Client Alert: SUPPORT for Patients and Communities A

On October 24, 2018, President Trump signed into law the SUPPORT for Patients and Communities Act, a comprehensive bi designed to address the current opioid crisis. The Act, which received wide, bipartisan support in Congress, is a follow up to t last bipartisan opioid crisis-focused legislation, the 2016 Comprehensive Addiction and Recovery Act (CARA). Like CARA, SUPPORT takes sweeping aim at the opioid crisis, focusing on numerous aspects of opioid prevention, treatment, and recove and expanding various types of coverage, use of telemedicine, and electronic prescribing, among other things. Several aspec the SUPPORT Act should be of particular note for substance use disorder (SUD) treatment providers, health professionals, a organizations treating people with SUDs.

Eliminating Kickbacks in Recovery

Section 8122 of SUPPORT makes it illegal to knowingly and willfully solicit or receive any remuneration, including any kickbac bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient to a recovery home, clinical treatment facility, or laboratory. SUPPORT imposes criminal penalties for a violation of this provision of up to $200,000 and/or 10 years in prison. The provision includes exceptions for referrals to legitimate addiction treatment providers, similar to exceptions that are applicable in Medicare and Medicaid.

Special Registration for Telemedicine

Section 3232 of SUPPORT requires the Attorney General to issue a special registration to health care providers to prescribe controlled substances via telemedicine in certain emergency situations. The Attorney General, in consultation with the Secreta Health and Human Services, has one year to issue final regulations. The goal of this provision is to provide emergency acces treatment for patients who lack access to an in-person specialist.

Partial Repeal of IMD Exclusion – State Option to Provid Medicaid Coverage

One of the most significant elements of SUPPORT is Section 5052, which at least temporarily (until a 2023 sunset) repeals or least narrows the IMD ("Institutions for Mental Disease") exclusion, a policy that barred states from receiving Medicaid funds f people under the age of sixty-five who are patients in "hospital[s], nursing facilit[ies], or other institution[s] of more than 16 bed that treat mental health and SUDs. In the pre-Medicare/Medicaid era (before 1965), states funded inpatient behavioral health services. The federal government imposed the IMD exclusion to prevent states from shifting mental health and addiction treat costs for state-run psychiatric hospitals (IMDs) to the federal government. The problem is that, since the 1960s, most of these state-funded institutions have closed, leaving a badly underfunded, massive shortage of residential or inpatient beds for peop with mental health and SUD needs—without any alternative available.

Until now, the Center for Medicare and Medicaid Services (CMS) found ways to circumvent the exclusion, such as state-by-st Section 1115 demonstration waivers, but this limited the building of desperately needed behavioral health and addiction treatm infrastructure. **SUPPORT enables states to reimburse for SUD treatment of patients ages 21-64 in facilities with up to 4 beds, for up to 30 total days of care during any 12-month period.** Implementation guidance will be forthcoming from the Department of Health Care Services. With one in three Californians enrolled in Medi-Cal, SUD providers and all healthcare providers should be considering how to meet the need and expanded coverage to fill the void in a broader continuum of servic for Medi-Cal beneficiaries.

Expanded Access to Medication-Assisted Treatment

Section 2005 of SUPPORT expands access to Medication Assisted Treatment (MAT), including treatment based on methadone and buprenorphine, by (among other things) raising the patient limit for physicians prescribing MATs to 275, making permanent the currently temporary law enacted by CARA permitting physician assistants and nurse practitioners to provide buprenorphine, and authorizing Medicare coverage for MAT at outpatient Opioid Treatment Programs (OTPs). (PAs and NPs continue to require 24 hours of training to qualify for the DEA waiver, in contrast to the 8 hour requirement for physicians.) Currently, OTPs are not recognized as Medicare providers, essentially requiring Medicare beneficiaries to pay out-of-pocket for receiving MAT at OPTs. Moreover, the Act directs that Medicare will reimburse OTPs via "bundled payments," rather than as fee-for-service, as a pilot program focused on what the Act considers to be a "holistic" approach to treatment.

While expanded coverage for MAT in the Medicare population is good news for OTPs, the expanding focus on MAT continues to reflect a tension in addiction treatment. Federal policy enabling broader coverage and a broader range of providers is based on a public health-focused, harm reduction approach in which buprenorphine reduces opioid overdoses and stabilizes people following opioid addiction. MAT access continues to be limited because the SUD treatment community has misgivings about a harm reduction approach that leaves many people with a continuing physical dependency on a different substance and fails to address the underlying issues in addiction and the need for a recovery-focused framework to sustain people and prevent relapse. The recent enactment of California's SB 992 prohibits licensed SUD treatment providers from denying admission to residential treatment centers on the basis that they are prescribed users of buprenorphine (Suboxone, Subutex, or Sublocade) or other MAT. SUD providers and other healthcare organizations should pay attention to these complicated issues.

Additional Provisions of the Act

The Act contains numerous additional provisions that may have an impact on providers' operations, and that are instructive of the federal government's focus going forward. Among the more significant aspects, the Act:

- Directs the Centers for Medicare & Medicaid Services (CMS) to issue guidance to states concerning telehealth services aimed at treating SUD, and directs CMS to issue a report to Congress detailing best practices for furnishing SUD servic children via telehealth.
- Requires electronic prescribing (e-prescribing) and electronic prior authorization approvals for controlled substances co by Medicare Part D.
- Modifies the Social Security Act to ensure that pregnant and postpartum women receiving SUD care at an IMD can con to receive other Medicaid-covered services (such as prenatal care) outside the IMD.
- Expands the scope of SUD screenings for Medicare beneficiaries during annual wellness and preventive care visits with aim towards early detection and treatment.
- Establishes heightened controls over the transmission of prescriptions for Schedule II, III, IV, or V Controlled Substance deter prescription fraud and the diversion of opioids and other scheduled substances.
- Establishes a voluntary "demonstration program" for participants providing both MAT and non-MAT services, to track outcomes based on established quality measures and to receive rewards for performance based on those measures.

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