Department of Health and Human Services

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Nevada Problem Gambling Services

STRATEGIC PLANNING WORKSHOP

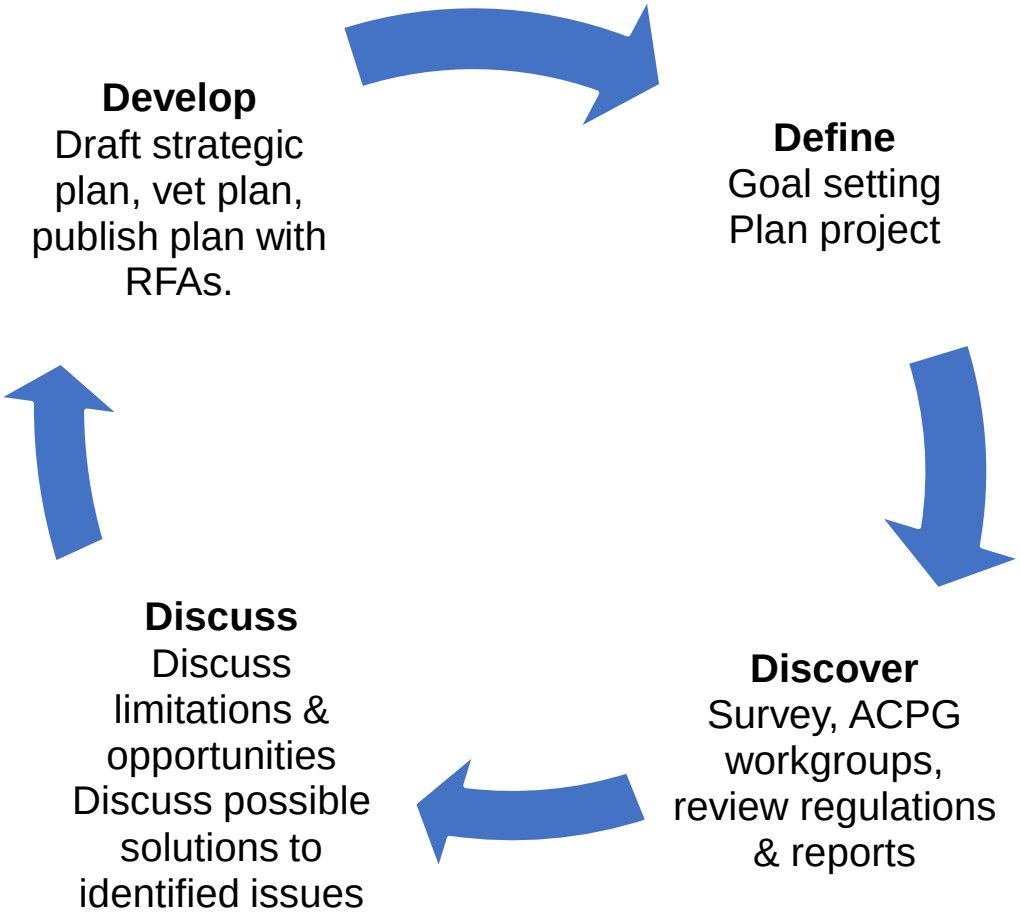
Facilitated by Jeff Marotta, Ph.D., ICGC-II

October 30, 2018

Project Vision

- Provide problem gambling services to more people in need;
- Identify gaps in problem gambling services and explore means to meet current and emerging service demands;
- Improve the effectiveness and efficiency of problem gambling services supported by DHHS;
- Support and acknowledge DHHS grantees, the Advisory Committee on Problem Gambling, and service consumers as partners in reducing harm caused by problem gambling.

DHHS PG Program Strategic Planning: Project Process



Today's objective:

Seek solutions to improve DHHS supported problem gambling services

To accomplish this we will

- Provide background information including survey findings
- Seek feedback for changes to the current strategic plan given projected SFY2020 program budget

Strategic Planning Stakeholder Survey Findings

- DHHS Office of Community Partnerships and Grants solicited input from hundreds of stakeholders & posted survey on website.
- The majority of current PGS grantees and ACPG members responded (10 total).
  - *Given number of grantees (9) and ACPG members (7), responses represented majority of grantees (6) and ACPG members (4).*
- Other than PGS grantees and ACPG members, no other completed survey were submitted.

Foundation Strengths

- Dedicated funding for PGS
- Committed stakeholders, including providers
- Experience / historical learning
- Sound system framework
  - System has worked well in past albeit funding has been inadequate
  - Historically the ACPG, DHHS, and providers have worked very well together. Collaborative relationships
  - Gambling treatment “Centers of Excellence” model working
  - Program evaluation, monitoring, and support system viewed as very strong

Service Strengths

- Financial means to pay for gambling treatment not a barrier to help seekers
- Very good information management system
- Treatment is available from specialized and competent providers in the state's two most populous areas and rural treatment services are available
- Many programs have strong elements
  - Persons seeking PG treatment "seen right away" in most programs.

