Section 1115 Demonstration Waiver

Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project

State of Nevada
Department of Health and Human Services

Nevada Department of Health and Human Services
Helping People
It's who we are and what we do.

September 10, 2021

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Governor
State of Nevada

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Section 1: Program Description

A. Program Summary

The Nevada Department of Health and Human Services (DHHS) is requesting authority from the Centers for Medicare & Medicaid Services (CMS) for a five-year, Section 1115 Demonstration waiver to expand statewide access to comprehensive behavioral health services for the most vulnerable Nevadans, including those with opioid use disorders (OUDs) and other substance use disorders (SUDs). Specifically, DHHS seeks a limited waiver of the federal Medicaid Institutions for Mental Diseases (IMD) exclusion (hereinafter referred to as the "Demonstration"). This Demonstration will further the objectives of Title XIX and Title XXI of the Social Security Act by improving access to high-quality, person-centered services that produce positive health outcomes for individuals; and advancing innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid. The Demonstration will not modify the State's current Medicaid program or Children's Health Insurance Program (CHIP) outside of the benefits and reimbursement methodologies described within this application.

B. Demonstration Rationale

SUDs are extremely common in the United States affecting 20.3 million.[1] Per Mental Health America (MHA), in 2021 there were 206,000 adult Nevadans with a SUD within the past year. This number represents 9.0% of the population in Nevada and is higher than the national average of 7.67%.[2] Nevada has been severely impacted by the opioid epidemic. The following statistics illustrate the current state of the opioid crisis in the State:[3,4]

- Preliminary data for 2020 showed 536 individuals died of an opioid overdose. The number of overdose deaths from heroin have increased from 19 in 2010 to 125 in 2020.
- In 2020, for every 100,000 people in Nevada there were:
  - 16.9 Opioid-related overdose deaths.
  - 30.4 Emergency department (ED) visits.
  - 14.2 Hospitalizations.
- 12% of opioid-related hospitalization visits in 2020 resulted in a length of stay of 15 days or more.
- Synthetic opioid deaths (e.g., fentanyl) sharply increased from 115 in 2019 to 273 in 2020.

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[1] SUBSTANCE ABUSE AND MENTAL HEALTH ADMIN. KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH ,
Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

[2] Mental Health America. Available at: https://mhanational.org/issues/2021/ranking-states

[3] Nevada Department of Health and Human Services. Office of Data Analytics. Nevada Opioid Surveillance June 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Opioid%20Surveillance%20Report_Jun2021.pdf. (Note: 2020 data is preliminary).

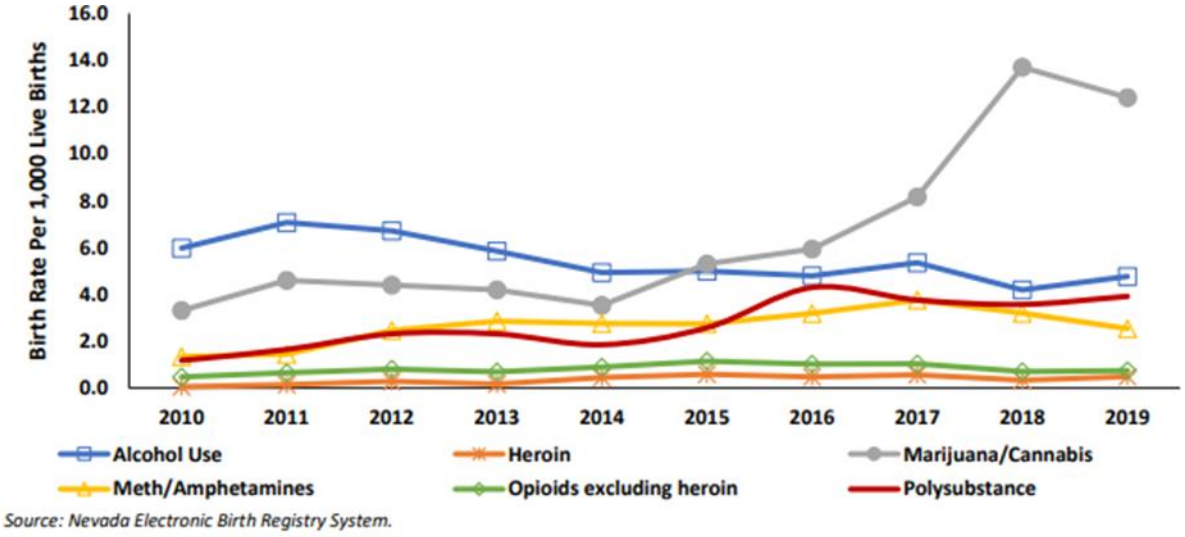
[4] Nevada State Office of Public Informatics and Epidemiology. Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2017-2019. Available at: https://scholarworks.unr.edu/bitstream/handle/11714/7350/2017-2019%20Nevada%20High%20School%20YRBS%20Comparison%20Report_acc.pdf?sequence=1&isAllowed=y

- Among Nevada's high school youth, per a survey conducted in 2019, 18.8% (an increase from 14.8% reported in 2017) had taken prescription pain medicine without a prescription or not as prescribed; 2.5% reported having used heroin.

From 2010 to 2019, on average, there were 35,352 live births per year to Nevada residents. Per review of birth certificate records in 2019, the following was shown: 167 indicated alcohol use, 434 indicated marijuana use, 89 indicated methamphetamine/amphetamine use, 26 indicated opiate use, and 17 indicated heroin use during pregnancy[5].

As shown in Figure 1.1, of the self-reported substance use during pregnancy among Nevada mothers who gave birth between 2010 and 2019, the highest rate was with marijuana use in 2018, at 13.7 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.8 per 1,000 births in 2019. In 2019, a rate of 2.5 per 1,000 live births was reported for meth/amphetamines, which is lower than in 2018 at 3.2 per 1,000 live births. Polysubstance use (more than one substance) has increased from 2.6 per 1,000 live births in 2015 to 3.9 per 1,000 live births in 2019.[6]

Figure 1.1 Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, Nevada Residents, 2010-2019.



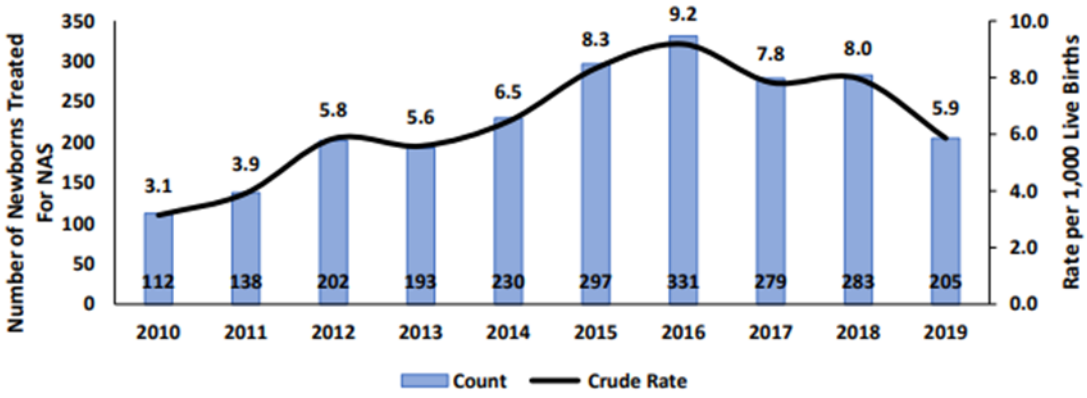
Nevada has high rates of opioid use among special populations and neonatal abstinence syndrome (NAS) when compared nationally. Data indicates stimulant usage is an issue for the country, as well as Nevada. In the U.S. in 2018, an estimated 561,000 people aged 12 or older had a stimulant use disorder in the past year. This corresponds to 0.2% of the population. Nationally, about 2.0% of the population 12 or older used cocaine in 2018, while 5.8 percent of

[5] Nevada Department of Health and Human Services. Office of Data Analytics. Substance Abuse Prevention and Treatment Agency 2020 Epidemiologic Profile. January 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Bureau%20of%20Behavioral%20Health%20Wellness%20and%20Prevention,%20Epidemiologic%20Profile%20for%20Nevada,%202020.pdf

[6] *Ibid.*

young adults used cocaine in the last year. In Nevada, the comparable yet slightly higher figures are 2.27 and 5.84 percent. In 2018, 0.7% of the U.S. population used methamphetamines in the past year, with young adults using at the highest rate of 0.8%. In Nevada, the rates were higher, with 1.29% overall, and 2.36% for young adults. [7] [8]
The rate of NAS in Nevada increased from 7.8 per 1000 births in 2017 to 8.0 in 2018 and down to 5.9 in 2019 as shown in Figure 1.2 below.[9]

Figure 1.2. Neonatal Abstinence Syndrome, Nevada Residents, 2010-2019.



Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

White non-Hispanic individuals have a significantly higher NAS rate when compared to all other races. The average length of stay for newborns with NAS in 2019 was 19 days.[10]

In 2016, Nevada ranked 22nd nationally in drug overdose deaths, two-thirds of which includes those related to prescription opioids, synthetic opioids, methadone, and heroin, with a rate of 21.7 per 100,000 population, compared to 19.8 in the United States.[11] The number of drug overdose deaths in the state has declined only slightly,[12] and Nevada now ranks 26th for drug overdose deaths as of 2019 at a rate of 20.1 per 100,000.[13] Reported provisional data indicates that drug overdoses increased by 28.7% between 2019 and 2020 in Nevada, which is slightly

[7] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
[8] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017 and 2018. https://www.samhsa.gov/data/sites/default/files/reports/rpt23235/2k18SAEExcelTabs/NSDUHsaePercents2018.pdf
[9] Nevada Department of Health and Human Services. Office of Data Analytics. Substance Abuse Prevention and Treatment Agency 2021 Epidemiologic Profile. January 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Bureau%20of%20Behavioral%20Health%20Wellness%20and%20Prevention,%20Epidemiologic%20Profile%20for%20Nevada,%202020.pdf
[10] *Ibid.*
[11] CDC, 2017, available at: https://www.cdc.gov/nchs/hus.htm.
[12] CDC Opioid Drug Overdose Death Rates, 2019, Available at: https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2019.html.
[13] *Ibid.*

lower than the reported percent increase for the United States of 29.6%.[14] This increase has been driven primarily by unintentional opioid-related overdose deaths, which make up 85% of deaths.[15] Closer examination of these overdoses during part of this time period shows a 221% increase in deaths attributed to illicitly manufactured fentanyl.[16]

It is also important to note the state of mental health in Nevada. The National Institute for Drug Abuse (NIDA) cites "about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa."[17] Additionally, the National Alliance on Mental Health notes that approximately 51.5 million American adults experience any mental illness (AMI) in a given year, while 13.1 million experience a serious mental illness (SMI).[18] Individuals with behavioral health disorders are significant utilizers of healthcare services, with approximately one in eight visits to emergency departments (ED) involving mental health and/or SUDs.[19] Medicaid is currently the single largest payer for behavioral health services and is increasingly playing a larger role in the reimbursement of SUD services.[20] According to the *Mental Health In America's 2021 State of Mental Health in America* report, Nevada currently ranks 51st in the nation for youth and 42nd for adults, for a high prevalence of mental illness and low levels of access to care. Nevada ranks 32nd in mental health provider availability with a provider to patient ratio of 470:1. For MHA's overall ranking, a combined score across 15 measures for both adult and youth measures including prevalence and access to care measures, Nevada ranked last or 51st among all the states.[21] Additionally, everyday there is an average of 102 individuals waiting in emergency rooms across Nevada for behavioral health services.[22] These statistics underscore the need to continue to increase availability of targeted services and enhance the mental health care system, as well as ensure processes and systems are in place to link patients to the right treatment and setting.

While the issues described above represent challenges for all Nevadans, the State's most vulnerable populations are particularly effected. The number of opioid-related emergency room

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[14] CDC, Provisional Drug Overdose Death Counts, 2021, available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[15] Nevada Department of Health and Human Services. Office of Data Analytics. Nevada Opioid Surveillance June 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Opioid%20Surveillance%20Report_Jun2021.pdf. (Note: 2020 data is preliminary).

[16] Thomas S. Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths from January to June 2020 - Statewide. Report, Nevada Public Health Training Center, School of Community Health Sciences, University of Nevada, Reno; 2021 Jun. Available from: https://www.nvopioidresponse.org/od2a/

[17] National Institute on Drug Abuse website. August 12, 2020. Available at https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/references

[18] AMI is defined as Adults aged 18 or older who "currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria."
SMI is defined as "currently or at any time in the past year [having] had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities." SUBSTANCE ABUSE AND MENTAL HEALTH (SAMHSA), BEHAVIORAL HEALTH BAROMETER: NEVADA, VOLUME 6 (LAST VISITED ON APRIL 13TH, 2021), AVAILABLE AT: https://www.samhsa.gov/data/sites/default/files/reports/rpt32845/Nevada-BH-Barometer_Volume6.pdf

[19] AUDREY J. WEISS ET AL., AGENCY FOR HEALTHCARE RES. AND QUALITY, TRENDS IN EMERGENCY DEPARTMENT VISITS INVOLVING MENTAL AND SUBSTANCE USE DISORDERS, 2006–2013, HEALTHCARE COST AND UTILIZATION PROJECT: STATISTICAL BRIEF #216 (2016), available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf.

[20] CTRS. FOR MEDICARE & MEDICAID SERVS., *Behavioral Health Services* (last visited April 13, 2021), https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[21] Mental Health America. 2021. Available at: https://mhanational.org/issues/2021/ranking-states

[22] Nevada Department of Health and Human Services. Division of Public and Behavioral Health. Towards a Comprehensive Crisis Response System in Nevada. Available at: https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/Nevada%20Crisis%20Systems%20White%20Paper%20Final%203-31.pdf

encounters for Medicaid beneficiaries in Nevada has increased from 435 in 2011 to 3,026 in 2020. Medicaid patients account for 52% of all opioid-related emergency room encounters.[23] Similarly, the number of opioid-related inpatient encounters among Medicaid beneficiaries in Nevada increased from 718 in 2011 to 3,825 in 2020, accounting for 45% of the opioid-related encounters in 2020.[24] The number of Medicaid emergency department (ED) visits for opioid poisonings show an increasing trend for substances other than heroin with an increase from 429 ED visits in 2019 to 641 in 2020.

In early 2021, Nevada surveyed Medicaid providers about providing MAT treatment in addition to other topics. 434 providers responded to the survey with 256 providers completing the survey (59% completion rate). When asked if the provider was treating patients at their MAT prescribing limit, only 43% of the surveyed providers who can prescribe for 30 or less patients were prescribing to their limit. Additionally, when asked what the top barrier to providing MAT services was, 53% stated it was little to no reimbursement from Medicaid or other payers to cover the additional time and operational costs required to deliver MAT services. This was following by 49% of respondents who indicated there is limited availability of mental health, psychosocial, or other ancillary services.

The opioid epidemic has highlighted the need for greater access to community-based treatment for opioid use disorder through access to behavioral health services and medication assisted treatment (MAT) while also increasing demand for higher levels of withdrawal management and residential and inpatient care.

Nevada Efforts to Combat the Opioid Crisis

Legislative Achievements

Nevada has made great strides in recent years 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.[25] In addition to providing immunity for personal use and possession of controlled substances for those seeking medical attention during a drug overdose, the law also requires that prescribing physicians obtain a patient utilization report on 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.[26] Further, the Act expands access to the opioid antagonist Naloxone by allowing providers to prescribe and/or dispense the product to persons in a position to assist another person at risk of an overdose and by allowing a pharmacist with standing orders to store and dispense the product.[27]

The Prescription Drug Abuse Prevention Act was passed unanimously by the legislature and was signed into law on June 16, 2017.[28] The law, which went into effect on January 1, 2018, expands

[23]Nevada Department of Health and Human Services. Office of Data Analytics. Nevada Opioid Surveillance January 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Opioid%20Surveillance%20Report_Jun2021.pdf. (2020 data is preliminary).
[24] Nevada SUPPORT Act Planning Grant Project Narrative.
[25] S.B. 459, 78th Leg. (Nev. 2015), available at: https://www.leg.state.nv.us/App/NELIS/REL/78th2015/Bill/2161/Text.
[26] *Ibid*.
[27] *Ibid*.
[28] A.B. 474, 79th Leg. (Nev. 2017), available at: https://www.leg.state.nv.us/session/79th2017/bills/ab/ab474_en.pdf.

and updates State laws requiring doctors and hospitals to report any drug overdoses to the State; permits licensing boards to access PMP 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.[29] For prescriptions over 30 days, a prescription medical agreement with the patient must be created.[30] 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.[31] Lastly, the law created the "Prescribe 365" initiative, which holds that no patient should receive more than 365 days' worth of medication in any consecutive 365-day period.[32] 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.[33]

However, despite these challenges, there has been an overall reduction in opioid prescriptions for pain, according to data from the Nevada PMP[34]. From January of 2017 to January of 2021, there has been approximately a 40% decrease in the rate of opioid prescriptions per 100 Nevada residents. Opioid prescriptions with a less than a 15-day supply decreased by 76% during this same time period.[35]

In April 2018, Nevada was acknowledged in *Prescription Nation 2018: Fighting America's Opioid Epidemic* 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

[29] *Ibid.*
[30] *Ibid.*
[31] *Ibid.*
[32] *Ibid.*
[33] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.
[34] Nevada State Opioid Response. Nevada Opioid Crisis Needs Assessment, 2018. Available at: https://www.nvopioidresponse.org/wp-content/uploads/2020/01/nevada-opioid-crisis-needs-assessment-3.21.19.pdf
[35] DHHS Office of Analytics Data Source: Prescription Drug Monitoring Program (PDMP; 2018). Available at: https://app.powerbigov.us/view?r=eyJrIjoiYjgyYzkyMzctNDg0OS00ZGY1LWJiMWYtM2E0NDlkZjI0MmEyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

clinical setting; 4) improving data collection/sharing; 5) treating opioid overdose; and 6) increasing availability of opioid use disorder treatment.[36]

Most recently in 2021, the Nevada legislature passed Senate Bill 154 which directs the Department of Health and Human Services to apply for a waiver to receive federal funding for coverage of the treatment of SUD of a person in an IMD. This bill was approved by the Governor on June 4th, 2021.

