FIVE YEAR STRATEGIC PLAN FOR PROBLEM GAMBLING TREATMENT SERVICES WITHIN THE STATE OF NEVADA

FISCAL YEARS 2012 – 2016

Revised August 13, 2014

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STRATEGIC PLANNING FOR PROBLEM GAMBLING TREATMENT SERVICES WITHIN THE STATE OF NEVADA

Fiscal Years 2012 - 2016

INTRODUCTION

This report is the culmination of a strategic planning process by the Nevada Department of Health and Human Services (DHHS) for the continued development and improvement of problem gambling treatment services within the State of Nevada. The stated objective for the project was to develop a five-year strategic plan for problem gambling treatment based on input from problem gambling treatment stakeholders within Nevada, evidenced-based practices from the field at-large, and expert analysis. For a statewide problem gambling treatment system to optimally perform, the components of that system must be effectively utilized. Thus, the problem gambling treatment strategic plan includes workforce development, program evaluation, treatment standards and practices, as well as program administration including procurement and reimbursement systems. The scope of the effort was limited to driving decisions and policies regarding DHHS funded problem gambling treatment programs and treatment system support.

The basic outline of the strategic planning process was guided by the principles and practices developed by Peter Drucker in his work with non-profit organizations.[1] The methodology included conducting a situational assessment of DHHS problem gambling services and documenting findings in a report.[2] Stakeholders participated in work sessions, interviews, and surveys to help assess system strengths, challenges, and opportunities. Survey respondents identified several infrastructure and program areas that could be improved upon and provided input on how to address those needs. Detailed assessment findings were presented to the DHHS Advisory Committee on Problem Gambling (ACPG). The ACPG formed a Treatment Strategic Plan Work Group and tasked this group with developing recommendations addressing a series of "critical questions" identified in the situational assessment. The Work Group's recommendations are incorporated into the present problem gambling treatment strategic plan.

[1] Drucker, P. (1990). Managing the Non-Profit Organization. HarperCollins Publishers.

[2] Marotta, J. J. (2010). Strategic Planning for Problem Gambling Treatment Services Within the State of Nevada: Situational Assessment June 2010. Carson City, NV: Nevada Department of Health and Human Services.

BACKGROUND

Nevada is viewed throughout the world as a leader in the casino and gaming sector with regard to regulation, technology, business strategies, and sophistication of its gaming companies. In the same manner, Nevada has sought to develop systems to reduce gambling related harms by addressing problem gambling and developing strategies that encourage responsible gaming. The 2005 and 2007 Nevada Legislatures recognized the serious need for State Government to develop publicly funded problem gambling treatment and prevention services. They knew that Nevada has one of the highest rates of Gambling Disorder in the country, that about 68,000 adult Nevadans are estimated to meet the criteria for Gambling Disorder, and that for each problem gambler many others are affected (e.g., spouse, children). Taken as a group, Nevada's disordered gamblers produce millions in social costs, impacting the criminal justice system, the corrections system, human service systems, and Nevada's overall economic health.

LEGISLATION AND FUNDING

In 2005, the Nevada State Legislature passed Senate Bill 357 to create the Revolving Account for the Prevention and Treatment of Problem Gambling and an Advisory Committee on Problem Gambling to advise the Department of Health and Human Services in its administration of this account. Created from Senate Bill 357 were Nevada Revised Statute (NRS) 458A, which provided the administrative structure for Nevada's publicly funded problem gambling treatment and prevention programs, and NRS 463.320(e), which stipulated that an amount equal to $2 for each slot machine was to be deposited into the revolving account for the prevention and treatment of problem gambling. The 2007 Legislature amended NRS 463.320(e) to remove a sunset provision and left the 2007 funding in place for 2008. The program budget for fiscal years 2008 and 2009 was $1,700,000. As Nevada entered a state fiscal crisis, the program budget was reduced by 24% (FY10 budget = $1,332,000) then further reduced in fiscal year 2011 by an additional 54% (FY11 budget = $600,000). At the time this report was written, the 2011 Nevada State Legislature was considering budget bill AB500, which would temporarily reduce from $2 to $1 the slot tax revenue directed to DHHS problem gambling services. This legislative bill corresponded to Governor Sandoval's recommended DHHS budget for problem gambling services, which translated into FY12 projected revenue of $766,297 with approximately $727,982 available to grant and FY13 projected revenue of $776,651 with approximately $737,818 available to grant. The legislative intent in temporarily reducing the problem gambling services budget by 50% was to fund only treatment services and treatment system support. Implied in this legislative bill was the intent to once again fund problem gambling services based on the $2 per slot machine revenue calculation in FY14 and FY15, assuming Nevada experiences an economic recovery.

The strategic plan for problem gambling treatment presented in this document is based on the projected budget provided above. That is, the first two years of this strategic plan includes a number of cost containment measures necessary to operate a problem gambling treatment system on a significantly reduced budget. Years three through five of this strategic plan assumes program funding sufficient to fully implement a comprehensive and sustainable gambling treatment system.

2010 PROBLEM GAMBLING TREATMENT

DHHS funded problem gambling treatment programs offer a range of treatment options, which include outpatient therapy, intense outpatient therapy (more than nine hours of services per week), and residential treatment. As of FY10 there were six funded programs offering the following levels of service:

Table 1. 2010 Nevada DHHS Problem Gambling Treatment Grantee Levels of Service

Grantee	**Outpatient (primary)**	**Outpatient**	**IOP (primary)**	**IOP**	**Residential (primary)**	**Residential**
LV Problem Gambling Center		X	X			
Reno Problem Gambling Center		X	X			
Bristlecone		X			X	
Pathways	X			X		
New Frontier		X	X			X
Salvation Army		X			X	

In FY09, 660 individuals received state subsidized gambling treatment services. The average length of stay for consumers was 77 days and the maximum length of stay was 411 days. The number of persons served in DHHS supported gambling treatment services has fluctuated over the past five years (FY2006 – FY2010). The five-year average number of annual intakes, combining enrollments into outpatient treatment with enrollments into residential gambling treatment, was 429.

Agencies receiving treatment funding are required to be staffed by Certified Problem Gambling Counselors (CPGC) or Certified Problem Gambling Counselor Interns (CPGC-I). Counselor certification is funded and administered through the State of Nevada's Board of Examiners for Alcohol, Drug and Gambling Counselors. Prior to FY11, the Nevada Council on Problem Gambling was the primary recipient of workforce development funding. To date, in Nevada, there are 10 Gambling Supervisors, 19 CPGC (18 active, 1 inactive), and 23 CPGC-I (19 active, 4 inactive).

Problem gambling treatment services in Nevada have provided help to thousands of individuals and in the process saved lives, preserved families, and strengthened communities. The system of services has been evolving for more than five years and will continue to evolve in its quest to meet DHHS Advisory Committee on Problem Gambling mission and vision statements.

MISSION AND VISION

In 2008, the DHHS Advisory Committee on Problem Gambling drafted the following Mission and Vision statements to guide their decisions:

Mission: To support effective problem gambling prevention, education, treatment, and research programs throughout Nevada.

Vision: Improve the public health of Nevadans through a sustainable and comprehensive system of programs and services that reduce the impact of problem gambling.

This Mission and Vision statements have since been vetted among stakeholder groups with responses uniformly supportive of the statements. This mission and vision statements have become the cornerstone of the overall Nevada strategy to reduce the impact of problem gambling.

