From: Barry Lovgren [mailto:barrylovgren@yahoo.com]
Sent: Tuesday, June 05, 2012 12:15 PM
To: Mastroluca, April Assemblywoman; Carlton, Maggie Assemblywoman; Hardy, Cresent Assemblyman; Wiener, Valerie Senator; Breeden, Shirley A. Senator; Hardy, Joe Senator
Cc: lesleyru@aol.com; Director
Subject: Testimony I'll be giving at Health Care Committee on June 12: Support Documents

The attachments are documents I will be referring to in testimony before the Committee on June 12. My testimony will be brief, and will make more sense if you've read these documents. If you only have time to read one, I recommend "Treatment Criteria", because it describes not only that issue but the more important problem of how SAPTA and MHDS deal with issues.

"Treatment Criteria" is a May 14 letter to Richard Whitley, Acting MHDS Administrator, about how SAPTA had certified some programs as being in compliance with Division Criteria that did not exist, and continues to certify programs as being in compliance with Division Criteria for specialty treatment for co-occurring disorders that still does not exist and continues to unlawfully fund this based upon this unlawful certification.

"Statutory Alignment" is a May 3 letter to Mike Willden, DHHS Director, about SAPTA's failure to carry out the responsibility assigned to it in the plan approved by the Legislature and the Governor for its transfer from the Health Division to MHDS. SAPTA was to have developed a legislative agenda for the 2007 session to align the NRS with this transfer, but didn't do it and still hasn't. As a consequence, the MHDS Commission has no statutory authority over SAPTA beyond responsibility for services for co-occurring disorders that were assigned to it at the 2009 Session, and there are no Evaluation Centers or treatment programs to which a court can lawfully assign a defendant under the DUI statutes. Since that letter was written, the Health Division has granted my petition that it start the process for adopting regulations to provide for Evaluation Centers until statutory alignment can be attained at the 2013 Session.

"Treatment Costs" is a May 1 report to the Prenatal Access to Care Workgroup of the Statewide Maternal and Child Health Coalition. It describes how SAPTA prohibits treatment programs from complying with its subgrant requirement that they bill on a Sliding Fee Scale based on 400% of the Federal Poverty Level (FPL) and generally doesn't regulate collection practices. SAPTA requires the programs to use the SAPTA Sliding Fee Scale which penalizes families with increasing severity as family size increases, There are inexplicably two different SAPTA Sliding Fee Scales, one disqualifying a member of a household of 8 if family income exceeds 98% of the FPL, the other if it exceeds 133%. Such a person is poor enough to qualify for Medicaid, but not for SAPTA-funded treatment, and Medicaid generally doesn't pay for substance abuse treatment.

"Washoe County Jail CPC" is a November 22, 2011, letter to the authorities about how SAPTA certifies and funds a Civil Protective Custody program at the Washoe County jail that can't be lawfully used. The Washoe County District Attorney's Office subsequently contacted me to say that they don't quite know what to do about this, but that the law in fact does require that public inebriates be taken elsewhere.

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May 14, 2012

Richard Whitley, Acting Administrator, Division of Mental
Health and Developmental Services (MHDS)
Nevada Health Division
4150 Technology Way, Third Floor
Carson City, NV 89706

Dear Mr. Whitley:

This is in response to the May 4 letter from Jane Gruner, MHDS Deputy Administrator, regarding the Division Criteria for Programs Treating Substance Related Disorders. While its focus upon denying problems instead of resolving them is troubling, I'm pleased that some problems with the Criteria are acknowledged, and that it's now clear how even those problems that have yet to be acknowledged can be resolved. When the problem with there being no Division Criteria for programs providing specialized treatment for Co-Occurring Disorders (COD's) is resolved, the Substance Abuse Prevention and Treatment Agency (SAPTA) will no longer necessarily be unlawfully certifying and funding these programs in violation of its own regulations.

The issue is whether SAPTA certifies and funds treatment programs in accordance with Division Criteria. These Criteria are MHDS policy establishing quality-assurance standards for substance-abuse programs. If a program meets these standards, it can be lawfully certified by SAPTA, providing assurance to consumers that the program meets State standards for program quality. One of those consumers is the State itself: Only SAPTA-certified programs can lawfully receive funding administered by SAPTA.

The laws to be observed are in both regulation and statute. NAC 458.118 requires that SAPTA certify and fund programs according to Division Criteria, and establishes that the Criteria can be amended by the Administrator upon recommendation of the SAPTA Advisory Board after the Board has approved the revision in an open meeting. NRS 433.314(2) mandates that the MHDS Commission "Set policies for the care and treatment provided for persons with… co-occurring disorders".

The importance of the Criteria is reflected in their being the sole MHDS policy for which regulation explicitly requires greater transparency in government than is the norm with revision of agency policies, requiring opportunity for public comment at an open meeting of the SAPTA Advisory Board prior to adoption of a revision of the Criteria.

I'm pleased that the letter says that the transparency of SAPTA is being enhanced. Since October 2011, to determine the extent to which SAPTA had issued unlawful certification

and funding to treatment programs, I had repeatedly submitted public record requests for the Criteria in effect prior to adoption of the November 2011 revision. What became the November 2011 revision had been posted in October in the online SAPTA Administrative Manual as current Division Criteria. Shortly after I then submitted a public record request for the legitimate Criteria, that posting was revised to indicate that it's a draft and the process for adopting it as MHDS policy was begun.

