# KEY PROVISIONS OF THE BIPARTISAN OPIOID PACKAGE: SUPPORT FOR PATIENTS AND COMMUNITIES ACT

## I. OVERVIEW

In early October, Congress passed opioid legislation with overwhelming bipartisan support. The Senate approved the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) (H.R. 6) by a vote of 98-1, while the House approved it 396 - 14 (section by section summary). On October 24, 2018, President Trump signed the bill into law.

The legislation is composed of more than 70 bills from both Republicans and Democrats. The package aims to ease the epidemic by increasing access to effective treatment within both Medicaid and Medicare, expanding alternative non-opioid pain management options, reducing overprescribing, educating patients, identifying best practices that can effectively address the epidemic in the future, and more.

Opioids kill nearly 50,000 people per year in the United States and harm hundreds of thousands more, including children forced into the foster care system, babies born with neonatal abstinence syndrome, young adults who overdose from fentanyl, and seniors who become addicted to opioids while trying to manage pain.

While the bill represents a positive step towards curbing the opioid epidemic, critics argue that it falls short of what is needed to solve a crisis of this magnitude. Many called for sustained, robust funding like the Ryan White HIV/AIDS Program enacted to combat an epidemic of similar size, and this bill is far from that. Included below is a description of some of the key components of the law.

## II. EXPANDING ACCESS TO MEDICATION AND TREATMENT

### A. Expanding Access to MAT

One of the most impactful changes H.R. 6 makes is to expand the type of health care providers who can prescribe or dispense medication-assisted treatment (MAT), as well as the number of patients providers are allowed to treat. The bill grants physician assistants (PAs) and nurse practitioners (NPs) permanent authority to prescribe MAT and expands the number of patients to whom a practitioner can prescribe MAT. It also authorizes three types of clinical nurses (nurse specialists, nurse midwives, and nurse anesthetists) to prescribe MAT for the next five years. Expanding who can prescribe MAT is the second largest projected expenditure in the bill – $395 million over 10 years. This includes grants for federally qualified health centers and rural health clinics to offset the cost of training providers to dispense medications to treat opioid use disorders.

The bill also expands access to treatment for Medicare patients by paying opioid treatment programs, which have historically not been eligible for reimbursement, a bundled MAT payment for medication, counseling, and treatment. The Congressional Budget Office (CBO) projects this will cost $250 million over the next decade.

The single largest expenditure in the package is the option for states to use their Medicaid program to cover care provided in institutions for mental diseases (IMD), which are otherwise often not eligible for Medicaid reimbursement. Over the five years this coverage is in effect (2019-2023), CBO estimates that it will cost $1.048 billion. This is a component of the law that generated intense debate in Congress. Some lawmakers wanted broader repeal of the Medicaid IMD exclusion that currently prevents Medicaid reimbursement within IMDs, while others expressed concerns about the costs to the federal government as well as the potential for such policy to take the nation back toward a historical emphasis on institutionalization instead of community-based care settings.

The bill also allows mental and behavioral health providers participating in the National Health Service Corps to provide care at school and community-based settings in shortage areas. It enhances access through comprehensive opioid recovery centers, which offer the full continuum of treatment services ranging from drugs and devices to counseling, peer support, and housing. The bill authorized $10 million in annual grants from 2019 to 2023. It's important to note that, as with most of the legislation's fiscal provisions, the bill *authorizes* Congress to appropriate the funds. Appropriation will take another act of Congress.

The bill authorizes $25 million a year from 2019 through 2023 to fund loan repayment agreements with substance use disorder professionals in mental health professional shortage areas or in areas most affected by the epidemic. When funded, this will help expand the number of available providers.

### B. Expanding Medicaid Eligibility for Former Foster Care Youth

Sought after by children's hospitals and other stakeholders, the law requires states to ensure that former foster children continue to have Medicaid coverage across state lines until the age of 26. This ensures health coverage for a vulnerable population, and a payer source for the clinical systems that serve them. It is not uncommon for children's hospitals and other health care systems to serve patients across regions, including multiple states. This provision will give young adults reliable access to a broad range of medical services, including addiction treatment.

## III. EXTENDING REIMBURSEMENT

### A. Requiring Medicaid Coverage of Medication Assisted Treatment (MAT)

The bill requires states Medicaid programs to cover MAT, including drugs, biological products, counseling services, and behavioral therapy, unless it is not feasible to do so due to a shortage of qualified providers or treatment facilities. The requirement applies for five years.

### B. Advancing Telehealth in Medicaid and Medicare

Medicare beneficiaries with substance use and mental health disorders will have expanded access to treatment utilizing telehealth. Providers will be eligible for Medicare reimbursement even when services are provided within a beneficiary's home, something that currently is difficult under the existing reimbursement system.

