MEETING NOTES

Statewide Substance Use Response Working Group
Treatment and Recovery Subcommittee Meeting

March 24, 2026
11 a.m.

Zoom Meeting ID: 865 8016 1096
No Physical Public Location

Members Present via Zoom or Telephone
Stephanie Cook, Assm. Rebecca Edgeworth (left meeting at 11:33 a.m.), Assm. Heather Goulding, Guiseppe Mandell, Dr. Jose Partida-Corona, and Steve Shell

Members Absent
Dave Briggs

Office of the Attorney General
CJ Brady, Dr. Terry Kerns, and DAG Joseph Peter Ostunio

Social Entrepreneurs, Inc. Support Team
Laura Hale and Kim Hopkinson, PhD

Members of the Public via Zoom
Beth Scott, bquezada, Cade Grogan, Jamie Ross, Jessica Johnson, Karina Tomco, Mark Funkhauser, Michele Solomon, Michelle Berry, Riley Shepherd, and Sabrina Petrel

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 11:00 a.m. Kim Hopkinson called the roll and confirmed a quorum.

2. **Public Comment**
   Mr. Mandell noted that treatment for adults and adolescents in Nevada is currently at the bottom, including all mental health and treatment. He knows that programs have moved out of state due to interference in their program models, including regulations and programming. Boys Town for adolescents is an example of a very successful program around the states. He added that they did remove their program from the state, which we did not need.[1] He advised members to be open-minded about how programs work, and not to try to alter them if they are succeeding in other states.

3. **Review and Approve Minutes from February 24, 2026, Treatment and Recovery Subcommittee Meeting**
   - Dr. Partida-Corona made the motion to approve the minutes.

[1] Sabrina Petrell commented on behalf of Boys Town, during the second period of public comment, noting that they have been in Nevada since 1991 and are still here – after 49 years, but they no longer have psychiatric residents.

- Mr. Mandell seconded the motion.
- The motion carried unanimously.

4. Presentation on Contingency Management

Michelle Berry, MBA, Executive Director, Center for the Application of Substance Abuse Technologies (CASAT), School of Public Health, University of Nevada, Reno presented slides[2] with support from Michele Solomon.

Ms. Berry welcomed any additional information from Jessica Johnson, who was also in attendance. CASAT was awarded grant funds for this project under Senate Bill 118, through the Southern Nevada Health District, to train providers in Clark County.

They facilitated a needs assessment with partners to survey approximately 22 agencies on awareness of contingency management (CM) and what they need to successfully implement it. Improved treatment engagement and outcomes are documented across a variety of settings, depending on organizational readiness, leadership support, and staff willingness to adopt new approaches.

The small sample size includes providers at the level of clinical, director, and above, with 64% in outpatient settings and also 64% that serve 60+ people per month. Residential treatment providers represented 18% of respondents, with the balance coming from community mental health, MOUD (medications for opioid use disorder) or MAT (medication-assisted treatment), prevention agencies, recovery community organizations, and Certified Community Behavioral Health Clinics (CCBHCs). Many of these agencies serve multiple functions.

Respondents include administrative (32%), clinical staff or coordinators (23%), other roles (23%), program managers or supervisors (18%), and peer support specialists (5%).

They found that a knowledge gap exists around CM, where 43% of respondents were somewhat familiar, but 56% were not confident they could explain it to a client or colleague; only 25% felt very confident on this metric. Approximately 70% said their organizations were supportive of behavioral health incentives like CM; 57% were very interested in participating in training and 58% already have formal systems in place that could be adapted for CM, such as tracking tools or appointment systems. The two biggest obstacles, cited by 55%, were lack of funding and limited staff time. Introductory overview, practical implementation, and workforce integration were cited by 77% of respondents as training topics that would be most useful. Self-paced online training modules were preferred by 40%, whereas 35% prefer live virtual training. Tuesdays and Wednesdays were the best days for scheduling training.

In summary, there were three clear priorities for CM training:

[2] The slides from this presentation are available as part of the March 24, 2026 meeting materials on the SURG website at https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

1. Start with this introductory overview, to lay a strong foundation;
2. Make it accessible (online delivery on Tuesday or Wednesday afternoon); and
3. Address real-world constraints head-on.

