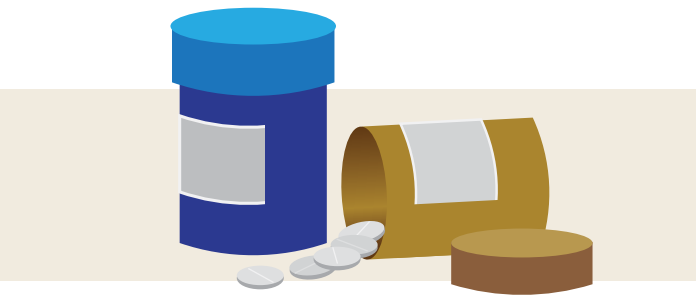
Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Consolidated Appropriations Act, 2024: Medicaid and CHIP Provisions Mental Health and Substance Use Disorder Provisions Explained

by Anne Dwyer

On March 9, 2024, President Biden signed into law the Consolidated Appropriations Act, 2024 (P.L. 118-42).[1] The Consolidated Appropriations Act, 2024 (CAA 2024) includes a number of Medicaid and Children's Health Insurance Program (CHIP) provisions related to mental health and substance use disorder (SUD) care and coverage including provisions extending and expanding policies from the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

This issue brief explains the Medicaid and CHIP mental health and SUD provisions of the CAA 2024. Among other provisions, the CAA 2024 permanently requires state Medicaid plans to provide coverage for certain medication-assisted treatment and related counseling services and therapy; implements new data collection and reporting requirements related to the treatment of SUD and mental health conditions; makes permanent the state plan option to cover services for certain individuals receiving treatment in institutions for mental diseases (IMDs); and mandates guidance related to improving the behavioral health workforce and integration of care with primary care under Medicaid and CHIP.



Provisions Explained in This Brief

1. SUPPORT Act Provisions Made Permanent and/or Modified
   - Requirement for State Medicaid Plans to Provide Medicaid Coverage for Medication-Assisted Treatment (MAT)
   - Collection and Reporting of Comprehensive Data for Specified Populations Enrolled in Medicaid and CHIP
   - Monitoring Prescribing of Antipsychotic Medication
   - Extension of State Option to Provide Medical Assistance for Certain Individuals in Institutions for Mental Diseases (IMDs)
2. Other Medicaid and CHIP Mental Health and SUD Provisions
   - Guidance Relating to Improving the Behavioral Health Workforce and Integration of Care under Medicaid and CHIP
   - Certified Community Behavioral Health Clinic (CCBHC) Services Under Medicaid
3. Related Medicaid and CHIP Provisions

1. SUPPORT Act Provisions Made Permanent and/or Modified

The bipartisan SUPPORT Act, which became law in October 2018, included a number of Medicaid and CHIP provisions related to coverage and services for individuals with SUDs and mental health conditions.[2] Some of the SUPPORT Act provisions were made permanent, such as the new requirement that state Medicaid programs must report annually on behavioral health quality measures of the adult core set and a requirement for state CHIP programs to include coverage of mental health services (including behavioral health).[3] But other provisions of the SUPPORT Act were temporary in nature and included sunset dates.[4] The CAA 2024 made permanent and/or further modified a number of these provisions, detailed below.

Requirement for State Medicaid Plans to Provide Medicaid Coverage for Medication-Assisted Treatment (MAT)

Under the SUPPORT Act, states were required to provide Medicaid coverage for all forms of FDA-approved drugs and biologics for medications to treat opioid use disorders, including related counseling services and behavioral therapy, for a period of five years (from October 1, 2020 until September 30, 2025). According to the Centers for Medicare & Medicaid Services (CMS), this could include counseling and therapy services such as individual and group therapy, peer support services, and crisis intervention services.[5] The provision also created an exception to the requirement for states that certified that implementation was infeasible statewide due to issues such as provider shortages, with approval of the Secretary of the Health and Human Services (HHS).

