H.R. 6 – *SUPPORT for Patients and Communities Act*

Section by Section

TITLE I -- MEDICAID PROVISIONS TO ADDRESS THE OPIOID CRISIS

Sec. 101. Sec. 101. At-risk youth Medicaid protection.

Section 101 requires state Medicaid programs to suspend, as opposed to terminate a juvenile's medical assistance eligibility when a juvenile is incarcerated. A state may suspend coverage while the juvenile is an inmate, but must restore coverage upon release without requiring a new application unless the individual no longer meets the eligibility requirements for medical assistance.

Sec. 102. Health Insurance for Former Foster Youth.

Section 102 requires states to ensure that former foster youth are able to keep their Medicaid coverage across state lines until the age of 26. Sec 102 requires states to adopt this policy in calendar year 2023 for individuals attaining the age of 18 that year, although a state may adopt the policy sooner at state option. This section also requires HHS to issue guidance within one year of enactment regarding best practices to enroll former foster youth in coverage.

Sec. 103. Demonstration project to increase substance use provider capacity under the Medicaid program.

Section 103 requires the Centers for Medicare & Medicaid Services (CMS) to carry out a demonstration project to provide an enhanced federal matching rate for state Medicaid expenditures related to the expansion of substance-use treatment and recovery services. The demonstration project would allow for at least ten states to receive planning grants while five states would be selected for the enhanced federal matching rate portion of the project.

Sec. 104. Drug management program for at-risk beneficiaries.

Section 104 requires states to operate qualified drug management programs whereby states may enroll certain at-risk beneficiaries beginning January 1, 2020. Section 104 describes the elements of a qualified drug management program including enrollment, notification, and re-enrollment, and allows States that currently operate a drug management program under a fee-for-service financial arrangement upon enactment to be considered a qualified program.

Sec. 105. Medicaid drug review and utilization.

Section 105 builds on current state Medicaid drug utilization review activities to help combat the opioid crisis. Under this section, state Medicaid programs will be required to have safety edits in place for opioid refills, monitor concurrent prescribing of opioids and certain other drugs, and monitor antipsychotic prescribing for children.

Sec. 106. Guidance to improve care for infants with neonatal abstinence syndrome and their mothers; GAO study on gaps in Medicaid coverage for pregnant and postpartum women with substance use disorder.

Section 106 requires the Secretary of Health and Human Services to issue guidance to improve care for infants with neonatal abstinence syndrome and their families. The section also requires the Comptroller General of the United States to conduct a study on gaps in Medicaid coverage for pregnant and postpartum women with substance use disorder.

Sec. 107. Medicaid health homes for Medicaid enrollees with substance use disorder.

Section 107 extends the enhanced matching rate for qualified activities for Medicaid health homes targeted towards Medicaid beneficiaries with Substance Use Disorders from eight quarters to 10 quarters. This incentive is targeted at new SUD health home activities.

TITLE II -- MEDICARE PROVISIONS TO ADDRESS THE OPIOID CRISIS

Sec. 201. Authority not to apply certain Medicare telehealth requirements in the case of certain treatment of a substance use disorder or co-occurring mental health disorder.

Section 201 expands the use of telehealth services by instructing the Centers for Medicare & Medicaid Services (CMS) to evaluate the utilization of such services in treating substance use disorder. The Secretary is given the authority to expand the utilization of telehealth services for the treatment of substance use disorder by waiving certain qualifications for an originating site and geographic limitations.

Sec. 202. Encouraging the use of non-opioid analgesics for the management of post-surgical pain.

Section 202 extends the eligibility to receive pass through payments from three years to five years for qualifying drugs. In order to qualify, the drug must be a non-opioid analgesic, demonstrate substantial clinical improvement through a process developed by the Secretary, and either be receiving pass through payment at the time of enactment or be a new drug coming to market after enactment of the bill.

Sec. 203. Requiring a review of current opioid prescriptions for chronic pain and screening for opioid use disorder to be included in the Welcome to Medicare initial preventive physical examination.

Section 203 increases screening and thus, early detection of potential opioid use disorder, upon a beneficiary's entry into the Medicare program. The bill would add items to the Welcome to Medicare initial examination in the case of a beneficiary with a current opioid prescription for chronic pain. The bill would require qualified practitioners to: (a) review the beneficiary's potential risk factors for opioid use disorder; (b) evaluate the beneficiary's level of pain; (c) provide the beneficiary information regarding non-opioid treatment options; and (d) provide a referral for additional treatment, where appropriate.

Sec. 204. Modification of payment for certain outpatient surgical services.

Section 204 freezes payments for certain non-opioid treatments administered in Ambulatory Surgery Centers (ASCs) for five defined Healthcare Common Procedure Coding System codes at the 2016 level for four years. Additionally, the Comptroller General is directed to collect data relating to those codes in the hospital setting, and the Secretary is directed to study whether the targeted treatments are effective at replacing the need for opioids.

Sec. 205. Requiring e-prescribing for coverage of covered part D controlled substances.

Section 205 deters prescription fraud and the diversion of opioids through the use of e-prescribing for such drugs. Prescriptions for a schedule II, III, IV, or V controlled substance covered under a part D prescription drug plan or MA-PD plan are required to be transmitted in accordance with an electronic prescription drug program starting by January 1, 2021. The Secretary may waive this requirement in certain defined cases, such as reasonable technological limitations.

Sec. 206. Requiring prescription drug plan sponsors under Medicare to establish drug management programs for at-risk beneficiaries.