Prognostic Strengths

- DHHS and ACPG actively engaged in service improvement initiatives
- Providers motivated to develop their PG services
- Strong advocates
  - ACPG, public support, political support

Changes Under Consideration

Move to SAPTA

Tapping Medicaid $

Funding Allocations

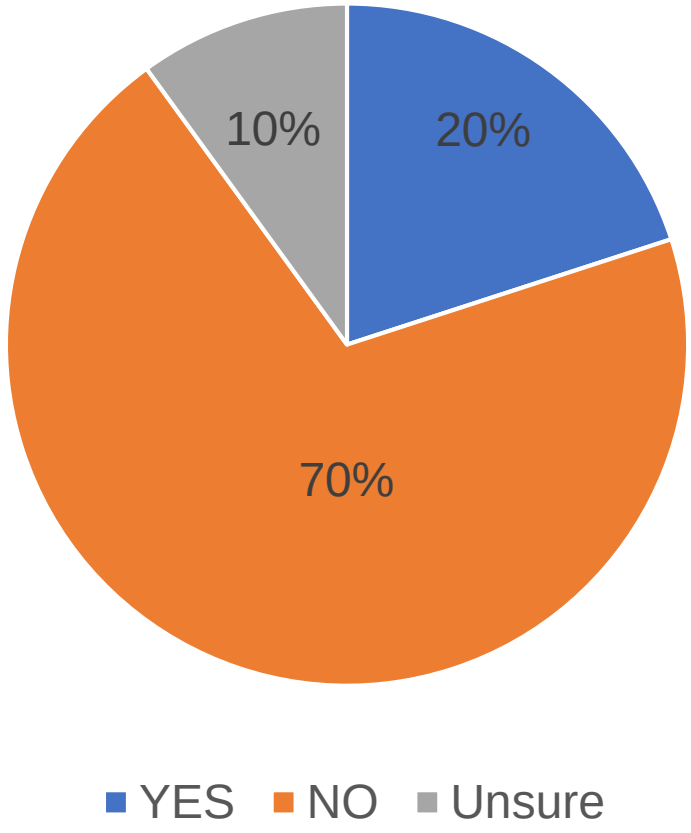
Revisions to Treatment Standards

PROPOSED MOVE TO SAPTA

Background:

- In 2005 legislation passed that created a dedicated fund for problem gambling services and placed DHHS with administrative oversight.
- Since the inception, the Directors Office, under the Grants Management Unit, renamed the Office of Community Partnerships and Grants (OCPG), was assigned stewardship over this fund.
- Beginning in 2015, discussions took place to consider moving stewardship from OCPG to Substance Abuse Prevention and Treatment Agency (SAPTA).
  - Viewed by DHHS as better fit, will help grow the program.
- This fall PG program funds, including program positions, were placed under SAPTA in the DHHS Agency Request for SFY2020.
- The request is pending legislative approval before being acted upon.

Support for Placing PGS Program Administration within SAPT: Survey Findings



Survey Question: DHHS is exploring shifting the administrative responsibility over their Problem Gambling Services from the Office of Partnerships and Grants to the Nevada Division of Public and Behavioral Health's Substance Abuse Prevention & Treatment Agency (SAPTA). ***Do you support this concept?***

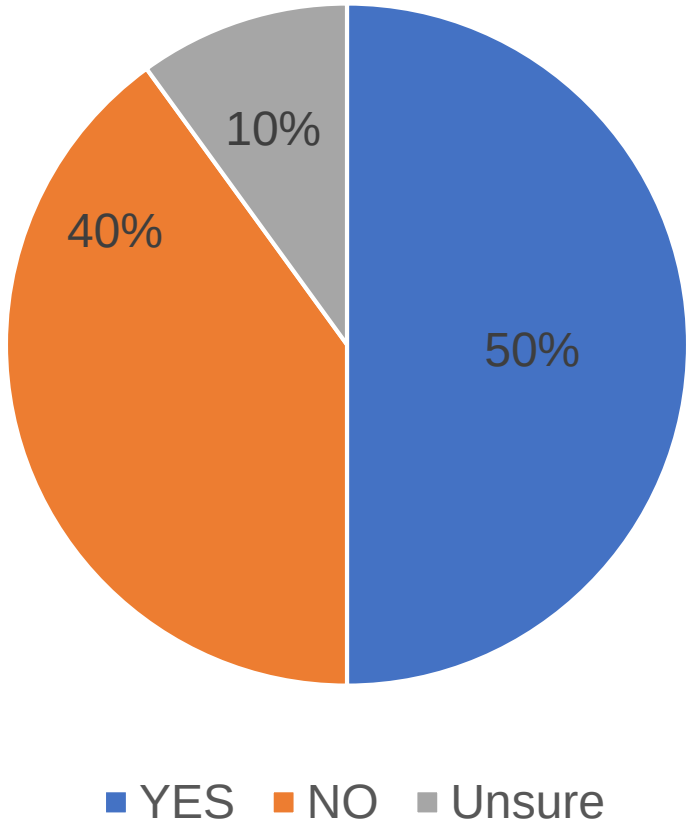
Move to SAPTA: Most Commonly Cited Concerns