The CAA 2024 strikes the 2025 sunset date, making the requirement for state Medicaid programs to cover medication for opioid use disorders permanent. It also modifies the exception implementation language to require that states must certify an inability to comply with the requirement due to provider shortages at least every five years. According to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA), most states generally appear to reimburse for medications for the treatment of opioid use disorder, however documentation available to the public is often incomplete.[6]

Collection and Reporting of Comprehensive Data for Specified Populations Enrolled in Medicaid and CHIP

The SUPPORT Act required the Secretary of HHS to publish an annual public report with comprehensive data on the prevalence of SUDs and services provided for the treatment of SUDs in Medicaid for 2019 through 2024. The most recent report to Congress, "T-MSIS Substance Use Disorder (SUD) Data Book, Treatment of SUD in Medicaid, 2021," was released in December 2023 and includes state-by-state information on the number and percentage of individuals enrolled in Medicaid who have a SUD, treatment services provided by state Medicaid programs including by service type and setting, delivery system employed to provide SUD services by state Medicaid programs (i.e., managed care vs. fee-for-service), and other information.[7]

The CAA 2024 builds off of the SUPPORT data reporting requirement by including a new and permanent data-reporting provision. Importantly, it also expands the data reporting to include include mental health conditions along with SUDs, as well as CHIP data. Beginning in September 2025, and annually thereafter, the Secretary of HHS is required to link, analyze, and publish, on a publicly available website, data reported by states relating to SUD and mental health services provided to individuals enrolled in Medicaid or CHIP and diagnosed with a SUD or mental health condition, including data that is disaggregated by age. Specifically, among other information, the updated annual analysis under the CAA 2024 must include state-by-state information on individuals enrolled in Medicaid or CHIP including:

- The number and percentage of individuals in each major enrollment category who have been diagnosed with an SUD, mental health condition, or both.
- For individuals with a SUD and/or mental health diagnosis, a list of treatment services including, to the extent such data are available, specific adult and pediatric services, by each major service type and within each major setting type.

- The number and percentage of individuals by major enrollment category, who have a SUD or mental health diagnosis and receive treatment via a Medicaid managed care organization (MCO), fee-for-service, or an alternative payment model.
- The number and percentage of individuals with a SUD or mental health diagnosis that received services in an outpatient or community-based or home-based setting after receiving mental health or SUD services in an inpatient or residential setting.
- The number and percentage of inpatient admissions in which services for a SUD or mental health condition were provided to an individual that occurred within 30 days after discharge from a hospital or residential facility.
- The number of emergency department visits by an individual who has a SUD or mental health diagnosis and who within the last seven days was discharged from an inpatient stay at a hospital, mental health facility, residential treatment facility or other similar settings where they received SUD or mental health treatment.
- The number and percentage of individuals that received an assessment for a mental health condition or substance use disorders and the number of SUD or mental health services provided in the 30 days post-assessment.
- Information on prescription drugs dispensed to certain individuals with inpatient admissions or emergency department visits for SUD or mental health treatment after recent discharge from inpatient or residential settings.

The CAA 2024 requirement also includes a number of provisions to make the data research-friendly. By March 2027, and annually thereafter, the HHS Secretary, must publish a revised analysis that allows for a research-ready and publicly-accessible interface of the data based on input from stakeholders on the usability of the data. Finally, it appropriates $10 million for the Secretary to carry out the required activities.

Data tied to a diagnosis may under-represent children and youth.