Within one year, the Centers for Medicare & Medicaid Services (CMS) is required to issue guidance to states regarding how federal reimbursement can be used to fund telehealth services within Medicaid, including school-based services and services for high risk individuals such as American Indians, adults under 40, persons with a history of non-fatal overdose, and individuals experiencing both a serious mental illness and a substance use disorder (SUD). Specifically, CMS will share guidance regarding how Federal reimbursement can be used for telehealth services including assessment, MAT, counseling, medication management, and medication adherence.

### C. Increased Reimbursement to Incentivize Technological Connections

Behavioral health providers, such as select community mental health centers, hospitals, NPs, and clinical social workers will be eligible for a Medicare incentive payment if they adopt certified electronic health records technology through the Center for Medicare and Medicaid Innovation (CMMI).

## IV. Investing in Pilot Programs and Delivery Reform

### A. Strengthening and Expanding Medicaid and Medicare Coverage

H.R. 6 appropriates $50 million for CMS to support state Medicaid demonstration projects to increase patient access to SUD services by increasing the number and/or treatment capacity of Medicaid providers. The funding will support 18-month planning grants in at least 10 states and enhance federal Medicaid matching rates for five states. Approaches will include provider education and training as well as increased reimbursement for and expansion of relevant services. The demonstration projects will serve a range of Medicaid enrollees, including infants with neonatal abstinence syndrome, pregnant and post-partum women, adolescents, young adults, and American Indians. As efforts successfully connect patients with treatment and service utilization increases, the CBO estimates that the total cost of the initiative will be $236 million over five years (2019-2023).

Similarly, the bill creates a four-year demonstration program within Medicare to increase access to comprehensive, evidence-based outpatient treatment for some Medicare beneficiaries, including medication, psychosocial supports, care management, and treatment planning. The program will cost $107 million over a 10-year period, and care will be provided by opioid use disorder teams including at least one physician or other prescriber, and the option of additional team members that would provide psychological, counseling, and social services. The program will also include incentive payments based on performance.

### B. Extending Medicaid Health Homes

The bill extends federal funding for Medicaid health home programs primarily serving individuals with SUDs and a chronic disease. For states that already have a health home programs and thus already have a SUD-focused state plan amendments (SPA) in place, the bill extends federal funding for an additional two quarters. For states that do not yet have these programs, the bill would allow them to add the program (via an SUD-focused SPA) and to receive enhanced federal funding for a two-and-a-half years. Helpful in this vein, the bill requires CMS to publish best practices regarding the design and implementation of SUD-focused state plan amendments by October 1, 2020. Enhanced federal funding for these programs is estimated to cost $323 million over five years (2019-2023) and $509 million over 10 years (2019-2028).

## V. ENSURING SAFE MEDICATIONS

### A. Ensuring Safe Access to Medications; Curbing Importation of Illicit Drugs

Under the bill, Medicaid programs and Medicaid managed care entities are required to have two types of safety mechanisms in place to help combat opioid overuse: safety edits for opioid refills to ensure that patients are not prescribed too much, and automated processes to review claims to catch duplicative prescriptions for opioids and other drugs. Similarly, states are required to have programs to monitor and manage the use of antipsychotic medications by children insured under Medicaid. Medicare providers are required to use e-prescribing for opioids and Medicare prescription drug plans are required to establish drug management programs for at-risk enrollees. CBO estimates that Medicare's e-prescribing efforts will save $250 million over 10 years while drug management programs will contribute an additional $55 million in savings. The overarching intention, of course, is to reduce unnecessary utilization and substance abuse.

Another strategy intended to curb overuse addresses drug packaging. The FDA can now require drug manufacturers to package opioids to allow for a set treatment duration, such as a three or seven-day supply, rather than the traditional 30-day supply that has been historically prescribed regardless of circumstances. The FDA may also require manufacturers to give patients safe options to properly dispose of medications when they are no longer needed thus lessening the chance that the surplus drugs will be abused in the future. These efforts are complemented by provisions within the law requiring patient education regarding safe disposal.

The law includes provisions to combat importation of illicit drugs like fentanyl, a powerful synthetic opioid that has caused many deaths. Because fentanyl is concentrated, it can readily be mailed undetected into the U.S. The law strengthens the FDA and Customs and Border Protection's (CBP) coordination to improve detection and testing equipment, as well as package inspection capacity. It also requires the FDA to develop and update a list of controlled substances to refer to CBP for detection of importation via international mail.

## VI. ALTERNATIVE TREATMENTS

### A. Expanding Access to Alternative Pain Treatments

One way to reduce opioid overuse is to direct patients toward non-opioid alternatives. The bill advances non-opioid alternatives in a number of ways. For example, the law requires the Department of Health and Human Services (HHS) to issue or update guidance regarding what options state Medicaid programs have for offering non-opioid treatment and pain management services and clarifies how non-addictive medical products might qualify for expedited review or approval by FDA (sections 1010; 3001). It also requires HHS to ensure that there are no financial incentives within the Medicare system to use opioids instead of evidence-based non-opioid alternatives. The bill authorizes $10 million per year for FY 2019 through 2021 to establish a demonstration program to test alternative pain management protocols in hospital emergency departments with the hope of lowering the use of opioid medications by increasing utilization of non-opioid alternatives instead.

