Attachment H
SUD Implementation Plan
Approved January 9, 2024

OVERVIEW

This Implementation Plan is submitted in conjunction with the New York Department of Health submission of a substance use disorder (SUD) demonstration pursuant to Section 1115 of the Social Security Act. New York is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs and expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

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

Milestones:

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

Section I – Implementation Plan Milestone Completion

This section contains information detailing New York's strategies for meeting the six milestones over the course of the demonstration. Specifically, this section:

1. Includes a summary of how, to the extent applicable, New York already meets each milestone, in whole or in part, and any actions needed to meet each milestone, including the persons or entities responsible for completing actions;
2. Describes the timelines and activities that New York will undertake to achieve the milestones; and

3. Provides an overview of future plans to improve beneficiary access to SUD services and promote quality and safety standards.

Milestones

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

New York offers a range of services at varying levels of intensity across a continuum of care because each type of treatment or level of care may be more or less effective depending on each beneficiary's individual clinical needs. To meet this milestone, New York's current SUD Medicaid treatment system includes coverage of the following:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Services
- Outpatient;
- Intensive Outpatient;
- Outpatient Rehabilitation
- Medication Assisted Treatment including Methadone Maintenance (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state);
- Ambulatory withdrawal management;
- Intensive LOCs in residential settings and withdrawal management;
- Intensive LOCs in inpatient hospital settings;
- Medically-managed and medically supervised withdrawal management;
- Residential Rehabilitative Services for Youth (RRSY); and
- Health Home for children and Adults with Serious Mental Illness, Serious Emotional Disturbance and Co-Occurring SUD.

This demonstration builds upon an extensive, existing array of New York Medicaid covered behavioral health (BH) services, including evidence-based services and will improve upon and enhance services that are currently covered only under non-Medicaid sources, including state funding and other federal funding.

New York Medicaid covers all ambulatory Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) LOCs, as well as medication-assisted treatment (MAT), residential and inpatient services and withdrawal management. New York's Medicaid state Plan includes authority for a complete continuum of care as approved in state Plan Amendment (SPA) #16-0004, 91-0039, 91-0075, 09-0034, 19-0017, 19-0013, 19-0018, 06-61, and 08-39. The Demonstration will permit DOH to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

The demonstration would permit DOH to provide medically necessary medical and BH care (including co-occurring mental health [MH] and SUD treatment services) in the most appropriate setting for individuals receiving residential and inpatient SUD treatment services. This approach is designed address the demonstration goals detailed below under Hypothesis and Evaluation, including improving health care outcomes for individuals with SUD (reducing

hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement and retention in treatment).

New York Medicaid currently covers adult SUD residential services under approved state Plan Amendment #16-004. However, the state has not yet implemented reintegration services under that state Plan. New York will begin reimbursing for reintegration services delivered by providers whose qualifications are consistent with LOCADTR, state regulations, and the already approved state Plan Amendment. Reintegration is a phase of care in residential treatment that correlated to 3.1 in ASAM. People in this level of care benefit from ongoing rehabilitation and skill building to support recovery and move towards independent living. A reimbursement SPA will be submitted to update reimbursement methodologies.

The New York Office of Addiction Services and Supports (OASAS) directly operates 12 Addiction Treatment Centers and oversees over 1,600 addiction treatment programs. In addition, expanded regional programming including Centers of Treatment Innovation (COTIs), Open Access Centers and Recovery Community Centers, treat New Yorkers wherever they may be in their recovery journey.

Summary of All OASAS Services

LOCATDR Service Description	NYCRR Title 14	# of providers	# of facilities	# of beds / slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY 2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Managed Inpatient Detoxification	816	17	18	350	32,079	3.7	120	4-WM
Medically Supervised Inpatient Detoxification	816	23	26	703	32,769	4.1	318	3.7-WM
Inpatient Treatment	818	62	65	2,492	49,553	15.7	354	3.7
Residential Rehabilitation Services for Youth	818	7	9	240	955	108.8	65	3.7

Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	17	32	1,154	6,724	50.3	268	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	17	35	1,849	4,892	110.9	352	3.5/3.3/3.1
Residential Services - Reintegration Only	820	15	29	730	977	201.8	107	3.1
Day Rehabilitation	822	28	35	NA	6,977	117.7	NA	2.5
Intensive Outpatient (Cohort Data is CY2021 Annualized)	822	28	40	NA	387	185.4	NA	2.1
Medically Supervised Outpatient Withdrawal	822	10	10	259	2,981	12.4	NA	2-WM
Outpatient Clinic	822	271	425	NA	158,158	185.4	NA	1
Opioid Treatment Program	822	56	103	40,886	54,976	481.2	NA	1

Residential Services - Intensive Residential	819	13	22	1,285	8,626	149.8	211	Comparable to ASAM 3.3
Residential Services - Community Residence	819	38	50	1,021	4,860	155.7	98	Comparable to ASAM 3.1
Residential Services - Supportive Living	819	22	27	659	1,965	209.2	159	Comparable to ASAM 3.1

This demonstration is necessary to address critical unmet needs for residential SUD treatment that continue to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. state-only funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds are used to support some residential services for individuals enrolled in Medicaid.

