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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 24-004

RE: Extension of Medicaid Coverage of Substance Use Disorder Treatment and Managed Care Medical Loss Ratio Provisions in the Consolidated Appropriations Act, 2024

November 19, 2024

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance to address the statutory requirements in the Consolidated Appropriations Act, 2024 (CAA, 2024) (P.L. 118-42), Division G, Title I, Subtitle B, Sections 201, 204, and 211 (hereinafter referred to as "section 201," "section 204," and "section 211").[1] Section 201 made permanent the mandatory Medicaid benefit for medications for opioid use disorder (MOUD). Section 204 made permanent and amended the state plan option at section 1915(l) of the Social Security Act (the Act) to provide medical assistance for certain individuals who are patients in eligible institutions for mental diseases (IMDs)[2] in which Medicaid benefits generally are not otherwise covered.[3] Section 211 made permanent a managed care provision relating to Medical Loss Ratio remittances.

Mandatory State Plan Coverage of MOUD

Background

On December 30, 2020, CMS issued State Health Official Letter #20-005: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment.[4][5] This guidance described the requirements of the mandatory MOUD benefit and opportunities for increasing treatment options for substance use disorders (SUDs). The mandatory MOUD benefit, as described at section 1905(a)(29) of the Act, requires coverage of counseling services and behavioral therapies associated with the provision of required drug and biological coverage. The drug and biological coverage, as described at section 1905(ee)(1) of the Act, requires states to cover all drugs

[1] https://www.congress.gov/118/bills/hr4366/BILLS-118hr4366enr.pdf
[2] Eligible IMDs are defined below and on pages 4-5 of SHO #20-005: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf
[3] For the purposes of the state plan option an IMD has the meaning given in section 1905(i) of the Act.
[4] SHO #20-005: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf
[5] The acronym MOUD is being used in this guidance to refer to the medication-assisted treatment required under section 1905(a)(29), as medication-assisted treatment can be stigmatizing, and to normalize the use of medications for OUD.

approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders (OUDs).

The mandatory MOUD benefit was initially effective for a five-year period beginning October 1, 2020, and ending September 30, 2025.[6] States were able to request an exemption from the mandatory coverage requirement if there was a documented shortage of qualified providers or facilities providing such treatment in either fee-for-service or managed care arrangements in accordance with section 1905(ee)(2) of the Act. Three states, Hawaii, South Dakota, and Wyoming, and four territories, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the US Virgin Islands, received exemptions.

Updates from CAA, 2024

Section 201 made the mandatory MOUD benefit at section 1905(a)(29) of the Act permanent by amending this section to remove the end date of "September 30, 2025." Section 201 also amended section 1905(ee)(2) of the Act to allow states to request an exemption from the mandatory coverage requirement due to a documented provider shortage if the state re-certifies *not less than every five years and to the satisfaction of the Secretary* that the provider shortage continues. The process to request an exemption will be conducted every five years and is the same as described in SHO #20-005.[7] The guidance in SHO #20-005 remains in effect except for the reference to the limited timeframe of this provision.

State Plan Amendment Option to Provide Medical Assistance for Certain Individuals Who are Patients in Certain Institutions for Mental Diseases

Background

In accordance with section 1915(l) of the Act, state Medicaid programs may cover services provided to Medicaid beneficiaries ages 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD. This state plan option was initially effective from October 1, 2019, through September 30, 2023.[8]

On November 6, 2019, CMS issued State Medicaid Director Letter #19-0003: Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(l) of the Act.[9] This guidance described the requirements under section 1915(l) of the Act, including that services are provided as part of a comprehensive continuum of care to treat SUD. An "eligible individual" is now defined in section 1915(l)(7)(A)[10] of the Act as an individual who with respect to a state, is enrolled for medical assistance under the state plan or a

[6] H.R.6 - SUPPORT for Patients and Communities Act: https://www.congress.gov/bill/115th-congress/house-bill/6
[7] SHO #20-005: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf
[8] Approval to provide services to Medicaid beneficiaries aged 21 to 64 who have at least one SUD diagnosis and reside in an eligible IMD does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's *Olmstead* decision.
[9] SMDL #19-0003: https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf
[10] This definition was previously in section 1915(l)(7)(B) of the Act. The CAA, 2024 renumbered this to 1915(l)(7)(A).

waiver of such plan, is at least 21 years of age, has not attained 65 years of age, and has at least one substance use disorder. The guidance stated that CMS interpreted section 1915(l)(7)(A)[11] of the Act implicitly to require that 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.

