Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project Section 1115 Demonstration Waiver – Implementation Plan

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Table of Contents

SUD Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

Goals:

1. Increase rates of identification, initiation and engagement in treatment for OUD and other SUDs.
2. Increase adherence to and retention in treatment for OUD and other SUDs.
3. Reductions in overdose deaths, particularly those due to opioids.
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD.
6. Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications.
4. Sufficient provider capacity at each level of care, including MAT.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Section I – Milestone Completion

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

Specifications:

To improve Medicaid beneficiaries' access to OUD and SUD treatment services, it is important to offer a range of services at varying levels of intensity across a continuum of care because the type of treatment or level of care needed may be more or less effective depending upon the individual. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services.
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management (WM).

Current State:

The State of Nevada has taken deliberate steps in recent years to improve access to behavioral health services for Medicaid beneficiaries. Beginning in 2014, the State adopted an integrated behavioral health clinic model to provide mental health and SUD treatment using American Society of Addiction Medicine (ASAM) criteria as the framework for levels of care and intensity of needs determination for placement (*See* Table 1 below for a list of benefits covered in a Non - Institution for Mental Disease (IMD) setting also within the 1115 SUD Demonstration application). In support of this effort, the State also leveraged several grants and an intensive technical assistance award through the Medicaid Innovation Accelerator Program to help develop a comprehensive, integrated behavioral health service delivery model.

Table 1: Current Nevada Medicaid and CHIP State Plan SUD Benefits by ASAM Level of Care

ASAM Level of Care	Benefit
0.5	Early Intervention/Prevention
1	Outpatient Services
2.1	Intensive Outpatient Services
2.5	Partial Hospitalization
3.1	Individual Services in Clinically Managed Low-Intensity Residential Non-IMD
3.2 WM	Individual Services in Clinically Managed Residential Withdrawal Management Non-IMD
3.5	Individual Services in Clinically Managed Residential Non-IMD
3.7 WM	Individual Services in Medically Monitored Inpatient Withdrawal Management Non-IMD
4	Medically Managed Intensive Inpatient Services Non-IMD

4-WM	Medically Managed Intensive Inpatient (Only) Services-Withdrawal Management Non-IMD
Office-Based Opioid Treatment	Medication Assisted Treatment (MAT)
Opioid Treatment Programs	MAT and Methadone Maintenance

Despite the above efforts, gaps in behavioral healthcare services remain for beneficiaries in need of community-based residential treatment and/or withdrawal management. Lack of access to these services has led to excessive use of higher cost services (i.e., emergency room and inpatient hospital services); low rates of initiation and engagement in treatment; failure to stabilize at lower levels of care and unnecessary readmissions to higher levels of care; and incarceration as an alternative to treatment. As such, Nevada is seeking to supplement current Medicaid and CHIP State Plan SUD benefits.

Future State:

Nevada Medicaid offers a full continuum of services consistent with the American Society of Addiction Medicine (ASAM) criteria. To improve quality of care and increase provider capacity, Nevada Medicaid plans to clarify these ASAM levels of care within the State Plan and will continue to encourage and promote availability and access to these services. With the continued evolution of substance use treatment services, Nevada Medicaid is dedicated to ensuring policy maintains consistent with evidenced based standards of care to improve quality and access to services.

To support the growth of providers performing these levels of care, Nevada Medicaid will continue to collaborate across Nevada Department of Health and Human Services' sister division, Division of Public and Behavioral Health (DPBH), to develop reimbursement rates to align with rates funded for gap services through the Substance Abuse Block Grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Nevada Medicaid will utilize DPBH Division Criteria to support the development of a dedicated substance use treatment Medicaid Service Manual to cohesively define Medicaid standards consistent with ASAM outpatient and residential levels of care.

Nevada will continue to recruit and train providers to become eligible to deliver treatment and recovery services to expand access and provider capacity, especially in rural areas. The state will provide ongoing assessment, engagement, and collaboration with the provider community and key stakeholders. Nevada will continue to refine the development of policies, protocols, and strategies to enhance access to services and improve coordination of services. Nevada will include best practices for screening, brief intervention, and referral to treatment (SBIRT) and medication-assisted treatment (MAT) in policy, consider alternative payment methodology (APM) for MAT services, encourage reimbursement optimization, and monitor utilization of telehealth and related technologies.

Table 2 Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of Outpatient Services	The Nevada Medicaid State Plan Attachment 3.1A page	Nevada will continue to provide	Review all substance use treatment

	6A.1 – 6C provides coverage for a wide array of outpatient services, including: • Screening • Assessment • Treatment Planning • Neuro-cognitive/psychological and mental status testing • Medication management • Drug Testing • Basic Skills Training • Psychosocial Rehabilitation • Crisis Intervention • Mental Health Therapies • Day Treatment • Peer to peer support services • Case management	services in accordance with current State Plan and offer a full array of evidence-based outpatient behavioral health services including substance use treatment in accordance with ASAM, which will be available in home and community-based settings as well as traditional clinical settings as appropriate. Nevada will leverage strategies and sustainability planning activities developed with support of the SUPPORT Act grants awarded to Nevada.	service definitions and staff qualifications to ensure alignment with ASAM (***Timeline 12-18 months)*** Amend State Plan to define substance use treatment services aligned with ASAM levels of care. ***(Timeline 12-18 months)*** Nevada Medicaid will create a new Medicaid Service Manual (MSM) chapter that is specific to substance use treatment services and remove current policy from MSM 400, which currently provides a broad array of behavioral health services. This new MSM chapter will include policy for the provision of substance use treatment services that align with ASAM Criteria ***(Timeline 12-18 months)***
Coverage of Intensive Outpatient Services	The Nevada Medicaid State Plan Attachment 2.1A page 6B & 6B 4 (continued) provides coverage for Intensive Outpatient Services and Partial Hospitalization Services that include requirements to align with ASAM criteria and Levels 2.1 and 2.5. These levels are reimbursable through FFS and	Nevada will continue to provide services in accordance with current State Plan to offer access to these higher levels of outpatient care in accordance with ASAM.	Over the demonstration period, Nevada Medicaid will continue to enroll Intensive Outpatient and Partial Hospitalization providers to expand this level of care across the state.