Each residential program in the table above is certified to provide one or more of the phases of care based on population served, staffing, physical environment and expertise. Individuals are placed in the most appropriate phase of residential care and provided services that match that level. Programs are designated in the certification process to provide one or more of the phases.

Additional residential SUD services will be included under the Medicaid state Plan with this demonstration. This transition to Medicaid reimbursement of residential and inpatient IMD services will ensure access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid. Most importantly, for some Medicaid-covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

The complete SUD benefit package includes support for evidence-based practices already implemented in the state, such as multi-systemic therapy (MST), Functional Family Therapy (FFT) and Multidimensional Family Therapy (MDFT) for children with SUD conditions. It also modernizes the SUD treatment benefit to include IMD levels of care that are currently outside of the benefit, but have always been a part of the treatment continuum that exists in LOCADTR criteria for outpatient, inpatient and residential treatment. Providers have been and continue to be trained using the most current edition of LOCADTR criteria to provide multi-dimensional assessments that inform placement and individualized treatment plans to increase the use of community-based and non-hospital residential programs and assure that inpatient hospitalizations are utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management.

Below is a table that describes how New York meets Milestone 1 for Medicaid beneficiaries, including a variety of services at different levels of intensity across a continuum of care.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	New York Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan using the LOCADTR level of care criteria: • Outpatient hospital (SPA 06-61, 08-39) • FQHC • Physician services • Rehabilitation services (3.1-a (3b-37).	All LOCADTR levels are covered.	No further action needed
Coverage of intensive outpatient services	New York Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the state Plan: • Outpatient hospital • FQHC • Rehabilitation Services	All LOCADTR levels are covered.	No further action needed
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	New York Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the state Plan: • Physician services • Rehabilitation Services • Medication-Assisted Treatment (MAT) 1905(a)(29) Page 3.1-a (8)	All MAT is covered.	No further action needed
Coverage of intensive levels of care in residential and inpatient settings	New York Medicaid covers residential SUD in a non- hospital setting under the Rehabilitative Services Option. (Page Attachment 3.1-A 3b-37(v)-(viii)) New York Medicaid covers the following inpatient SUD treatment: • Inpatient hospital services Inpatient hospital for individuals aged 65 or older in institutions for mental diseases • Inpatient psychiatric facility services for individuals under	New York Medicaid enrollees do not have access to residential services under the LOCADTR LOC for Reintegration (similar to ASAM 3.1). Under this demonstration, the state will begin authorizing Medicaid coverage of this residential level of care delivered in IMDs as providers enroll in	Within 6 months, New York will authorize and begin to reimburse for Medicaid individuals to receive services for the LOCADTR LOC for Reintegration services provided in an IMD. The state anticipates 50 providers to enroll within the first year.

	22 years of age	Medicaid.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of medically supervised withdrawal management	New York Medicaid covers medically supervised withdrawal management in a hospital and non-hospital setting. • Inpatient withdrawal management in a general hospital setting • Inpatient withdrawal management in a non-hospital setting • Ambulatory withdrawal management under the following authorities: • Outpatient hospital • Rehabilitative Free-standing services • FQHC services	All LOCADTR levels are covered.	No further action needed

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

New York has implemented the LOCADTR, which is evidence-based, SUD-specific patient placement criteria. New York Medicaid has adopted a complete array of SUD treatment services using a national placement criteria system (e.g., LOCADTR) or national provider standards. Specifically:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM Criteria; and
- Utilization management approaches are implemented to ensure that

(a) beneficiaries have access to SUD services at the appropriate level of care,
(b) interventions are appropriate for the diagnosis and level of care, and
(c) there is an independent process for reviewing placement in residential treatment settings.

Below, New York identifies how it requires all providers to use the LOCADTR evidence-based, SUD-specific placement criteria to provide treatment that reflects diverse patient needs and evidence-based clinical guidelines. This table includes current and intended actions and associated timelines needed to meet Milestone 2 (*Use of evidence-based, SUD-specific patient placement criteria)*. This milestone has already been met.

Milestone Criteria	**Current State**	**Summary of Actions Needed**
Implementation of requirement that providers assess treatment needs based on SUD- specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	New York providers are required to utilize assessments that are directly tied to the LOCATDR criteria for treatment planning. New York has implemented a universal training program for providers to assess treatment needs based on the LOCATDR's multi- dimensional tools and to base treatment needs on those assessments. New York requires all Medicaid SUD providers through regulation to use the for level of care (LOC) assessments using the LOCADTR, consistent with provider training. Under the regulations, providers are required to develop recommendations for placement in appropriate levels of care based on the LOCADTR and multi- dimensional assessments.	No further action needed
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	Regardless of payor type, all providers are required to utilize the LOCADTR as the utilization management tool for all Medicaid SUD services, as well as the patient placement criteria to review residential placements using the LOCADTR placement criteria. New York has ensured that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the LOCADTR dimensions of care. New York already requires through MMCP contract language that for utilization management MMCPs use LOCADTR language consistent with provider training. All website, provider information and internal documentation are consistent with the LOCATR. OASAS has a website with a provider search function for Medicaid beneficiaries and providers at all LOCADTR LOCs.	No further action needed

Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	Today, MMCPs and FFS providers utilize the LOCADTR to review utilization for ambulatory, residential care and inpatient hospital care. New York has developed program standards to ensure that providers' interventions are appropriate for the diagnosis and each LOCADTR LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.	No further action needed
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions. Oversight agency regulation of billing and certification requirements through 14 NYCRR Part 841, onsite chart reviews and general oversight of LOCADTR and placement as part of normal site review process. The placement criteria currently in use can be found at the following link: https://oasas.ny.gov/locadt r New York uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR. Additionally, plans are prohibited by state law from requiring prior authorization for addiction services but conduct retrospective review to ensure services were clinically appropriate, consistent with LOCADTR. The current Medicaid MMCPs already use the LOCADTR for residential and inpatient utilization review. MMCPs receive a copy of the LOCADTR report with clinical assessment information conducted by the provider. Plans have training on LOCADTR and complete LOCADTRs as necessary to independently review admissions. Oversight agency regulation of billing and certification requirements through 14 NYCRR Part 841, onsite chart reviews and general oversight of LOCADTR and placement as part of normal site review process. The placement criteria currently in use can be found at the following link:	No further action needed

	https://oasas.ny.gov/locadtr New York uses the LOCADTR for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation is consistent with the LOCADTR. Additionally, plans are prohibited by state law from requiring prior authorization for addiction services, but can conduct retrospective review to ensure services were clinically appropriate, consistent with LOCADTR.	

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

Through this demonstration, New York will receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases (IMDs). To meet this milestone, New York will ensure that the following criteria are met:

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

OASAS regulations and Medicaid policy manuals contain standards consistent with LOCADTR criteria for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. The policies already include a requirement that residential treatment providers offer MAT onsite or facilitate access offsite with a MAT provider not associated with the residential treatment owner.[10] New York will also continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the state regulation requirements which are consistent with LOCADTR placement standards.

Below, New York already incorporates nationally recognized, SUD-specific LOCADTR program standards into their provider qualifications for residential treatment facilities through their regulations, policy manuals and other guidance to meet Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities).*

[10] 14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance. Qualification should meet program standards in the LOCADTR, which is a nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	OASAS regulations outline the types of services, hours of clinical care, and credentials of staff for residential treatment setting, which are consistent with the LOCADTR. Medicaid contracts reflect that residential providers must meet these requirements for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. 14 NYCRR 800.4; 14 NYCRR 810.7; 14 NYCRR 816; 14 NYCRR 817.3(d)(1); 14 NYCRR 818; 14 NYCRR 820 and 14 NYCRR 841.	n/a	No additional action needed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	All SUD residential providers are licensed by the New York OASAS. All SUD residential providers are monitored and certified to provide the LOCADTR LOC for which the provider is enrolled in the Medicaid program. The monitoring of the providers includes a review of the facility's infrastructure, as well as how the infrastructure is applied to ensure compliance with the state standards consistent with the LOCADTR and state regulations supporting	New York will continue to implement the process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the state regulation requirements which are consistent with LOCADTR placement standards.	No additional action needed.

	the LOCADTR. The monitoring includes initial certification, monitoring and recertification. Additional oversight activities as described in 14 NYCRR Part 810 may include unannounced site visits or provider contacts including but not limited to: interim performance reviews, focused or targeted reviews, facility evaluations, fiscal audit or reviews, corrective action plan monitoring, cursory on-site visits, and/or accreditation surveys completed by nationally recognized accrediting organizations.		
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	New York has in place a regulatory requirement that residential treatment facilities offer multiple versions of MAT on- site or facilitate access off-site (14 NYCRR 817.3(d)(1) and 14 NYCRR 800.4) All residential treatment providers offer at least one version of MAT on-site or facilitates access off-site.	None needed – New York currently meets criteria.	No additional action needed – New York currently meets criteria.

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

To meet this milestone, New York will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment will determine the availability of treatment for Medicaid beneficiaries in each of these LOCs, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment will identify gaps in availability of services for beneficiaries in the critical LOCs and develop plans for enhancement of capacity based on assessments of provider availability.

To ensure there is necessary information regarding access to outpatient providers, OASAS maintains a website that is updated regularly. This report, which can be found at the following link https://webapps.oasas.ny.gov/providerDirectory/. The state also maintains a toll-free number called the HOPEline at 1-877-8-HOPENY where operators provide three referrals to assessment services in a caller's area.

The state maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: https://findaddictiontreatment.ny.gov/ This dashboard allows the state to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for particular areas.

New York currently contracts for 98,835 adult SUD residential treatment beds across 214 providers. All but 5,712 of these certified SUD residential, withdrawal management and inpatient SUD treatment service providers have more than 17 beds and meet the definition of an IMD. See the table below for the number of beds and providers providing each non-Medicaid residential level of care in New York.

