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SUPPORT Act: Highlights of the 2018 Opioid Legislation

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On October 3, 2018, the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or short hand—the "SUPPORT for Patients and Communities Act (the "SUPPORT Act")—was approved by the Senate, and sent to the President. The SUPPORT Act is the compromise version of the opioid response bills approved by the House[1] and Senate[2]. The legislation is expected to be signed by the President before the midterm elections in November 2018.

The bill package includes a broad array of new programs and reforms specific to the opioid crisis and substance use disorders (SUDs) generally advocated by the health care industry. The final compromise opioid package contains over 70 opioid-related bills. For a comprehensive summary of the package's provisions, *see* the section-by-section summary at: https://tinyurl.com/y9vlrsmy. Some of the key issues addressed in the SUPPORT Act are:

- **A federal ban on patient brokering:** This provision makes kickbacks for referrals to SUD treatment illegal and subject to hefty criminal and civil penalties, regardless of participation in governmental health care program.

- **Partial repeal of the "IMD exclusion":** This provision partially lifts the ban on use of federal Medicaid program funding for SUD treatment at facilities that are an institute for mental disease (IMD) with more than 16 beds (commonly known as the "IMD exclusion"). Under the provision, Medicaid programs may pay for care at an IMD facility for up to 30 days of residential SUD treatment annually per beneficiary, regardless of severity of diagnosis. The partial lifting of the IMD exclusion is only effective for the next five years. This provision does not mandate the coverage benefit by the states. It remains to be seen whether SUD treatment providers will enroll in the Medicaid program for such limited relief from the IMD exclusion.

- **Best Practices for Recovery Residences:** This provision provides for the identification and development of best practices for recovery housing (also known as “sober homes” or “recovery residences”), including model laws for implementing suggested minimum standards. The law requires coordinated consultation from various federal agencies (e.g., the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration, and the Indian Health Service), state Medicaid programs, and other relevant stakeholders, including but not limited to individuals with a history of SUD, national accreditation entities, providers of recovery housing, and representatives from health insurance issuers.

- **Survey of MHPAEA efficacy:** This provision calls for an analysis of the implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) by the states, in coordination with CMS and the Assistant Secretary of Labor of the Employee Benefits Security Administration. MHPAEA is designed to ensure that patient’s health insurance benefits for mental health and SUD services are comparable to those for medical and surgical services.

- **STOP Act:** This provision requires postal offices that process international mail and the U.S. Customs and Border Protection to crackdown on mailed shipments of illicit fentanyl, the powerful opioid that has fueled the latest dramatic spike in overdose deaths throughout the United States.

- **CAREER Act and Telehealth:** The CAREER Act provides a grant program to incentivize initiatives that support individuals in SUD treatment and recovery to live independently and participate in the workforce. Grant funding is earmarked for defined activities, including promoting telemedicine infrastructure and technology adoption, as well as case management, case coordination, or peer recovery support services. Grant funds will be awarded to the states based upon the rate of drug overdose deaths, rate of unemployment, and rate of labor force participation in the state. In addition to expanding some access to SUD treatment to Medicare beneficiaries via telehealth services, the bill also directs CMS to issue guidance to states on options for providing services via telehealth that address SUDs under Medicaid, including for federal reimbursement of services addressing high-risk individuals, for provider education, and for telehealth services to students in school-based health centers.

- **MAT Prescribing Expansions:** The packages pulls provisions from the TREAT Act and the Addiction Treatment Access Improvement Act to expand access to medication-assisted treatment (MAT), which is considered the gold standard of opioid use disorder treatment. Together, these

measures: (1) eliminate the sunset date for nurse practitioners' and physician assistants' prescribing authority for buprenorphine (a MAT medication); (2) temporarily expand the definition of "qualifying practitioner"[3] to prescribe buprenorphine to include nurse anesthetists, clinical nurse specialists, and nurse midwives; (3) permit a DATA-2000 waivered-practitioner to start immediately treating 100 patients at a time with buprenorphine (in lieu of the initial 30 patient cap) if the practitioner meets certain requirements; and (4) codify a change that expanded the number of patients a physician can treat with buprenorphine at any one time to 275 patients, up from 100 patients. A separate provision would also ensure physicians who have recently graduated in good standing from an accredited school of allopathic or osteopathic medicine, and who meet the other training requirements to prescribe MAT, can obtain a waiver to prescribe MAT.