	managed care organizations (MCO).		***(Timeline: Throughout the course of the Demonstration)***
Coverage of medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	MAT and the associated counseling and rehabilitative services are currently offered through Section 1905(a)(29) Supplement 2 to Attachment 3.1-A of the Nevada Medicaid State Plan and is reimbursed through FFS and MCO delivery. Currently, MAT can be delivered by a Physician, Advanced Practice Registered Nurse (APRN), Physician's Assistant (PA), and a Nurse Midwife. Many of Nevada's Certified Community Behavioral Health Centers (CCBHC) perform MAT on site and if unable to perform on site coordinate care to a MAT provider. As part of their state certification requirements, a CCBHC must have a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders. Nevada has 8 CCBHCs located throughout the State, 4 located in urban counties and 4 located in rural counties. As part of the 9 core service requirements, the associated counseling and	As MAT continues to evolve, Nevada will continue to update the State Plan as well as policy to align with evidenced based practices to support quality treatment of Opioid Use Disorders as well as substance use disorders. Nevada will take advantage of the Consolidated Appropriations Act of 2023 and associated guidance from the Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand access to MAT.	Nevada Medicaid will remove policy requirements from MSM for providers to have a Data 2000 or X-waiver for prescribing buprenorphine. **(*Timeframe: 6-12 months)*** Nevada will further enhance provider capacity by adding pharmacists as an eligible provider to provide MAT and prescribe medication for OUD when budgetary authority can be provided. **(*Timeline 24-36 months)***

	rehabilitative services can be done at the location of a CCBHC. Additionally, Nevada Medicaid's telehealth policies allow for payment parity between face to face and telehealth delivery of services. Many associated behavioral health services to MAT can be done through telehealth delivery, such as counseling. Nevada Medicaid has an open formulary for all drugs that are medically necessary, FDA approved, and are provided by a manufacturer participating in the Medicaid Drug Rebate Program and therefore does not have a formulary listing covered drugs.		
Coverage of Intensive levels of care in residential and inpatient settings	Nevada Medicaid State Plan Attachment 3.1-A page 1 and page 1a currently covers inpatient stays consistent with ASAM level of care 4.0 in a non-IMD setting through FFS and MCO delivery. Nevada Medicaid MCO are contractually permitted to authorize coverage for stays of up to 15 days in an IMD for inpatient services related to SUD in lieu of other settings; however, this option is limited to managed care enrollees and the allowance is not always sufficient to meet beneficiaries' clinical needs.	With 1115 waiver demonstration authority, Nevada Medicaid will expand coverage through FFS and MCO delivery of ASAM level 3.1, 3.2 Withdrawal Management, 3.5, and 3.7 Withdrawal Management in both an IMD and non-IMD setting. Nevada will evaluate the reimbursement rates as well as consider bundled payment for residential levels of care for substance use treatment.	Provide enrollment opportunity for IMDs under the 1115 waiver authority and training support for residential treatment providers ***(Timeline 6-12 months)*** The State Plan already covers individual services that can be provided in a non-IMD, substance use disorder residential setting. To provide greater clarity that the State covers these services for the treatment of substance use disorders, amending the State Plan is

			necessary to define substance use treatment services aligned with intensive levels of care in residential and inpatient settings that meet ASAM criteria. ***(Timeline 12-24 months)*** Nevada Medicaid will create a new Medicaid Service Manual (MSM) chapter that is specific to substance use treatment services and remove current policy from MSM 400, which currently provides a broad array of behavioral health services. This new MSM chapter will include policy for the provision of substance use treatment services that align with ASAM Criteria for outpatient levels of care, ASAM Level 1, 2.1, and 2.5 and residential levels of care ASAM Levels 3.1, 3.2 WM, 3.5, and 3.7 WM ***(Timeline 12-24 months)*** Nevada Medicaid will define reimbursement for residential levels of care as well as evaluate and

			collaborate with the DPBH to align reimbursement rates based on gap services funded through the Substance Abuse Block Grant for residential levels of care. ***(Timeline: 24-36 months)***
Coverage of medically supervised withdrawal management	Nevada Medicaid covers withdrawal management for medically complex SUD patients in a hospital setting via the covered inpatient level of care benefit located on state plan Attachment 3.1-A page 1 and page 1a.	Nevada Medicaid will add medically supervised ASAM level 3.7 withdrawal management services to the Medicaid state plan and make these services available in non-IMD residential and inpatient settings.	The State Plan already covers individual services that can be provided in a non-IMD, substance use disorder residential setting. To provide greater clarity that the State covers these services for the treatment of substance use disorders, amending the State Plan is necessary to define substance use treatment services aligned with clinically managed residential withdrawal management and medically supervised withdrawal management that meet ASAM criteria. ***(Timeline 12-24 months)*** Nevada Medicaid will create a new Medicaid Service Manual (MSM) chapter that is

			specific to substance use treatment services and remove current policy from MSM 400, which currently provides a broad array of behavioral health services. This new MSM chapter will include policy for the provision of substance use treatment services that align with ASAM Criteria for outpatient levels of care, ASAM Level 1, 2.1, and 2.5 and residential levels of care ASAM Levels 3.1, 3.2 WM, 3.5, 3.7 WM, and 4.0 WM ***(Timeline 12-24 months)***

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current State:

With the adoption of the American Society of Addiction Medicine (ASAM) criteria and the development of a community behavioral health safety net in recent years, Nevada has made considerable progress in meeting the milestones utilizing an SUD-specific patient placement criteria. Nevada Medicaid currently requires ASAM criteria to be utilized within the State Plan, Medicaid Service Manual policy, and DPBH Division criteria for substance use treatment provides.

Future State:

Allowing flexibilities around prior authorization gives providers room to take action to effectively and expediently handle patient needs. Bringing balance to both effectiveness and expedience is important to a growing focus on SUD treatment. Prior authorizations are used to manage quality, utilization, and cost; however, they can present a significant barrier to treatment. Administrative burden is consistently reported as a leading cause of provider burnout as it affects providers' perceptions of their ability to provide quality care. In order to support individuals returning to a healthy state of being, administrative barriers that interfere with recovery must be addressed.

