

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

DRAFT MINUTES

DATE: September 17, 2014
TIME: 9:30am
LOCATION: Truckee Meadows Community College
Redfield Campus
18600 Wedge Parkway
HTC Room 102
Reno, Nevada

Video-Conference
University of Nevada, Las Vegas
6375 W. Charleston Blvd. Bldg. I- Room 311
Las Vegas, Nevada

Elko County School District
1092 Burn Road – Conference Room
Elko, Nevada

BOARD MEMBERS PRESENT

Reno Site

Diaz Dixon
Ed Sampson
Jennifer Snyder
Lana Robards
Michele Watkins
Steve Burt (Chair)

Step 2
Frontier Community Coalition
Join Together Northern Nevada
New Frontier Treatment Center
Central Lyon Youth Connection
The Ridge House

Las Vegas Site

Debra Reed
Frank Parenti
Ron Lawrence
Yolanda Correa*

Las Vegas Indian Center
HELP of Southern Nevada
Community Counseling Center
Bridge Counseling

Elko Site

Ester Quilici*

Vitality Unlimited

BOARD MEMBERS ABSENT

Jamie Ross
Michelle Berry
Richard Jimenez/Kevin Morss
Tammra Pearce

PACT Coalition
CASAT
WestCare
Bristlecone Family Resources

STATE OF NEVADA STAFF

Betsy Fedor
Chuck Bailey
Justin Reynolds
Kendra Furlong
Kevin Quint
Meg Matta (recorder)

DPBH/SAPTA
DPBH/SAPTA
DPBH/SAPTA
DPBH/SAPTA
DPBH/SAPTA
DPBH/SAPTA

OTHERS PRESENT

Agata Gawronski
Barry Lovgren*
Deborah Wilson
Christopher Croft*
Denise Everett
Judy Morrison
Linda Merlin
Michelle Padden*
Monica Elsbrock
Lu Torres
Patrick Bosarth
Stuart Gordon
Tenea Smith*

Board of Examiners
Public
Community Counseling Center
Tahoe Youth and Family Services
Quest Counseling and Consulting
Nevada Department of Corrections
The Ridge House
CASAT
The Ridge House
Foundation for Recovery
Community Counseling Center
Family Counseling Service
Rural Nevada Counseling

* *Attended Telephonically*

#1 – Welcome and Introductions

Steve Burt opened the meeting in due form at 9:45 am with introductions.

#2 – Public Comment

Linda Merlin, Controller for the Ridge House, presented testimony on the difficulties in billing Medicaid and Amerigroup and collecting reimbursements for services provided. Ridge House began billing Medicaid on March 1st, and was fortunate to have staff experienced in pre-authorizations. They have had difficulty getting reimbursed for the H0038 codes, which are the peer-to-peer one-on-one services and the peer-to-peer group services which has an HQ modifier. These services have a back-log of over \$10,000 owed to the Ridge House.

Even though they obtained pre-authorization for the services, Medicaid denied reimbursement. They used the excuse that the codes were not yet in their system; and would be reimbursed as soon as their system was updated. The Ridge House waited until July, when they received only a single payment. Hewlett Packard, the Medicaid Fee-for Service payor out of Reno (HP), contacted Ridge House and requested that they re-bill the services for their first 10 clients on paper, rather than electronically. Linda said that once she had resubmitted on paper, HP picked through the one-on-one or groups services that were performed on the same day and paid only for the cheaper ones. To date, for the first 10 clients, Ridge House has only received partial payments; and they have received nothing further.

When Linda contacted HP in August, she was informed that HP wanted each service billed on a separate line for each day. Linda was asked to re-bill the same 10 clients so that HP could get it straight. Linda re-billed, and it was 45 pages of billing; for which they still have not received reimbursement. Additionally, HP asked them to continue in the same manner with the regular billing: put every code for every service on a different line. Linda said that recently she billed 4 clients, which would have been 4 pages under the old method; but now amounted to 30 pages of billing with 48 pages of remittance. HP did not pay any of the HQ codes, only the H00038 codes. Linda was informed by HP that they would be requiring all providers to bill every code for each service on a separate line, which Linda said would require hundreds of pages of billing. Furthermore, HP required Ridge House to go back to all services billed since March 1st and re-bill accordingly. She is still waiting to see if they will be reimbursed for the pre-authorized HQ services before she spends the time and resources to produce several hundreds of pages of rebilling. The Ridge House would need to bring in additional help to accomplish billing. Although the Ridge House received pre-authorization for the services, HP informed Linda that it didn't mean anything and Claims would make the final decision.

The other group they worked with was Amerigroup, which is a Managed Care Organization (MCO). Billing to Amerigroup began March 28th. Amerigroup set up their account incorrectly and rejected all billing. In the first 60 days, they received two payments totaling approximately \$300, but everything else was rejected. After many emails back and forth, and re-billing with the addition of MPI codes, they were rejected again. After continued communication, Amerigroup discovered their mistake. On the third round of re-billing, Ridge House was asked to resubmit all paper claims each with the additional attachment of a correction notice. Those were also rejected because Ridge House was now past the 90-day billing period. Vera Walker at Amerigroup has promised to straighten it all out; but after three billings nothing has been paid. Through the end of July, Amerigroup was rejecting all H0047 codes which are for individual counseling, with the note that they needed pre-authorization. However, Linda has in writing from Amerigroup that pre-authorization for those services was not required. Linda continues to pursue the matter, which Amerigroup claims has been fixed; yet no reimbursements have been received.

Ridge House continues to provide services although they are not getting paid. Linda feels it is no use going to (HVI?) because they are a whole new nightmare. Ridge House has submitted pars to them and after months, still has not received answers. Experience says that when they finally do get answers, their billing will be rejected for being over the 90-day limit. Linda says that it boggles her mind that they are supposed to be below Medicaid, yet make demands and deny payment for services. Clients are the most important priority to Ridge House, and they will continue to eat the loss.

Kevin commented that with all the restrictions SAPTA is experiencing with regards to reimbursements, it is of the utmost importance that Medicaid pay.

