DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMDL: 19-0003

RE: Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(l) of the Social Security Act

November 6, 2019

Dear State Medicaid Director:

This letter provides guidance on the implementation of section 5052 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act," also known as the SUPPORT for Patients and Communities Act (Pub. L. 115-271). Section 5052 of the SUPPORT for Patients and Communities Act amended the institution for mental diseases (IMD) exclusion and established a new section 1915(l) of the Social Security Act (Act) to include a state plan option to provide services to Medicaid beneficiaries age 21 through 64 who have at least one substance use disorder (SUD) diagnosis and reside in an eligible IMD from October 1, 2019 through September 30, 2023. The Centers for Medicare & Medicaid Services (CMS) is committed to supporting states that are interested in adding this option to their Medicaid state plan.

Background

Current Coverage of Withdrawal Management and SUD Treatment Services

States have flexibility to cover withdrawal management and SUD treatment services under a variety of section 1905(a) benefit categories under their Medicaid state plans. Potential benefit categories for withdrawal management and SUD treatment services include, but are not limited to: physicians' services, services provided by other licensed practitioners, diagnostic and rehabilitative services, inpatient and outpatient hospital services, and prescription drugs. State plan services must meet the requirements for the benefit category under which the services are provided.

State plan services must also meet three foundational requirements, except in the limited circumstances in which a particular benefit allows for any of these requirements to be disregarded:

- Comparability: A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees within a group;
- Freedom of choice: Medicaid beneficiaries must be permitted to choose a health care provider from any qualified provider who undertakes to provide the services, and any willing and qualified provider must be able to participate in the Medicaid program;

- Statewideness: The plan must be in operation statewide under equitable standards for assistance and administration that are mandatory throughout the state.

States have significant flexibility in how they may pay for withdrawal management and SUD treatment services. States may pay providers for medically necessary Medicaid state plan services provided to beneficiaries with SUDs who receive services in the community, a residential setting, or an inpatient facility setting (except when the IMD exclusion applies, as discussed below), and vary payment rates based on location and/or intensity of services. States may also pay for covered services individually or develop bundled rates for covered services if it is determined to be a more efficient payment method. In addition, states may develop methodologies that offer incentives for improved outcomes and quality of care. However, payments for services provided in a residential setting may not include costs associated with room and board, unless the facility meets the definition of an inpatient facility type for which expenditures for room and board may be made under the state plan.

Under Medicaid law, medical assistance payment for room and board is only available with respect to the following facility types that provide Medicaid-covered, institutionally-based benefits: nursing facilities, inpatient hospitals, psychiatric facilities for individuals under age 21, IMDs for individuals age 65 or older that otherwise would qualify as an inpatient setting, and intermediate care facilities for individuals with intellectual disabilities. These types of facilities must meet certain federal standards and Conditions of Participation requirements. Medical assistance payment that includes room and board costs could be available for facilities that meet the Medicaid requirements, including Conditions of Participation.

Institution for Mental Diseases (IMD) Exclusion

Although states have flexibility to cover withdrawal management and SUD treatment services, Medicaid payment is generally not available for services provided to individuals ages 21 through 64 who are patients in residential and inpatient treatment facilities that qualify as IMDs. An IMD is defined in section 1905(i) of the Act as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual under age 65 who resides in an IMD.[1] This is commonly known as the "IMD exclusion." The IMD exclusion applies to any care or services provided inside or outside of the facility or hospital to a Medicaid beneficiary residing in an IMD.