Table 3. Milestone #2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	Nevada Medicaid State Plan requires ASAM criteria for IOP & PHP (3.1-A pg. 6b.4 - 6b.4 continued page 1), and MAT (Supplement 2 to attachment 3.1-A) Nevada Medicaid Services Manual requires ASAM patient placement criteria to establish guidelines for level of care placements within the substance abuse continuum.	Nevada Medicaid and DPBH will continue to collaborate in ensuring SUD-specific, multi-dimensional evidenced based assessment tools aligned with ASAM are used universally throughout the Nevada substance use treatment system of care. This can be further enforced with clearer definition of ASAM Criteria with State Plan for all levels of substance use treatment services.	Nevada Medicaid will amend State Plan to require inclusion of a full psychosocial assessment covering the six dimensions in accordance with The ASAM Criteria for all substance use treatment services. ***(Timeline: 12-18 months)***
Implementation of a utilization management approach such that: (a) beneficiaries have access to SUD services	Nevada Medicaid requires the use of ASAM criteria to guide service delivery and level of care placement for outpatient SUD services. These	The state will continue utilization review processes currently in place that require the use of ASAM criteria for the appropriate level of care.	The state meets the milestone but plans actions to ensure beneficiary access to the appropriate level of care. Leverage the SUPPORT Act post

at the appropriate level of care.	services are currently available within non-IMD settings. Through a contracted vendor, the Center for the Application of Substance Abuse Technologies (CASAT), DPBH monitors access to SUD services through certification on-site visits to ensure proper documentation is in place to support the appropriate level of care. DPBH also utilizes the peer review process to continuously improve treatment services to alcohol and drug users within the treatment agencies across the State. Nevada Medicaid does not currently reimburse for residential levels of care in an IMD setting or if a provider is receiving funding through DPBH. DPBH utilizes substance abuse block grant funding to reimburse for residential services. As part of DPBH Division Criteria requirements, ASAM Criteria is used for all substance use treatment levels of care even if not funded through Nevada Medicaid.	State staff will leverage its enhanced Medicaid Management Information System (MMIS), to ensure the state is able to capture data needed to calculate any required quality measures.	planning demonstration grant activities to support growth in increased provider capacity at every ASAM level of care ***(Timeline: 6 – 18 months)*** State staff will continue to consider and evaluate policies that will enhance access to this service array, including review of prior authorization requirements to ensure these are not barriers to access to care. Reviewing data based on the number of prior authorization approvals, denials, or partial approvals may indicate if adjustment to prior authorization criteria and policies are needed to support increased access to care and to minimize the administrative burden on providers. ***(Timeline: Throughout the Demonstration period)***

Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care.	Nevada Medicaid utilizes a Quality Improvement Organization (QIO-like) vendor, currently Gainwell Technologies, for utilization management and prior authorization requests for medical necessity determinations. Nevada's QIO-like vendor utilizes ASAM criteria and MSM policy to support medical necessity and approval of services. DPBH utilizes certification reviews to ensure medical necessity and proper levels are care are aligned with ASAM criteria. The Managed Care Entities are responsible for their own utilization management criteria that aligns with FFS criteria.	All inpatient and residential placements will require prior authorization to support the utilization management process and will be determined through the QIO-like vendor to determine the interventions approved support the diagnosis and level of care. Quality measures to be collected will be explored with treatment providers to identify ways to support appropriate utilization management. With support of state collected data, like plan all cause readmissions, identification of follow up care, initiation of substance use diagnosis and engagement in treatment, this will be a valuable resource to support utilization management of SUD services.	Define prior authorization requirements for each reimbursable ASAM level of care and add additional policy to new MSM SUD chapter that describes each ASAM level of service available, including but not limited to duration of time services are typically delivered within each level of care setting, admission criteria consistent with ASAM Criteria, non-covered services, etc.. This will be developed to educate treatment providers and support utilization management to validate interventions are appropriate for the diagnosis and level of care determined. ***(Timeline: 6 – 12 months)*** Develop process to collect quality measures from providers ***(Timeline: 24-36 months)***
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings.	For Nevada Medicaid reimbursable services within a residential setting, the QIO-like contracted vendor utilizes ASAM criteria and Medicaid Services Manual policy to determine medical necessity for services. The QIO monitors	Collaboration between Nevada Medicaid, DPBH and CASAT to establish consistent provider standards within Medicaid Services Manual as well as DPBH division criteria. When on site reviews occur for residential treatment providers, there will be	With the addition of services in residential settings that are considered an IMD under waiver authority, Nevada Medicaid will use the QIO-like contracted vendor that currently uses ASAM criteria and MSM policy to determine

	oversight of the lengths of stay. For residential treatment settings not reimbursed through Nevada Medicaid, DPBH utilizes the Center for the Application of Substance Abuse Technologies (CASAT) to provide certification of residential treatment providers through on site reviews and ongoing educational support. These reviews include clinical documentation reviews to ensure appropriate placement for SUD levels of care.	one standard that meets requirements across Medicaid reimbursable and state funded programs.	medical necessity for placement in residential treatment IMD settings. ***(Timeframe: 6-12 months)***

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Specifications:

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Current State:

The Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC) has licensure authority over various health care facilities in the State of Nevada. For substance

use treatment facilities, the role of BHCQC is to license and regulate these facilities for compliance with safety and structure requirements. They serve as the regulatory authority for compliance with NRS and NAC Chapter 449.

In conjunction with the licensing component, the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within DPBH certifies agencies for substance use prevention, treatment, and recovery efforts per NRS and NAC Chapter 458. This certification is conducted by the Center for the Application of Substance Abuse Technologies (CASAT). BBHWP alongside BHCQC work together to ensure the quality of services are held to a high standard. Certification allows for review of clinical records for appropriate level of care placement.

Future State:

All Nevada Medicaid enrolled substance use treatment providers are required to submit their SAPTA certification upon enrollment verifying their compliance with the Bureau of Health Care Quality and Compliance (BHCQC) licensure as well as certification requirements based on ASAM level of care and DPBH Division Criteria. MMIS enhancements are in process to allow Nevada Medicaid to enroll residential and clinic provider groups as well as individual substance use treatment providers to inform value and enhance quality to delivery of SUD treatment.