Deborah Wilson works at Community Counseling Center of Southern Nevada as the Director of the Co-Occurring Program. She also is having Amerigroup problems from a clinical standpoint. To begin with, when they fill out a par for a medical assessment, Amerigroup will only allow 10 sessions for Intensive Out-Patient (IOP). Their program is for seriously mentally ill clients, and they cannot possibly be treated satisfactorily in 10 sessions. In the past, such clients would be in their program for 90 days. Furthermore when the 10 sessions are completed, they have to do concurrent review that takes an hour or more to produce about 4 pages of documentation. When that is submitted to Amerigroup, they may receive another 3 to 5 additional sessions, after which another concurrent review, and more time spent on paperwork, needs to be done. The second concurrent review is automatically denied and forwarded to Peer Review, where psychiatrists on their panel will meet with the clinician to find out why more services are needed. Deborah said that they have had some unique denials. One client who was co-occurring, was denied further treatment for mental illness because she was also attending AA meetings outside of the program. The reviewer's reasoning was that the client had sufficient support from AA and no longer needed mental health treatment. A second example was a client who was a high risk for relapse outside the structured environment. He had trauma issues, difficulty with cognition and problems with his coping mechanisms. When the situation was explained to the psychiatrist, he wanted to know what "step" the person was on, how the peers reacted to that client being on a step in AA and wondered why the client wasn't making more contact with the sponsor and basically felt that after 10 sessions that the client wasn't making progress and therefore denied them. When Deborah tried to argue that they weren't just dealing with that, that they were also looking at the mental health aspect, the psychiatrist basically said that this client needed to be in mental health IOP. She then went on to explain the details about other denials and expressed the frustration it causes. She added there are other issue that come up such as the Amerigroup clients are getting cut off at 10 sessions, and therefore having to spend their time working on an exit plan – which means going to places and trying to find housing and a job when many of these clients aren't even emotionally stable enough to begin going through that process much less adding that to going to 2 groups a week. Debbie went on to say that the other situation it causes is a logjam in housing. People coming out of Rawson-Neal trying to get into the program are on the waiting list – a month to 2 months based on bed availability - and now because the beds are filled up with declined Amerigroup clients there's a logjam. After a tele-conference with some of the key players a few weeks ago, it became apparent that they don't want to give more than 16 sessions to IOP whether it's co-occurring or not. HPN is easier to deal with but after 40 sessions, but right after 40 sessions the medical director starts arguing about cutting them off. Some of these clients are getting cut off before they're ready. One client recently relapsed as the result of the client being cut off too soon. Deborah expressed that she was very concerned about the whole situation. She said it seems like Amerigroup still doesn't understand about co-occurring serious mental illness (SMI) or our whole program and how it's affected.

Ron Lawrence then spoke up saying that services for the severely mentally ill have basically declined in nature and quality because of what the HMO's are creating. Major barriers to treatment have occurred. In reference to what Debbie is talking about, when we do Medicaid Fee for Service (FFS), when we basically get a client registered with Medicaid, Medicaid automatically gives us 64 sessions with a severely mentally ill person. When they switch over to Amerigroup, they get 10. So really it's about what's wrong with this picture. We have to do something soon, as quick as we can. This is not an issue that can continue to wait while everybody's in the state of deliberation. This is an emergency and we need to take care of it.

Steve Burt thanked Ron and Debbie, and asked for any other public comments. Someone asked what has happened with outpatient authorization? Is that extending to out pt? Or is this issue just with IOP? What happens with an OP client? Ron answered their question saying Level I isn't actually going too bad, but the moment we get up to IOP, whether it's SMI or not, we run into the same problem – they don't want to pay for IOP. Up until now, the results we've seen with SMI have been absolutely wonderful. Up to this time we've had a 5% recidivism rate. It's been a very successful program. He stated that Amerigroup was going to destroy this

success. The entire community is in a crisis with the mentally ill spending their entire lives in the revolving door of mental health treatment, and the ineptitude of Amerigroup is going to make sure that continues. Our emergency rooms are full to capacity with mentally ill folks and the entire community is in crisis and the HMO's are going to destroy anything we've built on.

Stu Gordon spoke next. He expressed concern in being able to hire qualified people (LCSW's, MFT's) when he can't compete financially with State, County, VA, and private hospitals, saying he's unable to meet the licensing requirements for this level of clients. He stated that he is currently recruiting but not receiving interest, and believes they are at a critical point with licensed individuals and individuals coming into the field because in the past they would bring in CADACs, LADACs, LCSWs, and MFTs but even there it's difficult because how do you bring an intern in and turn them over to this type of work especially when we can't bill for them, if we can't bill for them we can't pay for them. We're at a point now where I think some of our agencies will look at stopping substance abuse treatment in the near future. He stated he didn't know where the people who are coming into this field – the new individuals coming into this field – where they're going to find Internship's and how we will we pay for them if they do find internships? He called the whole thing is a huge debacle.

Denise Everett posed the question that if Medicaid is paying extensively for so many of these clients, what will SAPTA do if there's Block Grant money that's left over, and will that go to Medicaid -or can that go to Medicaid? She said it sounds like everybody's having so many difficulties – if the Block Grant money isn't all spent out, where does it go – is it given back to the Feds? From her understanding, that money was designed to provide a resource for folks who can't afford to get treatment, so when Medicaid denies so many things or it will pre-authorizes then deny a claim those questions come up. In talking to other people, and I just wanted to get this out on the table, there is actually a lot of money out there right now but seems like we are all having an incredibly difficult time accessing it and being able to provide appropriate services. We're providing the services but not getting reimbursed for them. I can tell you, she said, that in July I had our bookkeeper look up for me on the co-pays how much money we had gotten in on co-pays and apparently 34% of our SAPTA clients made their co-pays, and 66% had not. And the ones who had were on the lower end of the sliding fee scale, and the ones who had not were on the higher end of the sliding fee scale. That's a chunk of change to be missing. Steve thanked Denise and said we'll cover some of that in the Rates Subcommittee Report.

Stewart spoke up saying if we are not here to serve regardless of one's ability to pay are we not all in violation of this – if SAPTA won't pay, when someone falls off Medicaid, or Medicaid refuses payment it's not SAPTA in violation by not paying. This money sitting out there could be paying for these people and we could be continuing treatment but SAPTA's becoming a barrier to treatment. Steve thanked Stewart and Denise and stated that in Kevins SAPTA Report he will address as much of this as possible.

#3 – Approval of Minutes from the Meeting of August 20, 2014

Approval of the August 20th meeting minutes has been tabled, as those minutes are not ready yet.

#4 – Standing Informational Items: Chair person's Report, SAPTA Reports, and CASAT Report

Steve moved into item #4 and said regarding the Chairpersons report he has nothing to add and gave the floor to Kevin for the SAPTA report. Kevin said there's a lot to talk about and what we've been talking about is part of that. He spoke about two items, but said he wanted the teams that are here from SAPTA to talk first and asked Chuck to give an update on the Data Team. Chuck Bailey identified himself as the Data team supervisor, and started in talking about the number of help desk calls his team gets. In part they are concerning certification issues particularly with the residential services. He said those certification issues have been referred to Mark Disselkoe and Justin Reynolds. He went on to talk about the issues surrounding certification, and opening the service levels in NHIPPS. He said that at this point almost everything should be worked out – however in terms of the forms and documents there are still some inconsistencies and the GMU unit is working to bring some consistency to these documents. The inconsistencies have been identified and excel matrix has been created to make sure that when these things are changed in the future, that they start with certification and then move forward to everything that relates back to that. He added that outpatient should have been set up but we're still

