BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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MICHAEL J. WILLDEN
Director

LAURIE SQUARTSOFF
Administrator

Division of Health Care Financing and Policy
Notice of meeting to solicit public comments and intent to act
Upon Amendments to the Medicaid Services Manual (MSM)

Public Hearing January 9, 2014
Minutes

Date and Time of Meeting:	January 9, 2014 at 9:16 am
Name of Organization:	State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Nevada State Legislature Building 401 So. Carson Street Room 2134 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue Suite 4406 Las Vegas, Nevada 89101

Attendees

In Carson City, NV

Brian Baker, Value Options
Jenny Brenn, HBI
Joseph Haas, Washoe County Soc. Serv.
Erica Young, Pride House, LLC
Vicki McVeigh, Pride House, LLC
Melinda Matus, TYFS
Sarah Ramirez, HPES
Kim Telxeira, HPES
Tracy Palmer, DHCFP
Chris Empey, WCDSS
Amanda Perkins, DWSS
Jeanne Marsh, WCDSS
Ruth Condrey, DPBH
Stephanie Woodard, DBPH
Inna Botcharow, SAPTA
Genevieve Ramos, Serenity Mental Health
Joanna Jacob, Ferrari Public Affairs
Denise Everett, Quest Counseling
Susan Lippmann, TYFS
Jeanice Moore, Pride House, LLC
Tommy Gardner, Yunique Counseling
Ken Retteruth, Washoe County Soc. Serv.
A. Piceirilli, HPES
Marcia Warne, Com Counseling
Jenni Bonk, DHCFP
Sharon Willans, A Childs World
Iuette Munoz, DWSS
Alice LeDesma, WCDSS
Sandy Arguello, Koinonia
Janice Maddox, FCS
Amanda Nielsen, Vestige Project
Jon Sasser, WLS

In Carson City, NV Continued

Elizabeth Aiello, DHCFP
Mari Hutchinson, Step 2
Kenneth Arnold, Sankofa Providers
Jasmine Troop, West Care
Alexis Ulrich, DHCFP
Leah Lamborn, DHCFP
Suzanne Thompson, BFR
Ian Curley, RNC
Kevin Schiller, Washoe County
Marta Stagliano, DHCFP
Laurie Squartsoff, DHCFP
Stuart Gordon, FCS
Nedra Daugherty, HPES
Yuni Gardner, Yunique Counseling
Victoria Hare, Sankofa Providers
Jon Ray, Mountain Circle
Theresa Carsten, DHCFP
Theresa Rooker, DHCFP
Tammra Pearce, BFR
Judy Kroshus, Pyramid Lake Tribal Health Center
Mary Wherry, PBH
Darrell Faircloth, DAG
Brandi Johnson, PBH

In Las Vegas, NV

Daniel Ficacoka, Heads Up Guidance & Wellness Center
Gennette Herren, Community Counseling Center
Bailey Mattison, Empowerment Health
Dave Doyle, Eagle Quest
Michelle Agnew, HPN/BHO
Heather Bailey, Maple Star
Edylynn Quijano, Eagle Quest
Karlene Ulibarri, Bountiful
Robert Sandoval, Seeds 2 Succeed
Erin Kinard, West Care
Mark Wilson, Mojave
Kathy Holliday, Lift Inc. Restoration Hospice
Carl Pietrini
Barbara de Castro, NYCP Majestic
Josru Coello
Leticia Murphy
Jason Sanduav
Faye Kelly, Hope Counseling
Michael Adams
Jeremy Setters
Jon Watase, Quality Independent Care
Tiffani Hart, HPES
Andre Bailey, NVBHA
Alan Flagg, Harmony
Claudia Lopez
Viki Kinnikin, Mojave
Colleen O'Callaghan-Miele, Heads Up Guidance & Wellness
Kirby Burgess, A Brighter Day
Karen Walker, Steppin Out Family Services
Kay Velardo, Community Counseling Center
Jessica Cisneros, Olive Crest
Kurt Gunther, Solutions Recovery
Maria Cid, HBI
N. Kennedy, Mojave
Anis Abi-Karam, HBI
Yolanda Correa, BCA
David Tran, Beach Therapy
Melissa Maj, Maple Star
Ken Lange, Nevada Youth Care Providers
Gabriel Lither, Attorney General
Lisa Solby, Stepping Stones
Sandra Jones, Heads Up
Janice Wolf, Esq.
Leslie LaCombe
Jean Recomanta, Quality Independent Care
Geri Harz
James Raffec
Melinda Wiafe, Hope Counseling
Riley Kline, Bilingual Behavioral Services
Frank Parenti, Nevada AADAPJS
Kerri Korin, NYCP, Kids Peace
Hasani Jackson-Carroll, HPES
Monique Harris
Stan Jennings, Heads Up
Mary Jo Gill, Desert Rose Counseling
Ron Lawrence, Community Counseling
Blanca McCall, Desert Rose Counseling
Linda Austin, Steppin Out Family Services
Janise Holmes, Gov. CHA
Keith Beagle, HBI
Dana Hauger