Table 4. Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical.	Nevada Medicaid does not currently reimburse for residential treatment level of care for SUD treatment in an IMD for 22-64. Residential provider licensure requirements are outlined at NRS 449.00455 et seq. and NAC 449.019 et seq. and align with ASAM criteria. The BHCQC licenses health facilities in Nevada, including but not limited to, facilities for the treatment of abuse of alcohol or	Nevada Medicaid will continue to ensure all residential treatment providers are qualified to provide services in accordance with ASAM criteria with the established DPBH Division criteria. When a substance use treatment professional becomes licensed or certified, they will have opportunity to enroll as an individual specialty linked to a substance use treatment facility performing services to Nevada Medicaid eligible individuals.	MMIS will incorporate system enhancements to enroll substance use treatment providers that are licensed or certified as individual Medicaid providers and will be able to link to a substance use treatment provider agency ***(Timeline: 6 -12 months)***.

	drugs. This regulatory body provides oversight for health care inspections and complaints. BBHWP provides certification to all entities in Nevada that provide substance use prevention or treatment services that receive state or federal dollars. Both entities collaborate with requirements for each when conducting on-site visits of all substance use treatment facilities.		
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	Nevada's process for licensure and certification of residential treatment providers is established through DPBH. The Bureau of Health Care Quality and Compliance (BHCQC) licenses health facilities in Nevada, including but not limited to, facilities for the treatment of abuse of alcohol or drugs. This regulatory body provides oversight for health care inspections and complaints. The Bureau of Behavioral Health Wellness and Prevention (BBHWP) provides certification to all entities in Nevada that provide substance use prevention or treatment services that receive state or federal dollars. Both entities collaborate with	Already implemented.	No action required.

	requirements for each when conducting on-site visits of all substance use treatment facilities.		
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site.	Per DPBH Division Criteria, certified treatment programs, private, public, or funded cannot deny treatment services to clients that are on stable medication maintenance for the treatment of an opioid use disorder, including FDA approved medications.	Enforce requirements of facilities offering MAT on-site through use of Medicaid Service Manual policy.	Update Medicaid Service Manual policy to include requirement of offering all FDA-approved MAT on-site or facilitate access to off-site MAT. ***(Timeline: 12-18 months)***

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Specifications:

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current State:

In September 2019, the U.S. Department of Health and Human Services (HHS) and CMS awarded Nevada DHCFP the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Planning Grant in the amount of $1,684,013 over 18 months, October 2019 through March 2021.

The purpose of the planning grant was to increase the capacity of Medicaid providers to deliver SUD treatment or recovery services through:

- An ongoing assessment of the substance use disorder treatment needs of the state;
- Recruitment, training, and technical assistance for Medicaid providers offering substance use disorder treatment or recovery services; and
- Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers.

Nevada is committed to providing Nevadans with a broad service delivery system to increase access to behavioral health services with an emphasis on SUD or OUD by providing a coordinated, comprehensive, and whole-person approach. At the start of the SUPPORT Act planning grant, the lead agency, the DHCFP, established the Nevada SUPPORT Act Core Team (Core Team) as an active governance body, spearheaded by leadership from Nevada Medicaid and the DPBH's Substance Abuse Prevention and Treatment Agency (SAPTA). The Core Team's work engaged a diverse representation from other state agencies and divisions, as well as community partners and providers. Two major milestones accomplished during this phase of the SUPPORT Act grant that supported provider expansion of substance use treatment including MAT services were the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) codes and creation of a comprehensive MAT policy. SBIRT codes were activated on March 2, 2020, for various providers including physicians, Advanced Practice Registered Nurses (APRNs), physician assistants (PAs), and nurse midwives. An SBIRT Toolkit was also developed, and training was provided to Nevada's largest female reproductive health practice. The comprehensive MAT policy documents the process of treatment to outline expectations, the use of buprenorphine medication, and qualification of providers. A MAT billing guide was also created to further clarify billing expectations when performing MAT services. In December of 2020, through the work of the SUPPORT Act planning grant, Nevada was able to publish the Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report please find link to report under Section III: Relevant Documents. The purpose of the assessment report is to present the current policy and infrastructure landscape regarding SUD service system in Nevada, including provider capacity, benefit design and coverage, prior authorization management, integrated care delivery, and reimbursement. The report also illustrates areas of opportunity, and includes emerging and best practices, as well as recommendations to enhance and expand SUD treatment and recovery services statewide.

The assessment report covers the following main areas:

- Current Opioid Use and Provider and Treatment and Recovery Services Capacity in Nevada.
- Nevada Substance Abuse Healthcare System Landscape, Challenges, and Opportunities.
- Benefits Utilization Management Landscape and Opportunities.
- Technology-Enabled Approaches to Expand Capacity and Services.
- Application and Expansion of the Hub-and-Spoke Model.
- Fiscal Projections.

The report was developed between March 2020 and June 2020, and utilized information from various sources, including specific DHHS stakeholder discussions and communications, as well as statewide and county-level assessments, epidemiology and surveillance briefs, provider surveys, data reports, document review, and other research.

In September 2021, Nevada was among five states awarded the CMS SUPPORT Act Post-Planning Demonstration Grant Award. The Demonstration project further aims to increase the treatment capacity of providers participating under the Medicaid state plan (or a waiver of such plan) to provide SUD treatment and recovery services. This phase of the grant is awarded through September 2024.

Additionally, SAPTA funded providers are required to participate in a referral-based platform called OpenBeds. The primary functions of the platform are real-time cloud-based bidirectional referrals, bed

registry, and storing Comprehensive Addiction and Recovery Act (CARA) Plans of Safe Care. Data indicators that can be captured within this platform are the number of referrals, length of time to acknowledge a referral, bed capacity over 90%, average bed availability per day, gender, age, difficult to place clients, the reason for declined referral, payment method, special population, and substances. The providers can also track the referrals. There is an analytics section that can help the providers with staffing leaves and referral turnaround time. In addition, the platform can be used to link to social determinants of health by sending a request to Nevada 211.