STRATEGIC PLAN

This strategic plan follows the problem gambling treatment system needs assessment that was completed in June 2010. The four domains for which improvement were most compelling are presented below, with a discussion of the improvement goal for each followed by a list of activities intended to help achieve the stated goal. When the ACPG Treatment Strategic Plan Work Group developed strategies to address improvement domains, they were guided by the ACPG mission and vision statements and the following guiding principles.

- Ability to respond to changing funding conditions
- Utilize existing assets
- Evidenced-based practices and approaches drive the system
- System efficiency and quality of care are of upmost importance

Improvement Domain I: Procurement

Problem:

Past procurement practices have depended on the ACPG to review and make recommendations to DHHS regarding what proposals should be funded and to what extent. Some grantees believed the DHHS Grants Management procurement process was cumbersome and funding decisions were being made by persons without the appropriate level of knowledge and expertise. ACPG grant reviewers found it difficult to make recommendations due to not being fully informed of program practices, justification of need, and program performance. The result of the procurement process was a number of grantees funded at different amounts where the average cost per treatment case differed greatly across providers, as did treatment practices.

Goal:

DHHS will implement a procurement system that is fair, equitable, and supports the provision of evidence-based services, allowing consumers in all regions of Nevada timely access to services at an appropriate level of care.

Activities:

In year one (FY12):

- Implement standards for problem gambling treatment providers and gambling treatment services as recommended in Appendix A.
- Define data to be collected to develop performance benchmarks that establish goals for treatment utilization, timely access to treatment, treatment engagement, treatment retention, and treatment outcomes.
- Implement a gambling treatment funding system based on units of service.
- Develop methods to revise procurement practices as recommended in Appendix B.
- Implement revised procurement practice to develop grants for problem gambling treatment and treatment support beginning in July of 2013.
- Conduct program reviews to monitor compliance to treatment standards and to provide training and technical assistance to meet newly implemented treatment standards.

In year two (FY13):

- Conduct program reviews to monitor compliance to treatment standards and develop corrective action procedures and conditions upon which funding may be reduced, revoked, or redirected.
- Conduct an assessment of FY12 procurement process and recommend changes to address identified issues or areas in need of improvement.

In years three through five (FY14 – FY16):

- Establish corrective action plans to address situations where grantees are failing to meet minimum treatment standards or performance benchmarks.
- Award funds based on performance including service encounter claims, ability to meet performance benchmarks, and site review findings.
- Prior to soliciting service proposals, review assessment of FY 12 procurement process and make changes to address identified issues or areas in need of improvement.

Improvement Domain II: Information Management

Problem:

The current information management system is not adequately funded to conduct longer-term outcome evaluation and is in need of a redesign to support a treatment grant system incorporating fee-for-service allocations and performance-based grants management. Current measurement tools and processes could be improved to better support data-driven decisions for providers, the ACPG, and DHHS.

Goal:

To have access to valid and reliable data on the population being served, utilization of services, program performance, and the outcomes produced. The information management system will support and enhance data-driven program and policy decisions.

Activities:

In year one (FY12):

- Implement a system to collect, verify, and report on gambling treatment provider encounter claims beginning July 1, 2011.
- Identify critical data collection needs and methods for the accurate collection, analysis, and distribution of data collected at intake and discharge.
- Revise intake and discharge forms in preparation to begin implementation of the revised intake and discharge data collection by January 1, 2012.
- Develop a data collection manual for all grantees and provide training on the use of the manual. Manual to provide operational definitions on each item and response option along with reporting procedures.
- Survey grantees and produce preliminary report on function of new data collection system with recommended adjustments to improve system to more accurately monitor program performance on defined benchmarks.
- Conduct gambling treatment program site visits to verify encounter data claims and application of problem gambling treatment provider standards. In year one, focus on educating and providing technical assistance to help providers meet newly implemented standards.
- Develop protocols and instruments to conduct problem gambling treatment site reviews.

In year two (FY13):

- Based on first year experience with new encounter data, intake data, and discharge data system, revise as needed.
- Develop first "Problem Gambling Treatment Program Quality Improvement Report" based on data collected and report findings according to defined performance benchmarks.
- Conduct gambling treatment program site reviews to verify encounter data claims and application of problem gambling treatment provider standards. Provide technical assistance as needed. Produce site review findings reports for each gambling treatment grantee.

In years three through five assuming full program funding (FY 14 – FY16):

- Develop and implement a problem gambling treatment follow-up study to evaluate longer-term treatment outcomes.
- Develop and pilot the use of outcome-based problem gambling treatment protocols. If pilot project findings suggest efficacy in approach, develop for system wide use.
- Continue to collect encounter data, intake data, discharge data. Produce and disseminate on a consistent and recurrent schedule a program performance report based on data collection.
- Conduct gambling treatment program site reviews to verify encounter data claims and application of problem gambling treatment provider standards. Provide technical assistance as needed. Produce site review findings reports for each gambling treatment grantee.

Improvement Domain III: Treatment System

Problem:

The treatment system is serving fewer clients than years past. Lack of conformity with key aspects of treatment delivery, such as client eligibility, services offered, and documentation standards, creates regional disparities in access to services and contributes to artificially low penetration rates. Gaps in data collection hinder the ability to implement policy changes based on program performance.

Goals:

(a) To transform Nevada's system into a recovery oriented system of care through the use of data-driven program and policy changes.[3]

(b) Increase problem gambling treatment utilization by no less than 10% each year.

(c) 100% of gambling treatment grantees meet defined performance standards

Activities:

In year one (FY12):

- Implement gambling treatment program grant conditions and treatment standards (see Appendix A).
- Conduct review of the gambling treatment program standards and revise as needed for use in year two.
- Provide funding for continuation of gambling treatment services by gambling treatment grantees funded in fiscal year 2011. Base FY12 allocations on reported encounters during fiscal year 2011 as applied to service rates defined in the DHHS Problem Gambling Treatment Provider Guide 2011-2012 (Appendix A).
- Based on encounter claims from July 2011 through November 2011, adjust grantee allocations to increase the budget of grantees over-performing and decrease the allocations to grantees under-performing.

[3] A recovery-oriented system of care moves clients from screenings and brief intervention to residential care and stabilization as indicated, followed by continuing care/recovery support. Over 90% of rehabilitation today takes place in outpatient settings. Alcohol and drug treatment research suggests that about 90 days of treatment is associated with more positive outcomes than treatment of a shorter duration. Recovery support services can be provided in many settings: e.g. as an adjunct to outpatient treatment and local self-help programs. Recovery support and continuing care are critical elements in the continuum of care. Intervening as early as possible with clients who are beginning to relapse is an important part of recovery support.

In year two (FY13):

- Based on encounter claims, adjust allocations to gambling treatment grantees. Discontinue FY14 funding to grantees with encounter claims under $20,000 or serving fewer than 20 unique clients during year one.
- Create a policy which supports the creation and implementation of emerging interventions such as distance treatment and peer recovery services for implementation beginning in year 3.
- Explore development of recovery mentor programs and peer counselor programs.
- Explore development of a residential problem gambling treatment program located in southern Nevada that follows mainstream models for providing residential gambling treatment.
- At approximately half way through the FY13, based on encounter claims, adjust allocations to gambling treatment grantees.