LeAnzar Stuckby Elaine Nilso
Anthony Snowden

Introduction:

Ms. Marta Stagliano, Chief of Program Integrity, Division of Health Care Financing and Policy (DHCFP), opened the Public Hearing introducing herself, Ms. Laurie Squartsoff, Senior Deputy Attorney General (DAG) Darrell Faircloth.

Ms. Stagliano – The notice for this public hearing was published on December 9, 2013 in accordance with the Nevada Revised Statute 422.2369.

1. Discussion and Proposed Adoption of Substance Abuse Agencies Model (SAAM)

Ms. Coleen Lawrence:

Revisions to Medicaid Services Manual (MSM) Chapter 400 are proposed to enhance the Substance Abuse Services policy and to expand provider qualifications to cover entities that are licensed and funded by the Division of Public and Behavioral Health under Nevada Administrative Code (NAC) 458.103. In addition, utilization management criteria for outpatient substance abuse services is proposed to be changed to utilize the American Society of Addiction Medicine (ASAM) Patient Placement level of care criteria. Policy updates are proposed to revise the quality improvement language and provider enrollment qualifications to require compliance with certification requirements under the Division of Public and Behavioral Health. Furthermore, policies have been modified to reflect updated philosophies of substance abuse as supported by Substance Abuse and Mental Health Services Administration (SAMHSA). Revisions were made to delete the notification process for basic skills training and to add the requirement for authorization for all basic skills training services. Policy language has been included, which will require basic skills training to be reasonable and necessary. Service limitations for basic skills training will be modified to a two hour maximum per day for all levels of care.

The effective date is January 10, 2014.

At the conclusion of Ms. Lawrence's presentation, Ms. Stagliano asked Ms. Squartsoff, Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Squartsoff's Comments:

Ms. Squartsoff placed the letter received from Nevada Youth Care Providers (NYCP) dated January 2, 2014 on record. (See Attached)

Ms. Squartsoff thanked all who have taken the time to participate in this public hearing and the workshop regarding this policy change. Policy change for Medicaid come with thoughtful deliberation, careful conversation with the providers and it takes all to engage in the conversation to look toward improvements. Not only in health care delivery but how those resources are available in the community. This is a conversation expected to go all the way through to the legislative session. Many people are actively involved and policies can often be refined. The DHCFP will continue to work with sister agencies and county partners. The DHCFP will continue the review process, working with HPES, who is

the fiscal agent, to address the reviewers and how many will be taking care of the prior authorizations. They are working to make sure the requests coming into the system will be responded to in a timely manner. Should there be any difficulties, there is a process to follow to contact HPES and ensure prior authorizations are in process. There is an appeal process already established if a review is done and there is a dispute about the decision. It is expected that if a denial or prior authorizations comes in and is asking for additional information, the information needs to be provided in a timely manner. If there is a gap in the information being requested, provide it so the reviewers have a thorough case so they can make the decisions. The DHCFP is working on policies for Medicaid beneficiaries; however, the tone of this conversation also includes the fact that there are services needed not just for Medicaid beneficiaries. The ongoing participation in those discussions are very helpful as plans are being put into place and budget issues are being discussed. The DHCFP hopes having the public workshops gives everyone an opportunity to share their concerns. People are participating in the process and today's meeting is an ongoing expression of the fact everyone is interested in the concerns and ensuring the programs meet the community's needs.