Future State:

Nevada will continue to leverage the work developed through both phases of the SUPPORT Act Planning and Post Planning grants. With the construction of focused data reporting requirements, Nevada will leverage quarterly data reports identifying Nevada's current provider capacity for substance use treatment services, including MAT services, and monitor trends to evaluate provider capacity. Nevada will continue to evaluate and refine the SUD Data Book developed through the DHHS's Office of Analytics.

Nevada has increased focus in the delivery of crisis services across the state. During the 2021 Nevada Legislative session, Senate Bill 156 and Senate Bill 390 were passed to further Nevada's development of a comprehensive crisis response system. Senate Bill 156 required Nevada Medicaid to reimburse for crisis stabilization services performed in a Crisis Stabilization Center endorsed under a hospital licensure. To further expand crisis stabilization services, Nevada plans to reimburse for intensive crisis stabilization services within a CSC but also to providers meeting certification standards within a community setting to address crisis needs across the state. Senate Bill 390 enacted the 988 surcharge on telecommunication and established the Crisis Response account to support the infrastructure of the 988 call-center, interoperability technology, GPS deployment of mobile crisis teams, the implementation of mobile crisis teams, and provide sustainable funding for uncompensated care for services within the crisis continuum. Along with the legislation of Senate Bill 390, Nevada Medicaid was awarded the Section 9813 Mobile Crisis Planning Grant through the CMS to support the state in be preparing to elect and implement the new American Rescue Plan "State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services," that coincided with the national requirement of 988 behavioral health crisis line in July of 2022. States with a SPA, 1915(b) waiver, 1915(c) waiver, or 1115 waiver program with corresponding authority for Community-Based Mobile Crisis Intervention Services may receive an 85% FMAP for expenditures on qualifying Community-Based Mobile Crisis Intervention Services for the first 12 quarters (3 years) within the five-year period beginning April 1, 2022, during which the state meets the conditions for the 85% FMAP. With development of both intensive crisis stabilization services and community based mobile crisis teams, Nevada strives to increase high quality access to individuals struggling with a mental health or substance use crisis.

As Nevada moves forward with the implementation of the Crisis Response System, the Division of Public and Behavioral Health (DPBH) has released a Request For Information (RFI) for feedback on what Nevada is calling the Nevada Behavioral Health Crisis Care Hub (NBHCCH) serving as the software and call center to organize and deploy crisis response services, including a Suicide Lifeline, Designated Mobile Crisis Teams, and a bed registry. Once responses have been received, DPBH will release a Request For Proposal (RFP) targeted for Fall of 2023 for interested vendors of the NBHCCH. With the support of a NBHCCH, there will be increased interoperability and access to critical levels of care for individuals struggling with a mental health or substance use issue.

Table 5. Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: • **Outpatient** • **Intensive Outpatient Services** • **MAT (including counseling and medication)** • **Intensive levels of care in residential and inpatient settings** • **Medically supervised withdrawal management**	Through Section 1003 of the SUPPORT Act planning and post planning grants, Nevada has collected significant data for identifying the amount of enrolled Medicaid providers performing substance use treatment services, including MAT. On a quarterly basis, Nevada reviews data evaluating the amount of enrolled Nevada Medicaid providers and the amount of individuals with a diagnosis of SUD receiving care in an outpatient setting, inpatient setting and by provider type. SAPTA funded providers are participating in a referral-based platform called OpenBeds. The primary functions of the platform are real-time cloud-based bidirectional referrals, bed registry, and storing Comprehensive Addiction and Recovery Act (CARA) Plans of Safe Care. Data indicators that can be captured within this platform are the number of referrals, length of time to acknowledge a referral,	Increase quality access to individuals experiencing a mental health or substance use crisis. Evaluate and refine the SUD Data Book developed through the DHHS's Office of Analytics.	Nevada Medicaid will integrate intensive crisis stabilization services within the State Plan and MSM to support individuals experiencing a substance use disorder crisis in need of stabilization. With this new provider type and specialty, the Medicaid enrollment checklists will include language to participate in statewide crisis response system. Once NBHCCH is effective, these providers can be integrated into the response system for individuals experiencing a mental health or substance use crisis. (***Timeframe: 6-12 months)*** Nevada Medicaid will update MCO vendor contracts to include time and distance standard ratios for providers delivering services under this waiver (***Timeline: 6-12 months)*** Nevada Medicaid will utilize data gathered

	bed capacity over 90%, average bed availability per day, gender, age, difficult to place clients, the reason for declined referral, payment method, special population, and substances. The providers can also track the referrals. There is an analytics section that can help the providers with staffing leaves and referral turnaround time. In addition, the platform can be used to link to social determinants of health by sending a request to Nevada 211.		through the SUPPORT Act Post Planning Demonstration as well as Medicaid enrollment information to identify specific counts of current providers performing and accepting new patients at all critical levels of care through state collected information and also provider surveys to achieve a comprehensive updated outlook for provider capacity at critical levels of care. ***(Timeline: 12 months)*** Refine data collection to collect specifics on individually enrolled substance use treatment providers available in Nevada once new Substance Use Treatment Provider Type and individual enrollment specialties are created and providers are enrolled. ***(Timeline: 24 months -duration of waiver)*** Further develop and refine the SUD Data Book developed through the DHHS's Office of Analytics. ***(Timeline: 12-24 months)***

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Specifications:

To meet his milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current State:

Nevada has recently made great strides to improve the behavioral health related outcomes described above. For example, the Good Samaritan Drug Overdose Act of 2015 was signed into law on May 5, 2015, and codified as Chapter 453C in Nevada Revised Statutes. The law provides immunity for personal use and possession of controlled substances for those seeking medical attention during a drug overdose. It also requires that prescribing physicians obtain a patient utilization report from the state's Prescription Monitoring Program (PMP) before initiation of a schedule II, III, or IV prescription drug for a new patient, or for a course of treatment lasting longer than seven days that is part of a new course of treatment for an existing patient. Further, the Act expands access to the opioid antagonist Naloxone by allowing providers to prescribe and/or dispense the product to persons positioned to assist another person at risk for overdose and by allowing a pharmacist with standing orders to store and dispense the product without a prescription.