In years three through five assuming full program funding (FY14 – FY16):

- Conduct a problem gambling treatment needs assessment. Utilizing data collected during Year 2 (FY2013), develop a procurement strategy that will result in the purchasing of services for FY14 through FY16 to meet identified needs and objectives.
- Implement new grants, developed to create a comprehensive problem gambling treatment system. Possible elements to a comprehensive problem gambling service system for Nevada may include the following.
    - Two residential gambling treatment programs, one located in northern Nevada and one located in southern Nevada.
    - Outpatient treatment programs strategically located throughout Nevada so that 80% of the population is within a one-hour drive to a gambling treatment program or funded provider.
    - Distance treatment services to serve the 20% of the population that is not within a one-hour drive to a brick and mortar gambling treatment program or otherwise experiencing barriers to entering traditional treatment.
    - Peer recovery support services.
    - Programs and methods to better utilize emerging technologies to assist persons seeking or in recovery from gambling problems.
- Each year assess strengths and gaps in the provision of these services and make adjustments as needed.
- Approximately every six months, based on encounter claims, adjust allocations to gambling treatment grantees.

Improvement Domain IV: Workforce Development

Problem:

Due to budget reductions taken in fiscal years 2011 – 2013, the 2010 problem gambling workforce is shrinking. Developing new gambling counselors will be challenging without set-aside funding, and remaining Certified Problem Gambling Counselors will likely have difficulty maintaining certification due to a shortage of continuing education opportunities. Because a robust, well-informed, and professional workforce is vital to the success of a gambling treatment system, lack of attention to workforce development needs place the entire gambling treatment system in jeopardy.

Goal:

Offer training, education programs, and networking opportunities designed to develop provider competencies and foster a supportive and collegial workforce made up of sufficient numbers.

Activities:

In year one (FY12):

- Support the costs of providing clinical supervision to Certified Problem Gambling Counselor – Interns by allowing treatment Grantees to bill for a limited number of hours of supervision services provided by Board approved CPGC Supervisors.
- Send email notifications to Grantees regarding training opportunities on problem gambling related topics, such as workshops offered by the Center for the Application of Substance Abuse Technologies (CASAT) and courses offered by the University of Nevada, Las Vegas and the University of Nevada, Reno.

In year two (FY13):

- Support the costs of providing clinical supervision to Certified Problem Gambling Counselor – Interns by allowing treatment Grantees to bill for a limited number of hours of supervision services provided by Board approved CPGC Supervisors.
- Send email notifications to Grantees regarding training opportunities on problem gambling related topics, such as workshops offered by the Center for the Application of Substance Abuse Technologies (CASAT) and courses offered by the University of Nevada Las Vegas.

In year three through five assuming full program funding (FY14-FY16):

- If the overall budget allows, consider, building in a line-item for workforce development within each problem gambling treatment grant based on individual grantee needs.
- Establish a problem gambling workforce development grant to provide a variety of workforce development activities that may include:
    - Provide quarterly teleconferences as a method to share information between providers and provide regular updates.
    - Devise training and education programs to develop provider competencies. Explore the use and financial feasibility of best practice methods of developing the workforce including models that emphasize coaching and on-site implementation support.
    - Develop an e-learning training series via webinars
    - Sponsor a statewide problem gambling conference.
    - Survey workforce to assess training needs and satisfaction with training offered.
    - Utilize workforce survey results to continue to improve workforce development efforts.

APPENDIX A

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROBLEM GAMBLING TREATMENT PROVIDER GUIDE

INTRODUCTION: This Agreement/Provider Guide (hereinafter referred to as "Agreement") describes requirements that must be met by agencies and individual providers who wish to provide problem gambling treatment services funded by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e). Providers must meet the requirements contained in this Agreement in order to receive funds for services provided under grant or agreement with the Nevada Department of Health and Human Service (DHHS).

I. Definitions

Throughout this Agreement, the following words and terms are used as defined in this section unless (a) the context in which they are used clearly requires a different meaning or (b) a different definition is prescribed for a particular part or portion of a part.

"**Abuse**" is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary harm or cost to DHHS or clients, or in reimbursement for services that are not medically necessary or fail to meet Agreement standards.

"**Aftercare**" shall mean the stage following discharge, when the client no longer requires services at the intensity required during primary treatment.

"Board" shall mean the Nevada State Board of Examiners for Alcohol, Drug, and Gambling Counselors.

"**Certified Problem Gambling Counselor"** or "**CPGC**" means a person who is certified as a problem gambling counselor pursuant to NRS 641C.050

"Certified Problem Gambling Counselor Intern" or "CPGC-I" means a person who is certified as a problem gambling counselor intern pursuant to the provisions of NRS 641C.060.

"**DHHS**" shall mean The Nevada Department of Health and Human Services, and its employees, agents and representatives.

"**Distance Treatment**" shall mean professionally delivered treatment where the majority of time spent between a counselor and client are non face-to-face encounters. The primary forms that distance treatment take are phone, web-based or video counseling.

"Eligible Client" or **"Client"** shall mean, for purposes of this Agreement, an individual with a gambling related problem is an individual with (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31), (b) a primary diagnosis of sub-clinical Gambling Disorder (meets two to three DSM-5 diagnostic criteria for Gambling Disorder), or (c) a primary diagnosis of Relational Problem Related to Gambling Disorder (a variant of DSM-5 code V61.9).

"**Fraud**" is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"**May**" denotes the permissive.

"Outpatient Gambling Treatment Program" shall mean to provide problem gambling assessment, treatment and rehabilitation services delivered on an outpatient basis or intensive outpatient basis to individuals with gambling related problems who are not in need of 24-hour supervision for effective treatment. Outpatient Gambling Treatment Services must include regularly scheduled face-to-face or non-face to face therapeutic sessions or services in response to crisis for the individual and may include individual, group, couple, and family counseling.

"**Primary Diagnosis**" shall mean the main condition treated or investigated during the relevant episode of healthcare. The reason for admission in and of itself does not constitute the primary diagnosis. A primary diagnosis for Gambling Disorder, or other eligible client diagnoses, may only be made by CPGCs and mental health professionals qualified to make DSM-5 diagnoses as specified in their license or certification scope of practice.

"**Provider**" shall mean an institution, facility, program, agency, group or individual practitioner who has agreed to a written arrangement of cooperation with DHHS as an independent contractor or grantee to provide Problem Gambling Services. Provider is not an agent of DHHS, and shall not represent itself as an agent of DHHS.

"**Psycho-educational Group**" shall mean a specific type of group therapy that focuses on educating clients about their disorders and developing competencies in members through such structured groups as social skills, coping skills, relapse prevention skills, and life skills training.

"Residential Gambling Treatment Program" shall mean to provide problem gambling assessment, treatment, rehabilitation and twenty-four hour monitoring for pathological and problem gamblers consistent with Level III of ASAM PCC-2R. Residential Gambling Treatment Programs must be within a licensed inpatient mental health facility or residential alcohol and drug treatment facility that is in good standing and certified by a DHHS recognized accreditation board.

"Shall" denotes the imperative.

"**Self-refer**" shall mean a referral to a program without a prior assessment/treatment recommendation.

"**Service appointment**" shall mean a scheduled time for Client to meet with CPGC or CPGC-I for treatment session or assessment session.

"Session" or "treatment session" means services delivered in individual, couple, family, or group formats.

"**Treatment Episode**" shall mean the period beginning with the service date reported on the first encounter claim to the submission date of the discharge form.

II. Performance Standards

Providers funded through this Agreement must comply with the requirements set forth on Exhibits 1, 2, 3 and 4 attached hereto and incorporated herein by this reference.

Providers funded through this Agreement must meet the performance standards below. These performance standards are imposed and assessed on individual Providers and based exclusively on required data submitted by Providers to the UNLV International Gaming Institute, the current Information Management Contractor for DHHS gambling treatment services. If DHHS determines that a Provider funded through this Agreement fails to meet the specified performance standards, Provider will be required to submit a corrective action plan to DHHS's satisfaction. Repeated inability to meet the performance standards below may result in discontinuation of grantee funding. Providers are also subject to requirements imposed by DHHS in other documents attached to the Notice of Grant Award.