LOCATDR Service Description	NYCRR Title 14	# of Providers	# of Facilities	# of beds/ slots	Count Served Cohort CY2019	Avg Length of Stay (days) for CY 2019 Cohort	Vacancies as of 11/30/21 (Beds)	ASAM Level
Medically Supervised Inpatient Detoxification	816	20	22	646	29,919	4.1	292	3.7-WM
Inpatient Treatment	818	28	31	1,589	30,938	15.7	159	3.7
Residential Services - Stabilization / Rehabilitation (w/o Reintegration)	820	15	29	1,092	6,436	50.3	263	3.5 / 3.3
Residential Services - Stabilization / Rehabilitation (with Reintegration)	820	16	33	1,813	4,870	110.9	343	3.5/3.3/3.1
Residential Services - Reintegration Only	820	9	19	572	842	201.8	88	3.1
TOTAL / AVG			134	5,712		22.6		

In NYS, more than 78,600 patients were prescribed at least one buprenorphine prescription for outpatient treatment of OUD in 2019. The crude rate of buprenorphine prescribing for OUD increased by 28.5 percent from 314.8 per 100,000 population in 2016 to 404.5 per 100,000 in 2019. The rate was more than two times higher in NYS excluding NYC than that for NYC during 2016-2019.

The NYSDOH Buprenorphine Access Initiative began in July 2016 with the goal of increasing the number of healthcare practitioners certified to prescribe buprenorphine and thus, increase the number of patients receiving buprenorphine. In 2019 DOH AIDS Institute implemented a statewide AIDS Institute Provider Directory which includes a directory of buprenorphine prescribers. This website allows individuals to search for prescribers in their area by zip code and distance they are willing to travel. Coupled with clarifications done by DOH AIDS Institute and NYS education department a significant increase in waived buprenorphine providers in

NYS has occurred. Based upon the DEA record of waived buprenorphine providers in NYS, there has been an increase of 1,182 providers in 2018, with a total of 5,174 at the end of 2018 (Table 1b).

Table 1 Number of Buprenorphine-Waived Providers in NYS, by Type of Waiver

	2017	2018	2019
MD/DO- 30 patients	2,716	3,302	4,190
MD/DO- 100 patients	672	742	762
MD/DO- 275 patients	236	280	318
NP- 30 patients	287	567	928
NP- 100 patients	N/A*	69	143
NP- 275 patients	N/A*	N/A*	18
PA- 30 patients	81	185	282
PA- 100 patients	N/A*	29	62
PA- 275 patients	N/A*	N/A*	8
Total providers	3,992	5,174	6,711

** Note: NP/PAs could not prescribe in NYS until May 2017*

In NYS, the crude rate of patients who received at least one buprenorphine prescription for OUD increased between 2016 (314.8 per 100,000 population) and 2019 (404.5 per 100,000), representing a 29 percent increase (Figure 50). The rate was more than two times higher in NYS excluding NYC than in NYC during 2016- 2019. It is encouraging that more qualified practitioners have completed the required training and have received their SAMHSA DATA 2000 waiver and DEA X-designation so that they have the capacity to prescribe buprenorphine for the treatment of OUD. These qualified practitioners include physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Licensed Midwifes (LMs) and are in various settings increasing access for this life-saving medication.

The table below summarizes the current and future actions, including associated timelines, to meet Milestone 4 (*Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment)*. This milestone will be met within 12 months of Demonstration approval. *Note: It is necessary to ensure the complete implementation of the new service array in Medicaid prior to the capacity assessment being conducted.*

The anticipated penetration rate and geographic distributions of providers at each LOC is noted where available.

Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Completion of assessment of the availability of providers enrolled in Medicaid and	The state maintains a treatment availability dashboard for outpatient and bedded programs as well that can be accessed at: https://findaddictiontreatment.ny.	New York will examine the potential to enhance access monitoring	OASAS will work with NYS DOH to complete an assessment of providers accepting new patients (within 1 year of

accepting new patients in the following critical levels of care throughout the state including those that offer MAT: • Outpatient Services; • Intensive Outpatient Services; • Medication Assisted Treatment(medications as well as counseling and other services); • Intensive Care in Residential and Inpatient Settings; • Medically Supervised Withdrawal Management.	gov/ This dashboard allows the state to monitor capacity of all SUD treatment providers including MAT. It also allows New York residents to search for an open slot in a treatment program in their area. The treatment availability dashboard displays treatment programs with real-time availability for all regions across the state.	reporting under the Demonstration, including the provision of data related to Medicaid enrolled providers accepting new patients This initiative will leverage the current dashboard for ongoing access monitoring and recruitment and enrollment of new facilities as needed.	demonstration approval).