getting questions about residential, and directed anyone having questions about that to contact him or Sheri Haggerty and they will initiate a help ticket and make sure we do what we can so you can get clinical notes in – but then the reimbursement issue is something that's going to have to be worked out with fiscal and with the programmatic staff. Chuck then asked Kendra Furlong if she wanted to do an update on the AVATAR roll out. Kendra started by saying that the Avatar rollout is rather at a standstill at the moment, and that they have been working with MHDS and NETSMART to transfer the hosting of the system onto the Netsmart website to help with latency issues which is just to help the system run a little bit smoother and better. She said that occurred last weekend and everything so far has gone really well. The system speed has actually picked up somewhat and now they are just working out the bugs. She stated that she will be having a meeting with John Henick from Netsmart tomorrow to identify the new rollout dates for the initial 6 providers. She said she wasn't sure how far back this switchover is going to affect things. She is hoping not more than a few weeks but the upcoming holidays might create some issues with getting everybody in the right places at the right time for training and testing and getting the systems up and running. Once she has a more definite date from John on about how much time they need to build out our systems she and the team will be able to move forward and do the things we need to do with the providers to get everybody ready and set to go. She said they were successful at collecting all the information we needed to get the first 6 root system codes filled out and to her knowledge that is what the Netsmart team is working on at this point. So things are getting closer. Someone asked the question about when the roll out would start, and Kendra stated that she thought they were supposed to start rolling out in October, hoping by the first of the year to start bringing everybody else on. She said once they get through bringing the first few on, it should be a fairly easy process after that. She couldn't really give a good estimate time wise, other than hopefully at the first of the year. Currently she doesn't know what the exact go-live date is going to be. She said she anticipates that as soon as these first 6 out (and she's hoping by the time they get the first 2 out) that they will be into a much smoother running process and it should just be a smooth transition.

The same person posed a second question asking if they still have permission to find a different system. He stated that he is out of time and went on to say that everyone has heard the problems that have been generated by the lack of having an electronic health record. He reiterated that he is out of time. That he needs to start shopping, and needs to find a grant to pay for it within the next two months- which is not the first of the year because his staff is nearly in mutiny. Chuck said that is something that should be referred to Mary Wherry and Richard Whitley.

Next Chuck talked about the visibility issue in NHIPPS, and that his team is trying to get better visibility. He stated that people are working on getting the data in or corrected with the manual report, and is hoping that will be in place soon.

Kendra replied to the provider who posed the two questions, saying that if he would meet with her outside of the meeting she might be able to work something out with him to bring him forward if the need is that great. He replied saying that having missed a meeting that suddenly he wasn't one of the original 6 providers. Conversation ensued after which he stated that he would meet with her outside of the meeting.

At that point, Kevin said (and said he would check with Mary to make sure he's right about this) but that he didn't know that SAPTA could make a provider go on Avatar. He said a couple of the programs are doing their own electronic healthcare record, and that's not our call, however we would like everyone to be on the same system. He said it is very frustrating and seems to have morphed from a SAPTA project into a Division wide MH and SAPTA project where now we're in a cloud and Netsmart's hosting it, and it's frustrating. He said that for once it's not SAPTA, it's just the wheels turning very slowly, and he apologized. But off the cuff he wanted to say that people need to do what they need to do but at the same time, before you jump please tell us so we can try and find some solutions that can help. He said Kendra can help, and they would all talk to Mary about what the options are but that he didn't see how legally or ethically anyone could be made to go on Avatar.

Kendra added that they have a group of providers that are not coming on to Avatar, and recently one of them actually joined the program and really the big hold up has been the hosting transfer. She had hoped to have some

feedback from John Henick before today but he hasn't responded back so she's hoping that in tomorrow's meeting he'll have a better idea of what's happening with it. She added that if anybody has a need please bring it to her or Kevin's attention and they will try to accommodate that as best they can.

Ester Quilici spoke next, expressing her concern that Avatar is going to require daily charting. She stated that in the past they were doing 7 day notes. Now they're being told they have to go to everyday even with the NHIPPS. She said it's really hard to deliver the level of services that's required for III.5, then you're asking these clinicians to try to do notes every day and not giving any leeway. What happens if you have a crisis? What happens if you have someone out sick? In the past when things happened clinicians could wait until a certain period every week to put in their notes, or even take them home if they had to. She asked for a little more leeway in how they annotate in the system for residential, IOP, or whatever.

Chuck spoke up saying that when the roll out of many of these changes occurred, it coincided with where we tried to unbundle services, so he thinks there are communication issues and things that may have been miscommunicated or changes made 2 weeks after the start of the fiscal year that have impacted what Ester just talked about. He said if you're doing residential services nothing has changed. If you're putting them in as a III.1 or a III.5 you can still do a 7 day note. The issue is if you were unbundled that is not the correct way to do that and it would be a problem if you were trying to bill Medicaid and you don't have those notes. He added that the unbundling was a mechanism for reimbursement. Another situation would be with the transitional housing – nothing has changed. He said he's had help desk calls where he had to straighten that out. If you're billing the transitional housing services, you can still do the 30 day billing for that service. The question is whether it's appropriate to be billing for that service, and the appropriate way to do that. In the Medicaid world, if their services are unbundled you're going to have to bill it in the way that they will pay it. Medicaid does not pay for III.1 or III.5. It wasn't clear at the start of the fiscal year whether we were going to be paying for those services or not. Originally the understanding was that only for the IMD's - they were the only ones that would be eligible, but then some decisions were made because of the MCO situation. So again, if you're billing III.1 or III.5 it still can be a 7 day note. Someone asked what is meant by 'Unbundle', and Chuck replied that unbundle means that the treatment services are paid for separately from the room and board. And there have been some providers that have done that to some degree.

Someone else interjected saying that is good because if you have 16 beds or less, Medicaid reimburses for III.1 and III.5, they just don't cover housing. Kevin says they don't technically pay for the II.1 or the III.5, but they pay for the unbundled piece. Chuck said that he believes in that situation, and stated that although he is not a clinical person, but there was a question and he believes the H0017 code is the one that picks up the piece of the residential that Justin's talking about, and then Chuck thinks the provider would be eligible to put in for room and board for the \$40 dollar rate with SAPTA, that it would be put in as a Transitional Housing record, and added that although it says Transitional Housing, it's really now just Housing – the way to bill room and board.

Ester had a question for Kevin, saying she thought they were still able to bill for some of their services and because they were cut off from 14 and 82 and was told no. She asked if they could reinstate, saying they were eligible for both of those, and asked if they could be reinstated so they could bill for more services than they allowed to currently?

A male voice speaks up in agreement saying he recognized that there were some codes in 14 and 82 that didn't roll over into 17 that they are doing and would like to continue to do and ultimately create a more recovery oriented system of care anyway including case management codes.