Access: The amount of time between a problem gambling affected individual's request for outpatient services and the first offered service appointment must be five business days or less for at least 90% of all individuals receiving services funded through this Agreement.

Retention: The percent of problem gambling affected individuals receiving services funded through this Agreement who actively engage in problem gambling treatment for at least 10 clinical contact sessions must not be less than 40%.

Successful Completion: The percent of all individuals receiving services funded through this Agreement who successfully complete treatment must not be less than 35%. A successful problem gambling treatment completion is defined as the individual's: (a) achievement of at least 75% of short-term treatment goals, (b) completion of a continued wellness plan (i.e., relapse prevention plan), and (c) lack of engagement in problem gambling behaviors for at least 30 days prior to discharge from services.

Client Satisfaction: The percent of problem gambling affected individuals receiving services funded through this Agreement who complete a problem gambling client satisfaction survey would positively recommend the Provider to others must not be less than 85%.

Long-term Outcome: The percent of problem gambling affected individuals receiving services funded through this Agreement who successfully complete treatment whose responses to a problem gambling follow-up survey suggest maintained improvement at twelve months after discharge must not be less than 50%.

III. Special Reporting Requirements

Providers funded through this Agreement must submit the following information to Department (or to DHHS's designee), with respect to the individuals receiving services funded through this Agreement, as well as any other information related to the delivery of Services funded through this Agreement that DHHS reasonably requests from time to time:

A. Intake Data: The data form must be collected and submitted within 14 days of the first face-to-face treatment contact with an individual.

B. Client Consent Form: A completed client consent form for use in follow-up efforts must be collected and submitted prior to discharge. Client refusal to participate in the follow-up survey must be documented in the client file.

C. Encounter Data: Encounter data for billing must be collected and submitted as described in Exhibit 3 attached hereto and incorporated herein by this reference. Prior to submitting an encounter claim each claimed encounter must be documented in the clinical record. Encounter claim documentation placed in the clinical record must include the date of the encounter service; the type of service delivered, the length of service, a clinical note describing data from the session, the clinician's signature and date the note was completed.

D. Discharge Data: Discharge data must be collected and submitted within 90 days after the last date of service to an individual.

IV. Grant Award Calculation and Disbursement Procedures

A. Grant Award Calculation. DHHS grant awards are based on the following services and claim rates:

Services and Rates*

Types of Providers	Assessment \ Diagnostic Workups	PRIMARY TREATMENT			
		Individual Session	Psycho-therapy Group Session	Psycho-educational Group Session	Residential Bed-day
CPGC	$125 *($115)*	$66 *($60.50)*	$24 *($22)*	$18 *($18)*	$96 *($88)*

CPGC-I	$62.5 *($57.50)*	$33 *($30.25)*	$12 *($11)*	$9 *($9)*	$96 *($88)*

**Note: Rate in "(italics)"are to be in effect during fiscal years were DHHS problem gambling program funding is reduced from $2 per machine revenue calculation to $1 per machine revenue calculation. See Exhibit 4 for service and unit definitions.*

The above services and rates are subject to the following:

1. These rates are based on maximum allowable claims for the DHHS Grants Management Unit's Gambling Treatment Program, applicable only to granted DHHS Problem Gambling Treatment vendors.

2. Rates are on an hourly per person basis except for (a) assessment where 1 unit is for the complete activity including administrative time needed for documentation and enrollment and (b) residential bed-day where 1 unit is an overnight stay.

3. Psychotherapy Group size is not to exceed 12 participants.

4. Rates for individual counseling include family and marital counseling which are based on per session not the number of persons attending.

5. Residential Treatment Assessments / Diagnostic Workups must include the administration of the Gambling Patient Placement Criteria (GPPC) instrument. Outpatient Treatment Assessment / Diagnostic Workups must include the administration of the GPPC or other DHHS approved assessment tool(s) and protocol.

6. Only one assessment claim per client is allowable except in situations where a client was discharged then later re-enrolled.

7. If the person enters treatment, reimbursement eligibility begins after successful submission of client enrollment information to DHHS designated information management entity.

8. The types of services and number of sessions rests with the clinical judgment of the provider as reflected in the treatment contract between the provider and the client.

9a.[4] If provider does an assessment/diagnostic workup and the client enters treatment, those costs are considered part of the maximum allowed reimbursement per treatment episode of $2,000 for outpatient treatment and $3,500 residential treatment.

9b.[5] The maximum allowable reimbursement per treatment episode is:

[4] Condition VI (9a) is effective during fiscal periods where the allocation to the revolving account for the prevention and treatment of problem gambling is based on transferring $2 of the slot tax (full funding)

(a) $2,000 for residential problem gambling treatment

(b) $1,500 for outpatient problem gambling treatment

(c) $1,000 for the treatment of person with a primary diagnosis of Relational Problem Related to Gambling Disorder.

10. No state reimbursement payment will be made for a missed scheduled session. All services reimbursed by DHHS must be documented in the client chart.

11. The rate to be billed must be based on the educational and training level of the direct provider, not of the person supervising the provider.

12. Persons eligible to enroll into DHHS reimbursed gambling treatment must have a gambling related problem as defined by (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31), (b) a primary diagnosis of sub-clinical Gambling Disorder (meets two to four DSM-5 diagnostic criteria for Gambling Disorder), or (c) a primary diagnosis of Relational Problem Related to Gambling Disorder (a variant of DSM-5 code V61.9).

13. Persons eligible to enroll into DHHS reimbursed residential gambling treatment must have special needs as defined by all of the following: (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31); (b) referral from a certified problem gambling counselor or inpatient psychiatric facility; (c) must meet residential gambling treatment program admission criteria as defined in Exhibit 1.

14. Services that receive reimbursement must be face-to-face therapeutic sessions unless a specific distance treatment plan is documented in the client record and conforms to DHHS conditions to provide distance treatment.

15. Providers of services funded through this Agreement may charge client co-pays. The maximum client co-pay in a residential program is $10.00 per bed day. The maximum client co-pay in an outpatient program is $10.00 per session. No client shall be refused services due to inability to pay.

16. Total DHHS payment for all services delivered under this Agreement shall not exceed the total funds awarded for services as specified in the Notice of Grant Award.

17. DHHS is not obligated to provide payment for any Services that are not properly reported as described or referenced in this Agreement by the date 45 days after the termination of this Agreement.

18. If at the end of any six month period during the term of this Agreement, DHHS may unilaterally reduce or increase the amount of funds awarded based on one or a combination of factors including the underutilization or overutilization of the current grant budget, the efficiency of funds used as determined by average cost-per-

[5] Condition VI (9b) is effective during fiscal periods where the allocation to the revolving account for the prevention and treatment of problem gambling is based on transferring $1 of the slot tax (reduced funding)

treatment episode and performance in meeting standards as defined above in Section II, changes in grantee program capacity, changes in available funds from the DHHS Revolving Account for the Prevention and Treatment of Problem Gambling . Provider shall execute and deliver to DHHS an appropriate amendment, as written by DHHS, to reflect budget change. In addition to the six month utilization review and allocation adjustment, additional funding adjustments may be made at the request of the provider or DHHS.

B. Provider Audits. Providers and sub-contracted Providers receiving payments from DHHS are subject to fiscal review and/or audit for all payments applicable to services rendered. Refer to Grant Instructions and Requirements for further details.