- **Lack of justification**
  - Why is this being done? What problem is being addressed with such a move?
- **Lack of fit**
  - Problem gambling is not within the SAPTA name, mission, or strategic plan
  - The provider structure in SAPTA does not match PGS provider structure
  - The encounter and evaluation system are different; lack of data continuity with system change
  - We are not a substance abuse grant program: we are different
- **Lack of capacity**
  - I feel that the growing pains and continual change of staff within the SAPTA Agency at this particular point in time could not support another initiative to manage.
  - I do not see SAPTA as being able to absorb the specialty of gambling disorders effectively. I believe they are already overburdened.
- **Fragmentation will result in less focus on PG**
  - Will problem gambling become even more invisible than it is right now?
  - This agency has given short shrift to addressing problem gambling in the past
- **SAPTA administrative system less efficient than current PGS system**
  - SAPTA's reimbursement model is neither timely nor efficient; UNLV evaluation & data system better than SAPTA; more accountability under current system than SAPTA
- **Unnecessary costs**

MEDICAID

Discussion has been underway for the past two years to explore leveraging Medicaid funds to better support problem gambling services. This discussion continues today.

Support for tapping Medicaid funds to help support gambling treatment: Survey Findings



Survey Question:

Tapping into Medicaid funds to help support problem gambling treatment is under consideration.

Do you support this concept?

Using Medicaid: Most Commonly Cited Concerns

- **Cost-Benefit does not support effort**
  - Cost/benefit of any new funding stream must be carefully weighed. Only about 100 clients come through the gambling treatment system who are Medicaid eligible. Lot of work for small impact and could cost system in non-monetary ways such as loosing providers when very few experienced providers exists.
- **Disordered Gambling not a covered diagnosis under NV Medicaid**
  - Medicaid needs to recognize disordered gambling as a true and verifiable diagnosis and approve the PARs timely and efficiently
- **Pre-authorization problem; Problem gamblers need immediate engagement**
  - Consideration by Medicaid of lengths of engagement for pre-authorized services should be addressed.
- **Medicaid provider type issues**
  - Medicaid Provider Type 17 215 needs to be a behavioral health model rather than a SAM (Substance Abuse Model) as they are currently structured
  - There is no Medicaid provider type that recognizes CGAC; members of current workforce ineligible to bill Medicaid
- **Increased effort to bill Medicaid**
  - Administrative process to enroll clients and bill Medicaid much more extensive than current process; gambling treatment specialized clinics are currently struggling with administrative time to manage grant, this will make worse
- **Potential loss of valuable providers**
  - Four of seven current grantees are unable to bill Medicaid due to not being SAPTA certified. The requirements to become SAPTA certified may result in loss of our specialty clinics.

Increase System Efficiency: Survey says…

- **Increase program funding**; inadequate funding produces inefficiencies.
- Expand services to include case management and peer support.
- Incentivize new grantees to make Medicaid part of their system, rather than trying to "retrofit" existing grantees to do this.
- DHHS administration of grants can become more efficient by spending more time communicating with grantees and assuring new forms and procedures are well designed, tested, and necessary before implementing.
- Better use and support of the ACPG.
- I don't think we're broken, so I don't believe there is something needing to be fixed as far as "efficiency and effectiveness" goes.
- Set up the Nevada Council on Problem Gambling as the fund administrator.