Mr. Faircloth's Comments:

- No Comments

Public Comments:

- Ms. Janice Maddox asked if for the Level of Care (LOC) they are using the ASAM and not the LOCUS.

  Ms. Lawrence responded the ASAM will be utilized for substance abuse and the DHCFP has not changed policy regarding the LOCUS and the CASII for the behavioral health. When the utilization management criteria comes in they will use both policies.

- Dr. Yuni Gardner commented in 2010 when the rates for the Basic Skills Training (BST) were reduced from four units to two, there was an increase in the budget for BST services. Northern Nevada Adult Mental Health Services (NNAMHS) mandated the providers in Nevada had to do prior authorizations for BST services. NNAMHS was originally doing prior authorizations. A repercussion for allowing this medical review of BST is there will be a financial impact.

- Ms. Vicki McVeigh concurred with Dr. Gardner and commented they have been having trouble securing housing for recipients with mental disabilities due to the stigma attached to their disease. The services being cut will only make things more difficult because they have to keep staff there to provide services. In the past landlords have asked them to leave because if there is not anyone there to provide services; the recipients wander into the streets or call 911 and that is unwelcome in most residential communities. The BST services provided enables someone to always be there even if they are not working with that particular person.

- Dr. Gardner commented they understand BSTs are not being reimbursed for the support hours. The cost of BST services for two hours for one recipient is $72.00 a day versus if they were not receiving services. If they are inpatient hospitalized; Nevada Medicaid reimburses $460.00 a day. The state of Nevada has no long-term care facilities for the Seriously Mentally Ill (SMI) recipients in this state. NNAMHS is Nevada's acute care facility for Medicaid patients. Usually the recipient may stay for one day then they are discharged. If they do not have a group home to go to, no BST services to provide for them or a provider to help them, they are either homeless, incarcerated, or back in the Emergency Room (ER). The ER costs approximately $1200.00 a

visit, versus $72.00 a day if they had BST services for recipients. The medical review portion is concerning. Once it goes to medical review or prior authorization requests, they are not being approved. A doctor does the medical review and have no idea who the recipients are in Nevada's communities and are denying as does not meet criteria. This is frustrating for clinicians as they go through the verbiage of the Medicaid Manual for the definition of medical necessity. When a peer review with medical review personnel is requested, they say it does not meet criteria, they need other least restrictive services. NNAMHS has a back log of psycho psychologists and counselors. There is no individual therapy for all the recipients in Reno specifically. What will be the cost of hiring more medical reviewers? There are a lot of factors that maybe were not taken into consideration. Are there any clinicians or professionals on the DHCFP's board that know and work with mental health recipients that have submitted their opinion on this policy?

- Ms. Lawrence responded there are several board certified psychiatrists that have assisted with the policy. She clarified the definition of medical necessity is found in MSM Chapter 100. BST cannot be utilized for convenience of care takers. The definition of BST is also in the policy. The policy is not changing. Sometimes the recipients do not fit under the definition of BST and the service cannot be utilized in a mechanism that is not appropriate. They have to look at the system and different funding sources. If the services are not available within the community, it is not appropriate to make it fit under BST. She clarified the physicians are Nevada based.

- Dr. Gardner commented most of the BST services provided have helped stabilize the recipients. To take this away from the recipients is basically penalizing them for not getting better. Some of the criteria proposed states they have to make expectations that the recipients condition will improve significantly. Who is to say they have not improved and they are stable? Is the service to be taken away because they are doing well? Then they do not do well and go back to the hospital as an inpatient. Once they are stable the danger is removing the service, then they become unstable. It is harder to re-stabilize because they do not take their medication, or make appointments without a staff support persons assistance. This will affect the financial bottom line because the recipients will be hospitalized more frequently.

