PLAN A

An Act Addressing the American Addiction Crisis

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EXECUTIVE SUMMARY

Objective: Amend select federal laws to address the alarming rise in substance use disorders (SUDs) and related deaths across the U.S. by encouraging investment in the construction of SUD treatment facilities and programs, expanding coverage for treatment, improving access to evidence-based quality care, and eliminating disparities in coverage of medical/surgical services versus mental health/SUD treatment services.

Laws Encouraging Investment in SUD Treatment Facilities

New Markets Tax Credit Program

Summary of Current Law

The New Markets Tax Credit Program (NMTC) permits individual and corporate taxpayers to receive a credit against federal income taxes for making qualified equity investments (QEIs) in qualified community development entities (CDEs), which have a primary mission of serving or providing investment capital for low-income communities. The purpose of the tax credit is to create jobs and materially improve the lives of residents in low-income communities.

Using the funds raised from QEIs, CDEs make qualified low-income community investments (QLICIs) in qualified active low-income community businesses (QLICBs). QLICIs typically take the form of loans, but may also be in the form of equity investments. Each year, the Secretary of the Treasury declares a certain amount of tax credits available for allocation among CDEs and their investors, and allocates those credits to CDEs pursuant to an application review process that takes into account the types of investments in which the CDE proposes to invest and the locations of those investments.

PLAN A Amendments

Provide for tax credits under the NMTC Program for investors in CDEs whose primary missions include investing in residential SUD treatment facilities and/or outpatient SUD treatment programs in SUD treatment needs areas (defined in the same manner as under the PLAN A EB-5 amendments). Mirror the existing structure that allows CDEs to make QLICIs in QLICBs by

permitting CDEs to make "qualified substance use disorder treatment needs area investments" (QSTNAIs) in "qualified active substance use disorder treatment businesses" (QASTBs).

To further encourage investment in QASTBs, provide for favorable treatment (i.e., scoring bonuses) in the tax credit allocation process to CDEs that commit in their applications to making QSTNAIs. Specifically, provide for a "priority" bonus and a bonus for investing in an SUD treatment needs area, which will be deemed as an area in "severe distress."

EB-5 Program

Summary of Current Law

The EB-5 Program currently provides a foreign investor (and his/her spouse and unmarried children under age 21) with the opportunity to apply for permanent residency in the United States if the foreign investor makes a qualifying investment in a new commercial enterprise in the United States (among other investor-specific criteria). For the foreign investor's investment to qualify under the EB-5 Program, the amount of the investment must be at least $500,000 in a **targeted employment area** (i.e., a high unemployment or rural area) or $1,000,000 in a non-targeted employment area, and the investment must be in a new for-profit commercial enterprise that creates full-time positions for at least 10 qualifying employees.

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Include a "substance use disorder treatment needs area" within the definition of a "targeted employment area", such that a targeted employment area will include (1) a high unemployment area, (2) a rural area, and/or (3) a SUD treatment needs area.

Define a "substance use disorder treatment needs area" as "a county in which the rate of overdose deaths involving opioids, as reported by the U.S. Centers for Disease Control and Prevention, was greater than 10 individuals per 100,000 population during the most recently reported one-year period, as well as a 90-mile radius around such county."

Limit a qualifying investment in a SUD treatment needs area to an investment that (1) meets the minimum dollar threshold for a targeted employment area, and (2) is in a new commercial enterprise that owns and operates a residential SUD treatment facility or outpatient SUD treatment program located within a SUD treatment needs area.

Provide for expedited review of visa applications (Form I-526) for an immigrant investor in a residential SUD treatment facility or outpatient SUD treatment program located within a SUD treatment needs area.

Laws Expanding Coverage and Improving Access to Evidence-Based, High Quality SUD Treatment Services

All amendments to laws in this section include comprehensive definitions of SUD treatment services and SUD treatment facilities and programs to ensure that established treatment methods and standards are covered under applicable payor sources and patients receive the quality and levels of care necessary to give them the best chance at recovery.

Medicaid

Summary of Current Law

Medicaid is a joint federal and state health care program that has certain minimum and optional coverage requirements. Each State adopts its own State Medicaid Plan with the approval of CMS that must include minimum benefits set forth under federal law and may include optional benefits set forth under federal law. Federal financial participation (FFP) funds paid to the State cover part of the cost of benefits included in the State Medicaid Plan. The State reimburses participating providers by way of fee-for-service (FFS) payments made by the State Medicaid Agency, or through contracted managed care organizations (MCOs), which receive monthly capitated payments from the State for all enrolled Medicaid beneficiaries.

FFP may be used by the State to cover inpatient SUD treatment services provided to beneficiaries 65 and over and under 21 years of age rendered in **inpatient psychiatric hospitals** and **institutions that qualify as "institutions for mental diseases" (IMDs) (i.e., institutions having 17 or more beds)**. FFP may also be used by the State to cover inpatient SUD treatment services for beneficiaries between the ages of 21-64 in inpatient psychiatric units of general hospitals. However, FFP has not been directly available for inpatient SUD treatment services rendered to a beneficiary between the ages of 21-64 in a residential SUD treatment facility. The exclusion of beneficiaries aged 21-64 from accessing these services is known as the "IMD Exclusion". Certain states circumvented the IMD Exclusion through the use of an exception for MCOs to provide "in lieu of" services (i.e., services provided in lieu of services covered under the State Medicaid Plan that are eligible for FFP). However, pursuant to recent regulatory guidance issued by CMS, as of July 1, 2017, MCOs are no longer permitted to use FFP funds for residential SUD treatment services for beneficiaries aged 21-64 unless the beneficiary resides in the IMD for less than 16 days during a calendar month.

FFP is also available for certain outpatient SUD treatment services rendered to beneficiaries in the outpatient hospital setting or in outpatient clinics under the supervision of a physician, without age limitations.

The MCOs have discretion to use FFP funds to provide additional supplemental SUD treatment services to Medicaid beneficiaries, but these services may vary from plan to plan.

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Require states to cover residential and outpatient SUD treatment services for all age groups under each State Medicaid Plan, including coverage during certain minimum periods in which the beneficiary's treating physician determines that such services are medically necessary (the "Plan A Minimum Periods"). Clarify that a residential SUD treatment facility is not included in the definition of an IMD.

Medicare

Summary of Current Law

Medicare only covers inpatient and outpatient SUD treatment services provided in **inpatient psychiatric hospitals** and **community mental health centers**. Medicare beneficiaries must be aged 65 or over, have a qualifying disability, or be diagnosed with End-Stage Renal Disease.

PLAN A Amendments

Provide coverage under Medicare for residential and outpatient SUD treatment services provided by accredited and licensed SUD treatment facilities that meet specific standards. Require Medicare to reimburse SUD treatment facilities for such services when furnished during the Plan A Minimum Periods during a spell of illness, provided that the beneficiary's treating physician determines that the services are medically reasonable and necessary.

These amendments will require creation of a new Medicare Part A provider type and a new Medicare Part B supplier type, including establishment of conditions of participation and reimbursement rates in regulation.

Veterans' Benefits

Summary of Current Law

The Department of Veterans Affairs ("VA Department") may contract with civilian residential facilities and outpatient programs to provide inpatient and outpatient drug and alcohol rehabilitation treatment services for veterans under the Veterans' Choice Program or the Patient-Centered Community Care Program. VA Medical Centers may also contract directly with civilian residential facilities and outpatient programs for such services. Currently, most contracting for such services is done through the Veterans' Choice Program, due to it being the most flexible and effective program to date designed to provide veterans with the opportunity to seek care from civilian providers.

Under the Veterans' Choice Program, a veteran may be eligible to receive SUD treatment or any other treatment from a civilian provider under contract with the VA Department (or one of its

third-party administrators) following authorization by the VA Department for such treatment, provided that such veteran is enrolled in the general VA health care system and meets one of the following criteria: (1) the veteran lives 40 miles' driving distance or farther from a VA facility with a full-time primary care physician;[1] or (2) the veteran is informed by a local VA facility that an appointment cannot be scheduled for the veteran within 30 days of the clinically determined date requested by such veteran's VA doctor or within 30 days of the date requested by the veteran, and the local VA facility cannot refer the veteran to another VA medical facility or other federal facility able to provide such treatment within the 30-day time period (taking into consideration the unique circumstances of the veteran, such as extreme travel distance to the referred facility or the need for frequent visits).

If a veteran meets the eligibility criteria set forth above, the veteran must obtain verification of such eligibility and an initial prior authorization from the local VA facility to receive the requested treatment from a civilian provider under contract with the VA Department or one of its third-party administrators. The initial prior authorization for such services will last through the necessary course of treatment (also called an "episode of care"), which cannot last longer than one (1) year. A veteran who wishes to receive treatment that falls outside of the scope of the initial prior authorization must request an additional authorization prior to receiving such care from a civilian provider. Prior authorizations typically take up to 10 business days to be approved by the local VA facility, although there is an urgent review process that can result in an authorization in as early as 48 hours. Generally, emergency services provided to a veteran by a non-VA facility without prior authorization are covered only until the veteran is stable enough to travel to a VA facility (with certain exceptions).

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Modify the current eligibility and prior authorization requirements under all VA benefits programs (including the Veterans' Choice Program) with respect to SUD treatment services, so that the VA Department or its contracted third-party administrator must cover SUD treatment services furnished by a residential or outpatient SUD treatment facility to a veteran who (1) lives more than 40 miles' driving distance from a VA facility, (2) has waited more than 24 hours to receive a SUD assessment by a VA facility, or (3) following an SUD assessment and determination by the VA facility that SUD treatment services are medically necessary, the veteran is not immediately admitted to a VA facility for SUD treatment services.

Eliminate the initial prior authorization requirement for a veteran meeting either the distance or wait-time criterion, and require the VA Department to reimburse SUD treatment facilities for such services during the Plan A Minimum Periods, provided that the veteran's treating physician determines that such services are medically necessary. These services will include emergency services provided at a non-VA facility.

As the Veterans' Choice Program is set to expire when funds are depleted (which is estimated to be at the end of 2017) and may be replaced or reformed, a global amendment would be most effective and permanent. To achieve this goal, one statute specifically relating to the treatment of

[1] There are also exceptions for distances that are less than 40 miles if certain geographic hurdles (such as requiring other types of travel or being in a state without a VA facility) apply.

drug and alcohol dependency among all VA benefits programs has been selected for these amendments.