Noted barriers include funding and staff time, but the provider community seem very supportive of learning about and integrating CM within their organizations. CASAT will present a 3-overview training series to Clark County providers with a review of the following:

- scope of stimulant use in southern Nevada,
- effects on brain and behavior,
- psychological and behavior principles of CM,
- essentials for implementing and beginning a program, and
- strategies for financing and implementing.

Mr. Mandell thanked Ms. Berry for the great presentation and asked for an overview of contingency management because members are from different backgrounds and may not know. Ms. Berry explained it is an evidence-based approach that uses positive reinforcement to encourage desired behavior, such as testing clean with UAs (urine analysis), attending group, attending appointments, and being present in their treatment.

Assm. Goulding thanked Ms. Berry for the presentation and asked about costs associated with CM that could be included if members decide to make a recommendation. Ms. Berry explained the costs for reimbursement of incentives could extend over the duration of treatment, with states determining the amounts. There is no current reimbursement infrastructure in Nevada for CM; in California, she believes they fund incentives at $499, but it depends on how the organization wants to use them and for how long. For example, a patient might get $15 for a clean UA, or it could be a voucher for food or gas, depending on what is valuable to the individual attending treatment. Ms. Berry also confirmed that there would be no other costs than these modest incentives.

Dr. Partida Corona said they already use a level of contingency management for outreach predominantly to unhoused patients to encourage further engagement for labs and other testing to support overall health, which pays off in the long term, with advanced care for things like Hepatitis C that can lead to liver failure and expensive treatment if they end up in the hospital. Dr. Partida Corona asked how many of the respondents were actually treating stimulant use disorder (SUD), and whether different types of providers had different views about CM.

Ms. Solomon clarified that most survey respondents were seeing patients for methamphetamine use. While they didn't specifically identify differences among provider types, there was a high level of agreement for the protocol given the provision of incentives, when they implement the program.

Dr. Partida-Corona said it is vitally important that outreach providers understand the value of CM and there could be targeted education to any resistant providers. Ms. Solomon agreed this makes sense.

Ms. Cook oversees programs for the state of Nevada, Division of Public and Behavioral Health, including various federal grants and state funding where they are finalizing their CM model to support this work. Federal funds don't allow cash incentives and gift cards may also be restricted. They have done a pilot program with some agencies, building gift cards into their policy, including gas cards, bus passes, hygiene kits, and vouchers to support well-being and recovery. Once the funding model is finalized, they will be able to release funding specifically for this purpose. A lot of other supports are already in place at treatment agencies with teams to implement this model in the community.

5. **Discuss and Draft Proposed Treatment and Recovery Subcommittee Recommendations**
Chair Shell stressed the tight timeline that the subcommittee has for getting recommendations ready for presentation to the full SURG and that there was a lot of material to cover.

Kim Hopkinson shared slides to confirm that members had scheduled meetings on their calendars. She also explained the process and timing for recommendations to be included in the Annual Report due in August. There may not be time to schedule presentations and have sufficient discussion on some of the newer recommendations, but those will continue for review into the next cycle.

In April, preliminary recommendations will be shared with the full SURG, for possible feedback and/or alignment, and then in May, this subcommittee will finalize and rank preliminary recommendations for final presentation at the June SURG meeting. There is an additional subcommittee meeting scheduled for June in case it is necessary to incorporate feedback from the SURG for inclusion in the annual report.

Subcommittee members may also submit additional recommendations via the survey link provided to them by SEI staff. If members have questions or they are unable to complete any of the survey items, they can contact Kim Hopkinson and/or enter an asterisk (*) as a placeholder.

Chair Shell noted the excellent recommendations recently submitted and thanked Dr. Partida Corona. The total number of current recommendations for this subcommittee were 11 – a record number of submissions. Those that don't make it into this report cycle will go forward in the next cycle.

(*Note: Recommendations are posted on the SURG website for each subcommittee meeting.*)

Recommendation #1
Submitted by Chelsi Cheatom on 8/20/2025; Stephanie Cook adopted the lead for this recommendation in February 2026. Italicized content was added based on the prior month's meeting of this subcommittee

Presented Recommendation Description: A retrospective assessment or/ and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose. *This study*

should ideally cover a five-year period and include both people with private insurance and those who utilize Medicaid.