Adoption of Best Practices

In addition to the legislative efforts described above, the State 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. 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.

Development of Certified Community Behavioral Health Centers

In 2016, Nevada was selected to participate in a demonstration program to develop a network of Certified Community Behavioral Health Centers (CCBHCs). This demonstration was enabled through Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014. CCBHC certification indicates that the entity meets criteria as established by the State of Nevada, by the Division of Public and Behavioral Health's (DPBH) Health Care Quality and Compliance (HCQC) bureau. These entities, a new provider type in Medicaid, are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals. CCBHC services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. 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.[37]

Under the Section 223 Demonstration, Nevada certified three CCBHC providers and expanded their scope to allow for the provision of Medicaid State Plan services in an integrated setting. This expanded scope includes MAT and ambulatory withdrawal management; primary care services; 24/7 crisis intervention including mobile crisis; psychiatric rehabilitation services; assertive community treatment services; and family-to-family peer interventions. The Section 223 Demonstration, originally a two-year project, remains on-going at the time of this writing of this application under the funding provided under the American Rescue Plan Act of 2021.

[36] Opioid Response Summit. Final Report of Nevada's Summit Proceedings. August 2019. Available at: http://www.nevadapublichealthfoundation.org/wp-content/uploads/2019/12/Opioid_SummitReport_ADA.pdf

[37] CCBHCs are required to provide a comprehensive array of services including crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and SUD services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support services and family support services; and services for members of the armed services and veterans.

Building off of the success of this demonstration, in 2019 Nevada requested and was granted approval for a State Plan Amendment to establish services and a reimbursement methodology for additional CCBHCs. Currently there are six additional CCBHCs that are providing services under the State Plan authority.

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Section 1003 Demonstration Project

Despite this progress, Nevada recognized the need for increased access to community-based treatment, behavioral health services, and MAT for those with SUD and/or OUD. Nevada DHHS identified several opportunities to support expansion of these services to Medicaid beneficiaries by:

1. Increasing the number of providers eligible to offer some level of treatment and management services.
2. Improving outreach, training, and education available to providers of SUD and OUD services.
3. Developing a comprehensive MAT deployment and expansion strategy.
4. Implementing an Alternative Payment Model (APM) specifically for MAT services.

In an effort to achieve these objectives, Nevada applied for and was awarded the 1003 SUPPORT Act Planning Grant in 2019. Nevada's Division of Health Care Financing and Policy (DHCFP), the state's Medicaid authority, serves as the lead agency for the CMS SUPPORT Cooperative Agreement to increase substance use provider capacity. Using funds from this grant, DHCFP was able to assess the state's current infrastructure and policy to identify barriers and opportunities to increase efforts in targeting the OUD health crisis. Through the SUPPORT Act Planning Grant, Nevada DHHS aims to increase the capacity of Medicaid providers to perform SUD treatment and recovery services through ongoing needs assessments, recruitment of and training for SUD Medicaid providers, improved reimbursement for SUD treatment and recovery services, and dissemination of perinatal care practice standards. Specific goals and objectives the state is working towards in 2019 and forward under the SUPPORT Act Planning Grant include[38]:

1. Increasing access to SUD and OUD treatment and recovery services by increasing the number of providers eligible to provide some level of SUD services.
2. Conducting community engagement activities across the state and gather information which will be used to improve the education materials and training activities available to Medicaid SUD providers.
3. Creation of a comprehensive MAT strategy and development of a corresponding chapter in the Nevada State MSM. This was completed in 2020.
4. Eliminating the confusion regarding which providers are eligible to provide MAT and other challenges faced by providers that may hinder their willingness and ability to provide treatment and recovery services.
5. Focus on expansion of OUD treatment for the sub-population of pregnant and postpartum women and their infants to address NAS.

[38] Nevada SUPPORT Act Planning Grant Project Narrative.

Also under the SUPPORT Act Planning Grant, Nevada convened stakeholder workgroups to consider the current gaps to ensuring continuity of care across the care continuum for individuals with an OUD and/or SUD. The team recognized the increased demand for effective withdrawal management, residential and inpatient care and that despite all of the aforementioned efforts, the State's vast geography, healthcare provider shortage, and lack of access to community-based providers contribute to the challenge of the addressing the behavioral health needs of vulnerable Nevadans. For example, opioid treatment programs only exist in the three urban counties/cities (i.e., Clark, Washoe, and Carson City). Moreover, nearly 86% of the potentially available residential treatment and withdrawal management beds are not eligible for Medicaid reimbursement. This is primarily due to the IMD exclusion, which prohibits federal financial participation (FFP) for medically necessary services provided in hospitals, nursing facilities, or other institutions of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Due to the limited funding available for residential SUD services, need for this level of care continues to exceed what is available, leading to excessive use of higher cost services within the ED and inpatient hospital settings, low rates of initiation and engagement in services, unnecessary readmissions to higher levels of care, failure to stabilize at lower levels of care, and incarceration as an alternative to unavailable community-based residential services and withdrawal management care. Similarly, despite unprecedented access to healthcare coverage in Nevada, the infrastructure of the system of care to improve access to high-quality care is still evolving to meet the needs of children, individuals and families with behavioral health care needs.

In order to address identified gaps in the care continuum, Nevada committed to working with stakeholders to develop an 1115 SUD demonstration that gives the state authority to provide enhanced SUD benefits and receive a limited waiver of the federal Medicaid IMD exclusion (hereinafter referred to as the "Demonstration").

C. Demonstration Implementation

The State is requesting a five-year Demonstration waiver with an effective date of January 1, 2023, and intends to submit an implementation plan post-approval in accordance with CMS State Medicaid Director Letter #17-003, "Strategies to Address the Opioid Epidemic." Additional detail regarding the State's proposed implementation timeline is provided in Section 5 of this waiver application. Nevada Medicaid provides benefits through a mandatory managed care delivery system in two of the State's most populous, urban counties. Beneficiaries exempt from managed care, and those living in the State's remaining 14 counties and one independent city, receive benefits through a fee-for-service (FFS) delivery system.

D. Demonstration Hypothesis

Nevada is committed to providing high-quality health care through a comprehensive delivery system that promotes the use of evidence-based placement and practices. Through this Demonstration, the State is specifically seeking to increase access to services and improve

clinical outcomes for Medicaid beneficiaries with OUD and/or SUD. To accomplish these goals, the State will leverage prior experience, recent policy initiatives, as well as the proposed enhanced SUD benefits and IMD exclusion waiver. While the State anticipates partnering with CMS to develop a formal evaluation protocol post-waiver approval, Table 1.1 below represents a preliminary framework for evaluating the Demonstration, including hypotheses, methodologies, and example data sources.

Table 1.1: Preliminary Evaluation Plan

Hypothesis	Methodology	Example Data Sources
The Demonstration will increase access to intensive levels of care in residential and inpatient settings, as well as medically supervised withdrawal management services, for Nevada Medicaid beneficiaries with OUD and SUD.	Track and compare rates of OUD and SUD treatment among Medicaid beneficiaries with associated conditions.	Encounter and claims data; number and availability of residential treatment beds; and ED boarding data.
The Demonstration will improve outcomes for Nevada Medicaid beneficiaries by reducing the rate of OUD and/or SUD-related deaths.	Track and compare OUD and SUD overdose death rates.	Encounter and claims data.
The Demonstration will reduce preventable or inappropriate inpatient and ED utilization among Nevada Medicaid beneficiaries.[39]	Track and compare rates of OUD, SUD, and general behavioral health inpatient and ED encounters for Medicaid beneficiaries with associated conditions.	Encounter and claims data.
The Demonstration will increase adherence to treatment for parenting individuals (definition of parent can be found in Nevada Revised Statute (NRS) here: NRS 126) who will have their children with them in the transitional and residential IMD setting.	Track and compare rates of acute inpatient readmission and ED encounters for Medicaid beneficiaries with associated conditions following IMD discharge.	Encounter and claims data.
The Demonstration will increase access to medical and community-based services in pregnant and parenting individuals in an IMD.	Track and compare rates of OUD, SUD, and general behavioral health inpatient and ED encounters for Medicaid beneficiaries with associated conditions.	Encounter and claims data.

[39] Note, the State recognizes that waiver of the IMD exclusion may result in an increase in overall inpatient admissions for beneficiaries with OUD and SUD diagnoses. This measure is intended to focus on encounters that could be classified at triage as non-urgent or where similar medical services could be provided at alternative or more appropriate sites of care for a lower cost.

The Demonstration will allow for care coordination of services resulting in a better care transition upon discharge.	Track and compare rates of OUD, SUD, and general behavioral health inpatient and ED encounters for Medicaid beneficiaries with associated conditions.	Encounter and claims data.