The Nevada legislature passed the Prescription Drug Abuse Prevention Act unanimously and it was signed into law on June 16, 2017. The law, which went into effect on January 1, 2018, expands and updates state laws requiring doctors and hospitals to report any drug overdoses to the State; permits licensing boards to access Prescription Monitoring Program data to investigate inappropriate prescribing, dispensing, or use of a controlled substance; and requires that prescribers perform a risk assessment before prescribing a controlled substance. A prescription medical agreement with the patient must be created for prescriptions over 30 days. In addition, the prescriber must complete a risk of abuse assessment and obtain a patient utilization report every 90 days for the duration of the prescription.[3] Lastly, the law created the "Prescribe 365" initiative, which states that no patient should receive more than 365 days' worth of medication in any consecutive 365-day period. This impacts all prescriptions for controlled substances; however, most provisions apply specifically to only those controlled substances prescribed to treat pain. In 2019, the Legislature passed AB239, which further refined the law. Under the law, prescribers must review a patient's PMP report and perform a risk assessment before prescribing a controlled substance. The law includes guidelines for the treatment of acute pain and exemptions are made for hospice, palliative, cancer, and sickle cell prescriptions. This and other requirements are expected to reduce the number of people who develop SUD and OUD, while maintaining access to appropriate pain management medications and enhancing alternative pain management strategies.

Comprehensive knowledge of pain management strategies and training about pain management competencies that cross disciplines are known barriers to implementation of the law. Other challenges include communication between pharmacists and prescribers, confusion over interpretation of new provisions, misinformation to patients and prescribers, and knowledge of resources for SUD treatment.

However, despite these challenges, data from the Nevada Prescription Monitoring Program indicates

there has been an overall reduction in opioid prescriptions for pain. From January of 2017 to January of 2021, the rate of opioid prescriptions per 100 Nevada residents decreased by approximately 40%. Opioid prescriptions with a less than a 15-day supply decreased by 76% during this same time period.

In April 2018, *Prescription Nation 2018: Fighting America's Opioid Epidemic* acknowledged Nevada as one of two states recognized in 2018 by the National Safety Council for addressing six key indicators to address the crisis: 1) mandating prescriber education; 2) implementing opioid prescribing guidelines; 3) integrating prescription monitoring program into clinical setting; 4) improving data collection/sharing; 5) treating opioid overdose; and 6)increasing availability of opioid use disorder treatment.

Future State:

Nevada will work to expand the roles of pharmacists to include Opioid Maintenance Therapy (OMT) and explore reimbursable services regarding opioid management for pharmacists. An expansion to allow pharmacists would increase access to OMT to address opioid abuse and OUD. If a model could be established to partner pharmacies with established Opioid Treatment Programs (OTP) and create a fair level of reimbursement for a pharmacist's clinical services, this would serve as a win-win because it would expand the program as well as the pharmacist's clinical role in MAT.

Table 6. Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	Prescription monitoring thru the PBM and RX Team - new system in place Buprenorphine/Naloxone and Buprenorphine are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the Nevada Drug Utilization Review Board. The Pharmacy Lock-In Program is intended to prevent recipients from obtaining excessive quantities of controlled substances through multiple visits to	Already completed.	No action required.

	physicians, clinics, and pharmacies. When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be "locked-in" to a specific pharmacy. This means that Medicaid will only pay for controlled substance prescriptions at a single pharmacy.		
Expanded coverage of, and access to, naloxone for overdose reversal	Nevada Medicaid does not require any prior authorization for naloxone, which ensures that eligible Medicaid beneficiaries can receive the medication easily. Additionally, naloxone is available without a prescription throughout the state of Nevada as part of an ongoing effort to prevent drug overdose deaths in Nevada. There is training supported by CASAT and other community partners for overdose reversal, funded through the State Opioid Response Grant.	Over the course of the demonstration, Nevada will continue to support the statewide distribution of naloxone through increased provider communication through web announcements and monthly SUD treatment provider engagement meetings and provide consistent and integrated trainings conducted across stakeholder types. As supported through CMS' bulletin issued January 2017, Nevada will expand timely access to certain drugs in the interest of public health, specifically including naloxone. These options included expanding the scope of practices and range of services that	This milestone is met, as statewide access to naloxone is already in place. Nevada will continue work across DHHS to support access, training, and awareness of coverage through increased provider communication through web announcements and monthly SUD treatment provider engagement meetings. ***(Timeline: 6 months - Demonstration Period)*** If given budgetary authority, Nevada will further increase access to naloxone by adding pharmacists as an approved prescriber under a collaborative practice agreement (CPA) with other licensed prescribing healthcare providers like physicians,

		pharmacists can provide, "including dispensing drugs based on their own independently initiated prescriptions, collaborative practice agreements (CPA) with other licensed prescribing healthcare providers like physicians, 'standing orders' issued by the state [health authority], or other predetermined protocols".	'standing orders' issued by the state. ***(Timeline: 24-36 months)***
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Nevada State Board of Pharmacy oversees the vendor contract for the prescription drug monitoring program. Two Nevada Medicaid staff members have the ability to query the database. Query of the prescription drug monitoring program has been incorporated in the operations of the Pharmacy Lock-In Program	Nevada Medicaid is exploring additional data the program will need to provide regarding provider checking drug history and calculation for averages of morphine milligram equivalent prescribed for different groups.	Evaluate dashboard capabilities (***Timeframe: Throughout Demonstration Period)***

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Current State:

In 2016, Nevada was selected to participate in the federal Section 223 of the Protecting Access to Medicare Act demonstration program to develop a network of Certified Community Behavioral Health Centers (CCBCHs). These entities, a provider type in Nevada Medicaid, are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals, including members of the armed services and veterans. CCBHCs are responsible for providing nine specific service types, with

an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Future State:

This waiver will allow Nevada to expand and improve care coordination efforts for individuals transitioning between levels of care. It will ensure and support successful treatment for individuals with SUD and complement Nevada's increased access to residential levels of care provided. The ability to create and implement integrated care plans, ensure access to an array of linked services, and the exchange of information among consumers, family members, and providers will be necessary not only in outpatient settings, like CCBHCs, but also residential and inpatient levels of care.