Service Gaps

Areas for further development within all or some areas within the state

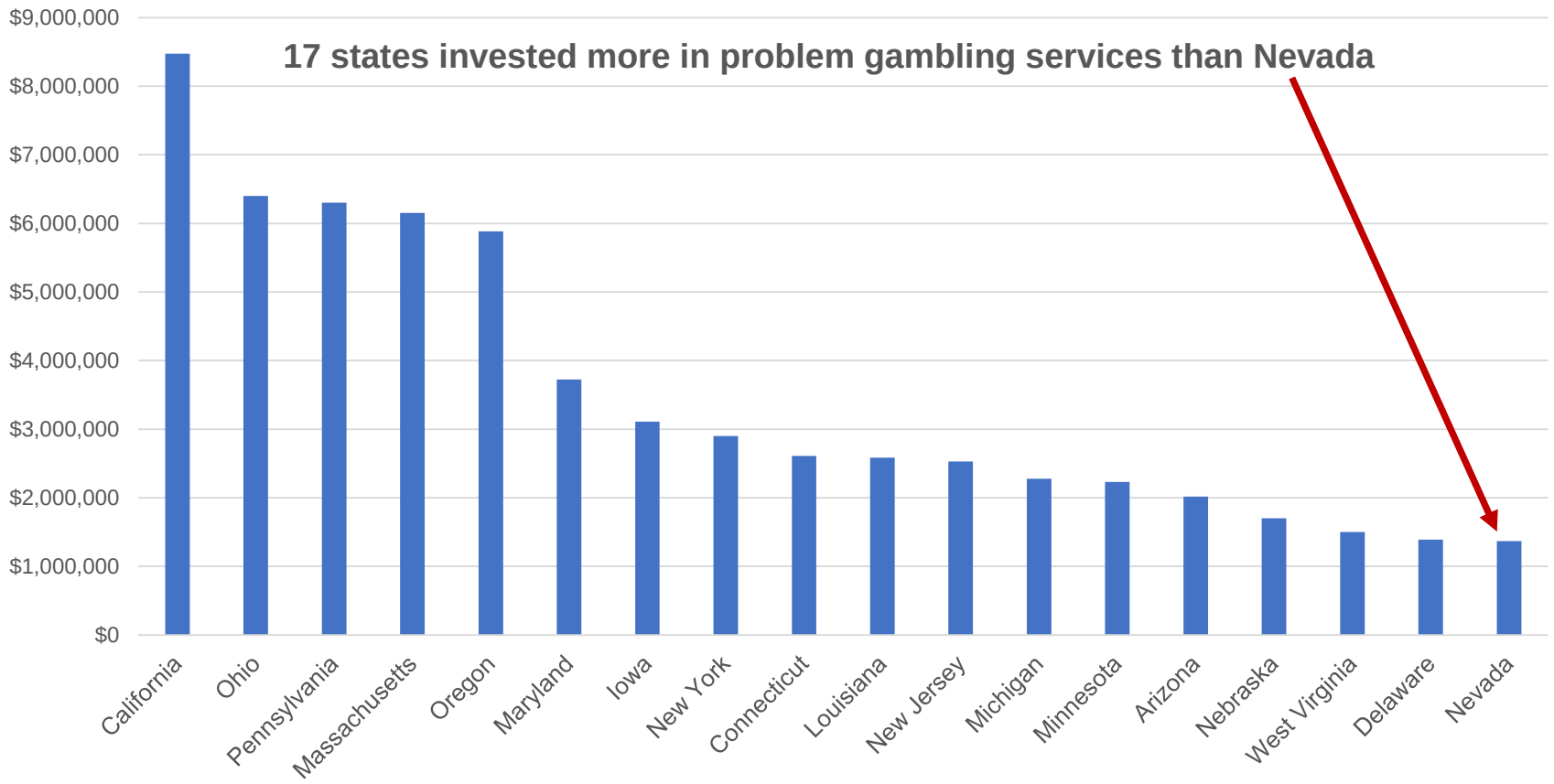
Service Gaps

- We are not adequately informing the public about the availability of services.
- There are far more people in need of services than are currently receiving them.
- Too few providers available to provide services
- Rurals underserved and lack of qualified counselors
- Education, training, prevention, research and workforce development resources are very few.
- Access to services, especially Spanish language services, needs improving
- Integration of PG into behavioral health prevention programs & treatment programs; ideally need system to fund providers for whole person's needs
- We need a new prevalence study