(Note: Kim Hopkinson noted that Assm. Edgeworth had left the meeting at 11:33, but there was still a quorum.)

Dr. Partida Corona noted that the School of Public Health and the fellowship at Southern Hills could probably coordinate to produce the recommended study. He suggested outreach to ask if they have the bandwidth needed to do so.

Ms. Cook expressed concern with the broadness of the recommendation. *Patient outcomes following discharge from detox* could be clarified as *withdrawal management,* and *examine mortality and overdose using SUTRS data.* She also asked if they would only look at withdrawal management facilities, which could limit types of insurance, and the state certifies those facilities.

Dr. Partida-Corona understood the intent to look at morbidity and mortality as associated with overdose, post-detox, including rehab to compare continuation of MAT versus not.

Mr. Mandell asked if the goal of the study would be to utilize what is working best among various treatment options and insurance coverages. He noted that Medicaid generally only pays for detox, versus a PHP (partially hospitalization program) IOP (intensive outpatient program) program, and private insurance pays for detox, residential, PHP, and IOP mixing both MAT and non-MAT depending on what the patient wants to do. He added that hopefully the state would step up a little bit and start helping the Medicaid population as well, so that the mortality rate lowers, and for the members to look at mortality rates across different insurers. He reminded Ms. Cook that we are at the bottom and behind the curve in these studies.

Ms. Cook said she is currently looking at substance-use treatment facilities because her team certifies them and has access to that data for assessment. If they look at all entities across the state, they would have to figure out how to incorporate multiple systems that are hard to link together. Getting data from specific facilities they already work with would be more manageable.

Chair Shell agreed with this approach, recalling a presentation from the state of Connecticut on robust studies conducted there that could be referenced.

Dr. Partida Corona suggested limiting the study to credentialed institutions to look at MAT versus non-MAT for post-detox and rehab treatment. Mr. Mandell clarified that his concern with Medicaid coverage is the limited time for detox and then residential treatment, versus expedited PHP directly from detox, noting that Nevada is unique.

Chair Shell confirmed with Ms. Cook that her recommendation is to focus on certified withdrawal management facilities where the state determines certification, and they could maybe examine causes of overdose to include both non-fatal and fatal, within six months of

discharge. They could look at where people are going and if they seek care in those first six months.

Dr. Partida Corona supported a longer term horizon, such as five years, for long-term recovery because they keep having relapses and repeat admissions.

Ms. Cook was concerned about calling out specific insurance types for a study because their scope might be limited to the available data sets.

Mr. Mandell reiterated the need for inclusion of commercial insurance because they will pay for residential treatment. This is limited by Medicaid, which he believes results in a cycle for patients going in and out of a facility with no progress, but a lot of Medicaid costs over time.

Ms. Cook asked if references to MAT could be clarified to MOUD to mean just the medication and not the provision of treatment. Dr. Partida Corona agreed with this.

Ms. Hopkinson revised the language to include *exploration of the patterns of stepdown and use of MOUD by these patients.*

Ms. Cook said they are trying to figure out why people are overdosing within 6 years of discharge from a withdrawal management facility and what missed opportunities there are, but mortality data will not follow people over that period.

Mr. Mandell suggested they could backtrack over that period with patients who sustained five years in recovery. He also asked what is meant by a certified withdrawal management facility and whether that refers to MAT treatment clinics and detox and residential treatment facilities.

Ms. Cook said the updated language for *detoxification* is *withdrawal management* to be less stigmatizing.

Chair Shell asked whether the distinctions for insurance types would remain.

Dr. Partida Corona thought *Medicaid* could be removed due to the patterns of step-down. Mr. Mandell wanted to retain the language to show the difference between state payers and commercially insured paid treatment, with part of the goal being to get the state to keep up with the times and increased costs.

Ms. Cook supported this concept, but she thought it might be a different recommendation, with the study being one issue, and increased support being another. They could include language to assess outcomes of all patients which could delineate among different contributing factors from insurance to diverse patients.