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

To meet this milestone, New York will ensure that the following criteria are met:

1. Continue efforts to increase utilization and improve functionality of the NYS Prescription Monitoring Program
2. Continue efforts to expand interstate PMP data sharing and PMP-EHR integration.
3. Provide reference to relevant opioid prescribing guidelines along with other interventions such as practitioner-focused training programs, to prevent and/or reduce prescription drug misuse
4. Expanded coverage of and access to naloxone for overdose reversal

Part of New York State Department of Health's (NYSDOH) efforts to address the opioid and prescription medication crisis includes several mandates that are focused on the practitioner's role in prevention or risk reduction. NYSDOH requires practitioners who prescribe controlled substances to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The data that populates the registry (dispensing data for Schedule II, III, IV, and V controlled substance prescriptions) is required to be submitted to New York state within 24 hours of dispensing. NYSDOH has also limited the initial prescribing of opioids for acute pain to no more than a seven-day supply of any schedule II, III, or IV opioid, within the scope of a practitioner's professional opinion or discretion. In July 2016, New York state limited the initial prescribing of opioids for acute pain to no more than a 7- day supply.[11] As a result, opioid prescriptions for more than a 7-day supply decreased steadily, from 28.7 percent in the first

[11] New York State Public Health Law Article 33 Section 3331 (5).https://www.nysenate.gov/legislation/laws/PBH/3331

quarter of 2017 to 15.3 percent in the fourth quarter of 2019.[12]

Additionally, NYSDOH has required by mandate that practitioners who treat humans and have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course work in pain management, palliative care, and addiction. These efforts, in addition to referral to relevant opioid prescribing guidelines assist practitioners in engaging in informed prescribing practices and improves their ability to recognize areas of concern related to patient patterns of behavior.

Attachment A describes the state's plans for enhancing its health IT infrastructure to improve the NYS Prescription Monitoring Program (PMP) as part of the state's efforts to address SUD.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid misuse	Centers for Medicare & Medicaid Services (CMS) issued guidance to the states in 2019 related to implementation of the Medicaid Drug Utilization Review (DUR) provisions that were included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act.[13] New York has amended the Medicaid State Plan to reflect the new Drug Utilization Review provisions required in federal law. The NYRx program has implemented opioid clinical edits such as requiring prior authorization for the following: 1. Initially prescribing >7-day supply of an opioid for acute pain. 2. ≥50 MME per day of an opioid for opioid-naïve patients. 3. ≥90 MME of an opioid per day to manage non-acute pain (>7 days). Excluded are patients diagnosed with cancer, sickle cell disease and/or in hospice.	NYSDOH (BNE and Office of Drug User Health) are currently working on revisions to the mandated prescriber training. This includes updating standards, guidance, language, and the addition of harm reduction concepts.	A revised version of the provider training will be completed in August 2023.

[12] New York State Opioid Annual Report 2020. https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2020.pdf

[13] CMS Informational Bulletin: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib080519-1004_64.pdf

	4. Initiation of opioid therapy in patients currently on established benzodiazepine therapy. 5. Initiation of opioid therapy for patients on established opioid dependence therapy. 6. Initiation of long-acting opioid therapy in opioid-naïve patients.		
Expanded coverage of, and access to, naloxone for overdose reversal	NYS has taken a number of steps over the past decade to make naloxone more widely available, including: expanded efforts related to addressing opioid overdose through Article 33, Title 1 Section 3309. This multi-pronged approach focuses on building overdose response capacity within communities throughout the state. The core of this program is for community laypersons to be trained by organizations registered with the NYSDOH to administer naloxone (an opioid antagonist also known by the brand name Narcan) in the event of a suspected opioid overdose. • There are currently more than 800 registered Community Opioid Overdose Prevention (COOP) programs, with over half a million individuals trained by them since the initiative's inception in 2006. Of these, 78,000 were public safety personnel and the rest were community responders. • In 2019, there were 1,558 naloxone administration reports by law enforcement (LE) to the NYSDOH and 2,749 reports by COOP programs. • In total, including unique administrations by Emergency Medical Services (EMS) agencies, there were 16,710 reported naloxone administrations in NYS in 2019. There were 12,403 unique naloxone administrations reported electronically by EMS	None needed – New York currently meets criteria.	None needed – New York currently meets criteria.

	agencies during 2019, about a 10 percent decrease statewide from 13,724 administrations in 2018, with a seven percent decrease in NYC and a 13 percent decrease in NYS excluding NYC. In 2011, New York implemented a Good Samaritan law which allows individuals to seek emergency assistance in the case of an overdose without fear of being charged or prosecuted for possession of a controlled substance under 8 ounces, alcohol, marijuana, drug paraphernalia or sharing substances.[14] New York has a non-patient specific prescription for naloxone with pharmacy dispensing protocol appliable to all NYS registered pharmacists. Naloxone available to all addiction and mental health providers to use and distribute to communities that they serve through a direct order process. A naloxone copayment assistance program to cover up to $40 in prescription co-payments to minimize out of pocket expenses. Require pharmacies with 20 or more locations to have a non-patient specific prescription with an authorized health care professional or register as an opioid overdose prevention program. Scope of practice protections for obtaining, administering, and possession of naloxone for licensed individuals.		