Active Duty Benefits

Summary of Current Law

Active duty members and veterans of the armed forces, as well as their dependents, may receive health care benefits in a military medical treatment facility through the medical care system for uniformed services. Supplemental programs are offered through the CHAMPUS Basic Program and Supplemental Health Care Program, which cover services obtained from civilian sources outside of the TRICARE Program, and the TRICARE Program, which implements a managed health care program for the delivery of health care services under three general programs: TRICARE Standard (which provides the same benefits as the CHAMPUS Basic Program, and has the highest cost-sharing requirements for beneficiaries); TRICARE Extra (a PPO providing certain additional benefits and having lower cost-sharing requirements for beneficiaries); and TRICARE Prime (an HMO providing certain additional benefits and having the lowest cost-sharing requirements for beneficiaries). Additional plans related to TRICARE Prime exist for certain situations (such as where the active duty service member lives outside a 40-mile radius of a military medical treatment facility or is a member of a military reserve group). All active duty service members must be enrolled with TRICARE Prime or a related plan.

On January 1, 2018, TRICARE Standard and TRICARE Extra will consolidate into one PPO plan called "TRICARE Select".

Generally, CHAMPUS and TRICARE cover residential and outpatient SUD treatment services, with the exception that residential SUD treatment facilities are not permitted to provide emergency SUD treatment services. Until 2013, a CHAMPUS or TRICARE Standard beneficiary was required to obtain a "non-availability statement" from a local military treatment facility to receive residential SUD treatment services if the beneficiary was located within a 40-mile radius of the military treatment facility. Non-availability statements are no longer required for residential SUD treatment services. However, under TRICARE Prime, active duty service members and their dependents must go to a military medical treatment facility for services (including SUD treatment services) prior to receiving covered services from a civilian provider. Additionally, pre-authorization requirements exist for SUD treatment services under all CHAMPUS and TRICARE plans, except under very limited circumstances.

PLAN A Amendments

Require all CHAMPUS and TRICARE Programs to cover residential and outpatient SUD treatment services as defined by the amendments (including emergency services furnished in a residential SUD treatment facility). Eliminate all pre-authorization requirements during the Plan A Minimum Periods where the beneficiary's treating physician has determined that SUD treatment services are medically necessary.

Eliminate any requirement for a beneficiary to seek SUD treatment at a military medical treatment facility prior to seeking treatment from a civilian provider. Active duty service members will be permitted to seek SUD treatment from a civilian provider only where certain distance and wait time criteria are met. Specifically, an active duty service member who (1) lives 40 miles' driving distance or farther from a military medical treatment facility, (2) has waited more than 24 hours for a SUD assessment from the member's local military medical treatment facility, or (3) has not been immediately admitted for SUD treatment following a SUD assessment.

As there are many statutes applicable to the CHAMPUS and TRICARE Programs, we believe that a global amendment would be most effective. To achieve this goal, a statute relating to the treatment of drug and alcohol dependency among active duty service members has been selected for these amendments. This statute currently has only one provision, requiring the Secretaries of Defense and Homeland Security to provide necessary facilities to identify, treat and rehabilitate members of the armed services who are dependent on drugs and alcohol.

Federal Employees Health Benefits Program

Summary of Current Law

The Federal Employee Health Benefits Program (FEHBP) contracts with health insurance issuers or group health plans to arrange for the delivery of health care to federal employees. The Federal Employee Health Benefits Act (FEHBA) and its related regulations provide broad requirements for the benefits plans that may be offered by contracted insurance issuers or group health plans, and do not expressly address inpatient or outpatient SUD treatment services. However, Congress noted in the FEHBA that participants in the FEHBP should receive adequate coverage for treatment of "mental illness, alcoholism and drug addiction". Congress further stated that the Office of Personnel Management (OPM), the administrator of the FEHBP, "should encourage participating health benefits plans to provide adequate benefits" relating to such treatment, including coverage for inpatient and outpatient treatment and "catastrophic protection benefits". Notwithstanding this encouragement by Congress, the OPM has not issued any regulations specifically addressing treatment services for mental illness, alcoholism or drug addiction. However, the OPM has voluntarily required that FEBHP plans comply with the parity requirements of the MHPAEA.

PLAN A Amendments

Require that residential and outpatient SUD treatment services are covered benefits under all plans. Also, require all plans to defer to the treating physician's determination of the medical necessity of SUD treatment services for a beneficiary during the Plan A Minimum Periods.

Patient Protections under the Public Health Service Act

Summary of Current Law

The Patient Protection and Affordable Care Act (ACA) amended the Public Health Service Act (PHSA) to include protections for enrollees in individual and group health plans or health insurance coverages subject to the ACA who require services for emergency conditions and obtain such services from out-of-network hospital facilities. The PHSA requires the group health plan or insurance issuer to cover the emergency services without the need for a prior authorization, without regard to whether the provider furnishing the services is in or out of the plan or issuer's provider network, and at a patient cost-sharing amount that would be required for use of an in-network provider.

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Redefine "emergency medical condition" to include symptoms of acute intoxication and/or substance use withdrawal symptoms or potential. Redefine "emergency services" to include those rendered by a residential SUD treatment facility accredited and licensed to provide medically-monitored intensive inpatient services.

Laws Eliminating Disparities in Coverage of Medical/Surgical versus Mental Health/SUD Treatment Benefits

Mental Health Parity and Addiction Equity Act

Summary of Current Law

The Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the 21st Century Cures Act, requires a group health plan or health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or SUD benefits to ensure that the financial requirements and treatment limitations applicable to such mental health or SUD benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical and surgical (med/surg) benefits covered by the plan or coverage, and that there are no separate financial requirements or treatment limitations that are applicable only with respect to mental health or SUD benefits. Treatment limitations are defined to include limits on the frequency of treatment, number of visits, days of coverage, or other similar scope or duration limits. As amended by the 21st Century Cures Act, the MHPAEA also requires the Secretaries of the agencies charged with implementation of the MHPAEA (Labor, Health and Human Services, and Treasury) to issue guidance to plans and issuers to assist with MHPAEA compliance, particularly with respect to nonquantitave treatment limitations (NQTLs), examples of which are included in the MHPAEA. QTLs are limitations such as outpatient visit limits and inpatient day limits, and NQTLs are comprised of limitations such as

prior authorization or fail-first requirements, among others. The majority of current violations of the MHPAEA fall in the realm of NQTLs.

The MHPAEA defines the terms "mental health benefits", "SUD benefits", and "medical or surgical benefits" by reference to the "terms of the plan or coverage" and, with respect to mental health benefits and SUD benefits, "in accordance with applicable Federal and State law".

The MHPAEA applies to group health plans and health insurers offering group or individual coverage, and includes Medicaid MCOs and health insurance issuers and health plans administering the FEHBP. However, the MHPAEA does not apply to Medicare, Medicaid fee-for-service enrollees CHAMPUS or TRICARE directly. The MHPAEA does apply to Medicaid managed care organizations (MCOs) and alternative benefit plans (ABPs) contracted with State Medicaid agencies to provide coverage to Medicaid beneficiaries. The MHPAEA also applies to all CHIP enrollees.

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The amendments require health plans and issuers to perform and document comparative analyses of how they design and apply mental health and SUD benefit NQTLs and how they design and apply medical and surgical benefit NQTLs. The amendments also provide a precise six-step process that health plans and issuers must follow in performing and documenting the analyses.

These amendments will provide group health plans and insurance issuers with a uniform documentation and reporting process, increasing compliance efficiency and effectiveness and reducing administrative burden. Health plans and issuers must submit these analyses to the appropriate state or federal regulatory agency immediately upon request beginning July 1, 2018, and must provide documentation for the prior 4 years, effective July 1, 2022. Any plan or issuer that fails to submit the analyses will be deemed non-compliant and subject to civil monetary penalties (described below) for violation of the MHPAEA.

The amendments revise the definitions of "mental health disorder benefits" and "SUD benefits" to mean benefits for any condition identified in generally recognized independent standards of current medical practice, such as those listed in the DSM or ICD, as well as under applicable State law.

Finally, these amendments provide that the Secretaries and State attorneys general may impose civil monetary penalties pursuant to 42 U.S.C. § 1320d-5 on any group health plan or health insurance issuer subject to the MHPAEA for a violation of the MHPAEA.

Note: Comparable amendments to the attached amendments to the MHPAEA (at 42 U.S.C. § 300gg-26) will also be made to ERISA (at 29 U.S.C. § 1185a) and the Internal Revenue Code (at 26 U.S.C. § 9812).

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PROPOSED AMENDMENTS

Laws Encouraging Investment in SUD Treatment Facilities

New Markets Tax Credit Program (26 U.S.C. § 45D)

(a) Allowance of credit.—

(1) In general.--For purposes of section 38, in the case of a taxpayer who holds a qualified equity investment on a credit allowance date of such investment which occurs during the taxable year, the new markets tax credit determined under this section for such taxable year is an amount equal to the applicable percentage of the amount paid to the qualified community development entity for such investment at its original issue.

(2) Applicable percentage.--For purposes of paragraph (1), the applicable percentage is—

(A) 5 percent with respect to the first 3 credit allowance dates, and

(B) 6 percent with respect to the remainder of the credit allowance dates.

(3) Credit allowance date.--For purposes of paragraph (1), the term "credit allowance date" means, with respect to any qualified equity investment—

(A) the date on which such investment is initially made, and

(B) each of the 6 anniversary dates of such date thereafter.

(b) Qualified equity investment.--For purposes of this section—

(1) In general.--The term "qualified equity investment" means any equity investment in a qualified community development entity if—

(A) such investment is acquired by the taxpayer at its original issue (directly or through an underwriter) solely in exchange for cash,

(B) substantially all of such cash is used by the qualified community development entity to make qualified low-income community investments or qualified substance use disorder treatment needs area investments, and

(C) such investment is designated for purposes of this section by the qualified community development entity.

Such term shall not include any equity investment issued by a qualified community development entity more than 5 years after the date that such entity receives an allocation under subsection (h~~f~~). Any allocation not used within such 5-year period may be reallocated by the Secretary under subsection (h~~f~~).

(2) Limitation.--The maximum amount of equity investments issued by a qualified community development entity which may be designated under paragraph (1)(C) by such entity shall not exceed the portion of the limitation amount allocated under subsection (h~~f~~) to such entity.

(3) Safe harbor for determining use of cash.--The requirement of paragraph (1)(B) shall be treated as met if at least 85 percent of the aggregate gross assets of the qualified community development entity are invested in qualified low-income community investments or qualified substance use disorder treatment needs area investments, or both.

(4) Treatment of subsequent purchasers.--The term "qualified equity investment" includes any equity investment which would (but for paragraph (1)(A)) be a qualified equity investment in the hands of the taxpayer if such investment was a qualified equity investment in the hands of a prior holder.

(5) Redemptions.--A rule similar to the rule of section 1202(c)(3) shall apply for purposes of this subsection.