Until receiving Ms. Gruner's letter, my seeking the legitimate Criteria in effect prior to adoption of that revision had left off with being required to submit $190.00 for the 10 hours of staff time that would be required to locate and provide a copy of the minutes of the SAPTA Advisory Board meeting at which they had been approved. However, it appears that the Governor made a similar inquiry, and the letter enclosed a copy of the minutes of that meeting, although just what the Board approved remains somewhat in question. I would have thought that the approved Criteria would be an attachment to the minutes.

That letter was most serendipitous, since on the same day it was written I submitted a public record request for the minutes of the May 21, 2004, meeting of the SAPTA Advisory Board, and for a copy of the document that was approved at that meeting as treatment program Criteria. That request was submitted after spending a few minutes reviewing SAPTA Advisory Board agendas; I did that to avoid paying for the 10 hours of SAPTA staff time that would otherwise have been required.

Ms. Gruner's letter did include a July 2005 version of the Criteria. While the Board could not have approved a 2005 document in 2004, the earliest version of the Criteria that had previously been provided is from 2006. I've acquired four different versions of the Criteria that SAPTA had provided directly or posted in its online Administrative Manual as the legitimate criteria in effect prior to one of them being adopted as the November 2011 revision, not including the Criteria for specialized treatment of co-occurring disorders.

On May 10 I received a response to my public record request for the document approved by the Board that states, "The document presented during this meeting is not available. However, the Division Criteria document from 2005 is the same document that was presented at the 2004 meeting." I assume the document not being available means that SAPTA has lost it. If that's the case, the response meets the requirements of the Public Records Act. Please let me know if it *doesn't* mean this, because then the requirements of the Public Records Act have yet to be satisfied. The 2005 document is identical to one of two different July 2006 versions of the Criteria.

The response does raise the question of how, without having access to the document approved by the Advisory Board eight years ago, it could possibly be known that the 2005 document is identical to it. But after seven months of repeated public record requests for the legitimate Criteria in effect prior to the November 2011 revision, I'll readily concede that the 2005 document is probably identical and is certainly the best available approximation.

Based upon the 2005 version of the Criteria, the letter acknowledges that prior to the November 2011 revision there hadn't been Division Criteria for Level IV-D Hospital-Based Detoxification, nor had there been Division Criteria for Adolescent Opioid Maintenance Therapy (OMT).

SAPTA issues certification acting in reliance upon findings of Center for the Application of Substance Abuse Technologies (CASAT) inspections. CASAT had found that Las Vegas Recovery Center and Adelson Clinic respectively had met Division Criteria for Adult Level IV-D Hospital-Based Detoxification and for Adolescent OMT that did not yet exist. When I submitted a public record request to CASAT for a copy of the criteria that had been used in determining these findings, I was referred back to SAPTA.

The letter is silent on SAPTA having certified these two programs for levels of service that did not yet exist.

The letter accurately states that no program is currently certified for Level IV-D Hospital-Based Detoxification, but is silent on why this is so. Las Vegas Recovery Center's certification for this was revoked after complaint to the Health Division about the Center using that certification to offer hospital services without a license. CASAT apparently hadn't noticed during inspection that the Center isn't in a hospital. That, and the findings that the Center and Adelson clinic met Division Criteria that didn't exist at the time of inspection, speaks to the validity of the CASAT certification inspection findings upon which SAPTA relies when making certification decisions.

The letter also inaccurately states that no program is currently certified for Adolescent OMT. SAPTA's current online listing of SAPTA-certified treatment programs shows that Adelson Clinic continues to be certified for this. However, SAPTA having unlawfully certified this program would have been resolved when that certification expired earlier this year and SAPTA re-certified the program according to the current Criteria.

But SAPTA continues to unlawfully certify and fund programs for specialized treatment of co-occurring disorders (COD's), i.e. substance abuse conjoined with mental illness. There still aren't Division Criteria for these programs. A draft amendment to the Criteria that would add standards for these programs is in Appendix C014 of the online SAPTA Administrative Manual. The Manual's table of contents had identified this document as a draft, but for some reason that notation was deleted two days before Ms. Gruner's letter.

Ms. Gruner's letter states, "co-occurring is not another level of service but an enhancement of a service offered in Division Criteria Level I and Level II. …Co-occurring enhanced endorsement is not a level of service and therefore did not require Division Criteria to be modified and approved by the SAPTA Advisory Board." MHDS thus contends that its document entitled "Division Criteria for Programs Treating Substance Related Disorders – Co-Occurring Enhanced Levels of Service" isn't what its title says it is, that the document doesn't amend Division Criteria by adding standards for

these services, so the enhanced transparency in government provided by approval of an amendment in an open meeting of the SAPTA Advisory Board wasn't required.

The letter explains that "Division Criteria for… Co-Occurring Enhanced Levels of Service" isn't an amendment of Division Criteria adding standards for programs providing this because "Co-occurring enhanced endorsement is not a level of service". I don't know where the Division got the idea that its Criteria for treatment programs are restricted to levels of service and don't include the Division's specialty endorsements of a program's levels of service.