E. Reporting and Monitoring

The State has sufficient capacity to ensure regular reporting on progress toward meeting Demonstration milestones and for collecting and reporting data on performance measures. Data is routinely collected by the Nevada DHHS Office of Analytics, Office of Public Health Informatics and Epidemiology (OPHIE) and Division of Health Care Financing and Policy (DHCFP), including Treatment Episode Date Set (TEDS), Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP), as well as Medicaid billing and claims data.[40] In addition, 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.

Section 2: Demonstration Eligibility

A. Eligible Populations

All mandatory and optional eligibility groups approved for full benefit coverage under the Nevada Medicaid and CHIP State Plans will be eligible for the Demonstration.[41] Only the eligibility groups outlined in Table 2.1 below will be ineligible.

Table 2.1: Ineligible Populations

Eligibility Group Name	Citation
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) and 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii)
Qualified Disabled and Working Individuals (QDWI)	1902(a)(10)(E)(ii), 1905(s), and 1905(p)(3)(A)(i)
Qualifying Individuals	1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D)

The Demonstration will target high-risk, high-need beneficiaries requiring enhanced services to effectively treat SUD and/or OUD. The criteria for each of these target populations is identified in Table 2.2 below.

Table 2.2: Target Populations

[40] These entities are further described in Attachment 1.
[41] A comprehensive listing of State Plan eligibility groups is available on the DHCFP website at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/Eligibility/MSPEligHome/

Initiative	Diagnosis	Criteria
SUD	Substance Use Disorder	Diagnostic Criteria[42,43]: A. A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12 month period: 1. The substance is taken in larger amounts or over a longer period than was intended. 2. There is persistent desire or unsuccessful efforts to cut down or control substance use. 3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recovery from its effects. 4. Craving, or a strong desire or urge to use the substance. 5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home. 6. Continued use of the substance despite having persistent or recurrent social impairment or interpersonal problems caused or exacerbated by the effects of the substance. 7. Important social, occupational, or recreational activities are given up or reduced because of substance use. 8. Recurrent substance use in situations in which it is physically hazardous. 9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. 10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect. b. Markedly diminished effect with continued use of the same amount of the substance. 11. Withdrawal, as manifested by either of the following: a. The characteristic withdrawal syndrome for the substance b. The substance is taken to relieve or avoid withdrawal symptoms. Severity of the substance use disorder: Mild: Presence of 2-3 symptoms Moderate: Presence of 4-5 symptoms Severe: Presence of 6 or more symptoms

[42] DSM-5 Diagnostic Criteria for a Substance Use Disorder (DSM-5; 2013)
[43] Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

Initiative	Diagnosis	Criteria
SUD	Co-Occurring Behavioral Health Disorder	Persons who currently, or at any time in the prior consecutive 12-month period, meet/met the following criteria: (1) have had both a diagnosable SUD and diagnosable behavioral health condition that meet current ICD coding and definition criteria, that resulted in functional impairment which substantially interferes with or limits one or more major life activities; and (2) have a functional impairment as determine through SED or SMI determination addressing the ability to function successfully in several areas such as social, occupational or educational.

B. Eligibility Determinations

No changes will be made to the State's Medicaid program eligibility standards, methodologies, or procedures as a result of the Demonstration. Eligibility assessment and determination processes will remain consistent with those outlined in the Nevada Medicaid State Plans. Beneficiaries eligible for services under the Demonstration will be selected based on the criteria outlined for the target population in Table 2.2 above.

C. Enrollment Projections

No enrollment limits will be applied to the Demonstration. Using files obtained from Nevada's Substance Abuse Prevention Treatment Agency (SAPTA), as well as provider specific IMD data supplied to the State, the State identified the unduplicated beneficiaries in the target population with an inpatient stay in an IMD facility of at least 1 day.

Below is the projected enrollment and expenditures for each demonstration year.

Table 2.2

	DY23	DY24	DY25	DY26	DY27
Member Months	5,587	5,643	5,700	5,757	5,814
Expenditures	$6,987,676	$7,361,049	$7,754,357	$8,168,668	$8,605,143

Section 3: Demonstration Benefits

The State of Nevada has taken deliberate steps in recent years to improve access to behavioral health services for Medicaid beneficiaries. Beginning in 2014, as described in Section 1 the State adopted an integrated behavioral health clinic model to provide mental health and SUD treatment using ASAM criteria as the framework for levels of care and intensity of needs determination for placement (*See* Table 3.1 below). 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 3.1: Current Nevada Medicaid and CHIP State Plan SUD Benefits by ASAM Level of Care[44]

ASAM Level of Care	Benefit
0.5	Early Intervention/Prevention
1	Outpatient Services
2.1	Intensive Outpatient Services
2.5	Partial Hospitalization
3.1–.5	Outpatient Services in Managed Residential
4	Medically Managed Intensive Inpatient Services
4-WM	Medically Managed Intensive Inpatient (Only) Services-Withdrawal Management
Office-Based Opioid 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.[45]

A. *State Plan Benefits*

Using state plan authority, the state seeks to add SUD residential and withdrawal management services consistent with ASAM levels of care 3.1, 3.2, 3.5, and 3.7. Clinically managed residential services will not include payment for room and board.

As with current level of care determinations, the DHCFP will assess beneficiary needs, clinical appropriateness, and medical necessity using the ASAM Patient Placement Criteria (ASAM PPC-2R), which provides a mechanism for an organized assessment of individuals presenting for SUD treatment to determine appropriate placement.[46] This process involves six dimensions of assessment including: (1) Acute Intoxication and/or Withdrawal Potential; (2) Biomedical

[44] NEV. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID SERVICES MANUAL (2019), *available at* http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/Medicaid_Services_Manual_Complete.pdf. Per Chapter 403.10 of the State's Medicaid Services Manual, ASAM levels 3.1–.5 are covered benefits under the following conditions: (1) the provider is not an Institution for Mental Disease (IMD); (2) the provider is a clinic model that meets the certification requirement Nevada Administrative Code 458.103 for alcohol and drug abuse programs; and (3) only outpatient services are reimbursable (i.e., room and board are not reimbursable). In addition, ASAM levels 4 and 4-WM are covered benefits under the following circumstances: (1) the beneficiary is age 21 – 64 and receiving services in an inpatient hospital not established and maintained primarily for the care and treatment of individuals with mental diseases; (2) the beneficiary is under age 21, or over age 65, and receiving services in an Institution for Mental Disease (IMD); or (3) the beneficiary is age 21 – 64, enrolled in managed care, and receiving substance use disorder inpatient or crisis residential services in an IMD for no more than 15 days in a month.

[45] Note, the Demonstration will not include long term services and supports. In addition, the State is not proposing to impose premiums, copayments, coinsurance, deductibles, or similar charges beyond what is permitted under the Nevada Medicaid or CHIP State Plans, nor will premium assistance for employer-sponsored coverage be made available to participants.

[46] NEV. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID SERVICES MANUAL (2019), *available at*: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/Medicaid_Services_Manual_Complete.pdf.

Conditions and Complications; (3) Emotional, Behavioral, or Cognitive Conditions and Complications; (4) Readiness to Change; (5) Relapse, Continued Use, or Continued Problem Potential; and (6) Recovery/Living Environment. Consideration of these dimensions permits the client to be placed in a particular level on a continuum of services ranging from intensive case management for individuals with serious mental disorders who are not motivated to change, to psychiatric inpatient care. On-going assessment will be conducted during treatment to identify whether beneficiaries meet continued stay or transfer/discharge criteria.

Additionally, Nevada will also request state plan authority for case management services for beneficiaries who have a diagnosis of substance use disorder without a co-occurring diagnosis.

B. *IMD Exclusion*

In addition to enhancing SUD benefits, the State seeks a limited waiver of the federal IMD exclusion to ensure meaningful access to services. Nevada residential and withdrawal management providers are currently licensed as either residential facilities (i.e., "Facility for the treatment of abuse of alcohol or drugs," or ADA), community triage centers (CTC), or withdrawal management facilities (i.e., "Facility for modified medical detoxification," or MDX).[47] As the majority of these providers are located in Las Vegas and Reno, Nevada's two urban areas, most individuals residing in rural or frontier areas must travel great distances to find an adequate level of care. Table 3.2 below provides a comprehensive listing of licensed Nevada providers as of June 2021.