(6) Equity investment.--The term "equity investment" means—

(A) any stock (other than nonqualified preferred stock as defined in section 351(g)(2)) in an entity which is a corporation, and

(B) any capital interest in an entity which is a partnership.

(c) Qualified community development entity.--For purposes of this section—

(1) In general.--The term "qualified community development entity" means any domestic corporation or partnership if—

(A) the primary mission of the entity is serving, or providing investment capital for, low-income communities ~~or~~, low-income persons~~,~~ and/or substance use disorder treatment needs areas,

(B) the entity maintains accountability to residents of low-income communities and/or substance use disorder treatment needs areas, as applicable, through their representation on any governing board of the entity or on any advisory board to the entity, and

(C) the entity is certified by the Secretary for purposes of this section as being a qualified community development entity.

(2) Special rules for certain organizations.--The requirements of paragraph (1) shall be treated as met by—

(A) any specialized small business investment company (as defined in section 1044(c)(3)), and

(B) any community development financial institution (as defined in section 103 of the Community Development Banking and Financial Institutions Act of 1994 (12 U.S.C. 4702)).

(d) Qualified low-income community investments.--For purposes of this section—

(1) In general.--The term "qualified low-income community investment" means—

(A) any capital or equity investment in, or loan to, any qualified active low-income community business,

(B) the purchase from another qualified community development entity of any loan made by such entity which is a qualified low-income community investment,

(C) financial counseling and other services specified in regulations prescribed by the Secretary to businesses located in, and residents of, low- income communities, and

(D) any equity investment in, or loan to, any qualified community development entity for a qualified low-income community investment.

(2) Qualified active low-income community business.—

(A) In general.--For purposes of paragraph (1), the term "qualified active low-income community business" means, with respect to any taxable year, any corporation (including a nonprofit corporation) or partnership if for such year—

(i) at least 50 percent of the total gross income of such entity is derived from the active conduct of a qualified business within any low-income community,

(ii) a substantial portion of the use of the tangible property of such entity (whether owned or leased) is within any low-income community,

(iii) a substantial portion of the services performed for such entity by its employees are performed in any low-income community,

(iv) less than 5 percent of the average of the aggregate unadjusted bases of the property of such entity is attributable to collectibles (as defined in section 408(m)(2)) other than

collectibles that are held primarily for sale to customers in the ordinary course of such business, and

(v) less than 5 percent of the average of the aggregate unadjusted bases of the property of such entity is attributable to nonqualified financial property (as defined in section 1397C(e)).

(B) Proprietorship.--Such term shall include any business carried on by an individual as a proprietor if such business would meet the requirements of subparagraph (A) were it incorporated.

(C) Portions of business may be qualified active low-income community business.--The term "qualified active low-income community business" includes any trades or businesses which would qualify as a qualified active low-income community business if such trades or businesses were separately incorporated.

(3) Qualified business.--For purposes of this subsection, the term "qualified business" has the meaning given to such term by section 1397C(d); except that—

(A) in lieu of applying paragraph (2)(B) thereof, the rental to others of real property located in any low-income community shall be treated as a qualified business if there are substantial improvements located on such property, and

(B) paragraph (3) thereof shall not apply.

(e) Qualified substance use disorder treatment needs area investments.--For purposes of this section—

(1) In general.--The term "qualified substance use disorder treatment needs area investment" means--

(A) any capital or equity investment in, or loan to, any qualified active substance use disorder treatment business,

(B) the purchase from another qualified community development entity of any loan made by such entity which is a qualified substance use disorder treatment needs area investment,

(C) any equity investment in, or loan to, any qualified community development entity for a qualified substance use disorder treatment needs area investment.

(2) Qualified active substance use disorder treatment business.--

(A) In general.--For purposes of paragraph (1), the term "qualified active substance use disorder treatment business" means, with respect to any taxable year, any corporation (including a nonprofit corporation) or partnership if for such year—

(i) at least 50 percent of the total gross income of such entity is derived from the active conduct of a residential substance use disorder treatment facility or an outpatient substance use disorder treatment program located within any substance use disorder treatment needs area,

(ii) a substantial portion of the use of the tangible property of such entity (whether owned or leased) is within any substance use disorder treatment needs area,

(iii) a substantial portion of the services performed for such entity by its employees are performed in any substance use disorder treatment needs area,

(B) Residential substance use disorder treatment facility and outpatient substance use disorder treatment program. —

(i) For purposes of subparagraph (2)(A), the term "residential substance use disorder treatment facility" means a non-hospital facility that –

(I) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in subparagraph (2)(B)(v)(III));

(II) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(III) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in subparagraph (2)(B)(v)(III)).

(ii) For purposes of subparagraph (2)(A), the term "outpatient substance use disorder treatment program" means a non-hospital program that is either –

(I) a structured sober living facility; or

(II) any other facility or program that:

(aa) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in subparagraph (2)(B) (vi)(III));

(bb) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(cc) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in subparagraph (2)(B)(vi)(III)).

(iii) For purposes of subparagraph (2)(B), the term "structured sober living facility" means a non-hospital facility or program that –

(I) furnishes structured sober living services (as described in subparagraph (2)(B)(vi)(I)) under 24-hour supervision of trained counselors and medical staff;

(II) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(**III**) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in subparagraph (2)(B)(vi)(I)).

(iv) For purposes of subparagraph (2)(B), the term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(v) For purposes of subparagraph (2)(B), the term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the individual's treating physician and multi-disciplinary team:

(I) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(II) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(aa) detoxification and withdrawal management services;

(bb) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(B)(v)(II)(aa) and (bb);

(III) clinically-managed high intensity residential services, which shall include, at

a minimum, the following:

(aa) detoxification and withdrawal management services;

(bb) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the individual and preparation of the individual for lower intensity outpatient substance use disorder treatment services; and

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(B)(v)(III)(aa) and (bb); and

(IV) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the individual's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(vi) For purposes of subparagraph (2)(B), the term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the individual's treating physician and multi-disciplinary team:

(I) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(aa) medium to high intensity rehabilitative services provided for 20 hours or more per week to a individual requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(bb) medium intensity rehabilitative services provided for 9 hours or more per week to a individual requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(B)(vi)(I)(aa) and (bb); and

(dd) direct access to medical services;

(II) partial hospitalization services, which shall include, at a minimum, the

following:

(aa) medium to high intensity rehabilitative services provided for 20 hours or more per week to a individual requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (2)(B)(vi)(II)(aa) and (bb); and

(cc) direct access to medical services;

(III) intensive outpatient treatment services, which shall include, at a minimum, the following:

(aa) medium intensity rehabilitative services provided for 9 hours or more per week to a individual requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (2)(B)(vi)(III)(aa); and

(cc) direct access to medical services;

(IV) outpatient services, which shall include, at a minimum, the following:

(aa) low intensity rehabilitative services provided for less than 9 hours per week to a individual requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (2)(B)(vi)(IV)(aa); and

(cc) access to medical services; and

(V) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the individual's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(vii) For purposes of subparagraph (2)(B), "medication-assisted treatment" means the

use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

(f) Low-income community.--For purposes of this section--

(1) In general.--The term "low-income community" means any population census tract if—

(A) the poverty rate for such tract is at least 20 percent, or

(B)(i) in the case of a tract not located within a metropolitan area, the median family income for such tract does not exceed 80 percent of statewide median family income, or

(ii) in the case of a tract located within a metropolitan area, the median family income for such tract does not exceed 80 percent of the greater of statewide median family income or the metropolitan area median family income.

Subparagraph (B) shall be applied using possessionwide median family income in the case of census tracts located within a possession of the United States.

(2) Targeted populations.--The Secretary shall prescribe regulations under which 1 or more targeted populations (within the meaning of section 103(20) of the Riegle Community Development and Regulatory Improvement Act of 1994 (12 U.S.C. 4702(20))) may be treated as low-income communities. Such regulations shall include procedures for determining which entities are qualified active low-income community businesses with respect to such populations.

(3) Areas not within census tracts.--In the case of an area which is not tracted for population census tracts, the equivalent county divisions (as defined by the Bureau of the Census for purposes of defining poverty areas) shall be used for purposes of determining poverty rates and median family income.

(4) Tracts with low population.--A population census tract with a population of less than 2,000 shall be treated as a low-income community for purposes of this section if such tract—

(A) is within an empowerment zone the designation of which is in effect under section 1391, and

(B) is contiguous to 1 or more low-income communities (determined without regard to this paragraph).

(5) Modification of income requirement for census tracts within high migration rural counties.—

(A) In general.--In the case of a population census tract located within a high migration rural county, paragraph (1)(B)(i) shall be applied by substituting "85 percent" for "80 percent".

(B) High migration rural county.--For purposes of this paragraph, the term "high migration rural county" means any county which, during the 20-year period ending with the year in which the most recent census was conducted, has a net out-migration of inhabitants from the county of at least 10 percent of the population of the county at the beginning of such period.

(g) Substance use disorder treatment needs area.--For purposes of this section, the term "substance use disorder treatment needs area" means a county in which the rate of overdose deaths involving opioids, as reported by the U.S. Centers for Disease Control and Prevention, was greater than 10 individuals per 100,000 population during the most recently reported one-year period, as well as a 90-mile radius around such county.

(hf) National limitation on amount of investments designated.—

(1) In general.--There is a new markets tax credit limitation for each calendar year. Such limitation is—

(A) $1,000,000,000 for 2001,

(B) $1,500,000,000 for 2002 and 2003,

(C) $2,000,000,000 for 2004 and 2005,

(D) $3,500,000,000 for 2006 and 2007,

(E) $5,000,000,000 for 2008,

(F) $5,000,000,000 for 2009

(G) $3,500,000,000 for each of calendar years 2010 through 2019.

(2) Allocation of limitation.--The limitation under paragraph (1) shall be allocated by the Secretary among qualified community development entities selected by the Secretary. In making allocations under the preceding sentence, the Secretary shall give priority to any entity—

(A) with a record of having successfully provided capital or technical assistance to disadvantaged businesses or communities, ~~or~~

(B) which intends to satisfy the requirement under subsection (b)(1)(B) by making qualified low-income community investments in 1 or more businesses in which persons unrelated to such entity (within the meaning of section 267(b) or 707(b)(1)) hold the majority equity interest~~.~~, or

(C) which intends to satisfy the requirement under subsection (b)(1)(B) by making qualified substance use disorder treatment needs area investments in 1 or more qualified active substance use disorder treatment businesses.