Under the CAA 2024, report data is required to include a list of SUD and mental health services received by individuals enrolled in Medicaid or CHIP with a diagnosis, including, to the extent available, specific pediatric services by each major service, such as counseling, intensive home-based services, intensive care coordination, crisis services tailored to children and youth, peer support services, family-to-family support, inpatient hospitalization, medication-assisted treatment, residential treatment, and other services identified by the Secretary of HHS. However, as noted by the CMS, states can also determine that certain services may be deemed medically necessary for children and youth without a diagnosed behavioral health condition.[8] For example, states like California cover non-specialty mental health services such as individual, group, and family psychotherapy to individuals with potential mental health disorders that have not yet been diagnosed.[9] As a result, steps may need to be taken to ensure that children and youth who receive mental health services without a diagnosis are also represented in report data.[10]

Monitoring Prescribing of Antipsychotic Medication

The SUPPORT Act required state Medicaid programs to have in place a program to monitor and manage the appropriate use of antipsychotic medications among children, including foster youth specifically, beginning October 1, 2020. According to CMS' 2022 report on state fee-for-service drug utilization review (DUR) programs, all state fee-for-service DUR programs reported having such a program in place.[11] Yet based on reported responses from MCOs as part of their managed care DUR report, only 88% of Medicaid MCOs had a program in place for managing or monitoring appropriate use of antipsychotic drugs in children, suggesting more work is needed in states to ensure sufficient oversight of MCOs.[12] The CAA 2024 builds on the SUPPORT Act requirement to also include monitoring and managing antipsychotic medication for adults over the age of 18 receiving home and community-based services and residing in institutional care settings such as nursing homes or inpatient psychiatric hospitals, starting March 2026.

Extension of State Option to Provide Medical Assistance for Certain Individuals in Institutions for Mental Diseases (IMDs)

The Medicaid statute generally prohibits federal Medicaid dollars from funding services provided to certain individuals in IMDs with more than 16 beds, also referred to as Medicaid's "IMD exclusion."[13] The SUPPORT Act created a limited and temporary exception to the IMD exclusion by creating a 1915(l) Medicaid state plan option to provide high-quality and clinically-appropriate withdrawal management and SUD treatment services in residential and inpatient treatment facilities that qualify as an IMD for adults covered by Medicaid aged 21 through 65.[14] As part of the state plan option, states and providers were required to meet a number of requirements, including a state maintenance of effort requirement to maintain certain state funding support for services provided in IMDs and outpatient and community-settings. Eligible IMDs were also required to meet other coverage and services requirements including offering at least two forms of MAT on-site alongside behavioral health services. The 1915(l) state plan option was made available from October 1, 2019 until September 30, 2023 after which it sunset. As of September 2023, two states (South Dakota and Tennessee) had adopted the state plan option.[15]

The CAA 2024 provision makes the 1915(l) state plan option permanent and allows existing states to receive state plan amendment approval retroactive to October 1, 2023. It also makes a number of amendments to the state plan option. This includes changing the state maintenance of effort requirement to apply to all non-Federal funds, only apply to outpatient and community-based services, and provide states with additional flexibility on the base year. It also modifies certain condition definitions.

Starting October 2025, states seeking the 1915(l) IMD state plan option must also have evidence-based substance use disorder-specific individual placement criteria and utilization management approaches in place to ensure eligible individuals receive an appropriate level of care. In addition, states must use a process to review compliance of eligible IMDs with certain standards that employ nationally recognized SUD-specific program standards. Not later than 12 months after a state plan amendment approval (or by March 2025 for states with existing state plan amendments), the state must also assess the availability of treatment for individuals enrolled in Medicaid in each of the required levels of care across the care continuum as well as the availability of MAT and medically-supervised withdrawal management services. The assessment must be completed within 12 months.

2. Other Medicaid and CHIP Mental Health and SUD Provisions

In addition to provisions extending or expanding policies from the 2018 SUPPORT Act, the CAA also includes additional Medicaid and CHIP mental health and SUD provisions.