Section 206 accelerates the development and use of drug management programs for at-risk beneficiaries within the Medicare program. Offering drug management programs for at-risk beneficiaries is currently voluntary, but would be made mandatory for all Medicare prescription drug plans by plan year 2021.

Sec. 207. Medicare coverage of certain services furnished by opioid treatment programs.

Section 207 expands Medicare coverage to include Opioid Treatment Programs (OTPs) for the purposes of delivering Medication-Assisted Treatment (MAT) to expand access to treatment options for Medicare beneficiaries. Currently, OTPs are not recognized as Medicare providers, meaning that beneficiaries receiving MAT at OTPs for their opioid use disorders must pay out-of-pocket. In thirteen states, the highest rate of opioid-related inpatient stays is among the over 65 population. Under the provision Medicare will pay OTPs through bundled payments made for wholistic services, including necessary medications, counseling, and testing.

TITLE III – OTHER HEALTH PROVISIONS TO ADDRESS THE OPIOD CRISIS

Sec. 301. Clarifying FDA regulation of non-addictive pain and addiction therapies.
Section 301 requires the Food and Drug Administration to hold at least one public meeting to address the challenges and barriers of developing non-addictive medical products intended to treat pain or addiction. Not later than one year after the public meeting or meetings are conducted, the Secretary shall issue new, or update existing, guidance documents to help address the challenges to developing non-addictive medical products intended to treat pain or addiction, including how such products may be eligible for accelerated approval or breakthrough therapy designation.

Sec. 302. Surveillance and Testing of Opioids to Prevent Fentanyl Deaths.
Section 302 authorizes grants to Federal, State, and local agencies to establish and operate laboratories to detect synthetic opioids and develop standards for the handling and testing of fentanyl, its analogues, and other synthetic opioids. This provision also directs the Centers for Disease Control and Prevention to enhance its drug surveillance program by increasing and accelerating the collection of data on synthetic opioids and new emerging drugs of abuse. Finally, this provision creates a pilot program through which five State or local agencies conduct point-of-use testing of illicit drugs for dangerous contaminants.

Sec. 303. Allowing for more flexibility with respect to medication-assisted treatment for opioid use disorders.
Section 303 increases the number of waivered health providers that can prescribe or dispense approved buprenorphine medications under the Drug Addiction Treatment Act of 2000 (DATA 2000) by authorizing clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists to prescribe buprenorphine for five years. In addition, this provision makes permanent the prescribing authority for physician assistants and nurse practitioners and permits a waivered practitioner to immediately start treating 100 patients at a time with buprenorphine (skipping the initial 30 patient cap) if the practitioner has board certification in addiction medicine or addiction psychiatry; or if practitioner provides medication-assisted treatment (MAT) in a qualified practice setting. Finally, this provision requires the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration, to submit a report assessing the care provided by physicians treating over 100 patients, and by non-physician providers treating over 30 patients.

TITLE IV – OFFSETS

Sec. 401. Promoting Value in Medicaid Managed Care.

Section 401 would provide an incentive for states voluntarily adopting a medical loss ratio (MLR) requirement for their Medicaid managed care organizations (MCOs) of 85 percent. Under current CMS regulations, if a state chooses to require a MLR for Medicaid MCOs, the regulations state that it must be set at least at 85 percent. Because Medicaid is paid jointly by the state and Federal government, the remittances are shared with the federal government at a state's applicable FMAP. (A remittance, or rebate, occurs when a plan does not meet the minimum percentage required by the State). This policy provides an incentive for states to adopt an MLR of 85 percent by allowing them to keep a bigger share of the remittances states collect from MCOs than under current law. Specifically, a state adopting a 85 percent MLR under this section would receive its share of any remittances from MCOs at the state's regular FMAP, whereas under current law, states only receive remittances for some populations under the expansion FMAP (currently 94 percent in 2018). This change is projected to achieve efficiencies in Federal Medicaid spending compared to current law because states are incentivized to collect rebates from MCOs that do not adhere to a reasonable MLR. This section also grandfathers states who as of June 1, 2018 have chosen to have an MLR above 85 percent.

Sec. 402. Extending period of application of Medicare secondary payer rules for individuals with end stage renal disease.

Section 402 would increase, by three months, the application of Medicare's secondary payer rules for beneficiaries with end stage renal disease (ESRD). Generally, Medicare is the primary payer for Medicare-covered individuals, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. However, in certain cases, the beneficiary's non-Medicare coverage pays first, and Medicare is the secondary payer. This is known as the Medicare secondary payer program (MSP). Under current law, Medicare coverage is secondary to any employer health coverage for the ESRD population for 30 months. This provision would extend the limited time period that employer health plans are the primary payer for beneficiaries with end-stage renal disease from 30 months to 33 months. The provision would apply for items and services furnished beginning January 1, 2020.

Sec. 403. Requiring reporting by group health plans of prescription drug coverage information for purposes of identifying primary payer situations under the Medicare program.

Section 403 extends mandatory reporting requirements to include prescription drug coverage in order to better coordinate benefits related to Medicare Part D. Although health plans offered by employers and unions are required by Medicare secondary payer-related law to report enrollment information on certain active employees, there is no requirement for other group health plans that offer a prescription drug benefit to report their plan enrollees with drug coverage to the Department of Health and Human Service (HHS) or the Part D plan sponsors. Starting in 2020, this extension ensures that all prescription drug coverage provided by group health plans that is primary to Medicare coverage is communicated to HHS and to Part D sponsors, thereby permitting sponsors to comply with the statutory Medicare secondary payer requirements.