[14] Good Samaritan Law was enacted as Chapter 154 of 2011; Publicly available brochure can be found at: https://www.health.ny.gov/publications/0139.pdf

	Yearly co-prescribing requirements for patients prescribed an opioid. Establishment of guidelines for onsite opioid overdose response capacity in nightlife establishments.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Since 2012, New York state has required most prescribers to consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. Establishing a duty to consult ensures practitioners have a fuller picture of their patient's controlled-substance history, which can inform treatment decisions, especially where practitioners recognize high risk patient behaviors. Additionally, NYS requires that data for all Schedule II, III, IV, and V controlled substance prescriptions dispensed by state- licensed pharmacies and dispensing practitioners be submitted to New York state within 24 hours. The requirement for data submission within 24 hours of dispensing makes helps to ensure that the data within the PMP registry is timely and accurate.	The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality. BNE will continue to provide the MME calculator as resource for practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	BNE completed its technical build in March 2023 and released the new format in late May 2023. Within 6-9 months of release, BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality. BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.

	• In 2021, NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose. • BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxCheck hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health • Services through the PMPi and RxCheck hubs. • BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. • As of May 2022, BNE has initiated the process for PMP data sharing and EHR integration with the US Department of Veterans Affairs (VA). Under Public Health Law (PHL) §3309-A (3), prescribers licensed under Title Eight of the Education Law in New York who are licensed to treat	BNE is currently working on project to redesign the PMP Registry patient search landing page. The enhancements will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the patient in the past 90 days, and how many prescriptions are present for Opioid, Benzodiazepine, or Stimulant to assist the practitioner in avoiding overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	A revised version of the provider training will be completed in August 2023.

	humans and who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three hours of course- work in pain management, palliative care, and addiction. Education must cover the following topics: New York state and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end of life care. BNE, within the NYSDOH, and in partnership with the SUNY University at Buffalo offers an accredited training to meet the mandatory Opioid Prescriber Education training needs.[15] NYS OASAS by regulation and guidance, requires providers to educate about overdose prevention and must make Naloxone available to all patients, prospective patients. 14 NYCRR §800.6. Guidance can be found at this link: https://oasas.ny.gov/system/files/documents/2020/05/naloxone-prescribing.pdf	BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate interoperability. The PMP-EHR integration pilot project has demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal. NYSDOH (BNE and Office of Drug User Health) are currently working on revisions to the mandated prescriber training. This includes updating standards, guidance, language, and the addition of harm reduction concepts.	

6. <u>Improved Care Coordination and Transitions between Levels of Care</u>

[15] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

New York will implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. The table below outlines New York's current procedures for care coordination and transitions between LOCs to ensure seamless transitions of care and collaboration between services, including:

1. Current content of specific policies to ensure these procedures;
2. Specific plans to help beneficiaries attain or maintain a sufficient level of functioning outside of residential or inpatient facilities; and
3. Current policies or plans to improve care coordination for co-occurring physical and mental health conditions.

New York has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DOH and OASAS. OASAS Providers utilize LOCADTR continuing care module to conduct ongoing assessments on the appropriateness of a level of care and to determine subsequent levels of care. OASAS has also utilized state Opioid Response dollars to support regional networks designed to improve successful transitions between residential and outpatient settings. Additionally grant funding has been utilized to support transportation initiatives which assist individuals with making successful connections to care.

Under the demonstration, New York will utilize the health home model and strengthen the transition management component for SUD populations between LOCs. DOH and OASAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure individuals receive appropriate follow-up care following residential treatment.

In addition, under the demonstration, in order to ensure improved care coordination and transitions between LOCs, New York will also monitor access and healthcare outcome measures by demographic information, including race and ethnicity. In addition, New York intends to implement coverage of enhanced individualized care coordination for individuals with SUD that is designed to identify, prevent, and address health inequities and challenges related to social determinants of health. New York state will evaluate the use of peers and other care connection mechanisms to ensure improved care coordination and overall health outcomes for individuals in care.

This milestone will be met within 12 to 24 months of demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities Additional policies to ensure coordination of care for cooccurring physical and mental health conditions	New York has multiple interventions for coordinating the care of individuals with SUD and transitioning them between LOCs, including, but not limited to, facility credentialing, discharge planning requirements (including but not limited to needed referrals for services and medication continuation if appropriate, appointment times/dates) and care management initiatives with MCCPs. Service coordination in all ASAM LOCs is required. Service coordination, includes, but is not limited to, provider-specific and LOC-specific activities that enhance and improve linking members between Medicaid treatment services and enhance and improve the likelihood of engagement in treatment.	Under the demonstration, OASAS will include all levels of services, including those over 16 beds in both managed care and fee for service environments. This will allow service recipients to obtain the full continuum of services as they progress in their recovery without interruption and will improve coordination and transitions between LOCs to ensure that individuals receive services and supports following stays in facilities and are retained in care. This will be done through increased clinical guidance and technical assistance, as well as data monitoring. There will also be increased case management staff/discharge planning staff as providers transition into the requirements of Part 820 regulations for service delivery and receive technical assistance and trainings/guidance from state Agency staff. 14 NYCRR Part 820 provides the staffing, programmatic and clinical requirements for the operation of a community based residential program providing stabilization, rehabilitation or reintegration services. MCCPs will be responsible for all residential levels of care which will allow them to coordinate services through an entire episode of care and provide care management. Providers will have an	OASAS will improve discharge planning and transition planning in the residential and ambulatory LOCs using LOCADTR standards within 12 months of Demonstration approval. To improve care coordination, OASAS will provide technical assistance, engage in ongoing review and updating of guidance as issues are identified. OASAS will also work with providers as they transition to 820 service delivery mechanism around staffing and programming to meet regulatory standards and program guidance that has been issued. These actions will be completed on an as needed basis and do not require statutory revision. Future state will be achieved by implementing existing regulatory requirements that increase staff responsible for coordinating care and improving transitions to community services, including transitional planning. The state will also provide additional technical assistance to MCCPs on 820 reintegration level of

