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TELEHEALTH AND SUBSTANCE USE DISORDER SERVICES IN THE ERA OF COVID-19: REVIEW AND RECOMMENDATIONS

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I. Overview

The COVID-19 pandemic has created an unprecedented public health emergency (PHE) throughout the world. In the United States, in response to the pandemic and its related safety restrictions, providers turned to telehealth to provide necessary health care to patients at a distance. Simultaneously, state and federal lawmakers worked quickly to loosen some of the previously restrictive laws on telehealth use to help practitioners provide care. These events have propelled telehealth use from a technology infrequently used by health care institutions to an ever-growing crucial tool at the forefront of health care during the COVID-19 pandemic (Office of Health Policy 2016, 4). There are many advantages to utilizing telehealth services. Telehealth can provide increased health care access to medically and socially vulnerable individuals, including people suffering from a substance use disorder (SUD); potentially decrease the costs of health care for consumers; and reduce the risk of contagion among patients and providers. However, the future of telehealth comes with limitations, from the challenges that can prevent a patient from accessing telehealth services to the complex state regulatory requirements that may bar health care practitioners from being able to offer the breadth of available telehealth services to patients. This paper analyzes the current state of telehealth services at the federal and state levels, as well as the benefits and limitations of telehealth technology use. It also offers public policy recommendations to improve telehealth services in the United States.

II. Introduction

The ongoing coronavirus pandemic had, and continues to have, a profound impact on the lives of individuals living in the United States. As of July 2021, more than 600,000 people in the United States have died due to, or resulting from, COVID-19 (Johns Hopkins University of Medicine 2021). The virus has also disrupted global supply chains due to business lockdowns necessitated by shelter-in-place orders (American Journal of Managed Care 2021). The lockdowns resulted in a record 3.28 million Americans filing for unemployment compensation for the week ending March 21, 2020 (Business Insider 2021). In October 2020, half of the adults who lost employment because of the pandemic remained unemployed (Parke, Minkin, and Bennett 2020). In addition, data collected from several sources by the nonprofit organization the Center on Budget and Policy Priorities show a “dramatic increase in the number of households struggling to put enough food on the table” (Center on Budget and Policy Priorities 2021).¹ The resulting emotional, mental, and physical toll that the COVID-19 pandemic has had on Americans has been profound. As a result of social distancing requirements and government-issued shelter-in-place orders, traditional ways of providing health care through in-person visits were deemed “unsafe” during certain periods of the pandemic. Health care providers turned to telehealth services to address the dual responsibilities of continuing to provide health care to

¹ In 2019, 3.4 percent of adults surveyed reported that their household did not have enough to eat at some point during the entirety of 2019 (Center on Budget and Policy Priorities 2021). By contrast, in a survey conducted between June 23 and July 5, 2021, 10 percent of adults in the US (more than 20 million people) reported not having enough for their household within the last 7 days (Center on Budget and Policy Priorities 2021).

patients and addressing the surge of medical needs triggered by COVID-19. Research indicates that telehealth use has increased significantly during the current pandemic. Data published in the Centers for Disease Control and Prevention's (CDC's) *Morbidity and Mortality Weekly Report* indicate that between January and March 2020 “. . . the number of telehealth visits increased by 50 percent, compared with the same period in 2019, with a 154 percent increase in visits noted in surveillance week 13 in 2020, compared with the same period in 2019” (Koonin 2020).

One section of the population that has been made particularly vulnerable during the pandemic is the section of individuals who are living with SUD. In addition to navigating the complex and ever-changing landscape of a society in the throes of a pandemic, many individuals with SUD were suddenly unable to access services that can be crucial to their treatment or recovery. First, “[e]mergency rooms, previously a common first stop for patients seeking help with their SUD, have become less accessible as patients hesitate to come to the emergency room due to fear of infection” (Oesterle *et al.* 2020, 2710). Second, health care providers, treatment centers, outpatient clinics, group therapy, behavioral therapy, and other similar services or programs that generally require continuity of care were abruptly reduced or shut down due to the pandemic and the need to physically distance (Haque 2020). Further, group therapy programs have been, and continue to be, an integral part of many treatment and recovery programs for substance use disorder (SAMHSA, Group Therapy 2021).

The sudden onslaught of shelter-in-place and social distancing requirements meant the discontinuation of Narcotics Anonymous and Alcoholics Anonymous, often the primary treatment option for individuals with SUD (Oesterle *et al.* 2020). As a result, many living with SUD lost the connection and community that is crucial to treatment and recovery (Bromley 2021).² “Addiction is often called a disease of loneliness, and during the pandemic, loneliness is something that many more people experienced” (Bromley 2021). Unfortunately, the data indicates that the abrupt loss of treatment and recovery resources had a real and negative impact on those with SUD. An analysis of 500,000 urine drug tests collected from a national laboratory service showed a 32 percent increase for nonprescribed fentanyl, a 20 percent increase for methamphetamine, and a 10 percent increase for cocaine from mid-March through May 2020 (Weiner 2020). Moreover, “[p]rovisional data show that drug overdoses have increased during the COVID-19 pandemic. Nearly 95,000 drug overdose deaths occurred in the United States from November 2019 to January 2021, the highest number of overdose deaths ever recorded in a 12-month period” (National Institute on Drug Abuse 2021).

To meet the increasingly urgent needs of individuals with SUD, care providers shifted to telehealth technology to deliver virtual care. Telehealth technology allows individuals with SUD to virtually access services vital to treatment, maintenance therapy, and recovery (Haque 2020). This shift to telehealth services was permitted by changes at the federal and state levels that

² Anthropology professors, Jarret Zigon and China Scherz, who study social systems related to substance abuse and treatment at the University of Virginia, believe that the rise in overdose deaths during the COVID-19 pandemic is in part due to the isolation necessitated by stay-in-place orders and social distancing requirements (Bromley 2021). “While [medication-assisted treatment] remains a profound and hard-won treatment avenue for those afflicted, recovery, like addiction itself, does not emerge in a social vacuum” (Bromley 2021).

removed barriers to telehealth access for individuals with SUD (Prevoznik 2021; Oesterle *et al.* 2020). It is unclear whether these changes to the law will be permanent or have long-term, quantifiable impacts on individuals with SUD.

A. Defining Telehealth

Telehealth is a word that has varying definitions. Generally, it involves some form of health or medical care through electronic means and can include care through telephonic video, remote monitoring, video communication, remote consultation, apps, and Web-based platforms (Haque 2020). There are also different terms for telehealth. These include telecare, e-health, telemedicine, telecommunications, direct-to-consumer telehealth platforms, and digital health, to name just a few. In addition, all 50 states, the District of Columbia, and the U.S. Virgin Islands have their own statutory or regulatory definitions of telehealth (Center for Connected Health Policy 2021).³

There are also contextual differences based on the service or services being utilized in the health care field. The World Health Organization (WHO) differentiates between telemedicine and telehealth (WHO 2010). WHO's 2010 global report on telemedicine noted that after an evaluation of peer-reviewed studies, telemedicine could be defined as the delivery of health care services using information and communication technologies by physicians, and telehealth describes services provided by a wide range of health care professionals, including nurses and