In addition to the priority which the Secretary shall give to qualified community development entities when making allocations under subsection (h)(2)(C), the Secretary shall designate substance use disorder treatment needs areas as areas of severe distress, and a qualified community development entity that has committed to making qualified substance use disorder treatment needs area investments shall be given favorable consideration by the Secretary in making allocations under this subsection (h)(2).

(3) Carryover of unused limitation.--If the new markets tax credit limitation for any calendar year exceeds the aggregate amount allocated under paragraph (2) for such year, such limitation for the succeeding calendar year shall be increased by the amount of such excess. No amount may be carried under the preceding sentence to any calendar year after 2024.

(ig) Recapture of credit in certain cases.—

(1) In general.--If, at any time during the 7-year period beginning on the date of the original issue of a qualified equity investment in a qualified community development entity, there is a recapture event with respect to such investment, then the tax imposed by this chapter for the taxable year in which such event occurs shall be increased by the credit recapture amount.

(2) Credit recapture amount.--For purposes of paragraph (1), the credit recapture amount is an amount equal to the sum of—

(A) the aggregate decrease in the credits allowed to the taxpayer under section 38 for all prior taxable years which would have resulted if no credit had been determined under this section with respect to such investment, plus

(B) interest at the underpayment rate established under section 6621 on the amount determined under subparagraph (A) for each prior taxable year for the period beginning on the due date for filing the return for the prior taxable year involved.

No deduction shall be allowed under this chapter for interest described in subparagraph (B).

(3) Recapture event.--For purposes of paragraph (1), there is a recapture event with respect to an equity investment in a qualified community development entity if—

(A) such entity ceases to be a qualified community development entity,

(B) the proceeds of the investment cease to be used as required of subsection (b)(1)(B), or

(C) such investment is redeemed by such entity.

(4) Special rules.—

(A) Tax benefit rule.--The tax for the taxable year shall be increased under paragraph (1) only with respect to credits allowed by reason of this section which were used to reduce tax liability. In the case of credits not so used to reduce tax liability, the carryforwards and carrybacks under section 39 shall be appropriately adjusted.

(B) No credits against tax.--Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

(j~~h~~) Basis reduction.--The basis of any qualified equity investment shall be reduced by the amount of any credit determined under this section with respect to such investment. This subsection shall not apply for purposes of sections 1202, 1400B, and 1400F.

(k~~i~~) Regulations.--The Secretary shall prescribe such regulations as may be appropriate to carry out this section, including regulations—

(1) which limit the credit for investments which are directly or indirectly subsidized by other Federal tax benefits (including the credit under section 42 and the exclusion from gross income under section 103),

(2) which prevent the abuse of the purposes of this section,

(3) which provide rules for determining whether the requirement of subsection (b)(1)(B) is treated as met,

(4) which impose appropriate reporting requirements,

(5) which apply the provisions of this section to newly formed entities, and

(6) which ensure that non-metropolitan counties receive a proportional allocation of qualified equity investments.

EB-5 Program (8 U.S.C. § 1153)

§ 1153. Allocation of immigrant visas

(a) Preference allocation for family-sponsored immigrants

…

(b) Preference allocation for employment-based immigrants

Aliens subject to the worldwide level specified in section 1151(d) of this title for employment-based immigrants in a fiscal year shall be allotted visas as follows:

…

(5) Employment creation

(A) In general

Visas shall be made available, in a number not to exceed 7.1 percent of such worldwide level, to qualified immigrants seeking to enter the United States for the purpose of engaging in a new commercial enterprise (including a limited partnership)—

(i) in which such alien has invested (after November 29, 1990) or, is actively in the process of investing, capital in an amount not less than the amount specified in subparagraph (C), and

(ii) which will benefit the United States economy and create full-time employment for not fewer than 10 United States citizens or aliens lawfully admitted for permanent residence or other immigrants lawfully authorized to be employed in the United States (other than the immigrant and the immigrant's spouse, sons, or daughters).

(B) Set-aside for targeted employment areas

(i) In general

Not less than 3,000 of the visas made available under this paragraph in each fiscal year shall be reserved for qualified immigrants who invest in a new commercial enterprise described in subparagraph (A) which will create employment in a targeted employment area.

(ii) "Targeted employment area" defined

In this paragraph, the term "targeted employment area" means, at the time of the investment, a rural area, a substance use disorder treatment needs area (but only with respect to investments in a residential substance use disorder treatment facility or an

outpatient substance use disorder treatment program) or an area which has experienced high unemployment (of at least 150 percent of the national average rate).

(iii) "Rural area" defined

In this paragraph, the term "rural area" means any area other than an area within a metropolitan statistical area or within the outer boundary of any city or town having a population of 20,000 or more (based on the most recent decennial census of the United States).

(iv) "Substance use disorder treatment needs area" defined

In this paragraph, the term "substance use disorder treatment needs area" means a county in which the rate of overdose deaths involving opioids, as reported by the U.S. Centers for Disease Control and Prevention, was greater than 10 individuals per 100,000 population during the most recently reported one-year period, as well as a 90-mile radius around such county.

(C) Amount of capital required

(i) In general

Except as otherwise provided in this subparagraph, the amount of capital required under subparagraph (A) shall be $1,000,000. The Attorney General, in consultation with the Secretary of Labor and the Secretary of State, may from time to time prescribe regulations increasing the dollar amount specified under the previous sentence.

(ii) Adjustment for targeted employment areas

The Attorney General may, in the case of investment made in a targeted employment area, specify an amount of capital required under subparagraph (A) that is less than (but not less than ½ of) the amount specified in clause (i).

(iii) Adjustment for high employment areas

In the case of an investment made in a part of a metropolitan statistical area that at the time of the investment—

(I) is not a targeted employment area, and

(II) is an area with an unemployment rate significantly below the national average unemployment rate,

the Attorney General may specify an amount of capital required under subparagraph (A) that is greater than (but not greater than 3 times) the amount specified in clause (i).

(D) Full-time employment defined

In this paragraph, the term "full-time employment" means employment in a position that requires at least 35 hours of service per week at any time, regardless of who fills the position.

(E) Residential substance use disorder treatment facility and outpatient substance use disorder treatment program defined

(i) In this paragraph, the term "residential substance use disorder treatment facility" means a non-hospital facility located within a substance use disorder treatment needs area that –

(I) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in subparagraph (E)(v)(III));

(II) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(III) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in subparagraph (E)(v)(III)).

(ii) In this paragraph, the term "outpatient substance use disorder treatment program" means a non-hospital program located within a substance use disorder treatment needs area that is either –

(I) a structured sober living facility; or

(II) any other facility or program that:

(aa) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in subparagraph (E)(vi)(III));

(bb) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(cc) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in subparagraph (E)(vi)(III)).

(iii) In this paragraph, the term "structured sober living facility" means a non-hospital facility or program located within a substance use disorder treatment needs area that –

(I) furnishes structured sober living services (as described in subparagraph (E)(vi)(I)) under 24-hour supervision of trained counselors and medical staff;

(II) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(III) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in subparagraph (E)(vi)(I)).

(iv) In this paragraph, the term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(v) In this paragraph, the term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the individual's treating physician and multi-disciplinary team:

(I) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(II) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(aa) detoxification and withdrawal management services;

(bb) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (E)(v)(II)(aa) and (bb);

(III) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(aa) detoxification and withdrawal management services;

(bb) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the individual and preparation of the individual for lower intensity outpatient substance use disorder treatment services; and

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (E)(v)(III)(aa) and (bb); and

(IV) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the individual's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(vi) In this paragraph, the term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the individual's treating physician and multi-disciplinary team:

(I) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(aa) medium to high intensity rehabilitative services provided for 20 hours or more per week to a individual requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(bb) medium intensity rehabilitative services provided for 9 hours or more per week to a individual requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(cc) medication-assisted treatment in connection with the services set forth in subparagraphs (E)(vi)(I)(aa) and (bb); and

(dd) direct access to medical services;

(II) partial hospitalization services, which shall include, at a minimum, the following:

(aa) medium to high intensity rehabilitative services provided for 20 hours or more per week to a individual requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (E)(vi)(II)(aa) and (bb); and

(cc) direct access to medical services;

(III) intensive outpatient treatment services, which shall include, at a minimum, the following:

(aa) medium intensity rehabilitative services provided for 9 hours or more per week to a individual requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (E)(vi)(III)(aa); and

(cc) direct access to medical services;

(IV) outpatient services, which shall include, at a minimum, the following:

(aa) low intensity rehabilitative services provided for less than 9 hours per week to a individual requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(bb) medication-assisted treatment in connection with the services set forth in subparagraph (E)(vi)(IV)(aa);

(cc) access to medical services; and

(V) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the individual's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(vii) In this paragraph, "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance

use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

(F) Expedited review of visa applications for investors in new residential substance use disorder treatment facilities or outpatient substance use disorder treatment programs

The United States Citizenship and Immigration Services shall expedite the review of any visa application (Form I-526, Immigrant Petition by Alien Entrepreneur) filed in connection with investment in a new residential substance use disorder treatment facility or outpatient substance use disorder treatment program located within a targeted employment area that meets the definition of a substance use disorder treatment needs area; provided, however, that no more than 10% of the total number of visas made available under this paragraph in each fiscal year shall be expedited pursuant to this subparagraph.

Laws Expanding Coverage and Improving Access to Evidence-Based, High Quality SUD Treatment Services

Medicaid

Medicaid (42 U.S.C. § 1396a)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

…

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), (28) and (298) of section 1396d(a) of this title, to—

(i) all individuals—

Medicaid (42 U.S.C. § 1396d)

§ 1396d. Definitions

For purposes of this subchapter--

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

…

but whose income and resources are insufficient to meet all of such cost—

…

(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; ~~and~~

(29) substance use disorder treatment services (as defined in subsection (ee)(1)); and

(30) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

…

(i) Institution for Mental Diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, excluding a residential substance use disorder treatment facility (as defined in subsection (ee)(4)), that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

…

(ee) Substance Use Disorder Treatment Services

(1) The term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(2) The term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(B) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(B)(i) and (ii);

(C) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the beneficiary and preparation of the beneficiary for lower intensity outpatient substance use disorder treatment services; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(C)(i) and (ii); and

(D) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(3) The term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(ii) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (3)(A)(i) and (ii); and

(iv) direct access to medical services;

(B) partial hospitalization services, which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (3)(B)(i); and

(iii) direct access to medical services;

(C) intensive outpatient treatment services, which shall include, at a minimum, the following:

(i) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (3)(C)(i); and

(iii) direct access to medical services;

(D) outpatient services, which shall include, at a minimum, the following:

(i) low intensity rehabilitative services provided for less than 9 hours per week to a beneficiary requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (3)(D)(i); and

(iii) access to medical services; and

(E) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(4) The term "residential substance use disorder treatment facility" means a non-hospital facility that –

(A) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in paragraph (2)(C));

(B) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in paragraph (2)(C)).