		increased capacity to provide care management due to increase in care management staffing to better follow individuals to the next level of care or for a period post-discharge to ensure that linkages have been made.	care decisions within LOCADTR to ensure plans and providers are using the tool to fidelity.

Section II – Implementation Plan Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title: Pat Lincourt, Associate Commissioner
Email Address: Pat.Lincourt@oasas.ny.gov

Section III – Implementation Plan Relevant Documents

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

Attachment A: Template for Substance Use Disorder Health Information Technology Plan
Attachment A Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of PDMPs, in SMDL 17- 003, states with approved Section 1115 Substance Use Disorder (SUD) demonstrations are generally required to submit a SUD Health Information Technology (IT) Plan as described in the Special Terms and Conditions (STCs) for these demonstrations within 90 days of demonstration approval. The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim federal financial participation for services provided in Institute for Mental Disease until the SUD Health IT Plan has been approved by CMS.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e., PMP functionalities, PMP query capabilities, supporting prescribing clinicians with using and checking the PMP, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State"). SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PMP

The specific milestones to be achieved by developing and implementing a Health IT Plan that can be used to address SUD include:

- Enhancing the health IT functionality to support PMP interoperability and integration.
- Enhancing and/or supporting clinicians in their usage of the state's PMP through improved functionality, education, and prescribing guidelines.

The state should provide CMS with an analysis of the current status of its health IT infrastructure "ecosystem" to assess its readiness to support PMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PMP milestone criteria to further describe its plan.

Table 1. State Health IT/ PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and Opioid Use Disorder, that is: • Enhance the state's health IT functionality to support its PDMP. Enhance and/or support clinicians in their usage of the state's PDMP	Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.	Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP	Specify a list of action items needed to be completed to meet the Health Information Include timeframe for completion of each action item
PDMP Functionalities			
Enhancing and/or supporting clinicians in their usage of the state's PMP through improved functionality.	• NYSDOH provides access to the NYS PMP Registry 24 hours/day, 7 days a week. Through the PMP Registry practitioners can review the controlled substance history of their patients, identify prescriptions prescribed by the searching practitioner or by other practitioners, designate a designee to search on their behalf, review their own prescription writing history, their search history, and review the searching history of their designees. • The MME calculator provides an opioid dosage's equivalency to morphine. Calculating the	Within the next two-years (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These enhancements are intended to enhance the functionality and usability of the PMP Registry. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding	Through combined support from NYSDOH and the CDC funded Overdose Data to Action Grant, BNE will work with NYS ITS to build out the technical architecture. BNE plans to conduct stakeholder engagement with PMP users to test system functionality and provide additional feedback regarding functionality.

