

COVID-19, Telehealth, and Substance Use Disorders*

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I. INTRODUCTION

A number of federal and state determinations, proclamations, statutes, regulations, executive orders, and notices of enforcement discretion (hereinafter authorities) have supported the rapid and unprecedented deregulation of telehealth and telemedicine in the United States during the coronavirus disease 2019 (COVID-19) pandemic.¹ On January 31, 2020, for example, Health and Human Services (HHS) Secretary Alex M. Azar II (Secretary Azar) used the authority vested in him under Section 319 of the

* This paper was published in November 2020 during the COVID-19 pandemic. All dates and time descriptions refer to the 2020–21 COVID-19 pandemic unless otherwise stated.

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1. See, e.g., Seema Verma, *Early Impact of CMS Expansion of Medicare Telehealth During COVID-19*, HEALTH AFFS. (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/> [<https://perma.cc/Q3R8-UZBG>] (“During the Coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS) has taken unprecedented action to expand telehealth for Medicare beneficiaries.”).

Public Health Service Act² to formally determine that a public health emergency (PHE) existed in the United States.³ On March 6, 2020, President Donald Trump (President Trump) signed the Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSAA), which included the Telehealth Services During Certain Emergency Periods Acts of 2020 (TSDCEPA), into law.⁴ On March 13, 2020, President Trump used the authority vested in him under Section 201 of the National Emergencies Act⁵ to formally proclaim that a national emergency existed.⁶ On March 17, 2020, HHS's Office for Civil Rights (OCR) announced that it would exercise enforcement discretion and waive potential penalties for Health Insurance Portability and Accountability Act (HIPAA) Rules violations against health care providers that serve patients through everyday communications technologies during the COVID-19 PHE.⁷ And, on August 3, 2020, President

2. Public Health Service Act, 42 U.S.C. § 247d(a) (“If the Secretary determines, after consultation with such public health officials as may be necessary, that . . . a disease or disorder presents a public health emergency . . . or a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists, the Secretary may take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder . . .”).

3. Alex M. Azar II, Sec’y, U.S. Dep’t of Health & Hum. Servs., *Determination that a Public Health Emergency Exists* (Jan. 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx> [https://perma.cc/9SZ5-JNY7]. Secretary Azar made his PHE determination retroactive to January 27, 2020. *Id.*

4. Coronavirus Preparedness and Response Supplemental Appropriations Act, Pub. L. No. 116–123, § 101, 134 Stat. 146, 155 (2020).

5. National Emergencies Act, 50 U.S.C. § 1621 (“With respect to Acts of Congress authorizing the exercise, during the period of a national emergency, of any special or extraordinary power, the President is authorized to declare such national emergency. Such proclamation shall immediately be transmitted to the Congress and published in the Federal Register.”).

6. Donald J. Trump, President, United States, Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (Mar. 13, 2020), <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/> [https://perma.cc/DB44-JYUW]. State governors likewise used their powers under state statutes and state constitutions to declare statewide emergencies. For example, Oklahoma Governor J. Kevin Stitt used the power vested in him under Article VI of the Oklahoma Constitution to issue Executive Order 2020-07, declaring an emergency across all seventy-seven Oklahoma counties. Okla. Exec. Order 2020-07 (Mar. 15, 2020), <https://www.sos.ok.gov/documents/executive/1913.pdf> [https://perma.cc/M4RD-CJLT].

