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Common themes in early state policy responses to substance use disorder treatment during COVID-19

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Abstract

Background: Limited research has examined how states have changed policies for treatment of substance use disorder (SUD) during the COVID-19 pandemic.

Objectives: We aimed to identify themes in state policy responses to the pandemic in the context of SUD treatment. Identifying themes in policy responses provides a framework for subsequent evaluations of the relationship between state policies and health service utilization.

Methods: Between May and June 2020, we searched all Single State Agencies for Substance Abuse Services (SSA) websites for statements of SUD treatment policy responses to the

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pandemic. We conducted Iterative Categorization of policies for outpatient programs, opioid treatment programs, and other treatment settings to identify themes in policy responses.

Results: We collected 220 documents from SSA websites from 45 states and Washington D.C. Eight specific themes emerged from our content analysis: delivery of pharmacological and non-pharmacological services, obtaining informed consent and documentation for remote services, conducting health assessments, facility operating procedures and staffing requirements, and permissible telehealth technology and billing protocols. Policy changes often mirrored federal guidance, for instance, by expanding methadone take-home options for opioid treatment programs. The extent and nature of policy changes varied across jurisdictions, including telehealth technology requirements and staffing flexibility.

Conclusion: States have made significant policy changes to SUD treatment policies during COVID-19, particularly regarding telehealth and facilitation of remote care. Understanding these changes could help policymakers prioritize guidance during the pandemic and for future health crises. Impacts of policies on disparate treatment populations, including those with limited technological access, should be considered.

Keywords

COVID-19; substance use disorder; telehealth; methadone; state law

Introduction

The COVID-19 public health crisis is colliding with an ongoing substance use disorder (SUD) crisis in the United States (1–3). For example, opioid overdoses among people with opioid use disorder are rising, potentially due to comorbid conditions and impaired lung function related to COVID-19, misuse of substances to alleviate negative emotions from increased daily stressors (1,2), decreased access to SUD treatment (1,2), and social distancing, which may prevent bystanders from administering naloxone during an overdose (1,2). People with other SUDs (e.g., involving methamphetamine, alcohol, and nicotine) are also at elevated risk of health problems during the COVID-19 pandemic (1,3). Furthermore, the pandemic may be worsening racial and ethnic health disparities in treatment engagement and retention among people with SUD, particularly since minority communities tend to have fewer community resources but higher rates of preexisting chronic health conditions (4–7).

To prevent interruptions to SUD treatment during the pandemic, scholars have recommended that policymakers and health care institutions promote remote care through telehealth or self-help mobile applications (8); increased reimbursement for telehealth services; increased take-home access to buprenorphine and methadone (9,10); and prescribing of naloxone along with medications for opioid use disorder (MOUD) (10). The federal government has adopted several new policies that impact SUD treatment. In 2020, the Drug Enforcement Administration (DEA) waived requirements for buprenorphine prescribers to conduct in-person visits before initiating treatment (11) and authorized prescribing buprenorphine via audiovisual or audio-only telehealth (12). The Substance Abuse and Mental Health Services Administration (SAMHSA) permitted opioid treatment programs (OTPs) to immediately expand take-home doses of methadone: up to one month for stable patients (i.e., those with

low risk of diversion or misuse of take-homes) and up to two weeks for unstable patients (13). In addition, several federal health care policies indirectly affected SUD treatment during COVID-19 – for example, the Office of Civil Rights relaxed enforcement of penalties for violation of the Health Insurance Portability and Accountability Act (HIPAA) in the context of telehealth (14) and the Centers for Medicare and Medicaid Services (CMS) expanded insurance coverage of telehealth (15).

In addition to incorporating federal policy changes into state policy (e.g., expanding methadone take-home dosages), U.S. states and Washington D.C. (hereafter collectively "states") can modify other aspects of SUD treatment policy that fall under their jurisdiction (16) or clarify the application of existing policies during COVID-19. Due to the decentralized nature of the federal guidance on SUD treatment during the COVID emergency and states' substantial leeway in implementing treatment policy changes, it is likely that states have adopted a range of policies to fill that gap. Each state has a single state agency (SSA) that is responsible for regulating SUD treatment providers/facilities, allocating block grants and Medicaid dollars to SUD treatment providers/facilities, and disseminating information about state policies and best practices. Since SSAs issue regulations and disseminate policy information related to many SUD treatment settings (e.g., outpatient treatment, opioid treatment programs) and topics (e.g., SUD treatment facility employment, admission policies, payment policies), analyzing the content of SSA policies can provide insight into the wide range of policies with which states are responding to the pandemic in the context of SUD treatment. To our knowledge, no study has used SSA data to identify themes in such policies. Therefore, the aim of our study was to identify themes in state policy responses to SUD treatment during COVID-19 using data obtained from SSA websites in all states from May through June 2020.

Methods

Data collection

State policy data include, but are not limited to, the text of state statutes and regulations, rules and guidelines issued by state agencies, and provider licensing requirements set by health care boards. The state SSA websites are one channel for providing information about state SUD treatment policies related to the COVID-19 pandemic, including changes related to SSA guidelines, changes to provider licensing rules, governors' executive orders, and statutory text that the SSA deems of particular relevance to SUD providers/facilities. Between May 12, 2020 and June 16, 2020, using the most recent version of SAMHSA's Directory of Single State Agencies for Substance Abuse Services available at that time, research team members (ORK and RT) examined each state's SSA website for all publicly available statements regarding SUD treatment policy responses to the COVID-19 pandemic. Because search term functionality is limited on many SSA websites (e.g., one could not search for both "substance use" and "COVID-19" terms simultaneously), researchers manually navigated each state's SSA website to the COVID-19 webpage with information for health care providers, and opened documents/links with titles that indicated relevance to SUD treatment. We initiated data collection in May as soon as we realized the potential importance of state policy changes related to SUD that occurred in response to the pandemic

outbreak and were able to arrange resources for the work, and we completed the data collection in June.

Documents that included information about state-level policies relating to SUD treatment during COVID-19 (i.e., our inclusion criteria) were either copied and pasted into a Word document as plain text or saved as a pdf file and then uploaded into Dedoose qualitative software (17). We excluded documents that were solely national guidance without any state-level specificities (e.g., CDC guidance directly from the CDC website), were unrelated to SUD treatment, or did not discuss the pandemic. Because this research did not involve human subjects it did not require institutional review board approval.

Data analysis

Research team members (BAC, KB, RH, ORK, MG, RT) conducted content analysis of SSA website data in Dedoose software (17), using a modified version of iterative categorization (18). After a preliminary review of the data, the research team developed codes for four general treatment settings to which policies might apply: opioid treatment programs (OTPs), outpatient settings (including office-based buprenorphine treatment), residential/inpatient settings, and nonspecific settings (i.e., not specific to any of the other settings). Researchers then categorized data into one or more of these treatment settings. Given substantial differences in topics for residential/inpatient settings (e.g., included policies related to visitation, bedrooms, and moving patients back home), the subsequent analyses focused on OTP, outpatient, and nonspecific settings only.

Senior researchers with expertise in SUD-related laws (BAC, RH) then created a codebook of SUD treatment-related policies based on a preliminary review of data. A sub-team of two or three researchers was then assigned to each of the three policy settings. Each sub-team used a consensus coding approach, during which they independently applied codes to meaningful data and then met to negotiate discrepancies. More than one code could be applied to data (e.g., a particular segment of a policy document could pertain to both telehealth technologies required and group size requirements). Policies regarding hygienic measures (e.g., handwashing regulations; temperature regulations; glove or mask wearing) were not coded, as they are unlikely to be unique to SUD treatment.

During the consensus coding process, new codes were identified and added to the codebook; previously coded data were recoded when appropriate. The sub-teams then conducted an inter-rater reliability test in Dedoose software, finding moderately high reliability to high reliability (average kappa > 0.73, depending on sub-team). The remaining data were then independently coded.

After coding was completed, data excerpts for each code were exported into separate Word documents, and sub-teams of researchers were assigned to review the excerpts for each code. Again, sub-teams focused on one specific policy setting. During this process, each sub-team member first independently labeled each data excerpt in the Word document with a summary of the policy (e.g., “audio-visual methods permitted for telehealth”) and then categorized the labels into subthemes based on consistencies and inconsistencies in labels. Sub-team members then met to compare and negotiate differences in subthemes they had identified for

their specific policy setting. Finally, the entire research team met to review similarities and differences between subthemes across the three policy settings and to categorize them into final, overarching themes.

Results

Description of analytic dataset

Our dataset included 220 documents from SSA websites of 45 states and Washington D.C. We excluded the SSAs of five states (Alabama, Delaware, Florida, Vermont and Wyoming) because the SSAs merely provided links to federal policies. The majority of documents (77%) retrieved were in the form of a policy memorandum; other documents included Frequently Asked Questions (FAQs) (18%), PowerPoint presentations (2%), and copies of state executive orders (2%). See Table 1.

Policy themes

We identified eight themes in the state-level SUD treatment policy responses to COVID-19. In general, the themes fall into two categories: facilitating remote treatment or providing flexibility in treatment. Table 2 provides a complete list of themes and related policies. Table 3 provides example policy statements for each theme.

Billing and payment

The most salient theme in our study was how states responded to SUD treatment billing and payment policies during COVID-19. A primary subtheme was expansion of public insurance coverage for counseling, case management, and health assessments via telehealth, as well as expansion of insurance coverage for certain non-telehealth services, including medication delivery from OTPs to patient homes (20). Related policies included comparable reimbursement rates for in-person and telehealth modalities for the same service, new billing codes and billing modifiers for telehealth provision of services, and expansions of permissible originating sites for telehealth (e.g., the health care provider's home). In addition, we identified a subtheme regarding other insurance-related flexibilities, such as waiving prior authorization requirements, extending previous prior authorizations, waiving copayments, and increasing the maximum supply of prescription refills.

Treatment facility infrastructure and operating procedures

We identified an infrastructure and operating procedures theme, with subthemes related to acceptance of new patients, emergency preparedness, open hours, and licensure requirements. One subtheme was the requirement that treatment facilities remain open and continue to accept new patients. However, we also noted policies that allowed flexible hours of operation if patient care was not disrupted or limited. For example, we identified permission for OTPs to stagger dosing hours or to provide half of the patients in-person dosages on alternating days to minimize potential COVID-19 exposure (27). A third subtheme involved policies that required pandemic-related emergency preparedness plans for facilities (e.g., in the event of staff shortages) and for clients (e.g., in the event of a crisis while they were receiving expanded take-home medications).

We also identified a subtheme of flexibility in SUD facility licensure requirements, including extensions of temporary licenses, suspensions or delays on certain licensing requirements, waivers or delays of inspections, waivers of the requirement that facilities/providers sign attestations for telehealth provision, as well as waivers of certain programming requirements (i.e., allowing facilities to offer fewer services). For example, Oregon's health authority suspended all inspection visits associated with license renewal and extended licenses that would expire during the state of emergency by six months. The rationale provided in the regulation was a desire for the health authority and providers to conserve resources and focus on caring for patients (28). Other states, however, explicitly stated that licensure or accreditation requirements for SUD treatment agencies and providers have not changed during the pandemic (21).

Assessment

The health assessment theme included permission or encouragement to conduct assessments via telehealth and increased flexibility regarding assessment timelines. For example, states permitted or encouraged physical examinations, laboratory tests, and mental health assessments via telehealth except for induction or dosage change during methadone treatment. For instance, the state of Washington encouraged OTPs to conduct complete laboratory testing on each new client but not to prevent client admission if laboratory tests were incomplete, since testing capacities have been "pushed to the limit" (22). Even when telehealth assessments were permitted or encouraged, some policies explained that telehealth assessment was not always appropriate and recommended that providers make decisions regarding its appropriateness on a case-by-case basis. We also identified policies relaxing timelines for assessments, such as by allowing providers to delay annual exams of clients by a specified number of months or until after the pandemic.

Pharmacological services

We identified a theme of changes in pharmacological service policy, primarily with respect to the OTP setting, as well as policies related to take-home dosages, in-person dosing rules, and patient monitoring. One subtheme was permission for buprenorphine induction via telehealth, including via audio-only modalities, without an in-person visit. A second subtheme was encouragement for expanding methadone take-home dosages within OTPs. For example, policies encouraged maximum allowable take-home dosages to patients who had previously qualified for take-home medications, permitted more limited take-home dosages for less stable patients, and permitted take-home dosages for patients diagnosed with COVID-19 or with a disproportionate risk of developing more severe symptoms of COVID-19 for the duration of the patient's illness or symptoms. Policies related to expanded take-home medications sometimes also included encouragement of naloxone prescribing and mandatory medication management calls or "check-ins" between the patient and OTP staff. A third subtheme was flexibility of in-person methadone dosing at OTPs, such as through curbside dosing or dosing outdoors. Additionally, we identified increased flexibility regarding drug screening or monitoring requirements at OTPs, with decisions left to medical directors on a case-by-case basis (23) or waived entirely for patients with a COVID-19 diagnosis or symptoms (24).

Non-pharmacological services

Policies related to non-pharmacological services included encouraging facilities/providers to deliver group counseling, case management, individual counseling, and peer support via telehealth and discouragement of providing these services, particularly group counseling, in person. We also identified a subtheme of special rules for group activities, such as prohibiting audio-only telehealth for group counseling, limitations on the number of in-person group counseling participants, prohibition of group counseling or peer support group meetings in-person (e.g., even if in-person individual counseling was still permitted), and permission to provide group counseling outdoors.

Documentation and informed consent

We identified a theme related to documentation and informed consent, particularly with respect to telehealth. This theme included policies permitting facilities/providers to obtain verbal informed consent for telehealth. Relatedly, the theme included requirements to record the verbal informed consent in the patient's medical record, to obtain informed consent in writing at a later date, to document the type of telehealth modality (e.g., audio-only), and to document the rationale for telehealth utilization and why verbal (rather than written) informed consent was obtained. Specific to OTPs, an additional subtheme included documenting the chain of custody and mode of delivery for third-party pickup and home delivery of methadone, as well as reasons for exceptions to take-home rules (e.g., if a client has COVID-19).

Staffing and supervision

We identified pandemic-related responses to staffing and supervision in SUD facilities. We found variation in scope of practice rules in response to COVID-19, ranging from increased flexibility (e.g., permission for supervised counseling interns to provide telehealth counseling or permission for pharmacist interns to administer medication in OTPs) to clarification that scope of practice rules have not changed. Another subtheme was increased flexibility regarding onsite staffing (i.e., who must be on site) and staff-to-client ratios, including temporary suspension of previous requirements. A third subtheme was permission for staff supervision (e.g., by medical directors or senior nurses) via telehealth.

Telehealth technology

We identified a subtheme of technology requirements for telehealth provision. Generally, synchronous video/audio telehealth was recommended as the primary modality of telehealth delivery, followed by audio-only modalities, and, lastly, texting or e-mail. Sometimes this order of preferences was reflected as a strict hierarchy in policy documents, wherein providers must use synchronous audio-visual technology, unless it is not feasible (25). Another subtheme was permission to use non-HIPAA compliant technology for telehealth purposes, so long as it is not public facing. Policies also sometimes stated that providers must obtain informed client consent regarding the risks associated with non-HIPAA compliant technology and inform clients that security of the session could not be guaranteed (26).

Discussion

Examining state responses is important given the lack of synergy between different federal agencies' regulatory responses to the COVID-19 crisis and flexibility afforded states in federal regulations (e.g., Medicaid regulations.) As expected, we found heterogeneity among state policy responses to COVID-19. Nevertheless, the themes emerging from the SSAs we reviewed can be aggregated into two overarching themes: 1) state facilitation of telehealth and 2) increasing state flexibility in regulating SUD treatment. The frequency of telehealth-related themes and subthemes is not surprising: the pandemic has necessitated social distancing measures during which telehealth may be the only feasible and safe treatment option for many patients and providers. In addition, the federal government has implemented policy changes facilitating telehealth (14,15,29), and in general states appear to have taken advantage of these federal flexibilities.

At the same time, states seem to have balanced expanded telehealth access with concerns about quality of treatment. For example, some states required synchronous video, unless unavailable, in which case audio-only services were permitted. Such policies suggest that policymakers believed synchronous video results in better quality treatment services, but that audio-only treatment is better than no treatment at all. Even when telehealth was permitted, states cautioned that it may not be appropriate for all patients and recommended that providers make telehealth decisions on a case-by-case basis. To our knowledge, guidelines do not yet exist to help providers determine clients for whom telehealth is or is not appropriate, including for buprenorphine treatment. Relatedly, states appear to be trying to balance expansion of telehealth access by permitting use of non-HIPAA-compliant software, while also acknowledging the privacy risks of doing so. For example, we found that states permitted use of non-HIPAA-compliant software for counseling but required explaining the associated privacy risks during the informed consent process.

States have also facilitated flexibility in SUD treatment requirements – for example, expanding OTP take-home medication and waiving requirements for health assessments, facility licensure or inspection, and staffing and supervision. It is unclear how policymakers decided which treatment requirements to waive and which to keep in place. Policymakers may have chosen to waive treatment requirements deemed less important or waived those they consider the least feasible while socially distancing. Some states took advantage of recent federal flexibility in OTP take-home rules (13) but imposed additional requirements, such as mandatory telehealth check-ins during take-home periods. The additional state-level requirements suggest that states are being cautious since the potential consequences of expanding methadone take-homes – such as increased diversion or worse patient health outcomes – are not yet known.

Telehealth-related policies were salient in our study. However, to provide context, we note that fewer than one-third of SUD treatment facilities nationally had the capacity for telehealth at the beginning of the pandemic (30). The extent to which state policies, such as those we identified, have changed telehealth capacity and utilization is unknown and should be explored, particularly since telehealth expansion could facilitate treatment engagement in previously underserved populations (e.g., if a local buprenorphine provider is unavailable

(4,31)). Telehealth could also facilitate integration of care between SUD, mental health, and primary care, and telehealth could be used to deliver low-intensity services to patients with SUD in remission (8). State policymakers must decide whether to sustain telehealth policy changes beyond the pandemic. That decision should be informed by information regarding telehealth's impact on SUD treatment engagement (32), health outcomes (33) and access disparities among historically underserved populations who may be less likely to have reliable Internet (3,8).

Our study has several important limitations. It is unlikely that all state SUD treatment policy responses to the pandemic were captured in our data set: SSAs likely post only those policies that they deem most relevant to treatment providers. A few states did not post any SUD treatment policy responses to COVID-19, and we have no information regarding policy changes that may have occurred in those states that were communicated to stakeholders in other ways. In addition, many states will continue to make policy changes in response to the evolving pandemic, and we have no information regarding policies subsequent to June 2020. Nevertheless, our results provide baseline information about policy themes that could aid future work exploring policy changes during different stages of the pandemic.

Conclusion

To our knowledge, our study is the first to use SSA data to systematically catalog state policy changes for SUD services that have occurred in response to the pandemic. Most policy changes involved facilitating telehealth, such as by expanding insurance coverage of this modality, or increasing flexibility in treatment, such as by waiving facility licensure or health assessment requirements. At the same time, some states seem to be curbing expanded access to remote care with quality measures, such as by requiring visual-audio telehealth modalities rather than audio-only modalities unless visual-audio modalities are infeasible.

Identifying themes in SUD treatment policy responses during the pandemic is important for several reasons. Themes could form policy domains for legal epidemiological research (19), facilitating examination of variation in state policies and exploring the empirical association between policies and health service utilization/health outcomes during the pandemic. Additionally, since states use SSA websites to disseminate information to providers/facilities, policy themes in SSA websites likely signal topics that state agencies deem most germane to SUD treatment providers/facilities during COVID-19. Identifying these topics could help policymakers prioritize areas in which states need guidance during the current pandemic and help them formulate/refine policies in advance of future health crises.

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Table 1.

SSA document type retrieved.

N =	N =	Percentage
Executive Order	5	2.3%
FAQs	39	17.7%
Health Memo	169	76.8%
Presentations + Powerpoints	5	2.3%
Other	2	0.9%
Total SSA Documents	220	100%

Table 2.

Common policy themes and subthemes of policy changes to SUD treatment during COVID-19.

Themes	Subthemes
1. Billing and Payment Changes	• Expansion of coverage of telehealth for pharmacological and non-pharmacological services (using new codes or telehealth modifier) • Billing rate is the same for tele-services as non-teleservices • Temporary flexibility of prior authorizations (e.g. waiving them; extending them) • Temporary waiving of copayments • Maximum supply of refills increased • Telehealth originating site expanded (e.g. provider home)
2. Changes to Infrastructure and Operating Procedures	• Facility must remain open • Facilities must continue to accept new patients • Facilities can be flexible regarding whether they are open and/or hours of opening, but they must accommodate or transfer patients, so care is not disrupted • Facility must develop emergency preparedness plans (client level, facility level) • Flexibilities on licensing (e.g. suspend or delay certain requirements; extend temporary licenses) • Flexibilities on inspections (waived, delayed) • Acceptable to not offer all regular programming (i.e. decrease counseling) • Must continue to offer all regular programming • Variability in attestation requirements for telehealth services (e.g. required, waived)
3. Assessment changes	• Assessments for new patients is acceptable via telehealth (except methadone) • Delay on certain assessments permitted (e.g. physical exams, labs) • Not all assessments are appropriate for telehealth (provider must decide appropriateness) • No in person visit necessary to initiate services (e.g. counseling) via telehealth
4. Non-pharmacological Services Changes	• Non-pharmacological services (e.g. counseling, case management, peer support) permitted via telehealth • Special rules for telehealth of group counseling (e.g. only video) • Strong encouragement to provide case management and counseling via telehealth
5. Pharmacological Services Changes	• OTPs may extend methadone take-homes to patients who had not previously earned them and who are unstable • OTP patients with earned methadone take homes are permitted the maximum amount of take homes • Dosing can occur in non-traditional locations (e.g. curb, outside) • More flexibility for buprenorphine than methadone (e.g. dosing adjustments)

Themes	Subthemes
	• Take home flexibilities for patients at risk of COVID-19 or with COVID-19
	• Increase amount of stored medications at OTPs and other dosing facilities (e.g. prisons)
	• Encouragement for providing naloxone
	• Buprenorphine prescribing and refills permitted without in-person visit
	• OTP requires engagement in telehealth (e.g. medication management service) for obtaining take home methadone
	• Services can be offered in new areas (e.g. curb, outside)
	• Drug screening flexibilities (e.g. waiver, or provider decides whether needed, or do via telehealth)
6. Documentation Changes	• Special rules for documenting telehealth (e.g. type of technology used)
	• Special requirements for documenting OTP medication delivery or third-party pick-up (e.g. chain of custody, mode of delivery)
	• Informed consent can be obtained verbally but must be documented in medical record
	• Special requirements for documenting OTP take home exceptions (e.g. for COVID patients)
	• Special informed consent to provide for telehealth patients (e.g. privacy risks on non-HIPAA compliant software)
7. Staffing flexibilities	• Supervision via technology is allowed
	• More flexibility regarding scope of practice (e.g. interns may provide counseling)
	• Scope of practice remains the same
	• More flexibility regarding onsite staffing presence and client-staff ratios
8. Technology for telehealth	• Hierarchy of technology exists (i.e. video preferred over audio, and audio preferred over text messaging)
	• Variability regarding state permission of using audio-only technology (some allow, some forbid, some only under certain conditions)
	• Non-HIPAA compliant technology is allowed, but not public facing

Table 3.

Themes and example policies.

Theme	Quotation 1	Quotation 2
Billing and payment changes	Virginia DMAS also recognizes that members may not be able to pick up their medications from OTPs during this State of Emergency. Thus, DMAS will allow OTP providers to deliver the medications to the member's location and be reimbursed for this service (14).	Maine During the emergency period associated with COVID-19, all copays are waived for Section 65, Behavioral Health Services. No copays are required for Sections 13, 17, 28, 92, or 93 services as a matter of general MaineCare policy (15).
Changes to Infrastructure and Operating Procedures	New Mexico Telephonic BH [behavioral health] visits must take place during the provider's normal business hours as if the provider's office were open and the member were able to attend the visit in person (19).	Maine Can we provide curbside dosing? The DEA supports "curbside" dosing on an individual basis directly at a vehicle parked with a patient inside should the medical team determine the patient should not be physically present in the OTP facility. In these instances, nurses should bring one individually pre-poured and labeled bottle in a locked box to the patient's vehicle outside of the OTP (e.g. in the parking lot) for observed dosing. If a nurse is transporting numerous doses for an individual patient curbside dosing, the DEA requires a security staff to accompany the nurse. The OTP must ensure that patient/designee identification and standard verifications occur as part of this process (34).
Assessment	Ohio New and established patients may be provided services through telehealth per this rule. No initial face-to-face visit is necessary to initiate services through telehealth (35).	Washington During the COVID-19 public health threat, as lab testing capacities are being pushed to the limit, and PPE is quite low in many healthcare settings including labs OTP and labs, each OTP should aim to complete serology and other lab testing as soon as reasonably possible, but please note that no client admission should be held up as a result of this testing not yet being completed (20).
Non-pharmacological services changes	New York Counseling visits: While OASAS remains committed to psychosocial treatment at OTPs, it is currently critical to reduce patient volume at OTPs, in order to reduce the spread of COVID-19, protect vulnerable patients and staff, and prioritize the essential function of safe medication dosing at OTPs. Therefore, during the COVID-19 crisis, programs should seek to reduce in-person individual and group counseling sessions, and do as many of them as are necessary and able via telehealth, per staff availability (36).	Illinois Minimize group gatherings; for example, group counseling and hosting 12-step meetings. Limit staff meeting or participation in upcoming staff trainings. Group counseling is highly discouraged at this time (21).
Pharmacological treatment changes	Utah For patients with only one take home (unearned), determined by the medical provider to be appropriate: a staggered take-home schedule whereby half the OTP's patients present will present on Mondays, Wednesdays and Fridays, and the other half of OTP patient's present on Tuesday, Thursday, Saturdays, with the remaining doses of the week provided as a take home would be appropriate. Patients should receive no more than two consecutive take homes at a time. This reduces the clinic's daily census in half and has a tolerable risk profile, as patients are still evaluated frequently and do not receive more than 2 days of take-home medication at any one time, as we often do clinic-wide during long holiday weekends. For patients who have already earned one additional take home: These patients have meaningfully fulfilled the eight take-home criteria and have done so for a period sufficiently long to suggest likely ongoing compliance. In the setting of a public health emergency, these patients have demonstrated enough clinical stability to warrant limiting their in-person dosing with Monday and Friday	Colorado For patients on buprenorphine: Based on the more favorable safety profile of buprenorphine, outpatient dosing on buprenorphine for new clients will be extended to one per week clinic visits with take-homes (no CSAT exemption required). Stable patients should already have earned at least a two-week clinic attendance schedule on average (37).

Theme	Quotation 1	Quotation 2
	clinic schedule for a total of 5 take home doses per week; e.g Attend clinic for dosing on Monday and Friday and receive take homes on the alternate days and weekend (16).	
Documentation changes	Iowa Licensure requires any treatment consent form (for telehealth and informed consent for treatment) to be documented in a patient record [641 IAC 155.21(14)]. It is recommended that written consent be obtained whenever possible. If written consent cannot be obtained, licensure would temporarily allow programs to obtain verbal consent until the patient is able to provide written consent. It is recommended to have all verbal consents witnessed by another staff. The verbal consent shall be documented in the patient record along with the rationale for why written consents were not obtained (22).	Hawaii Identify a trustworthy, patient-designated, uninfected member of the household to deliver the medications using the OTP's established chain of custody protocol for take home medication. This protocol should already be in place and in compliance with respective state and DEA regulations. OTPs should obtain documentation for each patient as to who is designated permission to pick up medication for them and maintain this process of determining a designee for any new patients (38).
Staffing flexibilities	Pennsylvania A narcotic treatment program shall provide narcotic treatment physician services at least 1 hour per week onsite for every ten patients. This regulation is being suspended for the duration of the disaster emergency (23).	Wisconsin While the changes in this Update are in effect, ForwardHealth will allow supervision requirements to be met via telehealth, but this flexibility does not change or replace licensure or certification requirements of the provider's supervising body or other regulatory authorities. When possible, face-to-face supervision requirements should be met via audio-visual technologies (24).
Technology for telehealth	Alaska Hierarchy for Provision of Services: With the Covid-19 public health emergency and the importance of Behavioral Health services during this time, it is critical that providers follow the below hierarchy for providing billable Medicaid services: Hierarchy for Individual Services: Level 1: In person - individual: As long as individuals can participate in settings that adhere to CDC guidelines of distancing providers should as much as possible provide face-to-face services. Providers must be cognizant of time based billing requirements per 7 AAC 105.230. Level 2: Telehealth - Video: Telehealth Video is the 2nd level providers may utilize any methods of face-to-face technology to facilitate telehealth service - Skype, Facetime, Zoom, Duo, etc. Level 3: Telephone Telephonic is an acceptable form of services; however, only utilize telephonic delivery if Level 1 in person or Level 2 video is not an option. Providers must be cognizant of time-based billing requirements per 7 AAC 105.230. Level 4: E-Mail E-Mail or exchanges via secure patient portal when available. Providers must be cognizant of time based billing requirements per 7 AAC 105.230 (25).	Maryland May a provider use Zoom given new issues that have arisen regarding the security of the Platform? Providers should use every effort to utilize a HIPAA compliant platform to conduct therapy with their clients. If a HIPAA compliant platform is not available (client lacks technology), then the Provider may utilize a non-compliant platform. The provider must obtain informed consent from the individual prior to initiating the clinical service. The individual must be advised that the clinical session will be transmitted over a non-secured technology, and the confidentiality or security of the session cannot be guaranteed. The form of the transmission (HIPAA compliant telehealth, telephonic, etc.) must be documented in the medical record as well as the individual's consent to the technology (26).