Table 3.2: Licensed Residential and Withdrawal Management IMD Treatment Providers, June 2021

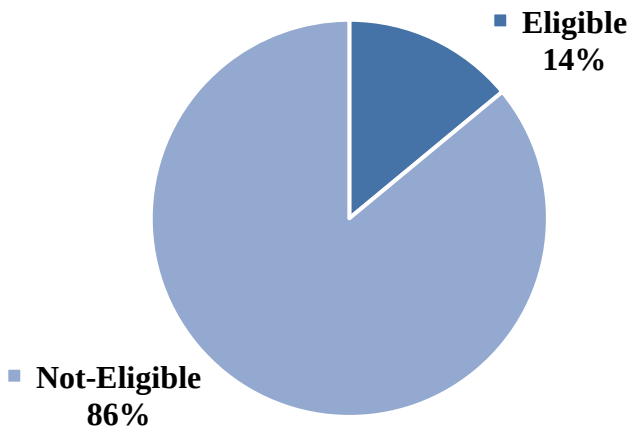
Name	Type	City	Beds
Step 1 Inc.	ADA	Reno	20
Step 2 Inc.	ADA	Reno	20
Narconon Rainbow Canyon Retreat	ADA	Caliente	24
Vitality Carson City	ADA	Carson City	25
New Frontier Treatment Center	ADA	Fallon	28
Freedom Behavioral Health	ADA	Las Vegas	40
Vance Johnson Recovery Center	ADA	Las Vegas	44
Bristlecone Family Resources	ADA	Reno	51
Crossroads of Southern Nevada	MDX	Las Vegas	64

[47] ADA, CTC and MDX are license types/designations established by the Nevada Bureau of Health Care Quality and Compliance (HCQC). *See* NV. DEPT. OF HEALTH AND HUMAN SERVS., *Health Facilities Licensing*, https://nvdpbh.aithent.com/Protected/LIC/LicenseeSearch.

Name	Type	City	Beds
Crossroads of Southern Nevada	ADA	Las Vegas	116
WestCare Nevada, Inc. (Harris Springs)	ADA	Las Vegas	56
WestCare Nevada, Inc.	CTC	Las Vegas	51
WestCare Nevada Women and Children's Campus	ADA	Las Vegas	130
The Desert Hope Center	MDX	Las Vegas	148
Vance Johnson Recovery Center	ADA	Las Vegas	44
Vouge Recovery Center of Nevada	MDX	Las Vegas	48
Well Care Foundation Community Triage Center	CTC	Reno	20
Total			**929**

Despite the number of licensed IMD providers in Nevada, access to SUD treatment services is severely limited for the uninsured, underinsured, and Medicaid beneficiaries. This is primarily due to the federal IMD exclusion, which prohibits FFP for medically necessary services provided in hospitals, nursing facilities, or other institutions of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.[48] Figure 3.1 further illustrates this lack of residential treatment beds eligible for Medicaid reimbursement.

Figure 3.1: Percent of Medicaid Eligible Residential Treatment Beds



[48] Limited State general funding and block grant funding is available for certain designated providers (i.e., those denoted with an asterisk in Table 3.3).

Nevada Medicaid managed care organizations 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. As such, the State is requesting a limited waiver of the IMD exclusion for all Medicaid beneficiaries ages 22-64, regardless of delivery system, with short-term stays averaging 30 days. The State does not intend to implement any limitations in amount, duration, or scope of these services beyond the aforementioned average length of stay target. By making residential and withdrawal management services reimbursable for these providers, Nevadans across the State will have significantly improved access to medically appropriate care.

Pursuant to guidance in CMS State Medicaid Director Letter #17-003, the State will maintain current funding levels for its current continuum of behavioral health services—this initiative is not intended to reduce or divert State spending on mental health and addiction treatment services as a result of available federal funding for services in IMDs. Further, the State will continue to adhere to existing regulations intended to ensure Medicaid beneficiaries are accessing high-quality treatment providers and to guard against fraudulent practices. Specifically, DHHS will continue screening all newly enrolling providers and reevaluating existing providers pursuant to the rules in 42 C.F.R. Part 455 Subparts B and E, ensure addiction treatment providers have entered into Medicaid provider agreements pursuant to 42 C.F.R. 431.107, and maintain rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues.

Section 4: Delivery System and Payment Rates for Services

Nevada Medicaid provides health care coverage for households whose family income is at or below 138% percent of the federal poverty level (FPL); Supplemental Security Income recipients; certain Medicare beneficiaries; and recipients of adoption assistance, foster care, and some children aging out of foster care. The State also operates three §1915(c) Home and Community-Based Services waivers. "Nevada Check Up," the State's CHIP, provides coverage to uninsured children, not otherwise eligible for Medicaid, whose family income is at or below 205% FPL.

Nevada Medicaid and Nevada Check Up beneficiaries living in the urban Clark and Washoe counties receive services through a managed care delivery system, authorized under §1932(a) of the Social Security Act. Managed care enrollment is mandatory for most beneficiaries in these counties, with the exception of American Indians and Alaska Natives, persons in the "aged, blind, disabled" Medicaid category, individuals receiving limited benefits, individuals dually eligible for Medicare and Medicaid, children with special health care needs, and foster care and adoption assistance children. Managed care enrollees receive the same benefits as beneficiaries receiving services through FFS. The State currently contracts with three managed care organizations (MCOs) and one dental benefit administrator. Beginning in calendar year 2022, the state expects to be contracted with four MCOs.

All remaining Nevada Medicaid beneficiaries not enrolled in an MCO receive services through traditional FFS. Table 4.1 below provides a breakdown of Medicaid enrollees by delivery system.

Table 4.1: Nevada Medicaid Enrollment by Delivery System as of June 2021

FFS		Managed Care (MC)		Total	% FFS	% MC
CHIP	Medicaid	CHIP	Medicaid			
3,115	206,244	22,446	609,602	841,407	24.88%	75.12%

The delivery systems used to provide benefits to Demonstration participants will not differ from those described above. With respect to FFS payments for enhanced SUD benefits (Table 3.2) authorized under the Demonstration, there will be no deviation from current State Plan provider payment rates. Regarding payments for enhanced SUD benefits made through MCOs, there will be no deviations from payment and contracting requirements under 42 C.F.R. Part 438. Current managed care capitation rates include an "add on" payment intended to reimburse MCOs for coverage for stays of up to 15 days in an IMD for inpatient services related to SUD in lieu of other settings. As capitation rates are updated annually, the State plans to adjust this rate for Calendar Year (CY) 2023 to account for coverage of stays averaging 30 days in an IMD for inpatient services related to SUD.

Section 5: Implementation of Demonstration

The State is requesting a January 1, 2023 waiver effective date. Potential Nevada Medicaid recipients who would benefit from the Demonstration initiatives, as well as Nevada Medicaid-enrolled providers, will be notified through the State's typical processes, which include DHHS physical mail and electronic announcements and newsletters, provider bulletins, etc. Notifications will highlight new services made available under the Demonstration, as well as locations and contact information where services may be obtained. As previously described in Section 4, the State contracts with three MCOs, no contract modifications are currently necessary, and no additional procurement actions will be required for implementation of the Demonstration.

A waiver effective date of January 1, 2023, will allow time to establish necessary provider types and enrollment procedures for residential and withdrawal management facilities; make necessary Medicaid Management Information System edits; and obtain approval of a Demonstration implementation plan.

Consistent with the option described in CMS SMD #17-003, the State intends to submit its Demonstration implementation plan as a post-approval protocol and consistent with approved Special Terms and Conditions. The plan will describe timelines and activities the State will undertake to achieve the following designated 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;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

With the adoption of ASAM criteria and the development of a community behavioral health safety net in recent years, the State believes considerable progress has already been made in meeting the aforementioned milestones. However, the State acknowledges that FFP for services provided in IMDs will be prospective only and contingent upon CMS approval of the Demonstration implementation plan. The following Table 5.1 provides a high-level "status report" of where the State currently stands with respect to meeting the milestones and outlined in CMS SMD #17-003.

Table 5.1: Nevada Status Report RE CMS SMD #17-003 Milestones

Milestone	Specifications & Proposed Timeframes	NV Status
Access to Critical Levels of Care for OUD and other SUDs	Coverage of: (a) outpatient; (b) intensive outpatient services; (c) medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); (d) intensive levels of care in residential and inpatient settings; and (e) medically supervised withdrawal management. <u>Proposed Timeframe:</u> Within 12 to 24 months of Demonstration approval.	DHCFP currently provides coverage of the following levels of care based upon ASAM placement criteria: (a) Level 0.5—Early Intervention/Prevention; (b) Level 1—Outpatient Services; (c) Level 2.1—Intensive Outpatient Program; (d) Level 2.5—Partial Hospitalization; (e) Level 3—Outpatient Services provided in a Licensed Level 3 environment; and (f) Level 4—Medically Managed Intensive Inpatient Treatment.[49] Through state plan authority, DHCFP will provide coverage of the following: (a) Level 3.1— Clinically Managed Low-Intensity Residential Program; (b) Level 3.2—Clinically Managed Residential Withdrawal Management; (c) Level 3.5—Clinically Managed Medium Intensity Residential Program; and (d) Level 3.7—Medically Monitored Inpatient Programs.
Use of Evidence-based, SUD-specific Patient Placement Criteria	Implementation of requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools (e.g., ASAM Criteria) or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. <u>Proposed Timeframe:</u> Within 12 to 24 months of Demonstration approval.	DHCFP utilizes ASAM Criteria for individuals presenting with SUDs to determine appropriate placement in a level of care.[50] DHCFP's utilization management approach for currently covered ASAM levels of care is provided as Attachment 2.[51] Within 12 to 24 months of Demonstration approval, DHCFP will develop and implement appropriate utilization management approaches for the additional

[49] NEV. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 44.
[50] *Ibid.*
[51] *Ibid.*

Milestone	Specifications & Proposed Timeframes	NV Status
	Implementation of a utilization management approach such 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. Proposed Timeframe: Within 24 months of Demonstration approval.	services to be covered under state plan.
Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	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, evidence-based SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Providers for residential treatment and withdrawal management are licensed (by setting) and certified (by level of care). None of these providers are required to provide MAT however, they must coordinate with off-site providers as needed. Denial of admission for an individual on MAT is not allowed.	Nevada residential and withdrawal management providers are currently licensed as either residential facilities (i.e., "Facility for the treatment of abuse of alcohol or drugs," or ADA), community triage centers (CTC), or withdrawal management facilities (i.e., "Facility for modified medical detoxification," or MDX).[52] ADA provider licensure requirements are outlined at Nevada Revised Statutes (NRS) 449.00455 et seq. and Nevada Administrative Code (NAC) 449.019 et seq. CTC provider licensure requirements are outlined NRS 449.003 et seq. and NAC 449.74311 et seq. MDX provider licensure requirements are outlined at NRS 449.00385 et seq. and NAC 449.15311 et seq.

[52] ADA, CTC, and MDX are license types/designations established by the Nevada Bureau of Health Care Quality and Compliance (HCQC). *See* NV. DEPT. OF HEALTH AND HUMAN SERVS., *Health Facilities Licensing* (last updated Aug. 15, 2018), https://dpbh.nv.gov/Reg/HealthFacilities/dta/Licensing/Health_Facilities_-_Licensing/
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Milestone	Specifications & Proposed Timeframes	NV Status
	Proposed Timeframe: Within 12 to 24 months of Demonstration approval. Implementation of State process for reviewing residential treatment providers to assure compliance with these standards. Proposed Timeframe: Within 24 months of Demonstration approval. Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site. Proposed Timeframe: Within 12 to 24 months of Demonstration approval.	
Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Completion of assessment of available providers enrolled in Medicaid who are accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT. Proposed Timeframe: Within 12 months of Demonstration approval.	Nevada currently has 598 total beds licensed at ASAM levels 3.1 and 3.5 (i.e., ADA). The State currently has 260 total beds licensed at a level 3.7 (i.e., MDX providers listed in Section 3, Table 3.3 above). With respect to the State's MAT infrastructure, there are 310 providers waivered to provide buprenorphine, however, not all prescribe. For those who do prescribe, very few prescribe to their upper limit. In addition, there are 16 opioid treatment programs concentrated within Clark, Washoe, and Carson City. While capacity exists in these programs, connection to high-quality, integrated services remains a challenge, and rural/frontier communities face considerable access challenges. The State anticipates re-assessing

Milestone	Specifications & Proposed Timeframes	NV Status
		these findings within 12 months of Demonstration approval.
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse. Proposed Timeframe: Over the course of the Demonstration. Expanded coverage of, and access to, naloxone for overdose reversal. Proposed Timeframe: Over the course of the Demonstration. Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs. Proposed Timeframe: Over the course of the Demonstration.	Please see Section 1 above describing the State's efforts to implement comprehensive treatment and prevention strategies to address opioid abuse and OUD through the Good Samaritan Drug Overdose Act of 2015 and the Prescription Drug Abuse Prevention Act of 2017.[53] These new laws establish opioid prescription guidelines and intervention strategies; enhance access to opioid antagonists; and implement initiatives to improve utilization and review of the State's PMP. The State will continue to evaluate the impact of these strategies and consider additional opportunities over the course of the Demonstration.
Improved Care Coordination and Transitions between Levels of Care	Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and/or SUD, with community-based services and supports following stays in these facilities. Proposed Timeframe: Within 12 to 24 months of Demonstration approval.	DHCFP will reimburse for case management (CM) services for patients in an IMD, this also includes patients with a diagnosis of SUD only (without another co-occurring condition), under the state plan. CM services for SUD as a co-occurring diagnosis is already a covered service under the State Plan.

The State also recognizes that a SUD Health Information Technology (HIT) plan will be required as component of the Demonstration implementation plan to provide assurance that a sufficient HIT infrastructure/"ecosystem" exists to achieve the goals of the Demonstration. Nevada is well positioned to fulfill this requirement as it has already developed a statewide "HIT Roadmap" to better understand current and future HIT and health exchange potential. This Roadmap was the

[53] S.B. 459, 78th Leg. (Nev. 2015), *available at* https://tinyurl.com/yxqvorky ; A.B. 474, 79th Leg. (Nev. 2017), *available at* https://tinyurl.com/yy9ero5h.

result of significant stakeholder engagement, fact gathering regarding existing and planned HIT assets in Nevada, use of guiding principles, and the application of the health IT/ Health Information Exchange (HIE) industry best practices. The initiatives recommended in the Roadmap provide guidance and suggested direction for all of Nevada's HIT efforts and include a focus on public-private collaborations, provider adoption and use of technology, data sharing among providers to increase reporting and drive innovation, and infrastructure to allow for a unified view of health data across the continuum of care. The HIT roadmap is currently being updated as part of the HITECH closeout activities.

Section 6: Demonstration Financing and Budget Neutrality

The State understands that it must demonstrate budget neutrality for the Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project. Please refer to the completed Demonstration financing and budget neutrality forms, inclusive of narrative discussion, at Attachment 3 for information regarding the basis of the budget neutrality calculations and trend rates.

Budget neutrality for the State's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project will be demonstrated through the use of the per capita method outlined in CMS SUD 1115 demonstration budget neutrality template ("CMS template").

The budget neutrality projections were developed using CMS requirements, with the format adjusted to accommodate the services outlined in this demonstration request.

As discussed above in this application, the State is requesting demonstration authority for the following cost not otherwise matchable (CNOM) expenditures:

1. Expenditures for services furnished to beneficiaries who are residing in an institution for mental diseases (IMD) primarily to receive treatment for a substance use disorder (SUD).

For the purposes of budget neutrality, this application assumes that this service shall be considered hypothetical expenditures and treated as pass-through services for the purposes of budget neutrality. As clarified by CMS guidance, SUD IMD expenditures are deemed as hypothetical as they would have been otherwise allowable under Medicaid were it not for the IMD/settings prohibition. Although authority is an option through a 1915(i) application, community integration services are requested as a CNOM under this 1115 SUD IMD Waiver application. This permits the State to preserve the SUD continuum of care while alleviating significant administrative burdens of creating and operating a separate Medicaid authority specifically for this service given it is limited to the targeted SUD population.

The narrative below describes the budget neutrality calculations outlined in Attachment 3.

Overall Approach

The State's budget neutrality calculations utilize the approach outlined under Scenario 2 on the CMS template as the state seeks CNOM authority for IMD expenditures. The CMS template has been modified to include two Medicaid eligibility groups (MEGs), as defined below.

Estimation for the IMD Cost Limit

To estimate the projected costs for medical assistance during months in which Medicaid eligible enrollees are at an IMD, 5 years of the State's historical data is provided on overall Medical Assistance (MA) costs for individuals with SUD diagnosis who received inpatient treatment for SUD (or could have received inpatient treatment if such services were available) to determine average cost per user of SUD inpatient services for each historical year.

The State's calculations of SUD IMD costs include all approved medical assistance services provided to Medicaid beneficiaries during an IMD member month - both IMD costs and non-IMD Medicaid costs - but do not include costs associated with room and board as specified by CMS. IMD member months are any whole month which a Medicaid eligible is inpatient in an IMD facility at least 1 day.

Data includes capitation payments and all approved fee-for-service payments made to providers in a month when a Medicaid beneficiary was inpatient in a SUD IMD for at least one day. Data excludes beneficiaries over age 64 and facilities with 16 or less beds.

Estimation of the SUD Hypothetical CNOM Services Limit

The State estimated the service limit for the SUD hypothetical CNOM expenditures with a projected average PMPM cost of the additional services for the population eligible to receive them. As the State has not covered these services historically, we do not have historical data for projecting future average expected costs for the individuals who are eligible for receiving the services. We determined the base year PMPM and member months on the current rates for these services while in treatment and the expected utilization based on the utilization of the services under treatment for Mental Health and Substance Use Disorder. A trend rate, as described below, was applied to the base projections.

Overview of Medicaid Eligibility Groups Included in Calculations

The IMD services will be utilized by Nevada Health Plan beneficiaries from the following Medicaid eligibility groups (MEGs):

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**(Without Waiver) WOW Per Capita**	**WOW Aggregate**	**With Waiver (WW)**	**Brief Description**

Managed Care IMD Services	Hypothetical	X		X	See Expenditure Authority #1
FFS IMD Services	Hypothetical	X		X	See Expenditure Authority #1

Application of Trends for Projections

The PMPM costs under the IMD Cost Limit are trended forward by MEG using the lessor of the President's Budget rate of 4.30% and The State's historical trend. Calculating the historical trend using data from 2021 reflects a positive PMPM trend for these MEGs. The PMPM costs under the SUD hypothetical CNOM services are trended forward by MEG using the President's Budget rate of 4.30%.

Member Month Non-Duplication

As outlined in the CMS template, the IMD Cost Limit member months in the State's calculation are non-duplicative of SUD hypothetical CNOM services limit member months. The IMD member month is defined in the calculations as any who month during with a Medicaid eligible is inpatient in an IMD at least 1 day. The SUD hypothetical CNOM member is defined as any month of Medicaid eligibility in which a person could receive a SUD hypothetical service that is NOT an IMD member month. These definitions also follow those in the CMS template.

Section 7: List of Proposed Waivers and Expenditure Authorities

Below is a preliminary list of expenditure authorities related to Title XIX and XXI authority that the State believes it will need to operate its Demonstration. The State acknowledges that additional authorities may be identified by CMS during the waiver approval process.

1. IMD Expenditure Authority

   Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.

2. Amount, Duration, Scope and Service Section 1902(a)(10)(B)

To permit the state to provide enhanced benefits for the populations covered under this waiver that are not available in the standard Medicaid benefit package. Enhanced benefits are outlined in Section 3.

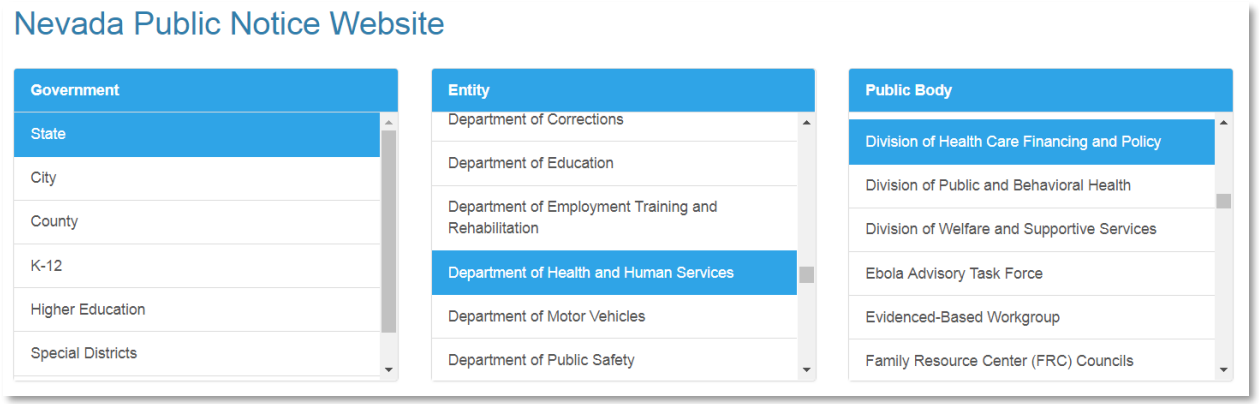
Section 8: Public Notice

As described below, the State is required to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements at Section 1902(a) (73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 C.F.R. 431.408, and the tribal consultation requirements contained in the State's approved Medicaid State Plan.

A. State Public Notice and Comment Period

The Nevada DHHS published a notice of the public comment period for the Demonstration wavier on September 23, 2021. The notice was published on the DHCFP website at http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/ , and on the State's public notice website at https://notice.nv.gov/ . The latter may be accessed by using the website's drop down menus by selecting "State" as the Government type, "Department of Health and Human Services" as the Entity type, and "Division of Health Care Financing and Policy" as the Public Body. Please see Figure 8.1 below which illustrates this process.

Figure 8.1: Nevada Public Notice Website



The published notice includes details of the waiver application, dates and locations for public hearings of which include teleconferencing and video-conferencing, as well as the physical and email addresses where interested parties could submit written comments (*see* Attachment 3). The period will begin on September 23, 2021**.** Further, the DHHS sent emails to stakeholder groups via an online announcement and a subscription email listserve to inform them of the waiver and the public comment period. All materials including the published notice, hearing information, and waiver application were made available online at: https://notice.nv.gov/Notice**.** The public hearing agenda was made available at District Offices throughout the State.

B. Tribal Notice

The Nevada DHHS is in the process of consulting with the State's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations. Consultation is being conducted in accordance with the process outlined in the State's approved Medicaid State Plan, which includes notification; description of the purpose of the waiver request and its anticipated impact on Tribal members, Tribes, Tribal Health Providers, and Urban Indian Health Providers (I/T/Us); and description of a method for providing official written comments and questions. Should Tribes and/or I/T/Us request in-person consultation meetings, DHHS will make such meetings available. A copy of the tribal notice is included in Attachment 4.

Section 9: Demonstration Administration

Contact information for the State's point of contact for the Demonstration is provided below:

Sarah Dearborn, Social Services Program Specialist III
Division of Health Care Financing and Policy
Nevada Department of Health and Human Services
Phone: (775)684-3732
Email: sdearborn@dhcfp.nv.gov

Attachment 1: Data Collection and Reporting Capacity

Nevada DHHS Data Collection and Reporting Resources

Office of Data Analytics

The Office of Analytics (OOA) collects and analyzes many other data sets. All state-funded substance abuse treatment providers are currently required to report Treatment Episode Data Sets (TEDS) to OOA monthly. The current system requires TEDS reporting through then Nevada Central Data Repository (CDR) for all state-funded substance use treatment facilities. Monthly the data is downloaded from the CDR via CSV files and is submitted to the Substance Abuse and Mental Health Services Administration's (SAMHSA) TEDS Project Office monthly. Included in the admissions and discharge TEDS data are data variables that can be used to capture detailed demographic information, referral sources, housing and employment status, primary substances used and frequency, and level of care required for treatment. This data is valuable for the Single State Authority (SSA) to determine length of stay and cost of treatment episodes with substance abuse treatment programs throughout the State as well as outcomes of such treatment. Included in the TEDS data are National Outcome Measures (NOMs), which are used to determine if there has been a change, or outcome, during the treatment episode related to social determinants of health, such as employment status, living arrangements, arrests, and participation in self-help groups. All prospective IMDs currently report TEDS data to the OOA and have extensive experience collecting and using such data as part of their Continuous Quality Improvement efforts. TEDS data, for the purposes of the National Evaluation, will be accessible directly through OOA.

Office of Public Health Informatics and Epidemiology (OPHIE)

The mission of OPHIE is to conduct disease surveillance, investigate disease outbreaks, and provide quality, timely, and relevant data and statistics to support and inform public health stakeholders. To carry out this mission, OPHIE records and analyzes reportable disease information; conducts interviews; assists in medical treatment planning; collects and analyzes data; identifies risk factors; recommends prevention and education opportunities and works in conjunction with many agencies throughout the state. OPHIE's staff performs data management, quality assurance, data analysis, and reporting in a broad spectrum of public health areas. In addition, OPHIE houses many core public health datasets, including, but not limited to, reportable disease registries, inpatient hospital discharge data, births, deaths, and fetal deaths. Common elements between databases enable matching or linking of these databases in order to provide newly accessible and standardized information for analytical and programmatic purposes. Extracted data derived from each database and linked databases are available for statistical data analysis.

OPHIE also collects and analyzes many other data sets. All state-funded substance abuse treatment providers are currently required to report Treatment Episode Data Sets (TEDS) to OPHIE on a monthly basis. The current system requires TEDS reporting through a legacy data system called Nevada Health Information Provider Performance System (NHIPPS), which was previously used as the Electronic Health Record (EHR) for all state-funded substance use treatment facilities; an organization administering their own EHR will extract their data, via a

CSV or tab-delimited file sent through secure file transfer protocol (SFTP), and report to OPHIE for processing. This is submitted to the Substance Abuse and Mental Health Services Administration's (SAMHSA) TEDS Project Office monthly. Included in the admissions and discharge TEDS data are data variables that can be used to capture detailed demographic information, referral sources, housing and employment status, primary substances used and frequency, and level of care required for treatment. This data is valuable for the Single State Authority (SSA) to determine length of stay and cost of treatment episodes with substance abuse treatment programs throughout the State as well as outcomes of such treatment. Included in the TEDS data are National Outcome Measures (NOMs), which are used to determine if there has been a change, or outcome, during the treatment episode related to social determinants of health, such as employment status, living arrangements, arrests, and participation in self-help groups. All prospective IMDs currently report TEDS data to the OPHIE and have extensive experience collecting and using such data as part of their Continuous Quality Improvement efforts. TEDS data, for the purposes of the National Evaluation, will be accessible directly through OPHIE.

The Uniform Reporting System (URS) and the Mental Health Statistics Improvement Program (MHSIP) are also managed and maintained by OPHIE. The children's behavioral health system is operated by DCFS and the adult behavioral health system is managed by DPBH, thus ongoing communication and data sharing between the divisions and OPHIE is paramount. Currently, both the child and adult mental health systems maintain their own electronic health records and collect their own MHSIP surveys. This data is then transmitted to OPHIE for analysis and submission to SAMHSA. The adult behavioral health system has historically conducted a brief point-in-time survey to capture the MHSIP survey data; however, this system was modified to require quarterly surveys as a result of the State's Certified Community Behavioral Health Center Demonstration.