7. Press Release, U.S. Dep’t of Health & Hum. Servs., Off. for C.R., OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency (Mar. 17, 2020) <https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html>

Trump issued an executive order directing Secretary Azar to: (i) propose a federal regulation extending beyond the duration of the PHE the telehealth services offered to Medicare beneficiaries, (ii) issue a report assessing telehealth and other policy initiatives designed to improve mental health in rural communities, and (iii) “develop and implement a strategy to improve rural health by improving the physical and virtual communications healthcare infrastructure available to rural Americans.”⁸

This essay describes how these authorities have supported the de-regulation of telehealth and telemedicine in the United States during the COVID-19 pandemic and considers the impact these changes may have for individuals with substance use disorders.⁹ As background, telehealth may be defined as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.”¹⁰ Technologies employed by telehealth providers include, but are not limited to, video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.¹¹ Although some authorities use the terms telehealth and telemedicine interchangeably,¹² telemedicine is sometimes defined more narrowly than

[<https://perma.cc/6Y5X-5V4H>]; Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, 45 C.F.R. § 160, 164 (2020), <https://www.govinfo.gov/content/pkg/FR-2020-04-21/pdf/2020-08416.pdf> [<https://perma.cc/G3WQ-634X>].

8. Exec. Order No. 13941, 85 Fed. Reg. 47881 (Aug. 6, 2020) [hereinafter Trump Executive Order], <https://www.govinfo.gov/content/pkg/FR-2020-08-06/pdf/2020-17364.pdf> [<https://perma.cc/Q8NC-WEWG>].

9. Substance use disorders include, but are not limited to, alcohol use disorder, hallucinogen use disorder, inhalant use disorder, opioid use disorder, stimulant use disorder, and sedative, hypnotic, or anxiolytic use disorder. *See* AM. PSYCH. ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 5–7 (5th ed. 2013) (listing American Psychiatric Association-recognized substance use disorders in the Table of Contents).

10. *See Telehealth Programs*, HEALTH RES. & SERVS. ADMIN., <https://www.hrsa.gov/rural-health/telehealth> [<https://perma.cc/R6XP-V8C5>]. Other authorities offer different definitions of telehealth. *See, e.g.*, TEX. OCC. CODE ANN. § 111.001(3) (West 2020) (defining telehealth as a “health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional’s license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology”). *See generally* Deborah R. Farringer, *A Telehealth Explosion: Using Lessons from the Pandemic to Shape the Future of Telehealth Regulation* (forthcoming 2021) (manuscript at 5–25) (providing an outstanding history of telehealth).

11. Farringer, *supra* note 10 (manuscript at 5–25).

12. *Telehealth and Telemedicine: A Research Anthology of Law and Policy Resources*, CTRS. FOR DISEASE CONTROL & PREVENTION,

telehealth; that is, “the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider.”¹³

One question that has been raised during the COVID-19 pandemic is the extent to which telehealth and telemedicine have improved access to mental health care and decreased exposure to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, for individuals with substance use disorder.¹⁴ This essay responds to this question first by identifying illustrative changes to the telehealth and telemedicine regulatory landscape, including changes relating to payment parity, originating sites, communication systems, in-person medical evaluation requirements, telehealth services, telehealth providers, in-state licensure, and telehealth privacy and security. Second, this essay considers the impact these changes may have on individuals with substance use disorders.

II. THE CHANGING TELEHEALTH REGULATORY LANDSCAPE

A. Payment Parity

Historically, covered telehealth and telemedicine patient visits were reimbursed by insurers at lower rates compared to in-person patient visits. In response to these payment disparities, many states implemented some form of telehealth or telemedicine payment mandate or payment parity prior to the COVID-19 pandemic.¹⁵ During the COVID-19 pandemic, additional public

<https://www.cdc.gov/phlp/publications/topic/anthologies/anthologies-telehealth.html> [<https://perma.cc/EW8G-SAS7>] (“Often, telehealth is used interchangeably with the terms telemedicine or eHealth.”).

13. FEDERATION OF STATE MED. BDS., MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 1 (2014), https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf [<https://perma.cc/Q52M-KY7X>]. Other authorities offer different definitions of telemedicine. OCC. § 111.001(3) (defining telemedicine as a “health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional’s license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.”). *See generally* Farringer, *supra* note 10 (carefully discussing the terms telehealth and telemedicine).

14. *See* AM. PSYCH. ASS’N, *supra* note 9, at 5–7 (listing illustrative substance use disorders).

15. AM. MED. ASS’N., COVID-19 STATE POLICY GUIDANCE ON TELEMEDICINE 1 (2020), <https://www.ama-assn.org/system/files/2020-04/covid-19-state-policy-guidance-on-telemedicine.pdf> [<https://perma.cc/5M6W-YR7A>] (“Prior to the COVID-19 pandemic, many

health care programs and private payors implemented telehealth and telemedicine payment parity in attempt to reduce payment disparities between tele-visits and in-person visits. For example, the Centers for Medicare and Medicaid Services (CMS) in April 2020 increased Medicare telehealth payment rates, which used to be between \$14 and \$41 per visit, to \$46 to \$110 per visit.¹⁶ CMS made these increased payments retroactive to March 1, 2020.¹⁷

Some state Medicaid programs and commercial insurers also implemented telehealth payment parity or otherwise increased telehealth reimbursement rates, at least for the duration of the PHE.¹⁸ For example, the New Jersey Department of Banking and Insurance on March 22, 2020 directed carriers in the individual, small group, and large group markets to “[e]nsure that the rates of payment to in-network providers for services delivered via telemedicine or telehealth are not lower than the rates of payment established by the carrier for services delivered via traditional (*i.e.*, in-person) methods.”¹⁹ Likewise,

states had laws in place that allowed broad coverage of telemedicine services and payment parity with in-person services. In response to the pandemic and need to quickly scale and expand the reach of telemedicine, Governors, regulators and legislators in many states have taken steps to amend or modify existing telemedicine laws through Executive Orders, agency directives or legislation.”); *see generally* Y. Tony Yang, *Telehealth Parity Laws*, HEALTH AFFS. HEALTH POL’Y BRIEF (Aug. 15, 2016), https://www.healthaffairs.org/doi/10.1377/hpb20160815.244795/full/healthpolicybrief_162.pdf [<https://perma.cc/896N-QHTR>] (thoroughly discussing trends in federal, state, and private health insurance coverage of, and payment parity for, telehealth and telemedicine).

16. *See, e.g.*, Medicare and Medicaid Programs, Basic Health Program, and Exchanges, 85 Fed. Reg. 27,550, 27,616 (May 8, 2020) (“[The Interim Final Rule] increases payment rates, for the duration of the PHE for COVID–19, for telephone E/M visits to match payment rates under the PFS for office/outpatient visits with established patients.”); Press Release, Ctrs. for Medicare & Medicaid Servs., Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic (Apr. 30, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid> [<https://perma.cc/5YSF-SXLL>] [hereinafter CMS Press Release] (“CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about \$14-\$41 to about \$46-\$110. The payments are retroactive to March 1, 2020.”).

17. CMS Press Release, *supra* note 16.

18. *See* Madeline Guth & Elizabeth Hinton, *State Efforts To Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19*, KAISER FAM. FOUND. (June 22, 2020) <https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicoid-coverage-access-to-telehealth-in-response-to-covid-19/> [<https://perma.cc/7P4S-QKKR>] (“States are newly allowing certain services to be delivered via telehealth and are adjusting provider reimbursement rates . . .”).

19. Press Release, Office of the Governor, New Jersey, Governor Murphy Announces Departmental Actions to Expand Access to Telehealth and Tele-Mental Health Services in

United Healthcare announced on its website, with respect to its individual and fully insured group health plans, that the insurer would “temporarily reimburse providers for telehealth services at their contracted rate for in-person services.”²⁰ In theory, telehealth payment parity should encourage and support health care providers in the furnishing of telehealth services to all individuals, including individuals with substance use disorders.