Nevada will consider financial incentives for care coordination across health care professional types including behavioral health counselors and other non-physicians in specialty and non-specialty settings. Allowing providers to receive reimbursement for a collaborative, team-based care model provides a pathway for primary care offices to deliver sustainable, high-quality, evidence-based treatment. If legislative authority, Nevada will have budgetary authority to move this forward.

As part of Nevada's 1115 application, Nevada plans to further expand the targeted case management benefit to include a specific target group for individuals with an SUD only diagnosis ensuring residential and outpatient providers will have reimbursement incentive to effectively support individuals transitioning between levels of care.

Table 7. Milestone #6: Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	Current Medicaid Service Manual discharge policy criteria requires providers to include a discharge plan within an individual's treatment plan and includes requirements for providers to recommend aftercare services for goals that were both achieved and not achieved during the duration of the treatment plan. Discharge criteria also requires providers to identify available agencies and independent providers	Redefining discharge criteria and transitions of care standards across DPBH Division Criteria and Medicaid policy to include but not limited to, support with setting follow up appointments with community-based providers prior to discharge, referral options provided to individual at time of discharge, ASAM score at time of discharge, statement of progress made during treatment between residential and outpatient levels of care. This will	Redefine discharge criteria specific for residential treatment providers and develop transition of care standards across DPBH Division Criteria and Medicaid policy to include but not limited to, support with setting follow up appointments with community based providers prior to discharge, referral options provided to individual at time of discharge, ASAM score at time of discharge, statement of progress made during treatment

	to provide aftercare services and the purpose of each for the recipient's identified needs under the treatment plan to ensure the recipient has access to supportive aftercare. Providers are expected to transition clients to lower levels of care once their residential needs are met. ASAM provides a robust continuum of care based on a person-centered need where the client moves through the continuum from higher levels to lower levels. During certification reviews, a sample of clinical records by level of care are reviewed to ensure providers are accurately moving clients through the continuum. The current contract with MCO includes care management. Care Management consists of both Level 1 Care Coordination and Level 2 Case Management. Care Coordination is designed to assist members with social determinants of health needs, challenges in accessing health and community resources or other member needs that fragment	support individuals with a full continuum of support and lead to enhanced provider network communication to support successful treatment outcomes.	within new Medicaid Service Manual policy for substance treatment providers and Division Criteria ***(Timeline: 12 -24 months)*** If provided budgetary authority, Nevada will integrate a new SUD-only target group within the targeted case management benefit to support case management activities for individuals transitioning between residential and outpatient SUD services. ***(Timeline: 24-36 months)***

	the member's care or lead to poor health outcomes. Case Management is designed to support members, regardless of age, based on an individualized assessment of health and social determinant of health needs. Case Management must be offered to members identified as high-risk, including members with SED/SMI, members with comorbid medical and behavioral health conditions, including substance abuse disorders, and members experiencing a high-risk pregnancy.		
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Nevada policies to ensure coordination of care for co-occurring physical and mental health conditions are outlined within our Certified Community Behavioral Health Centers (CCBHCs) which includes coordinating all behavioral/mental and physical health activities regardless if the care is provided directly by the CCBHC and its DCO or through referral or other affiliation outside of the CCBHC delivery model.	Develop MSM and Division Criteria standards for coordination of care for co-occurring physical and mental health conditions for residential levels of care transitioning to outpatient levels of care. Explore collaborative care model and consider adoption within Medicaid Services Manual policy and State Plan.	Develop MSM and Division Criteria standards for coordination of care for co-occurring physical and mental health conditions for residential levels of care transitioning to outpatient levels of care. ***(Timeline: 18-24 months)*** If provided legislative authority, integrate the collaborative care model within state plan and MSM. ***(Timeline: 24-36 months)***

Section II – Implementation Administration

The Division's point of contact for the Implementation Plan is:

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Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

SUPPORT Act Grant Sustainability Plan

SUPPORT Act Grant Strategic Plan

SUPPORT Act Grant Infrastructure Assessment Report

Attachment A – SUD Health Information Technology (IT) Plan

Section I.

Specifications:

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Monitoring the Health IT functionality to support Prescription Drug Monitoring Program (PDMP) interoperability; and working to support the Board of Pharmacy.
- Monitoring clinicians in their usage of the state's PDMP.

Current State-

Nevada's Pharmacy Board currently shares data nationwide with 40 States and Military Health System through an interstate data sharing agreement. This allows Nevada to share more complete data records of patient's-controlled substance medication history to healthcare providers in making decisions for their patients. Interstate data sharing varies based on each state's regulation policies.

Nevada shares prescription data across stateliness via PMP InterConnect® and RxCheck hubs. The data sharing hubs allow participating state PMPs to be linked and provide a more effective means of combating drug diversion and drug abuse nationwide. The PMP staff analyzes controlled substance prescription data to identify high prescribers and patients who are doctor shoppers. Currently the Board of Pharmacy Prescription Monitoring Program (PMP) staff submits a biannual report to each licensing board to alert them of their licensees who are identified on the high prescriber's report.

In addition, the Pharmacy Board currently utilizes Bamboo Health's PMP Gateway integration service and Electronic Health Records (EHRs) and Pharmacy Management Systems (PMS). The Pharmacy Board uses patient-clustering algorithms that result in 99.8% accurate patient matching, leading to more reliable prescribing and dispensing. Instead, the EHR or PMS will automatically initiate a patient query, which will return the patient's-controlled substance prescription records directly within the clinical workflow.

Nevada has a Health Information Exchange (HIE) but there is no requirement for data submission or data quality. DHCFP currently has no initiatives for HIE before legislature and does not have any intentions of doing any connectivity or innovations with the HIE as the data is unreliable and unusable.

Future State-

Nevada will support sharing data with the additional 10 States, based on the contingency of the other states processes and policies for interstate data sharing. Additional outreach efforts will occur with clinicians, providers, and other states.