Recommendation #1 following revision during the meeting:

A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.

Chair Shell reviewed the next recommendation:

Recommendation #2
Submitted by Steve Shell on 6/17/2025 and updated for Subcommittee member review prior to the February 2026 meeting. Italics represent edits proposed during the February 2026 Treatment and Recovery meeting.

Presented Recommendation Description: Recommend to the Nevada Department of Human Services that they financially support the implementation of *embedded* hospital emergency room-based peer recovery support teams. This could be via dedicated general funds made available to hospitals, or by encouraging applications for use of Fund for Resilient Nevada monies.

Chair Shell noted that the word "embedded" is italicized because it was incorporated at the last meeting. He referred to Dr. Partida Corona for other items to be added to this recommendation.

Dr. Partida Corona suggested that access to state opioid funds would be contingent on hospital adoption of delineation of privileges for addiction specialists and opening a pathway for mid-level providers who would be supervised by the addiction specialists and peer recovery navigators, whom he believes should be part of the same addiction consult team. The goal is to put the onus on the hospitals to open the door for addiction medicine in the hospital setting. Otherwise, he doesn't think they would give it priority.

Chair Shell asked how the rural hospitals could approach that with peer recovery support specialists in their communities, but without the means to hire addiction specialists.

Dr. Partida Corona suggested telemedicine could be a means for addiction specialists to weigh in on cases in rural communities. It's not a mandate for them to actually have an addiction specialty consult service, but a mandate to set up the mechanisms by which an addiction specialist or a mid-level provider can apply for privileges, or peer recovery navigators can apply for access. This wouldn't cost that much and may reduce costs in the long term. But they might not do it of their own volition.

Ms. Cook suggested encouraging applications through the department, rather than calling out specific funding sources. The program funding she oversees could possibly help, and the Fund for Resilient Nevada has a plan they're working from and may not always be able to start funding new things.

Chair Shell supported this change and suggested a change to the end of the first sentence in the recommendation.

Ms. Hopkinson noted that Dr. Partida Corona submitted a similar recommendation just the night before, and she asked if those could be merged. Several other recommendations were also submitted just the night before, so they were not included in the originally posted materials or those sent to members. Updated recommendations will be made available before the next meeting, bringing the total number of recommendations eleven.

Chair Shell agreed that the two recommendations could be combined, if that makes sense to the rest of the members.

Ms. Hopkinson asked for clarification if the intent is for DHS to financially support the establishment of cohesive addiction consult services within hospitals and ERs through specified steps.

Dr. Partida Corona agreed that having an addiction specialist on staff is infinitely better as backup for the physicians in the hospitals, as well as for warm handoffs to outpatient treatment. It also creates job opportunities for fellows graduating from Southern Hills, building the bench of treatment specialists.

Ms. Cook was concerned that the new language required the DHS to fund these services in a hospital. Mr. Mandell said the goal was to incentivize the hospitals. Dr. Partida Corona said the key was to incentivize the adoption of delineation of privileges for providers and mid-levels, and to financially support the adoption of peer recovery navigators to be embedded in the ERs in the hospitals. They would be employed by the hospitals but work with the consult team. This is similar to how ER nurses work with a contracted group for a particular hospital. That way, the only cost for the hospital is for implementing delineation of privileges and the cost of peer recovery navigators. The cost for the mid-level providers and addiction specialists would be borne by those applying for privileges as part of the consult group that would bill independently to generate their own revenue.

Dr. Partida Corona said he didn't think anyone would fund the adoption of specialists into the hospitals, but the funds are there for hiring peer recovery navigators. Currently, the ER group is contracted for services, similar to a hospitalist group that gets paid by Medicare and Medicaid, as well as by private insurance. But the hospital hires the ER nursing staff, as direct employees, although they work in tandem with and under the direction of the contracted ER group. Peer recovery navigators would similarly be hired by the hospital.

Ms. Hopkinson asked for clarification regarding what funding was being requested from DHS. Dr. Partida Corona explained that the hospitals would receive opioid settlement funding to hire the peer recovery navigators and to set up the delineation of privileges for addiction specialists and mid-levels.

