Federal agencies have issued guidance to help provide safe access to medication treatment for opioid use disorder (MOUD) during the COVID-19 pandemic. They have acted in two key areas affecting OUD treatment – telehealth and opioid treatment programs (OTPs). Many, but not all, of these loosened regulatory requirements are temporarily in place during the public health emergency declared by the Secretary of Health and Human Services (HHS), effective January 27. State officials should help providers use these tools to initiate treatment and facilitate continuity of care because tapering or discontinuing medications can lead to relapse and overdose. The period immediately after ceasing treatment is particularly risky when patients have reduced tolerance.¹

State officials should consider necessary emergency actions to align their rules and regulations with this new guidance, provide clarity to treatment providers about how to take advantage of these flexibilities, and – where appropriate – consider permanent action to increase patient access. This document summarizes the new federal flexibilities available to states, and actions states should take to ensure that people with OUD and their providers see the benefits.

**Opioid Treatment Programs**

Because OTP patients typically receive methadone during daily, supervised visits, alternative dosing strategies will minimize patient exposure to COVID-19. Federal regulations already allow some exceptions for take-home or unsupervised dosing, but in light of COVID-19, allowances for unsupervised dosing have been expanded.

**Take-Home Doses** - Substance Abuse and Mental Health Services Administration (SAMHSA)

States may make a blanket exception request to allow OTPs more flexibility providing medications to patients to reduce the risk of exposure. They can provide 28 days of take-home doses for stable patients and up to 14 days for less stable patients. SAMHSA does not define patient stability, though it could be determined through state guidance and at the provider’s discretion.

— **State Action**: Issue guidance to OTPs on how to take advantage of this dosing flexibility and administer care to patients diagnosed with COVID-19, showing symptoms or quarantined.

  o **Example**: SAMHSA released a sample frequently asked questions (FAQ) document based on Ohio’s guidance to providers. It addresses how to provide medications to patients diagnosed with COVID-19, exhibiting symptoms of a respiratory illness, or with significant co-morbidities, such as patients older than 60 or immunosuppressed, suggesting up to 14 days of take-home dosing for those patients.
The document also lays out strategies for continued care for less stable patients (with psychiatric disorders, chaotic living situations, etc.), patients in the beginning phase of treatment, or on buprenorphine. In some cases, staggered dosing days could help reduce the number of patients traveling to the facility daily.

— **State Action:** Ensure patient access to lock boxes and naloxone, through federal grant money or other available resources.
  - **Example:** Colorado Department of Human Services authorized State Opioid Response (also called SOR) grant money to be used to purchase lock boxes for take-home dosing and other OTP supplies, such as methadone take-home bottles and personal protective equipment. The Department also laid out a process for acquiring naloxone.

— **Federal Resources:** SAMHSA OTP guidance.

**Medication Delivery** - Drug Enforcement Administration (DEA) and SAMHSA

During the public health emergency, OTPs may facilitate home delivery of medications for patients medically ordered to be under quarantine or isolation. If a trustworthy patient-designated third party cannot travel to the OTP to receive the medication, home delivery in a lock box is an option. Deliveries can be made by non-licensed healthcare providers, including other OTP employees, law enforcement, and members of the National Guard.

— **State Action:** Issue guidance to OTPs making it clear that home delivery is allowed under federal law, and the process for designating a trusted third-party to facilitate pick-up or home delivery.

— **Federal Resources:**
  - DEA exemption, allowing non-healthcare workers to deliver methadone.
  - SAMHSA guidance for delivering medications patients medically ordered to be under quarantine or isolation.

**Telehealth**

For all non-emergency medical services, alternative methods of maintaining patient care, such as telehealth, should be considered to minimize patient exposure to COVID-19. With the public health emergency declaration, states and their providers can extend the use of telehealth services.

Research shows that use of telehealth to treat OUD is as effective as in-person visits on patient outcomes, while expansion of telehealth has been shown to significantly increase access to OUD treatment. Most of the new federal flexibilities on telehealth will be beneficial for all patients; one change—the implementation of new standards for controlled substance prescribing—will specifically assist patients on MOUD.
Controlled Substances Prescribing via Telehealth - DEA and SAMHSA

Under the public health emergency, DEA-registered practitioners can now prescribe buprenorphine to new and existing patients with OUD through telehealth, including by telephone, without an initial in-person visit. This includes patients receiving buprenorphine at OTPs. Although patients cannot begin methadone treatment through telehealth, existing patients can be maintained on methadone through telehealth.

--- State Action: Remove any legal or regulatory requirements for DEA-registered practitioners to conduct an in-person medical evaluation before prescribing schedule II-V controlled substances through telehealth.

- Example: Colorado’s Office of Behavioral Health issued guidance to suspend enforcement of state telehealth restrictions for telehealth services, including prescribing buprenorphine.

--- Federal Resources:

- DEA guidance on prescribing controlled substances through telehealth.
- DEA guidance on prescribing buprenorphine through the telephone to patients with OUD.
- SAMHSA guidance on in-person treatment requirements for patients receiving buprenorphine and methadone.

Penalties for Non-Compliance Suspended - HHS, Office of Civil Rights (OCR)

Under the public health emergency, health care providers can now use any non-public facing remote communication product (e.g. Apple FaceTime, Skype, GoToMeeting) to communicate with patients, including with patients in their home. These telehealth services must be provided in good faith and cannot violate state licensing laws or ethical board guidance, for instance.

--- State Action: Revise or suspend the enforcement of laws and regulations that require the strict use of Health Insurance Portability and Accountability Act (HIPAA)-compliant remote communication products to deliver health care services through telehealth, including telehealth services delivered to patients in their home.

- Example: Virginia’s Department of Medical Assistance Services issued a Medicaid Memo that, in part, suspends state Medicaid requirements for clinical staff to be present at the “originating site” of a telehealth interaction.

--- Federal Resources: OCR guidance to suspend penalties for non-compliance with HIPAA telehealth requirements.
Medicaid Reimbursement for Telehealth - Centers for Medicare and Medicaid Services (CMS)

Under the public health emergency, states can now cover a broad range of Medicaid services at the same reimbursement rate as in-person visits, including behavioral health, provided through telehealth. States have increased flexibility to include these services, including services provided by telephone, into their Medicaid state plan, Medicaid waiver or demonstration project, or their Medicaid managed care contracts.

— **State Action:** Review the Medicaid state plan, waivers, and managed care contracts to ensure that: telephonic services can be billed by all behavioral health providers; coverage of telehealth services is maximized in the Medicaid state plan; and telehealth services covered in the Medicaid state plan are included in all Medicaid managed care contracts. If any of these are missing, states should submit a Medicaid state plan amendment, revise their current waivers, or amend their Medicaid managed care contracts to include them.

- States should maximize their state plan coverage of telehealth services to encourage patient access during the public health crisis and after.
- States should ensure that high risk-populations, such as individuals being released from jails or prisons, have phones to access telehealth services.
- **Example:** Maryland Governor Larry Hogan issued an executive order authorizing audio-only services for Medicaid enrollees and individuals served with funds from the Behavioral Health Administration.

— **Federal Resources:**

- CMS guidance to states on maximizing use of telehealth in Medicaid.
- CMS encourages states to extend any telehealth flexibilities allowed under their state plan or any Medicaid waiver (e.g. section 1915(b) or (c)) or state demonstration waiver (e.g. section 1115) to services covered in their managed care contracts. If the state does not have telehealth flexibilities in their state plan, Medicaid waivers, or state demonstration waiver, telehealth services provided in the managed care contract could be covered as in-lieu of services or as additional services voluntarily provided by managed care contracts.

State Guidance to Providers

States should issue guidance to providers, including behavioral health service providers, to notify them of federal and state action to facilitate increased use of telehealth services. **Here are some examples of how states have distilled the above topics into crosscutting guidance:**

- Massachusetts’ Bureau of Substance Addiction Services issued an alert to all DEA-registered practitioners in the state informing them of the DEA guidance and its impact on their ability to prescribe medications for opioid use disorder (MOUD).
- New Jersey’s Department of Human Services directed its Medicaid managed care organizations and the state’s Medicaid fee-for-service program to provide...
reimbursement to providers for telehealth, including tele-mental health services, in the same manner as for face-to-face services; waive site of service requirements for telehealth; and permit use of alternative technologies for telehealth such as telephonic and video technology.

- Virginia’s Department of Medical Assistance Services issued a Medicaid Memo that provided in-depth guidance to behavioral health service providers to navigate the use of telehealth and other provider concerns related to Medicaid billing and patient care.

**Increase Access to Behavioral Health Services**

In addition to aligning state laws and regulations with guidance from federal agencies, states should take additional action to increase patient access to needed behavioral health services during the public health emergency, such as:

- Temporarily waive requirements that physicians and other health care providers are licensed in the state that they are providing services in, as long as those providers have an equivalent license in another state.
- Ensure behavioral health providers that receive federal (e.g. Substance Abuse Block Grant) or state grant funds can bill for telehealth services rendered, including to patients in their home.
  - **Example:** Pennsylvania’s Department of Drug and Alcohol Programs issued an informational bulletin to allow for providers that receive grants from the department to use those funds to deliver counseling and other clinical services through telehealth.

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