(5) The term "outpatient substance use disorder treatment program" means a non-hospital program that is either –

(A) a structured sober living facility; or

(B) any other facility or program that:

(i) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in paragraph (3)(C));

(ii) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in paragraph (3)(C)).

(6) The term "structured sober living facility" means a non-hospital facility or program that –

(A) furnishes structured sober living services (as described in paragraph (3)(A)) under 24-hour supervision of trained counselors and medical staff;

(B) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in paragraph (3)(A)).

(7) The term "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

(8) Notwithstanding anything to the contrary in this subchapter—

(A) Payment shall be made on behalf of any beneficiary who is admitted to a residential substance use disorder treatment facility for all residential substance use disorder treatment services furnished to such beneficiary and determined to be medically necessary by the beneficiary's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods

(i) the period during which such beneficiary is furnished emergency services (as described in paragraph (2)(A)) at the residential substance use disorder treatment facility;

(ii) the first seven (7) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished medically-monitored intensive inpatient services (as described in paragraph (2)(B)) or any detoxification and withdrawal management services; and

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished clinically-managed high intensity residential services (as described in paragraph (2)(C)).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of residential substance use disorder treatment service furnished to a beneficiary after such beneficiary has been furnished such residential substance use disorder treatment service for the applicable period set forth in subparagraph (8)(A)(i), (ii) or (iii) above.

(B) Payment shall be made on behalf of any beneficiary who is admitted to an outpatient substance use disorder treatment program for all outpatient substance use disorder treatment services furnished to such beneficiary and determined to be medically necessary

by the beneficiary's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subparagraphs (3)(A)(i), (iii) and (iv));

(ii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subparagraphs (3)(A)(ii), (iii) and (iv));

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished partial hospitalization services (as described in paragraph (3)(B));

(iv) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished intensive outpatient services (as described in subparagraph (3)(C)); and

(v) any period during which such beneficiary is furnished outpatient services (as described in paragraph (3)(D)).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of outpatient substance use disorder treatment service (other than outpatient services as described in paragraph 3(D)) furnished to a beneficiary after such beneficiary has been furnished such outpatient substance use disorder treatment service for at least the applicable period set forth in subparagraph (8)(B)(i), (ii), (iii) or (iv) above.

Medicare

Medicare (42 U.S.C. § 1395c)

The insurance program for which entitlement is established by sections 426 and 426–1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, ~~and~~ hospice care~~-~~, and substance use disorder treatment services, in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

Medicare (42 U.S.C. § 1395d)

(a) Entitlement to payment for inpatient hospital services, post-hospital extended care services, home health services, ~~and~~ hospice care and residential substance use disorder treatment services

The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title to him (subject to the provisions of this part) for—

…

(6) residential substance use disorder treatment services during a spell of illness, subject to the limitations in subsection (b).

(b) Services not covered

Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services or residential substance use disorder treatment services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services or residential substance use disorder treatment services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

…

(e) Services taken into account

For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, ~~and~~ post-hospital extended care services, and residential substance use disorder treatment services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1395f(a) of this title, made with respect to such services under this part.

…

(h) Special provisions for payment for residential substance use disorder treatment services

Notwithstanding anything to the contrary in this subchapter, payment shall be made on behalf of any beneficiary who is admitted to a residential substance use disorder treatment facility for all residential substance use disorder treatment services furnished to such beneficiary and determined to be medically reasonable and necessary by the beneficiary's treating physician. Such determinations of medical reasonableness and necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(1) the period during which such beneficiary is furnished emergency services (as described in section 1395x(jjj)(1) of this title) at the residential substance use disorder treatment facility;

(2) the first seven (7) consecutive or nonconsecutive days during each spell of illness in which such beneficiary is furnished medically-monitored intensive inpatient services (as described in section 1395x(jjj)(2) of this title) or any detoxification and withdrawal management services; and

(3) the first twenty-eight (28) consecutive or nonconsecutive days during each spell of illness in which such beneficiary is furnished clinically-managed high intensity residential services (as described in section 1395x(jjj)(3) of this title).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of residential substance use disorder treatment service furnished to a beneficiary after such beneficiary has been furnished such residential substance use disorder treatment service for the applicable period set forth in paragraph (1), (2) or (3) above.

Medicare (42 U.S.C. § 1395e)

(a) Inpatient hospital services; residential substance use disorder treatment services; outpatient hospital diagnostic services; blood; post-hospital extended care services

(1) The amount payable for inpatient hospital services, inpatient critical access hospital services, or residential substance use disorder treatment services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient ~~hospital~~ deductible

or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of ~~the inpatient hospital~~ such service deductibles for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of ~~the inpatient hospital~~ such service deductibles for each day (before the day following the last day for which such individual is entitled under section 1395d(a)(1) of this title to have payment made on his behalf for inpatient hospital services or inpatient critical access hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

…

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient ~~hospital~~ deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

…

(b) Inpatient ~~hospital~~ deductible; application

(1) The inpatient ~~hospital~~ deductible for 1987 shall be $520. The inpatient ~~hospital~~ deductible for any succeeding year shall be an amount equal to the inpatient ~~hospital~~ deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied under section 1395ww(d)(3)(A) of this title for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

(2) The Secretary shall promulgate the inpatient ~~hospital~~ deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

(3) The inpatient ~~hospital~~ deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services, ~~or~~ inpatient critical access hospital services or residential substance use disorder treatment services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services, inpatient critical access hospital services and post-hospital extended care services furnished in that year.

Medicare (42 U.S.C. § 1395f)

§ 1395f - Conditions of and limitations on payment for services

(a) Requirement of requests and certifications

Except as provided in subsections (d) and (g) of this section, ~~and~~ in section 1395mm of this title, and in subsection (h) of section 1395d of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if--

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1395x(aa)(5) of this title) who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services or residential substance use disorder treatment services not later than the 20th day of such period) that--

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

…

(E) in the case of residential substance use disorder treatment services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual with a substance use disorder; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1395cc(d) of this title (based on a finding that utilization review of long-stay cases is not being made in such hospital);

(6) with respect to inpatient hospital services, ~~or~~ post-hospital extended care services or residential substance use disorder treatment services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title, including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;

Medicare (42 U.S.C. § 1395k)

(a) Scope of benefits – The benefits provided to an individual by the insurance program established by this part shall consist of—

…

(I) prosthetic devices and orthotics and prosthetics (described in section 1395m(h)(4) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services; ~~and~~

(J) partial hospitalization services provided by a community mental health center (as described in section 1395x(ff)(2)(B) of this title)~~.~~; and

(K) outpatient substance use disorder treatment services.

(b) Definitions For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1395x of this title.

Medicare (42 U.S.C. § 1395l)

(a) Amounts Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k(a)(1) of this title—80 percent of the reasonable charges for the services; except that…

…

(2) in the case of services described in section 1395k(a)(2) of this title (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1395rr of this title)—

…

(I) with respect to outpatient substance use disorder treatment services, 100 percent of the reasonable charges for such services; provided, however, that payment shall be made on behalf of any beneficiary who is admitted to an outpatient substance use disorder treatment program for all outpatient substance use disorder treatment services furnished to such beneficiary and determined to be medically reasonable and necessary by the beneficiary's treating physician, and such determinations of medical reasonableness and necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subsections (1)(A), (1)(C) and (1)(D) of section 1395x(kkk)(1) of this title);

(ii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subsections (1)(B), (1)(C) and (1)(D) of section 1395x(kkk)(1) of this title);

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished partial hospitalization services (as described in section 1395x(kkk)(2) of this title);

(iv) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished intensive outpatient services (as described in section 1395x(kkk)(3) of this title); and

(v) any period during which such beneficiary is furnished outpatient services (as described in section 1395x(kkk)(4) of this title).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of outpatient substance use disorder treatment service (other than outpatient services as described in section 1395x(kkk)(4) of this title) furnished to a beneficiary after such beneficiary has been furnished such outpatient substance use disorder treatment service for at least the applicable period set forth in subparagraph (i), (ii), (iii) or (iv) above.

Medicare (42 U.S.C § 1395x)

For the purposes of this subchapter-

(a) Spell of Illness. The term "spell of illness" with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services, ~~or~~ extended care services or residential substance use disorder treatment services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1), or, if such individual is an inpatient of a residential substance use disorder treatment facility, ending with the close of the first period of 15 consecutive days thereafter on each of which he is not an inpatient in a residential substance use disorder treatment facility.

…

(k) Utilization review. A utilization review plan of a hospital, ~~or~~ skilled nursing facility or residential substance use disorder treatment facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this subchapter and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities or residential substance use disorder treatment facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services, ~~or~~ extended care services or residential substance use disorder treatment services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to subchapter XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this subchapter that the procedures established pursuant to subchapter XIX be utilized instead of the procedures required by this section.

[to be added after subsection (hhh)]

(iii) Substance use disorder treatment services

The term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(jjj) Residential substance use disorder treatment services

The term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(1) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(2) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(A) detoxification and withdrawal management services;

(B) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(C) medication-assisted treatment in connection with the services set forth in paragraphs (2)(A) and (B);

(3) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(A) detoxification and withdrawal management services;

(B) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the beneficiary and preparation of the beneficiary for lower intensity outpatient substance use disorder treatment services; and

(C) medication-assisted treatment in connection with the services set forth in paragraphs (2)(A) and (B); and

(4) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(kkk) Outpatient substance use disorder treatment services

The term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(1) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(A) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(B) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(C) medication-assisted treatment in connection with the services set forth in paragraphs (1)(A) and (B); and

(D) direct access to medical services;

(2) partial hospitalization services, which shall include, at a minimum, the following:

(A) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(B) medication-assisted treatment in connection with the services set forth in paragraph (2)(A); and

(C) direct access to medical services;

(3) intensive outpatient treatment services, which shall include, at a minimum, the following:

(A) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(B) medication-assisted treatment in connection with the services set forth in paragraph (3)(A); and

(C) direct access to medical services;

(4) outpatient services, which shall include, at a minimum, the following:

(A) low intensity rehabilitative services provided for less than 9 hours per week to a beneficiary requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(B) medication-assisted treatment in connection with the services set forth in paragraph (4)(A); and

(C) access to medical services; and

(5) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(lll) Residential substance use disorder treatment facility. The term "residential substance use disorder treatment facility" means a non-hospital facility that –

(1) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in subsection (jjj)(3));

(2) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(3) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in subsection (jjj)(3)).