Historically, there have been two exceptions to the IMD exclusion. First, Medicaid payment is permitted for inpatient hospital services, nursing facility services, and intermediate care facility services provided in IMDs to individuals age 65 and older.[2] Second, Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the "psych under 21" benefit, furnished by a psychiatric hospital, a general hospital

[1] Subdivision (B) following section 1905(a) of the Act.
[2] 42 C.F.R. § 440.140.

with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility."[3]

Recently, section 1012 of the SUPPORT for Patients and Communities Act added a new limited exception to the IMD exclusion.[4] Specifically, section 1012(a) states that for a woman who is eligible on the basis of being pregnant (and up to 60-days postpartum), who is a patient in an IMD for purposes of receiving treatment for a SUD, who is either enrolled under the state plan immediately before becoming a patient in the IMD, or who becomes eligible to enroll while a patient in an IMD, the IMD exclusion shall not be construed to prohibit federal financial participation (FFP) for medical assistance for items and services provided outside of the IMD to such women.

Section 1115 Demonstrations

Demonstration projects authorized under section 1115 of the Act allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. On November 1, 2017, CMS announced a section 1115(a) demonstration initiative to improve access to and quality of SUD treatment for Medicaid beneficiaries as part of a Department-wide effort to combat the nation's ongoing opioid crisis.[5] This initiative aims to give states flexibility to design demonstrations that improve access to high quality, clinically appropriate treatment for opioid use disorder (OUD) and other SUDs while incorporating metrics for demonstrating that outcomes for Medicaid beneficiaries are in fact improving. Through this section 1115 initiative, states can receive FFP for the continuum of services to treat addiction to opioids or other substances, including services provided to beneficiaries residing in residential and inpatient treatment facilities that qualify as IMDs.

Managed Care Authority

In accordance with section 1903(m)(7) of the Act and 42 C.F.R. § 438.6(e), states may receive FFP for monthly capitation payments for beneficiaries age 21 through 64 receiving SUD treatment in an IMD for a short term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the regulation are met. The IMD must be a hospital providing inpatient SUD treatment or a sub-acute facility providing SUD crisis residential services. The state must have determined that the IMD is a medically appropriate and cost effective substitute for the covered setting for providing SUD treatment under the State plan. The enrollee must not be required by the managed care plan to use or reside in the IMD and must have a choice of settings for the SUD treatment. The IMD services for treatment of SUD must be authorized and identified in the managed care contract between the state and the managed care plan, and offered to enrollees at the option of the managed care plan (i.e., coverage of the SUD treatment services in an IMD setting cannot be required of the Managed Care Organization, Pre-paid Inpatient Health Plan, or Pre-paid Ambulatory Health Plan).

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[3] 42 C.F.R. § 440.160.
[4] For more information about section 1012 of the SUPPORT for Patients and Communities Act, see https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf.
[5] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

1915(l) - State Plan Option to Provide Medical Assistance for Eligible Individuals who are Patients in Eligible Institutions for Mental Diseases

The new state plan option available under section 1915(l) of the Act permits states to provide high quality, clinically appropriate services in residential and inpatient treatment facilities that qualify as an IMD for calendar quarters during the period beginning October 1, 2019 and ending September 30, 2023. Under section 1915(l), states may receive FFP for items and services for which medical assistance is available under the state plan that are provided to eligible individuals residing in an eligible IMD. Pursuant to section 1915(l)(6), FFP is available for covered Medicaid items and services provided to eligible individuals inside and outside the facility while residing in an eligible IMD. Per section 1915(l)(2), FFP is available for a maximum of 30 days per 12-month period per eligible individual from the date an eligible individual is first admitted to an eligible IMD.