- Ms. Kerri Korin commented she opposes the proposed amendments to the MSM. Specifically, the change which deletes the notification process for BST. The BST notification process was implemented to fund specialized foster care after the decision was made to unfund at the rate structure for specialized foster care in 2007. At the time it was a temporary measure until an alternative funding structure could be developed. The necessary discussions on how to fund this critical service never occurred between Medicaid, DCFS, Clark County and Washoe County. Up until this point the use of BST funds and the notification process has been the choice of the State to fund specialized foster care. By removing the notification process an integral and significant foundation providing the service is threatened. Implementing the proposed change prior to developing a funding structure for specialized foster care may have a very detrimental impact on over 400 children who receive this service. Without a stable funding structure for specialized foster care, the organizations that are contracted to provide the services will not be able to maintain operations and the children they serve may face placement disruption and loss of continuity which is essential for healing and wellbeing. She is concerned the plan to change the first two hours of BST from notification only, to requiring medical necessity and time limiting the service is being fast tracked and has not allowed for the need of discussion about funding to occur prior to implementation. As the public hearing is being held today and the date for implementation is tomorrow, it appears Medicaid is not planning to consider any of the testimony being presented today. Many of the children currently receiving BST services have been doing so for six months or more. The trauma the children in specialized foster care have

endured can manifest multiple times over the lifetime of the child and the need for BST is continual as children grow through multiple developmental stages and begin to process and heal from their trauma. Placing an arbitrary and capricious time limit on needed services does not truly represent the best interest of the children or the State. She believes children and youth in specialized foster care constitute a special class entitled to a broad latitude in the determination of medical necessity and Medicaid should maintain the notification process for this unique population. If the funding provided by BST services is not replaced immediately most of the member agencies have reported they will not be able to provide specialized foster care or support their foster care divisions. This would have a negative fiscal impact on the State if specialized foster care agencies are not able to continue to operate leading to a loss of employment and more importantly children and youth needing to go into more costly residential treatment or out-of-state for treatment. When that happens, the agencies will need to provide notice to remove the children in their care to the respective child welfare agencies. They do not want to be in a position which forces this because it will add to the trauma and loss the child has experienced. NYCP is asking the implementation of the proposed changes be postponed until an alternative funding mechanism for specialized foster care is in place.

- Ms. Janice Wolf commented the Childrens Attorneys Project represents abused and neglected children in the foster care system. They support the proposed changes to the authorization process for BST services because it puts the emphasis where it should be, on the needs of the children and not on the demands and pocket books of the agency providers. In February 2012, they wrote a letter to the state and county outlining critical abuses in the mental health delivery system for children including, but not limited to, overuse and inappropriate use of psychotropic medications, children bouncing back and forth from facility to facility and home to home, and inappropriate use of PSR and BST services. These services seem to be motivated more by billing and less by desire to improve the childrens lives. These services indeed can be important to some children; however, there is no doubt that in too many cases these services are being provided to enrich the agencies, as agencies will pay the foster parents or the workers $15.00 per hour and bill Medicaid $75.00 per hour. Most providers require children to accept these services as a condition for placement and some force the children to have these services every day regardless of whether they need or want them. The children want what all children want, normalcy. They want to play sports, hang with friends, join scout troops, but they cannot because they are told they need services. If the children try to refuse services, they are told they will lose their home. Despite all of the BST and PSR services being provided as of today, placements still disrupt at rates that are considered alarming and for reasons that are alarming. When placements disrupt, services disrupt. When a child moves from one agency provider to another the child is forced to start all over again with a new BST and new PSR workers employed by the new agency. How is this in the child's best interest? The bottom line is an agency should never build services into their bottom line. Services should be given only to children who really need them. $71 million dollars is being spent by the state, much of it for no appreciable benefit. These funds should be redirected to help meet childrens needs more effectively.