Such a restriction would be extremely inappropriate. It would place such endorsements outside the scope of the Division's policy on quality assurance standards for substance abuse programs – i.e. the Division Criteria. Consumers, including the State and its taxpayers paying for funded specialized COD treatment, thus would have no assurance that the specialty treatment is good enough to meet State standards established in the Criteria. Thankfully such a restriction doesn't exist: Endorsement of levels of service is included in the Division Criteria. The 2005 version of the Criteria contains standards for endorsement of levels of service for "Women's Set-Aside Levels of Care", specialty treatment of pregnant women and women with dependent children. The current Criteria, adopted in November 2011, include that endorsement, and add standards for endorsement of levels of service for "Telecommunication: Mode of Delivery".

I agree that the "…Co-Occurring Enhanced Levels of Service" document isn't an amendment to the Division Criteria, but for an entirely different reason. The document isn't an amendment of Division Criteria for the same reason that none of the versions of the Criteria prior to adoption of the November 2011 revision that differ from the 2005 version were amendments of the Division Criteria: Like them, it's only a draft amendment of the Criteria, despite the deletion on May 2nd of the notation in the online SAPTA Administrative Manual's table of contents indicating that it's a draft.

To support the contention that the COD treatment program Criteria aren't subject to the enhanced transparency in government provided by approval in an open meeting of the SAPTA Advisory Board, enclosed with the letter is a copy of the SAPTA Advisory Board bylaws, with the provision that, "The Board shall not have any policy making or regulatory authority.", highlighted. This is quite irrelevant; I'm not aware of anyone ever contending that it does NAC 458.118 assigns to the Administrator authority to adopt the revised Criteria as MHDS policy upon the recommendation of the SAPTA Advisory Board, and NRS 433.314(2) requires that "The [MHDS] Commission shall: ...Set policies for the care and treatment of persons with… co-occurring disorders".

SAPTA has implemented the draft COD amendment to the Criteria without it having been approved by the SAPTA Advisory Board in an open meeting, without it having been approved by the MHDS Commission, and without it having been adopted by the Administrator. SAPTA has excluded the public and usurped the authority of the SAPTA Advisory Board, of the MHDS Commission, and of the MHDS Administrator by

unlawfully certifying and funding COD treatment programs. So far nobody seems to have noticed other than this member of the excluded public.

The anomaly of the MHDS Commission being mandated to set only a portion of MHDS policy establishing quality assurance standards for substance-abuse treatment programs, that portion establishing standards for programs that provide specialty treatment of COD's, is an artifact of NRS 433 not having been aligned with the transfer of responsibility for substance abuse services to MHDS.

AB 2 of the 2005 22nd Special Legislative Session transferred that responsibility from the Health Division to MHDS, and required a transfer plan approved by the Governor and the Legislature. Page five of the approved plan assigned responsibility to the Bureau of Alcohol and Drug Abuse, now SAPTA, for developing an agenda for the 2007 Legislative Session to obtain statutory alignment with the transfer. That portion of the plan wasn't implemented.

On May 3rd I sent a letter to Mike Willden, DHHS Director, describing the problems this created with NRS 433, the MHDS statutes, including the anomaly described above. This also resulted in there no longer being Evaluation Centers to which a court can lawfully refer DUI defendants, and there no longer being treatment programs to which a court can lawfully assign DUI defendants pursuant to the provisions of NRS 484C. That letter also described how these problems can be resolved and a copy of that letter was provided to you.

Criteria for COD treatment programs can be adopted by following the procedure required by NAC 458.118, and after the SAPTA Advisory Board has recommended that you adopt a COD amendment to the Criteria, the approved amendment then can be submitted to the MHDS Commission for approval. After Commission approval of the amendment, it can be adopted by you as MHDS policy. SAPTA then can begin lawfully certifying and funding COD treatment programs if they are in compliance with the policy.

But until then, SAPTA is continuing to unlawfully certify and fund COD treatment programs. I believe it's done so since 2007.

Before presenting the draft COD amendment of the Criteria to the SAPTA Advisory Board, you may want to first have it revised to reflect recommendations of the Governor's Committee on Co-Occurring Disorders, of which you're a member. Its January 31, 2011, report to the Legislative Counsel Bureau Director contains recommendations that are not incorporated into the current draft, which was developed back in 2007. For example, the draft doesn't "Assure that clinicians treating individuals with Co-Occurring Disorders obtain specific training in the recognition and treatment of COD's."

This letter is the product of over two years of research into the problem of SAPTA unlawfully certifying and funding treatment programs as a factor that may have contributed to the decline in treatment of substance-abusing pregnant women. For

example, the reputation of SAPTA-certified treatment programs certainly wasn't enhanced by SAPTA certifying Las Vegas Recovery Center for Level IV-D Hospital-Based Detoxification. That's treatment of choice for many substance-abusing pregnant women because of the danger that withdrawal can pose to the fetus if done outside a hospital; SAPTA certified a program for that which wasn't in a hospital and in the absence of Division Criteria for the certification. Because of this, an unknown number of unborn babies were placed at risk, and an unknown number of consumers thought they were paying for hospital-based services when that's not what they received. SAPTA's federal Substance Abuse Prevention and Treatment Block Grant applications show that treatment of substance-abusing pregnant women has fallen every year since 2004, the earliest year available, and in 2011 had fallen to but 38% of what it had been back then. State agencies are given to blaming problems on inadequate funding, and often this is valid. However, SAPTA's budget hasn't fallen to but 38% of what it had been in 2004.

