have established their leadership council, advisory committee, and subcommittees with subject matter experts that include representation for each of the three spokes of the crisis response: the crisis call center, mobile crisis, and the crisis stabilization unit. Most of the subcommittees have met. Senator Ratti added the Health District pulled together funding to set up a crisis response stabilization planning project. The goal of the project is to have a plan for how to implement or reform the behavioral health crisis response system in Washoe County. It will be easier for the public to reach 988 when they or struggling or have a family member who is struggling. The number will go to the National Suicide Prevention Lifeline system, which goes to Crisis Support Services of Nevada. The planning work will not produce a fully formed crisis response system within a year, but it will be a step forward; it will take a few years, given finance mechanisms. Needed are memorandums of understanding between the 988 and 911 systems and the ability to triage calls so public safety and behavioral health concerns are met regardless of whether a call comes into 988 or 911. They currently are identifying critical issues from many angles. They will not hold a finance subcommittee meeting until they have answers about how the ARPA dollars grants and the telephone line

fees will work. They are taking all the steps they can take as soon as they care capable of taking them.

6. New Membership Discussion with Possible Nominations and Voting
Ms. Edwards reminded the Board there are two vacant Board positions—for a representative of an insurance company and an appointee of the Governor with experience in social services, agency, or providing social services. Several people have submitted resumes for these positions. Senator Ratti stated applications must be submitted by the end of November. They plan to appoint members for those positions at the next meeting.

7. Discussion/Approval of Future Agenda Items
Ms. Edwards said there had been a request for presentation by the MCOs. Senator Ratti noted they have an item scheduled for spring on training the medical work force on diversity, equity, and inclusion. She suggested they start bringing forward ideas for their bill draft request.

8. Public Comment
There was no public comment.

9. Reminder of Next Meeting Date
The next meeting will be held on January 10.

10. Adjourn
The meeting adjourned at 4:30 p.m.