Ester expressed her frustration with case management reimbursement and getting reinstated. Lana asked Ester if she was talking about Peer Recovery or Peer Support Services under Provider type 17 or if she was talking about the case management services under Provider type 14 & 82? Ester replied saying her program got 1 unit a week of case management under what they are billing currently. After more discussion, Lana stated that her program is allowed to bill under provider type 17 any life skills, parenting case management or whatever it has to be Peer Recovery Services. Lana said she has 5 Peer Recovery Support Specialists and that's the only way her

program could get paid, and even that hinged on CASAT doing the trainings so those 5 people could get certified. She said she has other staff waiting for the next training. Lana stated that she wanted to go on record as that she went to every public meeting and offered all the public testimony as much as she possibly could in support of Medicaid allowing providers to be 14s, 17s, 82s –whatever they qualified for and then what happened in the end is they wanted to simplify matters so they pigeon holed all of the providers into a provider type 17 because of our association with SAPTA. Lana said her program has been providing services under 14 & 82 for years, and said they are pretty good at it. She said she is in favor of Medicaid opening up at least 14 for everyone.

Kevin remembered seeing some emails about this but didn't remember what the conclusion was. Lana said she thinks the conclusion was that they'd already made up their mind before the public hearing and that this is the way it's going to be and it didn't make any difference what anybody said. Lana went on to say it was January 9th and it was every single public hearing or whatever they wanted to call it before that and she stood in support of them allowing us to apply for and retain the licenses or approvals that we already had and then if to go into the provider type 17 for the substance use disorder which is something that unless it was co-occurring leaning with mental illness we were never able to bill for it before. So it really opened up this funding opportunity for all of the providers. At the same time they kind of tied everybody's hands by not allowing them to bill for the things that they also had developed and were very good at including the case management services and everybody that is providing services knows that unless you actually provide those support services and other services you're not going to be very effective at plucking out the addiction piece and trying to make that client have any positive outcomes, so a lot of the things that has happened has been in direct conflict what our mission, vision and values are – we're going backward, we're not going forward right now.

Steve thanked Lana and asked if there was anything else for Chuck or Kendra before giving the floor back to Kevin. Kevin said the last time we met you heard from Theresa Patrick who is head of our grants management unit, right now they are mainly working on policy and reimbursements so they are going to have a much wider work to do as we go along here. The prevention team, the big news there is Charlene Herst is retiring as of October 10th – she couldn't be here today because she's on annual leave. Also the Prevention RFA is going out this Fall hopefully not past the end of October – that's for the Coalitions. That group is also overseeing the Partnership for success grant which is a federal prescription drug grant that is going to the coalitions as well – 85% to the coalitions. Kevin said they are now in the recruitment mode for the Prevention team leader to see what we they can do to get a very competent, content-expert kind of person in that role to help us all move forward in prevention. Kevin added that Prevention doesn't have it easy, even though it's not having the problems that treatment is right now. He said that in the past it was pretty bad when PX was having their own set of issues, but they haven't been hit as hard in the funding issues – they've been hit in some ways, but not to portray it as perfect but right now it's a pretty solid system and he is kind of excited to see what comes out of the RFA process as well. He said coming up Sept 30th, there will be a big meeting of all the coalitions where the discussion won't be so much about what the funding ought to be –but about things like land mass, schools and population and how Prevention money should be distributed. He said if they just fund Prevention to populations, then all the money goes to Clark and Washoe without a penny going to the Rurals. He said there needs to be a multifaceted approach. He said when Maria Canfield was chief they had a pretty good formula that they hope to resurrect and see if it still fits. What's happened since she's been gone, he thinks, is that the prevention money just wasn't thought out as well, so he feels hopeful about using SAPTA's own process to do that. At this point Kevin asked Justin if he wanted to talk about the treatment team.

Justin said that right now his team is working on getting monitors started. He said he knows it is a sore subject dealing with Medicaid and dealing with these MCOs, but said one of the goals being worked on is they've got to get all of SAPTAs providers on the MCO panels. He said they are working with Diaz and starting that process, also working with WestCare and had some meetings over the last couple weeks. The plan is to start systematically going through and getting folks onto those panels. He said SAPTA will work directly with you, and with someone from Amerigroup in the room and starting figuring out where the issues are and what is need to fix them and moving forward. He said that is the direction that was given to him from SAPTAs Administrator

and Director. He went on to they had a meeting 2 weeks ago and SAPTA's Director said the right services have to be matched to the right payer source so if you're providing Medicaid eligible services to Medicaid eligible clients make sure you're billing Medicaid and your getting paid by them and we're doing what we need to do to move forward and be successful. Someone commented that "the phrase the right services have to be matched to the right payer source" sounds funny when we are all just trying to keep our doors open. Kevin said what it speaks to is that we are in a world now of insurance that we weren't in before. He explained that what it means is that we've had this cataclysmic change in our funding system that has gone from basically a "we pay you for your expenses" to more recently Fee for service and now the Medicaid thing and all of a sudden we're bound by rules that we didn't even know existed before. He said he is trying to figure out how we can navigate all that and find out what it means for Nevada. Kevin went on to say that other states are struggling this as well, and told about his recent conversation with a lady from Vermont who he met recently in another meeting. So these are things that we need to work on – not just at SAPTA, but as a field we need to figure out what this would look like.

Changing subjects, Kevin went over items given to him from SAPTA's Administrator. There are currently 20 FTE at SAPTA; there are 6 vacancies – David Lenzner who was at SAPTA for about a year in Fiscal has moved over to Admin Fiscal. He was good at getting things figured out and done, and it's because of him that this month's reimbursements have gone better. Kathy Meek also in Fiscal has been a person who also processed payments, she's also leaving and going to emergency management. Charlene Herst as I mentioned is retiring, Meg Matta is leaving as well. He explained how in the non-profit world people leave because they're not paid enough or they get burned out, and in State government people get burned out too, but they leave because they get promotions. He explained that with these vacancies we have to fill out a form called "Request to Fill" which includes a 1 page format along with the Essential Functions (the job description). He said those are done for Charlene and David; Kathy's is in process and we'll have to get Megs done. After that they have to do a recruitment process and we get a list of applicants for each position and schedule interviews, etc. So we have 6 vacancies (30%) and we're hoping to make that smaller. Also Nan Kreher retired in August and her position is going over to OPHIE which is Epidemiology. We'll be interviewing for that job tomorrow – that position will still be attached to SAPTA – not on-site but they'll still do work for us over in the Epidemiology area.