Chair Shell liked the revised language which is consistent with his original intent. Ms. Cook recommended removal of specifying opioid settlement funds, because they might not be able

to tap into that specific fund right now, depending on current priorities. Alternatively, if they specify department funds, there is more flexibility.

Dr. Partida Corona supported this change, and he noted that there is language already written on delineation of privileges that can be shared with hospitals so they wouldn't have to do that work.

Assm. Goulding suggested adding the word "fund" after "department."

Ms. Hopkinson updated the recommendation to the following:

> **Recommendation following revision during meeting:**
>
> **Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services.**
>
> **Hospitals would receive Department funds to hire peer recovery specialists, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.**

Chair Shell moved discussion to the third recommendation for Contingency Management, related to the earlier presentation from CASAT.

> **Recommendation #3: Submitted by prior Subcommittee member Chelsi Cheatom in 2025**
>
> **Presented Recommendation Description: Contingency Management can be used to support people in recovery through rewards for reaching their recovery goals. Increasing funding to support contingency management could help more providers offer this important support program to patients.**

Ms. Cook suggested that state funding be specified, if that is the intent of this recommendation.

Dr. Partida Corona suggested the recommendation should specify billing out in $15 increments because gift cards start at $15. Funders might be less hesitant if they know the increments are small. He also noted that $10 doesn't work because most gift cards start at $15.

Mr. Mandell asked about patient welfare laws with regard to funding. Ms. Cook explained the funds she oversees have stipulations attached to types of incentives that can be funded with federal dollars. They must adhere to federal guidance for contingency management, with a current cap of $750 per person. Specific dollar amounts may be too restrictive for the federal funding. If general funds are referenced, they have flexibility that do not apply for federal grant funds.

Ms. Cook suggested removing the last sentence from this recommendation; Mr. Mandell agreed.

Ms. Hopkinson revised the third recommendation to the following:

> **Recommendation following revision during meeting:**
>
> **Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.**

Chair Shell asked for a new lead for this recommendation. Ms. Cook thought it might be a conflict of interest for her, so Mr. Mandell agreed to serve as lead for this recommendation to move this recommendation forward.

Chair Shell asked for a motion:

- Dr. Partida Corona made the motion to approve this recommendation with the revised language.
- Ms. Cook seconded the motion.
- The motion passed unanimously.

Chair Shell asked for another motion to assign Mr. Mandell as the new lead for this recommendation.

- Dr. Partida Corona made the motion.
- Ms. Cook seconded the motion.
- The motion passed unanimously.

Chair Shell moved discussion to Recommendation #4.

> **Recommendation #4: Submitted on 3/23/26 by Jose Maria Partida Corona, MD, FASAM**
>
> **Presented Recommendation Description**: Elimination of prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder.

Dr. Partida Corona wanted to add that this would apply to Medicaid, including any and all MCOs because they're the biggest culprits regarding prior authorizations. This recommendation should apply for all payers, including Medicaid and MCOs.

Ms. Cook asked about adding specific settings such as the ER or EMS into this recommendation. Dr. Partida Corona said he doesn't want to specify settings because it

narrows the window of opportunity to initiate treatment for SUD. If they wait for prior authorization, relapse into overdose is possible.

Ms. Cook asked about changing from MAT to MOUD. Dr. Partida Corona said with methadone he can understand hesitancy due to legal requirements, but with buprenorphine, which they can use anywhere, it makes it easier for applications rather than trying to include all MOUD. Ms. Cook said this made sense.

Ms. Hopkinson revised the fourth recommendation to the following:

> **Recommendation following revision during meeting:**
>
> **Elimination of prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder. This would apply to all payors including Medicaid MCOs.**

Chair Shell asked if members were comfortable moving forward as is. There were no objections.

Ms. Hopkinson explained that background and justification information for the first four recommendations has been posted to the SURG website as part of the materials for this meeting. However, she received seven additional recommendations to be incorporated into an updated version of the document, and this information would be available for the next subcommittee meeting, due to time constraints.

Chair Shell noted the excellence of these seven recently submitted recommendations and asked if they were ready as currently presented or if further discussion was required.

Dr. Partida Corona said that the elimination of dosage limitations recommendations was the most important recommendation to discuss, and which he thought was ready to go.