(mmm) Outpatient substance use disorder treatment program. The term "outpatient substance use disorder treatment program" means a non-hospital program that is either –

(A) a structured sober living facility; or

(B) any other facility or program that:

(i) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in subsection (kkk)(3));

(ii) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in subsection (kkk)(3)).

(nnn) Structured sober living facility. The term "structured sober living facility" means a non-hospital facility or program that –

(A) furnishes structured sober living services (as described in subsection (kkk)(1)) under 24-hour supervision of trained counselors and medical staff;

(B) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in subsection (kkk)(1)).

(ooo) Medication-assisted treatment

The term "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

VA Benefits (38 U.S.C. § 1720A)

§ 1720A. Treatment and rehabilitative services for persons with drug or alcohol dependency

(a) The Secretary, in consultation with the Secretary of Labor and the Director of the Office of Personnel Management, may take appropriate steps to (1) urge all Federal agencies and appropriate private and public firms, organizations, agencies, and persons to provide appropriate employment and training opportunities for veterans who have been provided treatment and rehabilitative services under this title for alcohol or drug dependence or abuse disabilities and have been determined by competent medical authority to be sufficiently rehabilitated to be employable, and (2) provide all possible assistance to the Secretary of Labor in placing such veterans in such opportunities.

(b) Upon receipt of an application for treatment and rehabilitative services under this title for an alcohol or drug dependence or abuse disability from any individual who has been discharged or released from active military, naval, or air service but who is not eligible for such treatment and services, the Secretary shall—

(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining treatment and rehabilitative services from sources outside the Department; and

(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service and the Department for review of such individual's discharge or release from such service.

(c) (1) Any person serving in the active military, naval, or air service who is determined by the Secretary concerned to have an alcohol or drug dependence or abuse disability may be transferred to any facility in order for the Secretary to furnish care or treatment and rehabilitative services for such disability. Care and services provided to a member so transferred shall be provided as if such member were a veteran. Any transfer of any such member for such care and services shall be made pursuant to such terms as may be agreed upon by the Secretary concerned and the Secretary, subject to the provisions of sections 1535 and 1536 of title 31.

(2) No person serving in the active military, naval, or air service may be transferred pursuant to an agreement made under paragraph (1) of this subsection unless such person requests such transfer in writing for a specified period of time. No such person transferred pursuant to such a request may be furnished such care and services by the Secretary beyond the period of time specified in such request unless such person requests in writing an extension for a further specified period of time and such request is approved by the Secretary.

(d) (1) The Secretary shall ensure that each medical center of the Department develops and carries out a plan to provide treatment for substance use disorders, either through referral or direct provision of services, to veterans who require such treatment.

(2) Each plan under paragraph (1) shall make available clinically proven substance abuse treatment methods, including opioid substitution therapy, to veterans with respect to whom a qualified medical professional has determined such treatment methods to be appropriate.

(e) Notwithstanding anything to the contrary in this Chapter:

(1) The Department shall contract with (or engage a third-party administrator to contract with) residential substance use disorder treatment facilities and outpatient substance use disorder treatment programs to furnish substance use disorder treatment services to any veteran for whom such services are determined to be medically necessary by the Department or by such veteran's treating physician and who meets one of the following criteria:

(A) is forty (40) miles' driving distance or farther from a Department facility that can provide comparable treatment services to such veteran;

(B) has waited more than twenty-four (24) hours for a substance use disorder assessment by a Department facility, following such veteran's request for such an assessment; or

(C) following a substance use disorder assessment by a Department facility where substance use disorder treatment is determined to be medically necessary for such veteran, is not immediately admitted to a Department facility for substance use disorder treatment.

(2) The Department shall pay for the reasonable costs of all substance use disorder treatment services furnished to a veteran pursuant to this subsection.

(3) Substance use disorder treatment services shall be furnished to any veteran who meets the criteria set forth under paragraph (1) when such services are determined to be medically necessary by the veteran's treating physician in accordance with the following:

(A) Payment shall be made on behalf of any veteran who is admitted to a residential substance use disorder treatment facility for all residential substance use disorder treatment services furnished to such veteran and determined to be medically necessary by the veteran's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the period during which such veteran is furnished emergency services (as described in paragraph (5)(A)) at the residential substance use disorder treatment facility;

(ii) the first seven (7) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished medically-monitored intensive inpatient services (as described in paragraph (5)(B)) or any detoxification and withdrawal management services; and

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished clinically-managed high intensity residential services (as described in paragraph (5)(C)).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of residential substance use disorder treatment service furnished to a veteran after such veteran has been furnished such residential substance use disorder treatment service for the applicable period set forth in subparagraph (3)(A)(i), (ii) or (iii) above.

(B) Payment shall be made on behalf of any veteran who is admitted to an outpatient substance use disorder treatment program for all outpatient substance use disorder treatment services furnished to such veteran and determined to be medically necessary by the veteran's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished structured sober living services (as described in subparagraphs (6)(A)(i), (iii) and (iv));

(ii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished structured sober living services (as described in subparagraphs (6)(A)(ii), (iii) and (iv));

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished partial hospitalization services (as described in paragraph (6)(B));

(iv) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such veteran is furnished intensive outpatient services (as described in paragraph (6)(C)); and

(v) any period during which such veteran is furnished outpatient services.

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of outpatient substance use disorder treatment service (other than outpatient services as described in paragraph (6)(D)) furnished to a veteran after such veteran has been furnished such outpatient substance use disorder treatment service for at least the applicable period set forth in subparagraph (3)(B)(i), (ii), (iii) or (iv) above.

(4) For purposes of this section, the term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(5) For purposes of this section, the term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the veteran's treating physician and multi-disciplinary team:

(A) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(B) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (6)(B)(i) and (ii);

(C) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the veteran and preparation of the veteran for lower intensity outpatient substance use disorder treatment services; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (6)(C)(i) and (ii); and

(D) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the veteran's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(6) For purposes of this section, the term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the veteran's treating physician and multi-disciplinary team:

(A) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a veteran requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(ii) medium intensity rehabilitative services provided for 9 hours or more per week to a veteran requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (6)(A)(i) and (ii); and

(iv) direct access to medical services;

(B) partial hospitalization services, which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a veteran requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (6)(B)(i); and

(iii) direct access to medical services;

(C) intensive outpatient treatment services, which shall include, at a minimum, the following:

(i) medium intensity rehabilitative services provided for 9 hours or more per week to a veteran requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (6)(C)(i); and

(iii) direct access to medical services;

(D) outpatient services, which shall include, at a minimum, the following:

(i) low intensity rehabilitative services provided for less than 9 hours per week to a veteran requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (6)(D)(i); and

(iii) access to medical services; and

(E) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the veteran's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(8) For purposes of this section, the term "residential substance use disorder treatment facility" means a non-hospital, non-Department facility that –

(A) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in paragraph (5)(C));

(B) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in paragraph (5)(C)).

(9) For purposes of this section, the term "outpatient substance use disorder treatment program" means a non-hospital, non-Department program that is either –

(A) a structured sober living facility; or

(B) any other facility or program that:

(i) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in paragraph (6)(C));

(ii) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in paragraph (6)(C)).

(10) For purposes of this section, the term "structured sober living facility" means a non-hospital, non-Department facility or program that –

(A) furnishes structured sober living services (as described in paragraph (6)(A)) under 24-hour supervision of trained counselors and medical staff;

(B) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in paragraph (6)(A)).

(11) For purposes of this section, the term "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

CHAMPUS/TRICARE (10 U.S.C. § 1090)

§ 1090 – Identifying and Treating Drug and Alcohol Dependence

Notwithstanding anything to the contrary in this Chapter--

(a) The Secretary of Defense, and the Secretary of Homeland Security with respect to the Coast Guard when it is not operating as a service in the Navy, shall prescribe regulations, implement procedures using each practical and available method, and provide necessary facilities to identify, treat, and rehabilitate members of the armed forces who are dependent on drugs or alcohol.

(b) The Civilian Health and Medical Program of the Uniformed Services, the Supplemental Health Care Program for active duty members and the TRICARE Program (including TRICARE Select, TRICARE Prime and all other TRICARE-based programs) shall pay for substance use disorder treatment services that are determined to be medically or psychologically necessary for active duty members, dependents, former members and any other beneficiaries covered under such programs in accordance with subsection (e). The administering Secretaries of such programs shall have the authority to modify existing regulations and prescribe new regulations to ensure that such programs pay for or otherwise provide coverage for services substantially equivalent in scope and terms to substance use disorder treatment services.

(c) All programs set forth in subsection (b) shall pay for the reasonable costs of any substance use disorder treatment services furnished to a beneficiary pursuant to this section.

(d) Substance use disorder treatment services shall be furnished to any beneficiary when such services are determined to be medically necessary by the beneficiary's treating physician in accordance with the following:

> **(1)** Payment shall be made on behalf of any beneficiary who is admitted to a residential substance use disorder treatment facility for all residential substance use disorder treatment services furnished to such beneficiary and determined to be medically or psychologically necessary by the beneficiary's treating physician. Such determinations of medical or psychological necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:
>
> > **(A)** the period during which such beneficiary is furnished emergency services (as described in subsection (e)(3)(A)) at the residential substance use disorder treatment facility;
> >
> > **(B)** the first seven (7) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished medically-monitored intensive inpatient services (as described in subsection (e)(3)(B)) or any detoxification and withdrawal management services; and

(C) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished clinically-managed high intensity residential services (as described in subsection (e)(3)(C)).

The administering Secretaries shall establish by regulation how the determination of medical or psychological necessity shall be made for each type of residential substance use disorder treatment service furnished to a beneficiary after such beneficiary has been furnished such residential substance use disorder treatment service for the applicable period set forth in paragraph (1)(A), (B) or (C) above.

(2) Payment shall be made on behalf of any beneficiary who is admitted to an outpatient substance use disorder treatment program for all outpatient substance use disorder treatment services furnished to such beneficiary and determined to be medically or psychologically necessary by the beneficiary's treating physician. Such determinations of medical or psychological necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(A) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subsections (e)(4)(A)(i), (iii) and (iv));

(B) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished structured sober living services (as described in subsections (e)(4)(A)(ii), (iii) and (iv));

(C) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished partial hospitalization services (as described in subsection (e)(4)(B));

(D) the first twenty-eight (28) consecutive or nonconsecutive days during each calendar year in which such beneficiary is furnished intensive outpatient services (as described in subsection (e)(4)(C)); and

(E) any period during which such beneficiary is furnished outpatient services (as described in subsection (e)(4)(D)).