Guidance Relating to Improving the Behavioral Health Workforce and Integration of Care under Medicaid and CHIP

The CAA 2024 requires the Secretary of HHS to issue guidance to states on a number of topics related to improving the behavioral health workforce and integration of mental health or SUD care with primary care in Medicaid and CHIP. The guidance is required to be issued by March 2026. Among other requirements, the guidance to states must include:

1. Opportunities to increase access to mental health and SUD providers that participate in Medicaid or CHIP (with a focus on improving workforce capacity in rural and underserved areas) such as through education, training, recruitment and retention including best practices from states as well as opportunities to finance, support and expand the availability of providers of community-based mental health and SUD services including participation of paraprofessionals; and
2. Opportunities to promote the integration of mental health or SUD services with primary care services including an overview of state options for adopting and expanding value-based payment arrangements and alternative payment models, opportunities to leverage Medicaid to support integration including with respect to the use of electronic medical records in mental health care and SUD care settings, and examples of specific integration strategies and models (such as the collaborative care model or primary care behavioral health model for behavioral health integration) designed to support different age groups including children and youth and individuals over 65.

Certified Community Behavioral Health Clinic (CCBHC) Services Under Medicaid

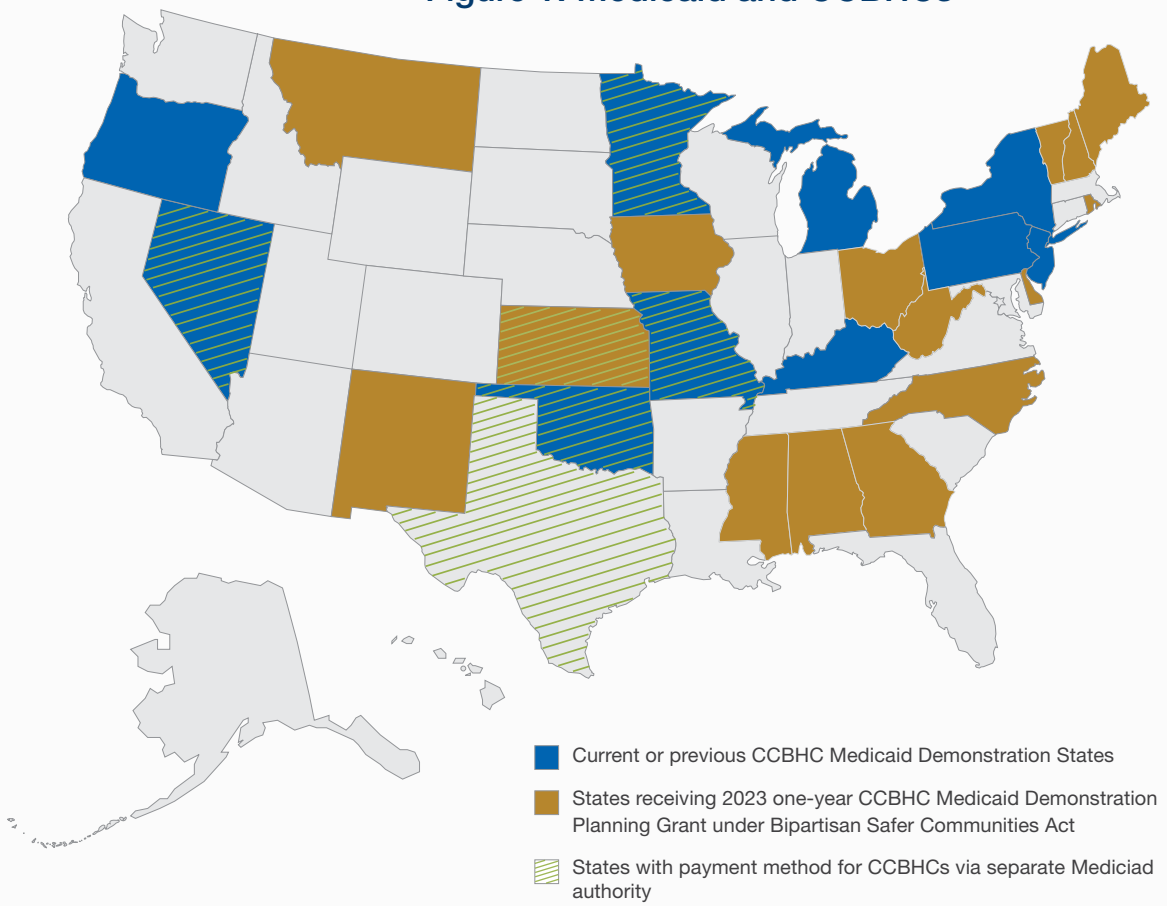
Under current law, a number of state Medicaid programs reimburse for services provided by certified community behavioral health clinics (CCBHCs) either via the Medicaid CCBHC Demonstration created under the Protecting Access to Medicare Act of 2014 (PAMA) and/or through existing Medicaid authorities such as a state plan amendment or section 1115 demonstrations.[16] The PAMA Medicaid CCBHC Demonstration program provides participating states with enhanced federal Medicaid matching funds (equivalent to a state's CHIP enhanced federal medical assistance percentage) for eligible CCBHC services provided to individuals covered by Medicaid. States participating in the CCBHC Demonstration are also required to establish prospective payment systems for Medicaid services delivered at CCBHCs and ensure CCBHCs meet federal standards such as providing 24-hour crisis services and routine outpatient care, ensuring that services for children and youth are family-centered, youth-guided, and developmentally appropriate, and serving anyone who requests care for mental health or substance use, regardless of their ability to pay.[17] States that reimburse for services delivered at CCBHCs outside of the CCBHC Demonstration continue to receive their regular federal Medicaid match for such services and have additional flexibility when it comes to reimbursement.