³ For example, Connecticut defines telehealth as the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management, and self-management of a patient's physical and mental health and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site and (B) synchronous interactions, asynchronous store and forward transfers, or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting, or electronic mail, according to Connecticut General Statutes § 19a-906 (West) (effective July 1, 2019). By contrast, in Alabama, there is no general statutory definition of "telehealth." However, the Alabama Medicaid manual for health care providers requires that "telemedicine" be administered through an interactive audio and video telecommunications system that permits two-way communication between the health care provider and the origination site where the recipient is located. The manual makes clear that telephone conversations and emails are not included in this definition. There is technically a definition of "telemedicine," which was enacted by the Alabama General Assembly on June 1, 2021. However, this definition is a section of the "Audiology and Speech-Language Pathology Interstate Compact" and may not necessarily apply to any situation that does not pertain to the topic of audiology and speech or the Compact, according to Alabama Code 1975 § 34-28A-61 (effective June 1, 2021). In Florida, the definition of "telemedicine" is defined in an administrative regulation as the practice of health care delivery by a practitioner who is located at a site other than the site where the recipient is located for purposes of evaluation, diagnosis, or treatment, per the Florida Administration Code Annotation r. 59G-1.057, adopted June 20, 2016. This definition was specifically adopted to describe service requirements for health care practitioners who provide Medicaid services via telemedicine. *Id.* See also Notice: 16726988, Florida Administration Code Annotation r. Florida's Child Protection Team Handbook also provides a definition of "telemedicine" that appears to apply solely to child abuse investigations. See also Florida Department of Health 2019. The U.S. Virgin Islands defines "telemedicine" as the use of medical information exchanged from one distant site to another via electronic communications to improve, maintain, or assist patients' health status. Videoconferencing, transmission of still images, and e-health including patient centers are all considered part of telemedicine and telehealth, per Virgin Islands Statute title 27, § 45a (amended July 9, 2018).

pharmacists (WHO 2010). These appear in state laws in the United States. In Utah for example, state law defines telehealth as any health-related service that uses information technology or electronic communications.⁴ That same law also defines telemedicine as telehealth services, including clinical care, health education, health administration, home health, and other health-related services provided by a specific means of communication that meets industry and privacy standards, including compliance with federal and state privacy laws.⁵

On the federal level, governmental agencies have differing definitions of telehealth. These definitions vary greatly depending on both the “legislative intent and the population . . .” that the agency serves. The Health Resource and Services Administration’s Office for the Advancement of Telehealth defines telehealth as “. . . the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration and public health” (Office for the Advancement of Telehealth 2021).⁶ This definition is quite broad and serves the mission of the agency, which is to “promote telehealth as a way to deliver healthcare.” By contrast, the Centers for Medicare and Medicaid Services (CMS) employs a more technical definition of telehealth or more specifically, an “interactive telecommunication system” (Federal Register 2021). Under 42 C.F.R. § 410.78, an interactive telecommunications system is defined as “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner” (Federal Register 2021). The definition of telehealth provided in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Report *Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders* is relatively simple (SAMHSA, Telehealth for the Treatment 2021). In that report, telehealth means the “use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions” (SAMHSA, Telehealth for the Treatment 2021).

B. Telehealth Modalities and Use in Services for Individuals with SUD

Telehealth encompasses a variety of health care services and practices. When a health care practitioner communicates with another practitioner through email or video, that interaction is considered “practitioner-to-practitioner” telehealth. This type of telehealth service would also include peer mentoring, for example. When a clinician interacts with a patient, whether through video, phone, email, remote wireless monitoring, or the Internet, it is deemed a “practitioner-to-patient” telehealth service. This type of telehealth service can also be used when a clinician is caring for chronic conditions, counseling a patient, providing mental health services, or engaging in post-discharge follow-up. Finally, there are “patient-to-mobile health” telehealth services, or mobile health, also known as mHealth (Phaneuf 2019). Mobile health is the monitoring and

⁴ U.C.A. 1953 § 26-60-102 (9) (eff. May 2020).

⁵ *Id.*

⁶ The Office for the Advancement of Telehealth provides information about telehealth services to patients and providers, and funds grant programs to expand telehealth, and supports partnerships between states in order telehealth more accessible (Office for the Advancement of Telehealth 2021).

sharing of health information via mobile technology, such as wearables and health-tracking apps (Phaneuf 2019).

No matter the type, these telehealth services can generally be categorized into four modalities:

- (1) Synchronous;
- (2) Asynchronous;
- (3) Remote monitoring; and
- (4) Mobile health app (Mechanic, Persaud, and Kimball 2020; Office of Health Policy 2016, 5).

Any telehealth service that involves the delivery of health information in real time is categorized as synchronous (Mechanic, Persaud, and Kimball 2020). Synchronous telehealth includes live discussions between a patient and a provider. Asynchronous telehealth services do not involve a provider or practitioner in person (Mechanic, Persaud, and Kimball 2020). An example of this would be “store and forward” telehealth services, where a “patient or physician collects medical history, images, and pathology reports (stored information) and then sends it to a specialist physician for diagnostic and treatment expertise” (Mechanic, Persaud, and Kimball 2020). Remote patient monitoring uses direct video monitoring of the patient to review tests and images collected remotely (Mechanic, Persaud, and Kimball 2020). There are also emerging technologies such as mobile applications and text apps for telehealth services that are not traditionally categorized under telehealth services but potentially offer an opportunity to increase access to vital services for individuals living with SUD.

Within the realm of SUD treatment and recovery, the four most common modes of providing telehealth services are:

- (1) Computerized/Web-based assessments (asynchronous);
- (2) Telephone-based recovery support (synchronous);
- (3) Telephone-based therapy (synchronous); and
- (4) Video-based therapy (synchronous) (Oesterle *et al.* 2020, 2710).

Forty-five percent of SUD-related telehealth services are provided via computerized or Web-based assessments (Oesterle *et al.* 2020). These asynchronous interactions are helpful because they allow patients to access the assessments at critical times in their recovery (Oesterle *et al.* 2020, 2710). Some examples of this type of assessment include the Alcohol Use Disorders Identification Test, motivational therapy sessions, psychoeducation, and computerized interventions (Oesterle *et al.* 2020, 2710). Evidence indicates that these types of computerized assessments positively impact individuals who use these tools as a means of receiving SUD services (Oesterle *et al.* 2020, 2711; Fowler, Holt, and Joshi 2016). Telephone-based recovery support comprises 29 percent of SUD-related telehealth services (Oesterle *et al.* 2020, 2711). Telephone-based therapy comprises 28 percent of SUD-related telehealth services (Oesterle *et al.* 2020). Telephone-based recovery and therapy provide live support to individuals living with SUD and are considered “minimally resource-intensive” or low-cost (Oesterle *et al.* 2020, 2711).

Finally, video-based therapy makes up the remaining 20 percent of SUD-related telehealth services (Oesterle *et al.* 2020, 2711). Preliminary evidence indicates that video-based therapy use has steadily increased with consumer access to smartphones and tablets (Huskamp *et al.* 2018).

III. Current Law and Policies Relating to Telehealth Services

A. Federal Telehealth Laws and Regulations

On January 31, 2020, former Secretary of Health and Human Services Alex M. Azar declared the COVID-19 pandemic to be a public health emergency (Azar 2020; HHS, Secretary Azar Declares PHE 2020).⁷ The PHE was declared to aid the nation's health care community in response to the COVID-19 pandemic (HHS, Secretary Azar Declares PHE 2020).⁸ The PHE declaration permitted federal agencies to make sweeping changes to laws and regulations (HHS 2019). This involved changes to laws that explicitly impact telehealth services, including:

- Modifying regulations and other laws that govern telehealth, including provisions of the Ryan Haight Online Pharmacy Consumer Protection Act (Ryan Haight Act) and implementing regulations that allow the Secretary, with the concurrence of the Administrator of the Drug Enforcement Administration (DEA), to designate patients, patient locations, and the use of controlled substances during a PHE declared by the Secretary;
- The ability to grant extensions or waive sanctions relating to the submission of data or reports required under laws administered by the Secretary; and
- Waiving or modifying certain requirements under Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (HHS 2019).

On March 17, 2020, CMS announced that it would be expanding access to Medicare telehealth services (Centers for Medicare and Medicaid Services 2020). This included broadening the types of services for which Medicare would pay if performed via telehealth (Centers for Medicare and Medicaid Services 2020). Until recently, neither Medicaid nor Medicare would cover the cost of most audio-only telehealth services (Schoonover and

⁷ Under Section 319 of the Public Health Services Act, the Secretary of the US Department of Health and Human Services (HHS) may determine that a disease or disorder presents a public health emergency (HHS 2019). Subsequently, on March 13, 2020, then-President Trump issued Proclamation 9994 under the National Emergencies Act (Congressional Research Services 2021). He also declared a nationwide emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act for the pandemic (Congressional Research Services 2021).

⁸ Under Section 319 of the Public Health Services Act, the Secretary of the US Department of Health and Human Services (HHS) may determine that a disease or disorder presents a public health emergency (U.S. Department of Health and Human Services 2019). Subsequently, on March 13, 2020, then-President Trump issued Proclamation 9994 under the National Emergencies Act (Congressional Research Services 2021). He also declared a nationwide emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act for the pandemic (Congressional Research Services 2021).

Lacktman 2021). CMS “has historically been reluctant to cover audio-only technology out of concern it could lead to inappropriate overutilization of services and concern that audio-video visualization is necessary to fulfill the full scope of service elements of CPT codes” (Schoonover and Lacktman 2021). Under the PHE, CMS covered audio-only telehealth services for diagnosis, evaluation, or treatment of mental-health disorders for established patients when the originating site was the patient’s home (Schoonover and Lacktman 2021; Centers for Medicare and Medicaid Services 2021, 25). CMS also clarified that Medicare would expand the list of providers that could provide telehealth services to Medicare patients. Previously, payment was only available for telehealth services from specific categories of providers (Centers for Medicare and Medicaid Services 2021, 25). Under the PHE changes, payment is available for all health care professionals who are eligible to bill Medicare for professional services (Centers for Medicare and Medicaid Services 2021, 25). Prior to this announcement, Medicare would only pay for telehealth services on a limited basis (Centers for Medicare and Medicaid Services 2021, 25). Subsequently, the Center for Consumer and Information and Insurance Oversight, a department within CMS, issued guidance encouraging state governments and private insurers to provide “similar flexibility under private insurance (such as by waiving certain federal and privacy and security standards)” (Volk *et al.* 2021; Center for Consumer Information and Insurance Oversight 2020).

Congress also appropriated \$200 million in funding to the COVID-19 Telehealth Program as part of the Coronavirus Aid, Relief, and Economic Security (CARES Act) (Federal Communications Commission (FCC) 2021). The COVID-19 Telehealth Program helps “health care providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic” by funding their telecommunication services, information services, and devices necessary for telehealth (FCC 2021). In addition, under the CARES Act, Congress increased funding to the Telehealth Network Grant Program, a grant program overseen by the federal Health Resources and Services Administration (HRSA). The program is tasked with expanding access to, and improving the quality of, health care services by funding and promoting rural tele-emergency services (HRSA 2021). Tele-emergency services connect providers and patients at small, remote, or rural hospitals with providers at a larger central hub location via video or other telecommunication channels. These changes to the law and regulations, which were initiated by the federal government and were urgently needed to aid practitioners in their abilities to continue providing adequate health care during the pandemic, aimed to increase the use of telehealth services in health care throughout the United States. Many individuals who had previously been unable to receive health care because of pandemic-related restrictions were then able to receive care.

Before these various telehealth services were introduced, ensuring adequate health care for individuals living with SUD during the COVID-19 pandemic was of particular concern. In 2018, it was estimated that two million Americans were living with an opioid use disorder (OUD), which is itself an SUD (SAMHSA, Key Substance Use 2019). Among individuals with OUD, only 26 percent received any form of treatment in 2018 (SAMHSA, Key Substance Use 2019). The COVID-19 pandemic has only exacerbated this treatment gap. The federal government closely regulates services related to treatment for individuals with any SUD,

particularly if these services involve medication for addiction treatment (MAT).⁹ MAT drugs such as buprenorphine¹⁰ and methadone¹¹ are considered controlled substances under the federal Controlled Substance Act (CSA).¹² Thus, any opioid treatment program (OTP), correctional setting where MAT is implemented, or recovery program must comply with laws and regulations overseen by both the DEA and SAMHSA. Moreover, any practitioner who wishes to prescribe these drugs must have a DEA registration in each state in which a patient is located. Prior to the PHE, if a qualified provider wanted to prescribe buprenorphine or methadone via telehealth, he or she would have to meet the requirements of the Ryan Haight Online Act, a 2008 amendment to the CSA, which requires an in-person examination before the issuance of a prescription.¹³ This act requires any practitioner who issues a prescription for a controlled substance to conduct an in-person medical evaluation, with a few limited exceptions.¹⁴

It is against this backdrop and with the knowledge that individuals living with SUD urgently needed access to health care services that both the DEA and SAMHSA significantly revised these regulations in response to the PHE license (HHS, Waiver or Mod of Req 2020). In a letter to qualified practitioners, the DEA provided guidance on changes implemented due to the PHE (Prevoznik 2021). These changes included:

- Authorizing qualified practitioners to prescribe controlled substances to patients using telehealth without first conducting in-person evaluations during the duration of the PHE (Prevoznik 2021);
- Partnering with SAMHSA to allow qualified practitioners to admit and treat patients with OUD during the duration of the PHE; and
- Authorizing qualified practitioners to prescribe buprenorphine to new and existing patients with OUD via telephone or through other telehealth means without requiring that the practitioners first meet face-to-face to conduct examinations with patients (Prevoznik 2021).

⁹ “Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient’s needs.” (SAMHSA, MAT, 2021).

¹⁰ Buprenorphine is an FDA-approved partial opioid agonist used to treat OUD by reducing symptoms of opioid withdrawal and lessening intense drug experiences (SAMHSA, Buprenorphine 2021). Buprenorphine carries less risk of abuse than methadone because it is a partial agonist. It is approved for both detoxification and maintenance therapy (SAMHSA, Buprenorphine 2021). Buprenorphine is a Schedule III substance under the CSA.

¹¹ Methadone is an FDA-approved full opioid agonist used to treat OUD by reducing opioid craving and withdrawals. Methadone suppresses withdrawal symptoms in detoxification therapy and controls opioid cravings in maintenance therapy (SAMHSA, Methadone 2021). By law, only a SAMHSA-certified opioid treatment program (OTP) can dispense Methadone for the treatment of OUD (SAMHSA, Methadone 2021). Under the CSA, methadone is classified as a Schedule II substance.

¹² Controlled Substances Act (CSA, 21 U.S.C. §§801 *et seq.*).

¹³ 21 U.S.C.A. § 829(e) (West) (effective July 22, 2016).

¹⁴ *Id.*

SAMHSA implemented regulatory changes that make it easier for qualified practitioners to provide telehealth services to individuals with OUD. SAMHSA exempted OTPs from performing in-person physical evaluations for any patients whom the OTP will treat with buprenorphine (Prevoznik 2021). In addition, SAMHSA announced that “DATA-waived practitioners”¹⁵ would be allowed to prescribe buprenorphine for maintenance or detoxification treatment via telephone (Prevoznik 2021). Changes were also implemented to SAMHSA regulations related to methadone treatment for OUD. By law, only a SAMHSA-certified OTP can dispense methadone for the treatment of OUD. SAMHSA still requires that all new OTP patients being treated with methadone be seen for in-person medical evaluations (SAMHSA, FAQs: Provision 2020). However, the new SAMHSA regulations allow qualified practitioners to treat existing OTP patients with methadone via telehealth (SAMHSA, FAQs: Provision 2020). This is unlike the regulatory changes that allow qualified practitioners to prescribe buprenorphine to new patients without the need for in-person examinations.

From a public policy standpoint, the new regulations implemented by the federal government represent a sea change to the barriers often faced by individuals with OUD to receiving treatment services. However, many of these changes are temporary and, by law, are currently slated to end at the conclusion of the PHE (HHS, Renewal of Determination 2021). Furthermore, whether these changes were effective and the extent to which providers used telehealth services is still largely unknown.

B. State Telehealth Laws and Regulations

State governments and territories began implementing various community mitigation policies in response to the federal PHE declaration (CDC, Timing of State 2020). Between March 1 and May 31, 2020, 42 states and five territories issued mandatory stay-at-home orders to help slow the spread of COVID-19 (CDC, Timing of State 2020). With stay-in-place orders imposed in most states and social distancing encouraged to limit the spread of the COVID-19 virus, state legislators and policymakers worked to ensure that Americans could receive health care in settings that were not in person. This included guaranteeing that private insurance companies licensed within a state covered the cost of telehealth services. Prior to the onset of the COVID-19 pandemic, only 35 states required individual and group health insurance to cover the costs of telehealth visits (Volk *et al.* 2021). States that did not require coverage included Alabama, Florida, Hawaii, Idaho, Illinois, Michigan, New Hampshire, North Carolina, Massachusetts, Oklahoma, Pennsylvania, South Carolina, Utah, West Virginia, Wisconsin, and Wyoming (Volk *et al.* 2021, Appendix A).

States also enacted legislation through emergency orders, regulations, or statutory enactments that mirrored many of the changes at the federal level, including the requirement of

¹⁵ Practitioners who have met specific SAMHSA qualifications and obtained authorization from the DEA to dispense buprenorphine for maintenance or detoxification treatment are referred to as “DATA-waived practitioners” in reference to the Drug Addiction Treatment of Act of 2000, which added 21 U.S.C. 823(g)(2) to the Controlled Substances Act. This act allows practitioners to dispense narcotic drugs like buprenorphine to individuals with an OUD for maintenance or detoxification treatment if certain requirements are met (Prevoznik 2021).

coverage of telehealth services by private insurance companies. For the first time, Utah,¹⁶ Illinois,¹⁷ West Virginia,¹⁸ Massachusetts,¹⁹ and Vermont²⁰ enacted laws or suspended legal restrictions on coverage of telehealth services (Volk *et al.* 2021, Exhibit 1). Arizona, Illinois, Maine, Massachusetts, Montana, New Hampshire, Rhode Island, Texas, and Washington enacted parity-in-provider reimbursement laws (Volk *et al.* 2021). These require private insurers to pay for telehealth visits at the same level that in-person visits are covered. In addition, Oklahoma, Washington, Oregon, California, Montana, Colorado, Arizona, North Dakota, Nebraska, Minnesota, Iowa, Texas, Louisiana, Mississippi, Maine, New Hampshire, Massachusetts, Vermont, Rhode Island, New Jersey, and New York expanded coverage to include telehealth services provided over the phone. (Volk *et al.* 2021). Subsequently, lawmakers in New York,²¹ Nebraska,²² and Oklahoma²³ permanently enacted laws that require insurance to include audio-only telehealth services or provided over the phone. This change in the law is significant, particularly for “. . . older patients who may be unfamiliar with audio-visual technology and for patients with behavioral health conditions who find audio-only visits more comfortable” (Volk *et al.* 2021). Prior to this change, only Kentucky, Connecticut, and Delaware required insurance to cover audio-only telehealth visits (Volk *et al.* 2021). Several states also enacted regulations that allow federally qualified health centers (FQHCs)²⁴ and/or rural health clinics (RHCs) to provide services via telehealth, which could significantly expand the reach of telehealth under Medicaid (Guth and Hinton 2020). Prior to this, FQHCs and RHCS were excluded from telehealth coverage because these centers bill as entities instead of providers, and they are often excluded from the telehealth-eligible provider list for this reason. Similarly, Medicare has also excluded FQHCs billing as telehealth providers (Center for Connected Health Policy 2021, 6).

IV. Telehealth for Individuals with SUD: Benefits and Limitations

¹⁶ Office of Governor Gary R. Herbert and Lt. Governor Spencer J. Cox, Temporarily Extending the Suspension of Enforcement of Statutes Relating to Telehealth Services, Executive Order No. 202-68 (September 25, 2020), <https://governor.utah.gov/executive-order-2020-68/>.

¹⁷ Office of Governor J.B. Pritzker and Lt. Governor Juliana Stratton, Executive Order to Expand Telehealth Service and Protect Health Care Providers in Response to COVID-19, Executive Order No. 7 (March 19, 2020), https://coronavirus.illinois.gov/resources/executive-orders/display_executive_order-2020-09.html.

¹⁸ Office of the Governor Ralph Northam and Lt. Governor Justin Fairfax, Executive Order No. 7-20 (March 19, 2020), <https://apps.sos.wv.gov/adlaw/executivejournal/readpdf.aspx?DocID=89501>.

¹⁹ Office of Governor Charles D. Baker and Lt. Governor Karyn E. Polito, Order Expanding Access to Telehealth Services and to Protect Healthcare Providers (March 15, 2020), <https://www.mass.gov/doc/march-15-2020-telehealth-order/download>.

²⁰ Vt. Stat. Ann. tit. 18, § 9362 (West) (effective March 30, 2021). *See also* S. 117 (Act. 6) (signed by the Governor on March 29, 2021).

²¹ Article 29-G. Telehealth Delivery of Services N.Y. Pub. Health Law § 2999-cc (McKinney)(effective April 1, 2021.)

²² Nebraska Telehealth Act, Neb.Rev.St. § 71-8503 (West)(effective August 28, 2021.)

²³ Definitions, 17 Okl.St. Ann. § 139.102 (West)(effective May 28, 2021.)

²⁴ FQHCs are “community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services and provide services regardless of patients’ ability to pay, often reaching underserved communities and populations.” FQHCs are a vital component of health care, providing health care to nine percent of the United States, including one in five rural residents (Demeke 2020, 1904).

For patients and health care providers, there are several potential benefits to utilizing telehealth services (Bonderud 2021; CDC, Using Telehealth 2020; HHS, What Is Telehealth? 2021). For patients, using telehealth services can lead to increased access to health care in general. Telehealth services can also potentially increase access to health care for vulnerable populations and individuals who might have difficulty accessing care, such as people with limited mobility. Additionally, patients may be able to save money by using telehealth services, a particularly important consideration for individuals who may not have access to health care because of their financial circumstances. For health care providers, utilizing telehealth services can decrease the risk of exposure to illness, a concern that is even more dire during the COVID-19 pandemic. Providers also have a unique opportunity to grow their practices by using telehealth services to reach new patients across state lines.

It can be hard to imagine any potential drawbacks to the use of telehealth services. Nevertheless, there are limitations to telehealth use, both in who can access the service and how it can and should be used within the health care system. There are also regulatory barriers that may limit a provider's ability to expand patient outreach.

A. Access to Health Care

Telehealth services offer patients the opportunity to receive different types of care from a wide variety of health care practitioners. Patients may be able to access their primary care providers and specialists, including for mental and behavioral health visits, without having to physically visit a health care office (CDC, Using Telehealth 2020). Patients can also receive “low-risk urgent care for non-COVID-19 conditions” through telehealth technology (CDC, Using Telehealth 2020). Through technology like remote patient monitoring, patients can also have their vital statistics monitored by their health care provider from their home and even have that data transferred to another practitioner when necessary (CDC, Using Telehealth 2020). In addition, patients can use telehealth services to discuss advance care planning with their provider (CDC, Using Telehealth 2020). If a patient is a resident in a long-term care facility, he or she may be able to utilize telehealth services to receive non-emergent care (CDC, Using Telehealth 2020).

The potential of telehealth to increase access to care is especially important for vulnerable populations. For millions of individuals living in America, access to health care services may prove challenging. This includes those with chronic health conditions, disabilities, and low incomes; those who are homeless or are otherwise experiencing geographic isolation (*e.g.*, living in a rural area with little to no access to technology); those who are living on reservations; LGBTQ+ individuals; and individuals living with SUD (American Journal of Managed Care 2006). For these vulnerable populations, health care services like primary care, prenatal care, home care, psychiatric treatment, substance use treatment, or dentistry can be out of reach (Bhatt and Bathija 2018, 1272). With the arrival of the COVID-19 pandemic, the ability of health care providers to reach vulnerable individuals became even more difficult (Joszt 2018). Individuals who may not have the financial or physical means to leave their homes are able to be seen by providers and receive care through telehealth. This is particularly beneficial for persons

with chronic health issues or those living with SUD, both conditions in which continuing care and follow-up are critical. In an audit conducted by the Office of the Inspector General at the U.S. Department of Health and Human Services (HHS) on the use of telehealth services by OTPs during the pandemic, one OTP official told investigators that “[o]ur no-show rate is nonexistent because of telehealth. We have bus and transportation issues when weather is bad, but with telehealth it is not an issue. The verbal feedback from patients is 100-percent satisfaction” (Office of Inspector General 2020).

Nevertheless, although telehealth services *can* be utilized by individuals in vulnerable populations, this does not mean that they are. Vulnerable populations, such as communities of color and individuals living in rural areas, are not accessing telehealth services at a particularly increased rate. Data collected before the COVID-19 pandemic indicated that the most rapid growth in telehealth use has been among younger, more educated, urban adults (Mehrotra 2019). In a comprehensive study of data culled from 148,402 patients during the COVID-19 pandemic and published in December 2020, researchers found that seniors, women, Black and Latinx individuals, and patients with low total household incomes were less likely to use video for telemedicine care (Eberly *et al.* 2020). Non-English speakers, Asian people, and older patients were less likely to complete telehealth visits (Eberly *et al.* 2020). Similarly, research indicates that individuals living in rural areas only use telehealth on occasion. (HMS 2017). Researchers at Harvard University and the RAND Corporation found that among 16.7 million Medicare Advantage enrollees, telehealth use was smallest among individuals over the age of 65. (HMS 2017). The study also found that rural counties saw a lower percentage of telehealth use when compared to urban counties. (HMS 2017). Although behavioral health services are especially suited to telehealth, newly released data indicates that Americans did not utilize telehealth services for behavioral health. The increased use of telehealth services has not had a huge impact on mental health services, which is often a crucial component of care for individuals living with SUD. In a series of *Time* magazine / Harris poll surveys, 50 percent of respondents stated that they used telehealth services since the pandemic began, as opposed to only about 25 percent usage pre-pandemic (Ducharme 2021). However, only five percent of individuals reported using telehealth services for mental health treatment (Ducharme 2021). This is despite the fact that the number of people reporting mental health issues grew from 11 percent in 2020 to 34 percent in 2021 (Vahratian *et al.* 2021; Ducharme 2021). This issue is particularly concerning for those with SUD. In a comprehensive study of data from over 15,000 outpatient behavioral treatment facilities from SAMHSA’s treatment services locator, researchers found that between January 2020 and January 2021, although the *availability* of telehealth services increased significantly at these facilities, actual use remained low (Cantor *et al.* 2021). Thirty-two percent of mental health facilities and 43 percent of SUD treatment facilities did not offer telehealth as of January 2021, “. . . nearly 1 year into the pandemic” (Cantor *et al.* 2021).

B. Decrease Person-to-person Contact

Currently, the only way to determine if a patient is actively infected with the COVID-19 virus is a viral test, either nucleic acid amplification or an antigen test (CDC 2021). However, prior to physically testing the patient or having the patient test him or herself, providers can use

telehealth services to remotely screen a patient rather than having him or her visit a hospital or doctor's office. Providers can also use telehealth technology to triage a patient who presents symptoms but who may not need medical intervention. This limits both the provider's and the patient's chances of potentially encountering contagions.

However, there are limitations on the degree to which a health care provider can use telehealth services to treat a patient. The use of telehealth services implies that in most instances, the patient and the provider are not in the same room. The provider may not be able to touch or examine the patient, which may limit what the provider can determine from an examination. This restriction means that telehealth technology may not be appropriate for all medical services or fields. CMS offers guidelines for providers on the use of telehealth services, including when telehealth use is and is not appropriate (Centers for Medicare and Medicaid Services 2021). In general, CMS considers telehealth use to be appropriate for instances in which the patient is following up with the provider regarding a previously discussed or evaluated condition (*e.g.*, discussing test results), general wellness visits, mental health counseling, nutrition counseling, or for discussing prescriptions for medicine (Centers for Medicare and Medicaid Services 2021, 5). CMS cautions providers that telehealth would be less appropriate for situations in which a physical examination of the patient may be necessary (*e.g.*, eye complaints) (Centers for Medicare and Medicaid Services 2021). In a technical brief published by the Agency for Healthcare Research and Quality, a department of HHS, researchers analyzed multiple systematic reviews of telehealth services (Pacific Northwest Evidence-Based Practice Center 2016). The stated goal of the 2016 brief was to analyze interventions that included health care providers interacting with a patient for the "purposes of treatment, management, or prevention of disease" (Pacific Northwest Evidence-Based Practice Center 2016, 3). After analyzing more than 1,494 citations from more than 58 systematic reviews on telehealth, the researchers concluded that telehealth was beneficial for specific uses and patient populations, particularly remote home monitoring of patients with chronic conditions, communicating and counseling patients with chronic conditions, and providing psychotherapy as part of behavioral health services (Pacific Northwest Evidence-Based Practice Center 2016, vi).

C. Revenue and Cost-savings Potential

Health care practitioners and organizations who use telehealth services may see increases in revenue and cost-savings. The American Hospital Association estimates that between March 1 and June 30, 2020, nonfederal hospitals lost more than 50 billion dollars per month because of restrictions required by the COVID-19 pandemic, including allocating resources to treat COVID-19 patients and stopping elective surgeries (Farr 2020; Bainbridge 2020; AHA 2020). The hospital operator, HCA Healthcare, Inc., reported a 70-percent decrease in outpatient surgeries in April 2020 compared with the previous year (Bainbridge 2020). Increasing telehealth service usage by hospitals and private health care providers can be a way of reaching patients who are unable to access care because of the pandemic; potentially expanding the type of care a patient may receive; and/or recouping some of the losses triggered by the COVID-19 pandemic. Telehealth may also expand access to health care that the average consumer would not typically

utilize if they were required to have an in-person visit (Lankford 2020). This includes services like dermatology, sleep management, and behavioral health services.

The increased use of telehealth services has the potential to help patients save on health care costs. On average, telehealth services cost less than in-person health care visits (Lankford 2020). The national median cost of a virtual telehealth visit for a minor health issue is \$50.00 (Lankford 2020). In contrast, the average cost of a visit to the doctor's office for a similar health issue is \$85.00 (Lankford 2020). For a visit to urgent care for that same minor issue, the average cost is \$130.00, and further, a visit to the emergency room costs \$740.00 (Lankford 2020). However, although there are indicators that telehealth services can save consumers money, it remains unclear whether such cost-savings will be significant in the long term. In a 2017 evaluation of a potential telehealth bill, the Congressional Budget Office (CBO) determined that “[b]ased on a review of the literature and discussions with experts, CBO concluded that coverage of telehealth services by private payers sometimes results in higher spending and sometimes results in savings; in either case, the effects on spending tend to be small.”²⁵

D. Patient Outreach

Many providers cannot reach some patients within their specialties due to geographical hindrances to in-office visits. Before the COVID-19 pandemic, in most states, a provider had to be licensed in the state in which a patient was located to provide telehealth services to the patient. As many as 4 out of 5 states required out-of-state clinicians providing telehealth services to be licensed in the state where the patient resided (Office of Health Policy 2016, 7). Thus, if a health care practitioner wanted to treat patients in more than one state, the practitioner would have to obtain multiple licenses (Wicklund 2020). This limited a practitioner's ability to provide telehealth services to new or existing patients. Furthermore, because the requirements for licensure can be state-specific, it can be difficult for a health care provider to meet the requirements of another state licensure board. In a 2018 joint report issued by HHS, the U.S. Department of the Treasury and the U.S. Department of Labor described their thoughts on reforming the country's health care system. In this report, the state-based health care license process was described as “. . . slow, burdensome, and costly” (HHS *et al.* 2018, 37). Until very recently, this “slow, burdensome, and costly” process was the reality for most practitioners who desired to practice across state lines (HHS *et al.* 2018). However, shortly after the pandemic began, HHS announced that during the COVID-19 emergency, it would allow licensure waivers for physicians participating in federal health care programs so they could receive payment for telemedicine services in states where they did not hold a license (HHS, Waiver or Mod of Req 2020). These waivers only apply for participation and payment for federal health care programs such as Medicare, Medicaid, and the Children's Health Insurance program (HHS, Waiver or Mod of Req 2020). However, state governments and state professional licensing boards quickly followed, with almost every state modifying licensure requirements and/or renewal policies for

²⁵ Congressional Budget Office, *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*, 5 (August 1, 2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s870.pdf>.

health care providers, including out-of-state requirements for telehealth (HHS, Telehealth Licensing Req 2021).

Unfortunately, licensing requirements may once again be an obstacle to providing telehealth services once the federal government declares the end of the PHE. These changes to federal and state licensing requirements are a crucial tool in expanding access to telehealth. However, as with many of the measures put in place during the COVID-19 pandemic, changes to telehealth licensing requirements may not be permanent at the federal or state levels (HHS, Waiver or Mod of Req 2020). This is the reality for practitioners who live in states that have chosen not to permanently adopt telehealth licensing requirements implemented during the pandemic. As of July 2021, Alabama, Arizona, Arkansas, Colorado, Delaware, Massachusetts, Montana, New York, and Rhode Island have ended the state of emergency that triggered the rollback of telehealth licensure requirements (Augenstein *et al.* 2021). In Arizona, Governor Douglas Ducey issued Executive Order 2021-16, rescinding any previous telehealth and licensure-related executive orders.²⁶ In Ohio, the state medical board published a fact sheet clarifying that as of June 9, 2021, the state medical board would enforce earlier state telehealth regulations, including licensing requirements (State Medical Board of Ohio 2021).

An alternative legislative route that some state legislators, policymakers, and medical boards have taken to lessen the barriers to the state licensure process is joining the Interstate Medical Licensure Compact (IMLC) and other professional medical compacts. The IMLC (also known as the Telemedicine Licensure Compact) is an agreement between participating states to work together to “significantly streamline the licensing process for physicians who want to practice in multiple states” (IMLC, n.d.). The Interstate Medical Licensure Commission oversees the compact between the states and is made up of representatives from each member state (IMLC, n.d.). For a state to join the compact, the state legislature must enact the compact into law, making only technical changes to the law (AMA 2019). The compact brings uniformity to the varying licensing processes by providing one process doctors can complete to be licensed in multiple states (AMA 2019).²⁷ As of August 2021, more than 25 states, the District of Columbia, and Guam are members of the compact (IMLC, n.d.).²⁸ The IMLC system is a significant step toward standardizing telehealth licensure requirements. However, the compact licensure route

²⁶ Exec. Order 2021-16, Rescinding Executive Orders (July 2, 2021), https://azgovernor.gov/sites/default/files/executive_order_2021-16.pdf.

²⁷ In practice, how the compact works is simple. A physician will designate a member state as the state of principal licensure and then select the other member states that they wish to apply for licensure in (American Medical Association 2019, 3). The state of principal licensure will review the physician’s qualifications and will attest to the Commission that the physician meets eligibility requirements (American Medical Association 2019, 3). The Commission will collect the applicable fees from the physician and send his or her information and fees to the additional states (American Medical Association 2019, 3). After receipt by the applicable state, the physician will be granted a license (American Medical Association 2019).

²⁸ These states include Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, South Dakota, Tennessee, Utah, Washington, Wisconsin, West Virginia, and Wyoming. Delaware, Ohio, Texas, Pennsylvania, and the District of Columbia have agreed to the terms of the compact, but implementation is in process or delayed (Interstate Medical Licensure Compact, n.d.).

has its limitations. Only medical and osteopathic doctors are eligible to apply (IMLC, n.d.). There are currently six different interstate compact organizations overseeing out-of-state licensing for various medical professionals, including:

- (1) The IMLC Compact;
- (2) The Nurses Licensure Compact, which, as of this writing, has 34 enrolled state members (NCSBN, n.d.);
- (3) The Psychology Interjurisdictional Compact (PSYPACT), which, as of this writing, has 15 enrolled state members (PSYPACT Commission, n.d.);
- (4) The Physical Therapy Compact, which, as of this writing, has 28 enrolled state members (FSBPT, n.d.);
- (5) The Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC) which, as of this writing, has 5 enrolled state members; and
- (6) The Emergency Medical Services Personnel Licensure Interstate Compact, which, as of this writing, has 20 state members enrolled (Center for Connected Health Policy 2021, 8).

Each of these individual licensure compacts requires state legislatures to enact into law the compact in their state. If and when changes to a compact need to be made, state legislatures must enact new legislation to remain in compliance with the compact.²⁹ This means that bureaucracy or politics can impact necessary legislative changes to each individual compact. Moreover, states can withdraw from a compact, which may leave providers in those states without no way of providing care to patients they previously saw via telehealth.

V. The Future of Telehealth: Recommendations

The sweeping changes implemented at the state and federal levels regarding telehealth have expanded access to health care for individuals with SUD. However, it is unclear if these changes will have a positive and quantifiable impact in the long term. Below are recommendations that some policymakers and advocates contend can help expand access to telehealth services for individuals with SUD.

A. Federal Support of Mutual Recognition and Reciprocity of State Licenses

As previously stated, there are currently at least six interstate medical compacts that cover different medical professions. Each compact has been enacted by a number of states. For example, at the time of this writing, 34 states have enacted the Nurse Licensure Compact, and only five states have enacted the ASLP-IC. Although these compacts may streamline the ability of some health care providers to practice in multiple states, enacting individual medical compacts

²⁹ In 2018, the National Council of State Boards of Nursing dissolved the Nursing Licensure Compact and subsequently implemented the Enhanced Nursing Licensure Compact (eNLC) (NCSBN, n.d., Explore NCSBN Through the Years). This new compact updated the previous compact, including requiring a federal background check from applicants (NCSBN, n.d.). Following this update, most state legislatures that had previously enacted the eNLC enrolled the new compact into law (NCSBN, n.d.).

is not efficient, because each one requires a separate enactment by the state legislature. Each state must enact the language of the compact exactly as written, and if the compact is modified or changed, that state must repeal and reenact the compact to stay in compliance. An alternative to this approach is for the federal government to consider legislative and administrative proposals that encourage reciprocity among state licensing systems (HHS *et al.* 2018, 42). This alternative has support. A joint 2018 report issued by HHS and the Departments of Treasury and Labor analyzed several paths to facilitating telehealth to improve patient access, including recommending that “Congress and other policymakers should increase opportunities for license portability through policies that maintain accountability and disciplinary mechanisms, including permitting licensed professionals to provide telehealth service to out-of-state patients” (HHS *et al.* 2018, 42). In effect, the current changes implemented by CMS have encouraged license portability and reciprocity. As discussed, many states followed suit and expanded telehealth privileges for health care practitioners. However, some states have already rescinded these changes.³⁰ In lieu of possible temporary changes to licensure portability, the federal government could use its resources to encourage permanent license reciprocity among states. In an article published in the *New England Journal of Medicine*, Ateev Mehrotra, MD, and Alok Nimgaonkar of Harvard Medical School and Beth Israel Deaconess Medical Center with Barak Richman, JD, PhD, of Duke University argued for federal government intervention in state license reciprocity. “. . . Congress could mandate licensure reciprocity in the context of Medicare, another federal program,” they wrote. “Physicians could be permitted to provide telemedicine services to Medicare beneficiaries in any state, as long as they possess a valid medical license. Such a policy would most likely accelerate the adoption of state legislation regarding reciprocity, thereby affecting patients with other forms of insurance as well” (Mehrotra, Nimgaonkar, and Richman 2021, 689).

B. Permanently Enact and Expand PHE Telehealth Regulatory Changes

The PHE declaration triggered sweeping changes to telehealth law throughout the federal government, which precipitated changes on the state level. Some of the changes triggered by the PHE have been made permanent through an Executive Order, including permanent changes to telehealth Medicare payments for certain health care providers (Executive Office of the President 2020). Many of these fundamental changes have had a significant impact on telehealth access. For example, historically, Medicare’s originating site and geographic requirements have been barriers to Medicare’s reimbursement of telehealth services (McDermott *et al.* 2020, 1). This is because typically, Medicare only reimburses telehealth services to beneficiaries when they are at a qualified originating site, such as a hospital or provider’s office (McDermott *et al.* 2020, 1). In practice, this means that beneficiaries are not permitted receive telehealth services in their own home (McDermott *et al.* 2020, 2). Under the CARES Act of 2020, Congress permitted the waiver of the originating site requirements in an emergency area during any period of the PHE (McDermott *et al.* 2020, 2). Unfortunately, this change is not permanent. Further, it would take an act of Congress for the waiver of the originating site requirement to become permanent,

³⁰ As noted above, Ohio and Florida have also rescinded the telehealth licensure permissions put in place by emergency order.

because the site requirement is set forth under 42 USC §1395m(m)(4)(C).³¹ Policy makers have signaled support for this change. Kyle Zebley, director of public policy at the American Telemedicine Association, said that “[i]f Congress does not act before the public health emergency ends, regulatory flexibilities that now ensure all Medicare beneficiaries maintain access to telehealth will go away” (Jercich 2021).

The DEA should also consider making permanent the SUD treatment and recovery changes implemented as a result of the PHE. This includes authorizing qualified practitioners to prescribe controlled substances to patients using telehealth without first conducting in-person evaluations, which was case during the PHE (Prevoznik 2021). The DEA partnered with SAMHSA to allow qualified practitioners to admit and treat patients with an OUD during the duration of the PHE and authorized qualified practitioners to prescribe buprenorphine to new and existing patients with an OUD via telephone or through other telehealth means without requiring that the practitioner first meets with the patient in person (Prevoznik 2021). The DEA may also consider applying the PHE in-person examination waiver to methadone treatment. At the time of this writing, the PHE in-person exam waiver is limited to the treatment of OUD with buprenorphine. Methadone treatment models that are covered under DEA-approved OTP programs are not covered for the in-person examination waiver. Conceivably, this may make treatment for those using methadone difficult. “SAMHSA’s ongoing refusal to make this accommodation made new methadone patient inductions more difficult and time-consuming than they needed to be, in addition to needlessly exposing our team members to a greater risk of COVID-19 infection,” one OTP told the Office of the Inspector General in response to an audit conducted by the office (Office of Inspector General 2020). The removal of this barrier would likely provide those who take methadone with the same increased access that is currently provided to individuals who take buprenorphine. Legislators have introduced several bills in Congress in an effort to make substantive changes to federal telehealth laws, particularly Medicare and Medicaid.³² In addition, as part of HRSA’s Office of the Advancement of

³¹ 42 U.S.C.A. § 1395m (West) (effective January 7, 2011).

³² *See for example:* Ensuring Parity in MA for Audio-Only Telehealth Act of 2021, S.B. 150, 117th Congress (2021)(“Allows audio-only diagnoses that are made via telehealth to be used for purposes of determining risk adjustments to payments under Medicare Advantage.”); Ensuring Telehealth Expansion Act of 2021, H.R.341, 117th Congress (2021)(“This bill makes permanent several telehealth flexibilities that were initially authorized during the public health emergency relating to COVID-19 (*i.e.*, coronavirus disease 2019), particularly with respect to Medicare coverage of telehealth services.”); Expanding Access to Mental Health Services Act, H.R. 4012, 117th Cong. (2021)(“Permanently broadens mental health options, including intake examinations and therapy, via telehealth for Medicare members.”); Advancing Telehealth Beyond COVID-19 Act of 2021, H.R. 4040, 117th Cong. (2021)(Permanently removes the originating site and geographical limitations, makes permanent the telehealth coverage at FQHC’s and RHC’s, removes restrictions that limit health care providers’ ability to provide access to smart devices and innovative digital technology to their patients.); Enhance Access to Support Essential Behavioral Health Services Act, H.R 4036/S. 2112, 117th Cong. (2021)(“Allows mental health professionals providing telehealth services through Medicare and Medicaid to be reimbursed at the same levels as mental health professionals conducting in-person visits.”); Increasing Rural Telehealth Access Act of 2021, S. 2110, 117th Congress. (2021)(“Expands access to health care by improving remote patient monitoring technology for individuals in rural areas.); and The Equal Access to Care Act, S. 155/H.R. 688, 117th Congress (2021)(“Would permit a licensed health care provider to provide health care services to individuals in one or more States in which the provider is not licensed.”)

Telehealth’s commitment to improving telehealth in rural and underserved communities, over \$19 million was awarded to 36 recipients in August 2021. (HRSA 2021)

C. Increase Funding for Mobile App and Assistive Telehealth Services

The number of Americans with access to fixed broadband Internet services has increased steadily over the last 10 years. However, the Federal Trade Commission estimates that more than 21 million Americans do not have access to these services. The company BroadbandNow Research believes that the number is closer to 42 million (BroadbandNow Research 2021). This inequity deepens when viewed by race or disability. Black and Latinx adults are less likely than White adults to have their own computer or high-speed Internet in their homes (Atske and Perrin 2021). Individuals with developmental and physical challenges are three times as likely as those without a challenge to never go online (*i.e.*, 23 percent versus eight percent) (Anderson and Perrin 2017). Adults who are challenged are also less likely to self-report that they subscribe to home broadband services and own a traditional computer, a smartphone, or tablet (Anderson and Perrin 2017).

Telehealth services cannot, and will not, be the future of medicine if vulnerable populations, individuals with limited financial means, individuals with SUD, individuals of color, and individuals with developmental and physical challenges are not able nor incentivized to use it. Adaptive technology, mobile apps, and public Wi-Fi access offer avenues for vulnerable populations to increase telehealth access. “Adaptive technology refers to special versions of already existing technologies or tools that provide enhancements or different ways of interacting with the technology. The adaptation helps individuals with a disability or impairment accomplish a specific task.” (ACT Center, n.d.). Ensuring that individuals with disabilities have access to telehealth services may mean encouraging and using adaptive technology such as live, closed-caption services or having a sign language interpreter on hand when using telehealth technology.

Text messaging, mobile apps, and virtual reality interventions are innovative ways to help individuals with disabilities access telehealth services because these services or devices can be adapted to make technology more accessible. Medical providers who want to ensure that they provide equitable access to telehealth service for all patients should consider hiring a telehealth coordinator (National Governor’s Association (NGA) 2020, 16). This person can work with the disabled, the elderly, and other vulnerable individuals to help foster digital literacy, including training and education on using telehealth or providing assistive services to help make telehealth use easier (NGA 2020, 16).

Recently, Congress passed the American Rescue Plan (ARP) Act, which included a multi-billion-dollar appropriation to help expand high-speed Internet access (Tomer and George 2021). The act provides a variety of avenues for bridging the digital divide between those who have ready access to the Internet and those who do not. “Three programs—the Emergency Broadband Benefit, the ARP Emergency Connectivity Fund, and the ARP Capital Projects Fund—*exclusively* set aside funding for digital equity policies. These three programs together

total \$20.371 billion” (Tomer and George 2021). The act funds a variety of programs, including providing funding to minority-serving institutions or historically Black colleges and universities to expand Internet access through the Connecting Minority Communities Pilot Program (Tomer and George 2021) and increasing funding for cities to expand public-private partnerships with private companies under the Promote Broadband Expansion Grant Program (Tomer and George 2021). For schools or libraries in rural or remote areas that would like to increase Internet access for students and patrons, there is the Emergency Connectivity Fund (Tomer and George 2021). The programs provided under the ARP Act are a step in the right direction. However, to help those who have difficulty with connectivity and Internet access, private companies and government organizations should consider funding projects that provide access to the Internet.

D. Consider the Privacy and Ethical Implications of Telehealth Use

Under the PHE, HHS waived HIPAA requirements with which providers must comply while engaging patients via telehealth services. Under HIPAA the Secretary of HHS must publicize standards for the electronic exchange, privacy, and security of health information (HHS, Summary of the HIPAA Privacy Rule 2021)).³³ Prior to this waiver, HIPAA-covered health care practitioners could not use certain mobile apps to provide services via telehealth (HHS, Notification of Enforcement 2021). After the PHE declaration, HIPAA-covered health care practitioners may, in good faith, use non-public-facing apps such as FaceTime, Facebook Messenger, Google Hangouts, Zoom, and Skype for telehealth services, even if these apps do not fully comply with HIPAA laws (HHS, What Is a Non-Public Facing Remote Comm. Product? 2020; HHS, Notification of Enforcement 2021). However, public-facing platforms such as Facebook Live and TikTok should not be used to provide telehealth (HHS, Notification of Enforcement 2021). These platforms are public-facing and are not “acceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication” (HHS, What Is a Non-Public Facing Remote Comm. Product? 2020). Many in the SUD field have urged the federal government to make these temporary rules permanent. The more choices patients have regarding the platforms they can use to engage their providers, the more likely they will be to seek health care. Confidentiality, however, must be considered. Many of the apps mentioned above are not HIPAA compliant. The risk of data breach is significant, but the cost-benefit analysis of providing more people with access to health care providers on platforms that they already use on a regular basis weighs heavily in favor of working with tech companies to gain HIPAA compliance.

Along with privacy concerns are the ethical considerations that telehealth access raises. “Ignoring the ethical impacts of information and communication technology health service delivery creates an unintended risk for patients and can lead to reduced effectiveness, noncompliance, and harm, undermining the best intentions of governments and clinicians” (Keenan, Tsourtos, and Tieman 2021, 1). Issues of consent, accessibility, data use, and protection are all important considerations that policy makers, legislators, and health care providers must

³³ Health Insurance Portability And Accountability Act (West, Westlaw through PL 104 -1)(1996); *see also* 42 U.S.C.A. § 1320d-2 (West)(effective March 23, 2010).

weigh to provide telehealth access and services ethically and honestly to patients. If a patient is treated via telehealth by a doctor in another state and treatment fails or the diagnosis is incorrect, who is responsible (Delgado, n.d.)? Does the doctor, the patient, or even the telehealth provider bear some complicity (Delgado, n.d.)? There is little clinical research on the ethical implications of telehealth use (Keenan, Tsourtos, and Tieman 2021, 2). This is a new area of the law, and the ethical questions it raises need to be answered proactively as the field of telehealth grows (Delgado, n.d.).

VI. Conclusion

Individuals living with SUD are part of a particularly vulnerable group of people who would likely benefit from increased accessibility to health care providers through telehealth. If some of these issues can be addressed and overcome, the future of health care in America can include telehealth services based on evidence-based, informed practices that are designed to be accessible to everyone.

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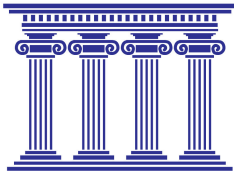
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ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.



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