DHHS
Problem Gambling Services

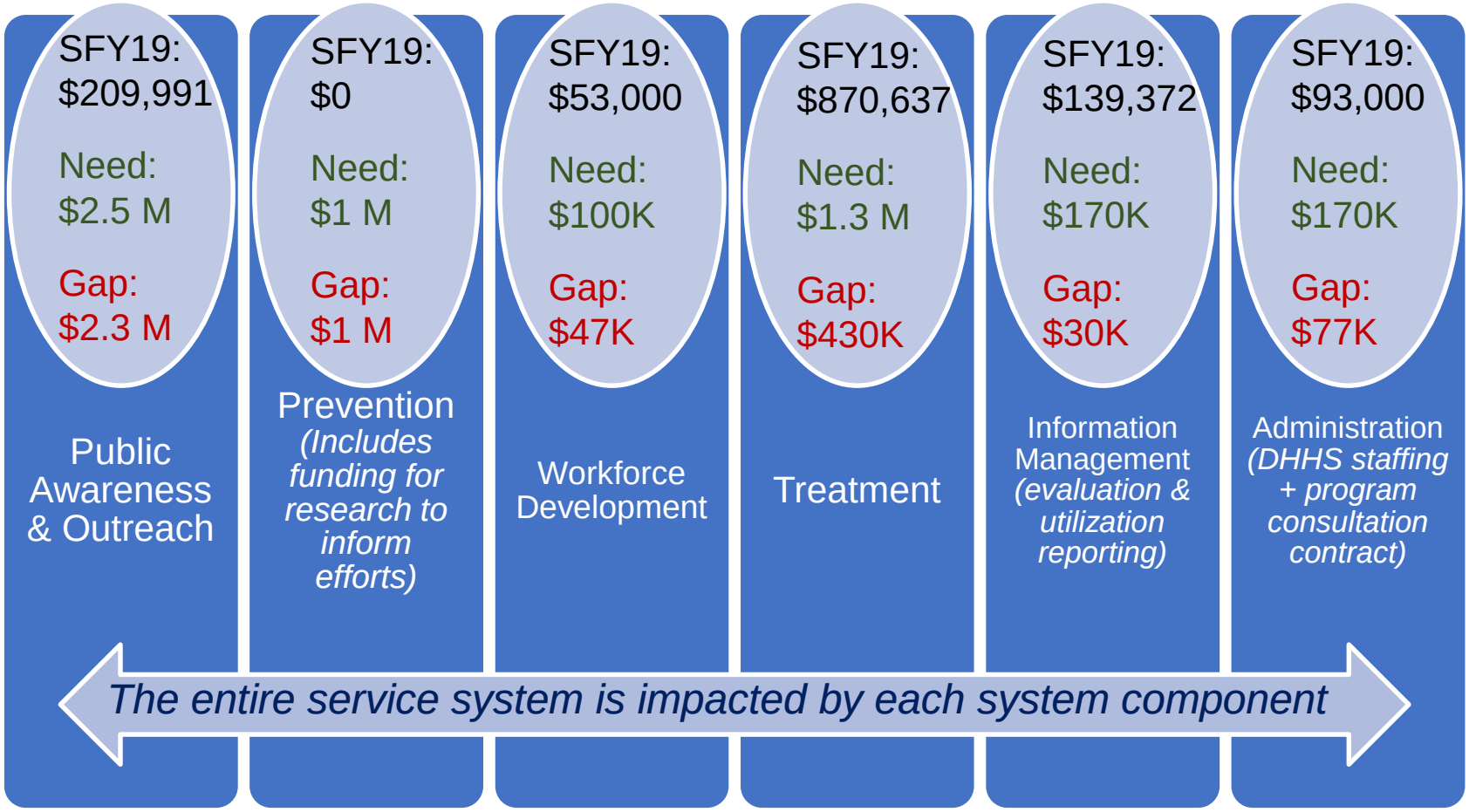
Funding

Nevada is leader in gaming but 18th in dedicated PGS funding



Source: Marotta, J., Hynes, J., Rugle, L., Whyte, K., Scanlan, K., Sheldrup, J., & Dukart, J. (2017). 2016 Survey of Problem Gambling Services in the United States. Boston MA: Association of Problem Gambling Service Administrators.

Problem Gambling Service Components: Budget, Need, Funding Gap



Need is based on combination of ACPG Sub-Committee discussions and budget data from other U.S. state problem gambling service systems. Est. annual budget need: $5.24 Million

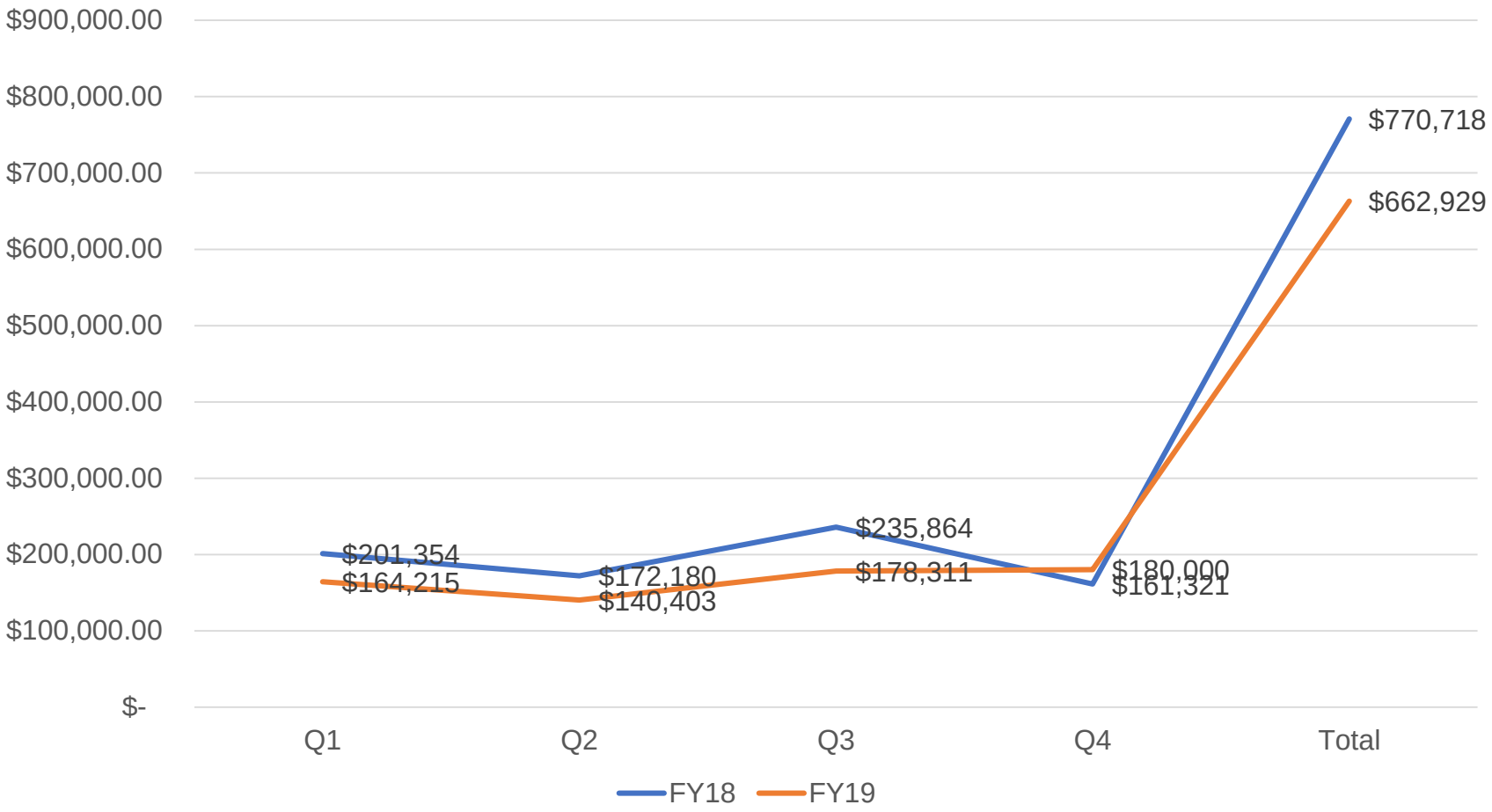
Slight Budget Reduction (4%) Projected for Next Biennium