The CAA 2024 amends the Medicaid statute to formally define and add CCBHC services to the list of Medicaid-coverable categories of services. The definition includes a list of services—including screening and assessment, outpatient mental health and SUD services, crisis mental health services, intensive case management services, and peer support and counsel services and family support—provided at a CCBHC. The provision also defines a CCBHC as an organization certified by a state to meet certain criteria established by the Secretary of HHS under the PAMA CCBHC Demonstration program (regardless of whether a state is participating in the demonstration program), provides all listed services, and agrees to provide relevant data such as encounter or quality data to the state or Secretary of HHS.

CCBHC Medicaid Demonstration Planning Grants

The 2022 Bipartisan Safer Communities Act opened participation in the CCBHC Medicaid Demonstration to all interested states under a phased-in approach under which 10 new states will be allowed to participate in the four-year demonstration program every two years.[18] In March 2023, HHS announced that it awarded 15 states each with $1 million, one-year CCBHC planning grants in support of state efforts to join the Medicaid-funded CCBHC demonstration program.[19] Up to 10 of the 15 states that received planning grants will be chosen to participate in the CCBHC demonstration program and be eligible to receive enhanced federal Medicaid funding starting this summer.

Figure 1. Medicaid and CCBHCs



Source: U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, "Certified Community Behavioral Health Clinics (CCBHCs)," accessed May 2024, https://www.samhsa.gov/certified-community-behavioral-health-clinics.

3. Related Medicaid and CHIP Provisions

The CAA 2024 also includes a number of broader Medicaid and CHIP provisions that, while not specifically limited to mental health and SUD coverage or care, are related to the provision of such coverage or services. This includes:

- Requiring states to suspend rather than terminate Medicaid or CHIP coverage for individuals who are inmates of public institutions starting January 1, 2026. States are currently required to suspend rather than terminate Medicaid coverage for youth in juvenile settings (as required by the 2018 SUPPORT Act) and will be required to do the same for youth covered by CHIP starting in January 2025 (as required by the 2023 Consolidated Appropriations Act).[20] The CAA 2024 would extend this requirement to all individual covered by Medicaid and CHIP including pregnant individuals. According to SAMHSA, an estimated 44% of individuals in jail and 37% of those in prison have a mental illness compared to 18% of the general public.[21] And as noted by the Medicaid and CHIP Payment and Access Commission, suspending Medicaid coverage rather than terminating it allows individuals to more quickly gain coverage upon release.[22]
- Providing $113.5 million in funding to the Secretary of HHS to award and administer grants to states to develop operational capabilities to promote the continuity of care for individuals who are inmates of a public institution and are eligible for Medicaid or CHIP. HHS must award funds by March 2025.
- Requiring the Secretary of HHS to issue guidance to states on common implementation and operation challenges states face in ensuring access to high-quality, timely, accessible care before, during, and after incarceration for individuals covered by Medicaid and CHIP including best practices and strategies, by September 2025. The CAA 2024 provides $5 million in funding to the Secretary to carry out this requirement along with the mandated guidance on improving the behavioral health workforce and integration of care and updated requirements related to monitoring of prescribing of antipsychotic medications.
- Eliminating reductions to Medicaid disproportionate share hospital (DSH) payments for fiscal year 2024 and delaying existing fiscal year 2025 cuts to January 1, 2025. DSH payments are payments made by states to hospitals that serve a high proportion of individuals covered by Medicaid or uninsured patients (which may include payments to IMDs).[23] According to the Congressional Research Service, while most states focus their Medicaid DSH funding on hospitals, in fiscal year 2022, 30 states provided Medicaid DSH payments to IMDs including two states that spent all of their Medicaid DSH funding on IMDs.[24]

Timeline: CAA 2024 Medicaid and CHIP Mental Health and Substance Use Disorder Provisions

March 2024

- The CAA 2024 is signed into law.
- Makes permanent the SUPPORT Act's requirement for state Medicaid plans to provide coverage for medication-assisted treatment (MAT) to treat opioid use disorders and related counseling services and therapy.
- Makes permanent the SUPPORT Act's 1915(l) state plan option to provide medical assistance for certain individuals in institutions for mental diseases (IMDs), inlcuding some modifications and allowing existing states to receive approval retroactive to expiration.
- Amends the Medicaid statute to add certified community behavioral health clinic (CCBHC) services to the list of Medicaid-coverable categories of services and provide a definition of CCBHCs and CCBHC services within the statute.
- Eliminates reductions to Medicaid disproportionate share hospital (DSH) payments for fiscal year 2024 and delays existing fiscal year 2025 cuts to January 1, 2025.

March 2025

- By March 2025 (or not later than 12 months after approval of a state plan amendment), states with the IMD state plan option must commence an assessment of the availability of treatment for individuals enrolled in Medicaid in each of the required levels of care across the care continuum as well as the availability of MAT and medically supervised withdrawal management services and complete such assessment within 12 months.
- Date by which the Secretary of HHS is required to award and administer grants to states for the purpose of developing operational capabilities to promote the continuity of care for individuals who are inmates of a public institution and are eligible for Medicaid or CHIP.

September 2025

- The Secretary of HHS must start publishing annual reports with comprehensive data on SUD and mental health services provided to individuals enrolled in Medicaid or CHIP.
- The Secretary of HHS is required to issue guidance to states that addresses common implementation and operation challenges states face in ensuring access to high-quality, timely, accessible care before, during, and after incarceration for individuals covered by Medicaid and CHIP including best practices and strategies.

October 2025

- States with the IMD state plan option are required to have in place evidence-based SUD-specific individual placement criteria and utilization management approaches.

January 2026

- States are required to suspend rather than terminate Medicaid or CHIP coverage for individuals who are inmates of public institution.

March 2026

- States are required to have in place a program to monitor and manage the appropriate use of antipsychotic medications among individuals over the age of 18 receiving home and community-based services and residing in institutional care settings such as nursing homes or inpatient psychiatric hospitals.
- The Secretary of HHS is required to issue guidance to states on improving the behavioral health workforce and integration of care in Medicaid and CHIP.

March 2027

- The Secretary of HHS must publish a revised publication of the SUD and mental health data analysis that allows for a research-ready and publicly accessible interface.

