Special Open Door Forum: Treatment for Substance Use Disorder During the Public Health Emergency, October 7, 2020

1. While we understand that the DEA and FDA consider the pharmacy the end user of opioids, I would like to ask whether HHS would consider using a home secure storage active control dispensing and destruction of unused pills as an option to prevent opioid usage disorder in the future?
    a. There is a provision in the SUPPORT Act. The number escapes me right now but there is a provision that requires CMS to provide guidance to beneficiaries on how to dispose of their medications safely. So that provision is going to be included in upcoming regulations that it will be publishing proposed in final regulations that instruct our Part B plans on the requirements for how to instruct beneficiaries again on safe disposal of their medications. So please stay tuned for that. Hopefully it's helpful.
2. Any consideration might be given to expanding availability of treatment for alcohol use disorders. Understandably, tremendous focus needs to be given and continued to be given to opioid use disorder. But more lives, greater mortality and morbidity has always been associated with alcohol and I'm wondering whether thought is being given to that work?
    a. When you mentioned alcohol use disorder one thing that does come to mind is our proposal in the CY 2021 Physician Fee Schedule proposed rule which was to expand the monthly bundled payments that we established last year for opioid use disorder. Our proposal is to expand that to be applicable for any substance use disorder. And I have kind of seen in comments coming in so far some mention of alcohol use disorder. So that's something you can look out for addressing in the CY 2021 PFS final rule. From the Medicaid perspective as we talked about earlier, states already have a lot of flexibility to cover services, treatment services for individuals with alcohol disorder. Just - and it also is part of the Section 1115 demonstration opportunity. The reason behind that that initiative was really designed to meet the needs of OUD and other substances. And so certain states that we've kind of participated in the demonstration that maybe you don't have quite as great of a need for the OUD population. There's still some need don't get me wrong but there are other substances are really their focus including alcohol disorder. From a Medicaid perspective states are - can and are covering services to treat that population.
3. On the prevention side why it lacks information about disposal since we know education is so critical and about this both safe storage and disposal, just wondering if that will be added down the road?
    a. Safe disposal is one of the important mechanisms for preventing substance use disorder along many lines. And so that is something that we can consider for future inclusion in the roadmap.
4. Speaking to many providers, I'm sitting on the insurance side of things and for so many of the big burning question is how permanent are these changes? How much of my practice is going to have to get rejiggered once again when all of this goes away? Do we have any sense of permanence and where should we do additional advocacy to help providers and payers frankly to know where we are heading?

a. For OTPs specifically, there the audio only flexibilities that were authorized in the interim final rules were for the duration of the PHE. But, we did separately propose for next year and ongoing to allow audio and video communication technology for furnishing the periodic assessments. That's just under OTP. I think you're probably asking more broadly about services generally. I know there's a lot of information posted online in terms of the flexibilities during the COVID-19 PHE. If you have specific questions though that you're not finding answers to there is a resource box for those COVID-19 questions. And I can give you that email address. It's hapg_covid-19@cms.hhs.gov, because I think Kim kind of spoke to this in her presentation which is that there's three different buckets of services, ones that have been added permanently, ones that are added only during this PHE and ones that are kind of requiring more thought and we'll do kind of future rulemaking on those. So check out the information that is posted and any other questions you can send to that email address. We have other states that didn't move quite that far but did provide more flexibility. And we have other states that were already pretty flexible to begin with. So we expect that states will assess where they've been during the course of the PHE and determine how they'd like to proceed going forward. I think all of their eyes have been opened with having to kind of implement telehealth so quickly for so many different providers throughout their states but that's really, that's the focus of the supplement of the toolkit that we'll be releasing is helping states assess where they've been and where they're headed. I think the states will start taking a look at this. I know some states probably already are looking at this. But we can't from the federal perspective we don't have limitations on what the state can do. They - these flexibilities exist within the PHE, beyond the PHE. They existed before the PHE so now it's just a time for assessment for states to figure out how they're going to be moving forward and then we'll support them in that if they need to submit any paperwork with us to effectuate any permanent changes or if they can just make their change and move forward without our having to bless it.

5. The question is regarding either continuation of or provision for a release for folks who are incarcerated very, very high risk population and continuing medications for opioid use disorder after folks who are, you know, say on a, you know, stable on a program either, you know, get incarcerated. I'm finding that beneficiaries that are either on, you know, on the Medicaid it doesn't cover them in, you know, while they're incarcerated. So I'm wondering, you know, what (thought has gone into) this - that especially during the Public Health Emergency?
    a. In terms of individuals who are considered inmates yes Medicaid coverage it can - states can make - can decide to continue to keep people eligible, but Medicaid will not pay for any services while an individual is incarcerated. ***[CORRECTION: Medicaid will pay for inpatient hospital services for Medicaid.]*** And that has not changed with the Public Health Emergency. That is a clear statutory requirement for Medicaid. As part of the Support Act though there was a Section 5032 that directs that HHS conduct a stakeholder group to solicit feedback and that there be a report to Congress on the subject and that ultimately CMS put out a - an 1115 demonstration authority opportunity similar to the one we've been discussing about they SUD opportunity for states. So those things are dependent on one another. I believe the stakeholder announcement for this – for the - I mean the announcement for the stakeholder group went out I'm going to say October 1 -- don't quote me on that -- in the Federal Register I believe. And once, you know, that needs to occur report to Congress needs to occur then CMS. And it's just the way the statute was written to have those dependencies built in. But we are actively involved in

that work and (then) supporting the people that are reporting on the stakeholder group. We also at CMS are required under again the SUPPORT Act 1001 to develop guidance for states who wish to for - so that states are more enabled to suspend coverage of juveniles as they enter incarceration so that the suspension can be lifted and their benefits can be reengaged more rapidly. That guidance is scheduled for release this fall as well and so that's another one to look for. But to your larger point, you know, this is a really important consideration. We know that folks who are incarcerated are at high risk when they exit. And unfortunately, we're prohibited from statute by covering services when they are incarcerated but were doing the best we can to reengage when they exit.