C. Prior Authorization. DHHS may grant the following exceptions with prior authorization.

1. The maximum allowed reimbursement per treatment episode may be exceeded. Treatment provides may request up to 10% of the grant award, for the current grant cycle, to be used for extensions of the client benefit cap. Only the actual amount expended on behalf of each client (rather than the requested amount) will apply toward the overall 10% extension limit.
2. Other exceptions to conditions or clauses of Agreement, as mutually agreed upon in writing by DHHS and Provider.

D. Procedure for requesting prior authorization.

1. Provider requests for prior authorization exceptions may be submitted via email to Pat Petrie (pdpetrie@dhhs.nv.gov) or other agent as designated by DHHS. Providers' prior authorization requests should not contain the name of the client or clinical information relating to the client as the DHHS management role in this process is solely related to fiscal and contract considerations and not clinical case management. Prior to submitting a request for a client's benefit limit to be increased, the provider must complete the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form". Prior authorization requests must include either the scanned copy of PART B from the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form" or within body of email all information from PART B of this form along with a statement that a completed Benefit Extension Request Form has been placed in the client's file. Information requested on this form includes:
    a) Name of agency requesting the exception;
    b) Client identification code (please do not include client name);
    c) Description of the exception request (if requesting funds in excess of benefit limit, must provide the specific dollar amount);

d) Statement indicating that the exception request was reviewed and approved by the agency's gambling treatment clinical team or clinical supervisor.

e) Statements indicating what other resources the client might have to pay for the additional service. Requesting State funds to pay for additional services should only occur if the client and/or agency have no other means to pay for continued services. Clients who have insurance but refuse to allow the provider to contact their insurance company are not eligible for benefit limit extensions.

2. Documentation must be placed in the client's clinical record describing the clinical review of the exception request including the clinical justification for requesting the exception. When requesting funds in excess of benefit limit, Part A of the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form" needs to be signed by client and Part B must be signed by clinic director and placed in client's clinical record documenting:
   a) The client does not have third-party payer to cover the costs of continued care;
   b) The client is experiencing financial hardship and is therefore unable to afford out-of-pocket payment for the full costs of continued services, and
   c) The treatment agency is not in possession of charitable contributions or other funds earmarked for covering the costs of care for those without treatment payment means.

Exhibit 1

Residential Gambling Treatment Admission Criteria

The following criteria shall be met before an individual is admitted to the residential care program.

A. Primary DSM-5 diagnosis by a qualified care provider as a pathological gambler; and

B. At time of admission, manifestation of at least one the following liabilities, as documented and supported by client responses to the Gambling Patient Placement Criteria (GPPC):

1. Severe Gambling Disorder symptom intensity to the extent symptom control can only be expected within a structured residential setting;
2. Depression and/or other emotional behavioral symptoms are sufficiently interfering with recovery efforts requiring residential care including endangerment to self or others; inability to function outside a controlled environment;
3. Even though faced with serious consequences, the individual does not accept them and requires intensive motivational strategies and efforts only available in a structured residential setting;
4. Failed attempts to achieve abstinence from gambling through formalized outpatient treatment or other residential treatment episodes;
5. Living in an environment where efforts to obtain even short-term abstinence in outpatient treatment are, or likely to be, thwarted, or living in a location where outpatient treatment is not available on a regular basis.

CONTRAINDICATIONS

A. Individual is physically, mentally, or behaviorally inappropriate for a residential setting and requires supervised medical attention, potential seclusion, or restraint.

B. Individual has a moderate to severe substance use disorder that is not in remission (less than 1 month of cessation of dependence)

Exhibit 2

Gambling Treatment Provider Standards

Providers of Services funded through this Agreement must comply with the conditions stated in the main body of this document and the standards set forth below. These standards were developed based on principles where (a) the safety and dignity of problem gambling treatment individuals should be maintained at all times and (b) treatment services should be designed to enhance the strengths of each client.

I. Accessibility – Providers of problem gambling treatment shall:

A. Deliver treatment at a physical location that conforms to the requirements of the Americans with Disabilities Act (ADA), to the extent reasonably practical.

B. The hours of operation and service availability shall reflect the needs of the clients served.

1. A client with emergency needs shall have immediate access to a clinician or a referral to emergency services.
2. Individuals not yet enrolled into service and requesting an appointment should be seen within twenty-four (24) hours, to the extent reasonably practical.
3. Make treatment available during both daytime and evening hours, to the extent reasonably practicable.
4. A client requesting services shall be seen for a routine office visit within ten (10) business days.

C. Develop and implement a policy of delivering treatment in a non-discriminatory and culturally sensitive manner. Recognize and respond appropriately to the unique needs of special populations (e.g., language, illiteracy, disability, culture, race, gender, sexual orientation, age-related differences, etc.) which could include but is not limited to: Making reasonable modifications in policies, practices, and procedures to avoid discrimination (unless the program can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity) such as:

1. Providing individuals capable of assisting the program in minimizing barriers (such as interpreters);
2. Translation of written materials to appropriate language or method of communication;
3. To the degree possible, providing assistive devices which minimize the impact of the barrier and;
4. To the degree possible, acknowledge cultural and other values which are important to the client including supporting the use of traditional healers and traditional healing methods, when advocated by the client and appropriate.

D. No person should be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category. The provider should have written criteria for accepting or refusing admission requests, including steps for making referrals for individuals not admitted to the program. For those clients refused admission based on assessment, the provider should document the reasons for refusal and subsequent referrals within seven days following the refusal decision.

E. In the treatment of clients under the age of fourteen the service plan must conform to State laws.

II. Eligibility – Persons acceptable to receive problem gambling treatment services funded by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e) shall:

A. Demonstrate residency within the State of Nevada, AND either

B. Present with a primary diagnosis of Gambling Disorder or sub-clinical Gambling Disorder, OR

C. Be a family member or significant other that is impacted by another's gambling behavior (even if the gambler does not seek counseling).

III. Eligible Providers – Persons administering gambling treatment clinical services, reimbursed through funds from by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e), shall hold current certification, in good standing, as a Certified Problem Gambling Counselor (CPGC) pursuant to NRS 641C.050 or Certified Problem Gambling Counselor Intern (CPGC-I) pursuant to the provisions of NRS 641C.060. Providers must be in compliance with ethical code of conduct commonly used by a CPGC or CPGC-I.

A. CLINICAL SUPERVISION: Problem gambling treatment providers who are not trained to diagnose or treat mental illness other than substance use disorders and gambling disorders, as determined by the scope of practice provided by their professional license, are required to make provisions for a minimum of two (2) hours per month of clinical supervision or consultation by a clinical supervisor with at least two years of postgraduate experience providing mental health services to adults. Supervisory staff who oversee the treatment of individuals with diagnoses other than substance use disorders and gambling disorders shall hold a license allowing them to diagnosis and treat a range of mental health disorders. Supervisors shall complete at least 10 hours of gambling specific education within the past two years including 2 hours on supervising gambling treatment counselors and maintain documentation evidencing each supervisor's compliance with this education standard.

Certified Problem Gambling Counselor Interns are required to make provisions for a minimum of two (2) hours per month of clinical supervision by a CPGC that is Board approved to supervise certified problem gambling interns.

B. COMPETENCY: Providers shall refer individuals to other professionals if an individual's clinical presentation is beyond the scope of the Provider staff's competency as determined by their certification restrictions, or license restrictions, or supervisor evaluation, or self-evaluation.