	FY16	FY17	ACPG Recommend SFY 18 & 19 Allocation %	$ amount based on %	SFY 18 & 19 Grants	Scenario if ACPG recommended allocation for FY18&19 applied to SFY 20 & 21 Allocation %	SFY 20 & 21 $ amount based on %
Treatment	68%	58%	60%	$ 788,962	$ 870,637	60%	$ 788,382
Prevention	15%	15%	16%	$ 210,390	$ 209,991	16%	$ 210,219
Workforce Development	4%	4%	4%	$ 52,597	$ 53,000	4%	$ 52,559
Treatment Indirect	1%	1%	0%			0%	$ -
Data Collection / Eval	8%	11%	11%	$ 144,643	$ 139,372	11%	$ 144,438
Consulting	4%	3%	4%	$ 52,597	$ 41,000	4%	$ 52,559
Reserve	0%	8%	5%	$ 65,747	$ 54,840	5%	$ 65,699
	100%	100%	100%			100%	
			Total Authority		**$1,368,840**		**$1,313,970**

SFY 20 & 21 budget based on estimated transfers to the Revolving Account for the Prevention and Treatment of Problem Gambling as of 10/29/18.

Allocations in red for discussion only : No SFY20 allocation decisions have been made.

SFY 18 PG Treatment Spending & SFY19 Projections Based on Q1 Actuals

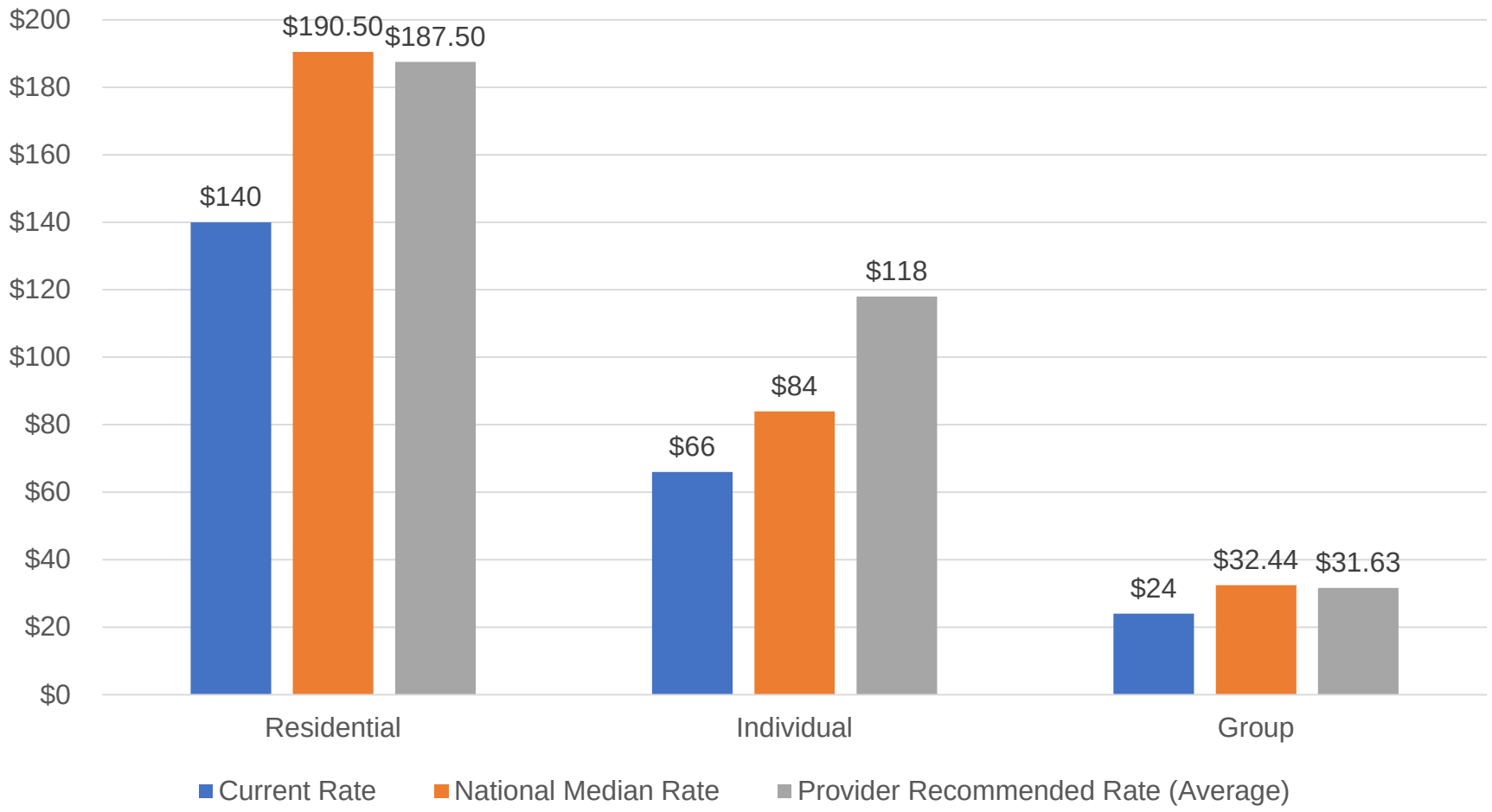