- Mr. Kevin Schiller commented the change is occurring in the context of a large picture which involves adults, children and many recipients receiving those services. As most people know, the treatment level system that supports child welfare children in need of those services is broken. One of the issues dealt with significantly over the past four years is funding of the system. Looking toward the upcoming session, this is becoming an unfunded mandate to the county. The reality is as these reductions occur, children have nowhere to be placed, they end up being placed in facilities which are non-Medicaid eligible. They need to bridge this gap, look at child welfare children specifically in terms of those treatment needs. There needs to be focus on those

outcomes and doing what is best for them. One of the key components for the upcoming session is they did not get funded in the block grant to take on childrens' mental health specific to therapeutic foster care. He requested the word therapeutic foster care be removed and call it mental health support for children in care. While he supports the medical model and where the DHCFP is moving, his focus is more on how they are going to support child welfare children so they meet their outcomes? At the end of the day those outcomes are what they are accountable to and ultimately that is what is best for the children. Providers are already contacting them and indicating they are giving notice on children that have been in facilities for over nine months. Those children will go into shelter care, they are losing their stability. It is a vicious cycle. The secondary piece is how they are going to meet the needs of these children and how do they start looking to get funding as an agency to support this.

- Dr. Joseph Haas commented in addition to finding cases where care may not be supported, goals may not be appropriate or medical necessity may not be justified, there will be many cases with credible disagreements between the medical professionals on the providers' side and the reviewers. This is possible, given there are no clear published standards for what is medical necessity for rehab that is shared between the two groups or how long care should persist. He is worried if providers take a stance, and someone has been in care for six months they automatically will be denied. There could be fallout if the reviewers interpret too strictly and they may in fact see a large portion of kids who are declined services, kids who have been receiving care for a long time. If that does come to fruition, he asks the DHCFP to look at the appeal process and streamline it so providers do not put themselves in fiscal risk and avoid the appeals process because it puts them at risk of losing revenue they cannot recount and then they move towards discharging youth early. Nevada does not provide habilitative care for its most seriously challenged youth, and the fact that the number remains constant means they have probably reached the tipping point. If they do not provide that LOC and they enact these changes, they will create for some kids the rollercoaster effect where they reach as good as they can get but that is still quite clinically impaired. They are disrupted and discharged into a lesser situation of care with new people who they do not know. They then get into clinical crisis and rebound to a level of intensity that is well beyond where they were originally, requiring Residential Treatment Centers (RTC) or acute hospitals. He believes it is highly possible for there to be a resurgence of applications of RTC care, arrests and incarceration if those kids are denied placement hospitalization, and habilitative care for these kids who live at a clinical level that still requires significant reports and are likely to do so for the rest of their lives.

- Mr. Chris Empey commented Washoe County is a smaller system. Two of their 13 providers solely bill for BST services in providing placement to specialized foster care. He concurred with Dr. Haas's comments. He commented specifically on the pilot program, although currently underfunded, they are starting to see some promising results. They are seeing greater stability of the kids using a stable set funding that has resulted in reunification as well as placement with relatives through the ICPC placement process.

- Ms. Lisa Solby concurred with everyone who spoke against the deletion of the notification process for BST. The proposed changes will affect more than 400 children presently in foster care. BST not only helps children by providing services, it also helps the parents of these children by providing them with parenting skills training. By providing these services to families many have been able to preserve the family unit, thus avoiding placement in foster care which is more costly. It is important to treat children when they are children. If they do not treat them when they are young, they will end up in the system one way or another and more than likely for a much longer period of time. The adults she has seen in the program have all suffered trauma as

a child that was not addressed until later in life. They all turned to drugs and alcohol, and have chronic medical conditions that need monitoring. They are in and out of the hospital for medical and psychiatric reasons which is very costly. There has been a large increase in the number of agencies providing services, and people with a degree and little experience are able to open an agency. She asked that rather than restricting services to children and families who really need them, look at who is providing these services. Consider requiring a license to own and operate an outpatient mental health agency and provide more oversight. Not only will this reduce fraud and shoddy services, it will give those who are providing good service credibility so they are not lumped in with agencies committing fraud. In regard to the six months maximum for the BST, mental health service is not a one size fits all. The six month maximum is not fair to those who need more time. Standards should never be that everyone gets the same; it should be everyone gets what they need.