IV. Accountability – Providers shall deliver the services in accordance with the following standards:

A. GUIDELINES FOR TREATMENT SERVICES – Providers shall provide a variety of diagnostic and treatment service alternatives to each individual receiving problem gambling treatment. Treatment plans shall be designed to meet the particular individual's needs and resources as identified in the comprehensive assessment. Providers shall offer, at minimum, the following types of problem gambling treatment services:

1. Assessment – The assessment involves a face-to-face interview with the individual completed within the fifth client contact following enrollment into the treatment program. The purpose of the interview is to collect and assess pertinent information regarding the individual's past history and current situation that results in a clinical diagnosis and a recommendation regarding the need for treatment. The Provider shall have the ability to perform a structured interview process to assess the existence of problem gambling and co-existence with other disorders including, but not limited to, substance abuse, mental disorders, and significant health problems. Suicide potential and potential to harm others must be assessed and clinical records must contain follow-up actions and/or referrals when a client reports symptoms indicating risk of harm to self or others.

2. Orientation: The provider shall give to the client, document the receipt of by the client, and make available to others, written program orientation information which includes:

   a) The program or provider's philosophical approach to treatment;

   b) A description of treatment services;

   c) Information on client's rights and responsibilities, including confidentiality, while receiving services and following discharge.

   d) Information on the rules governing client's behavior and those infractions that may result in discharge or other actions. At a minimum, the rules shall state the consequence of substance use and gambling while in treatment, absences from appointments and failure to participate in the planned treatment activities; and

   e) Information on emergency services.

3. Individual, Family, and Group Treatment – Treatment sessions must address the problems of the individual(s) as they relate, directly or indirectly, to the problem gambling behavior.

   a) CRISIS INTERVENTION – Providers shall accommodate after-hour crisis intervention as necessary. This may be accomplished through agreement with other crisis services or on-call staff.

   b) FAMILY & COUPLES COUNSELING – To the extent reasonably practicable, providers should make efforts to accommodate the therapeutic needs of family members, partners, and concerned others of problem gamblers. This may be accomplished, in part, by forming working relationships with other problem gambling counselors and referring to colleagues the partner and/or family members of a problem gambler when either such requests are made or it is in the best interest of the gambler and family member(s) to work with different counselors.

   c) DISCHARGE PLANNING – A recovery/wellness plan or relapse prevention plan shall be developed by the Provider in collaboration with the individual and placed in the individual's file. A wellness plan shall be initiated early in treatment and finalized prior to discharge. The client's signature and date is proof of participation in the discharge planning. If the client was not involved in discharge planning, the file must show documentation that the client was notified of file closure. The discharge plan/relapse plan must document the therapeutic closure of formal treatment for the identified individual as well as recommendations and community resources for ongoing recovery.

4. Continuity of Care (community resources) – Providers shall have the capacity to coordinate services and make appropriate referrals to other formal and informal service systems, such as: mental health, Gamblers Anonymous, Gam-Anon, financial consultants, legal advice, medical, crisis management, cultural issues, housing, vocational, etc. The referral and follow-up action needs to be documented in the client's file.

B. DOCUMENTATION

Providers shall create and maintain the following documentation with respect to each individual receiving problem gambling treatment.

1. Identifying and demographic information for the individual including, at a minimum: Client ID, name, address, telephone number, date of birth, gender, marital status, and emergency contact. Any additional identifying and demographic data reasonably required by funding body.

2. Intake assessment documentation for the individual, including all of the following.

   - Referral source.

- Presenting problem.
- Gambling history.
- Current financial status assessment.
- History of substance use and substance use disorders, including past treatment episodes, assessment of risk of possible withdrawal, and history of other behavioral addictions.
- Health status (e.g., last physical, diet, exercise), current medical problems including medication use.
- Mental health history and current mental health status (e.g., treatment history, psychiatric medications).
- Profile of family of origin and marital/relationship history which describes family composition and dynamics.
- Recovery environment.
- Strength and recovery assets.
- Education and vocational history.
- Legal history (including arrest and conviction history).
- Risk of harm to self or others (e.g., assess for suicide risk, intimate partner violence, child neglect and abuse, elder abuse).

The information gathered shall include an intake assessment summary containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider.

An individualized treatment plan shall be developed in accordance with general professional standards for either substance abuse or mental health outpatient services. The treatment plan shall be completed within 30 days of intake or the third session following the commencement of treatment to the individual. The treatment plan shall adhere to the following standards.

a) Address client-centered issues identified from the assessment and modified as appropriate.

b) Be written with clear and measurable objectives that are consistent with the client's abilities and strengths and that the individual agrees to as the foundation of treatment.

c) Include an adequate range of services.

d) Include a financial plan.

e) Include regularly scheduled sessions.

f) Document that participation of the family members was encouraged.

g) Reflect the theoretical treatment approach taken by the program in clinical sessions.

The treatment plan shall be reviewed and modified continuously as needed and as clinically appropriate, and documentation of a treatment plan review shall be no less frequent than once every 90 days.

The individual's signature and signature date will signify participation in the development and review of the plan. The treatment plan shall also be signed and dated by the clinician.

The individual's progress and current status in meeting the goals set in the treatment plan shall be documented within 72 hours of all clinical contacts. All progress notes shall be dated, indicate type and length of service, location of service, contain data from the session, clinical assessment, a clinical plan, and be signed by the person providing the service. Within a residential treatment setting, the use of weekly summary notes is sufficient to document clients' progress. Additionally, providers of residential gambling treatment services must document each per-diem treatment claim by asking clients to sign and date a residential gambling treatment log.

5. The following additional information shall be documented in the client file (as applicable).

   - Documentation that the individual has been informed of client rights and responsibilities, including the Health Insurance Portability and Accountability Act (HIPAA) privacy rule and other confidentiality protections and exceptions.
   - Results of all examinations, tests, intake, and assessment information.
   - Reports from referring sources.
   - Correspondence related to the individual, including letters and dated notations of telephone conversations relevant to the individual's treatment.
   - Information release forms, signed and dated with client and clinician's signatures.
   - Gamblers Anonymous or other community support network participation.
   - Consent to treat form signed by the individual (see Section VIII).

6. Within 30 days of the client leaving treatment, a treatment summary shall be completed stating the reason for discharge, progress toward treatment plan objectives, and recommendations.

7. Clients not provided services for 60 continuous days should be notified by letter of their case file closure, and invited back to treatment if appropriate. A treatment summary should be completed within 90 days of last service.

V. Financial - Providers of problem gambling treatment should implement a structured process for assessing client financial circumstances and needs of individual. Treatment strategies should be developed to address the individual's financial circumstances and needs that may include, but are not limited to the following.

- Developing a financial management plan for the individual that includes a restitution plan, if appropriate.
- Connection with relevant financial assistance services.
- Development of a plan with the individual to cope and manage with loan/debt collectors, if appropriate.

VI. Effectiveness – Providers should use appropriate treatment techniques and be able to document the effectiveness of treatment using measurable criteria.

A. Providers shall have a system for measurement of progress and outcomes as stated in treatment objectives on the treatment plan.

B. Providers shall clearly define the process for internal program review and self-correction (e.g., Continuous Quality Improvement Protocols). A program shall develop and implement written policies and procedures that describe program operations. Policies and procedures shall include a quality assurance plan for ensuring that clients receive appropriate treatment services and that the program is in compliance with relevant administrative rules and other reporting requirements.

C. If two or more staff provide services, the program shall have and implement the following written personnel policies and procedures, which are applicable to program staff and interns/students.