Note: For FY19, Q1 missing two data points otherwise based on actual claims for all providers and all months, all other FY19 quarters estimates based on FY18 claim pattern with exception of Q4 where in FY18 some grantees budgets fell short resulting in artificially reduced claims.

Problem Gambling Treatment

REIMBURSEMENT RATES

Nevada PG Treatment Reimbursement Rate Comparisons:
Current, National Median, Provider Recommended Average



Individual and Group rates based on one-hour of service

ACPG Reimbursement Subcommittee: Gambling Treatment Rate Survey *RESULTS*

- Provider survey responses indicate current rates:
  - *Do not support the cost of doing business*
  - *Are significantly detrimental to client care*
  - *Are significantly detrimental to employee retention*
  - *Are significantly detrimental to program sustainability*

- 50% of current gambling treatment providers indicated if rates do not change they are uncertain if they will re-apply for funding; 50% would re-apply

Respondents rated impact on a 4-oint scale with 0= no impact to 3 = critically detrimental. Average impact scores ranged from 2.0 to 2.5

Rate Increases: Projected Costs

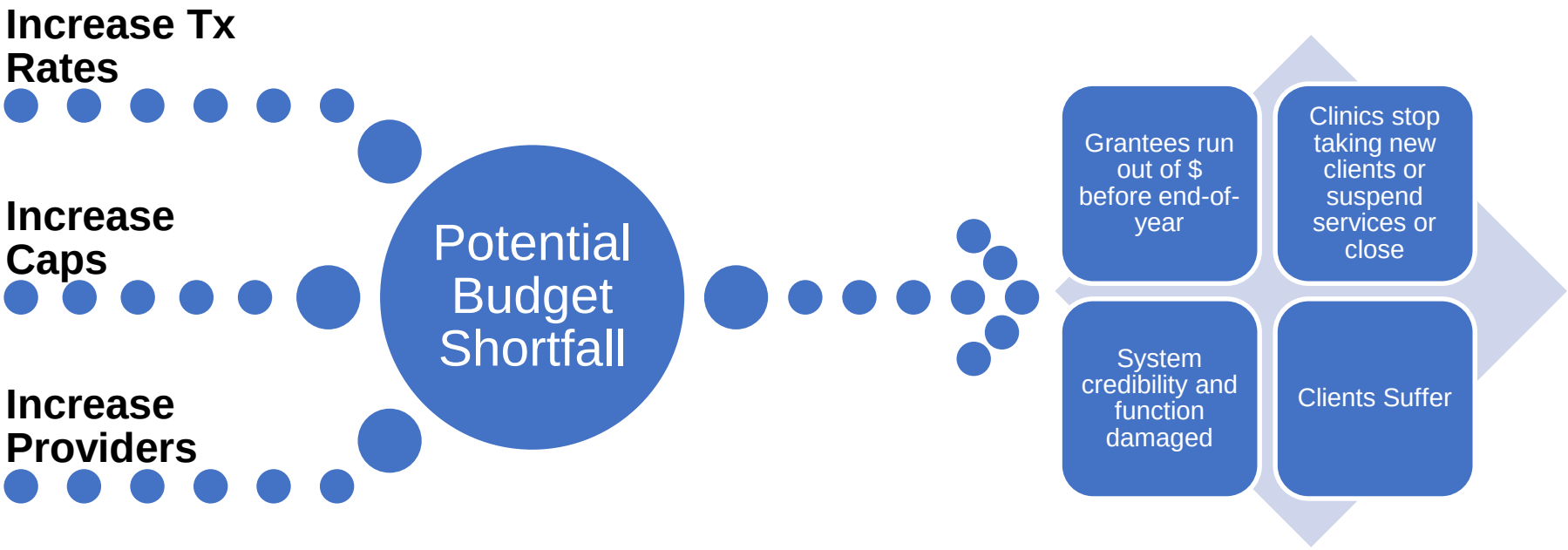
(based on SFY2018 data)