- Mr. Ron Lawrence commented the Substance Abuse Prevention and Treatment Agencies (SAPTA) funded in the state are at about 65% usage half way through the grant cycle. He asked for as much expediency as possible in the flow of these funds. If not, most of them were defunded approximately $350,000. They will never make services through this particular funding cycle. He requested they all work together to very expediently get substance abusers into services when they come to apply for services. This is one of the most different orientations as far as diagnosis is concerned. These clients have the potential to become drunk drivers or hit the person in front of them with their car and create a paraplegic. It is absolutely tantamount that these people get into treatment as soon as possible. Some of the concepts of the National Institute of Drug Abuse talks about the expediency of getting people into treatment and he is sure they will develop a methodology to work together to accomplish this amazing feat.

- Ms. Genevieve Ramos commented there are costs of doing business. They have locations where they have to pay rent, light bills, case managers, take time to do peer-to-peers and Payment Authorization Requests (PARs), writing supplies, paper and phone services. Instead of downplaying the amount they pay their workers, what about the training they get? She wishes they could pay workers more but with the cost of doing business it becomes more difficult. When the new change is implemented they face the possibilities of extending the cost of doing business because they are going to spend more time completing peer-to-peers, reconsiderations, out of the pockets of the case managers which are not billable services of which they still have to pay them their hourly wage. Additionally, if BST services go down to two hours it will be difficult to get workers to a person in the rural areas. If they are only able to provide two hours of services, then they can only be paid two hours worth of services because travel time is not a billable service. In addition, agencies like mine work with Division of Child and Family Services (DCFS) and DFS in Las Vegas to attempt to keep children out of foster care. Part of that is the parental training and other BST services to assist children in the home with behavior modification so they do not have to go into the foster care system. If those services are cut to a six month period they have the potential for helping for six months and then they are right back in the same situation again. To assist in decreasing the fraud, the fraud department should be more active. There have been several agencies within the last year where there were press releases talking about five years worth of fraud, a million dollars worth of fraud. She requested the DHCFP reconsider implementing this tomorrow, and take into consideration the things many have said and come up with a different program if BST is going to be cut.

- Ms. Lawrence clarified at six months there is not a cut in services for BST. BST is under the rehab design, the State Plan authority, and for it to be a rehabilitative model there has to be a demonstration of progress. There have to be measurable goals for this to occur, and on the

DHCFP documentation there has to be measurable goals. It is a rehab model not a habilitative model. There has to be a point where the DHCFP sees in the documentation, prior authorizations for example, if it exceeds the two hours and it comes to the prior authorization model what the DHCFP sees is services have languished for an exorbitant amount of time and the services are no longer rehabilitative. The recipient cannot rehab consistently for such a long period. The DHCFP added in a six month check point, not a six month termination. To help clarify, the DHCFP took the language from Medicare. The DHCFP took the policy language to help for people utilizing the Medicare policy to be consistent. The DHCFP is under a rehab model for all of the behavioral health services not habilitative. The DHCFP is under what is called a therapeutic design. Anyone who has a rehab service must also be complementing it with outpatient services. Agencies cannot solely be giving rehab services to recipients. Their care plan must be a comprehensive plan. The policy, since its inception in 2006 has had therapeutic design. Therapeutic design states the main services are adjunct, enhancing intervention design to compliment more intensive mental health therapies and interventions. It is a rehab and an outpatient services model. At six months of delivering services, the services must still be reasonable and necessary. In any medical model if the care plan is not working then changes are made. This is what the DHCFP requires; however, first it must be reasonable under the acceptable standard of practice. Then, if the goals are not being met, reevaluate the plan, the goals and objectives. The documentation must go back to the DHCFP's original policy. Document that the facility is doing the therapeutic design. This is what is lacking. The documentation is showing only BST. The DHCFP is not seeing fraud as much as policy not being incorporated. The prior authorizations are not being approved because the therapeutic design is not being done. If at six months the client is not improving, maybe it is because the facility is doing rehab and not incorporating outpatient services. Non-covered services are non-covered and there is a point where the DHCFP has to say that. At six months, reevaluate the plan, document the services and document the therapeutic design. It must be part of a best practice or best standard out there.