1. Rules of conduct and standards for ethical practices of treatment program practitioners.
2. Standards for use and abuse of alcohol and other drugs with procedures for managing incidents of use and abuse that, at a minimum, comply with Drug Free Workplace Standards.
3. Compliance with regulations related to employment practices.

D. Providers shall implement a written treatment approach that is defined and supported in current literature.

VII. Efficiency – Providers shall provide services in the least restrictive setting and in the most cost-effective manner based on the individual's needs, resources, and strengths as determined by the problem gambling assessment.

VIII. Client Protections and Rights – Providers shall:

A. Maintain the confidentiality of all client records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.

B. Develop and implement policies and procedures to safeguard and protect the case record of individuals against loss, tampering, or unauthorized disclosure of information. Maintenance of such records shall include adequate physical facilities for the storage, processing, and handling of the records. These facilities shall include suitably locked, secured rooms for file cabinets.

C. Retain the records of individuals as specified under HIPAA.

D. The client shall have the right of access to records. Access includes the right to obtain a copy of the record within 30 days of requesting it and making payment for the cost of duplication. The client shall have the right of access to the client's own records except:

1. When the clinical supervisor determines that disclosure of records would be detrimental to the client's treatment; or
2. If confidential information has been provided to the program on the basis that the information not be re-disclosed or may be obtained directly from originating source.

E. Require each individual to sign consent to treatment statements which includes conditions under which confidentiality can (or must) be broken.

F. Document, and inform each individual of the individual's rights and responsibilities in treatment. Each client shall be assured the same civil and human rights as other persons. Each program or private-practice provider shall develop and implement and inform clients of written policies and procedures which protect clients' rights including:

1. Protecting client privacy and dignity;
2. Prohibiting physical punishment or physical abuse;
3. Protecting clients from sexual abuse or sexual contact and
4. Providing adequate treatment or care.

D. Documentation must include a formal grievance procedure with provision for appeals. The program or private practice provider shall develop, implement, and fully inform clients of policies and procedures regarding grievances that provide for:

1. Receipt of written grievances from clients or persons acting on their behalf;
2. Investigation of the facts supporting or disproving the written grievance;
3. Initiating action on substantiated grievances within five working days, and
4. Documentation in the client's record of the receipt, investigation, and any action taken regarding the written grievance.

E. The client shall have the right to refuse service, including any specific procedure. If consequences may result from refusing the service, those consequences must be explained verbally and in writing to the client.

Exhibit 3

Encounter Data Reporting Requirements

INTRODUCTION:

In order to efficiently implement the disbursement of financial assistance it is necessary for all Providers of Services funded through this Agreement to submit individual-level service delivery activity (encounter data) each month.

OVERVIEW:

The encounter data collection process is intended to create as minimal a burden on Providers as possible, while creating a sound documentation trail for necessary fiscal auditing that will occur at least once each year for all Providers. The system is designed to provide optimal flexibility for Providers to facilitate minimum changes to local procedures. A standardized electronic transfer of detail service data is required monthly for Providers that currently have automated accounting and billing systems in place. All Providers will be required to comply with DHHS procedures for HIPAA compliance.

At the time the Treatment Strategic Plan was implemented (July 2011), the UNLV International Gaming Institute was the DHHS designee to manage the encounter data collection process. Should a different entity be designated in the future, DHHS will amend the Treatment Strategic Plan and communicate the change to Providers.

The UNLV International Gaming Institute shall generate a simple online encounter data reporting form, to be completed and transmitted electronically, for use by small Providers that do not have automated accounting systems in place. Completed reporting forms must be transmitted monthly to the UNLV Nevada Problem Gambling Project.

Client eligibility data will be required to be on file with the UNLV International Gaming Institute prior to the authorization of reimbursement for encounter claims. This eligibility data will consist of the current intake/enrollment forms as promulgated in the gambling program evaluation data collection protocol.

<u>Required Encounter Data:</u>

The following fields must be collected, with respect to each individual receiving Services funded through this Agreement, for the grants management disbursement system:

Individual Identification Code: Local code utilized to identify individuals for the Provider evaluation effort.

Individual's Date of Birth: This field will be utilized for individual identity verification in the event of incorrect or duplicate individual identification codes. Data to be provided in MMDDYYYY format.

Date of Service: Date the service that was provided in American format - MMDDYYYY.

Type of Service Session: Appropriate HIPAA compliant codes for eligible services must be used. See Exhibit 4.

Hours: Service hours will be reported in a manner that is consistent with current DHHS standards.

Counselor/Therapist: The identification of the counselor, or therapist, conducting the session. This must be a discrete identification that can be utilized during audits to enable verification of services performed from the clinical charting. The treating professional identification must be included in the appropriate field.

Provider Identification: The identification of the agency or organization providing the service..

Reporting Period: Each file must have the end dates of the reporting period in American format: MMDDYYYY.

Operational Reporting Schedule:

1. Encounter data must be submitted online via the UNLV International Gaming Institute web site (to be developed and provided by the UNLV research team), until or unless notified otherwise by DHHS.

2. Encounter data for the previous month must be entered on the UNLV International Gaming Institute web site no later than 4 p.m. on the 10th day after the period being reported (e.g., July 2012 encounter data is due on August 10, 2012).

3. The UNLV International Gaming Institute will assemble data and prepare summary reports to be submitted to DHHS and individual treatment Providers by the 30th of each month. The reports will include (at minimum) the total number of units of service claimed for the billing period under each billing code.

4. Each provider is required to respond to the summary report via an e-mail to the UNLV International Gaming Institute.
    a. The provider must either:
        (1) Verify that the amount on the summary report matches their original submission, or
        (2) Report discrepancies, including apparent cause and remedy.
    b. The timeframe for response is within 5 days from notification.

5. The UNLV International Gaming Institute will work with Providers to resolve any discrepancies and submit a revised summary to DHHS within 5 days of notification of the discrepancies.

6. DHHS will reimburse Providers within 15 days following receipt of the final summary report from the UNLV International Gaming Institute. Any additional discrepancies that are

identified after payment is made will be addressed as adjustments (credits or debits) on the next payment processed. After August 15th, no further adjustments will be made for service claims for the preceding grant year (July 1st through June 30th).

7. Encounter data for July 1 through December 31 of each grant year will be used to determine mid-year grant award adjustments. Adjustments will occur 45 days after the closing of the mid-year utilization period to allow any discrepancies identified for December to be resolved and to allow sufficient time for DHHS to evaluate the encounter data and prepare the necessary paperwork to execute grant amendments.

8. In even-numbered years when grants are renewed, encounter data for July 1 through April will be used to determine initial grant awards for the following grant year.

9. In odd-numbered years when a competitive grant process is conducted, encounter data from the preceding grant year may be used to help determine grant awards for any repeat grantees.