Ms. Hopkinson screen shared the justification/background and associated research regarding this recommendation (*hereafter referred to as recommendation #5*).

> **Recommendation #5: Submitted on 3/23/26 by Jose Maria Partida Corona, MD, FASAM**
>
> **Presented Recommendation Description**: Elimination of dosage limitations from Medicaid for buprenorphine when used for medication assisted treatment.
>
> **Justification/background:** Placement of limitations on buprenorphine dosages is actually counterproductive in several ways. First, by placing restrictions on dosing, it engenders in the minds of physicians a mindset that buprenorphine is a dangerous medication that could easily lead to overdose. This could not be further from the truth. It actually serves to protect from overdose. Second, it stigmatizes patients that are trying to stay in compliance and treatment for their opioid use disorder. Third, it creates a barrier

to trust between physician and patient, by introducing limitations from a third party, which is highly problematic when treating a stigmatized population. Fourth, it interjects a limitation to treatment that is not based on best practices, but that is, in fact, rooted in institutional stigmatization of a patient population.

Associated Research: NIDA. 2023, September 18. Higher buprenorphine doses associated with improved retention in treatment for opioid use disorder. Retrieved from https://nida.nih.gov/news-events/news-releases/2023/09/higher-buprenorphine-doses-associated-with-improved-retention-in-treatment-for-opioid-use-disorder on 2026, March 18

NNT Group. (n.d.). *Buprenorphine maintenance vs. placebo for opioid dependence*. The NNT. Retrieved March 22, 2026, from [https://thennt.com/nnt/buprenorphine-maintenance-vs-placebo-opioiddependence/](https://thennt.com/nnt/buprenorphine-maintenance-vs-placebo-opioid-dependence

Ms. Cook wanted to see data on what is currently happening in this space. For example, what are Medicaid or MCO (managed care organization) limitations? How many folks are on higher doses?

Dr. Partida Corona said that because fentanyl displaced heroin, the majority of patients aren't stable until they get 24 mg (buprenorphine). Associated research shows NIDA (National Institute on Drug Abuse) number needed to treat (NNT) is the number of patients to give that medication and dosage to, in order to get a beneficial effect. The lower the number, the better the treatment. For example, taking aspirin for a heart attack has a NIDA of 7, because on average, you would give 7 people a dose of aspirin to get 1 benefit. For buprenorphine, the next incremental dosage greater than 16 would be 24 milligrams and the NNT is 2, compared to the lower dosage having a NNT of 4.

So, people maintain sobriety better at higher dosages of buprenorphine. The vast majority of limitations on buprenorphine are set by people who have no understanding of how safe this medication is.

In toxicology, LD50 is how much of a medication is given for 50% of people receiving that medication to expire. The LD50 for Tylenol is 2400 mg per kg, compared to the LD50 of buprenorphine at 800 mg per kg. When the average Tylenol dose is 6500 mg and the average Suboxone dosage is 8 mg, buprenorphine is actually safer than Tylenol. Yet, we're treating it like it's radioactive.

Mr. Mandell urged caution, warning that there is a lot of conflicting data. Terms like "sustained recovery," can get resistance from the recovery community too, because a lot of data suggests the opposite, especially comparing buprenorphine to Tylenol. Mr. Mandell clarified that he was not giving an opinion one way or the other.

Dr. Partida Corona acknowledged that some patients do overdose while having buprenorphine in their system, but the vast majority of those patients are polysubstance users.

Mr. Mandell suggested that using terms like *higher probability of sustained recovery* could be up for debate and resistance.

Assm. Goulding was uncomfortable with this recommendation because it feels like a recommendation on how to practice medicine versus a recommendation on funding and programs, which is not the role of this subcommittee, and it's important for policy makers to avoid speaking as physicians. Dr. Partida Corona agreed with this, but when Medicaid limits medicine to 60 milligrams, they are practicing medicine without a license. That limitation shouldn't exist and should not be coming from those without a medical license. Assm. Goulding asked if there is broader language they could use that addresses this concern.