- Ms. Sandy Arguello commented there was some previous testimony in regard to billing at $75.00 an hour. There is not a rehab service that bills at $75.00 an hour. She clarified it is $72.72 for two hours. The recipients placed in therapeutic homes are not something providers just come up with. They work with placing agencies, Washoe County, DCFS, a parental placement even goes through the DCFS team and Clark County as well. There are clinical people who have already determined this as an appropriate placement. Then it is the agencies job to see if there is an appropriate placement in the agency. At some level, there is this idea that providers just magically come up with children, place children, provide services; however, there are clinical teams at the placing agencies as well. There has been testimony about what will happen in the next legislative session regarding another funding stream. They have known for years they need another funding stream. NYCP did a great job on testifying to this. Placements really are in jeopardy because providers will not be able to stay in business.

- Mr. Jeremy Setters concurs with Ms. Wolf's statements. He has witnessed youth who are in foster care who had no placement in a regular standard foster home be sent to a treatment level home and without even meeting the youth, automatically requesting BST and PSR services. That is at the expense of the youth. These are children; they should live like children. How are they going to have after school activities if for two or three years, they have to see a worker two, three, or five hours a day, five days a week? There needs to be something in place. He supports the new policy.
- Ms. Korin commented it seems people think children come into specialized foster care and providers automatically try to bill Medicaid as much as possible. The providers are contractually

obligated to submit a PAR on any child who comes into specialized foster care within 30 days of placement. They are required to approve PAR for BST to maintain the placement of the child.

- Dr. Gardner asked with this change if the two hours are mandated to be medically reviewed, and what date are the new policies going into effect. Are these opinions even going to matter?

- Ms. Squartsoff thanked Dr. Gardner for the comments. The public notice for this policy decision indicates this is the public hearing and the anticipated effective date is tomorrow.

- Mr. Anthony Snowden commented he came here expecting information to take back to the agencies and the respective provider community. If the DHCFP really had a good faith effort to make sure that everyone involved in the process actually had a chance to participate in the process they would have made it a little easier for people to come, provide testimony and get information. The medical review people who have decided they want to make this policy change and it is devoid of any other type of comments, concerns, solicitation of additional information for the people out there in the field. The fact is there are some gaps in the Medicaid policy. Nevada Medicaid has done a poor job in ensuring the state of Nevada is taken care of. There is talk about the exponential costs and growth of all behavioral health agencies that has now come to play. On a national level in terms of Medicaid spending, Nevada does a very poor job of protecting the people. They want the services to be provided in the least restrictive environment possible in the community. If these people are eradicated in the community, then what happens to those who desperately need services? The short sightedness of this implementation tomorrow needs to be discussed on a much broader level. He asked they postpone this, and go back and make sure the I's are dotted and the T's are crossed. At some point, they need to take care of the people in the community. A lot of people that come to behavioral health come from the lowest rungs of society and maybe the DHCFP needs to look at ways that all can work on some of these differences together. Someone from the county talked about the burden of the fiscal responsibility and the finances are going to be passed over to them. The best thing to do now is to look at and review some of the policies they are trying to implement today and say is this really going to be beneficial to the citizens of Nevada or to just the talking heads or the higher ups in the Medicaid that's making policy.