The administering Secretaries shall establish by regulation how the determination of medical or psychological necessity shall be made for each type of outpatient substance use disorder treatment service (other than outpatient services as described in subsection (e)(4)(D)) furnished to a beneficiary after such beneficiary has been furnished such outpatient substance use disorder treatment service for the applicable period set forth in paragraph (2)(A), (B), (C) or (D) above.

(3) Payment shall not be made in accordance with paragraphs (1) or (2) on behalf of any beneficiary who is an active duty member, unless such active duty member meets one of the following criteria:

(A) such active duty member is forty (40) miles' driving distance or farther from a military medical treatment facility that can provide comparable treatment services to such active duty member;

(B) such active duty member has waited more than twenty-four (24) hours for a substance use disorder assessment by a military medical treatment facility, following such active duty member's request for such an assessment; or

(C) following a substance use disorder assessment by a military medical treatment facility where substance use disorder treatment is determined to be medically or psychologically necessary for such active duty member, such active duty member is not immediately admitted to a military medical treatment facility for substance use disorder treatment.

(e) (1) For purposes of this section, the term "beneficiary" means an active duty member, a dependent, a former member or any other individual covered by any of the programs set forth in subsection (b).

(2) For purposes of this section, the term "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(3) For purposes of this section, the term "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(B) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (3)(B)(i) and (ii);

(C) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the beneficiary and preparation of the beneficiary for lower intensity outpatient substance use disorder treatment services; and

(iii)medication-assisted treatment in connection with the services set forth in subparagraphs (3)(C)(i) and (ii); and

(D) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(4) For purposes of this section, the term "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(ii) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (4)(A)(i) and (ii); and

(iv) direct access to medical services;

(B) partial hospitalization services, which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (4)(B)(i); and

(iii) direct access to medical services;

(C) intensive outpatient treatment services, which shall include, at a minimum, the following:

(i) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (4)(C)(i); and

(iii) direct access to medical services;

(D) outpatient services, which shall include, at a minimum, the following:

(i) low intensity rehabilitative services provided for less than 9 hours per week to a beneficiary requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(ii) medication-assisted treatment in connection with the services set forth in subparagraph (4)(D)(i); and

(iii) access to medical services; and

(E) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(5) For purposes of this section, the term "residential substance use disorder treatment facility" means a non-hospital, non-military medical treatment facility that –

(A) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in paragraph (3)(C));

(B) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the administering Secretaries for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in paragraph (3)(C)).

(6) For purposes of this section, the term "outpatient substance use disorder treatment program" means a non-hospital, non-military medical treatment program that is either –

(A) a structured sober living facility; or

(B) any other facility or program that:

(i) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in paragraph (4)(C));

(ii) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the administering Secretaries for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in paragraph (4)(C)).

(7) For purposes of this section, the term "structured sober living facility" means a non-hospital, non-military medical treatment facility or program that –

(A) furnishes structured sober living services (as described in paragraph (4)(A)) under 24-hour supervision of trained counselors and medical staff;

(B) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the administering Secretaries for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in paragraph (4)(A)).

(8) For purposes of this section, the term "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all

applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

Federal Employees Health Benefits Program (FEHBP)

FEHBP (5 U.S.C. § 8901)

For the purpose of this chapter—

…

(11) "qualified clinical social worker" means an individual—

…

(12) "beneficiary" means an employee, an annuitant, a member of the family of an employee or an annuitant, a former spouse, or a person having continued coverage under section 8905a of this title.

(13) "substance use disorder treatment services" means residential substance use disorder treatment services and outpatient substance use disorder treatment services.

(14) "residential substance use disorder treatment services" means any of the following services furnished by a residential substance use disorder treatment facility in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) emergency services described in section 2719A(b)(2)(B) of the Patient Protection and Affordable Care Act [42 U.S.C. § 300gg-19a(b)(2)(B)];

(B) medically-monitored intensive inpatient services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(iii) medication-assisted treatment in connection with the services set forth in paragraphs (14)(B)(i) and (ii);

(C) clinically-managed high intensity residential services, which shall include, at a minimum, the following:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour care by trained counselors and medical staff to treat substance use disorders and co-occurring disorders, including, but not limited to, stabilization of the beneficiary and preparation of the beneficiary for lower intensity outpatient substance use disorder treatment services; and

(iii) medication-assisted treatment in connection with the services set forth in paragraphs (14)(C)(i) and (ii); and

(D) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to residential substance use disorder treatment services, which may include, but are not limited to, room and board, laboratory services and telemedicine services.

(15) "outpatient substance use disorder treatment services" means any of the following services furnished by an outpatient substance use disorder treatment program in accordance with an individualized treatment plan developed and approved by the beneficiary's treating physician and multi-disciplinary team:

(A) structured sober living services, which shall be provided only in a structured sober living facility, and which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(ii) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming designed to stress interpersonal, independent and group living skills;

(iii) medication-assisted treatment in connection with the services set forth in paragraphs (15)(A)(i) and (ii); and

(iv) direct access to medical services;

(B) partial hospitalization services, which shall include, at a minimum, the following:

(i) medium to high intensity rehabilitative services provided for 20 hours or more per week to a beneficiary requiring crisis stabilization, acute symptom reduction or structured outpatient treatment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in paragraph (15)(B)(i); and

(iii) direct access to medical services;

(C) intensive outpatient treatment services, which shall include, at a minimum, the following:

(i) medium intensity rehabilitative services provided for 9 hours or more per week to a beneficiary requiring stabilization, symptom reduction or active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders, and which include, but are not limited to, clinically intensive programming;

(ii) medication-assisted treatment in connection with the services set forth in paragraph (15)(C)(i); and

(iii) direct access to medical services;

(D) outpatient services, which shall include, at a minimum, the following:

(i) low intensity rehabilitative services provided for less than 9 hours per week to a beneficiary requiring symptom reduction and active treatment in a stable, staff-supported environment for substance use disorders and co-occurring disorders;

(ii) medication-assisted treatment in connection with the services set forth in paragraph (15)(D)(i); and

(iii) access to medical services; and

(E) services, supplies, space, medication and equipment as may be necessary to fulfill the requirements of the beneficiary's individualized treatment plan with respect to outpatient substance use disorder treatment services, which may include, but are not limited to, room and board for structured sober living services, laboratory services and telemedicine services.

(16) "residential substance use disorder treatment facility" means a non-hospital facility that–

(A) furnishes residential substance use disorder treatment services, including, at a minimum, clinically-managed high intensity residential services (as described in paragraph (14)(C));

(B) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, clinically-managed high intensity residential services (as described in paragraph (14)(C)).

(17) "outpatient substance use disorder treatment program" means a non-hospital program that is either –

(A) a structured sober living facility; or

(B) any other facility or program that:

(i) furnishes outpatient substance use disorder treatment services, including, at a minimum, intensive outpatient treatment services (as described in paragraph (15)(C));

(ii) is accredited as an outpatient behavioral health care program or similar program by a national accrediting organization recognized by the Secretary for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, intensive outpatient treatment services (as described in paragraph (15)(C)).

(18) "structured sober living facility" means a non-hospital facility or program that –

(A) furnishes structured sober living services (as described in paragraph (15)(A)) under 24-hour supervision of trained counselors and medical staff;

(B) is accredited as a residential facility, behavioral health care facility or similar facility or an outpatient behavioral health care program or similar program in a residential setting by a national accrediting organization recognized by the Secretary for this purpose; and

(C) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish structured sober living services (as described in paragraph (15)(A)).

(19) "medication-assisted treatment" means the use of antagonist, agonist or partial agonist medication in combination with other substance use disorder treatment services to provide an individualized approach to the treatment of substance use disorders, where such medication is administered or dispensed in accordance with all applicable federal and state laws, including, but not limited to, any certification requirements of the Substance Abuse and Mental Health Services Administration under 42 C.F.R. Part 8.

FEHBP (5 U.S.C. § 8904)

§ 8904. Types of benefits

(a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) Service Benefit Plan.-

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(G) Substance use disorder treatment services benefits.

(2) Indemnity Benefit Plan.-

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribed drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(G) Substance use disorder treatment services benefits.

(3) Employee Organization Plans.-Benefits of the types named under paragraph (1) or (2) of this subsection or both.

(4) Comprehensive Medical Plans.-Benefits of the types named under paragraph (1) or (2) of this subsection or both.

(b) **(1)** All plans contracted for under paragraphs (1) and (2) of ~~this~~ subsection (a) shall include benefits ~~both~~ for costs associated with care in a general hospital, a residential substance use disorder treatment program, in an outpatient substance use disorder treatment program, and for ~~other~~ health services of a catastrophic nature.

(2) Benefits for costs associated with care in a residential substance use disorder treatment facility or an outpatient substance use disorder treatment program shall be provided in accordance with the following:

(A) Payment shall be made on behalf of any beneficiary who is admitted to a residential substance use disorder treatment facility for all residential substance use disorder treatment services furnished to such beneficiary and determined to be medically necessary by the beneficiary's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the period during which such beneficiary is furnished emergency services (as described in section 8901(14)(A) of this title) at the residential substance use disorder treatment facility;

(ii) the first seven (7) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished medically-monitored intensive inpatient services (as described in section 8901(14)(B) of this title) or any detoxification and withdrawal management services; and

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished clinically-managed high intensity residential services (as described in section 8901(14)(C) of this title).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of residential substance use disorder treatment service furnished to a beneficiary after such beneficiary has been furnished such residential substance use disorder treatment service for the applicable period set forth in paragraph (2)(A)(i), (ii) or (iii) above.

(B) Payment shall be made on behalf of any beneficiary who is admitted to an outpatient substance use disorder treatment program for all outpatient substance use disorder treatment services furnished to such beneficiary and determined to be medically necessary by the beneficiary's treating physician. Such determinations of medical necessity shall not be subject to prior authorization or concurrent management review, retrospective management review or any other utilization management review during the following periods:

(i) the first twenty-eight (28) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished structured sober living services (as described in sections 8901(15)(A)(i), (iii) and (iv) of this title);

(ii) the first twenty-eight (28) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished structured sober living services (as described in sections 8901(15)(A)(ii), (iii) and (iv) of this title);

(iii) the first twenty-eight (28) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished partial hospitalization services (as described in section 8901(15)(B) of this title);

(iv) the first twenty-eight (28) consecutive or nonconsecutive days during each plan year in which such beneficiary is furnished intensive outpatient services (as described in section 8901(15)(C) of this title); and

(v) any period during which such beneficiary is furnished outpatient services (as described in section 8901(15)(D) of this title).

The Secretary shall establish by regulation how the determination of medical necessity shall be made for each type of outpatient substance use disorder treatment service (other than outpatient services as described in section 8901(15)(D) of this title) furnished to a beneficiary after such beneficiary has been furnished such outpatient substance use disorder treatment service for at least the applicable period set forth in paragraph (2)(B)(i), (ii), (iii) or (iv) above.