Beneficiary Eligibility

Section 1915(l)(7)(B) of the Act defines an eligible individual for this state plan option as a person enrolled for medical assistance under the state plan or a waiver of such plan who is ages 21 through 64 and has at least one SUD. We are interpreting section 1915(l)(7)(B) implicitly to require that in order to be an eligible individual for this state plan option, the individual must be residing in an eligible IMD primarily to receive withdrawal management or SUD treatment services. We believe that this interpretation of section 1915(l)(7)(B) is appropriate because section 1915(l) includes provisions and requirements designed specifically to increase access to withdrawal management and SUD treatment services. For example, as further described in this guidance, states are required to cover withdrawal management and SUD treatment services across a robust continuum of care, including services delivered in residential and inpatient settings and outpatient services including early intervention for SUD. Furthermore, as we discuss below, eligible IMDs must offer at least two forms of medication as part of medication-assisted treatment (MAT) on-site for SUDs to be eligible to deliver services under section 1915(l) and states must maintain current state and local expenditures, excluding the state share of Medicaid expenditures, for certain withdrawal management and SUD treatment services for the duration of this new state plan option. These requirements would not be relevant for someone who has a SUD, but is in the IMD primarily to receive treatment for a condition other than SUD.

Eligible IMDs

Section 1915(l)(7)(D) defines an IMD for purposes of this state plan option as the meaning given in section 1905(i) of the Act. In addition, section 1915(l)(7)(C) defines an eligible IMD as an IMD that follows reliable, evidence-based practices and offers at least two forms of medication as part of MAT onsite, including, in the case of MAT for OUD, at least one FDA-approved antagonist[6] and one partial agonist[7].

For an IMD to comply with the requirement in section 1915(l)(7)(C)(ii) that it offer at least two forms of MAT onsite in order to be an eligible IMD, CMS clarifies that an IMD must make

[6] E.g., Naltrexone
[7] E.g., Buprenorphine

available at least two forms of medication as part of MAT onsite upon request but may also offer those forms, as well as others, furnished offsite by a qualified provider in the community that has an arrangement with the IMD. Eligible IMDs should also offer behavioral health services alongside MAT.

Evidence-based Clinical Screening

In accordance with section 1915(l)(4)(B), states must notify CMS how it will ensure that eligible individuals receive an appropriate evidence-based clinical screening prior to receiving services in an eligible IMD, including initial and periodic reassessments to determine the appropriate level of care, length of stay, and setting for each individual.

Comprehensive Continuum of Care

The 1915(l) option is designed to supplement and be coordinated with outpatient, community-based care as part of a comprehensive continuum of services to effectively treat beneficiaries with SUDs. Section 1915(l)(4)(C)(i) requires that states cover outpatient SUD treatment services consistent with each of the following levels of care: early intervention; outpatient services; intensive outpatient services; partial hospitalization; and section 1915(l)(4)(C)(ii) requires that states cover at least two of the following residential and inpatient levels of care:

- Clinically managed low-intensity residential services;
- Clinically managed, population specific, high-intensity residential services for adults;
- Clinically managed, medium-intensity residential services for adolescents;
- Clinically managed, high-intensity residential services for adults;
- Medically monitored, high-intensity inpatient services for adolescents;
- Medically monitored, intensive inpatient services withdrawal management for adults; and
- Medically managed intensive inpatient services.

Care Transitions

As required by section 1915(l)(4)(D)(i), states must ensure that placement of beneficiaries in an IMD will allow for their successful transition to the community, considering such factors as proximity to an individual's support network (e.g., family members, employment, counseling and other services near an individual's place of residence). Additionally, to ensure an appropriate transition from receiving care in an eligible IMD to receiving care at a lower level of clinical intensity, section 1915(l)(4)(D)(ii) requires states to ensure that eligible IMDs either provide services at lower levels of clinical intensity or establish relationships with Medicaid-enrolled providers offering services at lower levels of care. As beneficiaries transition between levels of care, it is important to note that beneficiaries must generally be able to receive covered services from any Medicaid qualified provider who agrees to furnish services to them. CMS encourages states to implement additional care coordination strategies and processes to ensure seamless transitions across the continuum of care and collaboration between different types of health care (e.g., primary care, mental health, etc.).