Acknowledgements

This brief was written by Anne Dwyer of the Georgetown University Center for Children and Families. The author would like to thank Elisabeth Wright Burak, Edwin Park, Natalie Lawson, Hannah Green, and Cathy Hope for their contributions to the report. Design and layout provided by Nancy Magill.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center based at the McCourt School of Public Policy. CCF conducts research, analyzes data, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Endnotes

[1] For the statutory language of P.L. 118-42, see https://www.congress.gov/bill/118th-congress/house-bill/4366/text.

[2] SUPPORT for Patients and Communities Act, P.L. 115-271, available at https://www.congress.gov/bill/115th-congress/house-bill/6.

[3] Centers for Medicare & Medicaid Services, "Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program," March 2, 020, https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf.

[4] M. Musumeci and J. Tolbert, "Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act," Kaiser Family Foundation, October 2018, available at https://files.kff.org/attachment/Issue-Brief-Federal-Legislation-to-Address-the-Opioid-Crisis-Medicaid-Provisions-in-the-SUPPORT-Act#:~:text=The%20SUPPORT%20Act%20prohibits%20states,and%20restore%20coverage%20upon%20release (the requirement that state Medicaid programs report annually on the behavioral health quality measures of the adult core set was effective starting FY 2024).

[5] Centers for Medicare & Medicaid Services, "Mandatory Medicaid State Plan Coverage of MedicationAssisted Treatment," December 20, 2020, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf.

[6] Substance Abuse and Mental Health Services Administration, "Medicaid Coverage of Medications to Reverse Opioid Overdose and Treat Alcohol and Opioid Use Disorders," 2024, available at https://store.samhsa.gov/sites/default/files/medicaid-coverage-reverse-overdose-pep22-06-01-009.pdf (summarizing Medicaid coverage policies as of 2023 for medications used to treat alcohol and opioid use disorders or reverse opioid overdose in the 53 states and territories).

[7] U.S. Department of Health and Human Services, "Report to Congress: T-MSIS Substance Use Disorder (SUD) Data Book, Treatment of SUD in Medicaid, 2021," December 12, 2023, available at https://www.medicaid.gov/media/167756.

[8] Centers for Medicare & Medicaid Services, "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth," CMCS Informational Bulletin, August 18, 2022, available at https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.

[9] Ibid; and Medi-cal, "Non-Specialty Mental Health Services: Psychiatric and Psychological Services," November 2022, available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[10] E. Burak, "Medicaid Policies to Help Young Children Access Infant-Early Childhood Mental Health Services: Results from a 50-State Survey," Georgetown Center for Children and Families, June 9, 2023, available at https://ccf.georgetown.edu/2023/06/09/medicaid-policies-to-help-young-children-access-infant-early-childhood-mental-health-services-results-from-a-50-state-survey/. (Data on infant and early childhood health-realted services is key to ensuring access to high-quality mental health care for infants and young children. For example, data on rates of child social-emotional and parent depression screening and the provision of services, such as evidence-based dyadic treatment, can show the extent to which preventive care and treatment of young children are being used at expected levels, or the extent to which they appear to be under-used).

[11] Centers for Medicare & Medicaid Services, "National Medicaid Fee-For-Service (FFS) FFY 2022 Drug Utilization Review (DUR) Annual Report," accessed May 2024, available at https://www.medicaid.gov/media/171456.

[12] Centers for Medicare & Medicaid Services, "National Medicaid Managed Care Organization (MCO) FFY 2022 Drug Utilization Review (DUR) Annual Report," accessed May 2024, available at https://www.medicaid.gov/media/171796 (While some MCOs may not cover pediatric populations or have psychotropic drug benefits carved out of their managed care programs, this is an area of for continued oversight given that a majority of children in the US are enrolled in MCOs and that many states enroll Medicaid-covered foster care children and youth in managed care); Medicaid and CHIP Payment and Access Commission, "EXHIBIT 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2021," MACStats, December 30, 2023, available at https://www.macpac.gov/wp-content/uploads/2023/12/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2021.pdf; R. Keefe, A. Cummings, et al., "Psychotropic Medication Prescribing: Youth in Foster Care Compared with Other Medicaid Enrollees," J. Child Adolesc. Psychopharmacol.