(~~b~~c) **(1)** **(A)** A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay a charge imposed by any health care provider, for inpatient hospital services or residential substance use disorder treatment services which are covered for purposes of benefit payments under this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges or charges for residential substance use disorder treatment services established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers or residential substance use disorder treatment facilities who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital or residential substance use disorder treatment facility is found to knowingly and willfully violate this subsection on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

(B) (i) A plan, other than a prepayment plan described in section 8903(4), may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not entitled to Medicare supplementary medical insurance benefits under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), to pay a charge imposed for physicians' services (as defined in section 1848(j) of such Act, 42 U.S.C. 1395w–4(j)) which are covered for purposes of benefit payments under this chapter and under such part, to the extent that such charge exceeds the fee schedule amount under section 1848(a) of such Act (42 U.S.C. 1395w–4(a)).

(ii) Physicians and suppliers who have in force participation agreements with the Secretary of Health and Human Services consistent with section 1842(h)(1) of such Act (42 U.S.C. 1395u(h)(1)), whereby the participating provider accepts Medicare benefits (including allowable deductible and coinsurance amounts) as full payment for covered items and services shall accept equivalent benefit and enrollee cost-sharing under this chapter as full payment for services described in clause (i). Physicians and suppliers who are nonparticipating physicians and suppliers for purposes of part B of title XVIII of such Act shall not impose charges that exceed the limiting charge under section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) with respect to services described in clause (i) provided to enrollees described in such clause. The Office of Personnel Management shall notify a physician or supplier who is found to have violated this clause and inform them of the requirements of this clause and sanctions for such a violation. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a physician or supplier is found to knowingly and willfully violate this clause on a repeated basis and the Secretary of Health and Human Services may invoke appropriate sanctions in accordance with sections 1128A(a) and 1848(g)(1) of such Act (42 U.S.C. 1320a–7a(a), 1395w–4(g)(1)) and applicable regulations.

(C) If the Secretary of Health and Human Services determines that a violation of this subsection warrants excluding a provider from participation for a specified period under title XVIII of the Social Security Act, the Office shall enforce a corresponding exclusion of such provider for purposes of this chapter.

(2) Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

(3) (A) Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

(B) For purposes of this paragraph, the term "Medicare program information" includes (i) the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), and (ii) the

fee schedule amounts and limiting charges for physicians' services established under section 1848 of such Act (42 U.S.C. 1395w–4) and the identity of participating physicians and suppliers who have in force agreements with such Secretary under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

(4) The Director of the Office of Personnel Management shall enter into an arrangement with the Secretary of Health and Human Services, to be effective before the first day of the fifth month that begins before each contract year, under which-

(A) physicians and suppliers (whether or not participating) under the Medicare program will be notified of the requirements of paragraph (1)(B);

(B) enforcement procedures will be in place to carry out such paragraph (including enforcement of protections against overcharging of beneficiaries); and

(C) Medicare program information described in paragraph (3)(B)(ii) will be supplied to carriers under paragraph (3)(A).

Patient Protections under the Public Health Service Act (42 U.S.C. § 300gg-19a)

§ 2719A – Patient Protections.

(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii) (I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this subsection:

(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, acute intoxication and/or withdrawal symptoms or potential) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term 'emergency services' means~~, with respect to an emergency medical condition~~ --

(i) with respect to an emergency medical condition of an individual who comes to a hospital emergency department—

(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; and~~.~~

(ii) with respect to an emergency medical condition of an individual who requests services (or on whose behalf such services are requested) from a residential substance use disorder treatment facility—

(I) an assessment of biopsychosocial severity and function, including acute intoxication and/or withdrawal symptoms or potential, and such ancillary services routinely available to the residential substance use disorder treatment facility to evaluate such emergency medical condition, as determined medically necessary by the treating physician, and

(II) within the capabilities of the staff and facilities available at the residential substance use disorder treatment facility, such further substance use disorder treatment services determined necessary by the treating physician until the treating physician determines that the individual can be safely discharged to an outpatient level of care.

(C) RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT FACILITY.—The term `residential substance use disorder treatment facility' means a non-hospital facility that—

(i) furnishes, at a minimum, medically-monitored intensive inpatient services (as defined in paragraph (2)(D));

(ii) is accredited as an inpatient nonhospital facility, inpatient nonhospital detoxification facility, residential facility, behavioral health care facility or similar facility by a national accrediting organization recognized by the Secretary for this purpose; and

(iii) is certified or licensed by a State certification or licensing agency as determined necessary or appropriate by the State to furnish, at a minimum, medically-monitored intensive inpatient services (as defined in paragraph (2)(D)).

(D) MEDICALLY-MONITORED INTENSIVE INPATIENT SERVICES. —The term "medically-monitored intensive inpatient services" means, at a minimum, the following services:

(i) detoxification and withdrawal management services;

(ii) high intensity, 24-hour nursing care involving a continuous, planned regimen of professional evaluation, care and treatment of substance use disorders and co-occurring disorders; and

(iii) medication-assisted treatment in connection with the services set forth in subparagraphs (2)(D)(i) and (ii).

(E) STABILIZE.—The term 'to stabilize', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Laws Eliminating Disparities in Coverage of Medical/Surgical versus Mental Health/SUD Treatment Benefits

Mental Health Parity and Addiction Equity Act (42 U.S.C. 300gg-26)

§ 300gg-26: Parity in Mental Health and Substance Use Disorder Benefits

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions. In this paragraph:

(i) Financial requirement. The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, as well as non-numerical limits on the scope or duration of benefits for treatment of a mental health or substance use condition or a medical and surgical condition.

(4) Availability of plan information. The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers. In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) Compliance program guidance document

(A) In general. Not later than 12 months after December 13, 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 1185a of Title 29, and section 9812 of Title 26, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled "Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance".

(B) Examples illustrating compliance and noncompliance

(i) In general. The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of Title 29,

or section 9812 of Title 26, as applicable, based on investigations of violations of such sections, including—

(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) Nonquantitative treatment limitations. To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

(iii) Access to additional information regarding compliance. In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable; and

(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(C) Recommendations. The compliance program guidance document shall include recommendations to advance compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) Updating the compliance program guidance document. The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or

individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(7) Additional guidance

(A) In general. Not later than 12 months after December 13, 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(B) Disclosure

(i) Guidance for plans and issuers. The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives. The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) Nonquantitative treatment limitations. The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, (and any regulations promulgated pursuant to such respective section), including—

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining—

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(D) Public comment. Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

(8) Compliance Requirements

(A) Nonquantitative Treatment Limitation Analysis Requirements

(i) Six-Step Process. All group health plans or health insurance issuers offering group or individual health insurance coverage shall perform comparative analyses about the design and application of nonquantitative treatment limitations imposed on mental health or substance use disorder benefits and those imposed on medical and surgical benefits in accordance with the following six-step process:

(I) Provide the specific plan language regarding each nonquantitative treatment limitation and describe all services to which it applies in each respective benefits classification for both mental health or substance use disorder benefits and medical and surgical benefits.

(II) Identify the factors and the source for each factor used to determine that it is appropriate to apply each nonquantitative treatment limitation to mental health or substance use disorder benefits.

(III) Identify and provide the source for the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each nonquantitative treatment limitation.

(IV) Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental health or substance use

disorder benefits are comparable to and no more stringent than the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits.

(V) Identify and describe the methods and analyses used, including the results of the analyses, to the determine that processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health or substance use disorder benefits are comparable to and no more stringent than the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits.

(VI) Create a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply each nonquantitative treatment limitation to mental health or substance use disorder benefits and to medical and surgical benefits have led the plan to conclude compliance with this section.

(ii) Determination of non-compliance. Beginning July 1, 2018, all group health plans or health insurance issuers offering group or individual health insurance coverage shall make immediately available upon request the analyses described in clause (i) of this subparagraph to the Secretary, any State insurance commissioner who may enforce this section in accordance with 42 U.S.C. § 300gg-22, or any State attorney general, and shall establish a database of these analyses that will be available for inspection by the Secretary, any State insurance commissioner, or any State attorney general for retrospective review for a four-year lookback period beginning July 1, 2022.

(iii) Enforcement by State Attorneys General. In any case in which a State attorney general has reason to believe that an interest of one or more of the residents of that State has been or is threatened or adversely affected by any person who violates a provision of this section, the State attorney general, as *parens patriae*, may bring a civil action on behalf of such residents of the State in a district court of the United States of appropriate jurisdiction-

(I) to enjoin further such violation by the defendant; or

(II) to obtain damages on behalf of such residents of the State

(b) Construction. Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption. This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 300gg–91 (e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption

(A) In general. With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage. With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries. Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations. If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification.

(i) In general A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies. To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Civil monetary penalties. The Secretary may impose a civil monetary penalty pursuant to 42 U.S.C. § 1320d-5 against a group health plan or health insurance issuer for a violation of this section by such plan or issuer.

(**e~~d~~**) **Separate application to each option offered.** In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(fe) Definitions. For purposes of this section—

(1) Aggregate lifetime limit. The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit. The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits. The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits. The term "mental health benefits" means benefits with respect to services for any mental health condition~~s~~ identified in generally recognized independent standards of current medical practice, including the most current version of *Diagnostic and Statistical Manual of Mental Disorders* released by the American Psychiatric Association, the most current version of the International Classification of Diseases, and applicable State law.

(5) Nonquantitative treatment limitations. Nonquantitative treatment limitation means any non-numerical limit on the scope or duration of benefits for treatment of a mental health or substance use condition or a medical and surgical condition. Nonquantitative treatment limitations include, but are not limited to:

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative

(B) Formulary design for prescription drugs

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design

(D) Standards for provider admission to participate in a network, including reimbursement rates

(E) Plan methods for determining usual, customary, and reasonable charges

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)

(G) Exclusions based on failure to complete a course of treatment

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

(I) In and out of network geographic limitations

(J) Standards for providing access to out-of-network providers

(K) Limitations on inpatient services for situations where the participant is a threat to self or others

(L) Exclusions for court-ordered and involuntary holds

(M) Experimental treatment limitations

(N) Service coding

(O) Exclusions for services provided by clinical social workers

(P) Network adequacy

(6) Substance use disorder benefits. The term "substance use disorder benefits" means benefits with respect to services for any substance use disorder condition identified in generally recognized independent standards of current medical practice, including the most current version of *Diagnostic and Statistical Manual of Mental Disorders* released by the American Psychiatric Association, the most current version of the International Classification of Diseases, and applicable State law.