The language in section 1915(l)(7)(C)[12] of the Act now defines an IMD in accordance with the meaning given in section 1905(i) of the Act.[13] In addition, section 1915(l)(7)(B)[14] of the Act now defines an eligible IMD as an IMD that follows reliable, evidence-based practices and offers at least two forms of medications for the treatment of substance use disorders (SUDs) on site, including, in the case of MOUD, at least one FDA-approved antagonist and one partial agonist.[15] CMS clarifies that an IMD must make available at least two forms of medication as part of MOUD 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 MOUD.

Updates from CAA, 2024

Section 204 made the 1915(l) state plan option permanent by amending section 1915(l)(1) to remove the end date of "September 30, 2023." In addition, section 204 made the following changes to the section 1915(l) state plan option.

Updated Guidance for New 1915(l) State Plan Amendments (SPAs): Maintenance of Effort (MOE)

Section 204 amended section 1915(l)(3)(A) of the Act by removing "other than under this title from non-Federal funds" and the requirement for states to maintain or exceed the level of state and local funding for items and services furnished to eligible individuals who are patients in eligible IMDs. The MOE requirement at section 1915(l)(3)(A) on funding expended by the state from non-federal funds for items and services described in section 1915(l)(3)(B) that are furnished to eligible individuals in outpatient and community-based substance use disorder treatment settings still applies. However, it now also includes the state share of Medicaid expenditures, in addition to other state and local funding. Additionally, section 204 amended section 1915(l)(3)(A) to specify that the level of state and local funding that must be annually maintained or exceeded is based on, at state option, either the fiscal year 2018 or the most recently completed fiscal year as of the date the state submits a section 1915(l) SPA.

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[11] In the SMDL #19-0003, the interpretation of the definition was cited to 1915(l)(7)(B), as described above the definition has changed to 1915(l)(7)(A).

[12] This definition was previously in section 1915(l)(7)(D) of the Act. The CAA, 2024 renumbered this to 1915(l)(7)(CC).

[13] The term ''institution for mental diseases'' as defined in section 1905(i) of the Act, means 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.

[14] This definition was previously in section 1915(l)(7)(C) of the Act. The CAA, 2024 renumbered this to 1915(l)(7)(B).

[15] For more information about MOUD drugs, please see pages 2-3 of SHO #20-0005: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

CMS interprets this statutory change to mean that states must annually maintain or exceed the level of state and local funding, including the state share of Medicaid expenditures, on items and services described in section 1915(l)(3)(B) that are furnished to eligible individuals in outpatient, community-based settings. The level of state and local funding that must be annually maintained or exceeded is based on, at state option, either federal fiscal year 2018 or the most recently completed federal fiscal year as of the date on which the state submits a 1915(l) SPA.

These changes are effective March 9, 2024 (the date of enactment of the CAA, 2024).

Updated Guidance for States with Approved 1915(l) SPAs: Maintenance of Effort (MOE)

States with an existing SPA in effect on September 30, 2023, will need to comply with the MOE changes described above effective March 9, 2025. These states should continue to adhere to the MOE requirements described at the top of page 6 of the 2019 guidance, SMDL #19-0003[16] through March 8, 2025.

New Guidance: Placement Criteria and Utilization Management

Preexisting requirements in section 1915(l)(4)(B) of the Act required states to ensure that eligible individuals receive appropriate evidence-based clinical screenings prior to being furnished with items and services in an eligible IMD, including initial and periodic assessments to determine the appropriate level of care, length of stay, and setting for such care for each individual. Section 204 amended section 1915(l)(4)(B) to require states to have in place evidence-based, SUD-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care, including criteria and approaches to ensure the preexisting requirements described above are met.

This new requirement is effective October 1, 2025, and applies to both states with approved SPAs as well as states submitting new 1915(l) SPAs.