Nevada Division of Health Care Financing and Policy (DHCFP)

DHCFP is Nevada's Division of Medicaid. DHCFP has had a long-standing relationship with the Center for Health Information Analysis (CHIA) for data analytics. The core mission of the CHIA is to act as a central health data information hub in Nevada, in an effort to indirectly improve health care quality and increase available health-related knowledge via public health information transparency. CHIA was founded in 1986 and has continuously worked under contract with DHCFP. CHIA has collaborated with DHCFP on various large-scale health data projects. From 1993-2003, CHIA housed, analyzed, and reported on Medicaid claims, Eligibility, and CHIP data. From 2000-2005, CHIA collected, evaluated, and compared hospital Charge Masters. From 1986 to the present, CHIA collects all hospital inpatient claims records. In 2009, this was expanded to include hospital outpatient data and ambulatory surgical center data. Since late 2015, CHIA now captures patient identifiers, which provide an opportunity to link individuals between multiple systems. CHIA worked extensively with the providers to ensure success for data reporting.

Attachment 2: Utilization Management Approach[54]

ASAM Level of Care	Benefit	Utilization Management
0.5	Early Intervention/Prevention	No prior authorization required. Limited to one screen per 90 days per disorder.
1	Outpatient Services	Prior authorization is required on services after service limitations have been exceeded. Post authorization is not required for substance use only crisis intervention. Refer to MSM 400 for co-occurring and mental health crisis intervention services and limitations. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required. Individual, group, family psychotherapy and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to 18 total sessions for adults before prior authorization is required.
2.1	Intensive Outpatient Services	Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24-hour crisis intervention.
2.5	Partial Hospitalization	Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24-hour crisis intervention.
3.1-3.5	Managed Residential	Prior authorization is required on services, after service limitations have been exceeded. Post authorization is not required for substance abuse only crisis intervention. Refer to MSM 400 for co-occurring and mental health crisis intervention services and limitations. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required. Individual, group, family psychotherapy and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to

[54] NEV. DEP'T OF HEALTH AND HUMAN SERVS.MEDICAID SERVICES MANUAL (2019), *AVAILABLE AT*: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C400/Chapter400/

ASAM Level of Care	Benefit	Utilization Management
		18 total sessions for adults before prior authorization is required. Intensity of service is dependent upon individual and presenting symptoms.
4	Medically Managed Intensive Inpatient Services	Prior authorization is required for all Medicaid and pending Medicaid recipients, and Medicaid recipients covered through primary insurance, except Medicare Part A. If this is the case, authorization may need to be sent through Medicare.
4-WM	Medically Managed Intensive Inpatient Services-Withdrawal Management	
Office-Based Opioid Treatment	MAT	Medicaid-covered outpatient drugs used for opioid addiction may be subject to prior approval and/or quantity limits and preferred drug list status. These conditions are outlined in the Medicaid Service Manual Chapter 1200.[55]
Opioid Treatment Programs	MAT and Methadone Maintenance	

[55] NEV. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 44; *see also* NEV. DEP'T OF HEALTH AND HUMAN SERVS., UPDATED NEVADA MEDICAID INFORMATIONAL BULLETIN ON MEDICATIONS AND SERVICES FOR SUBSTANCE USE DISORDERS (2020), *available at* https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/InformationalBulletinOnMedicationsAndServicesForSubstanceUseDisorders.pdf.

Attachment 3: Public Notice

NOTICE OF PUBLIC MEETING TO SOLICIT COMMENTS ON AMENDMENTS TO THE STATE PLAN FOR MEDICAID SERVICES AND THE 1115 DEMONSTRATION WAIVER

AGENDA

Date of Publication: <Date>

Date and Time of Meeting: October 26, 2021, at 9:00 AM

Name of Organization: The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

Place of Meeting:

DHCFP
1100 E. William Street
First Floor Conference Room
Carson City, Nevada 89701

Space is limited at the physical location and subject to any applicable social distancing or mask wearing requirements as may be in effect at the time of the meeting for the county in which the physical meeting is held.

Please use the teleconference/Microsoft Teams options provided below. If accommodations are requested, please advise using the information at the end of this agenda.

Note: *If at any time during the meeting an individual who has been named on the agenda or has an item specifically regarding them included on the agenda is unable to participate because of technical or other difficulties, please email Jenifer Graham at jenifer.graham@dhcfp.nv.gov and note at what time the difficulty started so that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.*

Please be cautious and do not click on links in the chat area of the meeting unless you have verified they are safe. If you ever have questions about a link in a document purporting to be from Nevada Medicaid, please do not hesitate to contact Jenifer.graham@dhcfp.nv.gov for verification.

Webinar: <TinyURL>

Select "Join," enter Meeting Number xxx xxx xx x, your name and email and then select "Join."

The meeting should not require a password, please search for the meeting manually using the meeting number above to join.

Audio Only: (775) 321-6111
Event Number: <xxx xxx xxxx>

PLEASE DO NOT PUT THIS NUMBER ON HOLD (*hang up and rejoin if you must take another call*)

YOU MAY BE UNMUTED BY THE HOST WHEN SEEKING PUBLIC COMMENT, PLEASE HANG UP AND REJOIN IF YOU ARE HAVING SIDE CONVERSATIONS DURING THE MEETING OR THOSE MAY BE HEARD BY OTHERS AND RECORDED
This meeting may be recorded to facilitate note-taking or other uses. By participating you consent to recording of your participation in this meeting.

AGENDA

1. General Public Comments (Because of time considerations, the period for public comment by each speaker or organization may be limited to three minutes and speakers are urged to avoid repetition of comments made by previous speakers)

2. Discussion of proposed Amendments to the State Plan for Medicaid Services and solicitation of public comments

   Subject: 1115 Substance Use Disorder (SUD) Demonstration Waiver

   DHCFP is proposing to submit an 1115 Substance Use Disorder (SUD) Demonstration Waiver application through the Centers for Medicare and Medicaid Services (CMS). In effort to combat the ongoing opioid crisis, CMS created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with substance use disorders (SUDs) including Opioid Use Disorder.

   The following Provider Type (PT) will potentially be affected by this change:
   This proposed change affects all Medicaid-enrolled providers delivering SUD services. Those provider types include, but are not limited to: Hospital, Inpatient (PT 11), Psychiatric Hospital, Inpatient (PT 13), Physician, M.D., Osteopath, D.O., (PT 20), Advance Practice Registered Nurse, (PT 24), Nurse Midwife, (PT 74), Physician's Assistant, (PT 77), Substance Abuse Agency Model (PT 17 Specialty 215), Certified Community Behavioral Health Center (PT 17 Specialty 288).

   The projected enrollment and expenditures for each demonstration year are:

	DY23	DY24	DY25	DY26	DY27
Member Months	5,587	5,643	5,700	5,757	5,814
Expenditures	$6,987,676	$7,361,049	$7,754,357	$8,168,668	$8,605,143

The effective date of change is January 1, 2023.

a. Public comment regarding subject matter.

3. Adjournment

NOTE: To use the long link to the meeting in the event there are issues with the URL shortener, please use the following complete link:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_NGNkNjhlYzAtZDhkZi00YzViLWFjNDgtM2YwYTg2YmQ5MmM1%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.

PLEASE NOTE: Items may be taken out of order. Items may be pulled or removed from the agenda at any time. All public comment may be limited to three minutes.

The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

This notice and agenda have been posted online at http://dhcfp.nv.gov and http://notice.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. E-mail notice has been made to such individuals as have requested notice of meetings (to request notifications please contact jenifer.graham@dhcfp.nv.gov, or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701
DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

If you require a physical copy of supporting material for the public meeting, please contact jenifer.graham@dhcfp.nv.gov, or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. Supporting material will also be posted online as referenced above.

Note: We are pleased to make reasonable accommodations for members of the public with a disability and wish to participate. If accommodated arrangements are necessary, notify DHCFP as soon as possible and at least ten days in advance of the meeting, by e-mail at jenifer.graham@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Attachment 4: Tribal Consultation

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
Helping people. It's who we are and what we do.

Suzanne Bierman, JD MPH
Administrator

April 28, 2021

Inter-Tribal Council of Nevada
Serrell Smokey, ITCN President
Tribal Chairman of Washoe Tribe
919 Highway 395 S
Gardnerville, Nevada 89410

Dear Tribal Members:

In accordance with established consultation guidelines, the Division of Health Care Financing and Policy (DHCFP) is notifying Nevada tribes of the following proposed change in policy:

Pending legislative approval of Senate Bill 154, DHCFP is proposing to submit an 1115 Substance Use Disorder (SUD) Demonstration Waiver application through the Centers for Medicare and Medicaid Services (CMS). In an effort to combat the ongoing opioid crisis, CMS created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with substance use disorders (SUDs) including Opioid Use Disorder.

There is no anticipated fiscal impact on the Tribal Government.

If you would like a consultation regarding this proposed change in policy, please contact Crystal Biselli at (775) 684-3722 who will schedule a meeting. We would appreciate a reply within 30 days from the date of this letter. If we do not hear from you within this time, we will consider this an indication that no consultation is requested.

Sincerely,

Jessica Kemmerer

Jessica Kemmerer
HIPAA Privacy and Civil Rights Officer, DHCFP

Cc: DuAne Young, Deputy Administrator, DHCFP
Cody Phinney, Deputy Administrator, DHCFP
Sarah Dearborn, SSPS III, Behavioral Health Unit, DHCFP
Briza Virgen, SSPS III, Medical Programs Unit, DHCFP