33(4): 149-155, May 2023, available at https://pubmed.ncbi.nlm.nih.gov/37204275/l (According to a 2022 study analyzing Medicaid MCOs in Texas, about 8% of children on Medicaid who were not in foster care were prescribed psychotropic medications, in comparison to the 35% of those who were in foster care); and A. Schneider, A. Corcoran, and E. Hurler, "Transparency in Medicaid Managed Care for Children and Youth in Foster Care," October 2021, available at https://ccf.georgetown.edu/wp-content/uploads/2021/10/MCO-Foster-Care-v4.pdf.

[13] Congressional Research Service, "Medicaid's Institution for Mental Diseases (IMD) Exclusion," October 5,2023, available at https://crsreports.congress.gov/product/pdf/IF/IF10222.

[14] Centers for Medicare & Medicaid Services, "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 56, 2019, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf.

[15] Congressional Research Service, "Expiration of 1915(l) Medicaid State Plan Option," August 3, 2023, available at https://crsreports.congress.gov/product/pdf/IN/IN12212; and KFF, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," April 23, 2024, available at https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ (The majority of states employ seperate section 1115 demonstrations to provide SUD services in IMDs rather than SUPPORT Act state plan option. As of April 23, 2024, 37 states had approved section 1115 demonstrations with waiver provisions to receive federal financial participation for SUD treatment provided in IMDs).

[16] For the statutory language of the Protecting Access to Medicare Act of 2014, P.L. 113-93, see https://www.congress.gov/bill/113th-congress/house-bill/4302; and Anne Dwyer, "The Bipartisan Safer Communities Act: Where Things Stand on the Medicaid and CHIP Provisions," August 2023 available at https://ccf.georgetown.edu/wp-content/uploads/2023/08/Safer-Communities-8-23.pdf.

[17] Substance Abuse and Mental Health Services Administration, "Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria," March 2023, available at https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[18] For the statutory language of the Bipartisan Safer Communities Act, P.L. 117-159, see https://www.congress.gov/bill/117th-congress/senate-bill/2938/text.

[19] U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, "HHS awards CCBHC Planning Grants to 15 States to Help Address Ongoing Mental Health Crisis," March 16, 2023, available at https://www.samhsa.gov/newsroom/press-announcements/20230316/hhs-awards-ccbhc-planning-grants-15-states-address-ongoing-mental-health-crisis.

[20] Ibid supra note 2; Consolidated Appropriations Act 2023, P.L. 117-328, available at https://www.congress.gov/bill/117th-congress/house-bill/2617/text; Centers for Medicare & Medicaid Services, "RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act)," January 18, 2021, available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf; and E. Park, A. Dwyer, et al., "Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained," January 5, 2023, available at https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

[21] Substance Abuse and Mental Health Administration, "About Criminal and Juvenile Justice, accessed May 2024, available at https://www.samhsa.gov/criminal-juvenile-justice/about#:~:text=People%20with%20mental%20and%20substance,(PDF%20%7C%20670%20KB).

[22] Medicaid and CHIP Payment and Access Commission, "Medicaid and the Criminal Justice System " Issue Brief, July 2018, available at https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf#:~:text=Most%20states%20suspend%20rather%20than%20terminate%20Medicaid%20benefits,agencies%20to%20bill%20Medicaid%20for%20allowable%20inpatient%20expenses.

[23] Medicaid and CHIP Access Commission, "Payment for services in institutions for mental diseases (IMDs)," accessed May 2024, https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/.

[24] Ibid supra note 13.