Next Kevin talked about CSAP and CSAT. He said SAPTA had a sight visit from CSAP back in February and it was a robust 70 page report – no all bad, not all good, but I thought to myself this is like getting free technical assistance – we had 2 people in the group from CSAP who had done Prevention work all across the nation who was there along with our project officer Kumar Mapp ←**spelling?**. They gave us great stuff we can use with the field. CSAT will be similar but it will be a little more robust because they haven't seen us for a few years. I truly welcome their scrutiny – that will be the week of Dec 8th. What we'll do is call them tomorrow and talk with the staff and get things set up but what I want to do is do some site visits. When Theresa Mitchell Hampton was here back in May that was more like a good will tour, she was just saying hi and checking things out and all that stuff – although I told her the truth about what was happening in the field, so she knows, but this will be a more in depth – that just scratch the surface, this will be digging down deep so what I want from the Treatment providers is to tell the truth. If there's a problem tell them whatever you'd say to each other. Be nice about it if you can, but I really want them to know what's going on in Nevada. So when we talk tomorrow, I'll know more – but the first 2 days that week there will be meetings at SAPTA and we'll invite people to come to that – probably not everybody, but people from different capacities so we'll have a cross section of providers – then Wednesday and Thursday we'll have 2 days of site visits – I don't know if they want to do Las Vegas, or the Rurals or what but I'll find out and make that happen. So we'll keep you posted on that. So again even though the Feds can't change our situation, they can help us look at things like what do certain things in our block grant mean that we might have questions about, etc. Again, I want to invite you as my colleagues, friends, and fundees I want to encourage you to be there and be part of the process and let's tell them what's going on, and they'll tell us what they think. We have a really good ally with SAMHSA, a guy named John Perez out of San Francisco region 9 Director, and he may be there for part of this. He really likes Nevada and wants to help us. He's been great, he's been like an oracle where Mary and I will call and have conversations about different

things and he brings other people to the table so it's helpful to get SAMHSA involved so they know what's going on.

Moving on, Kevin said that he went to a meeting Monday and Tuesday with the National Government Assoc (NGA) which is a very active group that our Governor belongs to and this meeting was on Prescription Drug Use in the country. This was a really great meeting because they brought 6 states together including NV, VT, Michigan, north Carolina, Wisconsin and he couldn't remember the 6th one. In addition to Kevin, the First Lady was on our team, also a lady from Medicaid, 2 people from the Governor's office, and Larry Pinson from the Pharmacy Board. So there was a wide representation. Governor Sandoval kicked it off (NV and VT sponsored the meeting) because he was one of the sponsors. So we'll probably see stuff about that topic in Legislature. It could include funding we don't know yet what the Governor wants to do, but that was talked about. Treatment as well as Prevention was talked about a lot in the meeting. So this is an opportunity for us to get some things on the map as far as Treatment and Prevention. The NGA will meet again next spring in Vermont. We also talked a lot about policy for the prescription monitoring program which is a big deal because some of our clients abuse Prescription drug. Kevin said Nevada has a pretty advanced model for that and they're doing evaluations to see how it's working and with different populations. It will help us take a look at – depending what the legislature wants to do with this, to make it mandatory for doctors to look at and use or not. So far it's not mandatory, it's just suggested. We talked about enforcement, disposal of drugs, there's a lot of drugs being collected out there. Did you know the DEA is pulling out of drug roundup after this month, and they're the ones that get rid of all our drugs for us here in Nevada. Since I work at SAPTA, I had the opportunity to brag about what the Coalitions are doing and the work that is being done in the field in the whole area of drug abuse. With Legislature, so far there is not a whole lot coming up as far as bills go (and he asks if anyone has heard anything about bills or BDRs that might be coming up) someone said the Board of Examiners is working on the Peer Recovery Specialist certification – which is a pretty significant legislative rewrite when all is said and done. Kevin said the big thing will be the budget and something he doesn't know yet because he hasn't been able to find out is if the budget created by our division cut anything from state general fund – he didn't think it did but needs to find out for sure so he can tell you that. Another issue that will probably be discussed in legislature is in government you have acronyms and you have numbers. The budgets all have numbers and our budget at SAPTA is called 3170. MH budget is called 3168. So there's a movement to combine the 3168 with SAPTA but it would only be the outpatient MH, not the hospitals. They are also talking about other programs that can be put under 3170. So we'll see how that works out. That could be a big change and actually represent an opportunity for more integration of public health and mental health and drug and alcohol.

Next Kevin talked about SAPTA receiving calls in from judges from across the state reaching out about the dilemmas of getting court ordered people into treatment due to payor source or waiting list. Someone from the Supreme Court office emailed Kevin and invited him to a judges meeting at Adele's here in Carson City on October 10th. Kevin is looking forward to putting on a little presentation for him to talk about these things. Their big thing is they can't get their people into treatment because of payor source or there's waiting list or things are cut back or because of some other blockage in the system. Also Dr. Green, Mary Wherr and Kevin and it's unsure who else, will do a panel at a big judges meeting coming up in Nevada as well. Dr. Green will talk about medical necessity with them and have Medicaid information there and hopefully just be able to talk about how to help make this work. We're trying to have conversations and move in that direction as you all know judges can be tough that way – they want to have their own domain and their own way of doing things and their own autonomy. So if you have any ideas, or anything you want to send my way please do so.

Kevin stated that the RFA for treatment will be in December or January. He said that will give us time to get everything done and done timely this year. It will be competitive. What we want to look at is the idea what can SAPTA pay for, what should SAPTA pay for, what's proper for SAPTA to pay for. If the Medicaid thing was going like it should go, and I know it's not but if it was I'd say let's get Medicaid going as best it can and then SAPTA will fill the gaps as best as it can. But to do that, Medicaid has to be working – meaning the MCO's, the HPN, FFS and all of it. So in our RFA we need someone to figure this out. Right now if Medicaid was working right, SAPTA would probably fund less Outpatient, because Medicaid will pay for OP meaning OP and IOP.

Then SAPTA could pay larger amount for things like possibly Residential, Detox, maybe Case Management, Peer Support Services. Because one thing that is a dilemma, and I know I'm preaching to the choir here, but we're being told there's money to do less and less with but yet we need to have a robust system of care. So how do we support someone who's 30 yrs old who comes into the system and stays sober for 20 years or the rest of their life what about or monthly recovery checkups or recovery coaching, a recovery support set up. Who would pay for that? Those are the kind of gaps that we need to identify to figure out how we're going to fund. I want to ask you and maybe we need to save this for another time, but I wanted to get this question out into everyone's mind is 'What Should the System Look Like'? I see everyone shaking their heads and that kind of answers it for me, at least in principle – but I really need your feedback now as well as on-going and as we develop the RFA. We're not going to build the RFA and then unveil it like a statue and say here it is, take it or leave it. We'll give you some previews of it before it goes out so you can give us some feedback.

Stewart Gordon spoke then saying there are a lot of nods coming from those of us who do Inpatient, but those of us who only do Outpatient (OP), if there's going to be less coverage in payment for that I think we're going to create a larger hole in the system – but the other thing is in grants, some of the funds have always gone towards supporting an infrastructure. If we're on a FFS basis, especially in OP, we'll get very little support from SAPTA – still meet the SAPTA requirements like Avatar and things like that – will there be any portion of the grant geared toward infrastructure? I can see that a portion would be billed out for FFS but will there be part the support programming like program development, staff development and things like that, if not then like you said before, we probably need to find a new business model because we can't run a drug and alcohol program without an infrastructure support and bill FFS and meet your requirements.

Kevin interjects tell Stewart - I love what you're saying but I need to take that back and talk to the staff and talk to the higher ups – because what we do at SAPTA is not like the non-profits where you're basically the director and the boss. I have a bunch of people above me that I have to get by to get to agree with me, but I'm willing to advocate for that. I think it's a wonderful idea. The question isn't should we do it this way – the question is can Sapta use some money to provide infrastructure and to do what you just said and you just said 3 or 4 things that we need to talk about, so how do we do that? We do that with the Coalitions. They get money to fund the Prevention providers, but they also get money for what we call infrastructure. In fact that's one of the things were going to talk about on the 30th with the Coalitions – how much money do you all need to actually stay in business. So without making any promises we'll charge forward with that and see what the possibilities are.

Justin added to that saying in a meeting last week it was said that WestCare had 80% of their clients that they served were Medicaid eligible. So when you think about the money that they have going towards that and you're billing Medicaid, you can take those extra funds and build the infrastructure. Build the gaps. We're not taking anything for anyone, we're not trying to tear the system down but we've got to look at a better way of doing business.

Someone else spoke up and said that it's a theoretical discussion at best to say that we're going have all this money from Medicaid when person after person after person is telling you Medicaid doesn't work, they're not doing what they're supposed to do, we can't get reimbursed under 17, the IOP programs don't work, you've got agencies that have been trying for 6 months to get on with MCOs and channels have been blocked at every possible opportunity – I don't see that there is a lot of money available, but what I would like to see is if Medicaid, HPs or MCOs say they won't pay anymore, that SAPTA would pick up the cost because it's medically necessary.

Denise said she I agreed and added that there's also the piece in all of this too that if we were being reimbursed by Medicaid or SAPTA at what it actually cost us to provide the service, then we wouldn't need money for infrastructure or administrative cost – but we're not being reimbursed. Even when we can get the money in it doesn't pay for what it costs us to actually provide the service and/or build our agency so we have appropriate clinicians to provide the services. Denise stated that at Quest I've lost 3 licensed people in the last couple of months because I couldn't afford to pay them what other places could. Agreement and discussion followed.

Ron in Las Vegas spoke up saying I think the thing we need to do is, when we're speaking of a new business model and when we're speaking of program survival what we need to build a safety net into the system and we don't have one right now. I agree with what Lana said that we are going downhill, and we can't even think about distributing grant funds in other directions until all the programs are safe and can remain in business because we're not even meeting the state needs right now. Basically we have to make sure that every service that we perform has a payment source, and now the bind that we're in – especially with co-occurring program, we have patients we're treating for free that are basically seriously mentally ill because SAPTA won't pay for them for one reason or another because they have insurance, their insurance has cut them off, so we've kept these people in program and we're eating the cost. Plus the HMO's have taken us down to 70% of the Medicaid rate. If we want to remain in business, we have to take us out of the starvation mode and get us into the survival mode. The first rule of the business model is there must be a payment source for everything and basically, I appreciate the watchfulness of SAPTA, but that has to be rule #1. Otherwise we're all going to go out of business. Further discussion ensued.

Someone else spoke up saying went to all these Medicaid workshops where didn't ask us they TOLD us what they were going to do, made promises, made a few minor adjustments along the way, but the system isn't working. Mike Willden before he left said it would take 2 years to figure this out, and we don't have 2 years. this is a dire situation for many agencies. This just isn't working. We have to be able to shore up what we know we need with the clients we can actually serve with the staff we have left.

Ester spoke saying apparently SAPTA funded a for-profit program in Las Vegas. Is that a trend? A new business model? For 1 thing I didn't know SAPTA could fund a for-profit; and secondly, Barry said it was so that they could accept Medicaid. So we're having not only this crisis, but we're having a deluded system because now it's allowing for-profits to get SAPTA money. Am I mistaken or not?

Kevin replies to Ester, saying Last spring Solutions Recovery in Las Vegas requested to get in on the Marijuana money, and we were given instructions to do a contract with them. That is state money – it's not Block Grant (BG) so it's legal to do that. We can't give them BG money. So the intention was to do that as a pilot to see if it's like \$19,900 contract that does allow them to become a provider type 17. So that was intended to see if that would work. One of the things you have to understand is that Medicaid is not – all of us want to see people get served, and there's a system that is consisted of SAPTA Funded Providers. There's also a system twice as big as that comprised of SAPTA Certified Providers that are serving people as well. So that was one of those programs that was granted that money and it's a contract with marijuana money only and again it's a pilot designed to see if that could work.

After sharing her thoughts about Solutions getting Marijuana money and saying that she could understand it, but saying yes that is a new business model, Ester asked Kevin what kind of rigorous standards do you make them meet that we are already meeting?

Kevin said they had the same assurances and the same requirements. They aren't held to BG requirements because it's not BG money, but they have the same rigors basically.

Ron in LV said he wanted to add 1 more thing to this discussion. I know this feels laborious for all of us but we have to talk about it. I want to talk about our Treatment Director that's sitting with me, Debbie Wilson. There's an ethical compromise that's being made. That's why she's treating people for free because her licensure has certain ethical standards. So we're being backed into a corner, being placed in double binds, and as Debbie tells me, there are certain clients that she can't let go to the street. We already have 2 clients that are basically living on the street from the co-occurring program because they were terminated early. But someone right in the middle of trauma treatment should never be let go, so we treat them for free. Let me explain something, our licensing boards hold us to certain ethical standards. There is a certain way that Debbie could be reported to her licensing board for compromising treatment for somebody, but what I want to point out is that these ethics that

we work under, they are also community wide. We are failing to keep our ethical standards in treatment in this extremely compromised system that we're living in right now.

Kevin said Ron I appreciate that and that's a really great way to frame it and say it because that is what's happening.

Denise said I absolutely agree with Kevin that we want to provide good services to clients, SAPTA wants to provide good services to clients, we're not so sure about Medicaid. Insurance companies, by definition, don't want to spend that money, so they will do just about anything they can to not be spending that money. So I just wanted to throw that out there that I'm not sure that we should lump Medicaid in with SAPTA and the providers as wanting to make sure that people get the services that they need.