## VII. PATIENT, PROVIDER, AND COMMUNITY EDUCATION

### A. Advancing Public Health Screening and Prevention

Screening for opioid use disorder and other use disorders will be added to Medicare wellness and preventive care visits with the intention of expanding early detection and timely treatment. Although this is relatively inexpensive – the CBO puts a $13 million price tag on it over 10 years – it is key to shifting activities toward prevention and early intervention, thus more effectively addressing the epidemic.

### B. Provider and Community Education

Medicare patients will begin receiving annual educational information about opioid use, pain management, and non-opioid treatment options available through Medicare. This will include information from Medicare Advantage plans regarding the risks associated with prolonged opioid use and Medicare coverage of nonpharmacological therapies, devices, and non-opioid medications (sections 6021; 6102). Educational resources will also be created for providers, including a toolkit that provides best practices to Medicare participating hospitals for reducing opioid use.

Medicare Advantage and prescription drug plans will also be required to provide information regarding the safe disposal of prescription drugs (sections 6092; 6103). SAMHSA and the CDC will partner to develop educational materials for clinicians to use with pregnant women for shared decision-making regarding pain management during, and purportedly following, pregnancy. Outreach and education grants totaling $75 million will also be available to support efforts to help outlier prescribers reduce the frequency and quantity of opioids that they prescribe.

## VIII. PUBLIC HEALTH AND RESEARCH

### A. Addressing the Social Determinants of Health

HHS will provide technical assistance to states to develop housing-related supports and care coordination services for Medicaid beneficiaries with SUDs. The agency will also report on innovative housing-related services offer in various parts of the country with the intention of sharing and expanding best practices in the effort to help individuals with SUD that are experiencing or at risk of becoming homeless.

### B. Impacts on Maternal and Child Health

The bill includes significant focus on increasing access to prevention and treatment for women and children impacted by the opioid crisis. Multiple components focus on reunifying families by authorizing $15 million to replicate a program that helps parents accelerate their recovery in order to more quickly reunify with their children that have been placed in foster care. An additional $20 million is authorized to help states develop, enhance, or evaluate family-focused treatment programs. HHS will help states identify opportunities to support these programs with help from federal matching funds.

The bill reauthorizes the Residential Treatment for Pregnant and Postpartum Women grant program. GAO is called on to study gaps in Medicaid coverage for pregnant and postpartum women with SUDs. Despite a multitude of provisions focusing on maternal and child health, the CBO only projects $48 million in expenditures nationwide over 10 years. To truly impact this segment of the population negatively impacted by the opioid crisis, additional funding will be needed in the future.

### C. Research and Sharing Best Practices

The bill directs federal agencies to conduct a range of studies to better understand best practices for addressing the opioid crisis. While these studies do not immediately impact the crisis, they do lay the groundwork for evidence-based policies and approaches in the future:

- GAO will study and report on three areas: gaps in Medicaid coverage for pregnant and postpartum women with substance use disorder; hospice programs' management and disposal of controlled substances; and peer support services, including payment models, types of services offered, and impacts on costs and outcomes.
- The Medicaid and CHIP Payment and Access Commission (MACPAC) will study and report on strategies related to medication-assisted treatment (MAT) options in both fee-for-service and managed care Medicaid programs (Sec 1014).
- HHS will examine and then submit a report to Congress regarding the effectiveness of and access to abuse-deterrent opioid formulations in Medicare.
- HHS will evaluate the extent to which Medicare Advantage plans offer MAT and cover non-opioid alternative treatments that are not otherwise covered under traditional Medicare.
- Within one year, a report will also be submitted to Congress regarding how to improve reimbursement and coverage for multi-disciplinary, evidence-based non-opioid chronic pain management for a diversity of high-risk communities.

- Last, HHS will be required to look at the impact of state and federal laws and regulations intended to limit opioid prescriptions, and submit a report to Congress regarding the findings and relevant recommendations. A number of the studies are required to include recommendations for Congressional legislation and/or administrative actions to address the epidemic.

H.R. 6 also includes provisions to support public health research regarding the opioid epidemic including annual reports and publicly accessible data regarding the prevalence of SUDs in the Medicaid beneficiary population, treatment of SUDs across states and territories, and details regarding the forms of treatment, payment structure, and treatment settings. By making this data publicly available, the bill has the potential to help researchers track the epidemic, identify interventions that are working, and subsequently advance those solutions in the future.