ternatively, learning from the failures of our response to HIV as well as our successes can help us leverage social and community support to ensure that the opioid response is maximally successfully and benefits all sectors of society.

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The SUPPORT for Patients and Communities Act — What Will It Mean for the Opioid-Overdose Crisis?

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Opioid-overdose deaths have increased every year for the past two decades, driving a drug-overdose epidemic that killed more than 72,000 Americans in 2017.[1] Thanks in large part to sustained efforts by health advocates, medical professionals, and affected people, Congress has acted on several occasions to address this ongoing and largely preventable crisis. In 2016, President Barack Obama signed the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, which contain numerous provisions designed to increase access to evidence-based care and treatment for people with substance use disorders (SUDs). Neither law substantially altered the federal policy landscape, however, and overdose-related deaths have continued to increase.

More than a decade into this crisis, the country still lacks an integrated federal response to reduce the rates of overdose-related death and disability. Although the office of the surgeon general has fought to address the stigma still associated with addiction and has strongly supported proven public health interventions such as increased access to sterile syringes and the opioid-antagonist naloxone, the office of the attorney general has embraced a "war on drugs" approach focused on arrest and incarceration. Meanwhile, the Office of National Drug Control Policy has been without a director since President Donald Trump was inaugurated, and the Trump administration has threatened crippling cuts to its budget and purview. Republicans in Congress have repeatedly attempted to repeal the Affordable Care Act, a law that significantly reduced the number of people with heroin use disorders who are uninsured.[2]

Against this backdrop, Trump signed the SUPPORT for Patients and Communities Act in October 2018. Although the 250-page law does little to further a coordinated federal strategy for addressing the epidemic, many of its provisions will be beneficial for people with SUDs and those at risk for SUDs, including provisions that are designed to improve pain management, support the development of the SUD-treatment workforce, and eliminate kickbacks for referring patients to so-called recovery homes. The law's most important provisions, however, are those intended to increase access to evidence-based treatment and follow-up care, particularly for pregnant women, children, people in rural areas, and people in recovery from an SUD.

Opioid-agonist therapy with methadone or buprenorphine is the standard for treating opioid use disorder (OUD), but legal restrictions and lack of funding have made these medications inaccessible for many people: only about 20% of Americans with OUD report having received treatment in the previous year.[3] The law attempts to address this lack of access to opioid-agonist therapy and other services and supports.

It focuses particular attention on pregnant women and children. Perhaps most notably, it requires that state Children's Health Insur-

ance Program plans provide mental health and SUD benefits on par with those for physical health conditions. It also clarifies that states may use Medicaid funds to pay for services for babies with neonatal abstinence syndrome, including counseling and other services for mothers and other caretakers, and makes a technical change to permit pregnant and postpartum women in what are known as Institutions for Mental Disease (IMDs) to receive Medicaid-covered care outside those facilities. The SUPPORT law also addresses a wrinkle in existing law by permitting young adults who were formerly in foster care to receive Medicaid coverage until 26 years of age, even if they leave the state where they aged out of the foster-care system.

SUPPORT focuses on older Americans as well, in part by improving screening for SUDs among Medicare beneficiaries and mandating coverage of services provided in opioid treatment programs, including opioid-agonist therapy and related counseling. Because Medicare does not currently cover services provided in these federally certified outpatient facilities — which traditionally provided methadone but increasingly offer buprenorphine as well — this change has the potential to dramatically increase access to these proven treatments.

The law also seeks to increase access to treatment more generally. In one potentially substantial change, it partially repeals the so-called IMD exclusion through September 2023. Under existing law, Medicaid does not cover treatment in IMDs that have more than 16 beds, including inpatient treatment facilities, for people younger than 65 years of age. The new law permits states that meet certain requirements to use Medicaid funds to cover up to 30 days per year of treatment in certain IMDs for people with an SUD who are 21 to 64 years of age. Because of extensive advocacy by the addiction medicine and health policy communities, funded IMDs must follow evidence-based practices, including offering both opioid-antagonist medications and buprenorphine. The law prohibits states that expand IMD treatment under this provision from reducing spending on outpatient and community-based SUD services and requires them to have a plan to ensure that people with SUDs are placed in an appropriate level of care and to cover the cost of that care.

