The push to keep pandemic-era addiction policies

As drug overdoses climb, experts are hoping to maintain substance abuse treatment flexibilities enacted during the COVID-19 health emergency.
With overdose deaths in the U.S. soaring, health experts want to see treatment flexibilities enacted during COVID-19 stick around.

The COVID-19 pandemic ushered in new ways of treating patients with opioid use disorders, including starting patients on certain treatments through telemedicine and allowing patients to take home medications that traditionally had to be given at a clinic.
But these flexibilities are temporary, tied to the duration of the pandemic. After the Centers for Disease Control and Prevention released preliminary data showing that more than 100,000 people died from overdoses between April 2020 and 2021, medical experts and advocates said they want the policies to outlast the COVID-19 emergency.

“One of the good things that’s come out of [the pandemic] is just the added flexibility around telemedicine...The ability to use telemedicine to manage this patient population in a way that doesn’t have them have to leave their family, leave their work, leave their life essentially,” said Dr. Bobby Mukkamala, chair of the American Medical Association’s Substance Use and Pain Care Task Force.

“The added flexibility that this has allowed, using telemedicine and even sometimes audio-only telemedicine, is something that we would love to see stick around long after the public health emergency is over,” he added.

These COVID-19-related policies allow opioid-treatment programs to start patients on buprenorphine, which is used to treat people with opioid-use disorders, through telemedicine. This flexibility is slated to last as long as the national emergency does and it does not apply to patients using another treatment, methadone.

But the Substance Abuse and Mental Health Services Administration provided some flexibility for methadone during the pandemic as well. Patients taking methadone, who would typically have to receive their doses from a clinic, are allowed to take a 28-day supply home. Opioid-treatment programs are also able to use telehealth to continue care. SAMHSA announced last week it would extend the take-home flexibility for a year after the public-health emergency ended.
The agency says it’s looking at options to make this a permanent practice. “SAMHSA in particular being able to demonstrate that they realize the extension of this flexibility, especially at a time when numbers like we just saw come out and people losing their lives to overdose, is vitally important towards changing the trajectory for the future,” said Reyna Taylor, vice president of public policy and advocacy at the National Council for Mental Wellbeing.

But the COVID-19-era policies need to be balanced with in-person medical visits, said Shawn Ryan, chair of the American Society of Addiction Medicine’s Legislative Advocacy Committee.

“What’s important, of course, is that we land somewhere in the middle of the road with telehealth,” he said. “It cannot go back to where it was. In fact, it should probably have never been as restrictive as it was, but also we don’t want to end up in a situation where there’s a telephonic only visit, with no oversight, no physical interaction, no testing of any sort.”

Ryan also said reimbursement needs to be high enough for practitioners, including through federal programs like Medicaid and Medicare, in order to spur take up of new ways to deliver substance-abuse care. “These reimbursement rates are a linchpin in the improvement of quality and quantity, both, of access to address this crisis...Rules and reimbursement. It has to be both,” he said.

The group highlighted several elements of the Build Back Better Act that could help improve access to addiction treatments, including a little-noticed provision that would penalize health insurers if they don’t follow mental health parity requirements. Federal law prohibits health insurance plans from placing treatment limitations and financial requirements that are more restrictive on mental health services.
Michael Kemp, cochair of the Public Policy Committee for NAADAC, the Association for Addiction Professionals, said the mental-health-parity law hasn’t been consistently enforced. “One of the things that we’ve been really working on is trying to put some teeth into the parity law, some enforcement,” he said, adding that the Build Back Better Act provision would achieve that goal.

But a handful of groups, including America’s Health Insurance Plans, urged Congress to drop the proposal in a letter last week to Senate and House leaders. “If Congress decides to move forward with the current proposed language in the Build Back Better Act, we urge you to amend the language to ensure adequate due process and ensure robust compliance assistance and opportunities to rectify identified issues before fines are imposed,” they wrote.

Advocates also said that the federal government has to ensure harm-reduction measures, like the overdose-reversal drug naloxone and fentanyl test strips, are readily available.

Shannon Mace, senior adviser for the National Council for Mental Wellbeing, praised the decision by U.S. agencies in the spring to allow federal funding to be used to purchase fentanyl test strips. But she added more action is needed to reduce barriers to access other resources, including needle exchange programs.

“The federal government has a huge role here in working with state governments as well,” she said. “We see really egregious disparities in terms of access to harm-reduction services at the state and county level, but I think we also need to really address in terms of where syringe-service programs are available and where they’re not.”

The White House’s Office of National Drug Control Policy last week unveiled model legislation for state
governments to encourage the take up of naloxone by expanding access to the opioid antagonist, providing immunity to individuals who administer the drug, and requiring health insurance coverage of the treatment.

But the Remedy Alliance/For the People, which operates a buyers club of harm-reduction programs that distribute naloxone to people who use drugs, said the model legislation from the administration is not enough.

“We’ve tried this state-level work around before, and it’s gotten us far, but we’ve already taken it as far as this can take us,” said Remedy Alliance Co-Director Maya Doe-Simkins. “So if we really want to amplify and ramp up, the next step is a federal response, not a federal response punting it back to states.”

The Remedy Alliance is calling on the Food and Drug Administration to reclassify generic naloxone as an over-the-counter drug or otherwise exempt the treatment from prescription drug requirements for harm reduction programs, saying that the requirements can make obtaining and distributing the drug difficult. Additionally, the alliance wants federal funding to be directed to groups like those in the buyers club. Remedy Alliance says less than half of the programs in their buyers club—which provide syringes, harm-reduction services, and naloxone—receive federal funding.