B. Originating Sites

Historically, many public health care programs and private payors required patients to be located in rural or other health professional shortage areas and to present to particular locations within those areas, such as rural health clinics, in order for their telehealth visits to be covered. Prior to the COVID-19 pandemic, for example, Medicare required telehealth services to be furnished to a Medicare beneficiary at an “originating site,” carefully defined as a rural health clinic or other designated office or hospital but only if the approved clinic, office, or hospital was located in a health professional shortage area, in a county outside a Metropolitan Statistical Area, or another designated geographic area.²¹ During the COVID-19 pandemic, several public health care programs and private payors temporarily waived their originating site requirements. On March 6, 2020, for example, President Trump signed the CPRSAA, which included the TSDCEPA, into law.²² The TSDCEPA gave Secretary Azar the authority to waive the requirement that telehealth services be furnished to Medicare beneficiaries only at originating sites.²³ As a result, and for the duration of the PHE, Medicare beneficiaries located in all areas of the country and in all settings, including their homes, may receive Medicare reimbursed telehealth services.²⁴

Response to COVID-19 (Mar. 22, 2020) [hereinafter Governor Murphy Announcement], <https://www.nj.gov/governor/news/news/562020/20200322b.shtml> [https://perma.cc/TD26-X5S6].

20. *COVID-19 Telehealth, UNITED HEALTHCARE*, <https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html> [https://perma.cc/8TZU-BKMF] (Oct. 7, 2020, 5:00 PM).

21. 42 C.F.R. § 410.78(b)(3)–(4) (2020).

22. Coronavirus Preparedness and Response Supplemental Appropriations Act, Pub. L. No. 116–123, § 101, 134 Stat. 146, 155 (2020).

23. *Id.* at § 102.

24. *Medicare Telemedicine Health Care Provider Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> [https://perma.cc/BTP8-CC9Y] (“Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make

Many state Medicaid programs and commercial insurers have likewise waived their originating site requirements for the duration of the PHE.²⁵ For example, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, directed Medicaid managed care organizations and New Jersey Medicaid/FamilyCare to “[w]aive site of service requirements for telehealth, allowing [New Jersey] licensed clinicians (such as physicians, nurse practitioners, clinical psychologists, and licensed clinical social workers) to provide telehealth from any location and allowing individuals to receive services via telehealth from any location.”²⁶ By further example, United Healthcare recently announced that “[f]or all UnitedHealthcare Individual and fully insured Group Market health plans, any originating site . . . are temporarily waived This means that telehealth services . . . can be billed for members at home or another location.”²⁷ In theory, the waiver of originating site requirements should improve access to care for individuals with substance use disorders who are: (1) not located in a health professional shortage area or a county outside a Metropolitan Statistical Area; or (2) unable or unwilling to present to a rural health clinic or other designated office or hospital due to a lack of transportation, stigma, fear, or other reasons.

C. Communication Systems

Historically, many public health care programs and private payors required telehealth or telemedicine visits to be furnished using certain approved communication systems. For example, prior to the COVID-19 pandemic, Medicare required telehealth services to be furnished through an “interactive telecommunications system,” carefully defined by CMS 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

payment for professional services furnished to beneficiaries in all areas of the country in all settings.”); *id.* (“While [Medicare beneficiaries] must generally travel to or be located in certain types of originating sites such as a physician’s office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.”).

25. See, e.g., UNITED HEALTHCARE, *supra* note 20 (“Originating Site Expansion: For all UnitedHealthcare Individual and fully insured Group Market health plans, any originating site or audio-video requirements under UnitedHealthcare reimbursement policies are temporarily waived This means that telehealth services provided by a live interactive audio-video or audio-only communication system can be billed for members at home or another location.”).

26. Governor Murphy Announcement, *supra* note 19.

27. UNITED HEALTHCARE, *supra* note 20.

practitioner.”²⁸ CMS clarified in its original coverage regulation, however, that “[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.”²⁹ CMS is now allowing, however, certain covered telehealth services to be provided to Medicare beneficiaries through audio-only telephones for the duration of the PHE.³⁰

Many states and commercial insurers have likewise expanded their definitions of (or approved additional) eligible telecommunications systems. For example, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, directed Medicaid managed care organizations and New Jersey Medicaid/FamilyCare on March 22, 2020, to “[p]ermit use of alternative technologies for telehealth such as telephonic and video technology commonly available on smart phones and other devices.”³¹ By further example, Blue Cross Blue Shield of North Carolina announced on its website on March 26, 2020, that “[f]or providers or members who don’t have access to secure video systems, telephone (audio-only) visits can be used for the virtual visit.”³² In theory, the approval of additional telecommunication systems should improve access to health care for individuals with substance use disorders who lack access, for financial, geographic, or other reasons, to otherwise approved communications equipment.

D. In-Person Medical Evaluations

Historically, some federal and state laws have required the first visit between a provider and a patient (*i.e.*, the visit that establishes the provider-patient relationship and/or that occurs before a particular therapeutic is prescribed) to be conducted in person and to include a traditional physical

28. 42 C.F.R. § 410.78(a)(3), (b) (2020).

29. *Id.* § 410.78(a)(3).

30. *Id.* § 410.78(a)(3)(i); CTRS. FOR MEDICARE & MEDICAID SERVS., PHYSICIANS AND OTHER CLINICIANS: CMS FLEXIBILITIES TO FIGHT COVID-19 1 (2020), <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf> [<https://perma.cc/4DFY-DZVM>] (“This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.”).

31. Governor Murphy Announcement, *supra* note 19.

32. *COVID-19: Additional Details About Relief Efforts*, BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA (June 1, 2020), <https://www.bluecrossnc.com/provider-news/covid-19-additional-details-about-relief-efforts> [<https://perma.cc/8SUG-JPUN>] (“For providers or members who don’t have access to secure video systems, telephone (audio-only) visits can be used for the virtual visit. Please use both Telehealth as Place of Service and CR (catastrophe/disaster-related) modifier for audio-only visits.”).

examination. For example, the federal Controlled Substances Act (CSA) generally prohibits a controlled substance that is a prescription drug from being “delivered, distributed, or dispensed by means of the Internet without a valid prescription.”³³ The CSA defines “valid prescription” as a prescription “issued for a legitimate medical purpose in the usual course of professional practice by” either a covering practitioner or “a practitioner who has conducted at least [one] in-person medical evaluation of the patient.”³⁴ The CSA further defines “in-person medical evaluation” as “a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.”³⁵ Similarly, Arkansas law traditionally provided that a “professional relationship” must be established “to provide healthcare services through telemedicine”³⁶ and defined “professional relationship” as, “at minimum[,] a relationship established between a healthcare professional and a patient when . . . [t]he healthcare professional has previously conducted an in-person examination.”³⁷ Arkansas specifically excluded from the definition of “professional relationship” relationships established only by internet questionnaires, email messages, patient-generated medical histories, audio-only communications, text messaging, and facsimile machines.³⁸

Because in-person visits can spread SARS-CoV-2, some in-person medical evaluation requirements have been waived by certain federal and state agencies for the duration of the PHE. For example, the Drug Enforcement Administration (DEA) is allowing DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients³⁹ and is permitting practitioners to prescribe buprenorphine to new patients with opioid use disorder for maintenance or detoxification treatment via telephone without requiring such practitioners to first conduct

33. 21 U.S.C. § 829(e)(1).

34. *Id.* § 829(e)(2)(A)(i).

35. *Id.* § 829(e)(2)(B)(i).

36. ARK. CODE ANN. § 17-80-404(a)(1) (2020).

37. *Id.* § 17-80-402(4)(a).

38. *Id.* § 17-80-403(c).

39. DIVERSION CONTROL DIV., DRUG ENF’T ADMIN., HOW TO PRESCRIBE CONTROLLED SUBSTANCES TO PATIENTS DURING THE COVID-19 PUBLIC HEALTH EMERGENCY [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-023\)\(DEA075\)Decision_Tree_\(Final\)_33120_2007.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf) [<https://perma.cc/C9BM-VV5T>]; Letter from Thomas W. Prevoznik, Deputy Assistant Admin’r of Diversion Control Div., Drug Enforcement Admin., to DEA Qualifying Practitioners & Other Practitioners (Mar. 31, 2020) [hereinafter DEA Letter], [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20\(Final\)%20+Esign.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf) [<https://perma.cc/5VMW-LQRM>] (“DEA has already announced that practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation during this public health emergency . . .”).

an in-person medical evaluation if the evaluating practitioner determines that an adequate evaluation of the patient can be accomplished via telephone.⁴⁰ Similarly, HHS announced a policy of enforcement discretion for Medicare telehealth services pursuant to which “HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.”⁴¹ HHS reasons that “[i]t is imperative during this public health emergency that patients avoid travel, when possible, to physicians’ offices, clinics, hospitals, or other health care facilities where they could risk their own or others’ exposure to further illness.”⁴²

In theory, the waiver of in-person medical evaluations could improve access to health care for individuals with substance use disorders who lack transportation to otherwise required in-person medical evaluations and/or who are unwilling or reluctant to present to in-person medical evaluations. However, in-person medical evaluations have not been waived in all contexts. For example, practitioners are permitted to prescribe buprenorphine to new patients with opioid use disorder (OUD) via telephone during the PHE but practitioners are not permitted to prescribe methadone to new patients with OUD via telephone during the PHE.⁴³ By further example, waivers of in-person medical evaluations do not include waivers of urine drug screens which, by definition, cannot be completed virtually.⁴⁴

E. Telehealth Services and Telehealth Providers

Historically, the number and types of health care services eligible to be provided through telehealth were limited by federal and state law as well as by individual and group policy. However, a number of public health care programs and private payors have significantly expanded the number and types of health care services that can be furnished through telehealth as a result of COVID-19. For example, and effective March 1, 2020, CMS significantly expanded the list of services payable under the Medicare

40. DEA Letter, *supra* note 39, at 1.

41. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 24; *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., COVID-19 FREQUENTLY ASKED QUESTIONS (FAQS) ON MEDICARE FEE-FOR-SERVICE (FFS) BILLING 85 (2020), <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf> [<https://perma.cc/W9FV-43UF>].

42. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 24.

43. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency* (Apr. 21, 2020), <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf> [<https://perma.cc/E9VN-7Q5H>].

44. Providers Clinical Support Sys., *Frequently Asked Questions (and Answers!): Treating Opioid Use Disorder via Telehealth Tips for Primary Care Providers 1–2* (2020).

Physician Fee Schedule when furnished via telehealth.⁴⁵ Illustrative examples of services now payable by Medicare when furnished via telehealth include certain emergency department visits, certain evaluation and management visits, and group psychotherapy.⁴⁶ By further example, the Oklahoma Health Care Authority announced on March 16, 2020, that it would allow expanded use of telehealth for any “services that can be safely provided via secure telehealth communication devices for all SoonerCare [Oklahoma Medicaid] members.”⁴⁷

Traditionally, the number and types of health care providers permitted to furnish health care services through telehealth were also limited by federal and state law as well as individual and group policy.⁴⁸ However, a number of public health care programs and private payors have waived their provider limitations, now allowing a broader range of providers to furnish telehealth care. Medicare, for example, now allows physical therapists, occupational therapists, and speech language pathologists to use telehealth to provide many Medicare services.⁴⁹ Blue Cross Blue Shield of Illinois (BCBSI) also expanded its group of approved telehealth-furnishing providers.⁵⁰ The newly expanded BCBSI group now includes “physicians, physician assistants, optometrists, advanced practice registered nurses, and clinical psychologists licensed in Illinois, prescribing psychologists licensed in Illinois, dentists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, and mental health professionals and clinicians authorized by Illinois law to provide mental health services.”⁵¹ In theory, the expansion of telehealth services and telehealth providers could benefit individuals with substance use disorders who desire access to the expanded tele-services (*e.g.*, group psychotherapy, buprenorphine) and/or the expanded tele-providers

45. *List of Telehealth Services*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes> [https://perma.cc/4DVM-HSRG] (Oct. 14, 2020).

46. *Id.*

47. *Expanded Use of Telehealth and Telephonic Services During COVID-19 National/State Emergency for COVID-19*, OKLA. HEALTH CARE AUTH., <https://www.okhca.org/providers.aspx?id=24604> [https://perma.cc/8EK2-JEYB].

48. *See generally* Nicol Turner Lee, Jack Karsten & Jordan Roberts, *Removing Regulatory Barriers to Telehealth Before and After COVID-19*, BROOKINGS (May 6, 2020), <https://www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/> [https://perma.cc/B3RW-5KN5].

49. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 30, at 1–2.

50. BLUE CROSS BLUE SHIELD OF ILL., COVID-19 PREPAREDNESS ANSWERS TO FREQUENTLY ASKED QUESTIONS (FAQS) FROM PROVIDERS 1 (2020), https://www.bcbsil.com/pdf/education/covid19_provider_faq.pdf [https://perma.cc/6UYP-FSGR].

51. *Id.* at 6.

(e.g., clinical psychologists, prescribing psychologists, clinical social workers, and mental health professionals).

F. In-State Licensure

Historically, a number of federal and state laws as well as public health care programs and private payors required telehealth providers to obtain and maintain licensure in states where patients receiving telehealth services from the provider reside. This requirement has been removed in several contexts so long as the provider is currently and actively licensed in some jurisdiction, even if that jurisdiction is not the same jurisdiction where the patient resides. For example, CMS waived the requirement that a provider be licensed in states where patients receiving telehealth services from the provider reside.⁵² However, this federal waiver applies to Medicare reimbursement rules, not to state licensure laws.⁵³

That said, many states have waived licensure laws that restrict out-of-state telehealth providers from providing services to state residents. For example, New Jersey Assembly Bill 3860, signed into law by Governor Phil Murphy on March 19, 2020, provides that

[a] health care practitioner who is not licensed . . . [to provide health care services by the State of New Jersey] may provide telemedicine and telehealth services . . . provided that . . . the health care practitioner is validly licensed or certified to provide health care services in another state or territory of the United States or in the District of Columbia, and is in good standing in the jurisdiction that issued the license or certification.⁵⁴

Assembly Bill 3862, a companion bill also signed into law by Governor Murphy on March 19, 2020, further provides that during a Governor-declared state of emergency or public health emergency, professional licensing boards may grant a license on an expedited basis to any individual who holds a corresponding license in good standing in another state.⁵⁵ In theory, the waiver of in-state licensure requirements could incentivize providers to

52. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 30, at 7 (“*Practitioner Locations*: Temporarily waive Medicare and Medicaid’s requirements that physicians and non-physician practitioners be licensed in the state where they are providing services. State requirements will still apply.”).

53. *Id.*

54. An Act Concerning the Use of Telemedicine and Telehealth to Respond to the Coronavirus Disease 2019, 2020 N.J. Laws A3860.

55. An Act Concerning Professional and Occupational Licenses, 2020 N.J. Laws A3862.

provide telehealth care to patients located in other states and could improve access to care for such patients located in such other states.

G. Privacy and Security

Finally, several federal and state agencies have issued notices of enforcement discretion and/or regulatory clarifications regarding the application of patient privacy and data security rules during the PHE. For example, the OCR announced on March 17, 2020 that it would exercise enforcement discretion regarding the HIPAA Rules in the context of the good faith provision of non-public facing telehealth.⁵⁶ OCR clarified that its nonenforcement policy applies to violations of the HIPAA Privacy, Security, and Breach Notification Rules that may be made by HIPAA covered entities during the good faith provision of non-public facing telehealth, such as telehealth conducted using Skype, Zoom, FaceTime, FaceBook Messenger, and Google Hangouts.⁵⁷ OCR's nonenforcement policy does not apply, however, to situations involving bad faith (*e.g.*, violations of state licensing laws, violations of professional ethical standards that result in documented disciplinary actions, and the use of public-facing (versus non-public facing) remote communication products, such as Facebook Live, Twitch, and TikTok).⁵⁸ By further example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized that federally assisted alcohol and drug use treatment providers may not be able to obtain prior written consent from patients to use or disclose substance use disorder treatment records while providing telehealth to such patients.⁵⁹ To this end, SAMHSA has reminded these providers that they can disclose substance use disorder treatment records to medical personnel without patient consent in a bona fide medical emergency if that disclosure is documented.⁶⁰

56. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, 45 C.F.R. § 160, 164 (2020), <https://www.govinfo.gov/content/pkg/FR-2020-04-21/pdf/2020-08416.pdf> [<https://perma.cc/G3WQ-634X>].

57. *Id.*

58. *Id.*

59. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., COVID-19 PUBLIC HEALTH EMERGENCY RESPONSE AND 42 CFR PART 2 GUIDANCE, <https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf> [<https://perma.cc/4J4W-DLWX>].

60. *Id.*

III. CONCLUSION

One question that has been raised during the COVID-19 pandemic is the extent to which telehealth and telemedicine have improved access to mental health care and decreased exposure to SARS-CoV-2 for individuals with substance use disorder.⁶¹ In theory, increased telehealth reimbursement, expanded telehealth services, expanded classes of telehealth providers, loosened licensure requirements, and privacy and security nonenforcement policies and regulatory clarifications should encourage and support health care providers in the furnishing of telehealth to individuals with substance use disorders. Also in theory, waivers of originating site, telecommunication system, and in-person medical evaluation requirements should encourage and support individuals with substance use disorders in terms of their receipt of telehealth. Still further in theory, the use of telehealth versus in-person care should reduce the spread of SARS-CoV-2 among or by individuals with substance use disorders.

To date, however, insufficient data are available to fully assess the extent to which access to care for individuals with substance use disorders has improved as a result of the federal, state, and private waivers and flexibilities discussed above. Recent data provided by CMS does show that the number of telehealth visits for all CMS beneficiaries (*i.e.*, those with substance use disorders and those without) increased from approximately 14,000 pre-PHE to almost 1.7 million in the last week of April 2020.⁶² In addition, an HHS report shows that 43.5% of Medicare fee-for-service primary care visits were provided through telehealth in April 2020 (after the PHE was declared) compared to 0.1% in February 2020 (before the PHE was declared).⁶³ Telehealth use increased more among dual-eligible (Medicare and Medicaid) beneficiaries.⁶⁴ Although mental health services remained one of the most frequently used telehealth services, the most commonly used telehealth service post-PHE was the traditional evaluation and management (E/M) visit.⁶⁵ Although interesting and important, the currently available data are insufficiently specific to individuals with substance use disorders to support claims of improved access to care, improved health care or, more broadly, improved health.

The COVID-19 pandemic has witnessed a rapid and unprecedented deregulation of telehealth. The extent to which a termination of the PHE will

61. See AM. PSYCH. ASS'N, *supra* note 9, at 5–7 (listing illustrative substance use disorders).

62. Trump Executive Order, *supra* note 8, at 47881.

63. *Id.*

64. *Id.*

65. *Id.*

return telehealth to its former, heavily regulated state remains to be seen.⁶⁶ The collection and analysis of data relevant to the furnishing of telehealth to individuals with substance use disorders during the PHE and the health outcomes of such individuals would inform debates about the desirability of permanent, versus temporary, telehealth de-regulation.

66. *See generally* Farringer, *supra* note 10 (manuscript at 42–56) (providing a nuanced discussion of whether the de-regulation of telehealth should survive COVID-19).