EXHIBIT 4

Nevada DHHS Problem Gambling Services
Procedure Codes and Reimbursement Rates

Code	Description	Upper Payment Amount*	Service Criteria
H0004	Gambling Treatment counseling and therapy, per 15 min	$16.50 *($15.13)*	Service provided by a CPGC. The treatment of a gambling disorder by psychological means.
H0004i	Gambling Treatment counseling and therapy, per 15 min	$8.28 *($7.56)*	Service provided by a CPGI. The treatment of a gambling disorder by psychological means.
H0005	Gambling Treatment counseling, group per 15 min	$6 *($5.50)*	Service provided by a CPGC. The practitioner seeks to help individual group members to understand and remediate their significant emotional and psychological problems, focusing on intrapersonal and interpersonal dynamics. Maximum group size of 12 clients.
H0005i	Gambling Treatment counseling, group per 15 min	$3 *($2.75)*	Service provided by a CPGI. The practitioner seeks to help individual group members to understand and remediate their significant emotional and psychological problems, focusing on intrapersonal and interpersonal dynamics. Maximum group size of 12 clients.
G2013	Residential gambling treatment service, per diem	$96 *($88)*	Services provided within a licensed inpatient mental health facility or residential alcohol and drug treatment facility designated as a residential gambling treatment program and intensively staffed 24-hour for which treatment includes an appropriate mix and intensity of assessment, medication management, individual and group therapies and skills development to reduce or eliminate the acute symptoms of the disorder and restore the client's ability to function in a home or the community to the best possible level. A claim for residential gambling treatment services can only be made for those days where the client is occupying a bed during sleeping hours or a client has been provided a therapeutic pass for up to 48 hours. With pre-authorization, exceptions to the 48 hour rule may be made with reasonable justification.
G2100	Problem Gambling Psychoeducational Group Services, per 15 min for gambler and/or family member	$4.50 *($4.50)*	Service provided by a CPGC. Service to clients with a specific type of group therapy that focuses on educating clients about their disorders and ways of coping.

G2100i	Problem Gambling Psychoeducational Group Services, per 15 min for gambler and/or family member	$2.25 *($2.25)*	Service provided by a CPGI. Service to clients with a specific type of group therapy that focuses on educating clients about their disorders and ways of coping.
G2200	Intake Assessment per activity	$125 *($115)*	Service provided by a CPGC. Biopsychosocial clinical assessment containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. Eligibility based on Provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS-funded gambling treatment services.
G2200i	Intake Assessment per activity	$62.5 *($57.50)*	Service provided by a CPGCI. Biopsychosocial clinical assessment containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. Eligibility based on Provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS-funded gambling treatment services.
S9484	Crisis Services, per 15 min	$16.50 *($15.13)*	Crisis Intervention Mental Health Services for Eligible Clients. Code for pre-enrollment use. For enrolled clients, use code H004. Use of this code is limited to no more than 10% of the total claims for any calendar month.
G3000	Clinical Supervision of CPGC-I, per 15 min	$16.50 *($15.13)*	Clinical supervision, by Board approved supervisor, provided to CPGC-I needed to meet minimum Board supervision requirement (60 hours total) or (2 hrs per month). For use only by Providers with CPGC-I staff that are employed or contracted to provide an average of 8 hours per week or more within the Provider's gambling treatment program. Every claim using this code must be documented in the CPGC-I staff file.
G2300	Continuing Care Group Services, per activity	$10.00 *($10.00)*	CC Group Services are provided by CPGC or CPGI to clients who have completed problem gambling treatment within the past 12 months and are utilized to facilitate continued recovery. Services can be provided within an existing therapy or psycho-educational group being provided to current clients or to a group of previous clients meeting on a regular basis for aftercare. To be entered as an encounter, the continuing care group must be at least 60 minutes in duration and the same participant may not be claimed more than once per week.

**Note: Rate in "(italics)" are to be in effect during fiscal years where DHHS problem gambling program funding is reduced from $2 per machine revenue calculation to $1 per machine revenue calculation.*

APPENDIX B

DHHS Problem Gambling Treatment Services
Recommended Procurement Process Outline

Requests for Proposals

- Develop two separate problem gambling treatment Requests for Applications (RFAs), one for residential gambling treatment and the other for outpatient problem gambling treatment.
- Allow for three categories of funding requests per application.
    - Treatment not-to-exceed budget (based on estimated claims, assuming fee-for-service system).
    - Optional budget supplement where applicants are given the opportunity to request base funds due to special needs or circumstances. For example, an applicant may use this budget line to make a request for a special allowance to cover the increased costs of delivering services in rural regions or to cover start-up costs for a new service area.

- RFAs to include a set of problem gambling treatment standards that clearly define client eligibility, provider qualifications, documentation requirements, etc.
- RFAs to contain a description of the reviewers scoring criteria and a description of the principles used when making appropriation decisions.

Proposal Review, Selection, and Allocation Process

Problem gambling treatment proposals typically include a description of treatment services, justification statements for proposed approach, staff qualifications, and a budget with justification. Because components of the proposal are technical in nature, reviewers with special knowledge are needed.

A five stage review process is suggested for the problem gambling treatment proposals. First, the proposals will be reviewed by DHHS staff to determine if they meet minimum qualifications such as eligibility requirements and application completeness. Second they will be scored, using a scoring document with defined criteria, by two or more persons with expert knowledge regarding problem gambling treatment programs. These reviewers will sign conflict of interest statements indicating they have no relationship to the applicants. The result of the first and second stage of this review process will produce a list of qualified providers (e.g., those applications obtaining a passing score). Only those proposals from qualified providers will enter the appropriation phase. In these stages of the review, the ACPG (excluding members who report a conflict of interest) will hold an application review meeting to discuss the proposals and use pre-determined principles to guide the recommended appropriation of funds. Using pencil, each reviewer will document their recommended appropriation on a DHHS approved form. The group will also generate a list of questions for applicants. During the fourth stage, an ACPG open meeting will be used to question applicants and ACPG reviewers will be provided the opportunity to document changes to their initial funding recommendation based on applicant response. During the final stage, each ACPG

reviewer's recommended funding sheet will be provided to DHHS. DHHS will take these recommendations into consideration when determining the initial appropriations.

Table 1. Suggested Procurement Process Stages

	Stage I	Stage II	Stage III	Stage IV	Stage V
Objective	Eligibility Review	Qualified Provider Review	Appropriation Review	Q&A / Recommended Appropriations	Final Selection & Appropriation
Review Body	DHHS	Expert Panel	ACPG	ACPG	DHHS

Utilizing the above suggested procurement process, the process will be transparent by virtue of the applicants being aware of the process, the scoring criteria, and maintaining the right to obtain the scoring forms from every stage of the process. This process has several distinct advantages to the procurement process used in previous years.

- Provider qualifications will be based on expert opinion.
- The ACPG will have defined principles to guide their appropriation recommendations.
- The ACPG will have the opportunity to discuss the proposals and obtain immediate procedural feedback from DHHS during a special (non-public) review meeting.
- The ACPG applicant review meeting will be streamlined where questions are addressed but the final tabulation of ACPG reviewers are not made.

The task of remedying any discrepancy between available funds and the final tally of the ACPG recommended funds will be left to DHHS. This change in procedure will allow DHHS to utilize the ACPG recommendations while increasing its discretionary control over the allocation of funds.

Applicant Award and Funding Process

During the discovery phase of this project, there was some concern expressed with the grant award notification and funding process. The issues most commonly stated were a delay in initial payment due to grant or contract execution delays and an inflexibility to adjust funding levels based on service levels. It may be helpful to move the timeline up for RFAs and application reviews. Ideally, providers should be selected three to four months prior to the beginning of a new funding cycle to allow time for contracts to be in place by July 1 of each fiscal year.

If the problem gambling treatment system moves to fee-for-service reimbursement, there will be added flexibility and added complexity. Because there will continue to be a finite level of funding, each provider should be given an annual allotment that can be accessed through monthly utilization claims. Once every three to six months, the annual provider allotments could be adjusted to re-align the providers' annual allotment with their level of claims. That is, funds can be shifted from under-performing providers to over-performing providers. Furthermore, it may be possible to hold some funds in reserve and add those to providers whose claims are exceeding their annual allotment.