Maintenance of Effort

Section 1915(l)(3) of the Act specifies that during the period in which a 1915(l) state plan amendment (SPA) is in effect, states must annually maintain or exceed the level of state and local funding for items and services furnished to eligible individuals who are patients in eligible IMDs as well as items and services described in section 1915(l)(3)(B) that are furnished to eligible individuals in outpatient, community-based settings. Section 1915(l)(3)(A) states that the maintenance of effort (MOE) applies to state and local funding "other than under this title from non-Federal funds." As section 1915(l) is included in Title XIX of the Act, "under this title" means Title XIX of the Act. Accordingly, only items and services that are funded with state and local dollars outside of the Medicaid program are subject to the MOE.

The MOE is based on federal fiscal year 2018 or, if the level of state and local expenditures is higher, the most recently completed federal fiscal year as of the date the state submits a new SPA. As required by section 1915(l)(3)(C)(ii), we are establishing the following process. When submitting a new 1915(l) SPA, the state shall report the total state and local expenditures, excluding the state share of Medicaid expenditures, applicable to the appropriate federal fiscal year for the following items and services provided to eligible individuals:

- All items and services provided while a patient in an eligible IMD; and
- Outpatient and community-based SUD treatment; evidence-based recovery and support services; clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention and emotional coping strategies; outpatient MAT, related therapies, and pharmacology; counseling and clinical monitoring; outpatient withdrawal management and related treatment; and routine monitoring of medication adherence.

For CMS to verify a state's compliance with the MOE, the state shall report the same categories of information mentioned immediately above for each year the SPA is in effect.

Concurrent Use of Medicaid Managed Care Authorities with Section 1915(l)

Section 1915(l)(5) specifies that payments for, and limitations to, services authorized under section 1915(l) shall be in addition to and not limit the ability of states to make monthly capitation payments to managed care organizations for individuals receiving treatment in an IMD in accordance with 42 C.F.R. § 438.6(e). Therefore, states that add the 1915(l) option to their Medicaid state plan may also receive FFP for monthly capitation payments paid to managed care plans for beneficiaries age 21 through 64 who receive inpatient treatment in an IMD in accordance with section 1903(m)(7) and 42 C.F.R. § 438.6(e).

Interaction with other SUPPORT for Patients and Communities Act Provisions and Section 1115 Demonstrations

Section 1012 of the SUPPORT for Patients and Communities Act[8] requires states to cover the services currently provided to pregnant and postpartum women when the woman has also been diagnosed with a SUD and is residing in an IMD. Under this provision, states can receive FFP for covered services, as long as those services are received outside of the IMD. States electing the 1915(l) option will also receive FFP for services provided inside the IMD to pregnant and postpartum women age 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD primarily to receive withdrawal management or SUD treatment services for up to 30 days per 12 month period.

Pursuant to section 5052(b) of the SUPPORT for Patient and Communities Act, the new state plan option available under section 1915(l) of the Act does not prevent states from pursuing or conducting a section 1115 demonstration to improve access to, and the quality of, SUD treatment for eligible populations.

SPA Submission Requirements

CMS is developing a SPA pre-print and MOE reporting template to assist states in developing a section 1915(l) SPA. To the extent a state chooses to pay for covered services provided within IMDs differently from other provider types, the state will need to issue a public notice and comprehensively describe the payment methodology. As with any SPA submission, CMS will request information on the source of the non-federal share of the service payments and information on the rate setting methodology. Specific guidance related to SPA submission procedures, including guidance on developing comprehensive methodologies and bundled rates, may be found on Medicaid.gov: https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/medicaid-spa-toolkit/index.html.

We look forward to working with states to implement this Medicaid state plan option. CMS is available to provide technical assistance to states as they consider making this option a part of a state's strategy for increasing access to high-quality, clinically appropriate services to effectively treat individuals with SUDs. If you have any questions, please contact Kirsten Jensen, Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, at Kirsten.Jensen@cms.hhs.gov.

Sincerely,

/s/

Calder Lynch
Acting Deputy Administrator and Director

[8] For more information about section 1012 of the SUPPORT for Patients and Communities Act, see https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf