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State Policy Changes Could Increase Access to Opioid Treatment via Telehealth

Removing restrictions and providing proper reimbursement would benefit underserved populations

Overview

When the COVID-19 pandemic struck in early 2020, social distancing guidance and stay-at-home orders threatened to disrupt medical care for hundreds of thousands of people receiving medication treatment for opioid use disorder (OUD) across the United States. In response, the federal government began allowing people to receive these health care services remotely, or via telehealth, by interacting with doctors and other providers over the internet and by phone. (See Box 1.)

Emerging research shows that allowing telehealth-based OUD treatment during the pandemic helped patients initiate and remain on medication treatment, and also that these patients stayed in treatment and abstained from illicit opioids at rates comparable to individuals who received care in person.¹ Clinicians who used telehealth during the pandemic reported that it increased access and convenience for their patients, particularly among historically underserved populations such as people in rural or remote areas, people leaving incarceration, clients of syringe services programs, and people experiencing homelessness.²

New policy measures are now needed to ensure that patients can continue to benefit from telehealth treatment for OUD after the pandemic. To accomplish this goal, state Medicaid agencies and lawmakers can take several measures, such as:

- Requiring public and private insurers to reimburse OUD treatment providers for all services delivered via telehealth.
- Setting public and private reimbursement rates for telehealth-based OUD services on a par with in-person treatment.
- Expanding locations where patients can receive OUD treatment services via telehealth, including their homes.
- Allowing patients with Medicaid to access OUD treatment services by telephone.
- Enabling correctional institutions to use telehealth for OUD treatment services.

States have broad latitude to develop their own laws and regulations governing the use of telehealth. In fact, 43 states and Washington, D.C., have laws that govern private payer reimbursement of telehealth.³ However, a variety of barriers slow the adoption of telehealth in practice: Technological infrastructure development can be expensive; nearly 14.5 million Americans lack access to high-speed internet;⁴ and monitoring and evaluating telehealth programs by Medicaid agencies and health departments requires resources. Although these obstacles might have discouraged state policymakers from expanding telehealth access in the past, states now can tap into federal and interstate resources—such as regional and national telehealth resource centers, federal monies, and peer states—to maintain and expand their telehealth capacities.

Box 1. Relaxed Federal Telehealth Rules for Treating OUD During the Pandemic

Before the COVID-19 pandemic, providers who prescribe buprenorphine for OUD could not use telehealth to initiate new patients on the medication because of regulatory barriers from the Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Ryan Haight Online Pharmacy Consumer Protection Act of 2008—which requires regulations to be set forth by the DEA—prohibits the prescribing and dispensing of controlled substances, including buprenorphine, without an in-person medical evaluation.⁵ In addition, SAMHSA requires all opioid treatment programs (OTPs)—the only facilities where methadone can be dispensed to treat OUD—to examine a patient before admission to treatment, and further agency guidance implies that the exam should be completed in person.⁶ Although the DEA is expected to put regulations into effect that allow practitioners to register to prescribe medications via telehealth—per the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, passed in October 2018—the agency has yet to do so.⁷

SAMHSA and the DEA each updated their guidance in response to the COVID-19 public health emergency, declared by the secretary of the Department of Health and Human Services, to allow medication initiation via telehealth. The agencies used their statutory authorities to remove the requirement for an in-person evaluation and allow buprenorphine prescribers to initiate medication treatment for new patients using an audiovisual or audio-only connection, though providers must still adhere to any state-specific requirements.⁸

SAMHSA's exemption allowing a telehealth visit to initiate medication treatment does not include methadone. Instead, the agency addressed the need to reduce in-person services by permitting OTPs to increase the number of days of take-home medication a patient may receive. Before the COVID-19 pandemic, federal regulations stated that patients could receive only one month of take-home doses after two years of continuous treatment. For the duration of the COVID-19 public health emergency, however, OTPs can allow patients to take home a 28-day supply of methadone as long as they are considered to be stable, a determination the OTP makes. Patients considered to be less stable are permitted up to 14 days' worth of take-home doses.⁹ During this period when patients are taking their medication at home, they can use telehealth for follow-up services such as counseling.¹⁰

Many states have taken advantage of these temporary relaxations in telehealth policy, though these flexibilities are set to lapse once COVID-19 is no longer declared to be a public health emergency.¹¹ However, the DEA and SAMHSA have the authority to issue new rules or guidance that continues both flexibilities. In addition, the agencies can continue them by invoking the separate opioid-specific public health emergency declaration that has been in place since October 2017.¹² Making these federal flexibilities permanent would build on the progress made during the pandemic to expand access to medication treatment and could also signal to states the importance of prioritizing policies that advance the telehealth delivery of OUD treatment services moving forward.

Policy recommendations

Require public and private insurers to reimburse all OUD treatment providers and services delivered via telehealth

State Medicaid programs and legislators should ensure that all telehealth-based OUD treatment providers and services—including clinical assessments, prescription of medication treatment, medication management, and individual and group counseling—are covered and eligible for reimbursement by Medicaid and private insurance whenever possible.

Ensuring that different types and levels of providers are eligible to bill for services, including the prescribing of buprenorphine, is critical for building a comprehensive and effective treatment system. For example, Minnesota Medicaid allows a wide variety of providers—including physicians, nurse practitioners, physician assistants, and mental health professionals—to deliver via telehealth the same services they are authorized to provide in person.¹³ The inclusion of midlevel practitioners is particularly important for expanding access to buprenorphine: Nurse practitioners and physician assistants have been responsible for the majority of buprenorphine prescription growth among patients with Medicaid and individuals living in rural areas where access to treatment is lacking.¹⁴

Medicaid programs and private payers that reimburse practitioners for providing OUD treatment in person should cover the same services provided via telehealth. For example, California passed legislation in 2011 to amend Medicaid regulations and allow providers to administer all covered benefits and services via telehealth, as long as the remote provider believes the services are clinically appropriate, meet the procedural definition and components of the medical billing codes, and satisfy all health care confidentiality laws.¹⁵

Medicaid programs and private payers can reimburse for the provision of buprenorphine to new and existing patients via telehealth.¹⁶ And states that allow medication treatment for OUD to be prescribed via telehealth are seeing positive results: In Maryland, one telehealth program providing buprenorphine found that patient

outcomes related to retention in treatment and cessation of opioid use were comparable to those from in-person programs.¹⁷ And during the COVID-19 public health emergency, a nationwide survey found that one-third of clinicians who prescribed buprenorphine via telehealth in the past year did so without conducting an in-person physical patient examination. Of these providers, only about 5% reported difficulties experienced with buprenorphine initiation, a figure consistent with available research on in-person programs.¹⁸

In addition, reimbursement for psychosocial services allows patients who receive methadone from an OTP to attend counseling sessions via telehealth, which reduces the burden of frequent in-person visits, especially for patients who are permitted take-home methadone doses.

Reimburse telehealth-delivered OUD services at in-person rates

Inadequate provider reimbursement is a common barrier to expanding the use of telehealth.¹⁹ Without assurances of sufficient reimbursement rates, providers may be unwilling to invest in telehealth infrastructure for their practices, or they may find it infeasible to increase the use of telehealth for OUD treatment.²⁰ Although some payers are concerned that payment parity for telehealth services would incentivize lower-quality care and lead to increased costs through overuse of services, evidence to date suggests that these outcomes have not materialized.²¹ For example, even though telehealth use has increased twentyfold since the start of the pandemic, total weekly outpatient visits—including telehealth and in-person services—are comparable pre- and post-pandemic, signaling that telehealth is replacing in-person care and not duplicating it.²²

Therefore, Medicaid programs should cover and reimburse for OUD treatment services delivered via telehealth in parity with in-person rates; states are able to do this without submitting a state plan amendment to the Centers for Medicare & Medicaid Services (CMS) for review and approval.²³ As of May 2020, Medicaid programs in 38 states and D.C. provided payment parity for some services delivered via telehealth.²⁴ Although it's not clear what share of these state policies includes OUD services, this demonstrates that states have successfully implemented payment parity on a large scale.

Additionally, state policymakers can require that private health plans cover and reimburse for OUD treatment services delivered via telehealth at parity.²⁵ As of the fall of 2019, about half of all states required private health plans to provide service parity for some services, and 10 states required them to provide payment parity for some services.²⁶ Although these laws do not all explicitly name OUD services, some states have taken this step. For example, in 2021 Arizona enacted legislation mandating that all health plans “must provide coverage for health care services that are provided through telehealth” if it would be provided in person and “shall reimburse health care providers at the same level of payment for equivalent services” whether delivered via telehealth or in person.²⁷ This legislation also requires all health plans to reimburse providers for “behavioral health and substance use disorder services ... if provided through telehealth using an audio-only format” at an equivalent reimbursement to services delivered in person.²⁸

Expand locations where patients can access OUD treatment services via telehealth

Telehealth can help close the treatment gap for people with OUD who are interested in starting treatment but lack access to treatment providers, particularly those with the required DEA waiver to prescribe buprenorphine for OUD. As of 2018, 40% of U.S. counties did not have clinicians with waivers to prescribe buprenorphine.²⁹ Yet patients are not always permitted to receive telehealth at home or at another convenient location of their choosing. Some states allow patients to receive treatment over the internet or by phone but require them to do so at treatment centers or other sites that may require them to travel long distances.³⁰ This creates barriers to care for people without transportation or with other responsibilities, such as a job or child care, that make such travel

difficult. Giving patients more options for places where they can participate in a telehealth visit can make it easier for them to access treatment.

State Medicaid agencies and legislatures should make regulatory or legislative changes, respectively, to allow for a wide variety of eligible originating sites, or locations where patients can be when services are delivered via telehealth, including the patient's home. In fact, Medicare already allows telehealth in a patient's home as a result of changes made by the 2018 SUPPORT Act, which expanded critical access to OUD treatment via telehealth by removing originating site restrictions. Observational studies indicate that patients can safely and successfully initiate buprenorphine unobserved at home; the research shows that adverse events and treatment retention for these patients are comparable to those of patients who initiate treatment in office.³¹ Moreover, one study found that more than half of patients chose home-based initiations, suggesting that patients prefer this option.³²

In line with this evidence, Missouri Medicaid has no restrictions on originating sites, as long as "the provider can ensure services are rendered meeting the standard of care that would otherwise be expected" if the services were provided in person.³³ And Washington state's revised code explicitly allows Medicaid members to use their "home or any location determined by the individual receiving the service" as an originating site for a telehealth visit.³⁴ As of February 2021, Medicaid programs in 26 states and D.C. allow members to use their homes as an eligible originating site for a telehealth visit; however, OUD treatment services are sometimes excluded from these policies.³⁵

Washington also passed legislation, effective in 2018 for all health plans, to permit a variety of facility types to serve as originating sites, including rural health clinics, federally qualified health centers, health care provider offices, and community mental health centers.³⁶ This option may be useful for patients of OTPs who are required to take their methadone in person, and could then use the OTP facility as an originating site for counseling sessions held elsewhere.

Allow audio-only OUD treatment services for patients with Medicaid

Although the DEA currently allows audio-only buprenorphine initiation only during the COVID-19 public health emergency, Medicaid programs can and should allow patients and providers to use telephones for delivering and receiving OUD treatment services such as intake evaluations, medication management, and counseling.

Treatment programs that permit patients to use audio-only technology during the pandemic have seen positive results—including engaging new people who would not have entered treatment.³⁷ Allowing for the use of telephones can address inequitable access to audiovisual technology: Video telehealth is not widely accessible for the 14.5 million Americans living in "digital deserts" as a result of inequities that include inadequate broadband, digital illiteracy, and health system barriers.³⁸ In fact, a recent study of a large integrated health system in Massachusetts found that patients who were Black, Hispanic, Spanish-speaking and/or living in areas with the lowest broadband internet access, median incomes, and educational attainment were less likely to use video visits than were privately insured White individuals living in areas with higher incomes and broadband access.³⁹ Another study found that telehealth encounters are more likely to be audio-only for individuals with public insurance or self-pay status, who may be less likely to have the mobile devices and computers required for audiovisual telehealth.⁴⁰

Medicaid programs should reimburse for audio-only services, which can help address geographic, socioeconomic, racial, and ethnic disparities in telehealth treatment access. Indeed, CMS' proposed physician fee schedule for 2022 makes permanent the allowance that OTPs provide the therapy and counseling portions of their weekly bundle of services using audio-only telehealth in cases where audiovisual communication is not available to the beneficiary. CMS states that allowing OTPs to deliver audio-only services "facilitates broader access to services,

particularly for vulnerable populations, and ensures providers have flexibility to deliver care to beneficiaries as efficiently and seamlessly as possible.⁴¹ As of February 2021, at least 15 Medicaid programs reimbursed for audio-only telehealth, but in many cases, it could be used only for certain specialties or services.⁴² Colorado's Code of Regulations specifies that telehealth may be provided using "interactive audio" (including telephone) as long as the communication meets "the same standard of care as in-person care," and this includes conducting intake evaluations, providing medication management for people with OUD, and delivering counseling.⁴³

Use telehealth to deliver OUD treatment services in correctional settings

Although telehealth is regularly used to deliver health care to people who are incarcerated in jails and prisons, correctional staff say it is minimally used to facilitate the delivery of OUD treatment.⁴⁴ To help jails and prisons start telehealth programs that serve individuals with OUD and other health conditions, or expand existing ones, states should allocate funding that affords facilities the flexibility to purchase telehealth equipment and infrastructure, medications, and other programming needs and hire staff.

The National Institute on Drug Abuse (NIDA) is funding research to determine best practices that correctional facilities can adopt for implementation of telehealth services for OUD treatment. (See Box 2.) In addition, as described below, at least two jails began using telehealth to facilitate care for people with OUD in response to the COVID-19 public health emergency.

The Hennepin County Jail in Minneapolis—a facility that offered all three forms of medication for OUD (methadone, buprenorphine, and naltrexone) before the public health emergency—is offering people with OUD the option to begin buprenorphine treatment via a telehealth visit in accordance with the DEA's flexibility policy.⁴⁵ The jail also uses telehealth to facilitate counseling sessions and the delivery of other medical services.⁴⁶

The Franklin County Jail in Greenfield, Massachusetts—another jail that offers all three forms of medication for OUD—expanded its telehealth capacity during the COVID-19 public health emergency by teleprescribing medications for OUD to individuals upon their arrival at the facility, offering individual counseling sessions, and conducting intake assessments at the jail's OTP.⁴⁷ The jail drew upon several funding sources to purchase laptops, TVs, and webcams for the OUD telehealth program, such as a state opioid response grant and a federal Prescription Drug and Opioid Addiction grant.⁴⁸

Programs such as these are well-positioned to identify best practices and share lessons learned with other jails and prisons interested in delivering OUD services via telehealth.

Box 2. Initiative for Individuals Who Are Incarcerated

The NIDA-funded Justice Community Opioid Innovation Network (JCOIN)—a system of over a dozen large clinical trials—is studying best practices in the delivery of OUD treatment within jails and prisons, including ways in which telehealth can be used to effectively engage and retain individuals in treatment.⁴⁹ For example, one of JCOIN's studies aims to evaluate whether women who are incarcerated and linked to community-based providers and peer navigators via telehealth are more likely to access and stay in treatment after returning to the community.⁵⁰ This study, which will involve 900 women with OUD at nine jails who are within 30 days of release, will contribute to the literature about how telehealth can help improve outcomes for people who are incarcerated or have recently been released.⁵¹

Telehealth can help extend the provider workforce and make evidence-based care more accessible for correctional facilities by enabling people with OUD who are incarcerated to meet with addiction treatment practitioners, mental health counselors, and peer support specialists who may be in short supply.⁵² At least for the duration of the COVID-19 public health emergency, telehealth can also help facilitate timely medication initiation—for example, by allowing an individual with OUD who is incarcerated to receive a prescription for buprenorphine from a waived provider at a location other than where the patient resides.⁵³

Overcoming barriers to telehealth

Even if states make the policy changes described above, they may encounter several barriers to expanding the use of telehealth, including scarce funding to support technological infrastructure, inadequate broadband internet access, and putting monitoring and assessment tools in place to evaluate telehealth implementation and outcomes in order to guide future policy changes and development.

Infrastructure. Building or expanding telehealth programs can require significant upfront investments in technological infrastructure, workforce training, and administrative planning—barriers that may hinder smaller or underresourced providers.⁵⁴ States must also consider the expertise involved in adopting telehealth platforms that integrate well with electronic health record systems and protect patient privacy.⁵⁵ One way that states can build telehealth capacity is by connecting with the National Consortium of Telehealth Resource Centers, a collaboration of 12 regional and two national telehealth resource centers administered by the Center for Connected Health Policy, which provides technical assistance, education, and resources for implementing telehealth programs.⁵⁶

Broadband access. Broadband internet is not available or accessible to many individuals in the U.S., a gap that is a barrier to telehealth expansion because states commonly require that telehealth visits take place in real time and include both audio and video components.⁵⁷ According to a 2020 Federal Communications Commission report, the dearth of fixed terrestrial broadband is experienced most heavily by individuals living in rural areas and on tribal lands, with approximately 17% and 21% of individuals in these groups, respectively, lacking access.⁵⁸ State and local governments can draw on the \$362 billion in funding recently made available through the American Rescue Plan Act—a stimulus package that gives states broad flexibility in determining how to use the funds, giving states the opportunity to invest in expanded broadband access.

Monitoring and evaluation. Lastly, with the rapid growth of telehealth use during the COVID-19 pandemic, states and providers may not have been prepared to collect and analyze data to evaluate what is working well and where improvements to telehealth infrastructure could be made. Moving forward, states should monitor metrics and health outcomes across program implementation, including patients' experiences with receiving telehealth treatment (e.g., reduced burden of travel time to appointments).⁵⁹ This data can also help states identify how telehealth affects different populations—for example, evaluating telehealth's role in addressing treatment gaps in rural areas and examining racial disparities in the receipt of telehealth services. Some states have sought to identify gaps in access to telehealth by developing resource-sharing networks, such as the regional interstate partnership formed by the governors of Colorado, Nevada, Washington, and Oregon.⁶⁰ These states agreed to share best practices on telehealth implementation and address access inequities experienced by Native American communities and communities of color in particular.⁶¹

Conclusion

More than 71,000 people in the U.S. died from an opioid overdose in the past year, and about 1.6 million more continue to struggle with OUD. During the COVID-19 pandemic, clinicians and researchers learned that telehealth-based OUD treatment is just as effective as in-person care. By permanently expanding access to telehealth-based OUD treatment services after the pandemic, state regulators and lawmakers can help more of their constituents recover from OUD.

States have broad authority to create their own definitions and reimbursement structures for telehealth services, and they should consider approaches to telehealth policy that remove restrictions for prescribers of medications for OUD, make it easier for patients to initiate and continue treatment via telehealth, provide adequate payment for telehealth services, and enable more widespread use of telehealth for OUD in correctional settings.

Endnotes

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For further information, please visit:
pewtrusts.org/substancemisuse

Contact: Erin Davis, communications manager
Email: edavis@pewtrusts.org
Project website: pewtrusts.org/substancemisuse

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