



Foundation *for* Opioid Response Efforts

'COVID-19 National Emergency Response' Webinar Series

Federal and State Policy Lever to Maintain Access to MOUD

During the COVID-19 Pandemic

March 26, 2020

Webinar Questions and Answers

Disclaimer: We have asked our webinar panelists to address questions from the webinar and are providing responses below, to the best of our current knowledge, given the rapidly evolving circumstances. These answers are informational in nature and are not intended as legal or medical advice.

1. Can Medicaid be expanded in a non-expansion state under these emergency waivers?

The [1135 waivers](#) allowable under a declared disaster or public health emergency are not a mechanism for eligibility expansion, as they only apply to certain Medicaid language sections that may need to be waived to address the needs of states for the duration of the emergency. This does not include categorical eligibility, and the waivers expire once the emergency has ended, though they can be extended 60 days thereafter if necessary. They are not, therefore, an avenue for expansion.

2. What is the difference between MOUD and MAT? Is MOUD the preferred term? Is it evidence-based like MAT?

MOUD refers to Medications for Opioid Use Disorder – the medications themselves, whereas Medically Assisted Treatment is a treatment delivery format that includes those medications. MAT implies that medications are a less important/assistive modality, when in fact we know that MOUD is the treatment that best prevents mortality. The policy and clinical vernacular are shifting to MOUD in acknowledgement of the medical component being a distinct modality.

3. I'm a 67-year-old Peer Specialist. Should I get out there and meet with clients at the residential campus? Rides in my car?

While we can't give folks direction on their individual practice, everyone should be assessing their risk based on their personal risk factors. Most states have developed mechanisms for which you can meet with clients via telehealth practices.

4. Do you know of great state guidance for harm reduction providers? Their protection, payment, and inclusion in broader policy conversations?

Formal state guidance specific to harm reduction providers has been difficult to come by, though the Harm Reduction Coalition released very comprehensive guidance to both [providers](#) and [clients](#), as well as guidance that can be distributed to people who are using drugs.

5. I think it's interesting that you stated that the SAMHSA guideline that new patients should be seen in person would be determinative over the DEA's suspension of that rule. Can you talk more about that? Many, including my company, have already moved forward in seeing new patients via telehealth for inductions.

Since the webinar, SAMHSA and DEA have released unified [guidance](#) that aligns on the fact that telephone inductions are permissible without audio-visual connection.

6. For states that are making telehealth changes, are the changes written such that these the relaxed rules are only allowable during this current public health emergency?

Yes. They are being written as policy changes under the authority of various emergency declarations, which means that they technically expire when those declarations end.

7. Any best place to go to see if a state has requested the blanket exception allowed by the updated SAMHSA guidance? ASAM has something on state [guidance](#), but a lot is on Medicaid or other issues and I haven't been able to easily ascertain whether a state has requested the blanket exception allowed by the SAMHSA guidance? Or is it matter of going to individual State Opioid Treatment Authorities (SOTAs)?

As of now, because guidance is still being released and even amended every day, it's best to go to your individual SOTA.

8. Can you discuss any new opportunities in telehealth and jail-based MAT if you have a chance?

We held a webinar on April 2nd, 2020 titled "Correctional Facilities and MOUD During the COVID-19 Pandemic," which contains a wealth of information on this issue. You can view a [recording](#) of the webinar and [slides](#) on our website.

9. Can you discuss how MAT programs can enhance their work with harm reduction programs to expand MAT access to people who use drugs?

We are not clear on whether this is specific to COVID policy, but the colocation and coordination of harm reduction and MAT programs is certainly ideal. From a reimbursement

and payment perspective, these are funded very differently, with very little Medicaid reimbursement for harm reduction services (NY state Medicaid does reimburse for some). Emergency declarations and policy shifts have not addressed harm reduction.

Some possible ways to harmonize MAT and harm reduction include: location of clinicians who can initiate buprenorphine at needle exchanges in an embedded clinic; distributing safer consumption kits from MAT programs (OTPs or clinic); and prescription of both naloxone and syringes from MAT programs.

10. Lock boxes seem essential for safety of others in home, especially children. How are those provided?

We agree that they are an essential tool for keeping medications safe in the home. Provision of those varies program to program; most programs will provide them to clients and have them on hand for take home doses.

11. Have states or insurers made changes to allow reimbursement for saliva tests (instead of urine tests) that are FDA-permitted but not CLIA-approved, and which can be used via video observation? These are not always reimbursed but could be a safer way to test.

We have not seen any indications of states shifting to reimburse for saliva tests. Lab testing for induction and continuing care has been virtually eliminated, either through non-enforcement of penalties or direct waiving of the requirement.