Kevin said he appreciated that. And that brings me to the last point I wanted to discuss. I know we're running over and I apologize for that. Back to the MCOs and Medicaid, I get emails and calls from many of you and it's never onerous, and I appreciate that. It's hard because it's hard for all of us. It's hard for you as providers, as you've all described this morning. It's hard for us because we watch what's going on and feel like we have a failing system, and I wish I could fix it all right this second and I realize I can't do that. But I do feel an obligation that SAPTA has to care about this stuff. Not just because it's our job and a paycheck, but this is our job and it's what we need to do. Richard Whitley recently issued a directive to me to work with Brandi Johnson of the Division to have a meeting with WestCare. We also got Amerigroup there, and Medicaid and HPN. I actually invited some of the wrong people and got a bit chastised by Amerigroup. So we had a recent meeting in Las Vegas and the idea was to set up a model for how we can speak and Brandi Johnson who came from Medicaid Billing set up the meeting agenda, the way she wanted to talk to people and things we were going to do afterwards. Richards vision is to have model that we can work off of, and that's what we're going to do. That being said though, we can't wait another 2 or 3 months to set up a model to get this going, so – at the same time without doing anything against what I've been directed to do, we've already been talking about this anyway for awhile, we need to step up the pace and get going on this. I mentioned to Ron earlier on the video before we started, that when I sent some information to Amerigroup, now a meeting has been set up for a week from Friday, but they didn't invite Community Counseling so I need to take care of that. I don't want this to turn into a disorganized mess either. We need to talk about the slow payments and the lack of payments and the arduous paperwork. This has to be made into an issue by SAPTA, not that we want to do it for you, but because we need to advocate. So we need to get moving on this. Justin and I have been talking for weeks about this. One of our top 2 or 3 priorities is to set up meetings about this. What I don't want to do is set up big meetings with all the providers in a big room less it become like a big town hall meeting where everyone's making speeches and nothing gets done. We'd like to sit down with individual providers and your staff, with Amerigroup, and then Medicaid as well and just hammer it out. We need to sit down with that same provider and HPN and hammer it out and really talk about it and figure out some solutions. Because what's happening is – and I'm going to back to my office as soon as we're done, and write an email to John Whaleys at Medicaid ←sp????? saying if we have a meeting about Community Counseling, they have to be there. This is like dysfunction junction so to speak, where we're talking about people who aren't in the room and figure out how to fix them. That's not how we ought to do business. So that's what our vision is. If you have a different vision tell me. If you have a better idea, I want to know it so we can adjust our strategy. But we need to get on this. And I know some of you have different issues. For instance the issues that 1 provider has may differ from what another provider has. There are a variety of different issues. But we can't wait very long because as you are all describing, your business are at risk, and your clients are at risk as well.

So on that note Steve encouraged everyone to send Kevin email feedback as we've already been doing. He's always good about getting back to us in a timely manner, and sometimes it's good just to have someone to vent to. So send him your questions and thoughts. Kevin interjected that Justin and Betsy will start contacting providers.

Next Steve asked Michelle Padden if she had anything for the CASAT report. (*it was very hard to hear what she was saying due to background noise*) Michelle talked briefly about what they are doing as far as Recovery

Month Activities. In addition she told about a new program for Dislocated and Adult workers called Career Health Care Connections that helped with tuition, training, and practicum assistance, and tries to reduce the educational barriers. Currently there are 5 training programs available. A handout on this will be available to everyone in the very near future telling all about CHC Connections as well as contact information.

#5 – Update and Approval on SAB By-Law Change to Increase Membership by One Seat to Include Representation of an Adolescent Program

Steve said there was a hiccup on this because I believed that the posting of the agenda being worded as clearly as it would, would meet the By-Law requirement of the 14 day prior to the meeting indication that we were going to make a By-Law change. However, the agenda wasn't actually posted 14 days ahead. So that means we would be violating the By-Laws by voting on that today, so we have to move past agenda item #5 as tabled as well.

#6 – Update, Discussion and Recommendations on the Chart of Service Codes and Unit Descriptions

Michelle talked about this and relayed information that Betsy and Mark gave her as she wasn't in the meeting on that. (it was very hard to hear what she said due to background noise) Steve commented that what she talked about wasn't new and wondered why this was an action item. He questioned if the members needed to vote. (*I could not understand Michelle's answer*), however after her comment Steve asked Meg if they had a quorum. Meg affirmed they did have a quorum, so Steve asked if anyone would entertain a motion to approve this criteria. Lana made the motion to approve this assuming it's the same one they've been living with and she believes it is because she read it. Seconded by Diaz. Hearing no opposition the motion carried. Steve then thanked Lana and Diaz and moved on to the next agenda item.

#7 – Discussion and Recommendations on the SAPTA Sliding Fee and Fiscal Policy

Steve said this is essentially a report on the Rates Sub-Committee, and the Rates Sub-Committee was made up of myself, Ester, Diaz, Kevin Morss and Mark Disselkoen. They talked at length on a conference call a few weeks ago about what we should do about the idea that the SAPTA sliding fee scale as it is tends to jump too quickly being only broken in to 4; 25%, 50%, 75% and 100%. For the purposes of the person who meets the discussion of a working poor person, where they might be working for \$10 an hour so they don't necessarily qualify for Medicaid, but they can't afford insurance and they can't afford their co-pays and they may be making enough money to have to pay \$29.85 for a group for instance and that may create a barrier to them. So we were talking about the idea of having SAPTA reimburse the entire amount of the billable rate and therefore we would still be able to potentially collect a co-pay but we wouldn't have to subtract that co-pay from what the reimbursement amount was from SAPTA. That was one of the recommendations. The other recommendation is that SAPTA will pay the full unit cost rate for the sliding fee scale for clients whatever the client is assessed at being – I just kind of said that. The other idea was that we would re-look at percentage breakdown for the sliding fee scale to make the unit cost rate more affordable for clients who exceed 100% of the Federal Poverty Rate and the actual 3rd one was the idea that the individual programs would submit to SAPTA what their actual unit costs were- the delivery of that service, and therefore SAPTA might be able to deliver that reimbursement amount. We sort of quickly ruled that out as cumbersome and we wouldn't want to necessarily put SAPTA through it because there are vast differences of unit costs between some of the providers, and it would be challenging for SAPTA to negotiate that.

Kevin interjected that he wanted to be clear that they aren't being difficult about it, we just don't have the workforce capacity to get that done. One the other hand I do think we need to find a way to get you closer to what it costs you to do business.

Steve went on saying what we get back down to is SAPTA will always pay the full rate. The idea behind this one was the fact that – and we did talk about this – the agencies are writing off a great deal of money for clients who don't end up making that co-pay but some clients do. So the idea here is that SAPTA will always pay the full rate and then if a co-pay comes in, the provider will pay that back to SAPTA on a future reimbursement on a subtraction to sort of encompass that working poor that – you know the person on paper it says they'll be able to

afford a 50% co-pay, but they don't end up paying it, so we don't end up getting it and then we don't end up having to pay that back to SAPTA. But for the ones that do, it gets reduced for that group.

Ester said Vitality has always been assertive asking for co-pays because they believe it is an accountability issue. Year to date, Vitality has written off 92.79% of the co-pays for 2014. She stated that they do better getting insurance co-pays because you know what you're dealing with right off the bat, plus you can negotiate. She went on to talk about how the challenges of not being able to turn anyone away in the SAPTA system and how she thinks they should be able to that.

Steve summarized that the Rates Sub-Committee met and the 3 recommendations really are: 1.) SAPTA always pays the full rate and when the co-pay comes in we subtract that from the reimbursement request 2.) SAPTA will pay the full unit cost rate regardless of whether the client is assessed a fee and regardless of whether they pay it or not and 3.) We reexamine the breakdown of the sliding fee schedule completely. So given that we can't direct SAPTA to make any of these 3 changes the Rates Sub-Committee respectfully presents these 3 options to suggest as a recommendation for SAPTA to take further down the road.