Dr. Partida Corona suggested that Medicaid should not dictate dosage limitations. Assm. Goulding agreed that policymakers and funders should not be making those decisions, and asked why they would limit it to Medicaid? Dr. Partida Corona referenced Medicaid because they actually made this policy and other insurances followed, but he agreed that it should impact all insurers or payers. Assm. Goulding asked if it is ever appropriate for insurers to limit dosages. Dr. Partida Corona cited insulin as an example where there's a huge range of doses that are appropriate depending on individual patients' needs and response. They might argue the brand based on a contracted rate, but they don't argue the dosage. With buprenorphine, they are finding that they need higher dosages against currently prevalent drugs.

Assm. Goulding suggested language for the recommendation that insurers or payers not impose dosage constraints or recommendations for MAT. Dr. Partida Corona agreed with this.

Chair Shell asked if she wanted to add language to support physicians making those decisions. Assm. did not want to add any more language for interpretation.

Ms. Cook recommended specifying buprenorphine because MOUD includes methadone. Dr. Partida Corona referenced current talk of opening up methadone for prescribing outside of a methadone clinic environment, so they may need to revisit this down the road. Ms. Cook noted that's been going on for many years now, but if buprenorphine is the current issue, she recommends limiting the language to that.

Ms. Hopkinson provided two options for recommendation revisions on screen for consideration:

- **Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for MOUD.**
- **Recommend that insurers and payors not impose dosage limitations for medication assisted treatment.**

Dr. Partida Corona said he was good with the top option.

Chair Shell confirmed unanimous support for the top option, resulting in a total of five recommendations to go forward to the full SURG, including the following:

Recommendation following revision during meeting:

Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for MOUD.

He asked Dr. Partida Corona if there were other new recommendations that he wanted to be considered at this meeting.

Dr. Partida Corona thought the methadone recommendation would be a quick one.

Ms. Hopkinson noted to the group that they were over the allotted time of 90 minutes.

Chair Shell offered sincere apologies to the members for not realizing they were over the allotted time and suggested they hold off on further discussion of this agenda item until the next meeting. Dr. Partida Corona agreed.

6. **Review and Consider Items for Next Meeting**
Chair Shell noted the additional recommendations from Dr. Partida Corona for future consideration.

7. **Public Comment**
Jamie Ross, CEO PACT Coalition, said she works with Peer Recovery Support Specialists in hospitals. Recent reports from JAMA found that connections for MAT and MOUD, and connection to services are more important than the lived experience. She is happy to send those articles to Ms. Hopkinson via email. She also was interested in potentially suggesting to Chair Shell to potentially put peers/navigators to allow CHWs and others who work in that field to also potentially be in hospitals. She added that Mr. Shell knows very well about the potential issues with peers in hospitals and their background checks. She realized members could not talk about public comments, but she wanted to bring this up for a potential future discussion.

Chair Shell thanked Ms. Ross for her comments.

Sabrina Petrell commented on behalf of Boys Town, wanting to clarify a comment from Mr. Mandell at the beginning of the meeting. She said that Boys Town has been in NV since 1991, and is still here, working statewide with children, families, and schools during wraparound care. But, after 49 years of research, Boys Town decided about a decade ago now to no longer have psychiatric residential treatment facilities in Nevada after Clark County changed their pay model. She just wanted to clarify that Boys Town is very much still active in Nevada, statewide. She would be happy to connect any members that have questions with the Boys Town Executive Director, John Edsel. Thanks!

Chair Shell thanked Ms. Petrell for her comments.

8. Adjournment

Chair Shell reminded members of upcoming meetings with the full SURG in April and then back as a subcommittee in May. They will be taking the five recommendations discussed today to the full SURG, and there may be follow-up work on those recommendations before the June SURG meeting.

Ms. Hopkinson asked for guidance regarding the additional recommendations from Dr. Partida Corona. Chair Shell recommended discussion of the remaining recommendations at their next subcommittee meeting, without inclusion in this year's Annual Report, so they can continue to refine them if necessary. Dr. Partida Corona was supportive of this approach.

Chair Shell adjourned the meeting at 12:51 p.m.

Chat File

00:17:53 Kim Hopkinson (she/her):Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.

02:00:25 Kim Hopkinson (she/her):Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.