SUPPORT also aims to expand both the number and reach of SUD providers. Less than 5% of practicing physicians have the necessary authorization to prescribe buprenorphine to treat OUD, and federal law caps the number of patients each provider can treat. In part because of these restrictions, nearly half the counties in the United States — and more than 60% of rural counties — don't have a single physician authorized to prescribe buprenorphine.[4] SUPPORT makes permanent CARA's temporary authorization for some nurse practitioners and physician assistants to prescribe buprenorphine to treat OUD, temporarily permits certain other nurses to prescribe the medication, and liberalizes the patient cap. It also creates a loan-repayment program for certain SUD-treatment professionals practicing in high-need areas, although no funds are appropriated to implement the program.

The law further aims to reduce disparities in access to treatment by requiring the Department of Health and Human Services (HHS) to issue guidance outlining opportunities for states to receive Medicaid reimbursement for assessment, medication-assisted treatment, counseling, and related SUDs services delivered using telehealth. This guidance, combined with a recently issued memo that clarifies that buprenorphine may be prescribed using telemedicine and a separate provision in the law that expands Medicare payment for some SUD services provided using telehealth, may help alleviate barriers to opioid-agonist therapy for people in rural areas and others without easy access to providers who offer SUD treatment.

Finally, the law takes several steps to improve transitions for people leaving institutional settings and those in recovery from an SUD. Medicaid does not cover services provided in jails and prisons, and many states terminate enrollees' coverage if they become incarcerated. Under the SUPPORT law, coverage for juvenile Medicaid enrollees must be suspended rather than terminated if they are incarcerated and must be reinstated on their release. The law also authorizes (but does not fund) a pilot program that would direct funding to states to provide people in recovery with stable housing for up to 2 years and requires HHS to convene a stakeholder group to develop best practices for care coordination for people leaving incarceration and to publish minimum standards for recovery housing. HHS is also required to issue a letter to state Medicaid directors outlining opportunities for improving care transitions for people leaving institutions, including the possibil-

ity of allowing such people to receive Medicaid coverage up to 30 days before their release date — although it is not clear that this policy is permissible under current Medicaid law.[5]

Although SUPPORT is a step in the right direction, substantially altering the trajectory of the opioid epidemic requires a comprehensive, integrated, and public health–oriented response coordinated throughout all branches and levels of government. Every dollar spent on incarcerating a person who uses drugs is a dollar that is not spent on prevention or treatment, and every person removed from the Medicaid rolls is a person who is unable to receive evidence-based care. We have the tools and knowledge to reverse the unprecedented, and largely preventable, avalanche of overdose-related morbidity and mortality. The question is not how to end the crisis of opioid-related harm but whether we will choose to mount an effective, evidence-based, and equity-focused response. The lives of thousands of people depend on the answer.

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Reducing Protections for Noncitizen Children — Exacerbating Harm and Trauma

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On June 26, 2018, a federal judge ordered the Trump administration to reunite families that it had separated at the U.S.–Mexico border. As of mid-October, however, an analysis by the American Civil Liberties Union showed that 245 children were still in government custody. About half those children remained in the United States when their parents were deported and were not seeking reunification; the other half were still waiting to be reunited with their parents.[1] Meanwhile, the total number of undocumented immigrant children in U.S. government custody has reached unprecedented levels (more than 14,000 as of mid-November), and President Donald Trump continues to crack down on immigrant families seeking asylum.

As part of the ongoing effort to deter immigrants from attempting to enter the United States, the Departments of Homeland Security (DHS) and Health and Human Services (HHS) have released a proposal (DHS Docket No. ICEB-2018-0002) to establish new regulations to replace the existing standards of care for noncitizen children. The current standards were established by the 1997 Flores Settlement Agreement, which resulted from a class action lawsuit filed against the government in response to the mistreatment of immigrant children in U.S. custody. Although the proposed regulations mirror much of the language in the Flores Settlement Agreement, the new proposal includes provisions that would permit the detention of noncitizen children and their families for indefinite periods in facilities without appropriate and independent monitoring. According to the proposal, the goal of the regulations is to reduce operational difficulties stemming from state licensing requirements for housing children and families who are undergoing immigration proceedings.

We believe that this proposal presents a grave and urgent risk to the health and well-being of noncitizen children and their families and would have important negative consequences for the United States. Children and fam-