DHCFP will encourage prescribers through the DHCFP website to utilize the Board of Pharmacy's resources and encourage the integration of the EHR or pharmacy management system, even though it is not mandatory. Nevada will encourage providers and pharmacies to integrate the NV PMP with their EHR or pharmacy management system but does not have any incentives or initiatives.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Nevada currently shares data nationwide with 40 states, as well as the Military Health System. Interstate data sharing efforts have increased the availability of a more complete record of a patient's-controlled substance medication history to health care providers to assist them in making the best decision for their patients and deterring drug diversion. Interstate data sharing varies based on each state's statutory limitations.	Data sharing with the additional 10 states will be pursued. This will be contingent on other states' processes and policies for interstate data sharing.	Review the remaining 10 states polices and statutory regulations for interstate data sharing and identify any limitations. For the states without policy or statutory limitations, data sharing will be a challenge.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Nevada shares prescription data across stateliness via PMP InterConnect® and RxCheck hubs. The data sharing hubs allow participating state PMPs to be linked and provide a more effective means of combating drug diversion and drug abuse nationwide. Interstate data sharing allows physicians and pharmacists to help identify patients with prescription drug abuse and misuse problems, especially those	Nevada currently has 8562 prescribers and 610 pharmacies enrolled in interstate data sharing with the PMP	Evaluate possible outreach efforts to prescribers and other eligible state and federal stakeholders through 12/2027.

	patients who cross state lines to obtain drugs.	InterConnect and RxCheck hubs.	Update DHCFP Pharmacy website to utilize the Board of Pharmacy's resources and encourage them to integrate the EHR or pharmacy management system, even though it is not mandatory through 12/2027.
Enhanced connectivity between the state' PDMP and any statewide, regional or local health information exchange	The Nevada PMP is not connected to the state Health Information Exchange (HIE).	Nevada has a Health Information Exchange (HIE) but there is no requirement for data submission or data quality. At this time, DHCFP currently has no initiatives for HIE before legislature and does not have any intentions of doing any connectivity or innovations with the HIE as the data is unreliable and unusable.	No actions necessary.

Enhanced identification of long-term opioid use directly correlated to clinician prescribing patters (see also "use of PDMP" #2 below)	The PMP staff analyzes controlled substance prescription data to identify high prescribers and patients who are doctor shoppers. The Board of Pharmacy PMP staff submits a biannual report to each licensing board to alert them of their licensees who are identified on the high prescribers report. If a doctor shopper is identified, they are referred to law enforcement.	Monitoring of fee for service claims and Managed Care encounter claims.	Create reports for monitoring purposes through 12/2027.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (I.e the state's master patient index (MPI) strategy with regard to PDMP query)	The Nevada PMP utilizes Bamboo Health's patient matching services which uses patient-clustering algorithms that result in 99.8% accurate patient matching, leading to more reliable prescribing and dispensing.	Due to the high percentage accuracy rate of 99.8% using Bamboo Health's patient matching services, further enhancements are not being considered at this time.	No actions necessary.
Use of PDMP – Supporting Clinicians with Changing Office Workflows/Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	The Nevada Prescription Drug Monitoring Program (PDMP) allows healthcare facilities to integrate data into approved Electronic Health Records (EHRs) and Pharmacy Management Systems (PMS). The PDMP utilizes Bamboo Health's PMP Gateway integration service. Prescribers and pharmacists will no longer need to navigate to the state Nevada PMP website, log in, and enter their patient's information. Instead, the EHR or PMS will automatically initiate a patient query, which will return the patient's-controlled substance prescription records directly within the clinical workflow.	Nevada will encourage providers to integrate the NV PMP with their EHR or pharmacy management system. The Nevada Prescription Monitoring Program (NV PMP) has	Evaluate possible outreach efforts to clinicians through 12/2027.

		partnered with Appriss Health to integrate NV PMP data into Nevada electronic health records (EHR) and Nevada pharmacy management systems via Appriss Health's PMP Gateway platform. This empowers clinicians at the point of care with information that can help the clinician make better informed prescribing decisions. Integration is NOT mandatory. PMP data can still be accessed through the NV PMP web portal. Integration of the NV PMP data into the	

		clinician's EHR or pharmacy management system is not mandatory but is available at no cost.	
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	Nevada Revised Statute 639.23507, implemented in 2017, requires practitioners to query a patient's PMP report prior to prescribing a controlled substance list in schedule II, III or IV or an opioid that is a controlled substance listed in schedule V at least once every 90 days thereafter for the duration of the course of treatment using the controlled substance.	No further enhancements are being considered at this time due to the requirements in Nevada Revised Statute 639.23507 which requires practitioners to query a patient's PMP report prior to prescribing a control substance list in schedule II, III, IV or an opioid that is a controlled substance listed in schedule V at least once every 90 days thereafter for the duration of the course of treatment using the	No actions necessary.

		controlled substance.	
Master Patient Index/Identify Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	Ambulatory Detox / Rehabilitation Residential ***Current Funded Programs:*** Ambulatory, intensive outpatient Ambulatory, non-intensive outpatient Detox, 24-hour, Free-Standing residential Detox, 24-hour Hospital inpatient Rehabilitation/ Residential, Hospital Rehabilitation/ Residential, Long Term>=30 days Rehabilitation/ Residential, Short Term <= 30 days Unknown	Continue with ongoing services that are in place	Hired TEDS Health Program Specialist and TEDS Business Process Analyst with SAPTA with the aim to aid in analyzing datasets as well as communicating with substance abuse treatment centers to identify barriers and gaps in reporting, in order to facilitate better data. The analyst from the Department of Behavioral Health is directly communicating with substance facilities and working with them on reporting gaps in the data.
Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities / capabilities /	(2017) Nevada Revised Statute 639.23507 requires practitioners to query a patient's PMP report prior to prescribing a controlled substance list	No further enhancements are being considered at	No actions necessary.

supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	in schedule II, III or IV or an opioid that is a controlled substance listed in schedule V and at least once every 90 thereafter for the duration of the course of treatment using the controlled substance.	this time due to the requirements in Nevada Revised Statute 639.23507 which requires practitioners to query a patient's PMP report prior to prescribing a control substance list in schedule II, III, IV or an opioid that is a controlled substance listed in schedule V at least once every 90 days thereafter for the duration of the course of treatment using the controlled substance.	

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

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Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.