Proposal	**Est. $ Impact to System**
Increase rates 6%	***$46,000***
Increase rates 9%	***$70,000***
Increase rates 12%	***$92,000***
Increase rates 15%	***$115,500***
Add 5% indirect: Subsidize costs of non-encountered services	***$38,500***
Increase Outpatient cap to $2500	***$50,000 - $75,000***
Increase Residential cap to $3500	***$30,000***
Others?	***?***

Based on total FY2018 claims of $770,000; Cap increases assume 33% outpatient enrollees and 80% residential enrollees would utilize cap increase

Reimbursement Rate Double Jeopardy:

Lower rates loose providers, increase rates loose providers



Break-out Exercise

- Break into small groups of three.
- Allow time for every person to contribute.
- Select a spokesperson for the group.

Small Group Discussion Topics

The DHHS Problem Gambling Services Strategic Plan is going to be updated for SFY2020 and SFY2021. Given the assumption that the program budget will be relatively flat . . . .

- Treatment system changes
  - Look at the “treatment system options” slide and discuss the options, feel free to think of others not on the slide, and give your thoughts about which take priority consideration.
- Other than changes to the treatment system, what can we do differently to continue to improve the system?
  - If there is a budget impact to an initiative you propose, how would you suggest changing the current budget to pay for that initiative?

Treatment System Options

(assuming $1.3 M program budget; 4% reduction from current FY or greater if reserves are released in FY19)

- Keep current rates and caps? *Require an est. 60% of funds dedicated to Tx.*
- Increase rates and reduce caps? *May have little net impact to providers & hurt clients*
- Increase enforcement of payer of last resort and primary diagnosis policies? *Could save funds for most needed but difficult to enforce, may impact access, small saving.*
- Reduce number of providers? *Too few $ to adequately support 7? Access would decrease.*
- Increase rates by consolidating residential Tx to one location?
- Replace fee-for-service system? *Would loose investment & add dev. costs.*
  - Episode-of-care payments? *Flat fee independent of length of service or hybrid system.*
  - Centralized enrollment voucher system? *Would increase precision but may be barrier to care.*
- Reduce prevention and/or WD funding? *Would enable Tx rate increases.*
- Do not spend reserves in FY19 and plan to use in FY20 & 21?
  - *Would allow for rate and/or cap increases + preservation of other services (adds about $164K to FY20 & FY21 if request approved).*
- Others?

Comments in blue provide brief analysis and/or opinion by program consultant, Dr. Marotta.

Notes from Small Group Discussions

Moving from macro view to micro view

REVISITING NEXT BIENNIUM'S PROBLEM GAMBLING TREATMENT PROVIDER GUIDE

Review of proposed changes and solicitation of additional input

Proposed revisions to DHHS Problem Gambling Treatment Provider Guide (Appendix A)

- Based on input and observations from provider reviews, the following changes are proposed:
  - Setting rate for CPGC Fill-in to match CPGC
  - Adding “Reporting Timeliness” as performance standard and removing “Case Cost” as performance standard
  - Adding “Family Therapy” as separate service and rate
    - Qualifications? MFT only?
  - Reducing maximum per grantee benefit extension request totals from 10% of grant to 5% of grant and better defining allowable usage
  - Adding ICGC-II with 6 hrs CEU in NV laws and ethics as qualified provider
  - Requiring supervisors to co-sign supervisee intakes, tx plans, discharge summaries
  - Requiring client session sign-in logs
  - Moving requirement to complete Tx plan from 3rd session to 5th
  - Request from client to obtain copies of records from less than 30 days to 60

Next steps

- Take today's discussion points, along with work to date, and draft strategic plan for next two years.
- Present draft plan at November 15th ACPG meeting for comments and consideration for endorsement

Your input is very valuable and appreciated.

THANK YOU!

Questions?