	MME allows for a standard for comparing different opioids and provides a tool for gauging the overdose potential of the amount of opioid that is being given to an individual. The MME calculator also assists the practitioner in identification of patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	overlapping prescriptions that could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhancing and/or supporting clinicians in their usage of the state's PMP through education.	• BNE has provided a series of demonstration tutorials intended to expand practitioners' capacity to access, use, and understand the functionality of the NYS PMP Registry. There are four trainings available focused on how to use and run reports, reporting suspicious activity, appointing designees, and a training geared toward residents and interns prescribing opioids under a medical teaching facility DEA registration number. • BNE, in partnership with the SUNY University at Buffalo offers two trainings targeted for physicians, physician assistants, nurse practitioners, and pharmacists. One is an accredited training to meet the educational requirements for the mandated Opioid Prescriber Education course work. The second is an overview training regarding the essential components of the NYS Prescription Monitoring Program.	BNE is working on an additional training series for pharmacists and dispensing vendors related to data submission to the PMP Registry and error correction to ensure the timeliness and accuracy of PMP data. Training development will be ongoing for the next two years. BNE is currently updating the mandated Opioid Prescriber Education training, with a target for completion within the next year.	This work is scheduled and continues on a routine basis. It requires meetings with internal BNE partners. This work is being done in collaboration with the NYSDOH Office for Drug User Health and the State University of New York (SUNY) at Buffalo (UB). Scheduled work group meetings will be held to review and revise content and provide feedback to UB.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhanced interstate data sharing.	• BNE, within NYSDOH has managed interstate PMP data sharing through the PMP Interconnect (PMPi) since 2015. In June 2021 BNE began interstate data sharing through the RxCheck hub. As of March 2022, BNE has data sharing agreements with 34 states, as well as Puerto Rico, Washington DC, and Military Health Services through the PMPi and RxCheck hubs. States may not participate in interstate data sharing due to several factors, with the most common barrier being: • A state is focusing on connecting with their border states first. • A state is currently transitioning to a new PDMP system. • A state has prioritized other PDMP projects over interstate connectivity. BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	BNE continues to identify new states with which to develop data sharing agreements and will continue to explore the capacity of the RxCheck hub to further interstate interoperability.	BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration. BNE will work with the VA and their integration vendor to ensure NYSDOH receives appropriate audit files in order for BNE to meet their responsibility in monitoring PMP access and use.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
PMP-EHR Integration. Enhanced clinical workflow for prescribers and other state and federal stakeholders.	• BNE has been working on a pilot project to integrate NYS PMP data into healthcare system electronic health records. As of May 2022, BNE initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal.	BNE continues to work with the Governance Board to aid in identification of state partners for interstate data sharing, as well as expand system knowledge to support NYSDOH's growth in the area of PMP-EHR integration.
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOS) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though there is potential to revisit this in the future.	Potential exploration of the feasibility of PMP data sharing through HIE.	Potential exploration of the feasibility of PMP data sharing through HIE.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/business processes to better support clinicians in accessing the PMP prior to prescribing an opioid or other controlled substance to address the issues which follow	BNE, within the NYSDOH has demonstrated capacity to integrate PMP data into a healthcare system's EHRs BNE has initiated the process for EHR integration with the US Department of Veterans Affairs (VA).	The PMP-EHR integration pilot project had demonstrated proof of concept and BNE is working to expand the number of sites engaged in PMP-EHR integration. BNE is exploring multiple options to meet this goal, including the use of RxCheck as a method for supporting PMP-EHR integration.	BNE will partner with federal and state partners through the Governance Board membership to identify additional options for expanding NYSDOH's PMP-EHR integration project.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	In previous years BNE explored PMP data sharing using health information exchanges (HIE) through the Regional Health Information Organizations (RHIOS) in NYS. At the time the RHIOs were not compatible with NYS security requirements. This resulted in NYSDOH exploring PMP-EHR integration, rather than data sharing through HIE. Currently, BNE is not supporting PMP data integration through HIE, though BNE is exploring the feasibility to revisit this in the future.	BNE is looking at the potential feasibility of revisiting PMP data sharing through HIEs.	There is potential for NYSDOH to revisit the potential for integration through HEIs, but this is not a current active project.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription	The Bureau of Narcotic Enforcement (BNE), within NYSDOH is working to enhance the NYS PMP Registry to improve utilization and functionality. In 2021 NYS implemented a Morphine Milligram Equivalents (MME) calculator. Calculating the Total Daily MMEs of opioids helps practitioners to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce	Within the next two-year (2022-23) BNE plans to incorporate two phases of revisions into the PMP Registry patient search landing page. These will include an indicator that notes the type of medication prescribed (Opioid, Benzodiazepine, or Stimulant), whether the prescription is current, a highly visual summary dashboard that notes the number of pharmacies or practitioners visited by the practitioner in the past 30 days, and how many prescriptions are present for Opioids, Benzodiazepines, or Stimulants to assist the practitioner in avoiding overlapping prescriptions that	BNE will work with NYS ITS to build out the technical architecture. BNE will conduct stakeholder engagement with PMP users to test system development and provide additional feedback regarding functionality.

	risk of overdose.	could lead to overdose. Ultimately these visual indicators will aid practitioners in identifying patient risk behaviors and assist in identifying patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The NYS PMP is not currently using a master patient index. The PMP is primarily used as one of many tools to support clinical decision making and is not currently used for tracking purposes.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.	If there is a future role for the NYS PMP it will need to be identified in collaboration with the Bureau of Narcotic Enforcement.
Using PMP Data to aid in efforts to manage Medicaid payments for opioids			
Leverage the above functionalities/ capabilities/ supports (in concert with any other state health IT, technical assistance or workflow effort) to provide support tools for practitioners to minimize the risk of inappropriate opioid overprescribing which can aid in management of efforts to mitigate inappropriate opioid payments by Medicaid inappropriately pay for opioids	Basic and advanced functionality of PMP allows practitioners to have an additional tool for their clinical decision making related to controlled substance providing. NYS Law related to 7-day supply also serves as a mechanism to decrease overprescribing. Practices can use Automated at Point-of-Service for Medicaid FFS to limit initial opioid prescriptions for a 7-day supply consistent with NYS Law.	Understanding where PMP data, NYS laws, and federal guidance, in collaboration with Medicaid health IT systems can work together to inform prescribing practices.	