New Guidance: Review Process for Eligible IMDs

Section 204 added a new section 1915(l)(4)(E) that requires states have in place a process to review the compliance of eligible IMDs using nationally recognized SUD-specific program standards with such program standards specified by the state. This process should also include a review of eligible IMDs for compliance with the requirements in section 1915(l)(4)(D) related to care transitions and section 1915(l)(7)(B)(ii)[17] related to MOUD as specified on pages 4 and 5 of SMDL #19-0003[18] under the subheader titled "Eligible IMDs" and "Care Transitions."

This requirement is effective October 1, 2025, and applies to both states with approved SPAs as well as states submitting new 1915(l) SPAs.

[16] SMDL #19-0003: https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf
[17] This requirement was previously listed at section 1915(l)(7)(C) of the Act. The CAA, 2024 renumbered this to 1915(l)(7)(B)(ii).
[18] SMDL #19-0003: https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf

New Guidance: SUD Provider Assessment

Finally, section 204 added a new section 1915(l)(4)(F) requiring states, not later than 12 months after the approval of a SPA, to assess the availability of SUD treatment for beneficiaries at each level of care described at section 1915(l)(4)(C), including the availability of medication-assisted treatment with medically supervised withdrawal management services and how such availability varies by region of the state.

States submitting new section 1915(l) SPAs must commence the assessment within 12 months of SPA approval and complete it no later than 12 months after the start of the assessment. For states with a SPA approved as of September 30, 2023, the assessment must begin no later than March 9, 2025 (12 months after the date of enactment of the CAA, 2024), and be completed by March 9, 2026. This assessment will need to be provided to CMS upon request.

State Plan Amendments

States interested in the section 1915(l) state plan option are encouraged to contact CMS for technical assistance on developing a SPA.

Medicaid Managed Care and Medical Loss Ratio Remittances

Background

States may utilize risk-sharing mechanisms (sometimes referred to as "risk mitigation strategies") in Medicaid managed care programs to address uncertainty due to the risk-based nature of a managed care delivery system.[19] For example, some states choose to utilize a remittance requirement on a medical loss ratio (MLR) as a risk-sharing mechanism for the expansion population (that is, the group described in subclause (VIII) of section 1902(a)(10)(A)(i) of the Act) given the uncertainty in initial rate development.[20] Section 4001 of the SUPPORT Act amended section 1903(m) of the Act to permit states to keep a larger percentage of MLR remittances collected specific to the expansion population, an amount consistent with the federal matching rate applicable to the state's traditional Medicaid population (that is, the Federal medical assistance percentage that applies under section 1905(b) of the Act), for a limited period of time.[21] This provision (in effect for any fiscal year (FY) after FY 2020 and before FY 2024) temporarily allowed states to keep a larger percentage of remittances from managed care plans when they did not meet MLR requirements. On June 5, 2020, CMS issued Frequently Asked Questions (FAQs) on this SUPPORT Act provision.[22]

[19] In accordance with 42 CFR § 438.6(b)(1), all risk-sharing mechanisms must be documented in the contract and rate certification prior to the start of the rating period.

[20] In accordance with 42 CFR § 438.8(c), if a state elects to mandate a minimum MLR for a managed care plan, that minimum MLR must be equal to or higher than 85 percent.

[21] See section 1903(m)(9) of the Act.

[22] CMCS Informational Bulletin: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib060520_new.pdf

Updates from CAA, 2024

Section 211 eliminated the limited timeframe for states to keep a larger percentage of MLR remittances collected specific to the expansion population in section 1903(m)(9) of the Act and made this provision permanent beginning with FY 2024. The FAQs published on June 5, 2020, for section 4001 of the SUPPORT Act, remain in effect except for the reference to the limited timeframe of this provision, as section 211 made this flexibility permanent.

Conclusion

CMS is eager to work with states to continue coverage of MOUD and to facilitate the implementation of a section 1915(l) state plan option. CMS also encourages states to reach out with any questions on the enhanced match rate available for Medicaid MLR remittances for the expansion population. If you have any questions regarding this letter or would like to request technical assistance, please contact Kirsten Jensen, kirsten.jensen@cms.hhs.gov for Sections 201 and 204, and Rebecca Burch Mack, rebecca.burchmack@cms.hhs.gov for Section 211.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director