With more transparency in government, it wouldn't have taken over two years of research to produce this letter. With more regulatory and statutory compliance, this letter wouldn't have been necessary.

The question that remains is whether MHDS will resolve the problem of SAPTA continuing to unlawfully certify and fund programs for specialized treatment of co-occurring disorders in the absence of Division Criteria for these programs.

I would like to emphasize that you did not create this problem. You inherited it when you became Acting MHDS Administrator. But you do hold responsibility to resolve it.

Sincerely,

Barry W. Lovgren

cc: Governor Brian Sandoval
Legislative Commission
Interim Finance Committee
MHDS Commission
Mike Willden, DHHS Director
Mary Woods, DHHS Public Information Officer
Deborah McBride, SAPTA Director
Julie Slabaugh, Deputy Attorney General

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May 3, 2011

Department of Health and Human Services (DHHS)
Attn: Mike Willden, Director
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

The purpose of this letter is to bring to your attention very serious problems with services for substance abuse that DHHS can resolve with appropriate Bill Draft Requests for the 2013 Legislative Session. At present services for prevention and treatment of substance abuse aren't integrated into the functions of the Division of Mental Health and Developmental Services (MHDS) and of the MHDS Commission in NRS 433, there are no Evaluation Centers to which a court can refer DUI defendants pursuant to NRS 484C.350, and there are no programs providing treatment for which DUI defendants can apply to a court pursuant to NRS 484C.320, .330, or .340.

This is the result of lack statutory alignment with the transfer of services for substance abuse by AB 2 of the 22nd Special Legislative Session in 2005. Statutes that weren't aligned by AB 2 were to have been identified in the DHHS legislative agenda for the 2007 Legislative Session. At the end of that Session AB 2's transfer of these services from the Health Division to MHDS went into effect through revision of NRS 458.

Section 211 of AB 2 called for DHHS to develop a plan, approved by both the Governor and the Legislature, for this transfer. The Bureau of Alcohol and Drug Abuse, now SAPTA, was responsible for that portion of the plan that called for developing the 2007 legislative agenda to attain statutory alignment with the transfer. That portion of the plan doesn't appear to have been implemented: Review of DHHS Bill Draft Requests for the 2007 Legislative Session shows none to attain statutory alignment with the transfer of services for substance abuse from the Health Division to MHDS.

I ran across this in the course of looking for statutory problems that may be part of why treatment of substance-abusing pregnant women has fallen by two-thirds in just a few years. I found two chapters of the NRS whose of lack of statutory alignment may have contributed to this decline. Please note the narrow focus of my review of the statutes. The plan approved by the Governor and the Legislature called for a comprehensive review of the NRS. There may be other chapters of the NRS that still need alignment.

Nevada Revised Statutes Chapter 433 (NRS 433), the general statutes for MHDS, was never aligned with this transfer by being revised to address services for substance abuse..

SAPTA isn't subject to the authority of the MHDS Commission as are other agencies within MHDS, and the MHDS Commission doesn't have authority to adopt regulations for services for substance abuse beyond the narrow scope of services for the care and treatment of persons suffering from co-occurring disorders.

For example, it's come up at MHDS Commission meetings that SAPTA policies such as its sliding fee scale, unlike similar policies for mental health services and for developmental services, aren't subject to the Commission's approval. SAPTA's sliding fee scale policy is beyond the Commission's purview, despite its penalizing families with increasing severity as household size increases by requiring ever-lower percentages of the Federal Poverty Level to be eligible for SAPTA-funded treatment, while it's relatively easy for a solitary individual to qualify.

NRS 484C, which contains the statutes for driving under the influence of alcohol or other drugs, also wasn't aligned with this transfer. There are no Evaluation Centers in Nevada to which a court can lawfully refer DUI defendants pursuant to NRS 484C.350, and there are no programs providing treatment for which DUI defendants can lawfully apply to a court pursuant to NRS 484C.320, .330, or .340.

A copy of the relevant sections of NRS 433 and NRS 484C is attached.

1. NRS Chapter 433 Mental Health General Provisions

   Title 39 is entitled "Mental Health", an inappropriately restrictive misnomer, and NRS 433, General Provisions, establishes MHDS, which has the same problem. The more appropriate term is "Behavioral Health". Title 39 and NRS 433 address much more than mental health: They address mental health, developmental disability, related conditions, co-occurring disorders – and should, but do not – address substance abuse outside the narrow context of co-occurring disorders.

   The lack of integration of services for substance abuse into MHDS is pervasive, and is reflected in SAPTA being the sole MHDS agency that isn't listed under MHDS in the AT&T phone book. SAPTA has the dubious distinction of being a State agency with an unlisted phone number. I brought this to SAPTA's attention back in 2009 as an impediment to substance-abusing pregnant women seeking treatment referrals.

   The statutory definition of "mental illness" excludes substance related disorders, as does the statutory definition of "mental retardation" (which most, including me, prefer to call "developmental disability"). The statutory definition of "related conditions" is disorders related to developmental disabilities. The statutory definition of "co-occurring disorder" is elsewhere, in the statute establishing the Governor's Commission on Co-Occurring Disorders. They're defined as mental illness conjoined with substance related disorder. NRS 433 is silent with regard to substance related disorders other than within the narrow context of co-occurring disorders.

The MHDS Commission has statutory powers and duties only related to services for mental illness, developmental disabilities, related conditions, and co-occurring disorders: The Commission has no powers or duties related to services to prevent and treat substance related disorders – the purpose of SAPTA - except within the narrow context of co-occurring disorders.

a. NRS 433.314 Duties of the MHDS Commission

Four mandated ("shall") duties are assigned to the Commission, including establishing policies relating to services for "persons with mental illness, mental retardation or co-occurring disorders and persons with related conditions, including services to prevent [these conditions]…", and reporting on the adequacy of services to these population.

This report is addressed in Section 4, and doesn't address services for the care and treatment of substance abuse, and doesn't address prevention services for any of the disorders within the purview of the Commission.

NRS 433.314 is silent on services related to substance abuse, except within the narrow context of co-occurring disorders.

My recommendation is that NRS 433.314 be revised to:

1. Address services for the care and treatment of abusers of alcohol and other drugs and for the prevention of substance abuse;
2. Have Section 4 provide for reporting on services for prevention of all disorders within the Commission's purview.

b. NRS 433.316 Powers of the MHDS Commission

Twelve discretionary ("may") powers are granted to the Commission. Most relate to mental illness, mental retardation, related conditions, and co-occurring disorders, but Section 9 (compilation of statistics) is restricted to mental illness alone, and Section 10 restricts prevention to prevention of institutionalization. Substance abuse, except in the narrow context of co-occurring disorders, is addressed nowhere in NRS 433.316.

My recommendation is that NRS 433.316 be revised to:

1. Include abuse of alcohol and other drugs;
2. Include in Section 9 compilation of statistics relating to all disorders within the Commission's purview; and
3. Include in Section10 prevention of all disorders within the Commission's purview, not just institutionalization due to the disorders.

c. NRS 433.324 Regulations

The mandated ("shall") duty to adopt regulations "For the care and treatment of persons with mental illness, mental retardation or co-occurring disorders and persons with related conditions…" is assigned to the Commission. It doesn't give the Commission authority to adopt regulations for services to prevent any disorders within its purview, and provides the Commission authority to adopt regulations for the care and treatment of substance abusers only within the narrow context of co-occurring disorders.

The Commission does have the duty to adopt regulations for the care and treatment of those with co-occurring disorders, and NRS 458.025 assigns to MHDS the duty to adopt regulations for the certification and continuing education of Detoxification Technicians. Neither the Commission nor MHDS has the power or duty to adopt regulations for the care and treatment of substance abusers who don't have a co-occurring mental disorder, nor to adopt regulations for services to prevent substance abuse – i.e. the bulk of the SAPTA regulations, NAC 458.

My recommendation is that NRS 433.324 be revised to:

1. Include within the mandate that the Commission adopt regulations for services to prevent substance abuse. If a mandate to adopt regulations for services to prevent other disorders within the Commission's purview is considered inappropriate, the Commission should at least be granted discretionary power to do so.
2. Include within the mandate that the Commission adopt regulations for services for the care and treatment of abusers of alcohol and other drugs.

2. NRS 484C – Driving Under the Influence of Alcohol or Another Drug

The Board of Health continues to be mandated to adopt regulations for the certification of Evaluation Centers, but hasn't done so for years.

a. NRS 484C.050 defines "Evaluation Center" as a facility "approved by the Health Division…" But the Health Division hasn't approved - i.e., certified - Evaluation Centers since the transfer of services for substance abuse to MHDS through revision of NRS 458 in 2007. Evaluation Centers are certified by SAPTA, in MHDS. There are no Evaluation Centers in Nevada to which a court can lawfully refer DUI defendants pursuant to NRS 484C.350.

I've informed the district attorneys and the courts of this, but most likely, forced to choose between both practical and humane referral of a defendant to determine if there is a need for treatment or ignoring the law,

they've been doing what they should never have been forced to do – ignore existing law.

This can be resolved on an interim basis by the Board of Health meeting the mandate of NRS 484C.310 to adopt regulations for Evaluation Centers (see "b", below) until NRS 484C is revised to align it with the transfer of services to MHDS.

My recommendation is that NRS 484C.050 be revised to define "Evaluation Center" as a facility certified by MHDS.

b. NRS 484C.310 mandates that, "The State Board of Health shall adopt by regulations the standards to be used for approving the operation of a facility as an evaluation center…"

Although the Board of Health continues to be mandated by law to adopt regulations for approval – i.e. certification - of Evaluation Centers, it doesn't do so. Evaluation Centers are certified by SAPTA, not by the Health Division pursuant to regulations adopted by the Board of Health.

I've submitted a petition for the Board of Health to comply with the mandate that it "adopt by regulations the standards to be used for approving the operation of a facility as an evaluation center". Richard Whitley, Health Division Administrator, has subsequently agreed to begin the process for adoption of such regulations. Hopefully this will be done as expedited emergency regulations: The Board of Health breaking a law that would allow the courts to comply with the law is, to say the least, an awkward situation that should be resolved as quickly as possible.

My recommendation is that NRS 484C.310 be revised to mandate that, "The Commission on Mental Health and Developmental Services shall adopt by regulations the standards to be used for approving the operation of a facility as an evaluation center…"

c. NRS 484C.320, .330, and .340 provide for first, second, and third-offense DUI defendants, respectively, to "apply to the court to undergo a program of treatment for alcoholism or drug abuse which is certified by the Health Division…"

The Health Division hasn't had authority to certify substance abuse treatment programs since NRS 458 was revised by AB 2 to transfer that authority to MHDS. There aren't any programs to which a DUI defendant can lawfully apply to a court for treatment under NRS 484C.320, 330, or .340, and there can't be until NRS 484C is revised.

I've informed the district attorneys and the courts of this, but most likely, forced into choosing between accepting unlawful applications or denying treatment to substance abusers and bankrupting the State with un-necessary incarceration costs, the district attorneys and the courts are doing what they should never have to do – ignore existing law.

My recommendation is that these sections of NRS 484C be revised to provide for DUI defendants to apply "to the court to undergo a program of treatment for alcoholism or drug abuse which is certified by the Division of Mental Health and Developmental Services…"

d. NRS 484C.370 allows a court to refer a DUI defendant to an Evaluation Center administered by a private company "if it meets the standards of the State Board of Health pursuant to NRS 484C.310…"

There haven't been "standards of the State Board of Health pursuant to NRS 484C.310" since AB 2's transfer of services for substance abuse from the Health Division to MHDS by revision of NRS 458 in 2007.

As noted in "a", above, the district attorneys and the courts are most likely addressing this by doing something they should never be forced to do: Ignore the law.

Presuming that NRS 484C.310 will be appropriately revised, my recommendation is that NRS 484C.370 be revised to state, "if it meets the standards of the Commission on Mental Health and Developmental Services pursuant to NRS 484C.310…"

I must emphasize that NRS 433 and NRS 484C may not be the only chapters of the NRS that have yet to be aligned with the transfer of services for substance abuse from the Health Division to MHDS by AB 2, and that comprehensive review of the Nevada Revised Statutes, required by the plan developed pursuant to Section 211 of AB 2 and approved by both the Governor and the Legislature, appears not to have been conducted.

Sincerely,

Barry W. Lovgren

cc: Catherine Cortez Masto, Attorney General
Richard Whitley, Acting MHDS Administrator, Health Division Administrator
MHDS Commission

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May 1, 2012

TO: Prenatal Access to Care Workgroup
Nevada Statewide Maternal and Child Health Coalition

FROM: Barry Lovgren

RE: Report on consumer costs for funded treatment of substance abuse

cc: Richard Whitley, Acting Division of Mental Health and Developmental Services (MHDS) Administrator, and Health Division Administrator
Kevin Quint, Chair, MHDS Commission and Chair, Substance Abuse Prevention and Treatment Agency (SAPTA) Advisory Board

At the April 9 meeting of the Prenatal Access to Care Workgroup, the question came up of the cost to the consumer of obtaining substance-abuse treatment funded by SAPTA. I said that I would get that information for the Workgroup.

Substance-abuse treatment is available at reduced fees to many low-income people through programs funded by SAPTA, through billing on a Sliding Fee Scale. No funded program is allowed to deny treatment due to inability to pay, although treatment of a client who can pay but refuses to do so may be terminated. Every SAPTA-funded treatment program is required to offer treatment and admission priority to substance-abusing pregnant women unless the program serves only men.

There are limits to what SAPTA can offer as funded services. If a person's household income is higher than the ceiling in the SAPTA Sliding Fee Scale, the person is not eligible for funded treatment and the program may charge the person its full fee-for-service rates, which are set by the program and vary by program. Initial assessment to determine whether the person needs treatment and, if so, what would be appropriate treatment, generally is not a funded service and even those who qualify for Sliding Fee Scale billing may be charged the program's full fee-for-service rate. But for persons with Co-Occurring Disorders (i.e. suffering from both substance abuse and mental illness), if that initial assessment is Comprehensive Evaluation (a specialized service for this population) provided at one of the nine SAPTA programs funded for this, even the initial evaluation is funded by SAPTA if the person qualifies for billing according to the Sliding Fee Scale.

The SAPTA Sliding Fee Scale is available online, and the SAPTA rates are listed in subsection "d", below. No client, even those who don't qualify for Sliding Fee Scale billing, can be denied treatment at a funded program due to inability to pay. That said,

there still are serious fiscal barriers to treatment of many low-income people, especially those with large families. Unfortunately, explaining that will be unavoidably lengthy.

The listing of SAPTA-funded treatment programs can be accessed online at the SAPTA website. That website can be accessed through the MHDS home page, but I usually just Google "Nevada SAPTA", and its website is usually the second hit listed. Click on "Programs", and then click on "Treatment Programs." Those that are funded are marked with an "F" in the first column.

To find the billing and collection protocols for these SAPTA-funded treatment programs, click on "Publications" on the SAPTA website, then click on "Administrative Manual."

- Appendix C005 is the "Sliding Fee Scale Policy";
- Appendix C005a is the "Federal Poverty Guidelines 2011";
- Appendix C005b is the "SFS Worksheet"; and
- Appendix C005c is the policy for "Refusal to Pay".

There are some difficulties with the protocols. There's ambiguity that I can't explain about just what the Sliding Fee Scale *is* and just what the treatment fees it relates to *are*. Programs are required to use SAPTA's Sliding Fee Scale, yet doing so violates the program's condition of subgrant award that it use a scale based on 400% of the Federal Poverty Level, and SAPTA's Sliding Fee Scale penalizes families with increasing severity as household size increases. In addition, collection practices aren't regulated beyond prohibiting denial of treatment due to inability to pay. Despite all this, SAPTA-funded treatment is still a great opportunity for many.

a. The Sliding Fee Scale in the online Administrative Manual, which as of April 27 was being used by my local SAPTA-funded treatment program, differs from the Scale provided to me by the Nevada Department of Health and Human Services (DHHS) in response to a public record request. I cannot explain this.

   The Sliding Fee Scale in the online Administrative Manual establishes that the maximum household income of those eligible for SAPTA-funded treatment, regardless of household size, is $37,010. The maximum allowable household income, again regardless of household size, in the Scale provided to me as public record is $50,048. In both scales, the share of cost for an eligible consumer ranges from 0% to 55% of the SAPTA rate (see "d", below).

   I've provided Pam Beal, lead for the Statewide MCH Coalition, a hard copy of my public record request and of the response to it that includes the Scale that differs from the one available in the online Administrative Manual.

b. Both versions of the Scale penalize families with increasing severity as household size increases, requiring an increasingly lower percentage of the Federal Poverty Level to qualify for funded treatment. The following is a table of maximum allowable household income for each of the two scales when converted to Federal Poverty Level by household size:

Household Size	Administrative Manual	Public Record
1	340%	460%
2	252%	340%
3	200%	270%
4	166%	224%
5	141%	191%
6	123%	167%
7	109%	148%
8	98%	133%

Under the Scale in the online Administrative Manual and used by my local SAPTA-funded treatment program, a solitary individual qualifies for funded treatment with household income of 340% of the Federal Poverty Level, while a member of a family of eight with household income at the Federal Poverty Level doesn't qualify. The public record version is more generous, but still penalizes families as household size increases: A solitary individual qualifies for SAPTA-funded treatment with household income of 460% of the Federal Poverty Level, but a member of a family of eight can have household income no greater than 133% of the Federal Poverty Level to qualify.

I don't know why the Federal Poverty Levels are given in Appendix C005a of the online SAPTA Administrative Manual. If either version of the SAPTA Sliding Fee Scale is based upon Federal Poverty Levels, it's done in a way that I can't understand.

Please bear in mind that those ineligible for reduced billing under the Sliding Fee Scale can be charged the program's full fee-for-service rates, which are set by the program and vary by program.

c. SAPTA has established with each funded treatment program a condition of subgrant award that it use a Sliding Fee Scale based upon 400% of the Federal Poverty Level. Yet SAPTA requires programs to violate this subgrant agreement by requiring them to use the SAPTA Sliding Fee Scale. Neither the version available in the online SAPTA Administrative Manual and used by my local funded treatment program, nor the public record version, is based upon 400% of the Federal Poverty Level as shown by the table in "b", above.

d. Under both versions of the Sliding Fee Scale, eligible persons are charged from 0% to 55% of the SAPTA rate for the service provided. SAPTA rates are not available in the online Administrative Manual, but my local program provided to me a copy of the rates that accompany the Scale that's in the Administrative Manual, and DHHS, in response to my public record request, provided to me a copy of the rates that accompany the Scale that's public record. Both are included in the documents I've provided to Pam Beal. The rates differ between the two.

The following are the SAPTA rates for services provided to SAPTA-funded clients.

Service	Rate accompanying Administrative Manual scale	Rate accompanying public record scale
Comprehensive Evaluation, Adult	$90.00	$120.00
Comprehensive Evaluation, Adolescent	$100.00	$120.00
Outpatient Services – Individual (Level I), Adult	$55.00	$65.00
Outpatient Services – Group (Level I), Adult	$20.00	$25.00
Outpatient Services – Individual (Level I), Adolescent	$55.00	$65.00
Outpatient Services – Group (Level I), Adolescent	$25.00	$25.00
Outpatient Services – Individual (Level I), Women's*	$55.00	$65.00
Outpatient Services – Group (Level I), Women's*	$25.00	$25.00
Intensive Outpatient (Level II.1), Adult	$75.00	$75.00
Intensive Outpatient (Level II.1), Adolescent	$60.00	$60.00
Intensive Outpatient (Level II.1), Women's*	$75.00	$75.00
Residential Treatment (Level III), Adults	$80.00	$100.00
Residential Treatment (Level III), Adolescents	$90.00	$100.00
Residential Treatment (Level III), Women's*	$80.00	$100.00
Opioid Maintenance Therapy	$64.00	$80.00
Transitional Housing, Adult	$30.00	$30.00
Transitional Housing, Adolescent	$30.00	$30.00
Transitional Housing, Women's*	[unspecified]	$30.00
Detoxification (Level III.2-D and III.7-D), Adult	$130.00	$130.00
Civil Protective Custody/ Detoxification, Adolescent	$80.00	$80.00
Civil Protective Custody/ Detoxification, Adult	$60.00	$60.00

Co-Occurring Disorder Services**

Comprehensive Evaluation, Adult	$100.00	$120.00
Comprehensive Evaluation, Adolescent	$100.00	$120.00
Outpatient Services – Individual (Level I), Adult	$70.00	$70.00
Outpatient Services – Group (Level I), Adult	$32.00	$32.00
Outpatient Services – Individual (Level I), Adolescent	$70.00	$70.00
Outpatient Services – Group (Level I), Adolescent	$32.00	$32.00
Intensive Outpatient (Level II.1), Adult	$100.00	$100.00
Intensive Outpatient (Level II.1), Adolescent	$100.00	$100.00

* Specialized services for pregnant women and women with dependent children. I believe two programs offer such services. But *every* funded treatment program is required to offer treatment and admission priority to pregnant women, even if they don't provide specialized services.