- Ms. Stagliano thanked Mr. Snowden. She clarified that the DHCFP held a public workshop regarding this. She clarified the DHCFP gives advance notice for public workshops. The notification is sent to the distribution list and through the normal processes to ensure the DHCFP receives public comment. It is important the DHCFP receives public comment so these decisions are thought out, and when the time comes to make them, they are not easy; however, sometimes they are necessary.

- Ms. Lawrence responded the workshop was held on November 20, 2013. They had providers in attendance and took public comment in regard to this policy change.

- Mr. Ian Curley commented he was forced to employ a physician to get accepted by Medicaid and he is not quite sure what to do with him. The physicians in rural areas have really limited experience with substance abuse and mental health. He is attempting to get the counselors to think in terms of medical necessity. The wording is important. The group he believes to be very helpful to Medicaid is Virtual Private Networks (VPNs). They have prescription writing ability when they are qualified. He would like them included as professional neutral, to be able to take the role on as a physician or an Advanced Practitioner of Nursing (APN). The rural area is in a medical crisis, so if the doctor they have leaves, how does he fill that? The South Lyon Medical

Center is down to one physician, so APNs are going to be very important in the health care delivery for Medicaid clients. They can do the health and wellness, medication reviews and prescribe when needed. They are going to be such a useful entity and the DHCFP should not avoid including and bringing them onboard. The Governor has put together a committee to see how the law is being implemented across the state. He is very supportive of utilization of VPNs for primary care under their scope of work. Medicaid has an opportunity here to do this and he would like to see it happen.

- Ms. Lawrence responded the part being discussed is when they were originally a Provider Type 14 in the medical directors' side of it. As far as the physician right now, they have an individual billing under Provider Type 17, so the Provider Type 20 fee schedule is available. It is independent, so they have full access to make sure there is not any access to care issues.

Ms. Stagliano – Recommended the Administrator approve as amended.

Ms. Squartsoff – Approved as amended.

Ms. Stagliano – Closed the Public Hearing for the Discussion and Proposed Adoption of MSM Chapter 400.

2. General Public Comments

- Ms. Denise Everett commented the DHCFP has contradicted themselves. On the following service, on page eight, Attachment B, the Opioid Treatment Programs service is covered. In regard to non-covered services, there should not have been any changes to maintenance treatment because they are not covering counseling services for opioid maintenance programs. It should have stayed the same.

- Ms. Maddox commented someone mentioned their interpretation of the LOCUS versus ASAM, if someone has a co-occurring disorder, even if its substance abuse treatment, that it is still both the LOCUS and the ASAM. She wanted to clarify under the SAM services, is it ASAM for all LOC even if they have a co-occurring disorder if the primary treatment is substance abuse?

- Ms. Lawrence responded they are to use the ASAM for substance abuse; however, if there is behavioral health they will need a LOCUS. That is why behavioral health is in there also.

- Ms. Maddox asked if they will still fill out both.

- Ms. Lawrence responded yes, the DHCFP does not pay for the counseling services under the OMT program itself. The DHCFP is clarifying in the language cleanup whether it was OMT or OTP. The ASAM, in their latest addition changed the acronym. Nevada Medicaid does not pay for or reimburse counseling services in an opioid program. They continue to not pay for counseling services. The DHCFP only pays for the pharmaceutical in the program. This is correct, the DHCFP still does not pay for the counseling services.

- Ms. Ramos requested an additional service be created or service limits be extended for services in rural communities from agencies based out of the major cities. Providers are finding it more difficult to get services and individuals out to the rural communities.
- Dr. Gardner commented one of the requirements is they have an MD as a medical review for Provider Type 14. She requested if they have a PHD as well, they would be able to be their own

director. If they only do counseling for Provider Type 14 services for behavioral health they would also be able to act as director versus having a medical director if they do not prescribe medication.

- Ms. Stagliano thanked all for their comments.

3. Adjournment

There were no further comments and Ms. Stagliano adjourned the public hearing at 10:55 am.

An Audio (CD) version of this meeting is available through the DHCFP Administration office for a fee. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Rita Mackie at rmackie@dhcfp.nv.gov or you may call (775) 684-3681.