Ester wanted to know how much was further down the road and asked if Kevin could make a quick decision. Kevin thought so, yes, but he just needs data on everyone's write-offs and he thought some kind of statement about their struggles getting paid – evidence of a billing system and write-offs that are substantial helps me advocate at a better level.

After a couple more people shared their thoughts, Steve asked if they wanted to table this for now or did they want to give Kevin one of these 3 directions. More discussion and more comments ensued. Lana wanted to point out to SAPTA people that even though it might be a couple of years old, you actually already have the actual breakdown of the cost of doing business for everyone as it was a requirement of the grant application when they applied for funding the last time and the time before that. So the information is already in your office, albeit not completely current but certainly will tell you the trend of what the cost range is for example as it existed then. Most of us are required to get our A133's and we base our numbers off of that when we do the analysis, so we can certainly do another one if that's the direction we need to go. But the bigger point I really want to make to SAPTA is that the rates committee is not asking for anything that wasn't in place on June 30th. On July 1 the rules changed. On June 30th the Sliding fee scale broke it down 2%, 2.5%, so that there was some obligation on the clients regardless of where they fell income wise. Now it's 25, 50, 75 and 100%. If you get a person that's caught in between and you put him at 25% there's just no way they will be able to pay that co-pay. It just doesn't make any sense. So, last year SAPTA recognized the need to drop those percentages – this year obviously they changed their mind. So I'm asking that SAPTA just re-visit that. Obviously they had good basis for making that change when they did. The other point is SAPTA has never in previous years as of June 30th never required us to deduct out the co-pay from the amount they reimbursed. Yet on July 1st all bets were off and now all of a sudden that co-pay gets deducted from the reimbursed rate that SAPTA has assigned to each of the respective services. So you've got \$73.92 for an individual service and if mine is a 25% client then that number comes down to \$55.44. It's never been structured that way – that changed on July 1st and I'm just simply questioning that SAPTA go back and visit why they were doing things as certain way last year and what their motivation may be for changing it. It would seem more fair to the Treatment Providers and cause a lot less headache if you just went back to where you were on June 30th.

Steve spoke to Kevin saying he heard everyone giving feedback on the Rates Sub-committee, but there's no vote-able recommendation at this point. We went on to say there seems to be a priority order here that we would like you to remove the co-pay altogether. If you keep it you've got to look it over again and worse case scenario is that it sounds like we'll settle for the pay back if that's the compromise you can get us. Ester wanted to know if we could do a motion, and Steve said he didn't think that was possible and right now it's too much to be a formal motion right now. Kevin said he wrote it all down and thanked everyone for their feed back saying it was very helpful.

#8 – Discussion and Recommendations on Revisions to the SAPTA Treatment Monitor

Michelle was called upon to talk about this. (*Due to background noise and paper shuffling next to the recorder it was almost impossible to hear what she said.*) She explained what people were looking at as they looked through both instruments together, based on the authorities that were guiding them and asked if there were any questions. She said the guiding force behind them was to look for duplications. Ester stated she had a lot of concerns that she would like to address but didn't know if they had time today. Steve told her to go ahead so she started in with C1 and talked about check signing. She stated that this needs to be looked at again. She proceeded to C4 regarding the tax deposit. She wanted to know what would happen if they were late with that deposit. She thinks this also needs to be looked at again. Moving on to C9 and said this also has to be looked at again. Looking at F1 she said it was impossible to do a PSA (public service announcement) in Elko. She stated that all the radio stations there said you can pay for an ad, but no – they don't have to do PSA's for you. More conversation ensued and people noted that a PSA can be on the radio, flyers and other methods of informing.

Someone else had a question for Michelle that isn't the purpose of this to get rid of the duplication? (Michelle said yes.) So...we're not actually asking to change anything other than just not have it be duplicative between the reviews. He said he actually liked it.

Ester continued on with her concerns about F2. After that she asked if they were going to table it or if they needed her vote, or what they wanted to do. Frank moved to accept as presented and Debra Reed seconded. All voted to pass the motion except Ester. The motion passes and Steve thanks Frank and Debra.

#9 – Update, Input and Recommendations Regarding NAC 458 Rule Revision

Michelle presented this (*and again it was hard to hear her*). She said she hasn't had any response back and asked Kevin if he had. Kevin said just up until about a month ago I was getting regular calls from Ann Iverson, one of the attorneys at LCB. She was asking for clarification. So I need to follow up with a phone call to her and see where it is because we need to start doing public hearings fairly soon. If we wait too long then it won't get done. So my next step is to do that. Steve asked if there was anything they needed to do on this agenda item, and Kevin said no, just to know there will be public hearings and we will keep you posted.

#10 – Discussion and Recommendations Regarding Telehealth Services Certification for Providers

Michelle presented this as well. (*and again it was hard to hear her*) She only spoke a few seconds saying something about it being incorporated into agenda #9, and Steve moved on to the next agenda item.

#11 – Update, Discussion, and Recommendations Regarding the Nevada Peer Support

Dave Caloiaro was to present this today but couldn't be here. So Steve said he knows they have assembled and met a Peer Planning Council and that has met once under the leadership of Daniel Fred from UNR. Otherwise we'll table that item we'll move on to the next item.

#12 – Discussion on Legislative Session

Steve and Kevin are presenters on this. Steve said he didn't have anything other than the moves that we're making on the Board of Examiners but that's not part of this group. Kevin just wanted to remind the group that once the Governor's budget is submitted (it's submitted from the Division, to the Dept of HHS, to the Governor) then we don't have any say over it any longer. So I cease to have an official opinion about anything in the budget. So I encourage you that once it's published that as providers and as a group that you become familiar with that budget and figure out how you want to advocate if at all. I mentioned earlier that there are no really big bills that I know of, but I encourage you to watch the headlines and the articles that come out on prescription drug issues. Someone spoke up and said that he was having the same issues with Medicare clients as with Medicaid clients, and he is having to turn seniors away for services who are on Medicare because SAPTA won't pay and Medicaid won't pay. So that's something else we may have to look at with the Legislature. Kevin stated that is something else that will have to be looked in to. Kendra looked up on her phone and saw that there is Medicare coverage for treatment of alcoholism and drug abuse. Kevin asked who and where that would be? Someone said you have to be a Psychologist or LCSW to be a provider with Medicare.

#13 – Review Possible Agenda Items for Next SAPTA Advisory Board Meeting

Kevin suggested that Prevention or Prevention Coalitions add their thoughts to this meeting's discussions. Everyone agreed to have the next meeting Oct 22nd.

- More discussion on the Sliding Fee Scale and Policy
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#14 – Public Comment

Barry Lovgren spoke up about the monitor form saying the form completely misses the point. That the point of the monitor form is to assess for compliance with conditions for receiving sub-grant money. He said the monitor form has not been revised to reflect the changes as to what is required for a sub-grant award so it doesn't assess for that. He said you need to list the requirements for getting the sub-grant award and then develop the monitor around that.

#15 – Adjourn

Steve adjourned the meeting without a vote as there was no quorum left.