** Specialized services for those suffering from both a substance-related disorder and mental illness. But the Americans with Disabilities Act prohibits *any* funded program from denying treatment to this population if reasonable accommodation to the psychiatric disability would make treatment of the substance-abuse disorder possible.

I believe the units of service are a session of Comprehensive Evaluation, individual counseling, or group counseling; a Methadone (or other opioid agonist) dose for Opioid Maintenance Therapy; and a day's service in Intensive Outpatient, Residential treatment, Transitional Housing, or Detoxification.

Definitions of the basic levels of service and the criteria for those providing specialized treatment for pregnant women and women with dependent children are given in Appendix C001 in the online SAPTA Administrative Manual, the "Division Criteria for Programs Treating Substance Related Disorders".

I cannot explain why the Division Criteria for specialized treatment for persons with Co-Occurring Disorders, Appendix C014 in the online SAPTA Administrative Manual, remain a 2007 draft that has yet to be adopted by MHDS. Regulation (NAC 458.118) authorizes SAPTA to certify and fund programs only according to MHDS Division Criteria, not according to SAPTA's unadopted drafts of it.

e. Collection practices of funded treatment programs are not regulated other than to prohibit denial of treatment due to inability to pay. Largely unregulated collection practices conjoined with providing the consumer something she can't afford to pay for can have disastrous consequences, as demonstrated by the current mortgage crisis which was created by that. A SAPTA-funded program may summarily refer a client in arrears to a collection agency, or summarily sue the client, so long as the client continues to be offered treatment that she can't pay for.

   In addition, the "Refusal to Pay" policy, which allows denial of treatment to those who can pay but refuse to do so, may not adequately distinguish between those who are unable to pay and those who refuse to do so.

It should be noted that while SAPTA's billing protocols for funded treatment programs require inappropriate billing that violates the subgrant requirement to bill according to a Sliding Fee Scale based upon 400% of the Federal Poverty Level, SAPTA's protocols for collection practices only allow - but do not require - inappropriate collection practices: A program may summarily sue or refer to collections a client even slightly in arrears, but is not required to do so.

It should also be noted that problems with SAPTA's protocols for the billing and collection practices of funded treatment programs are irrelevant to indigent substance-abusing pregnant women with no assets and no prospects of ever having any, who then for all practical purposes are immune from lawsuits to collect debts and for whom denial of treatment due to refusal to pay would be patently absurd. For others, especially those in large families, SAPTA's billing and collection protocols for funded treatment programs can be problematic. Even so, SAPTA-funded treatment has been a godsend for many low-income persons who needed substance abuse treatment.

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November 22, 2011

TO: Catherine Cortez Masto
Attorney General

Mike Haley
Washoe County Sheriff

Steve Pitts
Reno Chief of Police

Tammra Pierce, Director
Bristlecone Family Resources

Amy Roukie, Director
WestCare Nevada Community Triage Center

The purpose of this letter is to inform you that a peace officer who places a public inebriate in the Reno area into civil protective custody (CPC) pursuant to NRS 458.270 is required by law to deliver the person to Bristlecone Family Resources or to the WestCare Nevada Community Triage Center and is not authorized to deliver the person to the Civil Protective Custody program of the Washoe County jail.

NRS 458.270, "Procedure for placing person in civil protective custody", states in subjection 3, "If a licensed facility for the treatment of persons who abuse alcohol exists in the community where the person is found, the person must be delivered to the facility for observation and care. If no such facility exists in the community, the person so found may be placed in a county or city jail…"

Please note the mandatory requirement that the peace officer "must" deliver the person to a licensed facility for the treatment of persons who abuse alcohol if one exists in the community.

There are two such facilities in the Reno community. They are Bristlecone Family Resources and the WestCare Nevada Community Triage Center. They are licensed as Social Model Detoxification facilities by the Nevada Health Division. On the other hand, the Washoe County Sheriff's Office informs me that the only license held by its CPC program is Washoe County Health District licensure of the jail's food service.

The Substance Abuse Prevention and Treatment Agency (SAPTA) certifies the Washoe County jail's CPC program. However, program certification is not licensure as a facility for the treatment of persons who abuse alcohol. SAPTA does not have statutory authority to issue such licensure. SAPTA certifies and funds a CPC program to which statute does not allow peace officers to deliver a person taken in to CPC.

On November 9 I submitted written testimony to the SAPTA Advisory Board on how certification criteria for CPC programs that allowed for freestanding CPC not in a facility licensed for substance abuse treatment fails to provide adequate regulation to address staff training and health and safety issues. I did not know at that time that the Nevada State Legislature had already addressed that through requiring by law that a peace officer placing a person in CPC must deliver the person to a facility with such licensure if there is one in the community. And there are two in the Reno community.

I presume that peace officers in the Reno area delivering those taken into civil protective custody to the Washoe County jail's CPC program, instead of to Bristlecone Family Resources or to the WestCare Nevada Community Triage Center as required by law, has been an error made in good faith, and that this error will no longer be made.

Sincerely,

Barry W. Lovgren

cc: Richard Whitley, Acting MHDS Administrator
Deborah McBride, SAPTA Director
Kevin Quint, SAPTA Advisory Board Chair