- **Medicare SUD Treatment Access:** The bill creates a four-year demonstration project, to be developed by CMS in consultation with specialists in the field of addiction, clinicians in primary care, and a beneficiary group, that would allow Medicare beneficiaries to receive MAT and certain wraparound services at an Opioid Treatment Program (OTP). Currently, OTPs are not recognized as Medicare providers, meaning that Medicare beneficiaries receiving MAT at OTPs must pay out-of-pocket.

- **Medicare Part D Reporting Requirements.** Effective in 2020, the bill also extends mandatory reporting requirements for prescription drug coverage under the Medicare Part D drug program to group health plans for better coordination of benefits and compliance with Medicare secondary payer requirements.

Although the SUPPORT Act takes many important steps to address the opioid crisis, a number of notable measures were left out of the final legislation, including:

- **42 CFR Part 2 reform (sharing of SUD data):** A provision that would make SUD-related health records easier to share between Health Insurance Portability and Accountability Act (HIPAA) covered entities by aligning Part 2 with HIPAA for the purposes of treatment, payment, and health care operations. A broad cross-section of stakeholders strongly advocated for including this provision in the legislation, warning that the outdated nature of Part 2 has created barriers for providing the best care possible to individuals with SUDs. Their message was that a lack of access to the full scope of a patient's medical information can hamper the ability of providers and health systems to deliver safe, high-quality treatment and care coordination. The advocates of Part 2 reform believe current barriers can lead to potentially dangerous medical situations for patients receiving SUD treatment.

- **Medicare expansion:** Medicare payment for non-opioid alternatives that was in the House package was left out of the compromise legislation. Instead, the

final legislation authorized a short-term demonstration program, similar to what was proposed in the Senate bill, to better understand provider capacity under the Medicare program.

According to estimates from the Congressional Budget Office (CBO), the most costly provisions of the SUPPORT Act include Medicaid coverage for treatment at IMD facilities, estimated at more than $1 billion from 2019–2028; health homes for SUDs for Medicaid enrollees ($509 million); more flexibility for medication-assisted treatment for opioid use disorders ($395 million); the demonstration project to increase SUD treatment provider capacity under Medicare ($256 million); Medicaid coverage of certain services furnished by opioid treatment programs ($250 million); and health insurance for former foster youth ($171 million).

Offsets included in the legislation require Medicaid managed care organizations to spend at least 85% of their government funding on medical care rather than on administrative costs—known as the medical loss ratio (MLR)—or return it to the government.

CBO estimates that the offsets would reduce government spending by more than $2.7 billion. An offset included in the House version, but excluded from the final agreement, would have allowed end-stage renal disease patients to keep private coverage for an additional three months, for a total of 33 months, prior to moving into Medicare.

Congress also recently approved an estimated $4 billion in additional spending for fiscal year 2019 to support federal programs authorized in the new and prior legislation directed at opioid treatment and prevention activities.

Many experts acknowledge that additional measures will be needed to comprehensively address the addiction crisis. However, this bipartisan legislation takes an important step forward in providing additional tools to battle the opioid crisis.

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[1] H.R. 6(115), SUPPORT for Patients and Communities Act, *available at* https://www.congress.gov/bill/115th-congress/house-bill/6?q=%7B%22search%22%3A%5B%22hr6%22%5D%7D&r=1 (last visited, Sept. 28, 2018).
[2] S.2680, The Opioid Crisis Response Act of 2018, *available at* https://www.congress.gov/bill/115th-congress/senate-bill/2680) (last visited, Sept. 28, 2018).
[3] 21 U.S.C. § 823(g)(2)(G)(iv)